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Addressing Common Asserted Defenses to Coverage and Bad-Faith Liability

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Introduction

It often seems that buying an insurance policy, far from securing the peace of mind promised, merely grants to the policyholder the possibility that it may sue its insurer for benefits for which it paid premiums and which the policy on its face provides. In our coverage and bad faith practice we see, repeatedly, insurance companies insisting that there is no coverage, refusing to investigate or defend third-party claims, and denying first-party claims with spotty or even nonexistent investigation. Worse, insurance companies have initiated aggressive, offensive steps against insureds who have the temerity to make claims under their policies or to engage counsel to secure promised benefits. We will discuss some of these insurer tactics in this chapter and how an insured might respond based on the current law in California.

The "Genuine Dispute Doctrine"

An insurer who perceives it has only contractual exposure may have little incentive to defend or pay benefits at the outset. At worst, the insurer concludes that it will just have to pay later what it should have paid immediately.

However, an insurer is liable for bad faith—and extra contractual damages—if it *unreasonably* denies or delays benefits owed under a policy. If a jury finds bad faith, the range of potential damages expands, including the attorneys' fees incurred to prove the existence of coverage wrongfully withheld or even punitive damages. Faced with such exposure, insurers will strenuously fight allegations of bad faith. Often, the insurer asserts that the coverage dispute with the insured was "genuine," that it therefore fell within the so-called "Genuine Dispute Doctrine," and that while it may have to pay benefits, it cannot be liable for bad faith or punitive damages.

However, in recent years, it has become clear that this defense is far less robust than insurers urge that it is. The "genuine dispute" doctrine has been described by the California Supreme Court as a "close corollary" to the principle of liability for unreasonable conduct, providing the insurer with a defense if its denial or delay was "due to the existence of a genuine dispute with its insured as to the existence of coverage liability or the amount of the insured's coverage claim."[1]

[1] *Wilson v. 21st Century Ins. Co.*, 171 P.3d 1082, 1089 (Cal. 2007).

In response to a bad faith claim, insurers often invoke this defense as a talisman without regard to the genuineness of the dispute. The Supreme Court in *Wilson*, however, made clear that by "genuine," it means just that.

> The genuine dispute rule does not relieve an insurer from its obligation to thoroughly and fairly investigate, process and evaluate the insured's claim. A *genuine* dispute exists only where the insurer's position is maintained in good faith and on unreasonable grounds.[2]

The *Wilson* court put to rest any notion that the doctrine provides a defense to bad faith liability of an insurer who might have sincerely believed in the legitimacy of what was an unreasonable position:

> [W]e find potentially misleading the statements in some decisions that under the genuine dispute rule bad faith cannot be established when the insurer's withholding of benefits 'is reasonable' *or* is based on a legitimate dispute as to the insurer's liability: In the insurance bad faith context, a dispute is not 'legitimate' unless it is founded on a basis that is reasonable under all the circumstances."[3]

After *Wilson,* what remains as the potential subject of a genuine dispute? It is not clear. Depending on the context and the circumstances, the interpretation of a policy provision in a first party policy might be found by a court to be a "genuine dispute."[4] However, the insurer cannot latch onto an issue and through willful and contrived ignorance manufacture a "dispute." Do not allow an insurer's invocation of "genuine dispute" to distract from what is always the key question: is the insurer acting reasonably? The insurance policy's implied covenant of good faith and fair dealing requires the insurer to investigate the claim thoroughly: "To protect its insured's contractual interest in security and peace of mind; it is essential that an insurer fully inquire into possible bases that might support the

[2] *Id.*
[3] *Id.* at 1089 n.7.
[4] Note that where this proposition might be true in a first party property claim, it would *not* be true in the context of the duty to defend a liability policy, where the potential for coverage, *by itself* is sufficient to trigger a defense. *See Mt. Hawley Ins. Co. v. Lopez*, 156 Cal. Rptr. 3d 771 (Cal. Ct. App. 2013).

insured's claim before denying it."[5] If the insurer fails to conduct a reasonable investigation, "it has deprived itself of the ability to make a fair evaluation of the claim."[6] The insurer is charged with knowledge of any information that a reasonable investigation might have revealed.[7]

The facts in *Wilson* illustrate the limits of the genuine dispute doctrine as a shield to bad faith liability. The insured was injured in a collision with a drunk driver, suffering a number of injuries including neck, back, and arm pain. Her insurer, 21st Century, rejected her underinsured motorist coverage claim on the ground that she only suffered soft tissue injuries and had a "pre-existing" degenerative disc disease. 21st Century had no medical report supporting this conclusion, which was directly contrary to the conclusion of Wilson's orthopedist who found that her injuries were almost certainly due to the accident. The 21st Century claims examiner made no effort to talk to this doctor. Instead, the examiner put great stock in the fact that Wilson went "on vacation" in Australia after the accident, so how hurt could she be?

The Supreme Court first archly dispensed with this last point, noting that Wilson was in Australia for school, not vacation, and agreeing with the Court of Appeal that "it is just as possible to suffer severe pain in Australia as in Southern California."[8] The court then reasoned that 21st Century could have scrutinized the opinion of Wilson's doctor, investigated its basis, hired its own doctor to evaluate medical records, and then had Wilson examined by that doctor. "What it could not do, consistent with the implied covenant of good faith and fair dealing, was to ignore [Wilson's doctor's] conclusion without any attempt at adequate investigation, and reach contrary conclusions lacking any discernable medical foundation."[9]

However, protested 21st Century, there was at least a "genuine dispute" as to the value of Wilson's claim, pointing to three grounds of factual dispute: (1) a radiologist's characterization of the original x-ray as "normal," (2) the small amount of Wilson's initial medical bills, and (3) Wilson's travels in Europe and Australia. The court found that all of these points simply raised triable issues of fact and did not entitle 21st Century to summary judgment on bad faith.

[5] *Wilson*, 171 P.3d at 1087.
[6] *Id.*
[7] *KPFF, Inc. v. Cal. Union Ins. Co.*, 66 Cal. Rptr. 2d 36 (Cal. Ct. App. 1997).
[8] *Wilson*, 171 P.3d at 1088.
[9] *Id.*

In our practice, the key phrase in the court's analysis is this: "[A] dispute based on . . . an unreasonable position is not genuine."[10] In other words, asking if there is a "genuine dispute" is just another way of asking if the insurer acted unreasonably or reasonably. In addition, as the *Wilson* court made clear, that question "must be evaluated in light of the totality of the circumstances surrounding [the insurer's] actions."[11] Practically speaking, and as the *Wilson* court acknowledged, this should make summary judgment for the insurer on the issue of bad faith difficult to achieve if the dispute is over a factual issue:

> "[A]n insurer is not entitled to judgment as a matter of law where, viewing the facts in the light most favorable to the plaintiff, *a jury could conclude* that the insurer acted unreasonably."[12]

In short, the insured should look with healthy suspicion at a "genuine dispute" defense. That defense does not absolve the insurer of its duty to act reasonably. That question should remain, in most instances, one for the jury to answer. "The reasonableness of an insurer's conduct is ordinarily a question of fact except in the "exceptional instance when only one reasonable inference can be drawn from the evidence."[13]

Further, "genuine dispute" is not applicable in every context in which a dispute may arise. For example, suppose there is a fire in an insured's warehouse, and the insured seeks payment under a property policy. If there is evidence that the insured committed arson this could give rise to a genuine dispute over a factual issue. This is a "first party" insurance case—one only involving the insured and insurer—and a proper context for the "genuine dispute" doctrine.

However, insurers may *not*—although they will—invoke the "genuine dispute doctrine" in the third party context—at least as far as the duty to defend is concerned. In that situation, the insured, having been sued by a third party, seeks a defense under a liability policy. The duty to defend is, of course, broader than the duty to indemnify and is triggered if there is a *potential* for coverage of any single conceivable claim advanced by the third party claimant. The insurer

[10] *Id.* at 1089.
[11] *Id.* at 1088.
[12] *Id.* at 1089.
[13] *Mt. Hawley Ins. Co. v. Lopez*, 156 Cal. Rptr. 3d 771, 801 (Cal. Ct. App. 2013).

may not withhold a defense because it disputes coverage based on a factual issue, whether that dispute is "genuine" or not. We do not yet have California Supreme Court authority on that point, but intermediate courts of appeal have acknowledged that "[i]t is doubtful that the so-called 'genuine dispute doctrine' applies to third party 'duty to defend cases.'"[14]

When we look at the broad scope of the duty to defend, and the presumptions that favor the insured, we can see why this must be the case. Summary judgment is available when material facts are undisputed. If those facts are disputed, summary judgment is usually unavailable. When the duty to defend is the issue, that rule is altered and summary judgment is a powerful tool for the insured; the existence of a single disputed fact gives rise to a potential for coverage and entitles the insured to summary judgment on the issue of the duty to defend. "If coverage depends on an unresolved *factual* question, the very existence of that dispute would establish a possibility of coverage and thus a duty to defend."[15] In short, a "genuine dispute" means there is a potential for coverage. The insurer must defend.

This is the case even if coverage turns on a factual issue completely collateral to the issues involved in the underlying tort action against the insured. For example, a passenger in a car involved in an auto accident sues the driver of the car. The passenger is the driver's mother-in-law. The driver tenders the suit to his auto insurer for a defense. There is a factual question of whether the passenger lives with the driver at the same residence; if that were the case, then the driver would have no liability coverage for the damages she claimed. Of course, the issue of whether the plaintiff passenger resides with the defendant is of no importance whatsoever to the merits of her claims for the injuries suffered.

These were the facts in *Amato v. Mercury Casualty Co.*[16] The insurer, Mercury, argued that it did not have a duty to defend because this residence issue "was independent of and extraneous to the issues involved in the underlying tort action."[17] The court rejected this argument, holding that "although a coverage dispute is capable of being resolved without reference to the facts of the

[14] *Id.* at 801 n.20.
[15] *Mirpad LLC v. Cal. Ins. Guar. Ass'n*, 34 Cal. Rptr. 3d 136, 143 (2005).
[16] *Amato v. Mercury Cas. Co.*, 23 Cal. Rptr. 2d 73 (1993) (*Amato I*).
[17] *Id.* at 77.

underlying tort case, this fact does not permit an insurer to avoid its duty to defend where the facts determinative of coverage are disputed."[18]

Indeed, in the suit by the driver against Mercury, the jury ultimately sided with Mercury and found that the passenger was, in fact, a resident. There was no coverage for her injuries under the driver's policy. There was always, however, a *potential* for coverage. The court found there was a breach of the duty to defend because of the factual dispute on that issue, no matter how it ultimately was decided. "Although the jury subsequently agreed with Mercury as to the facts determinative of coverage, those facts were disputed at the time of refusal to defend, and Mercury therefore owed a duty to defend.[19]

A "genuine dispute" over a factual issue in the liability context—even a collateral issue—*establishes* the duty to defend. Therefore, "genuine dispute" not only provides no defense to bad faith, it could itself be evidence of bad faith if the insurer unreasonably denies a defense because of factual issues.

Ongoing Bad Faith After Suit Is Filed

An insured is stymied in its efforts to obtain indemnity or a defense under a policy and sues its insurance company. Now in the adversarial arena, are the gloves off? Is the "reasonableness" of conduct toward the insured no longer a concern? Can the insurer take whatever aggressive action it chooses, without regard to the implied covenant of good faith and fair dealing? This is an important question as more and more we see aggressive behavior by insurance companies toward their insureds.

White & Western Title Insurance Company[20] is the venerable California Supreme Court case on this issue and establishes that the insurer's obligation of good faith and fair dealing continues throughout the litigation process. If the insured can show that the insurer's litigation tactics are part of a "continuing course of conduct" that began before suit was filed, then such tactics can be evidence of bad faith.

In *White*, the insurer made low-ball settlement offers, untethered to any reasonable analysis of exposure to its insured, while the action was ongoing.

[18] *Id.*
[19] *Amato v. Mercury* Casualty, 61 Cal. Rptr. 2d 909, 912 (1997) (*Amato II).*
[20] *White & W. Title Ins. Co.*, 710 P.2d 309 (Cal.1985).

Those offers were properly admitted as evidence of the insurer's bad faith, notwithstanding Evidence Code § 1152[21] (settlement offers inadmissible to show liability) and Civil Code § 47[22] (litigation privilege), since the offers went to "show that the defendant was not evaluating and seeking to resolve their claim fairly and in good faith."[23]

Insurers like to suggest that *White's* power has been eroded over the last three decades, but it is not so much erosion as a clarification and balancing of the competing concerns of promoting insurer good faith and safeguarding the freedom to litigate aggressively without fear of independent liability for pure litigation tactics. The Supreme Court itself has not reexamined *White*. Cases declining to extend *White* either do not involve an insurance relationship at all or involve trial tactics unrelated to any pre-litigation conduct. For example, see *Palmer v. Ted Stevens Honda*[24] and *DuBarry Int'l Ins. v. Southwest Forest Industries, Inc.*[25] where the courts distinguished *White* because there was no insurance relationship involved. As examples of the second sort of cases, see *California Physician's Service v. Superior Court*[26] where there was no effort to tie the objectionable trial tactics to prior bad faith and *Nies v. National Auto & Cas. Ins. Co.*[27] where a single pleading filed by the insurer was held not to be relevant bad faith evidence, especially "given the paucity of evidence" of prior bad faith conduct. However, if an insured can fit litigation conduct within a pattern of similar pre-lawsuit bad behavior, *White* remains a strong authority that evidence of such conduct is admissible in the insured's bad faith case.

For example, imagine an insurer who denies the existence of an insuring relationship at all and claims it cannot find the policy or any evidence of an insuring relationship. This happens quite often in the context of claims arising out of continuous and progressive diseases (e.g., mesothelioma) that can trigger many liability policies going decades back. The insured, with evidence that the insurer had failed to review readily available documents in its own files and destroyed other documents evidencing an insuring relationship, sues

[21] CAL. EVID. CODE § 1152 (West 2014).
[22] CAL. LAB. CODE § 47 (West 2014).
[23] *White*, 710 P.2d at 318.
[24] *Palmer v. Ted Stevens Honda*, 238 Cal. Rptr. 363, 367 (Cal. Ct. App. 1987).
[25] *DuBarry Int'l Ins. v. Sw. Forest Indus., Inc.*, 282 Cal. Rptr. 181, 196 n.27 (Cal. Ct. App. 1991).
[26] *Cal. Physician's Serv. v. Superior Court*, 12 Cal. Rptr. 2d 95 (Cal. Ct. App. 1992).
[27] *Nies v. Nat'l Auto & Cas. Ins. Co.*, 245 Cal. Rptr. 518, 525 (Cal. Ct. App. 1988).

the insurer. During the subsequent breach of contract and bad faith litigation, the insurer engages in a series of discovery abuses—failure to produce documents and the like—that draws sanctions from the court. Why should these discovery abuses not be allowed as evidence of bad faith? The answer is, under the reasoning of *White,* they should. The jury should be allowed to consider this evidence, notwithstanding the so-called "litigation privilege." This is part and parcel of the same conduct the insurer engaged in before; it is evidence of a continuing pattern of bad faith conduct.

What if the insurer responds to a coverage action with an aggressive—and baseless—counterclaim for fraud? Or, perhaps, the insurer strikes first and, in response to an insured's tender, initiates an action for fraud. The Court in *California Physicians Service* noted that defensive pleadings could not be the basis for a claim of ongoing bad faith. However, a counterclaim or independent action is more than a defensive move. Insurers should not be allowed to bring their greater resources to bear in a counter-offensive against their insureds and retreat behind the litigation privilege if that strategy is an unreasonable one, and is consistent with past conduct.

Belying any diminishment in *White's* vitality is the fact that insurers routinely require that the insured and its counsel sign a "*White* waiver" agreement before beginning settlement discussions. We certainly recommend that the insured sign such agreements to facilitate the settlement process; insurers simply will not talk without the waiver. However, those agreements should be limited in scope and time. For example: "this agreement extends only to our discussions on October 15 and expires at 5:00 pm on that day." Waivers can always be renewed or extended if discussions progress. The insured should not enter into an open-ended "*White* waiver."

Policy Interpretation Issues

What if an insurer's refusal to pay hinges on its interpretation of a policy provision that is at odds with the insured's interpretation? The California Supreme Court set out the rules of policy interpretation in *Bank of the West v. Superior Court.*[28] Those rules are often misleadingly summarized as "ambiguities are construed against the insurer." That is true, but skips a couple of important steps in the analysis.

[28] *Bank of the West v. Superior Court*, 833 P.2d 545 (Cal. 1992).

First, the disputed word or phrase must be read in its "ordinary and popular sense."[29] Dictionaries are often the reference of first resort. However, a term may not be subject to two reasonable interpretations. The insurer or insured may simply be wrong in its interpretation; if so, the other side will prevail. However, if there are two reasonable interpretations, then the phrase is ambiguous and will be construed against the insurer. In *Bank of the West*, the Court did not reach this last part of the analysis because it found that the insured's interpretation did not comport with the reasonable expectations of an insured.

The buzzword in *Bank of the West* and other policy interpretation cases is "context." "[L]anguage in a contract must be construed in the context of that instrument as a whole, and in the circumstance of that case, and cannot be found to be ambiguous in the abstract."[30] "Context," the Court later said, "elucidates meaning."[31]

The court in *Bank of the West* found that claims for disgorgement under the Unfair Claims Practices Act were not covered under liability policy language covering "damages" for "unfair competition." The context it looked at was the "scope and purpose" of the statute and its legislative history.[32]

"Context," however, is a malleable concept; it can be broad or narrow depending on how wide you choose to cast your glance. While the Supreme Court took a fairly narrow view in *Bank of the West*—confining "context" to statutory language and purpose—ten years later it took an expansive view, this time in the insured's favor.

In *MacKinnon v. Truck Insurance Exchange*,[33] the court took a close look at the absolute pollution exclusion in the context of an insurer's refusal to defend or cover its insured landlord under commercial general liability policy. The landlord was sued for the death of a tenant after the apartment building was sprayed with pesticide to eradicate yellow jackets. The insurer, Truck, said the liability arose out of "dispersal" of a "pollutant" and was excluded. Truck's interpretation made some sense if one focused on these words standing alone.

[29] *Id.* at 552.
[30] *Id.*
[31] *Id.* at 557.
[32] *Id.* at 552-53.
[33] *MacKinnon v. Truck Ins. Exch.*, 73 P.3d 1205 (Cal. 2003).

The Supreme Court turned to "context" and that context was broad indeed. The court looked at what "dispersal" when used with "pollutant" meant in the world at large. The court began by looking at other cases and insurance industry publications, but then looked to newspaper articles, and radio broadcasts using those terms. The court concluded that a reasonable person of ordinary intelligence would understand the pollution exclusion to bar liability for claims of industrial and environmental pollution. Literally speaking, Truck's interpretation was correct. The pesticide was a "pollutant" or "irritant" and had been "dispersed" or "discharged." However, when one looked at context, Truck's interpretation was not only incorrect, it led "to absurd results."[34]

The California Supreme Court again recently looked to the reasonable expectations of the parties in a watershed ruling in favor of insureds, *State of California v. Continental Ins. Co.*[35] The court held that in cases of progressive damage that takes place over several years—so-called "long tail claims"—each liability policy in place over the course of time that injury occurs is liable up to its policy limits. This is called "all-sums-with-stacking." After a close textual reading led to a finding that commercial general liability policy language supported an "all-sums-with-stacking" rule, the court said:

> "An all-sums-with-stacking" rule has numerous advantages. It resolves the question of insurance coverage as equitably as possible given the immeasurable aspects of long-tail injury. It also comports with the parties' reasonable expectations, in that the insurer reasonably expects to pay for property damage occurring during a long-tail loss it covered, but only up to its policy limits, while the insured reasonably expects indemnification for the time periods in which it purchased insurance coverage.[36]

We see "reasonable expectations" closely associated with equity in the court's logic and an elevation of dry policy interpretation rules to a higher, broader plain: do what is fair. The lessons of *Bank of the West, MacKinnon,* and *State of California* for insureds are: take an expansive view of policy interpretation if you can do so to your advantage. Broaden the concept of "context." Address

[34] *Id.* at 1215.
[35] *California v. Continental Ins. Co.*, 281 P.3d 1000 (Cal. 2012).
[36] *Id* at 1008.

issues of equity when looking at "reasonable expectations." Do not let the insurer "make a 'fortress out of the dictionary.'"[37]

Conclusion

The issues we have raised above trigger significant tactical and strategic approaches. For many years, insurance companies have asserted the so-called "genuine dispute" argument as a defense to unreasonable conduct. Tactically, counsel for insurers often raise this "defense" on summary judgment. If a court grants summary judgment (that there was no bad faith as a matter of law, for example) then the value of the case is dramatically reduced and the possibility of punitive damages is removed. On the other hand, using the arguments that we set forth above—all grounded in solid California law—the court is far more likely to find that there are genuine issues of material fact, which preclude summary judgment and—on proper facts—keeps in play a claim for punitive damages. These issues can then be presented to a jury, rather than being resolved by a law and motion judge or by the court on motions *in limine*. Often, this can cause a case to resolve in settlement, rather than being forced to trial.

The same tactical and strategic considerations apply in the issues concerning *White v. Western Title*. Here, the question is a matter of discovery; the insured's advocate can dig into the behavior of the insurer, including communications by the claims staff occurring after the filing of the complaint. In the past, insurers have routinely taken the position that there can be no discovery as to any claims communications after the filing of the complaint. Properly seen, *White v. Western Title* authorizes discovery on these issues, because it is reasonably calculated to lead to admissible evidence.

With regard to the development of policy interpretation tools, the insured's advocate should focus on "context" in persuading a court that the proper interpretation inquiry continues to focus on the reasonable expectations of the insured in light of the purpose of the policy and the context in which it was issued. Often, this approach will lead—as it should—to a broader reading of the coverage grant and a more restricted reading of policy conditions and exclusions.

[37] *MacKinnon*, 281 P.3d at 1214.

Key Takeaways

- In first-party cases, the insurer cannot unreasonably manufacture a "genuine dispute" to avoid paying a claim.
- The "genuine dispute" doctrine usually raises questions of fact that should be resolved by a jury's close examination of the totality of the circumstances.
- The "genuine dispute" doctrine should not be applicable in the third-party duty to defend context.
- The litigation privilege is not an absolute defense to bad faith conduct by an insurer in the course of litigation, and conduct after litigation has commenced should be discoverable.
- Policy interpretation questions should be broadened to address context and equitable considerations.

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