CAALA VEGAS 2017

ROCK OF AGES

SECTION 20

INSURANCE
BAD FAITH

DISCOVERY NEEDED TO PROVE BAD FAITH
By Kathryn Trepinski

DISCOVERY NEEDED TO PROVE BAD FAITH

Kathryn Trepinski
September 3, 2017
CAALA Las Vegas

KT
LAW OFFICES of KATHRYN M. TREPINSKI

1

What is Bad Faith?

Silberg v. Cal Life Ins. Co.,
11 Cal.3d 452 (1974).

- 38 years old; dry cleaning business; laundromat
- Fire – climbed onto washing machine
- Foot injury – restored but 4 surgeries
- Medical policy, Cal. Life, had an exclusion for worker's compensation claims – "questionable" outside employment
- Cal Life caused an investigation re plaintiff's 10 year medical history – accuracy of application (heart or cancer)/uninsurable
- Delay led to downward spiral: $2,000 loan; lost business; ruined credit; moved 5 times; utilities turned off; could not afford medication; 2 mental breakdowns
- His wheelchair was repossessed
- Trial: $4,900 medical costs; $75,000 compensatory damages; $500,000 in punitive damages for bad faith
- Motion for New Trial & Appeal – insufficient evidence punitive damages

2

Defining Bad Faith

Bad faith is the breach of the covenant of good faith and fair dealing that is implied in every contract.

- More than a mistake
- More than a breach

Chateau Chamberay Homeowners Ass'n. v. Assoc. Int'l. Ins. Co., 90 Cal.App. 4th 335, 345 (2001); Rutter, *Insurance Litigation Practice Guide*, 12:1 (2016).

Actionable as a tort or contract claim.

- Tort claim – measure of damages is "extracontractual." Includes both compensatory and punitive damages.

3

DISCOVERY NEEDED TO PROVE BAD FAITH
By Kathryn Trepinski

First v. Third Party Claims

Bad Faith is Only Available in First Party Cases – insured's claim against his own carrier.

- Life, health, disability policies
- Homeowners insurance
- Auto policies

- Third party claimants may have "first party" coverages
  - Med-pay

Royal Indemnity Co. v. United Enterprises, Inc., 162 Cal.App.4th 194, 206 (2008).

4

Examples of Bad Faith

There is an implied covenant of good faith and fair dealing in every contract that neither party will do anything which will injure the right of the other to receive the benefits of the agreement. Must consider the insureds' interests as well as its own.

Comunale v. Traders & Gen. Ins. Co., 50 Cal.2d 654, 658 (1958).

- Refusal to settle liability claims against insured ("excess liability" cases). *Id.*

- Withholding of policy benefits due directly to the insured. *Gruenberg v. Aetna Ins. Co.*, 9 Cal.3d 566 (1973).
- Statutory Violations – Ins. Code Section 790.03 (unfair claims settlement practices). Delay, failing to settle. Actionable for a number of years until *Moradi-Shalal v. Fireman's Fund Ins. Co.*, 46 Cal.3d 287, 304 (1988) (held *Royal Globe v. Sup Ct.*, 23 Cal.3d 880 (1979) was incorrectly decided).
- Violations of the Unfair Claims Settlement Practices Act may be *evidence* of the insured's breach of the implied covenant. Rutter, *Insurance Litigation Practice Guide*, 12:13 - 26. (2016).

5

How Does Bad Faith Arise Today?
Areas of Institutional Suppression

- Renegade adjuster is rare ("de-risk" their business)
- Lack of, or limitations on, adjuster authority
- Roundtabling
- Metrics
- Deadlines
- Company policies and protocols
  - Training materials
  - Bulletins
  - Computer software with skewed data entry fields

6

Documents, Documents, Documents

Requests for Production of Documents or Things

1. Do first
2. Basis discovery plan
3. Do a written discovery plan
4. Documents and discovery plan help "box in" your case

The Basics:

- Policy
- Claim file
- Claim Manual/Guidelines
- Documents supporting carrier defenses

Advanced:

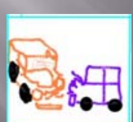
- Training materials
- Bulletins advising change
- Performance results

7

Interrogatories

FORM INTERROGATORIES

- Carefully evaluate whether these apply to your case
- Don't "stretch"

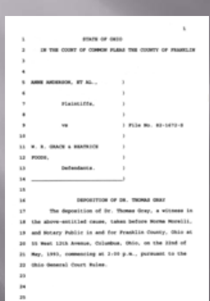


SPECIAL INTERROGATORIES

- No magic formula
- Draft to the specifics of your case
- Draft defined terms
- Draft with an eye toward supporting a Motion to Compel
- Draft after you have documents or a sufficient knowledge of the facts

8

Depositions


STATE OF OHIO
IN THE COURT OF COMMON PLEAS THE COUNTY OF FRANKLIN

ANNE ANDERSON, ET AL., Plaintiffs,

vs — File No. 82-1672-8

W. R. GRACE & BEATRICE FOODS, Defendants.

DEPOSITION OF DR. THOMAS GRAY

The deposition of Dr. Thomas Gray, a witness in the above-entitled cause, taken before Norma Morelli, and Notary Public in and for Franklin County, Ohio at 33 West 11th Avenue, Columbus, Ohio, on the 22nd of May, 1993, commencing at 2:00 p.m., pursuant to the Ohio General Court Rules.

Who?

- Adjusters
- Percipient witnesses
- Third Party Vendors

What?

- Events at issue
- Evaluation of case
- Investigation
- Company policies, claim manuals, guidelines and training materials
  - Adhere or Performance Issue
    - Unlawful
    - Missed a step

9

Requests for Admission

- Not that useful
- Met with objections
- Other side redefines
- New definition

narrows request to subatomic particle level

- Deny

10

SUMMARY OF BAD FAITH GAME PLAN

- Request documents at the beginning of and throughout your case
- Draft a discovery plan based on the facts and the documents and update it regularly
- Serve well-crafted special interrogatories
- Take depositions
  - Carefully identify who you want to depose
  - Immerse yourself in the documents
  - A well-prepared deposition outline, supported by key exhibits, will likely confirm what you already know (*i.e.*, mishandling of claim or unlawful company practice)

11

CONSIDERATIONS WHEN TAKING THE LID OFF THE POLICY

By Danica Crittenden

California law implies a covenant of good faith and fair dealing in liability insurance policies. The duty of good faith and fair dealing requires a third party liability insurer to settle a lawsuit against its insured when there is a clear and unequivocal offer to settle within policy limits at a time when liability is reasonably clear and there is a likelihood of a recovery in excess of the policy limits.

You will not find an express policy provision mandating that an insurer settle a case against their insured. But, as the California Supreme Court determined almost sixty years ago, "the implied obligation of good faith and fair dealing requires the insurer to settle in an appropriate case although the express terms of the policy do not impose such a duty." (*Comunale v. Traders & General Ins. Co.* (1958) 50 Cal.2d 654, 659.)

The insurer's duty to accept reasonable settlement offers is implied in order to protect the insured's reasonable expectations in purchasing the insurance and cope with the conflict of interest that inevitably arises when the injured third party offers to settle within policy limits.

> In most legal relationships determination of the merits of conflicting interests by one of the parties to the conflict is forbidden. No man can be judge in his own case; no trustee may weigh his personal interest against that of his beneficiary . . . Yet the carrier who receives an offer to settle an excess claim within policy limits is instructed to weigh its own interest on the scales along with those of its assured in order to make a good faith determination whether to accept or reject the offer. Patently, such an instruction is a counsel of perfection impossible of complete realization . . . Necessarily, the carrier must . . . conscientiously try to strike a balance between conflicting interests, and must attempt to evaluate the merits of an offer to settle within policy limits both from its own point of view and from that of the assured.
> *(Merritt v. Reserve Ins. Co.* (1973) 34 Cal.App.3d 858, 874.)

In deciding whether a claim against an insured should be settled, the insurer "must take into account the interest of the insured and give it at least as much consideration as it does to its own interest" even if the express provisions of the policy contain no such obligation. (*Comunale, supra,* at 659; See also *Egan v. Mutual of Omaha Ins. Co.* (1979) 24 Cal.3d 809, 818-819.)

If you are successful in opening up the policy, there will be a subsequent bad-faith action. In the second case against an insurer, you would need to show the following in order to prevail:

1. That the plaintiff in the underlying action brought a lawsuit against [the insured] for a claim that was covered under the policy;
2. That the insurer failed to accept a reasonable settlement demand for an amount within policy limits; and
3. That a monetary judgment was entered against the insured for a sum greater than the policy limits. (CACI Jury Instruction No. 2334.)

It is important to keep these requirements, as well as the points below in mind when you are trying to open up the policy.

A. IS THE INSURER DEFENDING THE INSURED?

An insurer owes a duty to defend the insured if there is coverage or a potential for coverage at the outset of the proceedings, even if it is later determined that the claim against the insured was not covered under the policy. Where a potential for coverage exists, a refusal to defend without proper cause may be actionable. (*Montrose Chem. Corp. v. Superior Court* (1993) 6 Cal.4th 287, 295.)

Yet, in applying the *Comunale* rule, the cases demonstrate that it makes no difference whether a carrier had assumed the defense of the insured or not. Where an insurer wrongfully refuses an offer to

settle within policy limits, the same rule applies. The California Supreme Court has held insurers liable for an entire judgment, without regard to policy limits, in either context. (See *Johansen v. California St. Auto. Assn. Inter-Ins. Bur*., (1975) 15 Cal.3d 9 (where the insurer was defending but refused to settle within policy limits) and *Samson v. Transamerica Ins. Co*., 30 Cal.3d 220 (where the insurer refused to either defend or settle).)

In *Johansen*, the insurer argued that the *Comunale* rule requiring the payment of the full judgment, without regard for policy limits, only applied to insurers that both refused to settle and defend. In rejecting that argument, the California Supreme Court stated:

> Defendant, however, seeks to avoid the *Comunale* rule by asserting that it only applies to an insurer who breaches its duty to defend in addition to failing to settle. Although in *Comunale* the insurer not only refused to settle but also failed to defend, its liability for the excess judgment did not turn on this latter factor. As this court unequivocally stated: 'The decisive factor fixing the extent of [the insurer's] liability is ***not the refusal to defend***; it is the ***refusal to accept an offer to settlement within the policy limits***.
> (*Johansen*, 15 Cal.3d at 17, emphasis added.)

While the *Comunale* rule applies even if an insurer is defending, the denial of a defense does give an insured greater options to protect its own self-interests to avoid personal liability as will be discussed in further below.

B. IS THE INSURER RELYING ON A COVERAGE DISPUTE IN REFUSING TO SETTLE?

Sometimes an insurer decides not to settle because it believes that there is no coverage for the incident or the insured. In other words, the carrier takes the position—or does not dispute—that the claim may be worth more than the policy limits, but continues to refuse to settle because its believes that there is no coverage. In such cases, it is important to note that the California Supreme Court in both *Comunale* and *Johansen* specifically addressed the issue of considering a carrier's "good faith" decision to not settle based on non-coverage. In both cases the court concluded such considerations were ***irrelevant***. As the court stated in *Johansen*:

> Defendant asserts, however, the *Comunale* principle does not apply to an insurer whose refusal to settle stems from a bona fide belief that the policy does not provide its insured coverage. In *Comunale*, the insurer asserted a virtually identical claim . . . This court nevertheless held the insurer liable for the excess judgment against its insured, stating: 'an insurer who denies coverage ***does so at its own risk***, and although its position may not have been wrongful it is liable for the full amount which will compensate the insured for all the detriment caused by the insurer's breach of the express and implied obligations of the contract . . . accordingly, ***an insurer's good faith though erroneous belief in noncoverage affords no defense to liability flowing from the insurer's refusal to accept a reasonable settlement offer***.
> (*Johansen, supra*, at 16-17, emphasis added.)

Furthermore, the California Supreme Court in *Johansen* made it clear that a "wrongful" decision in noncoverage in the above quote does not mean "culpable", but simply an "erroneous" decision:

> FN4. Defendant seeks to avoid the import of this language by asserting that 'wrongful' must be equated with 'culpable', a proposal for which there is absolutely no support in *Comunale*. Indeed, the language immediately preceding

> this portion of *Comunale* expressly states that the insurer denies coverage at its own risk. Viewed in context, it becomes apparent that a ***'wrongful'*** denial of coverage as used in *Comunale* means ***merely an erroneous denial of coverage*** required by the policy.
> (*Id*., at 16-17, emphasis added.)

In addition, when an insurer is faced with the decision of settlement, it is not permitted to even consider coverage issues or policy limits. This is the standard that is clearly set forth in *Johansen*:

> Moreover, in deciding whether or not to compromise the claim, the insurer must conduct itself as though it alone were liable for the entire amount of the judgment. Thus, the ***only*** permissible consideration in evaluating the reasonableness of the settlement offer becomes whether, in light of the victim's injuries and the probable liability of the insured, and ultimate judgment is likely to exceed the amount of the settlement offer. ***Such factors as the limits imposed by the policy, a desire to reduce the amount of future settlements, or a belief that the policy does not provide coverage, should not affect a decision as to whether the settlement offer in question is a reasonable one***.
> (*Id*. at 16, internal citations removed.)

In many cases, an insurer who has refused to settle based on a belief that there is no coverage will later argue that it relied on the advice of its coverage lawyers in refusing to settle, commonly known as the "advice of counsel" defense. But "advice of counsel" does not provide a defense to payment of the entire excess judgment since an insurer is not permitted to even consider coverage issues when deciding whether or not to compromise a claim in the first instance. Accordingly, the reasonableness of its coverage position or the attorneys' analysis of coverage is irrelevant; the insurer remains liable for the entirety of the underlying judgment so long as there is coverage.

C. IS THE INSURER RELYING ON A DISPUTE ABOUT THE VALUE OF THE CASE TO JUSTIFY ITS REFUSAL TO SETTLE?

An insurer may decide not to settle based on a belief that the underlying claim is not worth the full policy limit, even though there is no dispute that whatever damages are ultimately awarded are covered under the policy. The implied obligation of good faith and fair dealing requires an insurer to accept a ***"reasonable settlement demand"*** which is defined as follows:

> A settlement demand for an amount within policy limits is reasonable if [the insurer] knew or should have known at the time the demand was rejected that the potential judgment was likely to exceed the amount of the demand based on [the injured party's] injuries or loss and [the insured's] probable liability.
> (CACI 2334.)

Thus, in a subsequent bad-faith case, the person seeking to obtain the policy benefits and other bad-faith damages needs to prove that the judgment in the underlying action was likely to exceed the amount of the demand. In your offer to settle the underlying action, make sure to provide as much detail as possible about the damages to prove the value of the case, including medical bills, a detailed explanation of the non-economic damages, photographs and videos where helpful, and anything else that you believe evidences the value.

If you have an open policy and you get to a bad faith case, you must be prepared to re-try the underlying action in the subsequent bad faith case to prove that it was worth more than the policy limit. Notably, the actual judgment provides ***presumptive proof*** of the value of the claim. As the court stated fifty years ago in *Crisci v. Security Ins. Co. of New Haven* (1967) 66 Cal.2d 425, 430 "[t]he size of the judgment recovered in the personal injury action, although not conclusive, ***furnishes an inference that the value of***

the claim is the equivalent of the amount of the judgment and that acceptance of an offer within those limits was the most reasonable method of dealing with the claim."

D. WHAT IS CONSIDERED AN "OPPORTUNITY TO SETTLE"?

In order to open up a policy, there must be an *opportunity* to settle the claim within its policy limits. (*Howard v. American Nat'l Fire Ins. Co.* (2010) 187 Cal.App.4th 498, 525; *Reid v. Mercury Ins. Co.* (2013) 220 Cal.App.4th 262, 272; *Graciano v. Mercury Gen. Corp.* (2014) 231 Cal.App.4th 414, 425.) An opportunity to settle is usually shown with evidence that a) the injured party made a "reasonable" settlement demand within the policy limits and b) the insurer either rejected the demand or failed to accept it within the time provided for acceptance. Most often, a subsequent "bad faith" claim is based on the insurer's failure to accept an offer to settle within policy limits from a third party claimant.

There is some uncertainty as to whether an insurer's failure to initial settlement negotiations or make a settlement offer to the third party plaintiff can trigger bad faith even if the third party never made an offer to settle. In other words, while the insurer must act in good faith in an effort to negotiate a settlement, the question remains whether they have an affirmative duty to initiate settlement absent a demand.

In *Boicourt v. Amex Assurance Co.* (2000) 78 Cal.App.4th 1390, 1399, the court stated that it was "not explor[ing] the degree to which the implied covenant of good faith and fair dealing imposes on a liability insurer a duty to be 'proactive' in settling cases …". In *Du v. Allstate Ins. Co.* (9th Cir. 2012) 697 F.3d 753, 757-758 (applying Calif. law), the court collected cases construing an insurer's settlement duty as extending "beyond mere acceptance of a reasonable settlement demand," but declined to reach the issue. In *Pray By & Through Pray v. Foremost Ins. Co.* (9th Cir. 1985) 767 F.2d 1329, 1330 (applying Calif. law), the court determined that the insurer had affirmative duty to attempt to effectuate settlement where liability is reasonably clear, even in absence of demand.

Other authority requires seems to require that there be a) evidence that the claimant *made a settlement demand* or otherwise communicated an interest in settlement to the insurer; b) some other circumstance demonstrating the insurer *knew a settlement within policy limits was feasible*; or c) evidence the insurer *actively foreclosed the possibility of settlement*. (See *Reid v. Mercury Ins. Co.* (2013) 220 Cal.App.4th 262, 272, 277-278; *Graciano v. Mercury Gen. Corp.* (2014) 231 Cal.App.4th 414, 426—wrongful refusal to settle claim "cannot be based on insurer's failure to *initiate* settlement overtures with the injured third party" (emphasis in original).) Furthermore, although the Unfair Claims Practices Act requires insurers to attempt "in good faith to effectuate prompt, fair, and equitable settlements" after liability has become "reasonably clear" (California Insurance Code § 790.03(h)(5))), there is no private right of action under this statute. Additionally, nothing in the Unfair Claims Practices Act requires or suggests that an insurer's failure to initiate settlement discussions, in the absence of expressed interest from the claimant, gives rise to a viable bad faith claim. (*Reid v. Mercury Ins. Co.*, supra, 220 CA4th at 276.)

Until this issue is decided by the California Supreme Court, it is best to make a well-documented offer(s) to settle in trying to open up the policy instead of waiting for the insurer to initiate settlement negotiations.

E. IS THE SETTLEMENT OFFER YOU ARE MAKING REASONABLE?

In many insurance bad-faith cases, insurers will attempt to raise the "genuine dispute" defense to argue that even though its settlement position in the underlying action turned out to be wrong, it acted reasonably as a matter of law in rejecting the offer because it relied on the advice of its lawyers and consultants in its valuation of the case. (See *Chateau Chamberay Homeowners Association v. Assoc. International Ins. Co*. (2001) 90 Cal.App.4th 335.) Despite the debate in the last few years in the proposed revisions to the CACI jury instructions, the focus is still on the reasonableness of the *settlement offer* that was ultimately rejected, *not* the reasonableness of the *insurers' conduct* leading up to that rejection.

In *Betts v. Allstate* (1984) 154 Cal.App.3d 688, which followed the *Johansen* and *Comunale* authorities, reinforced that the relevant inquiry is the reasonableness of the ***settlement offer***, not the

reasonableness of the ***insurers' conduct*** when dealing with exposure for an excess judgment. In *Betts*, the court stated:

> [In *Comunale*] the Supreme Court held an insurer in determining whether to settle a claim must give at least as much consideration to the welfare of the insured as it gives its own interest . . . An insurer may be held liable for a judgment against its insured in excess of its policy limits where it has breached the implied covenant of good faith and fair dealing by unreasonably refusing to accept a settlement offer within limits….Allstate's argument that liability for an excess judgment is not imposed unless there is a 'bad faith' breach of the contract is ***unsound***. Liability is imposed "for failure to meet the duty to accept ***reasonable settlements***, a duty included within the implied covenant of good faith and fair dealing." …***"Recovery may be based on an unwarranted rejection of a reasonable settlement offer and …the absence of evidence, circumstantial or direct, showing actual dishonesty, fraud, or concealment is not fatal to the cause of action***."
> (*Id*. at 706, emphasis added.)

The *Betts* court went on to state the standard for evaluating the reasonableness of a settlement offer: "Thus, the permissible considerations in evaluating the reasonableness of the settlement offer are whether in light of the victim's injury and the probable liability of the insured the ultimate judgment is likely to exceed the amount of the settlement offer." (*Id*., at 706-707.) "A key factual question put to the jury was: Were the repeated offers made by the Trotter firm reasonable in light of all of the circumstances of this case? If reasonable, their rejection by Allstate became unreasonable, therefore imposing on Allstate responsibility for the excess judgment." (*Id.*, at 707.)

Betts reinforced the *Johansen* rule, which focuses on the reasonableness of the settlement offer, rather than the reasonableness of the insurer's conduct.

In *Archdale v. American Intern. Specialty Lines Ins. Co*. (2007) 154 Cal.App.4th 449, 464, the Court reiterated that the focus is on the reasonableness of the offer:

> (1) "The implied covenant of good faith and fair dealing imposes a duty on an insurer to accept a reasonable offer to settle a claim against its insured."
> (2) "[W]hether a liability insurer's failure to accept a settlement offer constituted a breach of the implied covenant depends on whether that settlement offer was "reasonable."

In preparing your offer to settle and evaluating the reasonableness of your offer, be sure to clearly state the terms of your settlement demand so as to constitute an offer as a matter of contract law. Notably, though, the insurer may be required to seek clarification if there is an ambiguity or uncertainty in your offer. (*Betts v. Allstate Ins. Co.* (1984) 154 Cal.App.3d 688, 708, fn. 7.) Also, make sure that your offer to settle does not exceed the policy limits as the implied covenant does not obligate the insurer to accept a settlement demand requiring performance beyond that due under its policy. (See *Heredia v. Farmers Ins. Exch.* (1991) 228 Cal.App.3d 1345, 1357.)

Once a carrier rejects a reasonable settlement offer, it has breached the implied covenant of good faith and fair dealing at that point and is liable for the entire judgment, irrespective of the policy limit.

F. IS AN ASSIGNMENT OF RIGHTS AND COVENANT NOT TO EXECUTE AGREEMENT APPROPRIATE?

When an insurer refuses to defend and/or settle, the insured is free to protect itself by entering into an assignment agreement with a covenant not to execute even before trial in the underlying action.

More than fifty years ago, in *Critz v. Farmers Ins. Group* (1964) 230 Cal.App.2d 788, 801–02, the court held that after an insurer failed to settle the claim against its policyholder within policy limits, the policyholder was entitled to enter into an assignment agreement with the party asserting the claim. *Critz*

expressly held that entering into such an agreement before trial *does not* constitute a violation of the insured's duty to cooperate. (*Id*.) The court explained:

> When the insurer breaches its obligation of good faith settlement, it exposes its policyholder to the sharp thrust of personal liability. At that point, there is an acute change in the relationship between policyholder and insurer. The change does not or should not affect the policyholder's obligation to appear as defendant and to testify to the truth. He need not indulge in financial masochism, however. Whatever may be his obligation to the carrier, it does not demand that he bare his breast to the continued danger of personal liability. By executing the assignment, he attempts only to shield himself from the danger to which the company has exposed him. . . . The insurer's breach so narrows the policyholder's duty of cooperation that the self-protective assignment does not violate it.
> (*Id.* at 801-802.)

Since *Critz* was decided, at least three decisions of the California Supreme Court have approved the use of assignment agreements when the insurer has failed to settle within policy limits: *Johansen v. California State Auto. Assn. Inter–Ins. Bureau* (1975) 15 Cal.3d 9; *Samson v. Transamerica Ins. Co.* (1981) 30 Cal.3d 220, 240–241; and *Hamilton v. Maryland Cas. Co.* (2002) 27 Cal.4th 718, 725.

In *Samson*, there were two assignments, one made before and the other after the adverse judgment. Specifically, one of the insured's carriers, State Farm, agreed to defend the insured, while the other, Transamerica, denied a defense. Consequently, the insured and State Farm collectively entered into an agreement with the Samsons—the underlying plaintiffs—before the action went to trial.

The agreement provided that, in exchange for State Farm's payment of its $100,000 policy limit and the insured's assignment of any rights against Transamerica, the Samsons would sign a covenant not to execute any judgment ultimately obtained against the insured. Moreover, the insured agreed to cooperate with the Samsons in the action against him. This agreement was reached without the knowledge of Transamerica.

At trial, the insured did not contest liability or damages, presented no defenses, and did not cross-examine witnesses. Although Transamerica had been informed of the pendency of the action, it was not informed of the trial date. The trial court ultimately awarded the Samsons $725,000. Thereafter, the Samsons—as judgment creditors—sued Transamerica.

The *Samson* court pointed out that Transamerica had been given notice of the pendency of the underlying action, but it refused to defend. Under those circumstances, the *Samson* court noted "…the insured is relieved of his obligation to inform the insurance company of the services of summons or the date of trial of the action." (*Samson, supra*, 30 Cal.3d at 238.)

Transamerica also argued that the judgment was the product of "fraud and collusion" and that, therefore, it was not liable for the judgment. Transamerica pointed to the fact that the assignment agreement was reached before the commencement of trial, and that no defense was presented at trial and the insured did not cross-examine any witnesses. In response, the *Samson* Court stated:

> ***An insured breaches no duty to the insurance company when he assigns his rights against the company to the injured plaintiff in return for a covenant not to execute***. 'Where the insurer had repudiated its obligation to defend, a defendant in the absence of fraud or collusion may, without forfeiture of his right to indemnity, settle with the plaintiff upon the best terms possible, taking a covenant not to execute. ***When the insurer 'exposes its policy holder to the sharp thrust of personal liability' by breaching its obligations, the insured 'need not indulge in financial masochism***.
> (*Samson, supra*, 30 Cal.3d 220 at 241 (citing *Critz v. Farmers Ins. Group* (1964) 230 Cal.App.2d 788, 801) emphasis added).)

Based on this standard, the *Samson* Court held that there was nothing fraudulent or collusive about the insured's agreement to assign his cause of action to the Samsons: "[The insured] acted in his own self-interests after Transamerica's denial of coverage, as he had every right to do. Any resulting damage to Transamerica was caused not by [the insured's] supposed misconduct, but by Transamerica's own intransigence." (*Id*., at 241.)

In 2002, the *Hamilton* case resolved any question about whether the procedure followed in *Critz* is permissible under California law. There, the California Supreme Court explained that an insured could assign a claim against the insurer for breaching the duty to settle, and that, [*s*]*uch an assignment may be made before trial*, but the assignment does not become operative . . . until a judgment in excess of the policy limits has been entered against the insured." (*Hamilton*, 27 Cal.4th at 725, emphasis added.)

If the insurer tries asserting a breach of the insured's duty to cooperate as a coverage defense, it must to show "substantial prejudice" resulting from the breach. (*Campbell v. Allstate Ins. Co.* (1963) 60 Cal.2d 303, 305.) In order to meet this burden the insurer "must establish at the very least that if the cooperation clause had not been breached there was a substantial likelihood the trier of fact would have found in the insured's favor." (*Xebec Development Partners, Ltd. v. National Union Fire Ins. Co.* (1993) 12 Cal.App.4th 501, 533.1) This burden is challenging for the insurer to meet.

In *Johansen*, the assignment was made after a judgment had been entered against the insured. Again, the court found the insured was entitled to enter this agreement.

These cases demonstrate that an insured can enter into an assignment once the insurer refuses to settle the case.

G. BE CAREFUL NOT TO IMPROPERLY "SPLIT" A CAUSE OF ACTION

In California, an insured can assign to a third party claimant all assignable claims and causes of action against an insurer. But, as a matter of law, the insured cannot assign claims for emotional distress and punitive damages, which are retained by the insured. (*Murphy v. Allstate Ins. Co.* (1976) 17 Cal.3d 937, 942.) When entering into an assignment agreement previously discussed, it is important that both the third party claimant (the assignee) and the insured (the assignor) have an understanding about whether the non-assigned claims for emotional distress and/or punitive damages will be pursued. This is to avoid an improper "splitting" of the bad faith cause of action.

If an insured intends to pursue the non-assigned claims for emotional distress and punitive damages, those claims must be brought in a joinder action by the insured along with the third party claimant's prosecution of the assigned claims. If the assigned and non-assigned claims are pursued in separate actions, it would constitute an improper "splitting" of a cause of action and neither action could proceed. (See *Purcell v. Colonial Insurance Company* (1971) 20 Cal.App.3d 807 and *Cain v. State Farm Mutual Automobile Insurance Company* (1975) 47 Cal.App.3d 783.) Because of the rule established in *Purcell* and *Cain*, the assignment agreement should specifically address whether and how the non-assigned claims will be pursued. The assignment agreement should expressly state that the non-assigned claims will not be pursued, or if pursued, will be done in a joinder action to avoid an improper "splitting" of a cause of action.

H. IS IT APPROPRIATE TO OBTAIN A STIPULATED JUDGMENT ONCE THE INSURER REFUSES TO SETTLE, OR PROCEED WITH AN INDEPENDENT JUDICIAL HEARING?

When the insured and the third-party claimant agree to terminate the underlying litigation with an agreement that purports to fix the amount of damages suffered by the third-party claimant, such as a stipulated judgment, a question can arise about whether the settlement properly represents the amount of

---

1 The *Xebec* court's holding that claims for *Brandt* fees are not assignable was disapproved in *Essex Ins. Co. v. Five Star Dye House, Inc.* (2006) 38 Cal.4th 1252.

damages sustained, or whether it is collusive. (*Pruyn v. Agricultural Ins. Co.* (1995) 36 Cal.App.4th 500, 518.) The concern arises in this situation because it is in the insured's interest to agree to damages in any amount as long as the agreement provides that the insured will not be personally responsible for payment. (*Ibid*.)

The situation is different, however, when the agreement between the insured and the third-party claimant does not purport to fix the amount of the third-party's damages, and where that determination is left entirely in the hands of an independent trier of fact, such as the trial court, based on the evidence presented to it. "These circumstances necessarily involve significant ***independent adjudicatory action*** by the court, thus mitigating the risk of a fraudulent or collusive settlement between an insured and the claimant." (*Pruyn*, 36 Cal.App.4th at 517, emphasis added.) The *Pruyn* court explained that when the third-party's action against the insured culminates in a court judgment, it will be binding on the insurer and may be directly enforced by the third-party claimant under Insurance Code section 11580. (*Id*.) The court explained the basis for this rule:

> An insurer who has wrongfully abandoned its insured should not be heard to complain or allowed to relitigate the trial court's judgment merely because the default or uncontested proceedings followed, and were related to, an agreement between the insured and the claimant. ***Whatever the terms of the settlement, the entry of***
>
> ***judgment was based on an independent review and adjudication of the evidence by the trial court***.
> (*Id*. at 517, emphasis added.)

The issue in *Pruyn* was whether the stipulated judgment between the insured and the third-party claimant would be binding on the insurer. The claimant argued that it should be binding because the stipulated judgment was found to constitute a "good-faith" settlement under Code of Civil Procedure section 877.6. The *Pruyn* court surveyed the law, and determined that the rule that a final judgment entered against an insured would be binding on the insurer did not apply when there was a stipulated judgment that had only been subject to approval under section 877.6.

The court held that a stipulated judgment approved as a good-faith settlement would not be treated as the equivalent of a judgment entered after a default hearing or an uncontested trial and, therefore, the insurer would be given an opportunity that is generally not available when there is a judgment entered after an adjudicatory proceeding – the opportunity to attack the amount of the settlement as the product of fraud and collusion. (*Pruyn,* 36 Cal.App.4th at 526.) *Pruyn* therefore makes it clear that the insurer does not have a right to collaterally attack the judgment in the underlying action based on a claim of fraud and collusion, but is instead bound by the underlying judgment, where it is entered after an independent judicial review and adjudication. The court explained:

> A nonparty insurer must be given a fair opportunity to litigate the question of whether the settlement was unreasonable or was the product of fraud or collusion between a settling insured and the claimant. To hold otherwise would in effect treat a determination of good faith under section 877.6 as the procedural equivalent of a judgment entered after a default hearing or uncontested trial. This we cannot do. ***As we have already stated, those latter proceedings provide an opportunity for independent judicial review and adjudication of evidence relating to the fact and amount of the insured's liability***. The risk of fraud or collusion is sufficiently reduced by such judicial adjudicative participation that the breaching ***insurer is properly bound by the resulting judgment***.
> (*Pruyn,* 36 Cal.App.4th at 526-527, emphasis added.)

The *Samson* court also rejected the insurer's argument that it was not bound by the underlying judgment because the insured failed to present a defense at trial, noting that the insured had no obligation to put on a defense. (*Samson,* 30 Cal.2d at 242.)

In *Sanchez v. Truck Insurance Exchange* (1994) 21 Cal.App.4th 1778, the insurer refused to defend its insured, who, in turn, stipulated to a judgment against him and in favor of the third party plaintiff. When the third party claimant sued the insurer directly to recover the judgment, the insurer argued that the judgment was not the result of an "actual trial" as required by the policy, and therefore was not binding. The *Sanchez* court rejected the argument, concluding that "where the insurer refuses to defend, to indemnify, or to participate in any way in the underlying lawsuit, the insured may settle the lawsuit to his or her best advantage. . .." (*Id*. at 1787.)

In *Amato v. Mercury Cas. Co.* (1997) 53 Cal.App.4th 825, 838, the court held that a judgment entered after the insured's default was also binding on the insurer. Applying the logic of *Pruyn*, the *Amato* court explained that a default judgment can only be entered after the trial court considers the evidence and awards such damages as are just given that evidence. (*Id*.) Given this "significant adjudicatory action by the court," the *Amato* court held that, "***final judgments entered under these circumstances are binding on the insurer which has wrongfully abandoned its insured***." (*Id*., citing *Pruyn*, 36 Cal.App.4th at 517.)

The court in *Xebec Development Partners Ltd. v. National Union Fire Ins. Co*. (1993) 12 Cal.App.4th 501, made the same point, observing that the prove-up proceeding that is necessary to obtain a default judgment provides the requisite independent adjudication necessary to bind an insurer. (*Id*., 12 Cal.App.4th at 541, 544.)

Similarly, in *National Union Fire Ins. Co. v. Lynette C.* (1994) 27 Cal.App.4th 1434, 1449, the court observed that a judgment entered by a court after an uncontested trial was an "independent adjudication of the facts based on an evidentiary showing" because "[the parties] did not resolve the issues of liability and damages in the [underlying] action. A court did." (*Id*.)

As these decisions demonstrate, whether the underlying judgment is binding on the insurers will depend on whether a judge made the adjudication of liability and damages. Where the decision is made by a judge, the adjudication is binding on a breaching insurer. (*Pruyn*, 36 Cal.App.4th at 527; *Amato*, 53 Cal.App.4th at 838.). Accordingly, while a stipulated judgment is permissible when an insurer has refused to both defend and settle, the better practice to proceed to judgment with an independent judicial adjudication.

COMMON DEFENSES IN DISABILITY CASES AND HOW TO DEFEAT THEM

By Michael B. Horrow and Nichole D. Podgurski

Private disability insurance is a highly specialized product that professionals purchase to protect their income in the event that they become disabled and cannot practice in their chosen profession. It is an extremely valuable asset with many different features.

Disability policies typically condition benefits on whether the policyholder is unable to perform the duties of one's own occupation or any occupation, or a hybrid of both. There are varying definitions of what total disability benefit the policy provides.

For example, under the "own occupation" provision, one is eligible for disability benefits if he or she is unable to perform the material and substantial duties of his or her own occupation with reasonable continuity in the usual and customary way. Thus, under an own occupation policy, if a surgeon can no longer perform surgery, the policyholder is entitled to disability benefits, even if that person can still make a living as a doctor.

For example, under the "any occupation" provision, the disability must be so severe that insured must be unable to perform the duties of any occupation. "When coverage provisions in general disability policies require total inability to perform 'any occupation', the courts have assigned a common sense interpretation to the term 'total disability' so that total disability for purposes of coverage results whenever the employee is prevented from working 'with reasonable continuity in his customary occupation or in any other occupation in which he might reasonably be expected to engage in view of his station and physical and mental capacity.'" *Moore v. American United Life Ins. Co.* 150 Cal.App.3d 610, 618, 630 (1984).
Some policies provide "own occupation" benefits for a period of time, and then require that the insured satisfy the "any occupation" condition for benefits to condition.

The policy may also provide for residual or partial disability benefits. Residual disability is provided if the insured experiences a certain percentage loss of income compared to prior income and the loss is due to the disabling condition. Partial disability coverage is similar to residual disability and provides benefits if one is able to perform some, but not all, of the duties of their own occupation.
The policies also require that the insured be under the care of a physician.
The policies typically contain an elimination period. The elimination period is a waiting period in which the insured must be continuously disabled before it has the right to payment of disability benefits. The elimination period is different in every policy and ranges from 30 days to 365 days, for example, depending on the policy. The policy typically provides maximum benefits to age 65, or for the insured's life. This maximum benefit period can hinge on many things, such as the age in which the insured became disabled or whether the disability was caused by an accident versus a sickness. The policy may also contain a cost of living adjustment (COLA) provision whereby the COLA increases the benefit over time based on the increased cost of living set by the Consumer Price Index.

Another important feature is that the majority of disability policies are noncancelable and guaranteed renewable. This means that the insurance company may only cancel the policy for nonpayment of premiums and must renew the policy each year without any reduction in benefits or any change in policy terms.

Once the insured experiences a sickness or accident and can no longer work, they turn to their disability insurance carrier for the income protection that they dutifully paid for. They submit a claim to their insurance company. The insurance company requires that certain information be provided to support that claim. This typically includes a statement from the insured describing their occupational duties, a description of the disability, a full and complete list of all treating providers, and it requires that the insured's treating "attending" physician certify the disability. The attending physician describes the

insured's disability and describes the insured's restrictions and limitations. The insured also signs an authorization giving the insurance company broad authority to obtain private information such as medical records and tax returns.

California affords protections to insureds during the investigation and evaluation of the claim. For example, it is essential that an insurer fully inquire into all possible bases that might support the insured's claim…"[A]n insurer cannot reasonably and in good faith deny payments to the insured without *thoroughly investigating* the foundation of its denial." *Egan v. Mutual of Omaha Ins. Co.*, 24 Cal.App.3d 809, 819 (1979). An insurer is required to give the interests of its insured equal consideration as with its own interests; it therefore cannot subordinate its insured's interests to its own interests. *Id.* at 818-819. An insurer may not ignore evidence available to it which supports the claim. The insurer may not just focus on those facts which justify denial of the claim. *Wilson v. 21st Century Ins. Co*., 42 Cal.4th 713, 721 (2007). If the insurance company violates these principles, it may be liable for breach of the implied covenant of good faith and fair dealing.

However, despite these obligations, the insurance company launches into an investigation that is focused on minimizing its exposure. The insurance company may perform surveillance, conduct thorough background checks on the individual and any business he or she may own, hunt the internet for any social media postings, request field visits to interview the insured and any witnesses relevant to the disability, obtain billing data on the insured, obtain medical records, send medical records to third party physicians or have them reviewed in-house. The insurance company may deny the claim outright, pay benefits subject to a reservation of rights, or pay benefits for a certain period of time and then abruptly deny the claim.

This denial of an otherwise valid claim forces the insured into litigation for breach of contract and breach of the implied covenant of good faith and fair dealing for failing to pay disability benefits in their time of need. To help prepare you for what is assured to be a knock down drag out fight, this article will explain some of the common defenses and strategies and different tactics to overcome them.

A. Surveillance

We routinely see insurers conduct a background search and order surveillance at the outset of a claim. Time and time again the insurer claims to have surveillance that it believes shows the insured acting inconsistent with his or her claim disability. The insurer treats this surveillance like their golden ticket to get the jury to believe your client is exaggerating about their disability and is lying.

How to combat the surveillance defense:

- At the outset of the case, always serve a request for production for the surveillance which should include a request for the surveillance, the actual raw footage data (and not the edited portions) and all corresponding reports.

- Don't allow the defendant to withhold the production of the surveillance until after your client's deposition. The insurance company will try to argue that they have a right to withhold the surveillance until after the deposition for impeachment purposes. This is improper as the surveillance is part of the claim file. File a motion with the court to obtain the documents.

- Does the footage actually show what the insurer purports it to show? Examine the footage yourself in great detail. For example, the insured is restricted from sitting for longer than 30 minutes. The surveillance shows the insured getting in to the passenger seat of a car and driving two hours to a destination. Was the insured sitting or lying reclined (which relieves

the disability) during the drive? Or, the defense may argue the surveillance shows your client lifting what appears to be a heavy box when she is limited from lifting anything greater than five pounds. What is in the box? Be careful, surveillance videos are not clear; was it actually the insured lifting a box or a similar aged and appearing individual?

- Review the actual footage with the insured's treating physicians for their opinions and whether the activities shown are consistent with their restrictions and limitations. Keep in mind that the footage shows sporadic events and is not comparable to the insured performing the material and substantial and duties of his or her occupation with reasonable continuity – rather, it shows the insured for 30 minutes which is different from the insured's ability carry out their occupational duties for 8 hours a day, five days a week. The footage does not show how the insured recovers in the privacy of their home from an activity.

- Confirm whether the insurance company provided any of their reviewing physicians the actual surveillance footage (as opposed to providing just the surveillance report). Often times, the actual footage appears much more harmless than as described in the surveillance report.

B. Dual Occupation

The insurance company may argue that the insured has a dual occupation and therefore cannot be considered totally disabled. For example, the insurance company may characterize a physician, who also runs his own practice, as having a dual occupation, because they operate as a business owner.
To overcome this defense, examine the insured's substantial and material duties at the *onset* of his or her disability. The onset of the disability may be well before the date that the insured considered himself to be totally disabled. Recall that the insurance company has an obligation to place its interest equal to or greater than its own and this includes looking at the earliest point in time of the onset of the disability to determine what his or her occupational duties were, especially if the dual occupation at the time of the disability claim may preclude benefits. What percentage of time did the insured spend performing clerical duties as opposed to seeing patients at the onset of his disability? If the insured was engaged in other businesses at the onset of his disability, what were his roles in those businesses? Does the insured's tax returns support the fact that the insured was a passive income earner in these other businesses as opposed to an active income earner? In order to support this argument, hire a vocational expert to analyze his or occupational duties. Hire a financial expert to analyze the tax returns.

C. Unsupportive 3rd Party Witnesses

The insurance company will do everything it can to find any third party witness who will discredit its insured. There may be a disgruntled former employee, ex-spouse, or former business partner willing to sabotage the claim. Conduct your own research. Does the former employee have any pending claims (such as worker's compensation) against your client or former company that will affect the witnesses' credibility in this case? Does the ex-spouse have a financial incentive to harm the claim? Are there any lawsuits between the parties involved?

D. Financial Gain

Under this defense, the insurance company will argue that the insured is not disabled, but making a choice to claim disability as a means of an early retirement. They will make every attempt to argue that the insured is leaving their occupation because he or she is burnt-out, fed-up with dealing with patients or clients, or simply was in a business or practice that was already headed downhill. To attack this defense, we suggest:

- Discuss the defense's argument with your client at length in order to obtain details to support your argument about how much the insured loved his career and how he reluctantly filed a disability claim when he could no longer keep up with the physical or mental demands of the occupation. The insurance company may have visited the insured during the claims process and captured statements from your client in a field memorandum from this visit. Be sure to have your client review this statement for any mischaracterizations and always serve a request for production for any audio recording from the field visit to combat any misstatements.

- Interview former employees and business partners to support your client's story and offer these witnesses for deposition or obtain sworn statements from them in support.

- The insurance company will subpoena any broker who assisted with the sale of your client's business, if applicable. Make sure to obtain all written communications the insured exchanged with the broker about the practice as it was usually done at a time before you were involved with the claim and you need to assure consistency with your client's disability.

- Use your client's billing and financial data to show that he was making more money in his occupation than he ever would make from the insurance claim and therefore there was no financial incentive to file a claim.

E. Misrepresentations in Underwriting

In some scenarios, an insurance company can contest the policy for material misrepresentations during underwriting. The insurance company may also allege that there were misrepresentations made during an application for the policy, even for a rider that increases the monthly benefit, after the policy was issued.

Always obtain the underwriting file and the guidelines at issue. The underwriting file will explain what the insured represented to the insurance company at the time of the application. The underwriting guidelines will allow you to determine what information the insurance company required to be ordered and examined before making a decision on the policy.

Look at the records that the insurance company had knowledge about (and may not have obtained) at the time of the underwriting. Were they on notice of a condition, or the onset of a condition, that they are now claiming invalidates the policy or supports reformation? Were the underwriters trying to "rush" the application and overlook obtaining certain information in order to collect a premium? Did the insurance company act contrary to their own guidelines? Fail to analyze required financial information? Most importantly, take the depositions of those involved in the underwriting and the deposition of the person most knowledgeable at the insurance company and develop testimony to show that the company was on notice of the misrepresentation that they now claim to rescind the policy under and prove how they did not follow their own internal guidelines as to the information that they were aware of. Argue waiver and estoppel if the misrepresentations occurred remote in time.

F. Other Applications

For medical and dental professionals, the insured may have completed applications of malpractice or credentialing at, around or after submitting his or her disability claim. Or, the insured sold his or practice at the onset or around the time of the disability and may have made representations to brokers or used practice data, such as medical billing, to show the strength of the practice at the time of sale. The insurance company will subpoena the records from these sources to determine whether statements made were consistent with the claimed disabling conditions. In this scenario:

- Pay close attention to the actual wording on the applications and the response.

- Office staff may have completed the forms on the insured's behalf without having an understanding or even having knowledge of, the insured's disability. Confirm whose handwriting and signature is on each of the documents and understand the process involved with completing the forms.

- Have an understanding as to how the medical billing is conducted at the insured's office. The insured could be physically present at the office but not performing any of the hands on work.

G. Appropriate Care

Most policies contain varying care provisions which require the insured to be "under the care of the physician other than yourself" or receiving "appropriate care for the condition causing the disability" or "under the regular care of a physician" or "under the care and attendance of a physician." Initially, these care provisions were created to make certain that an insured was being treated and certified as disabled by a psychiatrist (and not an internist, for example) for a depression claim. However, the insurance companies have transformed these definitions to expand these terms to impose unwritten restrictions on the insured. The scenario presented with most often is when the insured is disabled from practicing the substantial and material duties or his or her occupation as a dentist, for example, due to bilateral carpel tunnel syndrome. The insured files a disability claim and undergoes conservative treatments and therapy, which fail. The treating physician recommends carpel tunnel release surgery. The insured does not want to accept the risks associated with surgery and then the insurance company denies the claim asserting that the insured is not receiving the "appropriate care."

There are three reported cases on the issue in California: *Provident Life & Accident Insurance Co. v. Henry* (C.D. Cal 2000) 106 F.Supp.2d 1002 (holding that "appropriate care for the condition causing disability" created a duty on the part of the insured to submit to appropriate medical treatment, which may include a surgical procedure); *Provident Life and Accident Ins. Co. v. Van Gemert* (C.D.Cal. 2003) 262 F.Supp.2d 1047 (holding that the "under the care and attendance of physician" provision may consist of surgery where surgery is the course of medical treatment that a reasonably prudent person would pursue); and *Buck v. UNUM Life Insurance Co. of America* (N.D.Cal. 2010) 2010 WL 887379 (holding that the provision "under a care of a physician other than yourself" does not condition benefits on the insured submitting to surgery but the court refused to hold that the "appropriate care for the condition causing disability" did not require surgery.

If you are handling a claim where this issue comes up, you must argue that surgery should never be required as a condition to disability benefits as the policy is silent on the issue and the care language is ambiguous and cannot require surgery. Support these arguments by doing the following:

- Request all marketing materials used to sell the policy. You will find that the companies may make no mention that surgery is required or even tout the simplicity of complying with the policy's care provision requirement when it comes time to make a claim.

- Request all claim and policy-and-procedure manuals and training materials regarding the care provisions. You should obtain these materials that were in place at the time the policy was sold, issued and the materials in place at the time the claim was made. The materials will likely make no mention of any requirement that the insured must undergo surgery as a condition to receiving benefits. This will allow you to argue that the insurer did not understand the policy to require surgery at the time that it was issued and therefore, since it did not hold this view, it cannot credibly argue that the provision now requires the insured undergo surgery.

- Find out how the provision was treated by the California Department of Insurance ("DOI"). Subpoena records from the DOI for materials that that the company submitted to the DOI at the time it was seeking approval of the policy for sale in California. It is the policy of the DOI that any exclusions and limitations in an individual disability policy are spelled out as clearly as possible. Take the deposition of the person most knowledgeable at the company regarding the approval of the insurance policy form and the authority for allowing insurance companies to manage and dictate the insured's medical care as a pre-condition to receiving disability benefits under the policy.

- Locate former employees who worked for the insurance company at the time the policy form was drafted. We have found employees who were involved in drafting the care provisions of the language in dispute who testified that the care language did not include a surgical requirement.

- Locate and depose agent who sold the policy to the insured. The agent may have training materials issued by the company that explains to the agent how to sell and explain the care provision of the policy, which likely did not contain any requirement that the insured undergo surgery.

- Obtain the informed consent form for the proposed surgery. This form will contain a list of complications that undercut the insurance carrier's claim that the surgery is safe and simple.

There are many creative defenses the insurance companies attempt to dismantle a valid insurance claim. Use the insurance company's actions – or lack of action – to not only prove that the insured's claim, but also that the insurer's actions were in breach of the implied covenant of good faith and fair dealing.