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Software as a Service: The Past Through Tomorrow

Robert V. Hawn

Long, long ago, in a Silicon Valley far, far away, back office accounting was processed using a timesharing service accessed through an acoustic modem, a telephone, and a teletype machine. In today's world of smart phones, laptops, and Web 2.0, the modem is in your telephone, the telephone is wireless, and the teletype machine is in a museum. Although the hardware has shrunk, the ability to access and use increasingly sophisticated applications has grown.

Get SaaSy!

Software as a service, otherwise known as "SaaS," is rapidly expanding. In a press release published October 22, 2008, by Gartner, Inc., worldwide enterprise application SaaS revenue was forecasted to reach \$14.8 billion by the end of 2012. See <http://www.gartner.com/it/page.jsp?id=783212>.

Investors are attracted to the SaaS industry due to its ability to penetrate the market for small- and medium-sized business, reduce the transactional friction often associated with licensing transactions, and threaten the predominance of large software vendors.

—continued on page 71

IN THIS ISSUE

Software as a Service: The Past Through Tomorrow.....	69
by Robert V. Hawn	
Special Committees for Tough Economic Times and Beyond.....	88
by Eric Landau, Shawn M. Harpen, and Kevin H. Logan	
Insurance "Bad Faith" Basics, Part I.....	96
by Guy O. Kornblum	

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CONTINUING EDUCATION OF THE BAR ■ CALIFORNIA

Insurance "Bad Faith" Basics, Part I

Guy O. Kornblum



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INTRODUCTION

Implicit in every insurance contract is a covenant of good faith and fair dealing. This covenant of good faith serves as the foundation for the expansion of an insurer's legal duty into the realm of potential tort liability for "bad faith" conduct. The term "bad faith" is a generic reference to actions seeking recovery beyond the policy, regardless of the theory of recovery. The term "bad faith" can also refer specifically to the theory of violation of the implied covenant of good faith and fair dealing. If the insurer breaches the covenant of good faith by wrongfully handling an insurance claim under the applicable standard, a tort is committed. See, e.g., *Gruenberg v Aetna Ins. Co.* (1973) 9 C3d 566, 575, 108 CR 480; *Sparks v Republic Nat'l Life Ins. Co.* (Ariz 1982) 647 P2d 1127, 1136.

When the insurer's conduct constitutes a tort, the plaintiff can recover damages for injuries that were proximately caused by that conduct, whether or not the injuries could have been anticipated when the contract was executed. Thus, in addition to contract damages, the insured may be able to recover extra-contractual compensatory damages, including damages for emotional distress, economic losses, and even attorney fees. See, e.g., *Gruenberg*, 9 C3d at 579.

Moreover, punitive damages may be awarded on these tort claims if certain levels of misconduct are proven. Indeed, the potential exposure to punitive, or exemplary, damages is the greatest danger to an insurer defending an extra-contractual claim. See *Egan v Mutual of Omaha Ins. Co.* (1979) 24 C3d 809, 169 CR 691. See also *Neal v Farmers Ins. Exch.* (1978) 21 C3d 910, 148 CR 389. For example, Idaho courts have allowed the recovery of punitive damages when the insurer's breach is accompanied by an independent tort or when a serious wrong of a tortious nature has been committed and the public interest would be served by the deterrent effect of punitive damages. See, e.g., *White v Unigard Mut. Ins.* (Id 1986) 730 P2d 1014, 1017.

Insurance bad faith cases fall primarily into two categories: first-party and third-party cases. First-party cases evolve from coverage in which the insurance company is obligated to indemnify or reimburse its insured directly or to defend an insured against lawsuits brought by third parties. See, e.g., *Garvey v State Farm Fire & Cas. Co.* (1989) 48 C3d 395, 399, 257 CR 292; *Bodenhamer v Superior Court* (1987) 192 CA3d 1472, 1476, 238 CR 177. Third-party cases involve claims by parties who are strangers to the insurance relationship and in which (*Garvey*, 48 C3d at 407):

the right to coverage . . . draws on traditional tort concepts of fault, proximate cause and duty. . . . In liability insurance, by insuring personal liability, and agreeing to cover the insured for his or her own negligence, the insurer agrees to cover the insured for a broader spectrum of risks.

If the insurer breaches the covenant of good faith by wrongfully handling an insurance claim under the applicable standard, a tort is committed.

Liability policies are usually thought of as involving third-party claims; however, they may include first-party coverage. As such, a liability policy may constitute a basis for both first- and third-party bad faith suits. A typical liability policy, such as an auto policy, protects first parties by providing coverage for medical payments, an insured's property damage, and uninsured/underinsured motorist coverage. In the so-called "excess cases," in which the insurer has unreasonably refused to settle a third-party claim within the policy limits, the insured may assign his or her rights to the excess judgment and the third-party claimant may file suit for the amount of excess. See, e.g., *Murphy v Allstate Ins. Co.* (1976) 17 C3d 937, 942, 132 CR 424; *Cain v State Farm Mut. Auto Ins. Co.* (1975) 47 CA3d 783, 794, 121 CR 200; *Purcell v Colonial Ins. Co.* (1971) 20 CA3d 807, 813, 97 CR 847. However, the insured cannot assign the personal claims to emotional distress damages and punitive damages. See *Purcell*, 20 CA3d at 814. Also, a third-party claimant's actions based on traditional tort theories of fraud or intentional infliction of emotional distress may result in an extra-contractual award. See, e.g., *Fletcher v Western Nat'l Life Ins. Co.* (1970) 10 CA3d 376, 89 CR 78. The third party's direct action against a tortfeasor's insurer (i.e., the defendant in the third-party action) based on Ins C §790.03(h) was abolished by the court in *Moradi-Shalal v Fireman's Fund Ins. Cos.* (1988) 46 C3d 287, 250 CR 116.

THIRD-PARTY CASES

Failure to Settle

Third-party lawsuits are based on claims arising under liability policies, brought by a claimant who is not in contractual privity with the insured. The focus of a third-party case is on the failure to settle a case in which a judgment is entered in excess of the liability protection.

"Failure to settle" lawsuits may be brought directly by the insured or by a third-party claimant through an assignment from the insured. See, e.g., *Hamilton v Maryland Cas. Co.* (2002) 27 C4th 718, 732, 117 CR2d 318. The covenant of good faith and fair dealing that is implied in every insurance contract obligates the insurer to avoid conduct that would deprive the insured of the contract's protection for which he or she bargained. Thus, when there is a substantial likelihood of recovery in excess of the policy limits, the insurer owes a duty to the insured to settle within those limits. See *Comunale v Traders & Gen. Ins. Co.* (1958) 50 C2d 654, 328 P2d 198. To do otherwise would expose the insured to a risk of excess personal liability, and thereby deprive the insured of the bargained-for protection. *Crisci v Security Ins. Co.* (1967) 66 C2d 425, 430, 58 CR 13.

An insurer's failure to settle within policy limits under these circumstances subjects the insurer to liability for all damages proximately resulting from its refusal to settle, regardless of whether the damages were anticipated. See *Hamilton*, 27 C4th at 725. As a result, the insurer may be liable to the insured for the entire judgment plus other compensatory damages resulting from the wrongful conduct. Other damages may include damages for emotional distress and even punitive damages, as long as there is an additional showing of the proscribed conduct. If the cause of action is assigned to a third-party claimant, then only the amount of the excess judgment may be transferred to the assignee. *Murphy*, 17 C3d at 946. However, a receiver may be allowed to pursue punitive claims against an insurer that were within the scope of the receivership. See *Baron v Fire Ins. Exch.* (2007) 154 CA4th 1184, 65 CR3d 502. An insured's claims to compensatory damages for emotional distress and punitive damages are unassignable. *Murphy*, 17 C3d at 942. These claims can only be pursued by the insured, who may join with the third party to bring the bad faith claim. *Cain*, 47 CA3d at 795. The insured and third party claimant cannot sue separately because that would split the single cause of action that originally resided in the insured. *Purcell*, 20 CA3d at 814.

Elements of the Third-Party Case

To recover on a theory of breach of the implied covenant of good faith and fair dealing by failure to settle, the insured (or the third-party claimant by assignment) must plead and prove the following elements:

- That the carrier received timely notice of the insured's claim and had a reasonable opportunity to settle within the policy limits;
- That the insurer *unreasonably* rejected or refused a settlement offer within the policy limits;
- That an excess judgment was returned against the insured, or that the underlying case has been otherwise concluded and that judgment is final; and
- In an action by a third party, that the excess judgment against the insured was assigned to the third party. See generally California Civil Jury Instruction (CACI) 2334.

[W]hen there is a substantial likelihood of recovery in excess of the policy limits, the insurer owes a duty to the insured to settle within those limits.

Standards to Determine Liability

The standards used to determine whether the insurer acted reasonably in refusing to settle the insured party's claim depend in part on the grounds on which the insured based its decision not to settle. If the refusal was based on a coverage dispute and the insurer is later determined to be wrong, the insurer acted at its own risk; its good faith belief regarding noncoverage is no defense to a bad faith action by the insured. See *Johansen v California State Auto Ass'n Inter-Ins. Bureau* (1975) 15 C3d 9, 16, 123 CR 288.

In contrast, if the insurer's refusal to settle was based on its evaluation of the demand, *i.e.*, if the insurer took the position that it could obtain a defense verdict or that the plaintiff's verdict would be lower than the demand, the insurer is judged by the "prudent insurer" standard. *Crisci*, 66 C2d at 429. This test asks whether a prudent insurer would have accepted the settlement offer if it alone were liable for the entire judgment. However, the excess judgment itself may be sufficient evidence of the case's value. See *Johansen*, 15 C3d at 17.

The insurer is obligated to consider the interests of the insured as well as its own interests when evaluating a settlement offer. Whether the insurer acted reasonably is determined in part by the following criteria:

- The strength of the insured claimant's case.
- Any attempt by the insurer to induce or coerce the insured to contribute to the settlement.

- The insurer's failure to properly investigate the circumstances to ascertain evidence against the insured.
- The insurer's rejection of advice from its own lawyers or claims investigators.
- The insurer's failure to inform the insured of the compromise offer (to enable the insured to consider "adding to the pot" to effectuate settlement). The fact that the insured is not financially solvent or has insufficient assets to pay a personal judgment does not relieve the insurer of its duty to settle in the face of an opportunity to do so or within the liability limits of coverage (see *Purdy v Pacific Auto Ins. Co.* (1984) 157 CA3d 59, 73, 203 CR 524; *Kinder v Western Pioneer Ins. Co.* (1965) 231 CA2d 894, 900, 42 CR 394).
- The financial risk to which the insured is exposed in the event of a refusal to settle.
- The fault of the insured in inducing the insurer's rejection of the proposed compromise settlement by misleading it as to material facts.
- Any other factors tending to establish or negate bad faith on the part of the insured (see *Brown v Guarantee Ins. Co.* (1957) 155 CA2d 679, 319 P2d 69).

[I]t is risky for an insurer to allow a third-party settlement demand to expire without making some response.

To avoid bad faith exposure, an insurer should respond to each settlement demand, even if the offer is perceived as uncertain. Ignoring an incomplete or defective demand may constitute a breach of the insurer's duty. In the face of a problematic demand, the insurer should make a timely response to the demand, point out the specific reasons why the demand is incomplete or cannot be acted upon, and manifest a willingness to negotiate further. If the demand is reasonable and the insurer does not accept the offer within the time limits stated (if those time limits are reasonable), a breach of the implied covenant has occurred, and the injured party is relieved of any further duty to continue negotiations. See, *e.g.*, *Coe v State Farm Mut. Ins. Co.* (1977) 66 CA3d 981, 994, 136 CR 331. Thus, it is risky for an insurer to allow a third-party settlement demand to expire without making some response. At a minimum, an insurer should request additional time in which to respond. Even though a delayed acceptance of a reasonable settlement demand will not "cure"

the insurer's previous bad faith conduct, a belated settlement offer for the amount demanded *may* cut off liability for further damages for emotional distress and economic loss.

Breach of the Duty to Defend

The duty to defend inures to the benefit of the insured, not the injured party. An insurer has four alternatives when faced with a claim involving a question of coverage. The insurer may:

- Refuse to defend;
- Defend under a reservation of rights;
- Reserve rights and offer to pay for independent counsel (referred to as "*Cumis* counsel") to defend the action against the insured; or
- Accept a defense of the third-party suit and waive objections to the lack of coverage.

To maintain a bad faith action against an insurer for wrongful refusal to defend, the insured must plead and prove that (see CACI 2336):

- The insured was insured for liability coverage that contained a duty to defend;
- A lawsuit was brought against the insured;
- Notice and opportunity to defend was given to the insurer;
- The insurer unreasonably refused to defend the insured;
- The insured was damaged; and
- The insurer's conduct was a factor in causing the insured's resulting damages.

Without additional facts, an insurer's erroneous refusal to furnish a defense is simply a breach of contract. However, extra-contractual damages may be awarded for breach of the implied covenant of good faith if the refusal to defend is unreasonable or without proper cause. "[D]eclining to perform a contractual duty under the policy *with proper cause* [which may include mistake] is not a breach of the implied covenant." *California Shoppers, Inc. v Royal Globe Ins. Co.* (1985) 175 CA3d 1, 54, 221 CR 171 (emphasis in the original). "[I]t is our view that a *mistaken withholding* of policy benefits . . . is consistent with observance of the implied covenant of good faith and fair dealing because the mistake supplies the 'proper cause.'" 175 CA3d at 55 (emphasis in the original).

A bad faith refusal to defend exposes the insurer to compensatory damages under the tort measure of damages for attorney fees, costs incurred by the insured in defending the lawsuit, and damages for emotional distress. When the insurer has unreasona-

bly refused to defend the insured in a third-party claim, the insured is entitled to make a reasonable settlement of the claim and then seek reimbursement. A reasonable settlement is presumptive evidence of the insured's liability on the underlying claim. *Isaacson v California Ins. Guar. Ass'n* (1988) 44 C3d 775, 791, 244 CR 775. In extreme cases, when the refusal to defend and denial of coverage are coupled with conduct that constitutes severe misconduct, punitive damages may be awarded. See *Tibbs v Great Am. Ins. Co.* (9th Cir 1985) 755 F2d 1370.

[E]xtra-contractual damages may be awarded for breach of the implied covenant of good faith if the refusal to defend is unreasonable or without proper cause.

Cumis Counsel

When a disqualifying conflict of interest arises between the insurer and the insured, the insurer's duty to defend the insured may obligate it to furnish independent counsel, also known as "*Cumis* counsel." See *San Diego Navy Fed. Credit Union v Cumis Ins. Soc'y, Inc.* (1984) 162 CA3d 358, 208 CR 494; *Dynamic Concepts, Inc. v Truck Ins. Exchange* (1988) 61 CA4th 999, 1007, 71 CR2d 882. A conflict of interest between jointly represented clients exists "whenever their common lawyer's representation of the one is rendered less effective by reason of his representation of the other." *Spindle v Chubb/Pacific Indem. Group* (1979) 89 CA3d 706, 713, 152 CR 776. See also CC §2860(b). Whether the insurer's denial of coverage of a third-party claim obligates it to provide independent counsel for the insured depends on the nature of the coverage dispute. Independent counsel may be required when the insurer elects to defend under a reservation of rights and the outcome of the action may control the coverage issue. See CC §2860(b). Under such circumstances, a conflict of interest may exist such that the insurer is required to pay for the insured's lawyer. For example, a dispute concerning whether the policy had lapsed usually would not require independent counsel for the insured in the third-party action. Independent counsel is not required simply because coverage is denied for the allegations or facts in the third-party action; the allegations or facts showing noncovered conduct do not by themselves constitute a conflict of interest requiring in-

dependent counsel. *Dynamic Concepts, Inc. v Truck Exch.* (1998) 61 CA4th 999, 71 CR2d 882; *Blanchard v State Farm Fire & Cas. Co.* (1991) 2 CA4th 345, 2 CR2d 884; *McGee v Superior Court* (1985) 176 CA3d 221, 221 CR 421.

Whether the insurer's denial of coverage of a third-party claim obligates it to provide independent counsel for the insured depends on the nature of the coverage dispute.

**FIRST-PARTY CASES:
THE THREE-TIER
ANALYTICAL PROCESS**

Principles of First-Party Bad Faith

The classic first-party insurance bad faith case is represented by a three-tiered analytical framework: (1) breach of the insurance contract; (2) the tort of insurance bad faith (or other tort converting the contract action to a tort claim); and (3) the punitive damages claim. These tiers involve a mixture of legal theories and remedies. The first tier is based on a contract theory of recovery, the second on a tort theory, and the third on a remedy (*i.e.*, punitive damages) that is available only if a tort is proven. See, *e.g.*, *Transportation Ins. Co. v Moriel* (Tex 1994) 879 SW2d 10, 17; *Erie Ins. Co. v Hickman* (Ind App 1993) 622 NE2d 515.

Tier One: Breach of Contract

The first-tier issue is whether a breach of the policy's terms has occurred (*i.e.*, a breach of contract) and, if so, what policy benefits (*i.e.*, contract damages) are owed. Contract damages are limited to those damages reasonably contemplated by the parties at the time the bargain is struck. See CC §3300; California Law of Contracts §§10.3–10.6 (Cal CEB 2007). Such damages are ordinarily limited to the payments or benefits due under the policy and rarely include future contract benefits or damages for emotional distress or punitive damages. But see *Frazier v Metropolitan Life Ins. Co.* (1985) 169 CA3d 90, 102, 214 CR 883. In *Frazier*, the court found that the plaintiff had proved damages sufficient to entitle her to claim emotional distress on a breach-of-contract theory, but rejected her request for exemplary damages because her action was on the contract and her cause of action for breach of the implied covenant of good faith was time-barred.

Tier Two: Breach of the Covenant of Good Faith—A Tort

The second tier involves looking at the *conduct* of the insurer in handling the claim or matters entrusted to it. Has the *tort* of insurance bad faith been committed? If so, what *extra-contractual compensatory* damages (*i.e.*, financial injury resulting in economic losses coupled with emotional distress and attorney fees) have resulted from this conduct? In a long-term disability case, bad faith may result in future benefits being awarded. See *Egan v Mutual of Omaha Ins. Co.* (1979) 24 C3d 809, 824 n7, 169 CR 691; *Austero v National Cas. Co.* (1978) 84 CA3d 1, 148 CR 653.

Tier Three: Punitive Damages

A punitive damages claim is not a separate legal claim but a remedy appended to a tort claim. In insurance bad faith law, the right to pursue punitive damages exists only if an underlying tort, such as insurance bad faith, is established. Without the underpinning of the tort claim, no punitive damages are available.

The third tier requires examining again the conduct of the company and determining, by the requisite burden of proof, whether punitive damages would be awarded under the applicable standard. CC §3294(a). See also *Linthicum v Nationwide Life Ins. Co.* (1986) 723 P2d 675, 681. For a recent case analyzing the standard for awarding punitive damages, see *Sloan v State Farm Mut. Auto. Ins. Co.* (10th Cir 2004) 360 F3d 1220. In California, a punitive damages award requires proof of "oppression, fraud, or malice" by "clear and convincing" evidence. CC §3294(a).

Summary

A bad faith claim therefore has three separate and distinct components. A breach of contract alone is not "bad faith"; there must be an examination of the company's conduct to determine whether the manner of handling the claim was consistent with "good faith" principles. Moreover, proof of bad faith is not enough to impose punitive damages. Something more is required, which has been expressed as an "evilness" in the corporate scheme of things or the collective corporate conduct. As Judge Cameron stated in *Linthicum v Nationwide Life Ins. Co.* (1986) 723 P2d 675, 679:

To recover punitive damages something more is required over and above the "mere commission of a tort" [citations]. The wrongdoer must be consciously aware of the wrongfulness or harmfulness of his conduct and yet con-

tinue to act in the same manner in deliberate contravention to the rights of the victim. . . . We hold that before a jury may award punitive damages there must be evidence of an "evil mind" and aggravated and outrageous conduct.

Of course, any punitive award is susceptible to post-trial review by the appellate courts. See, e.g., *State Farm Ins. Co. v Campbell* (2003) 538 US 408, 155 L Ed 2d 585, 123 S Ct 1513. See also *Philip Morris USA v Williams* (2007) 549 US 346, 166 L Ed 2d 940, 127 S Ct 1057. For a recent California case in which the trial court reduced a punitive award from \$8.3 million to \$1.5 million using the "Campbell" standards, see *Walker v Farmers Ins. Exch.* (2007) 153 CA4th 965, 63 CR3d 507, which involved an insurer's breach of the duty to defend. The trial court found that the ratio of punitives to compensatory damages of 5.5 to 1 was excessive and reduced the punitives to a 1-to-1 ratio, even though *Campbell* approved a 9-to-1 ratio.

Plaintiff's counsel must evaluate and apply the different standards and burdens. Otherwise, the defense has an excellent opportunity to defeat the plaintiff's effort to obtain relief for the wrongs done in an amount sufficient to accomplish the goal of giving notice that such conduct must be stopped.

[A]n erroneous decision not to pay a claim for benefits due under a policy does not, by itself, justify an award of extra-contractual compensatory damages.

**The Standard to be Applied
in First-Party Bad Faith Cases**

California has been a leader in the development of insurance bad faith law. It is now well settled that an erroneous decision not to pay a claim for benefits due under a policy does not, by itself, justify an award of extra-contractual compensatory damages. These damages may be awarded only if a tort is also committed, such as a breach of the implied covenant of good faith and fair dealing.

As noted, if the plaintiff proves that the erroneous decision not to pay a claim was made unreasonably, the California standard of liability for a breach of the implied covenant of good faith has been met. See CACI 2331. Accordingly, an insurer that has proper cause to decline to perform a contractual duty does not breach the implied covenant of good faith. See, e.g., *Seamen's Direct Buying Serv., Inc. v Standard Oil Co.* (1984) 36 C3d 752, 770, 206 CR 354, overruled on other grounds in *Freeman Mills,*

Inc. v Belcher Oil Co. (1995) 11 C4th 85, 87, 44 CR2d 420.

**Statutory and Regulatory Basis for
"Good Faith" Claims Handling Standards**

Both the California Insurance Code and the California Code of Regulations (10 Cal Code Regs §§2695.1-2695.17) provide standards for insurance company conduct in California. California Ins C §790.03, which addresses certain unfair claims settlement practices, is derived from the Unfair Claims Practices Act drafted by the National Association of Insurance Commissioners in 1972. It became part of Ins C §790.03 in 1973 and has been amended multiple times since then. It now contains 16 subsections identifying "unfair claims settlement practices," which constitute prohibited "unfair methods of competition and unfair and deceptive acts or practices." The list of prohibited unfair or deceptive acts or practices is set forth in Ins C §790.03(h)(1)-(16) and includes:

- Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue;
- Failing to acknowledge and act reasonably promptly on communications with respect to claims arising under insurance policies;
- Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies;
- Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured;
- Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;
- Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds, when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered;
- Attempting to settle a claim by an insured for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application;
- Attempting to settle claims on the basis of an application that was altered without notice to, or knowledge or consent of, the insured, his or her representative, agent, or broker;

- Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made;
- Making known to insureds or claimants a practice of the insurer of appealing from arbitration awards in favor of insureds or claimants for the purposes of compelling them to accept settlements or compromises less than the amount awarded in arbitration;
- Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;
- Failing to settle claims promptly, where liability has become apparent, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;
- Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement;
- Directly advising a claimant not to obtain the services of an attorney;
- Misleading a claimant regarding the applicable statute of limitations; and
- Delaying the payment or provision of hospital, medical, or surgical benefits for services provided with respect to Acquired Immune Deficiency syndrome or AIDS-related complex for more than 60 days after the insurer has received a claim for those benefits, when the delay in claim payment is for the purpose of investigating whether the condition preexisted the coverage. However, this 60-day period shall not include any time during which the insurer is awaiting a response for relevant medical information from a health care provider.

These specified acts provide standards that, if violated, may constitute a breach of the covenant of good faith and fair dealing. *Frommoethelydo v Fire Ins. Exch.* (1986) 42 C3d 208, 215, 228 CR 160 (citing Ins C §790.03(h)(3), (5)). Referring to the fact that an insurance company is privileged to make reports regarding suspected fraudulent claims to California's Bureau of Fraudulent Claims, the court stated (42 C3d at 219):

This does not mean that an insured may not recover damages for a failure to investigate in violation of the implied

covenant, fiduciary duty or the duty to engage in fair practices. The insured may recover damages for such violations where the recovery is not predicated upon injury due to a report to the Bureau but upon other injuries.

The California Supreme Court has thus blessed the concept that Ins C §790.03(h) sets standards by which to determine whether an insurer has violated good faith claims practice rules, even though the subdivisions of that code section may not be used as a basis for a private right of action. *Moradi-Shalal v Fireman's Fund Ins. Cos.* (1988) 46 C3d 287, 250 CR 116.

Title 10 Cal Code Regs §2695 was adopted in 1993 to expand the prohibited acts and to outline them as they pertain to specific types of insurance coverage. As in the case of Ins C §790.03, the regulations also set standards for insurers and, if violated, may serve as a basis for a claim that the insurer violated the implied covenant of good faith and fair dealing. See *Spray, Gould & Bowers v Associated Int'l Ins. Co.* (1999) 71 CA4th 1260, 84 CR2d 552. The Insurance Commissioner promulgated the regulations to accomplish the following objectives (10 Cal Code Regs §2695(1)(a)):

(1) To delineate certain minimum standards for the settlement of claims which, when violated knowingly on a single occasion or performed with such frequency as to indicate a general business practice shall constitute an unfair claims settlement practice within the meaning of Insurance Code Section 790.03(h);

(2) To promote the good faith, prompt, efficient and equitable settlement of claims on a cost effective basis;

(3) To discourage and monitor the presentation to insurers of false or fraudulent claims; and

(4) To encourage the prompt and thorough investigation of suspected fraudulent claims and ensure the prompt and comprehensive reporting of suspected fraudulent claims as required by Insurance Code Section 1872.4.

Insurers issuing policies in California customarily follow these "good faith" rules. Virtually all the insurers not only adopt the rules, but have internal operating policies for implementing them in their claims manuals and memoranda for their claims administrators.

Factors Showing Breach of Covenant of Good Faith

Although not an exhaustive list, the following are indicia of bad faith conduct:

- Failure to investigate a claim thoroughly;
- Failure to evaluate a claim objectively;
- Unduly restrictive interpretation of policy language or claims forms;

- Unjustified delay in payment of a claim;
- Dilatory handling of claims;
- Deceptive practices to avoid payment of a claim;
- Abusive or coercive practices to compel compromise of a claim;
- Unreasonable conduct during litigation;
- Arbitrary and unreasonable demands for proof of loss;
- Absence of a reasonable basis for delay in payment or for the denial of a claim;
- Improper refusal to defend an insured;
- Improper handling of defense of an insured, resulting in loss of goodwill; and
- Deliberate misinterpretation of records or the policy to defeat coverage.

Although there is no formal affirmative defense of a bad faith claim (*Kransco v American Empire*

Surplus Lines Ins. Co. (2000) 23 C4th 390, 411, 97 CR2d 151), the conduct of the insured is admissible on the question of whether the insurer met its obligations of good faith and fair dealing. For example, an insurer may claim that the insured failed to cooperate in the investigation of a claim or failed to provide necessary information for a claim's evaluation, which resulted in the inability of the insurer to process the claim fully.

* * * * *

The second installment of this article will appear in the next issue of the California Business Law Practitioner. It will address the insurer's duty to investigate; the insurer's defense of "good faith dispute," also known as the "genuine issue rule"; and damages. It will conclude with the author's comments on trial of an insurance bad faith case.