

**EMERGING INSURANCE BAD FAITH THEORIES AND DEFENSES**

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## **I. INTRODUCTION**

This article addresses three issues of current interest involving emerging insurance bad faith theories and defenses, as follows: (1) refinement of the definitions and standards for finding insurance bad faith conduct; (2) limitation of the use of the genuine dispute rule as a defense to insurance bad faith claims; and (3) expansion of insurer liability for excess judgments on covered claims in the absence of a settlement demand within the policy limits when coverage and a defense are denied.<sup>1</sup>

## **II. REFINEMENT OF THE DEFINITIONS AND STANDARDS FOR FINDING INSURANCE BAD FAITH CONDUCT**

The tort of insurance bad faith grew out of judicial recognition that contract remedies were inadequate to address abuses by insurers of their insureds. The first published case holding an insurance company liable for bad faith appears to be Brassil v. Maryland Casualty Co. 210 N.Y. 235, 104 N.E. 622 (1914). The case involved an insurer who exerted control over litigation against its insured that resulted in a judgment against the insured in excess of the policy limits, whereupon the insurer refused to appeal and also refused to pay the

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<sup>1</sup> The conference presentation will include additional comments on the availability of the bad faith remedy in employers' claims against workers compensation insurers for mishandling of, or overpayment of, workers compensation claims adversely affecting premium obligations, and post-claim underwriting and rescission issues in the life, health and disability insurance areas.

judgment. In an apparent case of first impression in the United States, the New York Court of Appeals held, as follows:

Without attempting to further characterize the defendant's position, it is enough to say that it would be a reproach to the law if there were no remedy for so obvious a wrong as was inflicted upon this plaintiff. His rights, as we have said, go deeper than the mere surface of the contract written for him by the defendant. Its stipulations imposed obligations based upon those principles of fair dealing which enter into every contract. Even the defendant has invoked this implied obligation of good faith and fair dealing not expressed in the terms of its written contract, for by its answer it has set forth that it was incumbent upon the plaintiff to "deal fairly and in good faith...and that he should not voluntarily or knowingly do any acts which would impose or tend to impose on him or on this defendant a loss in the premises." If this was the plaintiff's duty, it was not less the correlative obligation of the defendant to "deal fairly and in good faith" with him. 210 N.Y. at 242, 104 N.E. at 624.

The origins and rational basis for imposition of tort liability on insurance companies has been well recognized not only by courts, but by commentators. DiMugno and Glad, observe in their book, *California Insurance Law Handbook*, as follows:

Recognizing the inadequacy of contract remedies, courts began to treat insurers' unfair claims practices as a tort. Initially, the courts relied on traditional tort theories (citing cases between 1924 and 1931 from New Hampshire, Texas and South Carolina). Many (of) these traditional tort theories remain viable.... In the late 1950's, however, courts started to shift the theoretical justification for imposing tort liability on insurers away from traditional theories to the implied covenant of good faith and fair dealing present in all contracts. While a cause of action for breach of the covenant in most contracts still lies solely in contract, courts have permitted tort remedies for breach of the covenant under contracts involving a "special relationship," characterized by elements of public interest, adhesion, and fiduciary responsibility. The classic example of this type of contract is, of course, the insurance contract. (citing numerous California cases). DiMugno and Glad, *California Insurance Law Handbook*, Chapter 11, §11.1, page 225-226 Thomsen/West 2007.

The first opinion in California to find that an insurer could be held liable in tort for insurance bad faith was issued by the United States District Court for the Northern District of California. In that case, an insurance company argued that it should not be held liable in tort based on ordinary negligence, but rather based on the comparatively higher standard of bad faith. In *Christian v. Preferred Acc. Ins. Co.* 89 F.Supp. 888 (N.D.Cal. 1950), the plaintiff had sued the insurance company in an excess judgment setting for negligence and for bad faith. The court held that the proper theory for tort liability should be bad faith, and not ordinary negligence, thereby adopting the position argued by the defendant insurance company. The court indicated as follows:

Defendants on the other hand contend that the criteria is whether or not there was a showing of bad faith on the part of the insurance company in the failing to compromise before a cause of action would arise making an insurance company liable for an excess over the policy limit for which the insured is liable to the injured party recovering the judgment. *Royal Transit v. Central Surety and Ins. Corp.* 7 Cir. 168 F.2d 345, is an example of the cases relied upon by the defendants to support their contention. 89 F.Supp.at 889.

The *Christian* court observed that the decisional law in the various jurisdictions that had addressed the issue at the time were not uniform. Some jurisdictions were holding insurance companies liable in tort under a negligence theory and some jurisdictions were holding insurance companies liable in tort under bad faith. Still other jurisdictions, the court noted, used the terminology interchangeable, such as holdings from the Fourth Circuit and the States of Washington, New York and Kentucky. In support of the defendant insurer's position that the proper standard should be tortious bad faith, the district court noted that in

addition to the 7th Circuit the bad faith remedy had been held to be the proper one previously in the 6th and 10th Circuits.

The *Christian* court also noted that under standard procedural law applicable to diversity cases, California state court decisions would be controlling. However, there was no California appellate court decision at the time, although there had been a prior San Francisco Superior Court ruling to that effect. The *Christian* court further noted the standard procedural rule that in the absence of any expression of a common law rule by the Supreme Court of California, the final authority on state law, it was “the duty of the federal court to follow the decisions of intermediate state courts unless convinced that the supreme court would rule otherwise.” 89 F.Supp. at 890.<sup>2</sup>

The next published case in California upholding the right to sue in tort for insurance bad faith was *Brown v. Guarantee Ins. Co.* (1957) 155 Cal.App.2d 679, which also involved an excess judgment situation. The *Brown* case cited with approval language from a Mississippi case, as follows:

In resolving problems such as the one before us, any one of several approaches to the issues may present itself. The solution may be sought in the terms of the policy itself, and the court may attempt to resort to contract law. Or the insurer may be viewed as a fiduciary, possibly as an agent, and thereupon the court will employ the principles of law which govern an agent’s relationship to his principal. In such situations the law generally demands good faith. Or the courts may turn to tort law and hold that the insurer in dealing with the defense, including the matter of settlements, must exercise due care. 155 Cal.App.2d at 683.

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<sup>2</sup> See also Federal Rules of Evidence, Rule 501.

The *Brown* court, noting that no other California appellate court had yet passed on the question before it, and further noting that the *Christian* case “has held such action exists in California and is based upon bad faith rather than negligence,” the court adopted the position that tort liability was based on bad faith, as had been urged by the insurance company defendant in *Christian*. 153 Cal.App.2d at 683-684. In so holding, the *Brown* court also drew from prior cases from Wisconsin, Tennessee, New York, Kentucky, and from the federal courts.

The next California case on the subject, *Ivy v. Pacific Automobile Ins. Co.* (1958) 156 Cal.App.2d 652, acknowledged that the insurance company’s attorney owed allegiance to two clients and had a “high duty of care to both clients,” the insurer and the insured. 156 Cal.App.2d at 659. The *Ivy* court noted that there was a conflict among jurisdictions “as to whether liability in such cases is predicated on negligence or upon bad faith.” *Ibid*. The court noted that “California has recently aligned itself with the jurisdictions that apply the bad faith test,” citing *Brown v. Guarantee Ins. Co. supra*, referring to it as a “well reasoned opinion.” *Ibid*.

Following *Ivy*, the California Supreme Court issued its opinion in *Comunale v. Traders & General Ins. Co.*, (1958) 50 Cal.2d 654, 328 P.2d 198. The *Comunale* court noted that one question presented to it on appeal from the judgment in the case was, as follows: “Did Sloan have a cause of action against Traders for the amount of the judgment in excess of the policy limits?” 50 Cal.2d at 657. Citing with approval both *Brown v. Guarantee Ins.*

*Co., supra*, and *Ivy v. Pacific Automobile Ins. Co. supra*, the court held that an insurer that did not protect its insured while exercising control over the litigation was “guilty of bad faith in refusing a settlement.” *Ibid.*

The tort of insurance bad faith was being adopted by courts all over the country, not just in California, and the courts were simultaneously establishing the tort’s elements and parameters. The *Crisci* court referred to the determination of whether an insurer had given consideration to the interests of its insured as involving the application of a test of whether a “prudent insurer” would have acted in such a way. 66 Cal.2d at 429. Likewise, the *Crisci* court indicated that “liability is imposed not for a bad faith breach of the contract, but for failure to meet the duty to accept reasonable settlements, a duty included within the implied covenant of good faith and fair dealing.” 66 Cal.2d at 430.

In *Gruenberg v. Aetna Ins. Co.* (1973) 9 Cal.3d 566, the California Supreme Court dealt with a first party insurer-insured relationship. It reviewed the prior third party bad faith cases discussed above, and noted that “...in *Comunale* and *Crisci*, we made it clear that ‘(liability) is imposed (on the insurer) not for bad faith breach of the contract, but for failure to meet the duty to accept reasonable settlements, a duty included within the implied covenant of good faith and fair dealing.’” 9 Cal.3d at 573. Breach of that duty, the court observed, gave rise to a cause of action in tort for breach of the implied covenant of good faith and fair dealing. 9 Cal.3d at 574. The court commented, as follows:

It is manifest that a common legal principle underlies all of the foregoing decisions; namely, that in every insurance contract there is an implied covenant of good faith and fair dealing. The duty to so act is immanent in the

contract whether the company is attending to the claims of third persons against the insured or the claims of the insured itself. Accordingly, when the insurer unreasonably and in bad faith withholds payment of the claim of its insured, it is subject to liability in tort. 9 Cal.3d at 577.

In *Frommoethelydo v. Fire Ins. Exchange* (1986) 42 Cal.3d at 208, the California Supreme Court observed that “an insurer holds itself out as a fiduciary,” and that “with the public trust must go private responsibility consonant with the trust, including qualities of decency and humanity inherent in the responsibilities of a fiduciary.” 42 Cal.3d at 215.

Typically, insurers offer jury instructions that are based on cases that state that insurers cannot be held liable in bad faith for merely breaching the contract or for merely being mistaken or negligent, such as the following:

On the tort liability issue, even accepting the failure to defend as having been a breach of contract, an insurer’s responsibility to act fairly and in good faith in handling an insured’s claim “is not the requirement mandated by the terms of the policy itself--to defend, settle, or pay. It is the obligation under which the insurer must act fairly and in good faith in discharging its contractual responsibilities. The elements of the tort cannot be defined by the terms of the policy; for there to be a breach of the implied covenant, the failure to bestow benefits must have been under circumstances or for reasons which the law defines as tortious. The mere denial of benefits does not demonstrate bad faith. *California Shoppers, Inc. v. Royal Globe Ins. Co.* (1985) 175 Cal.App.3d 1, 14.

As for mistake itself, bad faith implies unfair dealing rather than mistaken judgment. *Id.* at 55.

Bad faith implies unfair dealing rather than mistaken judgment or poor prognostication. Good or bad faith is a question of fact in each case. *Critz v. Farmers Ins. Group* (1964) 230 Cal.App.2d 788, 796, disapproved on other grounds in *Crisci v. Security Ins. Co.* (1967) 66 Cal.2d 425.

The precise nature and extent of the duty imposed by the implied covenant of good

faith and fair dealing will depend on the contractual purposes. Negligent behavior alone does not constitute a violation of the covenant of good faith and fair dealing. *National Life & Accident Ins. Co. v. Edwards* (1981) 119 Cal.App.3d 326.

Jurisdictions that use the term “no reasonable basis” in conjunction with bad faith causes of action are among those minority jurisdictions in which the bad faith cause of action has evolved, and is viewed, as an intentional tort. See e.g., *Anderson v. Continental Ins. Co.*, 86 Wisc. 2d 675, 692, 271 N.W. 2d 368 (1978). California is not such a jurisdiction, and the fact that an insurer may act reasonably in one aspect of claim handling does not necessarily relieve the insurer of bad faith liability; the totality of the circumstances must be considered and evaluated. See *Jordan v. Allstate Insurance Company* (2007) 148 Cal.App.4th 1062, 56 Cal.Rptr.3d 312 (insurer’s reasonable, though erroneous, interpretation of policy exclusion did not excuse its failure to investigate other possible bases for insured’s claim). The key bad faith standard of unreasonableness under California law, like that of the majority of jurisdictions, includes some element of consciousness or deliberateness of action or omission, but not the intent to harm.

Some foreign jurisdiction courts have taken the position that imposition of bad faith in third party cases requires something more than negligence. See *Wasserman v. Buckeye Union Casualty Company*, 29 N.E.2d 837 (1972). One court has defined third party bad faith as the insurer’s intentional disregard for the financial interest of its insured to escape the full responsibility imposed by the policy. *McCombs v. Fidelity Casualty Company*, 89 S.W.2d 114 (Mo. 1935). Other courts have included insincerity, dishonesty, disloyalty, duplicity,

deceitful conduct or an extraordinary showing of dishonest failure to carry out a contract within the definition of third party bad faith. See *Webber v. Biddle*, 43 P.2d 55 (Wa. 1971).

On the other hand, one court has held that the mere failure to consider the possibility of an excess judgment may be bad faith on the part of the insurer. *Goings v. Aetna Casualty and Surety Co.*, 491 S.W.2d 847 (Tenn. 1972).

Any unreasonable conduct by the claims department of an insurance company that amounts to a delay or rejection of otherwise payable insurance proceeds may constitute bad faith conduct. See, for example, the insurance bad faith statutory provisions in Pennsylvania and Washington. The question of whether the conduct is unreasonable becomes the focus of the investigation. The majority of jurisdictions allow a liberalized standard of reasonableness which essentially equates to whether the claim should be payable and whether the investigation was even-handed and fairly conducted. It could also translate to whether or not the facts, once investigated, were fairly and even handedly applied to the policy or extrinsic law where a conclusion of coverage should have been made, but was not. Different jurisdictions define it differently.

In California, bad faith is frequently defined as the unreasonable denial of a benefit or withholding of a claim payment. In other jurisdictions, it could be construed as the insurer's intentional or reckless disregard of its responsibility to its policyholder. While usually the "state of mind" of the insurance company is not important to assess insurance bad faith conduct, it depends on the jurisdiction. In California, under Civil Code section 3294, intentional misconduct or conscious and willful disregard of the rights of the insured

constitute a basis upon which to award punitive and exemplary damages, which requires a higher showing than bad faith. This further demonstrates that intentional or willful misconduct is not a requisite for finding bad faith in the first instance.

The standard for determining whether bad faith has occurred has been succinctly stated as follows:

The ultimate test of bad faith liability in the first party case is whether the refusal to pay policy benefits was unreasonable. In other words, before an insurer can be found to have acted tortiously, i.e., in bad faith, in refusing to bestow policy benefits, it must have done so without proper cause. *Opsal v. United Services Auto Association* (1991) 231 Cal.App.3d 1530. (involving a homeowner's insurance - earth movement case)

In *Wilson v. 21<sup>st</sup> Century Insurance Co.*, 42 Cal.4th 713, 68 Cal.Rptr.3d 746 (2007), which significantly limits the genuine dispute rule as a defense for insurers, the California Supreme Court also restated the appropriate standard for determining insurance bad faith liability. The court reiterated the legal standard for determining breach of the implied covenant of good faith and fair dealing, as follows:

The implied promise requires each contracting party to refrain from doing anything to injure the right of the other to receive the agreement's benefits. To fulfill its implied obligation, an insurer must give at least as much consideration to the interests of the insured as it gives to its own interests. When the insurer unreasonably and in bad faith withholds payment of the claim of its insured, it is subject to liability and tort. 42 Cal.4th at 720, citing *Frommoethelydo v. Fire Ins. Exchange* (1986) 42 Cal.3d 208, 214-215, 228 Cal.Rptr. 160.

Thus, the Supreme Court reaffirmed that the essence of insurance bad faith, in the context of withholding payment of a claim, is unreasonableness. The court noted that "the critical issue being the reasonableness of the insurer's conduct under the facts of the particular case, stating a general rule as to how much or what type of investigation is needed

to meet the insurer's obligations under the implied covenant is difficult. An insurer's good or bad faith must be evaluated in light of the totality of the circumstances surrounding its actions." *Id.* at 723. In fulfilling its obligations, an insurer cannot deny the claim "without fully investigating the grounds for its denial;"... "it is essential that an insurer fully inquire into possible bases that might support the insured's claim before denying it." *Id.* at 721, citing *Egan v. Mutual of Omaha Ins. Co.* (1979) 24 Cal.3d 809, 819, 169 Cal.Rptr. 691. In addition, "denial of a claim on a basis unfounded in the facts known to the insurer, or contradicted by those facts, may be deemed unreasonable." *Ibid.* The insurer may not ignore evidence available to it which supports the claim, nor may the insurer just focus on those facts which justify denial of the claim. *Ibid.*, citing *Mariscal v. Old Republic Life Ins. Co.*, (1996) 42 Cal.App.4th 1617, 1623, 50 Cal.Rptr.2d 224, and *Shade Foods, Inc. v. Innovative Products Sales & Marketing, Inc.* (2000) 78 Cal.App.4th 847, 880, 93 Cal.Rptr. 2d 364.

The court also noted that while an honest mistake, bad judgment or negligence does not necessarily constitute bad faith, "... a conscious and deliberate act, which unfairly frustrates the agreed common purposes and disappoints the reasonable expectations of the other party thereby depriving that party of the benefits of the agreement" can support a finding of bad faith. Citing *Chateau Chamberay Homeowners Assn. v. Associated Internat. Ins. Co.* (2001) 90 Cal.App.4th 335, 346, 108 Cal.Rptr. 2d 776.

In so holding, the Supreme Court in *Wilson* rejected language, definitions or standards that would suggest that a finding of insurance bad faith requires any evidence of intentional misconduct or intent to harm, including such phrases as "no reasonable basis" or "willful

misconduct.” The standard “unreasonable and in bad faith”, while something more than honest mistake, bad judgment, or negligence, is clearly something less than intentional misconduct. As the court noted, what constitutes bad faith must be evaluated in light of the totality of the circumstances on a case by case basis.

The evaluation of whether the insurer has acted in bad faith is also aided by the regulatory standards that apply. For instance, California Insurance Code §790.03(h) lists fifteen separate unfair claims settlement practices which may be evaluated on a case-by-case basis. In addition, the California Fair Claims Settlement Practices regulations, 10 CCR §2695.1 *et. seq.*, provide additional specific standards against which insurer conduct is measured in bad faith cases. Of particular note, 10 CCR §2695.2 (y) defines “willful” or “willfully” when applied to evaluation of unfair claims settlement practices, as follows: willful or willfully “means simply a purpose or willingness to commit the act, or make the omission referred to in the California Insurance Code or this sub-chapter. It does not require any intent to violate law, or to injure another, or to acquire any advantage.” This is consistent with, and supportive of, the standard of bad faith articulated in *Wilson v. 21<sup>st</sup> Century*.

### **III. LIMITATION OF THE USE OF THE GENUINE DISPUTE RULE AS A DEFENSE TO INSURANCE BAD FAITH CLAIMS**

Over the last ten years insurers increasingly asserted in defense of bad faith claims the so-called “genuine dispute doctrine.”

A few things must be made clear. First, the issue of “genuine dispute,” in spite of some characterizations in case law, is not a “doctrine,” but rather one of a number of factors

that may be considered along with other factors in deciding whether an insurer acted unreasonably and in bad faith; second, there is nothing “new” about the issue of the possible existence of a genuine dispute being considered in evaluating bad faith conduct of an insurer; third, summary judgment standards still apply; and fourth, questions of fact are for juries for resolve, and genuine dispute constitutes determination of a question of law .

Courts recognized for some time that if a genuine issue exists as to the legal liability of an insurer on the insurance contract (e.g., the threshold issue of existence of coverage) a court may find that an insurer is not liable for bad faith as a matter of law. See e.g., *Opsal v. United Services Automobile Association* (1991) 2 Cal.app.4th 1197, 1205-1206, 10 Cal.Rptr.2d 352. See also, more recently, *Chateau Chamberay Homeowners Association v. Associated International Ins. Co.* (2001) 90 Cal.App.4th 335-347-348, 108 Cal.Rptr.2d 776.

What changed and emboldened insurers to increasingly assert “genuine dispute” as a defense was when courts began holding that consideration of the existence of a “genuine dispute” in evaluating whether an insurer was in bad faith was not limited to legal questions or questions of law about coverage, such as the meaning of insurance terms or whether an insured’s claim is legally covered, but might also be considered in disputes about expert opinion presented in certain claims. See e.g., *Fraley v. Allstate Insurance Company* (2000) 81 Cal.App.4th 1282, 1293, 97 Cal.Rptr.2d 386; *Guebara v. Allstate Insurance Co.*, 237 F.3d 987, 993-994 (9<sup>th</sup> Cir. 2001).

Taken together, insurers began to assert these “genuine dispute” cases in defending against insurance bad faith claims not only involving disputed questions of law, but also

involving factual disputes. Insurers asserted that a court could conclude as a matter of law that an insurer's denial of a claim was not unreasonable so long as there existed any genuine issue as to the insurer's liability, whether it was based on resolution of questions of law or of fact. In most cases, this was an unsupportable, overreaching proposition.

A careful reading of the "genuine dispute" cases cited above indicates that the presence or absence of a genuine dispute is but one factor to be considered in evaluating the conduct of an insurer in its investigation, claim handling, and its delay of or withholding of benefits. All of these cases acknowledge the long-standing rules on insurance bad faith, including the primary rule that "the key to a bad faith claim is whether or not the insurer's denial of coverage was reasonable." See e.g., *Guebarra v. Allstate, supra*, at 992; *Fraley v. Allstate, supra*, at 1292. It is also important to point out that these "genuine dispute" cases recognize that summary judgment is only appropriate in insurance bad faith cases, like any other case in which summary judgment is sought, where there are no disputed material facts and reasonable minds could only draw one conclusion. See e.g., *Chateau Chamberay v. Associated International, supra*, at 344-345. The cases also acknowledge that reasonableness is typically a question of fact, and rarely a question of law.

Consistent with these observations, the Ninth Circuit observed in *Amadeo v. Principal Mutual Life Insurance Company*, 290 F.3d 1152, (9<sup>th</sup> Cir. 2002) that the "genuine issue" rule allows summary judgment in bad faith claims only when "it is undisputed or indisputable that the basis for the insurer's denial of benefits was reasonable..." 290 F.3d at 1161. "On the other hand, an insurer is not entitled to judgment as a matter of law where,

viewing the facts in the light most favorable to the plaintiff, a jury could conclude that the insurer acted unreasonably.” *Id.* at 1162.

In *Wilson v. 21<sup>st</sup> Century Ins. Co.*, *supra*, the California Supreme Court clarified that the genuine dispute rule, contrary to its recent unsupportable overuse, has limited effect and will rarely apply to an insurance bad faith case. The court held, as follows:

The genuine dispute rule does not relieve an insurer from its obligation to thoroughly and fairly investigate, process and evaluate the insured’s claim. A *genuine* dispute exists only where the insurer’s position is maintained in good faith and on reasonable grounds. Nor does the rule alter the standards for deciding and reviewing motions for summary judgment... and insurer is not entitled to judgment as a matter of law where, viewing the facts in the light most favorable to the plaintiff, a jury could include that the insurer acted unreasonably. Thus, an insurer is entitled to summary judgment based on a genuine dispute over coverage or the value of the insured’s claim only where the summary judgment record demonstrates the absence of triable issues as to whether the disputed position upon which the insurer denied the claim was reached reasonably and in good faith. (citations omitted) 42 Cal.4th at 723-724.

In reaching this holding, the Supreme Court rejected the insurer’s attempt to justify summary judgment based on (1) the existence of disputed medical evidence in supportive theory of pre-existing condition, (2) an amount of medical bills allegedly inconsistent with serious injury, and (3) plaintiff’s extensive travel and studying abroad allegedly being inconsistent with continuing significant neck pain. *Id.* at 724-725.

In a significant footnote, the court in *Wilson* disapproved of what had previously been cited by insurers as indicating a claimed expansive reach of the genuine dispute rule, as follows:

In this connection, we find potentially misleading the statements in some decisions that under the genuine dispute rule bad faith cannot be established where the insurer’s

withholding of benefits “is reasonable *or* is based on a legitimate dispute as to the insurer’s liability.” (referring to *Century Surety Co. v. Polisso* and *Chateau Chamberay HOA v. Associated Intl. Ins. Co.*) (“if reasonable or if based on a legitimate dispute”); and *Tomaselli v. Transamerica Ins. Co.* (same). In the insurance bad faith context, a dispute is not “legitimate” unless it is founded on a basis that is reasonable under all the circumstances. 42 Cal.4th at 724 n.7.

In opposing summary judgment, including motions asserting the existence of a “genuine dispute,” plaintiff should take full advantage of the largely favorable body of insurance bad faith law, the insurer’s claim file and claims manual, depositions of claims personnel, claims expert opinion and California’s Fair Claims Practice Statute and regulations (Ins.Code §790.03(h); 10 Cal.Admin. Code §§2695.1 et seq.). If more discovery needs to be done, plaintiff can request the opportunity provided by the applicable statute. See C.C.P. §437c(h); FRCP, Rule 56(f).

Following the holding in *Wilson*, “genuine dispute” should be confined to summary judgment proceedings involving legal issues, such as whether a claim was covered under a policy as a prerequisite to finding the existence of a duty of good faith, or where the facts are not in dispute but rather there are certain conflicting expert opinions, such as varying valuation opinions of independent experts concerning a property damage claim. See e.g., *Chateau Chamberay, Fraley and Guebarra, supra*. “Genuine dispute” merely describes a determination that based on indisputable facts a court has determined as a matter of law that no reasonable person could conclude that the insurer acted in bad faith. Therefore, genuine

dispute has no legitimate role to play in trial of disputed issues before a trier of fact (i.e., a jury).

Even if post-*Wilson* an insurer attempts to raise “genuine dispute” at the time of trial, and a judge improperly allows it over plaintiff’s objection, a careful reading of the “genuine dispute” cases reveal that an effective jury instruction will counteract an insurer’s assertion of “genuine dispute” as a defense. In addition to other comprehensive jury instructions on the duty of good faith and fair dealing, breach of duty and damages, plaintiffs can offer an instruction, supported by the cases, of the type crafted pre-*Wilson* along the following lines.

An insurer’s assertion that a “genuine dispute” existed concerning an insurance benefit claim does not prevent a finding that the insurer acted unreasonably and in bad faith or dealt unfairly with its insured.

In order to find that a “genuine dispute” existed, an insurer’s questioning of a claim must have been both legitimate and reasonable, and any delay in, or withholding of, a benefit must have been reasonable and with proper cause.

The presence of any of the following on the facts of the case prevent the finding of a “genuine dispute”:

1. Lack of thorough investigation or evaluation;
2. An incomplete, inadequate or unreasonable investigation or evaluation;
3. Bias in investigation or evaluation;
4. Use of improper standards in the investigation or evaluation;
5. Unreasonable conduct, including delay in evaluation or payment of benefits;
6. Misleading of the insured about any aspect of the investigation or evaluation;
7. Misrepresentation or concealment relating to the nature of the investigation proceedings;
8. Lying by any of the insurer’s employees to the insured or in deposition testimony;
9. Dishonest selection of experts; or
10. Unreasonable conduct or opinions by experts.

This is not an exhaustive list.

Authority: *Wilson v. 21<sup>st</sup> Century Ins. Co.* (2007) 42 Cal.4th 713, 68 Cal.Rptr.3d 746; *Chateau Chamberay Homeowners Association v. Associated International Ins. Co.* (2001) 90 Cal.app.4th 335, 348-349, as modified on denial of rehearing (July 30, 2001); *Guebarra v. Allstate Ins. Co.*, 237 F.3d 987, 992-994 (9<sup>th</sup> Cir. 2001); *Amadeo v. Principal Mutual Life Insurance Co.* 290 F.3d 1152, 1161-1162.

There is a significant difference between a legal dispute that presents a genuine legal issue and a factual dispute. Questions of law arise from, and in the context of, undisputed facts and are generally beyond the control of the insurer to resolve; they are resolved by the court as a matter of law. Factual disputes, on the other hand, may be more readily manufactured, and unreasonably resolved, by an insurer and its hired or retained personnel. The facts in the cases that found a “genuine dispute” to exist before *Wilson* reveal that, by and large, the disputes would be deemed genuine even in the context of the duty of good faith and fair dealing imposed upon the insurer, and that duty remains unchanged by the finding of a “genuine dispute.” In other words, in addition to those exceptions noted above in the pre-*Wilson* jury instruction, an insurer cannot reasonably manufacture a genuine dispute; it still must investigate all reasonably available evidence that could support a claim, it cannot focus unduly on facts that would justify denial of a claim, it cannot place its interests above that of its insured, and it cannot act unreasonably. See e.g., *Gruenberg v. Aetna Ins. Co.* (1973) 9 Cal.3d 566, 574, 108 Cal.Rptr.480; *Silberg v. California Life Insurance Company* (1974) 11 Cal.3d 4521, 113 Cal.Rptr. 711, *Neal v. Farmers Insurance Exchange* (1978) 21 Cal.3d 910, 920, 148 Cal.Rptr.389; *Egan v. Mutual of Omaha Ins. Co.*

(1979) 24 Cal.3d 809, 818-820, 169 Cal.Rptr. 691.

The finding of a “genuine dispute” sufficient to justify holding that an insurer is relieved of its duty of good faith and fair dealing on the facts of a particular case, or sufficient to remove consideration of factual disputes from a jury on the issue of bad faith, should be, as it historically has been, a rare occurrence reserved only for extraordinary circumstances in which there are no disputed material facts and no reasonable mind could not differ about the conclusion.

#### **IV. EXPANSION OF INSURER EXCESS JUDGMENT LIABILITY ON COVERED CLAIMS IN THE ABSENCE OF A SETTLEMENT DEMAND WITHIN POLICY LIMITS WHERE COVERAGE AND DEFENSE ARE DENIED**

Insurers assert, without directly citing any legal authority, that they cannot be held liable for amounts in excess of policy limits unless they violate the covenant of good faith and fair dealing. From that unsupported premise, they then argue that the covenant of good faith and fair dealing is violated only when an insurer refuses to accept an offer of settlement within its policy limits, citing *Comunale v. Traders & General Ins. Co.* (1958) 50 Cal.2nd 654, 659-660, and *Johansen v. California State Automobile Association etc.* (1975) 15 Cal.3d 9, 14-19. While it is certainly true that an insurer who refuses to reasonably settle within a policy limit is in bad faith, neither *Comunale* nor *Johansen* hold that an insurer cannot be found in bad faith if it improperly refuses to provide coverage and a defense following which no demand for settlement is made within policy limits.

An insurer’s argument that it cannot be held liable on the judgment unless it was given

a demand to settle within applicable policy limits during the underlying litigation is not supportable. The cases cited in support of their argument do involve factual circumstances where the insurer was presented with the settlement offer within the policy limits. (e.g., *Comunale v. Traders & General Ins. Co.* (1958) 50 Cal.2nd 654; *Johansen v. California State Auto. Assn. Etc.* (1978) 15 Cal.3rd 9). However, where an insurer denies coverage and refuses to defend, the cases hold that the insurer does so at its own risk, and the insured is not required to communicate with, or to cooperate with, the insurer; thus, the insured is under no obligation to give notice of any kind relating to the litigation activities such as receipt of summons and complaint, or even the fact of, or the date of, trial or arbitration in the case. (e.g., *Johansen v. California State Auto. Assn., supra*; *Clemmer v. Hartford Ins. Co.* (1978) 22 Cal.3rd 865; *Samson v. TransAmerica Ins. Co.* (1981) 30 Cal.3rd 220).

*Comunale* and *Johansen* are particularly inappropriate authorities for the proposition that a settlement within policy limits is a necessity in order to open policy limits. What the *Comunale* court said was that “certainly an insurer who not only rejected a reasonable offer of settlement but also wrongfully refused to defend should be in no better position than if it has assumed the defense and then declined to settle. The insurer should not be permitted to profit by its own wrong.” 50 Cal.2nd at 660. The *Johansen* court later explained that the *Comunale* court’s discussion of the duty to defend was in the context of the insurer seeking to use its failure to defend as a justification for refusing to settle within policy limits on the grounds that it did not have control over the litigation and thus lacked authority to effectuate a settlement. *Johansen v. California State Automobile Assoc. etc., supra* at 17, fn. 7. The

*Johansen* court observed that it was an inescapable conclusion that an insurer who refuses to defend should not be given greater deference than an insurer who was defending when they refused to settle within policy limits. *Ibid.*

Insurers' arguments asserting the necessity of an opportunity to consider a demand within the policy limits as a predicate to excess judgment liability unduly focus on only one duty - the duty to settle. In doing so, insurers ignore the other applicable duties imposed upon them - the duty to provide indemnity coverage and the duty to defend - and the subsequent body of case law that supports a cause of action that would hold them liable for an excess judgment.

In *State Farm Mut. Auto. Ins. Co. v. Allstate* (1970) 9 Cal.App.3d 508, 528, the court held that "(g)enerally, an insurer's breach of its duty to defend subjects it to liability for the judgment against its insured, as well as the latter's litigation expenses."

The *State Farm* court acknowledged that prior to that time (1970) the California cases treated breach of the duty to defend as a contract remedy; including *Comunale*. *Ibid.* *Comunale* also observed that the policy limits do not restrict the amount an insurer may owe for breach of the duties in the contract, including the duty of good faith and fair dealing. *Comunale v. Traders and General Ins. Co.*, *supra* at 658.

Insurers' references to, and quotations from, *Johansen v. California State Auto Insurance Inter-Insurance Bureau*, *supra*, are often taken out of context. *Johansen* involved an insurer's refusal to settle where an offer was made within the policy limits; citing its earlier decision in *Comunale*, the California Supreme Court held, in a circumstance where the

insurer provided a defense, that when the insurer fails to accept a reasonable settlement offer within policy limits it assumes the risk for all resulting damages. In *Comunale*, the insurer denied the defense, but was nevertheless presented with a settlement offer which it refused. *Comunale v. Traders and General Ins. Co.*, *supra* at 658.

Citation of *Johansen* is merely a reference to the *Johansen* court citing *Comunale* in the context of rejecting the insurer's self-serving and illogical argument that it could not be held liable for refusing to settle because it had also refused to defend. *Johansen* makes it clear that an insurer "denies coverage at its own risk." 15 Cal.3d at 15, fn. 4. In that regard, liability for an excess judgment may stem from a breach of contract as well as breach of a tort duty. *Id.* at 17; see also *Archdale v. American International Specialty Lines Ins. Co.* (2007) 154 Cal.App.4th 449, 471, 64 Cal.Rptr.3d 632 .

In other words, neither *Comunale* nor *Johansen*, nor *State Farm Mut. Auto. Ins. Co. v. Allstate*, *supra*, hold or stand for the proposition that an insurer cannot be held liable for an excess judgment where it refuses to defend its insured. The duty to settle is different than the duty to provide indemnity coverage or the duty to defend, as recognized by the resulting and varying case authority regarding each duty or the combination of duties. Where an insurer not only renounces coverage without reasonably investigating available coverages, it refuses to defend or participate in any way. In such a circumstance, plaintiffs are not merely asserting a bad faith refusal to settle, but rather refusal to cover and defend, and numerous subsequent cases support insurer liability for the entire judgment in the face of denial of coverage and a defense.

An insurer's denial of coverage relieves the insured from even having to give notice of service of summons or tender a defense; the insurer may still be bound by the judgment. *Clemmer v. Hartford Ins. Co.* (1978) 22 Cal.3d 865, 883-885. Following denial of coverage and defense, the insured has no obligation to notify the insurer further regarding the litigation, including the date of and the fact of a trial, let alone settlement offers. *Ibid.*; see also *Samson v. TransAmerica Ins. Co.* (1981) 30 Cal.3d 220, 238-239.

An insurer that refuses to defend without adequately investigating the potential for coverage has a duty to pay the judgment against its insured. *Mullen v. Glenn Falls Ins. Co.* (1977) 73 Cal.App.3d 163, 173-174.

“Wrongful failure to defend opens the insurance carrier to liability for the whole amount of the judgment including any amount in excess of the policy limits.” *Miller v. Elite Ins. Co.* (1980) 100 Cal.App.3d 739, 756.

Further support for the proposition that settlement demands within policy limits are not necessary to establish excess judgment liability comes from the holding in *Noya v. A.W. Coulter Trucking* (2006) 143 Cal.App.4th 838, 49 Cal.Rptr.3d 584, which rejected the attempt of an insurer who had denied the insured coverage and a defense to intervene in the third party action when it discovered that its insured and the third party had entered into an excess judgment settlement. In that circumstance, an insured is entitled to make a reasonable, non-collusive settlement without the insurer's consent and seek reimbursement for the settlement from the insurer. 143 Cal.App.4th at 842, citing *Hamilton v. Maryland Casualty Co.* (2002) 27 Cal.4th 718, 728, 117 Cal.Rptr.2d 318 (“Having rejected the

opportunity and waived the chance to contest liability, it cannot reach back for due process to void a deal the insured has entered to eliminate personal liability”), and *Roman v. Unigard Ins. Group* (1994) 26 Cal.App.4th 177, 180, 184, 31 Cal.Rptr.2d 501.

If an insurer refuses to defend a covered action the insured may recover the amount of judgment in the action, plus the insured’s cost of defense. *Xebec Development Partners, Ltd. v. National Union Fire Ins. Co.* (1993) 12 Cal.App.4th 501, 538. The same is true even where the insured is provided a defense by another insurer who also contributes a lower policy limit to partial satisfaction of the indemnity obligation. *Wint v. Fidelity & Cas. Co.* *supra* at 261.

The same rule applies where an insured cannot afford a defense and suffers an uncontested default judgment. *Amato v. Mercury Casualty Co.* (1997) 53 Cal.App.4th 825, 831-835.

An insurer that refuses to defend on the ground that the alleged claim is not within the policy coverage is bound by a judgment in the action in the absence of fraud or collusion. *Zander v. Casualty Ins. Co. of Cal.* (1968) 259 Cal.App.2d 793, 804, citing *Geddes & Smith, Inc. v. St. Paul Indem. Co.* (1959) 51 Cal.2d 558, 561; but see *Isaacson v. California Ins. Guarantee Assn.* 91988) 44 Cal.3d 775, 791-793, 244 Cal.Rptr. 655 (settlement establishes presumption of insured’s liability and amount of that liability, but insurer may present evidence in subsequent action on the settlement to attempt to rebut the presumption that the settlement amount reflected the actual amount of liability).

*Pruyn v. Agricultural Ins. Co.* (1995) 36 Cal.App.4th 500, 517, fn. 16, involved a

stipulated judgment as part of a settlement that included a covenant not to execute on the judgment against the insured. The defendant insurer contended that such a judgment could not be enforced against them. 36 Cal.App.4th at 509. The *Pruyn* court held against the insurer, as follows:

We disagree and hold that when, as plaintiff alleges happened here, a liability insurer wrongfully denies coverage or refuses to provide a defense, then the insured is free to negotiate the best possible settlement consistent with his or her interests, including a stipulated judgment accompanied by a covenant not to execute. Such a settlement will raise an evidentiary presumption in favor of the insured (or the insured's assignee) with respect to the existence and amount of the insured's liability. The effect of such presumption is to shift the burden of proof to the insurer to prove that the settlement was unreasonable or the product of fraud or collusion. If the insurer's unable to meet that burden of proof then the stipulated judgment will be binding on the insurer and the policy provision proscribing a direct action against the insurer except upon a judgment against the insured after an "actual trial" will not bar enforcement of the judgment. *Ibid.*

A settlement that involves a stipulated judgment and assignment of rights against an

insurer that is approved as a good faith settlement under CCP §877.6 fully supports the conclusion that the parties were not engaging in collusive or abusive conduct. See e.g., *Roman v. Unigard Insurance Group* (1944) 26 Cal.App.4th 177, 184.

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