Summary Judgment in Bad Faith Cases: Strategies and Countermeasures, Current Case Law

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Summary Judgment in First-Party Bad Faith Cases

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§ 17.03 Where Undisputed Evidence Establishes Existence of Bona Fide Dispute as to Insured’s Right To Payment, That Ordinarily Supports Judgment as Matter of Law That Nonpayment Was Not First-Party Bad Faith

[1] In All But Few Jurisdictions, First-Party Bad Faith Requires Lack of Any Genuine Issue as to Insured’s Right To Payment

The law of bad faith seeks to protect insureds with valid claims against abuse of the insurer’s power to force them to litigate. (See § 5.02[1] above.) But, because paying unmeritorious claims would inflate insurance costs, insurers are given wide latitude to challenge claims without fear of tort liability. (See § 5.02[2] above.) Accordingly, almost all jurisdictions recognizing expanded liability for first party bad faith require proof that the insurer delayed or denied payment of benefits without a reasonable basis. (See §§ 5.03[1]–[2]; compare §§ 5.03[3]–[4] above.) In all but a few jurisdictions, an insurer is allowed to withhold payment of a claim so long as there is a genuine issue or (to use different words for the same concept) a bona fide dispute as to the insured’s entitlement to payment. Stated otherwise, a “reasonable basis” for denying a claim is one that warrants testing the claim in court. (See § 5.02[2] above.)

“A reasonable basis for denying insurance benefits exists if the claim is ‘fairly debatable’ as to either a matter of fact or law.” A fairly debatable claim is one that is “open to dispute on any logical basis.” “Stated another way, if reasonable minds can differ on the coverage-determining facts or law, then the claim is fairly debatable.”1

[2] There Are Two Types of Disputes: Factual and Legal

In considering a possible summary judgment motion on bad faith, it is important to know the nature of the coverage dispute that led to the denial or delay of benefits. Broadly speaking, there are two types of coverage issue (though both may be present in the same case). In cases presenting the first type of issue, the policy language and legal rules applicable to the claim are clear, making coverage turn on factual issues or application of a fact-intensive standard. Examples include (1) whether coverage for a fire loss is precluded because the insured committed arson or false swearing, (2) whether uninsured motorist coverage for the insured’s injuries is precluded or limited by the uninsured motorist’s lack of negligence or the insured’s contributory or comparative negligence, and (3) whether coverage for medical services is precluded because they were not “necessary.” Disputes involving the second type of coverage issue center on the proper interpretation of the policy or on applicable legal rules, such as those governing the validity of policy provisions or the time to bring suit. These two types of coverage dispute may be termed “factual” and “legal,” respectively.

The two types of dispute call for different approaches to summary judgment. Factual disputes are addressed in § 17.03[4] and legal disputes in § 17.03[5] below.

[3] While Existence of Bona Fide Dispute as to Coverage Should Defeat Any Bad Faith Claim, Motion Based Solely on Pleadings Is Usually Not Good Vehicle To Present Such Defense

[a] Illustrative Case

The difficulty of litigating existence of a genuine dispute on a pleading motion is illustrated by Brehm v. 21st Century Insurance Co.,1,1 a bad faith suit arising from an underinsured motorist claim. Natalie Aguirre rear-ended the Brehm car while it was stopped at a red light, injuring Brehm and each of his parents. Aguirre’s insurer exhausted its limits by paying $10,000 to each of the Brehms. The Brehms had a 21st Century policy with $100,000 per person underinsured motorist coverage and $5000 in medical payments coverage. Stuart Brehm, IV, the sole plaintiff (“Brehm”), made a claim for benefits. There was no agreement on the amount due, and an arbitrator awarded $90,000 (the policy limit less the $10,000 paid by Aguirre’s insurer) plus unpaid medical benefits. Brehm sued for bad faith delay in payment. 21st Century demurred to the first and second amended complaints, the latter demurrer being sustained without leave to amend. The court of appeal reversed.2

Brehm submitted medical documentation in support of his claim, initially requesting $85,000 plus unpaid medical benefits. 21st Century obtained an evaluation from Dr. Swickard, which concluded that Brehm’s injuries were limited to soft tissue and the surgeries recommended by Brehm’s doctor were unnecessary. According to Dr. Swickard, “Brehm had only ‘subjective complaints with no objective evidence of injury or problem.’”3 21st Century offered $5000 plus unpaid medical benefits.4

Brehm then consulted Dr. Glousman, a highly credentialed orthopedic surgeon and submitted his report. Dr. Glousman opined that Brehm had suffered a cervical strain, lumbar strain, and a right shoulder rotator cuff strain and would require further treatment, likely including surgery. Dr. Glousman estimated the cost of surgery and post-surgical physical therapy at over $19,000. Brehm raised his demand to $90,000 plus unpaid medical benefits, but 21st Century did not raise its offer. Arbitration ensued, with the result stated.5

In his second amended complaint, Brehm alleged that

the medical evidence in 21st Century’s possession at the time it rejected Brehm’s policy limit demand and made a $5,000 counteroffer showed its offer was “extremely unrealistic;” 21st Century knew from the information it had received Brehm was entitled to the full policy limits based on the injuries sustained in

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3 166 Cal. App. 4th at 1231.
4 166 Cal. App. 4th at 1231–32.
5 166 Cal. App. 4th at 1231–32.
the accident with Aguirre and also knew any fair arbitration would likely award that sum to Brehm. Nonetheless, 21st Century made an unreasonably low offer to delay paying his legitimate claim and in the hope of compelling him to accept less than the full amount he was due. Brehm further alleged Dr. Swickard, a nonpracticing professional expert witness, was known to the insurance industry to be biased in favor of the defense and was retained, not to objectively and fairly evaluate Brehm’s shoulder injury, but with the intent that he minimize its seriousness to make it appear-falsely—there was a genuine dispute about the extent of that injury.6

If Dr. Swickard’s evaluation was adequately based, and unless Brehm could actually support his allegations of disqualifying bias, it would appear that 21st Century had sufficient grounds to establish a genuine dispute. But, instead of moving for summary judgment, it filed a demurrer, admitting for purposes of the motion that Brehm’s allegations were true.

21st Century argued that Brehm had alleged “a classic” genuine dispute as to the value of the UIM claim, and the superior court sustained the demurrer.7 It ruled that there could be no breach of the duty of good faith without a breach of contract, which had not occurred.8 That ruling was incorrect, as 21st Century conceded on appeal.9 But 21st Century attempted to sustain the order on the ground that there had been a “genuine dispute” about the value of the claim.10 The court of appeal disagreed.

It pointed to the California Supreme Court’s holding that “‘[a] genuine dispute exists only where the insurer’s position is maintained in good faith and on reasonable grounds.’”11 It also relied on the rule that that “‘an expert’s testimony will not automatically insulate an insurer from a bad faith claim based on a biased investigation.’”12 Brehm’s allegations that Dr. Swickard was dishonestly retained and that his report was a sham fell squarely within a recognized limit to the genuine dispute rule, so the allegations could not be dismissed as insufficient to state a cause of action.13

As the court pointed out, the key point regarding Brehm is that it arose on demurrer, not on a motion for summary judgment, so the focus was entirely on the pleading, not on any evidence:

6 166 Cal. App. 4th at 1232.
7 166 Cal. App. 4th at 1233.
8 166 Cal. App. 4th at 1233.
9 166 Cal. App. 4th at 1237.
10 166 Cal. App. 4th at 1237.
Although we may entertain some skepticism as to the nature of the competent and credible proof Brehm will be able to offer in support of these allegations, the issue before us is not whether his evidence will be sufficient but whether his allegations of intentional misconduct and bad faith are. Under Wilson and Chateau Chamberay, the answer to that limited question, inescapably, is yes … . The reasonableness of 21st Century’s settlement counteroffer at the time it was made is simply not a question that can be resolved at the pleading stage.\textsuperscript{14}

Because an insurer’s conduct in withholding benefits due under an insurance policy invariably turns on the reasonableness of the basis for the insurer’s position, the result in Brehm is not surprising. Precisely for that reason, the genuine dispute doctrine is procedurally better suited for summary judgment rather than a pleading motion. This was noted in Boykin v. State Farm General Insurance Co.:\textsuperscript{15}

It should not be surprising that defendant was unable to establish a genuine dispute about the value of the loss at the demurrer stage. The genuineness of a dispute about the reasonable value of an insured’s claim is an intensively factual matter. The facts necessary to establish this kind of genuine dispute are not likely to be admitted in the complaint and unlikely to be judicially noticeable. Genuine factual disputes establishing a defense to bad faith have been held to exist as a matter of law on summary judgment. Defendant has cited no case, and we have found none, in which one was found to exist as a matter of law on demurrer. For all these reasons, the demurrer could not have been properly sustained on the basis of defendant’s argument that the complaint and judicially noticeable facts disclosed a genuine dispute.\textsuperscript{16}

[b] Exceptions: Illustrative Cases

Contrary to Boykin, there are cases in which demurrers have been sustained based on the genuine dispute rule, and there are other cases in which that might have been possible. Rappaport-Scott v. Interinsurance Exchange of the Automobile Club\textsuperscript{17} sustained dismissal of the insured’s complaint by demurrer based on the genuine dispute doctrine because the “vast difference between the $346,732.34 in losses claimed by [the insured] and the $63,000 in actual losses as determined by the arbitrator demonstrates, as a matter of law, that a genuine dispute existed as to the amount payable on the claim.”\textsuperscript{18} (The Brehm decision acknowledged the result in Rappaport, but it could not determine that the insurer’s valuation of Brehm’s claim, compared to Brehm’s valuation, established a genuine dispute as a matter of law as to the amount of the tort claim. Unlike Rappaport, the arbitration decision in Brehm lent no credence to the reasonableness

\textsuperscript{14} 166 Cal. App. 4th at 1240 (citations omitted).
\textsuperscript{16} 2006 Cal. App. Unpub. LEXIS 3265, at *20–21 (citations omitted).
\textsuperscript{18} 146 Cal. App. 4th at 840 (emphasis original).
of 21st Century’s valuation.)\textsuperscript{19} While there are cases where a genuine dispute can be found from the face of the complaint, defense counsel should exercise caution in raising “genuine dispute” issues on demurrer.

The Supreme Court has toughened federal pleading requirements, but those are usually thought of as impacting cases involving such subjects as securities fraud and antitrust, where the defendant has control of much relevant factual material. But \textit{Luna v. Nationwide Property \\& Casualty Insurance Co.},\textsuperscript{19.1} applied those requirements to dismiss bad faith allegations. Plaintiffs should make such allegations more specific, and defendants should force them to do so.

\textit{Luna} arose out of a claim for damage caused by Hurricane Ike. Luna claimed extensive damage throughout the house, including ceilings, walls, insulation, windows, screens, and flooring, as well as structural and exterior damage. He also claimed damage to his patio, fence, and shed. He filed a claim with Nationwide for food and contents loss, structural damage, roof damage, water damage and wind damage. The adjuster, Rehders, whom Luna alleged was improperly trained, allegedly spent only 30 minutes inspecting the property, did not go inside, and did not go on the roof. His report was allegedly devoid of pictures and provided payment only for one roof turbine and half a square of roofing (and similarly modest repairs to the shed). Moreover, the estimate allegedly used prices not in accord with those in the area (especially in the wake of the hurricane) and included no allowance for overhead and profit. (It did not specify what damage was sustained by the roof or what prices should have been used.)\textsuperscript{19.2}

Luna alleged that, because of Nationwide’s superior knowledge of prices, it was aware that its offer would not suffice to repair his property and therefore constituted a misrepresentation. Luna alleged that Nationwide was responsible for training and supervising Rehders and for allowing his inadequate report to be the basis of payment and that it had yet to give him an explanation for any lack of coverage or for its failure to pay the claim in full.\textsuperscript{19.3}

In addition to breach of contract, Luna alleged a number of extracontractual statutory and common law claims: unfair or deceptive acts or practices (based on failure to assure that the adjuster was adequately trained, inadequate claim procedures, outcome-oriented investigation of the claim, underestimation of damages, and failure to include overhead and profit); misrepresentation of material facts relating to coverage; failing to attempt a reasonable settlement where liability was reasonably clear; failing to provide a reasonable explanation of the basis for its offer; failure within a reasonable period of time to affirm or deny coverage; failure to investigate and promptly pay claims; common law fraud; and breach of the duty of good faith and fair dealing (based on inadequate investigation and payment).\textsuperscript{19.4} The court dismissed all of Luna’s extracontractual claims.\textsuperscript{19.5}

The court stated the (recently toughened) pleading standards as follows:

“A pleading that states a claim for relief must contain … a short
and plain statement of the claim showing that the pleader is entitled to relief.” All well pleaded facts must be viewed as true, “in the light most favorable to the plaintiff. The plaintiff must allege “enough facts to state a claim to relief that is plausible on its face.” “Factual allegations must be enough to raise a right to relief above the speculative level, on the assumption that all allegations in the complaint are true (even if doubtful in fact).” “[A] plaintiff’s obligation to provide the ‘grounds’ of his ‘entitle[ment] to relief’ requires more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do.” “Without some factual allegation in the complaint, it is hard to see how a claimant could satisfy the requirement of providing not only ‘fair notice’ of the nature of the claim, but also the ‘grounds’ on which the claim rests.” A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged.\textsuperscript{19.6}

Moreover, fraud claims are subject to a heightened pleading standard:

“In allegations alleging fraud …, a party must state with particularity the circumstances constituting fraud or mistake. Malice intent, knowledge, and other conditions of a person’s mind may be alleged generally.” The Fifth Circuit strictly construes the Rule and requires the plaintiff pleading fraud in federal court “to specify the statements contended to be fraudulent, identify the speaker, state when and where the statements were made, and explain why the statements were fraudulent."\textsuperscript{19.7}

This heightened pleading standard applies to all allegations of fraud, whether or not included in a claim for fraud.

In dismissing the claims, the court concluded that:

Plaintiff’s amended complaint is composed of vague, general conclusions without the kind of factual support that would state a plausible claim under Rules 8 and 12(b)(6), no less a fraud based claim under Rule 9(b). Not only does he fail to allege an actionable misrepresentation for his fraud claim, but he fails to provide sufficient facts to state claims for violations of the Texas Insurance Code. Examples of Plaintiff’s vague allegations are such charges as Nationwide’s failure to properly train Rehders, without identifying what it should have taught him but did not, failure to show with particularity how Rehders’ investigation was unreasonable or “outcome-oriented,” the absence of any

\textsuperscript{19.6}798 F. Supp. 2d at 825–26 (citations omitted).

\textsuperscript{19.7}798 F. Supp. 2d at 826 (citations omitted).
example of an undervalued or denied claim, no indication of how and how much overhead and profit of which Plaintiff was allegedly deprived, vague and ambiguous assertions of unfair settlement practices, failure to specify what was unreasonable delay in payment … .

* * *

[As to the claim for common law bad faith,] Plaintiff … does not provide any facts that show that Nationwide’s liability was reasonably clear, that his claims were covered under particular provisions of the policy, what Nationwide knew at the time it denied his claims, any proposed settlement within the policy limits that Nationwide failed to effectuate, why and how Nationwide’s payments were unreasonably delayed, or where its investigation was not reasonable.19.8

For suggestions on pleading bad faith claims, see ch. 13–14, esp. § 14.01 above.

[4] If, Taking Into Account All Facts That Proper Investigation Would Have Developed, There Is Genuine Factual Issue on Coverage, There Ordinarily Can Be No First-Party Bad Faith


[i] Dutton

A seminal case on bad faith in the context of factual coverage disputes is National Savings Life Insurance Co. v. Dutton.20 Dutton was a medical insurance case turning on whether the insured, Mrs. Dutton, had made material misstatements on her application. In applying for coverage, Mrs. Dutton denied ever having had “high or low blood pressure, pain in chest, varicose veins, disease of heart or circulatory system.” Roughly a year later, she visited a physician, complaining of chest pain. The initial history taken by the doctor indicated that she had suffered such pain intermittently for two to three years, but that it recently had become worse. The doctor ordered hospitalization for testing. The hospital record repeated the history of prior chest pain and indicated that Mrs. Dutton took blood pressure medication. The ultimate diagnosis was probable ulcer or gall bladder disease.

The insurer rescinded the policy based on misstatements about chest pains and blood

pressure problems, noting that it based its decision on the medical records and inviting corrections. Mrs. Dutton’s physician responded with a letter stating that she had no history of hypertension or of medication for that condition. Subsequently, Mrs. Dutton again was hospitalized for chest pain. When her insurer declined to reinstate the policy or pay her claims, she sued for benefits and bad faith. The trial court granted the insurer summary judgment on bad faith, but submitted the misrepresentation claim to the jury.  

On appeal, the Alabama Supreme Court affirmed the summary judgment on bad faith. The court found that the insurer had a “reasonably legitimate or arguable reason” for seeking rescission, even if it did not ultimately succeed on that point:

Whether an insurance company is justified in denying a claim under a policy must be judged by what was before it at the time the decision is made. Here, the company had before it a hospital record which purported to quote Mrs. Dutton as saying, upon her admission, that she was suffering chest pain and had experienced chest pain for two or three years. This was in direct contrast to the answer which she gave to a direct question on the application. When the company informed her that it was denying the claim and cancelling the policy because her answers to the questions on the application conflicted with the medical records, she did not come forward with any additional information with regard to a history of chest pain. She did not tell the company that the hospital admission record was false; in fact, she did not attempt to refute it in any way except to have her physician write a letter in which he did not dispute the record. He simply said that, insofar as he knew, she had no history of hypertension before he first saw her and hospitalized her.  

The Dutton court then formulated a far-reaching rule supporting disposition of bad faith claims as a matter of law:

In the normal case in order for plaintiff to make out a prima facie case of bad faith refusal to pay an insurance claim, the proof offered must show that the plaintiff is entitled to a directed verdict on the contract claim and, thus, entitled to recover on the contract claim as a matter of law. Ordinarily, if the evidence produced by either side creates a fact issue with regard to the validity of the claim and, thus, the legitimacy of the denial thereof, the tort claim must fail and should not be submitted to

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21. The jury was instructed that only a fraudulent misstatement would support rescission and rendered a verdict for Mrs. Dutton. Because any material misstatement, even if innocent, would support rescission, the instruction was error and required retrial of the coverage issue. 419 So. 2d at 1360–61.
22. 419 So. 2d at 1362. The court also rejected Mrs. Dutton’s claim “that the company had an affirmative duty to investigate further.” Id. The court noted that the insurer had invited Mrs. Dutton to supply additional information if the information it had was inaccurate, but she did not do so. Id.
the jury.\textsuperscript{23}

In applying this rule, it is not necessary that the insured actually obtain a directed verdict so long as she would be entitled to one.\textsuperscript{24}

The \textit{Dutton} rule is said to apply “[i]n the normal case.” Alabama has developed a unique standard for bad faith in what is described as the “abnormal case,” a standard described and critiqued in § 5.03[3]. The analysis here will develop the logic of the \textit{Dutton} rule, some of the exceptions implied by that logic, and a “modified \textit{Dutton} rule which incorporates such exceptions.

[ii] While Many Jurisdictions Follow Some Version of Directed Verdict Rule, Some Do Not

The \textit{Dutton} approach is widely followed, even by courts that do not articulate it so precisely.\textsuperscript{25} The logic of the \textit{Dutton} rule is simple. An insurer is entitled to dispute claims so long as it has a reasonable basis. If reasonable minds could not differ on the coverage-determining facts, a verdict should be directed or summary judgment rendered on coverage. If that cannot be done, it ordinarily must follow that the insurer had reasonable grounds to dispute the facts, precluding any possibility of bad faith.

Thus, sufficient circumstantial evidence of arson or false swearing by the insured to create

\footnotesize{\textsuperscript{23} 419 So. 2d at 1362 (emphasis added).}{

\textsuperscript{24}

\textsuperscript{25} See, e.g.,

\textit{Alabama:} Intercont’l Ins. Co. v. Lindblom, 571 So. 2d 1092, 1097 ( Ala. 1990); Morton v. Allstate Ins. Co., 486 So. 2d 1263, 1268 (Ala. 1986);

\textit{Florida:} Robinson v. State Farm Fire & Cas. Co., 583 So. 2d 1063, 1065 n.6 (Fla. Dist. Ct. App. 1991);


\textit{Delaware:} Casson v. Nationwide Ins. Co., 455 A.2d 361, 368–69 (Del. Super. Ct. 1982) (material factual dispute as to coverage precludes bad faith);

\textit{Oklahoma:} Garnett v. Gov’t Employees Ins. Co., 2008 OK 43, ¶¶ 22–23 (legitimate dispute as to amount of liability precluded bad faith);

\textit{Utah:} Prince v. Bear River Mut. Ins. Co., 2002 UT 68, ¶ 34 (“if the evidence presented creates a factual issue as to the claim’s validity, there exists a debatable reason for denial, thereby legitimizing the denial of the claim, and eliminating the bad faith claim’ ”);

a jury issue precludes any possibility that denial of a fire claim constituted bad faith. Similarly, when the evidence creates genuine issues as to the negligence of an uninsured motorist or the contributory negligence of the insured, an insurer that denies uninsured motorists benefits should not be subject to liability for bad faith. This is equally true when there is an issue as to whether

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US/Indiana: Continental Casualty Co. v. Howard, 775 F.2d 876, 880–82 (7th Cir.1985), cert. denied, 475 U.S. 1122 (1986);

Alabama: National Sec. Fire & Casualty Co. v. Bowen, 417 So. 2d 179, 183–85(Ala. 1982);

Iowa: Hoekstra v. Farm Bureau Mut. Ins. Co., 382 N.W.2d 100, 110–11 (Iowa 1986);

see also

US/Mississippi: Dunn v. State Farm Fire & Cas. Co., 927 F.2d 869, 874 (5th Cir.1991) (husband’s admission of arson coupled with reasonable basis to believe wife consented to his actions and made willful false statements precluded bad faith claim with respect to benefits allegedly due to wife).

But see

Colorado: Brewer v. Am. & Foreign Ins. Co., 837 P.2d 236, 238 (Colo. Ct. App. 1992) (rejecting Dutton rule and arguably suggesting that industry custom required more reliable evidence to deny claim than is required to create jury issue, but relying principally on deficiencies in investigation and improper communication to third parties of insurer’s suspicion of arson);

Indiana: Riverside Ins. Co. v. Pedigo, 430 N.E.2d 796, 806–08 (Ind. Ct. App. 1982) (even though insurer’s suspicion of arson was reasonable, jury could find bad faith when insurer hampered insureds’ ability to clear themselves by concealing suspicion from them and harmed their reputation by disclosing suspicion to interviewed witnesses). Pedigo has been read as based on a conclusion that the insurer’s grounds were pretextual and deliberately false. Indiana Ins. Co. v. Plummer Power Motor & Tool Rental, Inc., 590 N.E.2d 1085, 1095 (Ind. Ct. App. 1992). Alternatively, the defamation aspect of the case could support a finding of bad faith without coverage (see § 5.06[1]), and a reasonable dispute as to coverage would not defeat a claim entirely independent of coverage. On either reading, Pedigo would be consistent with the Dutton rule.

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Alaska: Hillman v. Nationwide Mut. Fire Ins. Co., 855 P.2d 1321, 1326 (Alaska 1993) (arbitrator’s findings that insured was 66% at fault for fatal accident and her parents were 85% at fault for their ensuing emotional distress showed that insurer had reasonable basis to demand arbitration, even though ultimate award exceeded policy limit for uninsured motorist coverage);

Iowa: Dirks v. Farm Bureau Mut. Ins. Co., 465 N.W.2d 857, 862 (Iowa 1991);

Louisiana: Gibson v. Dixie Ins. Co., 542 So. 2d 635, 638 (La. Ct. App. 1989);


But see Employers Mut. Casualty Co. v. Tompkins, 490 So. 2d 897 (Miss. 1986) (discussed in
the tortfeasor was uninsured or underinsured.\textsuperscript{28} Bad faith can be precluded by evidence creating a genuine issue whether the claimant was an insured at the time of the loss or whether the injury involved an insured vehicle or location.\textsuperscript{29} The same is true if there is evidence that the cause of the loss was an excluded one.\textsuperscript{30} Evidence of application misrepresentations sufficient to permit

\textsuperscript{28} Iowa: Kirk v. Farm & City Ins. Co., 457 N.W.2d 906, 909–10 (Iowa 1990) (one-car accident with reasonable question whether driver at time of accident was uninsured owner of vehicle or fatally injured insured claimant);


\textsuperscript{29} US/Montana: Safeco Ins. Co. of Am. v. McAllister, 785 F. Supp. 119, 122 (D. Mont. 1990) (evidence that accident did not occur at “insured location”), aff’d mem., 944 F.2d 909 (9th Cir.1991);

\textit{Alabama:} Smith v. MBL Life Assur. Corp., 589 So. 2d 691, 698 (Ala. 1991) (genuine factual issue as to whether parent corporation was obligated to issue policy pursuant to conditional receipt given by subsidiary when subsidiary’s underwriting guidelines would not permit insuring of risk, but parent’s guidelines could);

\textit{California:} Austero v. National Cas. Co., 148 Cal. Rptr. 653, 673–75 (Ct. App. 1978) (insured’s own statements and those of his physicians were contradictory, and many of them supported belief that disability did not commence until after policy had lapsed), \textit{overruled on other issues by} [Egan v. Mutual of Omaha Ins. Co., 598 P.2d 452, 460 (Cal. 1979)];

\textit{Rhode Island:} Calenda v. Allstate Ins. Co., 518 A.2d 624, 629 (R.I. 1986) (evidence that policy was properly canceled prior to accident);

\textit{Wisconsin:} Mowry v. Badger State Mut. Casualty Co., 385 N.W.2d 171, 182 (Wis. 1986) (evidence that newly acquired automobile was not insured because not owned by named insured).

\textsuperscript{30} US/South Dakota: Case v. Toshiba Am. Info. Sys., Inc., 7 F.3d 771, 773 (8th Cir.1993) (evidence indicating that disease involved in workers’ compensation claim was not work-related);

\textit{US/Mississippi:} Hans Constr. Co. v. Phoenix Assur. Co., 995 F.2d 53, 55 (5th Cir.1993) (independent expert’s opinion that cause of accident was one excluded from coverage);

\textit{US/Rhode Island:} Pace v. Ins. Co. of N. Am., 838 F.2d 572, 577 (1st Cir.1988) (evidence supporting inference that loss was due to unseaworthiness rather than covered “perils of the sea”);

\textit{Alabama:} King v. National Found. Life Ins. Co., 541 So. 2d 502, 505 (Ala. 1989) (hospital discharge summary provided reasonable basis to believe treatment was for preexisting condition; when insured informed insurer of error in summary, it reopened claim);

\textit{Georgia:} Neal v. Superior Ins. Co., 432 S.E.2d 253, 254 (Ga. Ct. App. 1993) (independent medical examination finding treatment “unnecessary” precludes bad faith in denying coverage unless denial was
rescission of the policy can preclude bad faith.\(^{31}\) Prima facie evidence of other facts that would defeat the obligation to pay should have a similar effect.\(^{32}\) Even some of the decisions purporting to reject a strict directed verdict rule appear to apply similar logic.\(^{33}\)

patently erroneous based on facts timely brought to insurer's attention).

\(^{31}\) Alabama: Dutton itself exemplifies this point. (See § 17.03[3][a]).

\(^{See also}\).

\(^{Louisiana:}\) Darby v. Safeco Ins. Co., 545 So. 2d 1022 (La. 1989) (insurer had sufficient basis to assert that insureds had intentionally misrepresented that son no longer resided with them in order to obtain renewal, even though factfinder properly determined that insured made statements in belief, induced by agent, that they meant only that son would no longer drive family cars);


\(^{US/South Dakota:}\) Ulrich v. St. Paul Fire & Marine Ins. Co., 912 F.2d 961, 963 (8th Cir.1990) (evidence that injured worker was not entitled to rehabilitation benefits because she was able to return to her former occupation);

\(^{US/Louisiana:}\) Schwegman Giant Super Markets v. Golden Eagle Ins. Co., 693 F. Supp. 478, 488 (E.D. La. 1988) (reasonable dispute as to value of insured horse; insurer paid undisputed amount);


\(^{Alabama:}\) Morton v. Allstate Ins. Co., 486 So. 2d 1263, 1270 (Ala. 1986) (one insured committed arson, and facts created genuine issues as to extent of loss, if any, suffered by innocent coinsured);

\(^{Arizona:}\) Lasma Corp. v. Monarch Ins. Co., 159 Ariz. 59, 62 (1988) (evidence that insured horse was not in good health at time of insurance, as required by policy condition, and that loss payee knew horse’s condition);

\(^{Delaware:}\) Bryant v. Federal Kemper Ins. Co., 542 A.2d 347, 350–52 (Del. Super. Ct. 1988) (evidence that insured had been offered and had rejected increased limit of uninsured motorist coverage);

\(^{Rhode Island:}\) Rumford Prop. & Liab. Ins. Co. v. Carbone, 590 A.2d 398, 400–01 (R.I. 1991) (facts created issue whether failure expressly to exclude parking lot from coverage was product of mutual mistake).


\(^{Alaska:}\) Hillman v. Nationwide Mut. Fire Ins. Co., 855 P.2d 1321, 1325 (Alaska 1993) (rejecting Dutton rule, but affirming summary judgment for insurer, despite evidence of improper subjective attitude, because insurer had objectively reasonable basis for denial);
A number of courts have purported to reject the *Dutton* rule (as they understood that rule), but many have done so only in dicta accompanying insurer-favorable rulings on summary judgments or directed verdicts or where there was other basis to reject the insurer’s position consistently with the *Dutton* rule. Courts purporting to reject the rule usually offer no meaningful reasons for doing so and no alternative standard.

For example, in *Colonial Life & Accident Insurance Co. v. McClain*, the Georgia Supreme Court has rejected “the rule that a finding of bad faith is not authorized if the evidence would have supported a verdict in accordance with the contentions of the defendant.” Georgia does not

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*Iowa:* Reuter v. State Farm Mut. Auto. Ins. Co., 469 N.W.2d 250, 254–55 (Iowa 1991) (rejecting *Dutton* rule, but affirming summary judgment for insurer in light of independent consultant’s report finding that chiropractic treatment was not necessary for injury incurred more than three years earlier);


34 Of course, courts that employ a standard not depending on whether the insurer has a reasonable basis to contest coverage (see § 5.03[4]) do not follow the *Dutton* rule. (See also § 17.04[3]). While the Colorado Supreme Court appears to have prescribed a standard that does depend on whether the insurer has a reasonable basis to contest coverage, Travelers Ins. Co. v. Savio, 706 P.2d 1258, 1274 (Colo. 1985) (discussed in § 5.02[2] above), the Colorado court of appeals has rejected the *Dutton* rule and affirmed a bad faith verdict where, at the close of trial, there was a genuine issue as to coverage. Herod v. Colo. Farm Bur. Mut. Ins. Co., 928 P.2d 834, 835 (Colo. Ct. App. 1996); Brewer v. American & Foreign Insurance Co., 837 P.2d 236, 238 (Colo. App. 1992). While the *Herod* court cites evidence of other improper conduct, the opinion is too cryptic to assess the significance of that conduct or the possibility that the case falls within an exception to the *Dutton* rule. In *Brewer*, the insurer failed to properly investigate the claim, and a claim cannot be considered fairly debatable unless that is true after considering all of the facts that a proper investigation would have revealed. (See § 5.04[1], above) No substantive reasoning was offered in either case to explain rejection of the rule’s logic. Nor has either been followed on this point by other cases. (A related aspect of Colorado law is examined in § 17.05[10]).

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*US/North Dakota:* Bilden v. United Equitable Ins. Co., 921 F.2d 822, 828–29 (8th Cir.1990);


*Colorado:* Brewer v. American & Foreign Ins. Co., 837 P.2d 236, 238 (Colo. Ct. App. 1992) (results of insurer’s investigation of arson claim did not preclude bad faith because there was evidence that investigation inadequate);


*Montana:* Palmer v. Farmers Ins. Exch., 261 Mont. 91, 103–104 (1993) (by implication);


*See also* William T. Barker & Robert C. Johnson, *Sonnenchein Nath & Rosenthal, LLP on Bad Faith & Summary Judgment in Iowa*, LEXISNEXIS® EMERGING ISSUES ANALYSES, 2008 Emerging Issues 308 (arguing that the Iowa Supreme Court has now adopted a modified directed verdict rule).

recognize common-law bad faith, but has various penalty and attorney-fee statutes that depend on good faith or bad faith.\textsuperscript{37} Unlike the usual bad faith rule, liability for the penalty does not depend on the information available when the insurer acted upon the claim, but upon the “case made at trial.”\textsuperscript{38}

In refusing payment after due demand according to the statute, the company would act at its peril, a peril neither increased nor diminished by the amount of information it might have or obtain, but only by the weakness or strength of its defence as manifested at the trial, any weakness in the plaintiff’s case being, of course, counted as part of the strength of the defence. A defence going far enough to show reasonable and probable cause for making it, would vindicate the good faith of the company as effectually as would a complete defence to the action. On the other hand, any defence not manifesting such reasonable and probable cause, would expose the company to the imputation of bad faith and to the assessment of damages therefor.\textsuperscript{39}

According to the McClain court, “[t]he proper rule is that the [bad faith] judgment should be affirmed if there is any evidence to support it unless it can be said as a matter of law that there was a reasonable defense which vindicates the good faith of the insurer,” and bad faith can sometimes be found even “if the evidence would have supported a verdict in accordance with the contentions of the defendant.”\textsuperscript{40} The difficulty is that if there is a factual issue that would have supported a verdict in favor of the insurer, one would think that the issue must have been “a reasonable defense which vindicates the good faith of the [insurer]” unless some exception to the Dutton rule, as discussed in § 17.03[2][b]–[c], is established. Georgia does not appear to have definitively clarified how a court should decide what when a factual issue constitutes “a reasonable defense which vindicates the good faith of the [insurer].”

The cases indicate that “‘bad faith on the part of an insurance company is a ‘frivolous and unfounded denial of liability.’”\textsuperscript{41} “[A]n insurance company is not acting in bad faith if there is any reasonable ground for contesting liability.”\textsuperscript{42} If the insurer’s defense or reason for not paying the benefits demonstrates a ‘reasonable or probable cause’ for refusing payment, then this defense vindicates the good faith of the company.\textsuperscript{43} As to legal issues, “‘[b]ad faith’ does not exist if there is a doubtful question of law involved and a close question as to interpretation of policy provisions is presented.”\textsuperscript{44} But the mere fact that the issue is one of first impression will not

\textsuperscript{37} E.g., \textit{GA. CODE ANN. \S 33-4-6} (50% penalty (capped at $5,000) plus attorneys fees for bad faith delay or denial of payment 60 days after demand; testimony of “expert witness [shall not] be the sole basis for a summary judgment or directed verdict on the issue of bad faith”).
\textsuperscript{38} \textit{Travelers Ins. Co. v. Sheppard}, 85 Ga. 751, 765 (1890).
\textsuperscript{39} 85 Ga. at 765, \textit{quoted as authoritative in Interstate Life & Acc. Ins. Co.}, 220 Ga. 323, 325 (1964) (insurer may rely on defense discovered after running of the statutory deadline for payment).
\textsuperscript{40} 253 S.E.2d at 745.
\textsuperscript{42} 579 F. Supp. at 295.
preclude a bad faith finding if the proper resolution was never in real doubt. This appears to correspond with the bad faith law elsewhere. (See § 17.04).

Turning to factual issues, it is said that
“[p]enalties for bad faith are not authorized where the insurance company has a reasonable ground to contest the claim and there is a disputed issue of fact. Where the question of liability is close and the facts are disputed so that the insurer has reasonable grounds to contest the claim, no penalty should be permitted.”

Thus, if an insurer had sufficient circumstantial evidence of arson, denial of the claim is not bad faith, even if the jury ultimately awards benefits. But where an insurer had no medical basis for denying the necessity of private duty nursing, it could be penalized for bad faith.

But for McClain, these cases would suggest that Georgia does follow the Dutton rule. Perhaps the reconciliation is in cases like Cincinnati Insurance Co. v. Kastner. The insureds reported a burglary claim, occurring while movers had begun emptying the house. While there had been some reason for suspicion (the house had supposedly been locked and the insured had all the keys) other evidence prevented it from establishing a circumstantial case of fraud. The court recognized that a conflict in the evidence on coverage could establish that “the insurance company had reasonable grounds to contest the particular claim,” but held that caution was required in applying that rule: “‘In reaching this determination a court should carefully scrutinize any claim of a contest in facts to preclude the reliance by an insurance company on fanciful allegations of factual conflict to delay or avoid legitimate claims payment.’” That point is certainly correct (and consistent with the Dutton rule): the circumstantial evidence relied upon in Kastner is not enough to support the insurer’s position, when taken together with other undisputed evidence in the case. (See § 17.03[4][c])

It also seems that McClain and other courts rejecting the Dutton rule are or may be ignoring the Dutton court’s qualifications that its rule applies “in the normal case” and “ordinarily;” to that extent these courts have rejected only a broader, absolute rule that Dutton does not purport to establish and that this analysis does not advocate. If these courts understood the modified Dutton rule as developed here, many of them might accept it. (As a matter of practice, Georgia may already be applying something like that rule, though not so well articulated.) Given the compelling logic of the rule, it should be accepted universally.

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45 Mowry, 145 Ga. App. at 50–52 (statute not vague on point at issue).
47 196 Ga. App. at 355. See also Georgia Farm Bur. Ins. Co. v. Troupe, 154 Ga. App. 108, 110 (1980) (where one of insured’s own doctors opined that his problem was not accident related and insurer had no reason to question that, it vindicated insurer’s good faith in denying claim).
[b] Some Exceptions to Directed-Verdict Rule

[i] Lying Insurer Witnesses—Illustrative Case

To repeat, the “directed verdict” rule is not absolute. Exceptions have been developed extensively in post-
Dutton cases in Alabama (before the development of its current law of “abnormal” bad faith (see § 5.03[3])) and in Mississippi, which adopted essentially the same rule shortly after Dutton. These exceptions correspond to inherent limits on the logic of the basic rule, so they do not undermine it.

The most basic limit on the directed verdict rule was enunciated in Jones v. Alabama Farm Bureau Insurance Co., in which the coverage dispute concerned the cause of the loss. If caused by lightning, it was covered; if by power surge, it was not. The insurer claimed that the insured’s husband had admitted that the cause was a power surge, but he denied making such an admission and denied that a power surge was the cause. All other evidence was consistent with lightning, but did not compel that conclusion. The trial court submitted the coverage issue to the jury, but rendered summary judgment for the insurer on bad faith because there was a fact issue on coverage. The jury found coverage, and the Alabama Supreme Court ordered a trial on bad faith, reasoning that

Precluding a plaintiff’s bad faith action by application of “directed verdict on the contract claim” test when the disputed factual issue arises solely from a contradicted oral conversation between the insurer and the insured or a third person puts too onerous a burden on the plaintiff. Moreover, it would frustrate the purpose of the bad faith action by allowing an insurer simply to misrepresent the content of an oral conversation to avoid liability.

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51 State Farm Fire & Casualty Co. v. Simpson, 477 So. 2d 242, 252 (Miss. 1985); Blue Cross & Blue Shield v. Campbell, 466 So. 2d 833, 843 (Miss. 1984) (“It can be argued with considerable persuasion that unless the trial judge grants a directed verdict to the insured plaintiff on the contract claim, then, as a matter of law, the insurance carrier has shown reasonably arguable basis to deny the claim; and, therefore, the carrier should never be subjected to the possibility of punitive damages based upon “bad faith.” [¶] There is compelling logic behind this argument and this would certainly appear to be true in the vast majority of cases. This criterion should ordinarily determine the answer to the question.”).

52 Two courts declined to adopt a strict “directed verdict” rule in part because Alabama does not uniformly apply such a rule, without considering the more refined rule reflected by the exceptions.

US/North Dakota: Bilden v. United Equitable Ins. Co., 921 F.2d 822, 829 (8th Cir. 1990);


54 507 So. 2d at 401. One court that has rejected what it thought was the Dutton rule did so in part because it mistakenly thought the rule ignored the possibility that the jury might “totally reject the insurer’s version of the facts.” Bilden v. United Equitable Ins. Co., 921 F.2d 822, 829 (8th Cir.1990) (ND law). As Jones and
Put simply, the rationale is that an insurer is deemed to know if a person whose knowledge is attributable to the insurer is lying, and the insurer cannot in good faith rely on the factual issue thereby created. Not all courts have followed this logic, but it is a readily understandable basis for a modest exception to the general “directed verdict” rule. It has been followed in many cases, such as:

- bad faith liability properly submitted to jury despite disputes as to whether insured gave to agent certain health information that agent failed to record in application and as to alleged misstatements by agent regarding coverage provided;

- testimony of insurer’s employees that insurer had sent prelapse notices to policyholder, who denied receiving them, could not create factual issue precluding bad faith liability based in part on insurer’s failure to notify policyholder of irregular way in which her policy was being handled;

- factual issue whether insurer received certain telephone calls and letters from insured regarding claim does not preclude liability for bad faith;

other cases cited in this section illustrate, the rule properly accounts for that possibility.

55 E.g.,

US/Oklahoma: Oulds v. Principal Mut. Life Ins. Co., 6 F.3d 1431, 1439–41 (10th Cir. 1993) (agent denied insured’s claim that she had given complete oral responses to application questions but agent had failed to record them on application; summary judgment affirmed because insurer could reasonably believe agent and agent’s supposed contrary knowledge was not imputed to insurer);

US/Montana: Safeco Ins. Co. v. McAllister, 785 F. Supp. 119, 122 (D. Mont. 1990) (insurer delayed payment until it learned of agent’s statements at variance with policy terms; summary judgment on bad faith), aff’d mem., 944 F.2d 909 (9th Cir.1991);

Delaware: Bryant v. Federal Kemper Ins. Co., 542 A.2d 347, 352 (Del. Super. Ct. 1988) (agent’s assurance, later repeated under oath, that increased limits of uninsured/underinsured motorist coverage was orally offered and rejected provided reasonable basis to dispute claim despite insured’s denial of those statements; summary judgment on bad faith claim, though offer issue would require trial);


US/California: Gasnik v. State Farm Ins. Co., 825 F. Supp. 245, 250–51 (E.D. Cal. 1992) (insured claimed to have made oral request to agent for increased coverage, which had not been afforded, but acceptance of eight renewals without any increase provided reasonable basis to deny increased coverage).


• testimony of insurer’s employees, including its employee medical director, that jury could find to be fabricated, could not preclude bad faith claim by creating issue on whether hospitalization was necessary for test. 59

The extremely limited nature of this exception has been emphasized by one of its proponents:

This exception … would be operative only where the jury is asked to reject on grounds of deliberate falsehood or fabrication the insurer’s defense to the underlying contract claim. The fact that there is present a credibility issue with respect to the litigation of the underlying contract claim is wholly consistent with the insurer’s having a viable arguable reason defense where all that is suggested is that the insurer’s representative is mistaken in his view of the facts. 60

This point requires attention in jury instructions and may justify use of a special verdict or special interrogatory. It ordinarily will not alter the summary judgment analysis. However, it may explain cases denying summary judgment based on disputes about communications between insurer and insured. 61 Note also that a dispute as to the authority of a purported agent who allegedly made or received the asserted communications will suffice to preclude bad faith. 62

[ii] Improperly Selected Experts

A variant on the problem of the lying employee is the improperly selected expert: one who is hired, not for an honest opinion, but because he can be relied upon to give the desired answer regardless of the facts (or at least to shade the answer when shading is possible). That is what the Texas Supreme Court meant in State Farm Lloyd v. Nicolau 63 when it affirmed a bad faith judgment on the ground that “the Nicolaus presented evidence from which a fact finder could logically infer that Haag’s reports were not objectively prepared, that State Farm was aware of Haag’s lack of objectivity, and that State Farm’s reliance on the reports was merely

59 Aetna Life Ins. Co. v. Lavoie, 470 So. 2d 1060, 1073–75 (Ala. 1984), vacated on other grounds, 475 U.S. 813 (1986), reinstated with remittitur on punitive damages, 505 So. 2d 1050 (Ala. 1987). LaVoie and the later cases cited in the preceding notes may overrule Lamplighter Dinner Theater, Inc. v. Liberty Mutual Insurance Co., 792 F.2d 1036, 1042 (11th Cir. 1986) (AL law), insofar as it held that a contradiction between the written terms of the policy and the alleged statements of the selling agent created a factual issue precluding bad faith liability. But see Thompson v. National Health Ins. Co., 549 So. 2d 12 (Ala. 1989) (when agent allegedly omitted disclosure of child’s preexisting health condition from application, telling applicants that insurer would request medical records and that condition would be covered unless specifically excluded, but letter transmitting policy stated that insurer was relying on written application attached to policy, insurer’s reliance on preexisting condition exclusion could not be bad faith).

60 Blue Cross & Blue Shield v. Campbell, 466 So. 2d 833, 852 (Miss. 1985) (Robertson, J., concurring) (dictum) (emphasis original).


62 See, e.g., 523 So. 2d at 364.

63 State Farm Lloyd v. Nicolau, 951 S.W.2d 444 (Tex. 1997).
The key point is that the logic of the directed-verdict rule permits only narrow room for exceptions. If the insurer has evidence of noncoverage that a jury would be permitted to accept, the insurer ordinarily should not be liable for bad faith unless it was culpable in selecting the expert or in relying on the expert’s opinion. At a minimum, such conduct must have been unreasonable; if some level of subjective culpability is part of the applicable bad faith standard, that level of culpability must be proven.\(^{(65)}\) (See also § 5.04[2][c][iii])

[iii] Facially Inadequate Expert Reports

An insurer cannot rely on an opinion that is facially incomplete or inadequate in a way that even a lay adjuster can see. (See § 5.04[2][b][iii]) Even if such an opinion is admissible as evidence, it will not support summary judgment on bad faith.

(iv) Unreasonable Employee Experts—Illustrative Case

A related exception may be read into Bankers Life & Casualty Co. v. Crenshaw.\(^{(66)}\) The policy in question covered accidental loss of limb. Before discussing the facts of the claim, it is worth noting that a side issue (for the purpose of this discussion) materially affected the court’s analysis. The precise coverage was for loss due to “accidental bodily injury directly and independently of all other causes.” The court described this as an “invalid” provision.\(^{(67)}\) In fact, it is merely a provision that the courts have interpreted—much more broadly than a casual reader would expect—to cover all injuries in which trauma was a significant causative factor, even if an underlying condition also contributed to the result. The insurer appears to have applied it in light of the evidenced interpretation. The court, however, expressed concern that without explanation, which the insurer did not provide, the provision might lead insureds to accept denials that do not take account of this definition or are more readily challengeable than the language would lead a layman to believe. As a result, the court declared that the insurer’s invocation of this language as a basis for denial was not an “arguable defense under Mississippi law.”\(^{(68)}\) The court went so far as to say that the insurer’s invocation of the language in its denial letters did not inform the insured of the true reason for denial of his claim,\(^{(69)}\) even though any failure to communicate the information prior to his retention of counsel (who himself invoked the judicial interpretation)
appears to have done no harm to the insured. The court’s anger on this point appears to have influenced its evaluation of other aspects of the case.

To repeat, the insured’s right leg was amputated. The issue was whether the cause of the loss was purely atherosclerosis, which had severely limited the circulation to both legs (not covered), or trauma that had aggravated the underlying condition (covered). The nature and existence of the alleged trauma were not entirely clear, especially at the time of claim handling. The insured reported having dropped an alternator on his slippered foot while working on his car, and the only documentation of any trauma in the medical records was one emergency room record indicating a blow from a rebounding clutch. In either event, the trauma, if it occurred, was facially minor, but the evidence at trial showed that legs with severely impaired circulation are highly vulnerable to such trauma.

Both in its initial denial and at trial, the insurer, Bankers, relied solely on the opinion of Dr. McParland, its employee medical director and a vascular surgeon. Dr. McParland took the position throughout that there was no evidence of any traumatic injury of a sort that could have produced the need for an amputation and that the diagnostic findings indicated the underlying circulatory problem to be the sole cause.

The court focused on what it regarded as an inadequate basis for the initial denial. Because the insured was treated at an Air Force hospital, his doctors were not permitted to provide routine claim forms regarding his diagnosis and treatment. However, he provided Bankers with excerpts from his hospital records and authorization to obtain all of his medical records.

The insurer’s own investigative procedures called for review of all such records and personal interviews with the insured and his attending physician, none of which was done. The denial was based solely on the records supplied by the insured, even though Dr. McParland noted the absence of the emergency room records and considered the absence of any documentation of the trauma (available only in those records) significant in denying the claim. Nor was Dr. McParland instructed, prior to the initial denial, regarding the legal standard to be applied in evaluating the claim. In the court’s view, both legal and medical standards required that he obtain more information before he reasonably could form an opinion that would permit denial of the claim.70

The court conceded that “[a]n insurance company faced with two separate and distinct medical theories, each of which is supported by reputable physicians, and one of which would exclude liability, probably should not have punitive damages assessed if it asserted in court the theory favorable to its position.”71 However, as the court viewed the evidence, that principle was not applicable to the case before it. Dr. McParland was not an independent physician; he was an employee whose knowledge and actions were attributable to Bankers.72 The jury was free to find that he had knowingly acted on incomplete information and/or ignored later information that could have altered his opinion.73 The court also suggested that his opinions at trial were unreasonable in their substance or might have been so regarded by the jury, given the other

70 483 So. 2d at 272–73.
71 483 So. 2d at 274.
72 483 So. 2d at 273–74.
73 483 So. 2d at 274.
The Crenshaw scenario might form the basis for another exception to the strict “directed verdict” rule. Just as an insurer may not safely rely on employee testimony that a jury could find to be knowingly false, it also may not conclusively establish the reasonableness of its conduct by relying on what a jury may find to be unreasonable expert opinions of its own employees, especially in a case in which other deficiencies in claim handling will permit inference of an improper subjective attitude. If such an exception is permitted, however, it must be narrowly construed to protect the insurer against routine second-guessing of claim decisions by factfinders.

[c] Modified Directed-Verdict Rule: If Other Evidence Shows That Insurer Culpably Ignored Fact That Some Evidence Allegedly Supporting Denial Was Unworthy of Reliance, Existence of That Evidence Does Not Preclude Bad Faith

[i] Overview

The court in Cabell Electric Co. v. Pacific Insurance Co., has offered a standard that embraces all of the exceptions to the Dutton rule discussed above and describes the broader class of exceptions implied by the logic of the Dutton rule. The justification for an exception to the directed-verdict rule is the bad faith jury’s ability to determine, from additional evidence, that some of the evidence supposedly creating a factual issue on coverage was known by the insurer to be unworthy of consideration or that the insurer culpably disregarded the unworthiness of the evidence. An insurer cannot, in good faith, rely on evidence it knows to be false or unreliable or whose falsity or unreliability it culpably ignores.

For this purpose, the required level of culpability is that required by the relevant jurisdiction’s law of bad faith. At a minimum, the insurer would have to be unreasonable in not recognizing the falsity or unreliability of the evidence. In most jurisdictions, it would have to have known of or recklessly disregarded the falsity or unreliability of the evidence. (See § 5.03[1]–[2])

[ii] Iowa and the Modified Directed-Verdict Rule

[A] Iowa Bad Faith Law and Rejection of the Dutton Rule

As explained here, we contend that Iowa bad faith law should be read to include or imply the modified directed-verdict rule. A federal district court rejected that contention in Zimmer v. Travelers Insurance Co. That case can thus be used to frame the issue.

The Zimmer court correctly summarized the governing Iowa bad faith standards as

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74 483 So. 2d at 274–76. The dissenters vigorously disputed the propriety of any such view of the evidence. 483 So. 2d at 284–85 (Robertson, J., dissenting).


74.2 Zimmer v. Travelers Ins. Co., 521 F. Supp. 2d 910 (S.D. Iowa 2007) (“Zimmer II”). Some of the analysis here was developed for use in post-trial motions and appeal in Zimmer, where Barker was one of the post-trial and appellate lawyers for Travelers. The case was settled on appeal, for a confidential amount.
In order to prevail in a claim for bad faith, the insured party must prove by substantial evidence: “(1) that the insurer had no reasonable basis for denying benefits under the policy and, (2) the insurer knew, or had reason to know, that its denial was without basis.” The first element is objective, and the second element is subjective.

* * * *

In considering bad faith tort cases against insurers, the Iowa Supreme Court has held that “[a] reasonable basis to deny a claim exists when the claim is fairly debatable.” Whether a claim is fairly debatable is generally a question of law. “The fact that the insurer’s position is ultimately found to lack merit is not sufficient by itself to establish the first element of a bad faith claim. The focus is on the existence of a debatable issue, not on which party was correct.”

The Iowa Supreme Court rejected the Dutton rule in Reuter v. State Farm Mutual Automobile Insurance Co. Reuter was injured in an accident on September 27, 1984 and received medical and uninsured motorist benefits, including benefits for chiropractic services through December 26, 1985. On May 28, 1986, Reuter began receiving further chiropractic treatments and sought further medical benefits. State Farm’s consultant was not able to verify the medical necessity of resuming treatment for the 1984 injury, so State Farm denied benefits for some further treatments, paying $594 but leaving $556 unpaid. In response to a request by the chiropractor, a state utilization review committee found the services provided reasonable and necessary, and Reuter sued State Farm for bad faith denial. At trial, Reuter sought a directed verdict on the contract, which was denied. Invoking the Dutton rule, State Farm sought directed verdict on bad faith, which was granted. The jury returned a verdict of $556 on the contract claim and Reuter appealed the directed verdict on bad faith.

While recognizing that “where a claim is ‘fairly debatable,’ the insurer is entitled to debate it,” the Iowa Supreme Court did not agree that “the mere denial of a plaintiff’s motion for directed verdict establishes that the issue is ‘fairly debatable.’ The trial court should carefully review the facts and the particular circumstances in making its determination as to what is the precise issue or issues that are debatable.” Nonetheless, on the facts here, the directed verdict

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74.5 469 N.W. 2d at 251–53.
74.6 469 N.W. 2d at 253–54.
was correct, as the consultant’s opinion provided a reasonable basis to challenge the claim.\textsuperscript{74.7}


While determining the propriety of summary judgment or directed verdict in various individual bad faith cases, the Iowa Supreme Court initially said little more on the general standard for some time. But it addressed that subject at length in Bellville v. Farm Bureau Mutual Insurance Co.\textsuperscript{74.8} Bellville was injured by an underinsured motorist, with a $50,000 policy; Farm Bureau’s policy provided $300,000 in underinsured motorist coverage. Bellville demanded (1) consent to accept the tortfeasor’s policy limits and (2) payment of $300,000, later reduced to $270,000, both of which Farm Bureau denied. Asserting that both denials were in bad faith, Bellville sued Farm Bureau. A jury awarded both compensatory and punitive damages; the Iowa Supreme Court reversed and directed judgment for Farm Bureau.\textsuperscript{74.9}

On the objective element, it reaffirmed the rule that any fairly debatable claim could be denied without incurring bad faith liability:

A reasonable basis exists for denial of policy benefits if the insured’s claim is fairly debatable either on a matter of fact or law. A claim is “fairly debatable” when it is open to dispute on any logical basis. Stated another way, if reasonable minds can differ on the coverage-determining facts or law, then the claim is fairly debatable.\textsuperscript{74.10}

On this point, the court relied on William T. Barker & Paul E.B. Glad, \textit{Use of Summary Judgment in Defense of Bad Faith Actions Involving First-Party Insurance},\textsuperscript{74.11} an article (the “Barker & Glad Article”) in which the analysis in this section was first presented.

The court further recognized that “[w]hether a claim is fairly debatable can generally be decided as a matter of law by the court. As one court has explained, ‘[c]ourts and juries do not weigh the conflicting evidence that was before the insurer; they decide whether evidence existed to justify denial of the claim.’”\textsuperscript{74.12} It approvingly quoted Steven Ashley’s bad faith treatise on the standard:

\begin{quote}
[A]n insurer is innocent of bad faith as a matter of law … if the insurer took a position in regard to the claim that reasonable minds could hold. Unless the trial court is prepared to grant a directed verdict to the insured on his claim under the policy and to hold that reasonable minds could not disagree as to the
\end{quote}

\textsuperscript{74.7} 469 N.W. 2d at 255.
\textsuperscript{74.9} 702 N.W.2d at 471–72.
\textsuperscript{74.10} 702 N.W.2d at 473.
insured’s entitlement to proceeds under the policy, it follows that reasonable minds could disagree about the insured’s entitlement to policy proceeds. Therefore, the insurer should be entitled to a directed verdict in its favor on the insured’s bad faith claim unless the insured is entitled to a directed verdict in his favor on the policy claim. 74.13

Looking at Farm Bureau’s valuation of the claim, the court noted that the issue was not, as Bellville urged, “whether that Farm Bureau’s offer was ‘unreasonably low,’ [but rather] whether there was no reasonable basis for Farm Bureau’s denial of the plaintiff’s demand for a $270,000 payment.” 74.14 As a matter of law, there was such a reasonable basis, because Farm Bureau had valued the claim at $300,000, attributed 30% of the fault to Bellville, and deducted his $50,000 recovery from the tortfeasor. 74.15 It was not enough that Bellville’s experts thought Farm Bureau’s valuation unreasonable; “there must be evidence that the basis for [that] valuation was unreasonable.” 74.16

The investigating officer had found it a contributing circumstance that Bellville had run a traffic light. 74.17 While this was not admissible evidence at trial, a reasonable person could have relied on it to attribute fault to Bellville. 74.18 Farm Bureau was not obliged to accept the conflicting views of Bellville’s experts. 74.19 Nor did Bellville prove that he had brought to Farm Bureau’s attention any evidence demonstrating that “the officer’s report was patently wrong.” 74.20 Thus, as a matter of law, Bellville fault was “fairly debatable.” 74.21

On Bellville’s contract claim against Farm Bureau, the jury had valued his personal injury claim at $756,714.95 (and found him 5% at fault). 74.22 But, because Farm Bureau had a reasonable basis to attribute 30% fault to Bellville, its rejection of a $270,000 demand was not bad faith as long as Farm Bureau had a basis to value the claim at less than $415,000. 74.23 An insurer is not obliged to pay based on analysis of jury verdicts in other cases unless their facts are shown to be similar to those in the claim. 74.24 Nor was it sufficient to offer expert opinions that a

74.13 Bellville, 702 N.W.2d at 474 (quoting Stephen S. Ashley, Bad Faith Actions Liability & Damages § 5:04, at 5-17 to 5-18 (2d ed. 1997) (also discussing exceptions to this rule)).
74.14 Bellville, 702 N.W.2d at 475.
74.15 702 N.W.2d at 475.
74.16 702 N.W.2d at 475.
74.17 702 N.W.2d at 477. Bellville claimed that, when the light turned yellow, there was not time to stop before entering the intersection.
74.18 702 N.W.2d at 477–78.
74.19 702 N.W.2d at 478.
74.20 702 N.W.2d at 478.
74.21 702 N.W.2d at 479 (citing Szumigala v. Nationwide Mut. Ins. Co., 853 F.2d 274, 280–81 (5th Cir.1988) (liability for accident fairly debatable because it presented “a classic jury question”)).
74.22 702 N.W.2d at 479.
74.23 702 N.W.2d at 479–80 & n.3. As the court explained, 30% fault would allow subtraction from a $415,000 verdict of $94,500, and the $50,000 recovery from the tortfeasor would allow subtraction of that amount, leaving a net award of $270,500. 702 N.W.2d at 479–80 n.3.
74.24 702 N.W.2d at 480–81.
reasonable insurer would have paid Bellville’s demand, because bad faith is not shown by mere proof of negligence; the plaintiff must negate the existence of a reasonable basis for the insurer’s actions.74.25 And, in Bellville, there were conflicting expert opinions as to the value of the case, which “simply demonstrates the obvious: it is difficult, if not impossible to determine with any precision how the jury will value such a claim,” particularly its noneconomic components.74.26

As a matter of law, it could not be said that Farm Bureau lacked a reasonable basis for rejecting the $270,000 demand, because that value was subject to debate:

Certainly there may be cases in which the UIM limits are so low or the undisputed damage items so high that there would be no reasonable basis to refuse payment notwithstanding the impossibility of accurately predicting the value of the insured’s damages. But this case is not one of those.74.27

Turning to Farm Bureau’s refusal to consent to settlement with the tortfeasor, the court noted that consent to settle provisions had previously been upheld, though breach of such a provision would not preclude a claim unless the insurer could show that (absent the settlement) it would have been able to recover from the tortfeasor. The court agreed with Bellville that an insurer in Farm Bureau’s position should have a good faith duty to consent to settlement if it lacks a reasonable basis to believe that its subrogation claim has value.74.28 But the existence of such a duty had been fairly debatable, because the issue had never been decided in Iowa.74.29 Moreover, that question was one on which reasonable minds could differ, as illustrated by the fact that the court of appeals had reached a different conclusion.74.30

Because each of Farm Bureau’s challenged actions had a reasonable basis, Farm Bureau was entitled to judgment as a matter of law.74.31

Bellville supports a modified directed verdict rule. A starting point in this analysis is the Iowa Supreme Court’s approving quotation from the Ashley treatise.74.32 While that quotation reads like the strict directed verdict rule rejected in Reuter, Bellville did not overrule Reuter, holding only that “[w]hether a claim is fairly debatable can generally be decided as a matter of law by the court.”74.33 In fact, both the Ashley treatise and the Barker & Glad Article recognized

74.25 702 N.W.2d at 481.
74.26 702 N.W.2d at 481.
74.27 702 N.W.2d at 481–82.
74.28 702 N.W.2d at 483–84.
74.29 702 N.W.2d at 484, citing, inter alia, William T. Barker & Paul E.B. Glad, Use of Summary Judgment in Defense of Bad Faith Actions Involving First-Party Insurance, 30 Tort & Ins. L.J. 49, 86 (1994). (“Many courts have found insurer legal positions reasonable, even in the absence of clear supporting authority, because the issue was an open one or one of first impression in the controlling jurisdiction.”).
74.30 702 N.W.2d at 484, citing William T. Barker & Paul E.B. Glad, supra, 30 Tort & Ins. L.J. at 83 (stating “the most reliable method of establishing that the insurer’s legal position is reasonable is to show that some judge in the relevant jurisdiction has accepted it as correct”).
74.31 702 N.W.2d at 485.
74.32 702 N.W.2d at 474 (quoting STEPHEN S. ASHLEY, BAD FAITH ACTIONS LIABILITY & DAMAGES § 5:04, at 5-17 to 5-18 (2d ed. 1997) (also discussing exceptions to this rule)).
74.33 702 N.W.2d at 473.
exceptions to any such rule, exceptions that reconcile their rule with Reuter and indicate how one can determine when the directed verdict rule will not apply, producing a “modified directed verdict rule,” which is fully consistent with Reuter’s rejection of a strict directed-verdict rule.

The Ashley treatise identifies exceptions, such as the insurer’s knowing use of false testimony to create a fact issue and reliance on an expert known to be unreliable. The Barker & Glad Article similarly identifies exceptions for coverage testimony by lying insurer employees, dishonestly selected experts, and unreasonable insurer-employee experts. As pointed out in Cabell Electric Co. v. Pacific Insurance Co., the justification for an exception to the directed-verdict rule is the bad faith jury’s ability to determine, from additional evidence, that some of the evidence supposedly creating a factual issue on coverage was known by the insurer to be unworthy of consideration. An insurer cannot, in good faith, rely on evidence it knows or should know to be false or unreliable.

But if there is any evidence that the insurer could, in good faith, rely upon and which would permit a reasonable factfinder to rule against the insured, then the issue is fairly debatable and there can be no bad faith. So, for example, Bellville was entitled to rely on the police officer’s report in attributing fault to Bellville, unless presented with proof that “the officer’s report was patently wrong.” As the Iowa Supreme Court succinctly put the point: “if reasonable minds can differ on the coverage-determining facts or law, then the claim is fairly debatable.”

Bellville also approvingly quoted a Texas case saying “‘[c]ourts and juries do not weigh the conflicting evidence that was before the insurer; they decide whether evidence existed to justify denial of the claim.’” Bellville quoted the same case for the proposition that “‘[t]he issue in the bad faith case is not whether the factfinder believes the evidence that [the insurer] believed when it denied the claim; the issue is whether such evidence existed.’”

All of these statements indicate that juries have an extremely limited role in evaluating the objective element of bad faith: determining whether the evidence creating the fairly debatable coverage issue “existed.” (As already noted, juries may also consider whether the insurer knew (or, perhaps, should have known) that some of the evidence was unworthy of reliance.)


This aspect of the law of bad faith is reinforced by Gilbert v. USF Holland, Inc Gilbert reversed an award of workers compensation penalty benefits. The workers compensation statute provides for penalty benefits “[i]f a delay in commencement or termination of benefits

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74.34 Stephen S. Ashley, supra, § 5:04, at 5-18 to 5-21.
74.35 William T. Barker & Paul E.B. Glad, supra, 30 Tort & Ins. L.J. at 68–74.
74.37 Bellville, 702 N.W.2d at 478 (emphasis added).
74.38 702 N.W.2d at 473.
74.39 702 N.W.2d at 474 (quoting State Farm Lloyds, Inc. v. Polasek, 847 S.W.2d 279, 285 (Tex. Ct. App. 1992)).
74.40 702 N.W.2d at 473.
74.41 Gilbert v. USF Holland, Inc., 637 N.W.2d 194 (Iowa 2001).
occurs without reasonable or probable cause or excuse ...”74.42 A reasonable excuse exists if the claim for benefits is fairly debatable.74.43 Section 86.13 “codifies, in the workers’ compensation context, the common law rule that an insurer with a good faith dispute over the legal or factual validity of a claim can challenge the claim, if its basis for doing so presents a fairly debatable issue.”74.44 Because the substantive standards are identical, denial of penalty benefits precludes any bad faith claim.74.45 So, reversal of penalty benefits in *Gilbert* meant there could be no bad faith liability on those facts. In *Gilbert*, as in *Bellville*, the Iowa Supreme Court held that “[w]hether the issue was fairly debatable turns on whether there was a disputed factual issue that, if resolved in favor of the employer, would have supported the employer’s denial of compensability.”74.46

Gilbert was a truck driver for USF Holland. He bent over to pull up a dock plate, a heavy metal ramp balanced in a way that is usually easy to move. This time, it stuck and jerked Gilbert down. He felt some pain but thought nothing of it. A second attempt disengaged the dock plate. He went to a nearby desk and signed a weigh bill. When he straightened up, he felt great pain, which he reported.74.47

The next day, Gilbert wrote a report, saying that his neck popped as he was getting up. He had no idea why. He said nothing about the stuck dock plate. Nor did he mention it to his physician, Dr. White.74.48

His compensation claim was denied because his injury did not arise out of any peculiar work stress. Gilbert then “clarified” his report by telling the adjuster about the dock plate. The insurer reaffirmed the denial.74.49

About a month later, Gilbert developed severe neck pain and consulted Dr. Carlstrom, whom he told about the entire incident, including the stuck dock plate. Dr. Carlstrom attributed Gilbert’s current symptoms to that incident. Eventually, Gilbert returned to work with no restrictions.74.50

USF Holland still denied compensability. Gilbert submitted (1) a causation opinion from Dr. Carlstrom, (2) a letter from Dr. Minervi stating that his progress notes never denied work-relatedness, and (3) testimony to the dock plate incident. But compensation was still denied. Gilbert was awarded both benefits and penalty benefits.74.51 The award said, “continued denial of the claim after such matters were addressed by Drs. Carlstrom and Minervi was not fairly

74.42 IOWA CODE § 86.13.
74.44 *Gilbert*, 637 N.W.2d at 199.
74.46 *Gilbert*, 637 N.W.2d at 199.
74.47 637 N.W.2d at 195.
74.48 637 N.W.2d at 195-96.
74.49 637 N.W.2d at 196.
74.50 637 N.W.2d at 196.
74.51 637 N.W.2d at 196–97.
debatablble and was not reasonable.” But the Iowa Supreme Court struck the penalty benefits.

The compensability issue was whether the injury arose out of Gilbert’s employment. “Whether the issue was fairly debatable turns on whether there was a disputed factual issue that, if resolved in favor of the employer, would have supported the employer’s denial of compensability.”

Based on Gilbert’s initial explanation, USF Holland maintained that the injury had been caused simply by straightening up, not any “hazard connected with the employment.” The Iowa Supreme Court said the issue remained fairly debatable, even after the doctors supported work-relatedness and the co-worker corroborated Gilbert’s account:

Although the physicians concluded that Gilbert’s injury was caused by his employment, these opinions were based on Gilbert’s revised history of his injury. The employer has never asserted that the act of tugging and lifting on a stuck dock plate could not have caused the injuries suffered by Gilbert. What the employer disputed is whether the employee’s revised or amplified version of the events of June 4—that he first felt pain when he pulled on a stuck dock plate—was true. Thus, the industrial commissioner should have focused on whether there was a fair debate over how the injury occurred. We think there indisputably was.

If, as Gilbert had first reported, the injury occurred as he straightened up, the occurrence might have been unrelated to his work. The Iowa Supreme Court held that “the employer was entitled to rely on Gilbert’s original version of his injury even though he subsequently changed his story of how the injury occurred.”

Gilbert argued that he never changed his story, but simply amplified it when he learned additional facts were relevant. The Iowa Supreme Court held that the difference in accounts created an issue of credibility:

Regardless of how Gilbert’s reporting of his injury is characterized, it cannot be disputed that he never mentioned that he first felt pain after pulling up on the dock plate, as opposed to when he straightened up, until after his claim had been denied. The employer was certainly entitled to argue that this previously undisclosed fact was a fabrication. Given the fact that not even the eyewitness corroborated this aspect of Gilbert’s history, that pulling on the dock plate triggered the onset of pain, resolution of the matter rested on Gilbert’s credibility, which the employer

74.52 637 N.W.2d at 197.
74.53 637 N.W.2d at 199.
74.54 637 N.W.2d at 199.
74.55 637 N.W.2d at 200.
74.56 637 N.W.2d at 200.
was free to challenge. As the deputy noted, there was a credibility issue in this case for the commissioner to resolve. The fact that the commissioner resolved the credibility issue in favor of the employee did not mean that there was not a reasonable dispute with respect to how the accident occurred.74.57

Gilbert also argued that the medical evidence pointed to work causation, and USF Holland never obtained any contrary medical opinions. But the Iowa Supreme Court held that the relevant issue was not medical:

the debatable issue in this case was factually how the injury occurred. Medical testimony on causation is simply not relevant to resolution of this contested factual issue. In other words, the fact that the physicians relied on the revised history rather than the original history did not resolve the factual dispute as to how the injury occurred. Thus, the commissioner’s reliance on the medical testimony as support for her finding that there was not a reasonable basis to contest compensability was erroneous.74.58

Finally, Gilbert argued that there had been an inadequate investigation, because the witness to the incident was not interviewed. But, even if that should have been done, there was no evidence that the witness would have added any new information. So, failure to interview the witness did not support the finding that there was no reasonable basis to dispute compensability.74.59

Both Bellville and Gilbert demonstrate that an insurer may view the facts relating to the claim in an adversarial manner, looking solely to whether there is a genuine issue warranting submission of the issue to a trier of fact. Indeed, Bellville approvingly cites authorities which make that point.74.60 Neither of those cases recognizes any qualification to that rule, except a bar against relying on evidence that the insurer knows is unworthy of reliance.

74.57 637 N.W.2d at 200 (emphasis original).
74.58 637 N.W.2d at 200.
74.59 637 N.W.2d at 201.
74.60 Bellville, 702 N.W.2d at 478–79 (“because the relationship between an insurer and its insured is arm’s-length with respect to UIM coverage, Farm Bureau was not required to view the facts of the accident in a light most favorable to Bellville. Compare N. Iowa State Bank, 471 N.W.2d at 829 (stating insurer does not occupy a fiduciary relationship to insured when evaluating insured’s claim under policy; rather, parties are in an “arms-length” relationship), with Long v. McAllister, 319 N.W.2d 256, 262 (Iowa 1982) (stating in meeting its fiduciary duty to insured, “insurer must give as much consideration to its insured’s interests as it does to its own”); see also Hutchinson v. Farm Family Cas. Ins. Co., 273 Conn. 33, 867 A.2d 1, 10 (2005) (stating relationship between insured and UIM insurer is adversarial, not fiduciary); Ellwein v. Hartford Accident & Indem. Co., 142 Wash. 2d 766, 15 P.3d 640, 647 (2001) (holding relationship between UIM insurer and insured is adversarial, and therefore, insurer does not have to give equal consideration to the insured’s interest), overruled on other grounds by Smith v. Safeco Ins. Co., 150 Wash. 2d 478, 78 P.3d 1274, 1278 (2003).”).
[D] All Other Iowa Bad Faith Cases Are Consistent with a Modified Directed Verdict Rule.

This reading of Iowa law is consistent with other Iowa precedent. Many cases hold bad faith claims or penalties precluded because the insured’s coverage claim was fairly debatable.\footnote{74.61} Two cases found the coverage claim not fairly debatable precisely because the insurer had been entitled to summary judgment on coverage.\footnote{74.62} Another case would fit within an exception just described.\footnote{74.63} In yet another case the injured worker had recovered penalty benefits and, as so far as the opinion indicates, the denial had been based solely on unsupported suspicions.\footnote{74.64} Only two cases suggest that the question of fair debatability might have been for the jury, and in both

\footnote{74.61}{\textit{Bellville}, 702 N.W.2d at 475–82 (comparative fault of uninsured motorist and amount of insured’s damages); City of Nadrid v. Blasnitz, 742 N.W.2d 77, 83 (Iowa 2007) (issue re causation of injury rendered benefit claim fairly debatable; while one witness gave two statements, one favorable to compensable injury, “the insurer is not required to accept the evidence most favorable to the claimant and ignore contradictory evidence”); Wilson v. Farm Bureau Mut. Ins. Co., 714 N.W.2d 250, 262-63 (Iowa 2006) (insurer’s reasonable legal arguments on unresolved coverage issue); Seastrom v. Farm Bureau Life Ins. Co., 601 N.W.2d 339, 347 (Iowa 1999) (conflicting testimony on whether insured given conditional receipt); Thompson v. U.S. Fid. & Guar. Co., 559 N.W.2d 288, 292 (Iowa 1997) (existence of evidence supporting insurer’s intoxication defense); Morgan v. Am. Family Mut. Ins. Co., 534 N.W.2d 92, 97 (Iowa 1995) (conflicting evidence on whether injuries caused by accident), overruled on other grounds by Hamm v. Allied Mut. Ins. Co., 612 N.W.2d 775 (Iowa 2000); Wetherbee v. Economy Fire & Cas. Co., 508 N.W.2d 657, 662 (Iowa 1993) (insurer’s legal arguments); Reuter v. State Farm Mut. Auto. Ins. Co., 469 N.W.2d 250, 255 (Iowa 1991) (chiropractic consultant’s report challenged bills); Dirks v. Farm Bureau Mut. Ins. Co., 465 N.W.2d 857, 862 (Iowa 1991) (factual dispute as to underinsured motorist’s liability); Kirk v. Farm & City Ins. Co., 457 N.W.2d 906, 910–11 (Iowa 1990) (lack of evidence that uninsured motorist was the driver and evidence of possible comparative negligence); Dolan v. Aid Ins. Co., 431 N.W.2d 790, 794–95 (Iowa 1988) (evidence of insured’s pre-existing condition); Hoekstra v. Farm Bureau Mut. Ins. Co., 382 N.W.2d 100, 111–12 (Iowa 1986) (evidence of possible arson); Pirkl v. Nw. Mut. Ins. Ass’n, 348 N.W.2d 633, 636 (Iowa 1984) (weakness of insured’s evidence of theft); Higgins v. Blue Cross of W. Iowa & S.D., 319 N.W.2d 232, 236 (Iowa 1982) (insurer’s defense of application misrepresentation provided reasonable basis to deny claim; “trial court must have determined that this was so when it denied [the insured’s] motion for a directed verdict on that claim.”); City of Davenport v. Newcomb, 820 N.W.2d 882, 894 (Iowa Ct. App. 2012) (while original doctor’s opinion later undermined by remand for new examination, it provided a sufficient basis to render claim fairly debatable when the claim was denied and there was no showing that the insure should have later concluded that there was no reasonable basis to continue relying on it); Spencer v. Annet Holdings, Inc., 757 F.3d 790, 796–97 (8th Cir. 2014) (employee’s refusal to submit to independent medical examination rendered claim for workers compensation benefits fairly debatable, barring penalties); Merriam v. Nat’l Union Fire Ins. Co., 572 F.3d 579, 585–86 (8th Cir. 2009) (despite claimed deficiencies in insurer’s investigation, undisputed facts provided support for denial to render it fairly debatable); 733 F. Supp. 2d 1065, 1072–76 (S.D. Iowa 2010) (while no one fact sufficed to support denial based on exclusion for arson, there was sufficient circumstantial evidence to render it fairly debatable); M-Z Enters., Inc. v. Hawkeye-Sec. Ins. Co., 318 N.W.2d 408, 415 (Iowa 1982) (evidence supporting application of exclusion); Reid v. Pekin Ins. Co., 436 F. Supp. 2d 1002, 1012–13 (N.D. Iowa 2006) (conflicting expert opinions).}


\footnote{74.63}{Buhmeyer v. Case New Holland, Inc., 446 F. Supp. 2d 1035, 1042–44 (S.D. Iowa 2006) (insurer’s coverage defense (a) relied on doctor’s statement that it knew was based on an erroneous premise and (b) ignored a later report free from that error).}

\footnote{74.64}{Etten v. U.S. Food Serv., Inc., 446 F. Supp. 2d 968, 976–80 (N.D. Iowa 2006).}
the insured appears to have been entitled to a directed verdict on coverage.

Nassen v. National States Insurance Co,\(^{74.65}\) affirmed judgment on a verdict finding bad faith and fraud. The insurer had claimed application misrepresentations based on supposed hospital diagnoses of pre-existing health conditions, but existence of those conditions was negated by the discharge summary for that hospitalization and other information in the insurer’s claim file.\(^{74.66}\) “Under the circumstances, the question of bad faith was for the jury to decide.”\(^{74.67}\) In Nassen’s procedural context, this did not mean that the jury could decide whether the insurance claim was fairly debatable: there clearly was nothing to debate. The subjective element of bad faith might have required jury factfinding. Or the court might have meant only that there was no legal obstacle to the bad faith verdict, perhaps because Nassen would have been entitled to summary judgment on coverage. Either meaning would support the affirmance.

In McIlravy v. North River Insurance Co.,\(^{74.68}\) the insurer had obtained summary judgment on the issue of bad faith, and the Iowa Supreme Court remanded for trial. It concluded that McIlravy’s initial interview provided a reasonable basis for the initial denial, because the injury appeared not to result from any work-related stress.\(^{74.69}\) McIlravy’s doctor, Dr. Gehrke, said in a letter that the injury was work-related, but provided no factual basis; accordingly, “North River had no additional facts or information to reevaluate its earlier response that the injury was not work-related.”\(^{74.70}\) But North River then deposed Dr. Gehrke, who now explained that McIlravy’s job placed him at greater risk of the sort of injury he suffered.\(^{74.71}\) Despite this new evidence, North River continued to deny the claim and (so far as the summary judgment record revealed) conducted no further investigation of a claim now prima facie established.\(^{74.72}\)

The Iowa Supreme Court observed that “the new information provided in the deposition did not necessarily render the compensability issue undebatable …”\(^{74.73}\) In theory, other evidence (not in the summary judgment record) might have kept the issue of compensability in dispute, but that would have at least required North River to have investigated to see whether such evidence could be found.

The court said that Dr. Gehrke’s deposition testimony “did transform the reasonableness of the continued denial by North River into a jury question.”\(^{74.74}\) As the court explained:

> Bad faith may be inferred from a flawed investigation, and the facts of this case place the adequacy of the investigation conducted by North River after the deposition of Dr. Gehrke into question. We recognize an incomplete investigation will not

\(^{74.66}\) 494 N.W.2d at 236.
\(^{74.67}\) 494 N.W.2d at 236.
\(^{74.69}\) 653 N.W.2d at 331–32.
\(^{74.70}\) 653 N.W.2d at 332.
\(^{74.71}\) 653 N.W.2d at 332.
\(^{74.72}\) 653 N.W.2d at 332–33.
\(^{74.73}\) 653 N.W.2d at 333.
\(^{74.74}\) 653 N.W.2d at 333.
alone support recovery for bad faith if the insurer nevertheless had a reasonable basis for denial. Yet, the failure of North River to investigate in this case went to the very foundation of the basis for its denial. North River previously denied the claim based on the lack of facts to show the injury was work-related, and the deposition of Dr. Gehrke supplied the missing facts. A reasonable inference to be drawn from North River’s failure to investigate further is that it knew it had no reasonable basis for denying McIlravy’s claim.74.75

McIlravy did not say the dispute requiring jury trial was whether the claim remained fairly debatable. Indeed, unless North River at least sought evidence to dispute work-relatedness, (1) there was no further basis to dispute coverage, and (2) McIlravy could have obtained summary judgment in the workers’ compensation proceeding. The issue requiring trial apparently was the subjective element of bad faith.74.76

In sum, all Iowa bad faith precedents are consistent with the modified directed-verdict rule that can be extracted from Bellville and Gilbert.

[E] The Zimmer Court Takes a Different View

This issue was presented on post-trial motions in Zimmer v. Travelers Insurance Co.,74.77 where the federal district court disagreed with the analysis here. Because the case was settled on appeal, that decision will never be reviewed.

Kris Zimmer recovered workers’ compensation (“WC”) benefits for a back injury on June 1, 1999 that aggravated preexisting psychological problems; he then sued for bad faith benefit denial.74.78 The jury found bad faith, awarding Zimmer $10,087,453 in compensatory damages and $3,000,000 in punitive damages.74.79 The district court struck $571,529 in compensatory damages and $2,000,000 in punitive damages, for reasons not relevant here.74.80 It declined to grant Travelers judgment as a matter of law.

74.75 653 N.W.2d at 333.
74.76 See also MC & R Pools, Inc. v. Shea, 2011 Iowa App. LEXIS 409, at *12–14 (June 15, 2011) (upholding an award of penalties where insurer continued to rely on opinion of its first doctor, despite contrary opinion of its second doctor based on new information, without having first doctor reconsider in light of second doctor’s opinion).
74.77 Zimmer v. Travelers Ins. Co., 521 F. Supp. 2d 910 (S.D. Iowa 2007) (“Zimmer II”). One of the authors (Barker) was among the post-trial counsel for Travelers in Zimmer II.
74.78 Identity of the defendants is itself a complicated issue. The workers compensation insurer was Continental Casualty Co., erroneously sued as Continental Insurance Co, an error never corrected in light of the affiliation between the two and the indemnification described below. Claims were administered by Constitution State Services, LLC (“CSS”). Actual claim handling was done on behalf of CSS by employees of St. Paul Travelers Insurance Companies, now Travelers Insurance Companies. The distinctions among the parties make no difference for purposes of this analysis, so all will be described collectively as “Travelers.”
74.79 521 F. Supp. 2d at 915–16.
74.80 521 F. Supp. 2d at 961.
The Zimmer claim was a complicated one, but the argument for judgment as a matter of law focused on a single issue: had it been fairly debatable whether Zimmer had actually suffered the work injury he claimed. The evidence on that point can be summarized as follows.

On June 1, 1999, Zimmer worked at a unit of Wells Fargo. He reported to his superior, Dennis Woolums, that he had suffered a work-related back injury; Woolums sent him home. The next day, Zimmer went to the emergency room (“ER”) of Des Moines General Hospital, where he was met by Dr. Carol Horner, his regular doctor. Dr. Horner gave him a note: “[p]lease excuse Mr. Zimmer from work from 6/1/99 until released due to medical illness.” Zimmer has not worked since.74.81

Wells Fargo said Zimmer’s claim was questionable. The adjuster, Beerbower, interviewed Zimmer:

“I called and talked to the IW [injured worker]. He kept telling me that he has had previous back problems and when he bent over to pick up some confidential papers off the ground he felt a rip in his left side of his lower back … He states that he informed Tim Enos [a co-worker] that he had hurt his back when picking up the papers off the ground …

“… He kept saying over and over that this was the final straw that broke the camel’s back.”74.82

Pre-June 1 medical records showed that Zimmer had a history of worsening back and emotional problems starting in early 1999.74.83 Wells Fargo reported that Zimmer’s boss said Zimmer “walks like he does every other time he has a bad back.”74.84 Enos denied having been told of the injury, though saying that Zimmer bent over to pick up the papers.74.85

On June 2, Zimmer visited the ER. The hospital records do not mention any June 1 injury. The triage nurse’s notes state: “Severe back pain. Chronic” They describe bruising and discoloration of his fingers. Dr. Abbassi’s notes describe Zimmer’s “[c]hief complaint” as “[t]ingling sensations on the three fingers of his left hand with discoloration of those fingers.” Under “review of systems,” Dr. Abbassi noted, “[t]he patient denied any falls or injury … He does complain of back pain, which is chronic in nature.” Dr. Horner ordered tests with a diagnosis of “severe back pain,” but did not indicate any injury.74.86

In the ER, Dr. Horner referred Zimmer to Dr. Rettenmeier. Dr. Rettenmeier wrote a June 3 letter describing the visit, which does not mention any June 1 injury. He said Zimmer “presents for evaluation basically of a variety of pain issues, primarily left sided leg greater than arm, as well as some vague discoloration changes in his hands. He dates the onset of his problems to

74.81 521 F. Supp. 2d at 916–17.
74.82 521 F. Supp. 2d at 918–19.
74.83 521 F. Supp. 2d at 916.
74.84 521 F. Supp. 2d at 916.
74.85 521 F. Supp. 2d at 918–19.
74.86 521 F. Supp. 2d at 916–17.
After discussing the events of 1988 and their consequences, Zimmer said that “[a]bout 2 1/2 years ago, he started developing other pain issues. He apparently started having some pains that started in the left side of his lower back and chest and moved up into his arm. He talked about pains that radiate up his arm into the left side of his face and neck.” Dr. Rettenmeier understood that Zimmer had gained control of that problem. Zimmer then talked about more current problems:

“since January of this year, he has had progressive worsening … He talks about low back pain that has been unmanageable. In the past, it has always been manage[able], but has subsequently been unmanageable … Tuesday around 2 p.m., he apparently missed his Xanax, an hour late. He developed the sudden onset of discoloration in his left hand … He also has been having a lot of anxiety issues. This apparently has been a significant problem for several years. About 2 1/2 years ago, he apparently had stress at work and dropped 35 pounds in a quick period of time … He admits to a lot of work stress. He readily admits to anxiety issues … He really does not describe work depressive symptoms …”

Dr. McGuire had seen Zimmer for his back problems in March 1999; Beerbower had Zimmer see him again, hoping Dr. McGuire could distinguish what was pre-existing from anything caused by the reported June 1 injury. Unfortunately, Dr. McGuire did not address that point. After noting Zimmer’s report of the June 1 injury, he said that Zimmer’s problems were outside his expertise:

“His back is the somatization of all his other problems. There is absolutely nothing for me to do. [] He needs to resolve stress and psychological problems before we can do anything. [] … From my standpoint, as far as his spine is concerned, he can be working full time. As far as his psychological problems and his dealings with superiors and other people, that needs to be resolved and that is in someone else’s area of expertise. [] … As far as the back is concerned he could be working. The psychological problems and the job conflict situation would probably prevent him from working.”

Dr. Horner’s records begin on July 8, 1997, discussing back and abdominal pain. They show increasing back problems in early 1999 through late May, including referrals to Dr. Koithan (a psychiatrist), and Drs. Stein, Igram, and McGuire. They include a copy of part of the ER record. They say nothing about what Zimmer said in the ER. Zimmer saw Dr. Horner on June 30, 1999; July 14, 1999; July 23, 1999; July 26, 1999; and July 27, 1999. The first mention of the
The July 27 note describes Zimmer’s then-current complaints of back, abdominal, and leg pain and his consultation with Dr. Leth. The note then discusses the reported June 1 injury:

The patient’s presenting symptoms were reviewed with him at length. The patient reports that he bent over to chase some papers on June 1, 1999 about 9:10 in the morning on 8th Street outside his home office. He was trying to pick up some of the company’s confidential memos, apparently [sic] some QA type forms. … The patient was plugging a parking meter with quarters when he looked up and saw the papers flying up the street. Previously, they were in the back seat in a binder. Another employee or co-worker was apparently getting these papers out of the car. Paper hit his leg. The patient picked this up, saw it was confidential, and went in pursuit of the other papers. When bending over to pick these up he noticed the feeling of something ripping or tearing in his left lower back. He had to leave work later that morning, about 10 o’clock, due to the pain in his back. The next day he went to the Des Moines General emergency room where I saw and evaluated him.

The patient reports that he is presently unable to work as he cannot sit for long, cannot bend over or flex, cannot pick things up, cannot walk upstairs. He states that his wife must help him get out of bed or he must use a cane to help him get himself up due to his pain.74.93

In July, Zimmer saw Dr. Leth (a pain specialist) and Dr. Koithan (a psychiatrist). He gave both a history that included the June 1 injury.74.94 Over the years following, Zimmer saw many other doctors, giving them similar histories. Eventually, Dr. Horner (and Dr. Giordano, who treated Zimmer, starting in 2000) provided an opinion that Zimmer’s disability was caused by the June 1 injury.74.95

Travelers argued that it was fairly debatable whether Zimmer suffered any work injury on June 1, 1999. The following undisputed evidence existed: (1) Enos’s failure to corroborate Zimmer’s account; (2) ER records reporting Zimmer’s denial of any fall or injury; (3) absence from the ER records and Dr. Rettenmeier’s records of any mention of any June 1, 1999 injury; and (4) absence from Dr. Horner’s records of any contemporaneous reference to any such injury and, despite two supplements requested by Zimmer, of any indication that Zimmer reported that injury in the ER. This created a factual issue whether the reported work injury had occurred, because an injured worker seeking medical treatment for back problems would be expected to tell doctors about any recent back injury.

74.93 This evidence, appearing in the Zimmer record, is substantially quoted 521 F. Supp. 2d at 920–21, where it is mistakenly said to be dated August 27.
74.94 521 F. Supp. 2d at 930.
74.95 Curiously, the Zimmer court did not rely on that opinion, and it is not mentioned by the court.
These facts closely parallel those in *Gilbert*. Indeed, *Zimmer* is an even clearer case than *Gilbert* for presence of a fairly debatable factual issue. In the emergency room, Zimmer actually denied any fall or injury, something Gilbert never did. Both Zimmer and Gilbert omitted mention of the work injury at crucial points immediately after it allegedly occurred. (To be sure, Zimmer promptly reported the alleged work injury to his supervisor, while Gilbert did not; that makes little difference and is offset by Zimmer’s emergency room denial of any recent injury.) In neither case did the witness corroborate the injury, though both corroborated the relevant incident. In neither case could the doctors shed any light on the factual question of how the injury occurred, i.e., whether the worker first felt pain at the time claimed. In neither case is there any evidence that further investigation would have produced additional evidence supporting the claim.

The *Zimmer* court offered several distinctions of *Gilbert*, mostly in an unreported memorandum denying a motion to reconsider the motion for judgment as a matter of law. First, *Gilbert* involved review of an administrative decision for substantial evidence, a review that is more searching than review of a jury verdict. But that assumes that there was some relevant fact that the jury could have determined. Bad faith requires that a plaintiff establish two elements, one subjective and one purely objective. Given the close similarity of the facts in *Zimmer* and *Gilbert* and the identity of the legal standards, the standard in *Zimmer* was the same as in *Gilbert*: “Whether the issue was fairly debatable turns on whether there was a disputed factual issue that, if resolved in favor of the employer, would have supported the employer’s denial of compensability.” That depends solely on an objective evaluation of the evidence available to the insurer (about whether the worker felt pain when claimed); the only facts to be found are what that evidence was. Both in *Zimmer* and in *Gilbert*, there was no dispute as to that evidence. The question whether that evidence created a disputed issue was a question of law, not one of fact.

The *Zimmer* court also suggested that the ER notes might be interpreted in a more favorable light to Zimmer, relating the denial of any falls or injury only to the discoloration of his fingers. Moreover, the failure to report the injury to his doctors might be seen as outweighed by his prompt report to his supervisor and to Beerbower, especially as these reports (unlike Gilbert’s) were made before his claim was denied.

The *Zimmer* court held that the existence of competing inferences from the evidence permitted the jury to find that there was no objectively reasonable basis to deny the claim. That misconceives the inquiry. Availability of competing inferences allowed the workers’ compensation arbitrator to make factual findings favoring Zimmer. But the question on bad faith liability is whether there was an objectively reasonable basis for the insurer to insist upon adjudication of the facts. *Gilbert* held such a basis exists when there is a genuine factual issue, e.g., on when the worker felt pain. If the available evidence presents a “fairly debatable” question, then an insurer is entitled to debate that question by denying the claim and requiring that the facts be adjudicated.

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74.96 *Zimmer v. Travelers Ins. Co.*, No. 4:04-cv-00542, slip op. at 6 (S.D. Iowa Dec. 20, 2007) (opinion on reconsideration of motion for judgment as a matter of law) (“*Zimmer III*”).
74.97 *Gilbert*, 637 N.W.2d at 199.
74.98 *Zimmer III*, slip op. at 7 (S.D. Iowa Dec. 20, 2007).
74.99 *Zimmer III*, slip op. at 8.
74.100 See *Bellville*, 702 N.W.2d at 473 (“if reasonable minds can differ on the coverage-determining facts or law, then the claim is fairly debatable.”).
The *Zimmer* court also relied\(^\text{74.101}\) on *Etten v. U.S. Food Service, Inc.*\(^\text{74.102}\) Etten had delayed reporting a slip and fall to his employer because the onset of symptoms had been delayed.\(^\text{74.103}\) Given the delayed onset, the delay in reporting gave no reason to question the injury. Thus, as the *Etten* court said, the questions raised were “based ‘purely on speculative inferences from a highly selective reading of [Etten’s] medical records.’”\(^\text{74.104}\) In contrast, Zimmer reported immediately to his supervisor but, strangely, not to his doctors. Zimmer’s failure to tell his doctors, when he would be expected to do so if the injury had occurred, created a question not present in *Etten.* n127. The inference drawn from Zimmer’s failure to tell his doctors was not “speculative.”

The *Zimmer* court pointed to the various medical records, starting with Dr. Horner’s July 27 note, that showed Zimmer reporting the injury and even connected it causally with his disability.\(^\text{74.105}\) But there were similar medical records and causation opinions in *Gilbert,* so those cannot be a distinguishing factor. The suspicious fact in *Zimmer* is Zimmer’s failure to report his injury to his doctors, *when first seeking treatment,* despite having reported it to his supervisor. Neither later reports nor medical opinions based on those reports can eliminate the resulting question.

Precisely because Dr. Horner’s medical records, even as supplemented, say only that Zimmer reported the injury on July 27—not June 2—the *Zimmer* court erred in thinking it significant that Beerbower denied the claim before getting those records. As *Gilbert* held, inadequate investigation cannot support bad faith unless that investigation would have revealed significant information. On the factual issue of whether Zimmer felt acute pain on June 1, Dr. Horner’s records contained no significant information. So, while Beerbower’s action must be judged *as if* she had waited for those records to arrive, her failure to wait did not make Zimmer’s claim undebatable.

Thus, the *Zimmer* court erred in concluding that it was proper to uphold the jury’s verdict when the modified directed-verdict rule called for judgment as a matter of law in favor of Travelers. Other courts ought not to follow *Zimmer* on this point.

[F] More Recent Cases Provide No Support for *Zimmer*’s Rejection of the Modified-Directed Verdict Rule

Only one later case has relied on *Zimmer* in a relevant way. *Schultz v. Ability Insurance Co.*\(^\text{74.106}\) did rely on *Zimmer*’s conclusion that *Reuter*’s rejection of the directed-verdict rule was still good law, even after *Bellville.*\(^\text{74.107}\) But that point does not appear significant to any of the court’s rulings.

Schultz sought long-term care benefits, which were payable if she met any one of three

\(^{74.101}\) *Zimmer II,* 521 F. Supp. 2d at 930–31; *Zimmer III,* slip op. at 8.
\(^{74.102}\) *Etten v. U.S. Food Serv., Inc.*, 446 F. Supp. 2d 968, 976–80 (N.D. Iowa 2006).
\(^{74.103}\) 446 F. Supp. 2d at 974.
\(^{74.104}\) *Zimmer III,* slip op. at 3.
\(^{74.106}\) 2012 U.S. Dist. LEXIS 154145, at *24 n.12.
benefit qualifiers: medical necessity, loss of functional capacity, or cognitive impairment. She made claims at two different times. Ability moved for summary judgment on bad faith. As to loss of functional capacity, there was conflicting evidence and a legal question of policy interpretation that rendered coverage fairly debatable.\footnote{2012 U.S. Dist. LEXIS 154145, at *34–38.} As to cognitive impairment, there was a legal question that rendered denial of Schultz’s first claim fairly debatable, but deterioration of Schultz’s condition made this a much closer call on the second claim.\footnote{2012 U.S. Dist. LEXIS 154145, at *38–40.} As to medical necessity (the easiest benefit qualifier to satisfy), Ability had evidence of progressive dementia, supporting placement in the facility and arguably ignored that evidence by relying on evidence supporting failure to satisfy the other benefit qualifiers.\footnote{2012 U.S. Dist. LEXIS 154145, at *40–42.} Schultz had affidavits from two doctors concluding that placement in the facility was “consistent with accepted medical standards,” which (if correct) qualified Schultz for benefits.\footnote{2012 U.S. Dist. LEXIS 154145, at *40–41.} The court does not identify any contrary evidence available to Ability regarding medical necessity or any basis for challenging the evidence supporting medical necessity to which the court referred. Thus, it does not appear that Ability established existence of a factual question as to coverage that would support summary judgment on bad faith under the modified directed-verdict rule.

The Iowa Supreme Court again addressed summary judgment standards regarding bad faith in \textit{Thornton v. American Interstate Insurance Co.}\\footnote{Thornton v. Am. Interstate Ins. Co., 2017 Iowa Sup. LEXIS 52 (May 19, 2017).} This arose from a workers’ compensation claim. American Interstate disputed permanent total disability (“PTD”), but continued to pay benefits while trying to settle. It also contested Thornton’s petition for partial commutation (a lump sum payment for disability while continuing American Interstate’s obligation to pay medical expenses). The district court granted Thornton summary judgment that American Interstate had acted in bad faith on both counts. The supreme court agreed that there had been no reasonable basis to dispute PTD, but found there had been a reasonable basis to contest commutation.\\footnote{2017 Iowa Sup. LEXIS 52, at *1–3.}

As to PTD, the court reasoned as follows:

\begin{quote}
American Interstate does not argue on appeal it had a reasonable basis for denying Thornton’s PTD status. Indeed, it would be hard-pressed to do so, since, as early as two weeks after Thornton’s accident, it had received opinions from a medical professional and its claims adjustor that Thornton, a quadriplegic, was PTD. American Interstate internally recognized as much when setting reserves, and its outside counsel expressly recommended that American Interstate concede PTD status. We agree with the district court that contesting Thornton’s PTD status under these facts constituted
\end{quote}
bad faith as a matter of law.74.114

Turning to commutation, the court described the applicable standard:

Commutation is unlike the payment of weekly benefits in which the statute commands the employer (or insurer) to take action and, thus, establishes the type of statutory duty for which a willful and deliberate breach can give rise to bad-faith liability in the workers’ compensation field. By contrast, future benefits “may be commuted” by the commissioner only if preconditions are met. Section 85.45 imposes an affirmative burden on the employee to demonstrate commutation is in his or her best interest. This determination involves a weighing by the commissioner of individual and personal considerations that may be clarified when the employee testifies at the commutation hearing.74.115

While Thornton contended that commutation would be in his best interest and had expert testimony to support that contention, the court found the issue fairly debatable on its facts:

Thornton had never managed a large lump sum of money. Alexander testified commutation would be in Thornton’s best interest only if Thornton could avoid invading the lump-sum principal. But that begs the question whether Thornton would invade the principal. Omissions in Thornton’s proposed budget, his past spending habits, and his lack of experience with investments gave American Interstate a reasonable basis to question the commutation.

The commissioner’s role in approving commutation is not a rubber stamp. Commutations have been denied based on concerns like those that American Interstate raised here.74.116

The court does not identify any evidence that commutation would not have been in Thornton’s best interests, so American Interstate was apparently only arguing that the evidence Thornton submitted did not establish that commutation was in his best interests. Thus, even a factual argument of that sort, if it involves a dispute that a reasonable factfinder could resolve against the insured or worker is sufficient to preclude bad faith or penalties.

74.114 2017 Iowa Sup. LEXIS 52, at *41–42 (citations omitted). American Interstate argued that there had been no bad faith, because it never denied benefits and continued to pay them throughout the compensation proceeding. The court disagreed, because Thornton had been forced to litigate an issue that American Interstate had no reasonable basis to dispute. 2017 Iowa Sup. LEXIS 52, at *35–42.
74.115 2017 Iowa Sup. LEXIS 52, at *49–50 (citations omitted).
74.116 2017 Iowa Sup. LEXIS 52, at *51 (citations omitted).
Deficient Investigation May Affect Analysis

Any Attempt To Establish Conclusively Existence of Genuine Issue Precluding Bad Faith Must Account Not Only for Information Insurer Had, But Also for That It Should Have Had If It Had Investigated Properly—Leading Case

Before an insurer can safely deny a claim, it must take account of all evidence supporting the claim which a reasonable investigation would have revealed. (See § 5.04) The insurer will be charged with knowledge of whatever facts it should have discovered had it conducted a proper investigation. (See § 5.04[3][a])

Accordingly, if the record indicates that relevant information favorable to the claim was missed in the insurer’s investigation, that information must be addressed, either by showing that (even with that information) a reasonable basis for delay or denial of benefits remained (see also § 17.03[4][d][v]) or by showing that it was reasonable for the investigation not to have uncovered that information. The latter justification will often present an issue of fact, not susceptible to summary judgment, as to what was reasonable.

This point was the key holding of the California Supreme Court in Wilson v. 21st Century Insurance Co., which arose from an underinsured motorist claim. Wilson, a college student, was injured on November 22, 2000, when an intoxicated driver turned left directly in front of her, leading to a collision. She complained of pain in her neck, shoulder and wrist. When a spinal x-ray was found normal, with no fractures, Dr. Jackson prescribed physical therapy. On January 29, 2001, Wilson saw Dr. Southern, complaining of continued neck, back and arm pain. From a new x-ray, Dr. Southern found degenerative changes that he described as “‘atypical for a patient of [Wilson’s] age and are almost certainly due to the history of trauma. She probably has degenerative disk changes as a result of occult disk injury at the levels in the neck from her high speed motor vehicle accident.’” Wilson was then planning a trip to Australia; Dr. Southern arranged for an MRI, which confirmed abnormalities, but not ones so significant as to call for delay of her planned departure.

Wilson’s lawyer, Hall, notified 21st Century of an impending UIM claim, settled with the tortfeasor for his $15,000 limits, and, on June 28, 2001, submitted a demand package and documentation, requesting payment of $85,000 (Wilson’s $100,000 UIM limit less the $15,000 recovered from the tortfeasor). At the time of the letter, Wilson was studying in Australia but still “experiencing pain ‘on a regular basis.’” After the accident (apparently before the visit to Dr. Southern), Wilson “had made a long-planned trip to Europe which was ‘ruined’ by her injuries.” Considering the expected impact over the remainder of Wilson’s life, he asserted that her general damages exceeded $100,000.

The adjuster, Le, spoke with Hall and was told there was no additional medical

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76 42 Cal. 4th at 717–18 (quoting doctor’s chart notes).
77 42 Cal. 4th at 718 (quoting letter).
78 42 Cal. 4th at 718.
79 42 Cal. 4th at 718.
documentation, though Hall pointed out that Dr. Southern indicated that the disk changes would affect Wilson later in life. Le’s notes posed the question “‘why is she in Australia if [her] injury [is] so severe?’ Le also observed that Wilson was young and might not exhibit future pain and opined that the MRI did not show any bulge touching the nerves.\(^{80}\)

Le recommended payment of $5000 in medical payments benefits but denial of Wilson’s UIM claim, on the basis that the $5000 payment, coupled with the $15,000 paid by the tortfeasor was adequate to compensate Wilson’s injuries.\(^{81}\) In the memo recommending this course, he wrote that Wilson:

> has a pre-existing condition pertaining to scolosis [sic], MRI shows no encroachment of a neural structure, it is unlikely that the 2mm bulge was produced by this accident. Presently, the [insured] is on vacation in Australia and is not expected to return until November, this discounts her attorney’s allegation that the pain & suffering and injuries are severe.\(^{82}\)

The condition Le referred to as “scolosis” is actually “scoliosis,” which Dr. Southern’s MRI had diagnosed.\(^{83}\) Le had no evidence of preexisting scoliosis, though he may have been confused by Dr. Jackson’s reference to mild “lordosis,” a different spinal condition.\(^{84}\)

Le’s supervisor approved his recommendation, opining that “Wilson’s injuries were ‘really just soft tissue injuries.’”\(^{85}\) No effort was made to contact Dr. Southern or to consult any other doctor. The July 17, 2001 denial letter asserted that Wilson had only “‘soft tissue injury superimposed on preexisting degenerative disc disease.’”\(^{86}\)

Wilson initiated arbitration of the UIM claim and received continued treatment for her pain. One surgeon recommended spinal fusion surgery, but Wilson did not have that surgery then. In 2002, 21st Century learned of this recommendation through discovery and obtained an IME and records review, which supported Wilson’s claim. A new adjuster then paid $85,000 on July 23, 2003. Wilson sued for bad faith delay in payment. The superior court granted summary judgment for 21st Century, but the court of appeal reversed, finding triable issues of fact. The California Supreme Court granted review.\(^{87}\)

By a vote of 5-2, the California Supreme Court agreed that there were triable issues. It pointed out that an insurer cannot properly deny a claim “‘without fully investigating the grounds

\(^{80}\) 42 Cal. 4th at 718 (quoting claim file).
\(^{81}\) Note that, even if Wilson’s demand for $85,000 was excessive, her UIM claim could not properly be denied if she was entitled to any amount at all in addition to the $5000 medical payment. So, the coverage issue was whether the tort claim (including medical expenses) exceeded $20,000.
\(^{82}\) 42 Cal. 4th at 719 (quoting claim file).
\(^{83}\) 42 Cal. 4th at 719 at 718.
\(^{84}\) See 42 Cal. 4th at 717 (quoting Dr. Jackson’s report), 717 n.1 (defining “lordosis”), 718 n.3 (defining “scoliosis”).
\(^{85}\) 42 Cal. 4th at 719 (quoting claim file).
\(^{86}\) 42 Cal. 4th at 719.
\(^{87}\) 42 Cal. 4th at 719–20.
for its denial.’ 88 Moreover, ‘it is essential that an insurer fully inquire into possible bases that might support the insured’s claim’ before denying it.’ 89 Nor can an insurer deny a claim without a factual basis for doing so or on a basis contradicted by facts known to it. ‘A trier of fact may find that an insurer acted unreasonably if the insurer ignores evidence available to it which supports the claim. The insurer may not just focus on those facts which justify denial of the claim.’ 90

In Wilson, 21st Century ignored Dr. Southern’s opinion on the nature, causation, and consequences of Wilson’s injuries. It did so based solely on the opinions of adjusting personnel not qualified to make medical judgments. Moreover, Le misread the records to show a preexisting condition which those records did not support. Of course, 21st Century was not obliged to accept Dr. Southern’s opinion, and would have been entitled to investigate (as it later did) by questioning Dr. Southern, by having Wilson’s records independently reviewed, or by having an IME done. 91 ‘What it could not do, consistent with the implied covenant of good faith and fair dealing, was ignore Dr. Southern’s conclusions without any attempt at adequate investigation, and reach contrary conclusions lacking any discernable medical foundation.’ 92 In the court’s view, “[a] jury could reasonably find that 21st Century” had done just that. 93

21st Century argued that the evidence showed three grounds of bona fide factual dispute. First, the initial x-ray had been “normal,” showing no injuries. But that was not inconsistent with subsequent degenerative changes caused by the accident. And 21st Century did not deny on the ground that Wilson had no degenerative changes, but on the baseless ground that the changes were preexisting. Second, 21st Century argued that the relatively modest medical expenses ($4275) indicated lack of a severe injury. This had not been asserted in the denial and, in any event, the claim was not that Wilson had required expensive treatment, but rather that a lifetime of future pain and suffering would aggregate to sizeable damages. 94 Third, 21st Century argued that her extensive travels (to Europe and Australia) negated a severe injury. But a jury might find that these did not provide a reasonable basis for rejecting her claim. 95

The dissent suggested that differences among doctors as to the need for surgery indicated a “genuine dispute.” 96 But the court pointed out that Wilson’s claim was not based, at the time of

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91 42 Cal. 4th at 722.
92 42 Cal. 4th at 722 (emphasis original).
93 42 Cal. 4th at 722.
94 Moreover, Wilson need not have suffered a severe injury to be entitled to somewhat more than the $20,000 he had received, even if he was not entitled to the $100,000 he demanded.
95 42 Cal. 4th at 724–25. The court noted that “the Court of Appeal aptly observed that ‘it is as possible to suffer “severe pain” in Australia as in Southern California.’ ” 42 Cal. 4th at 722. Moreover, pain can be severe without being disabling. Faced with the prospect of continuing pain, Wilson might have decided that she simply had to get on with her life and complete her studies (which Le mischaracterized as a “vacation”).
96 42 Cal. 4th at 726–29.
denial, on any need for surgery, but rather on a lifetime of general damages.\textsuperscript{97}

In addressing the relevance of the “genuine dispute” rule, the court emphasized 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 reasonable grounds.”\textsuperscript{98}

Stated differently, the genuineness of a dispute must be evaluated in light of all information the insurer possessed \textit{and} all of the information it should have gathered if it had conducted a reasonable investigation. In Wilson, 21st Century did not have any evidence sufficient to rebut the opinions of Dr. Southern and it never found any such evidence, even after the bad faith claim went into litigation. This alone sufficed to permit a finding of bad faith. Moreover, when 21st Century did seek an independent medical opinion, that opinion agreed with Dr. Southern’s opinion. A jury might even be able to find that this would have been the result if 21st Century had obtained an IME when it first considered the claim, though one cannot evaluate that possibility without knowing more about the basis of the IME opinion.

Of course, an insurer may stop its investigation if it finds evidence sufficient (if believed) to negate coverage and there is no prospect that further investigation would undermine that evidence. Nor ought it to matter that an investigation were arguably incomplete, if further investigation would not have revealed any information eliminating any genuine dispute about the insured’s entitlement to payment.\textsuperscript{99}

[ii] Issues with Respect to Summary Judgment Motions Raised by Deficient Investigations

Allegedly deficient investigations generate three different types of questions. First, the insurer may have discovered, after denial, additional evidence to support its position. If so, what is the relevance of that information to a summary judgment motion on bad faith? Second, additional investigation may have been indicated, but it later may appear that such investigation would not have uncovered any additional relevant evidence. What, then, is the significance of the failure to investigate? Third, it may be that additional investigation would have developed evidence favorable to the insured, but not enough to eliminate all reasonable grounds for dispute. How does this scenario impact the summary judgment analysis?

[iii] Some Jurisdictions Will Not Permit Insurer To Defend Against Bad Faith with Evidence Discovered After Denying the Claim

In most jurisdictions recognizing the bad faith tort, existence of coverage for benefits denied or delayed is, at least ordinarily, a necessary requirement for a bad faith claim. (See § 5.06) Consequently, if an insurer overlooks a good coverage defense and relies on one that does not support a bona fide dispute, it can still assert the good defense when sued and thereby defeat a bad faith claim.\textsuperscript{100}

\textsuperscript{97} 42 Cal. 4th at 725–26.
\textsuperscript{98} 42 Cal. 4th at 723 (emphasis original).
\textsuperscript{100} E.g., Republic Ins. Co. v. Stoker, 903 S.W.2d 338, 341 (Tex. 1995) (right decision for the wrong reason not actionable).
A number of jurisdictions now hold that, if a belated coverage defense fails, the insurer cannot rely on that defense to show existence of a reasonable basis to challenge coverage. This subjects an insurer to liability if none of the grounds actually relied upon constituted a reasonable basis for denial. While denial without having identified a reasonable basis does indicate the claim was mishandled, the insured would rarely, if ever, be prejudiced by the insurer’s failure to identify before denial a better ground that it could have relied upon. This would indicate that the mishandling of the claim was not the cause of any harm to the insured, and the lack of injury seemingly should preclude liability for the mishandling.

It is also true that an insurer receives something of a windfall from a rule totally precluding liability where the claim was meritorious and where the insurer denied the claim without identifying any reasonable basis for denial. If only the insurer’s own interest were at stake, its arguments for such a rule would be somewhat weakened by this fact.

But allowing recovery to an insured who has not been damaged by an insurer’s mishandling of the claim has the effect of inflating future rates that will be charged for similar insurance. Members of the insurance-buying public would have no reason to wish to pay higher rates so that a few of them could recover for a type of mishandling of claims that ordinarily causes no damage. Accordingly, the rule limiting an insurer’s defense of a bad faith claim to the grounds relied on for denial appears unsound, though any deleterious effects should be modest. (Only occasionally will all the grounds relied upon for denial be inadequate, and very rarely will there be an overlooked reasonable ground for denial; even then, coverage may be defeated on that

101 E.g.,

US/Mississippi: Sobley v. So. Nat. Gas Co., 210 F.3d 561, 564 (5th Cir. 2000) ("[A]n insurer may rely on any exclusion in the policy to show that no coverage existed, whether or not the exclusion was the stated basis for denial. However, once coverage is established, a court should evaluate whether there was an arguable basis for denial of coverage based solely on the reasons for denial of coverage given to the insured.");

US/Missouri: Buffalo Ins. Co. v. Bommarito, 42 F.2d 53, 57 (8th Cir.1930) ("a refusal to pay is vexatious if founded not upon what appear to be facts but only on a possibility that later investigation may develop facts justifying refusal to pay, even if such further investigation does develop such facts. The facts as developed may defeat recovery altogether, and if so, of course, they will incidentally defeat recovery of damages for vexatious refusal to pay; but if an insurance company desires to defeat recovery of damages for vexatious refusal to pay even though it may fail to defeat recovery on the contract of insurance, it must show that at the time it should have paid under the contracts the facts as they then appeared justified that refusal.");

Oklahoma: Buzzard v. Farmers Ins. Co., 824 P.2d 1105, 1109 (Okla. 1991) (insurer’s good faith in denying coverage evaluated solely based on evidence in its possession at the time the claim was denied); Newport v. USAA, 2000 OK 59, ¶ 37 (Okla. 2000) (allegedly reasonable ground for denial raised for first time on eve of bad faith trial need not be considered; ground also insufficient);


Thus, just as an insurer would be chargeable, in the absence of investigation, with knowledge of all facts supporting payment that a reasonable investigation would have disclosed (see § 5.04[3][a]), it also should be given the benefit of later-discovered facts that support denial.

The First Circuit so held in *Pace v. Insurance Co. of North America*,\(^{102}\) a suit on a policy of hull insurance. The insurer argued that the loss of the vessel was not due to a peril of the sea (covered), but was due to unseaworthiness (not covered). The court upheld a jury verdict finding coverage, but set aside a verdict finding bad faith. It ruled that ample evidence existed to support a jury verdict either way on the coverage issue, so the insurer had reasonable grounds to dispute the claim.\(^ {103}\) While it agreed with the insured that the jury might have found inadequacies in the insurer’s initial investigation, it found that these inadequacies could not vitiate the effect of an objectively reasonable basis for denial, even though they delayed full development of the evidence supporting unseaworthiness for some months after the insured presented the claim.

To establish bad faith, Rhode Island law, which governed in *Pace*, required both lack of an objectively reasonable basis to deny the claim and the insurer’s knowledge or reckless disregard of that lack of basis.\(^ {104}\) The purpose of these requirements is to protect an insurer’s right to challenge questionable claims without facing extortionate lawsuits.\(^ {105}\) The *Pace* court reasoned:

>To remove the objective component of the test—to permit recovery against an insurer because of flaws in the investigation even though the insurer has, in fact, a reasonable basis for denying coverage—would be to remove most of the protection for insurers and premium payers [provided by the standard], since it is almost impossible to conduct an investigation as to which some question of its adequacy, sufficient to get to the jury, cannot, in hindsight, be raised.\(^ {106}\)

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\(^{102}\) *Pace v. Ins. Co. of N. Am.*, 838 F.2d 572 (1st Cir.1988) (RI law).

\(^{103}\) 838 F.2d at 575–78, 581–82.

\(^{104}\) 838 F.2d at 580 (citing *Bibeault v. Hanover Ins. Co.*, 417 A.2d 313, 319 (R.I. 1980)).

\(^{105}\) 838 F.2d at 584.


Cf.

US/Kansas: *Pacific Employers Ins. Co. v. Hoidale*, 782 F. Supp. 564, 566 (D. Kan. 1992) (third-party failure to settle case; insurer allowed to present an expert witness to support its prior evaluation of the underlying case as “weak” even though it had not consulted the expert in connection with the underlying case).
Thus, even a belatedly developed reasonable basis for denial can preclude bad faith as a matter of law, despite initial inadequacies in the insurer’s investigation. (While Pace inaccurately predicted Rhode Island law,107 its reasoning should still be persuasive elsewhere.)

This analysis also calls for rejection of suggestions that an insurer might be liable for bad faith because it adopted a reasonable legal position supporting denial only after denying the claim,108 or because the insurer’s personnel regarded the ground of denial as invalid when it actually may have been tenable.109 In either event, existence of what in fact is a reasonable ground of denial establishes that the insurer’s actions were objectively proper. Thus, such suggestions will only prolong discovery and require additional trials for the sole purpose of punishing “bad attitude” that caused no improper conduct.

Insofar as the Dutton or directed verdict rule (see § 17.03[4][a][i]) or its modified form (see § 17.03[4][c]) calls for analysis of the evidence presented at trial, a rule excluding consideration of evidence not available to the insurer at the time of claim denial would require modification of that rule to reflect the exclusion.110

[iv] Deficient Investigation Should Not Matter Unless Significant Evidence Favorable to Insured Was Missed

If the insurer fails to conduct an adequate investigation, but a proper investigation would have uncovered no additional evidence favorable to the insured, the deficiency in the investigation causes no harm to the insured. Inadequate investigation is ordinarily not an independent ground of liability, absent resulting damage in the form of improper denial of benefits. (See § 5.04[3][c].) But there may be issues as to who has the burden of producing evidence of what a proper investigation would have found. (See § 17.03[4][e][ii].)

[v] Deficient Investigation Which Misses Information Favorable to Insured, but Does Not Negate Reasonable Basis for Denial, May Create Factual Issue on Causation of Harm

[A] Insured May Be Able To Argue That Insurer Would Have Paid Claim Had It Obtained All Information in Timely Manner—Illustrative Case

Suppose the facts that investigation would have uncovered (and that the insured presents at trial or in opposition to summary judgment), though favorable to the insured, do not negate the existence of a reasonable basis for dispute. The insurer could properly have denied the claim even if it had conducted the investigation and uncovered the evidence in question. On this basis, it can again be argued that the inadequate investigation caused no harm and, therefore, is not actionable

107 Skaling, 799 A.2d at 1010–11.
in and of itself. If so, it is no impediment to summary judgment.

The causation analysis is not so simple, however, as demonstrated in Linthicum v. Nationwide Insurance Co.\textsuperscript{111} The insurer in Linthicum denied a medical claim as treatment for a preexisting condition. The initial denial was based on a dubious reading of the policy language, without review of the full medical records or discussion with any treating physician (one of whom had invited a call), and without review by any physician, even though the insurer’s procedures called for review by its medical director. The fact that a disputed issue remained even after full preparation for trial did not end the bad faith inquiry.

The Arizona Court of Appeals reasoned that “[a] reasonable insurer conducts a neutral and detached investigation and then determines whether the investigation indicates that the claim is ‘fairly debatable.’”\textsuperscript{112} Insurers do not deny every claim that is fairly debatable, but an insurer that has denied a claim without adequate consideration may be motivated to justify its prior action by seizing on any excuse to reaffirm that action, or at least a jury might so find.\textsuperscript{113} (That would be shortsighted, as an insurer ought always to be alert to the opportunity to detect and correct prior errors, thereby limiting their consequences, but human nature is not always so rational.) As a result, the inadequacy of the initial investigation might have injured the insured by depriving him of an unbiased decision on whether to pay the claim in light of the full factual picture an adequate investigation would have revealed.

This line of analysis might be enough to prevent summary judgment on bad faith in some cases in which the evidence to be presented at trial would leave a legitimate factual question.\textsuperscript{114} But that result makes sense only when, as in Linthicum, the question remaining after full factual development is, at best, only barely arguable and, as a result, an insurer not already predisposed to uphold a prior denial might have paid the claim despite that question. If, on the other hand, the full evidence would have weighed heavily against payment (though less so than the evidence at the time of denial), the lack of further investigation should not have affected the outcome, and

\textsuperscript{112} 150 Ariz. at 363–364 (emphasis added).
\textsuperscript{113} See Arizona:
\textsuperscript{114} See Burgess v. Mid-Century Ins. Co., 841 P.2d 325, 328–29 (Colo. Ct. App. 1992) (independent medical examination finding the treatments for which coverage was denied to be unnecessary did not preclude a finding of bad faith; insurer had failed to consult the treating physician to ascertain the basis of his contrary conclusion).
summary judgment might be proper.

This last point would seem applicable in *Employers Mutual Casualty Co. v. Tompkins*, in which a bad faith verdict was upheld, but without evident consideration of the argument presented here. The case involved an uninsured motorist claim. The claim initially was denied on the basis of a clearly invalid exclusion that the insurer had left in its policy form. Five months later, the insured’s lawyer demanded settlement. The insurer promptly recognized the invalidity of the exclusion.

Due to unsettled law on invalid exclusions, there was a question whether the effective policy limit was $20,000 or $50,000. The insurer’s lawyer advised that the effective limit probably was $20,000, and the insurer immediately offered that amount. The insured refused, demanded $50,000, and commenced a bad faith action seeking punitive damages. The insurer brought a declaratory judgment action to determine the limits. When a court found that the effective limit was $50,000, the insurer immediately offered that amount. The insured refused this offer as well.

The uninsured motorist was joined in the bad faith action. Because the insured’s negligence contributed heavily to the accident and the negligence of the uninsured motorist was modest, the jury returned a verdict against the uninsured motorist of only $500, even though the insured suffered severe injuries. This indicates that the insurer would have had ample reason to dispute the claim vigorously and to question whether any payment was due even if it recognized $50,000 in coverage from the outset. Thus, the claim handling error appears to have benefitted the insured by leading to offers that the insurer probably would not have made on the merits of the underlying claim against the uninsured motorist. Only the insured’s own greed in seeking an even larger punitive damage award prevented the claim from settling for one of the insurer’s offers. Because the insurer had an ample, though unasserted, basis for denying the claim, the court’s decision permitting a bad faith verdict to stand seems highly questionable.

[B] But Where the Grounds for Denial Were Solid, They May Support Summary Judgment Even Though Some Evidence Favorable to the Claim Was Overlooked—Illustrative Cases

This conclusion is supported by *United Nuclear Corp. v. Allendale Mutual Insurance Co.* This case involved property insurance coverage for losses suffered when an earthen dam collapsed, releasing 94,000,000 gallons of tailings. The policy covered “collapse,” but excluded loss or damage resulting from subsidence or any other earth movement. All parties agreed that the

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115 *Employers Mutual Casualty Co. v. Tompkins*, 490 So. 2d 897 (Miss. 1986).
116 The court found this advice “not altogether reasonable.” 490 So. 2d at 905.
117 It returned a $50,000 compensatory damage verdict against the insurer, but the Mississippi Supreme Court reduced this award to equal the $500 award against the uninsured motorist. 490 So. 2d at 902. A $400,000 punitive damage award was affirmed in light of the insurer’s improper conduct in retaining a clearly invalid exclusion for nearly a decade.
118 See *Hillman v. Nationwide Mut. Fire Ins. Co.*, 855 P.2d 1321, 1326 (Alaska 1993) (even though arbitrator found liability of uninsured motorist equal to policy limit, insurer acted reasonably in demanding arbitration because police report indicated that insured also was at fault and arbitrator found insured preponderantly at fault).
“collapse” was caused by “differential settlement.” The major coverage issue was whether
differential settlement fell within the exclusion. The trial court held that it did not, and the New
Mexico Supreme Court affirmed, ruling that the policy language and the insurer’s own manual
distinguished between “settlement” and “subsidence” and that “earth movement” referred only to
naturally occurring phenomena.120

The jury awarded policy benefits of $24,670,724 and punitive damages of $25,000,000 for
bad faith. The supreme court set aside the finding of bad faith. Without deciding whether the
insurer’s argument on the major coverage question was reasonable (and the opinion on coverage
suggests it was not), the court found its refusal to pay reasonable on other grounds:

[Although the questions of coverage were the major reasons
given by Allendale for not paying UNC’s claim, they were not
the only reasons. There remained questions regarding the amount
of damages available to UNC under its insurance policy with
Allendale. UNC’s amended complaint sought $30,032,152 in
compensatory damages. The trial court judgment for UNC was
for $24,670,724 in compensatory damages, a difference of
$5,361,428. These are very substantial differences in the amount
claimed and the amount awarded. It cannot reasonably be argued
that Allendale did not have a legitimate reason to question, in a
court of law, the amount of damages claimed by UNC. There
existed legitimate issues under various policy provisions
regarding UNC’s claim for lost net operating profits,
extraordinary costs, carrying costs and costs of repair. Therefore,
since there were legitimate questions regarding the amount of
UNC’s claimed damages, as is evidenced in the trial court’s
judgment awarding substantially different amounts than those
claimed by UNC, we cannot say that Allendale’s failure to pay
UNC’s claim was malicious or in bad faith (i.e., an unfounded
refusal to pay).121

The court may have gone a bit too far in setting aside the finding of bad faith (as opposed
to just the punitive damage award)122 if it would not have found the coverage argument
reasonable. When only a portion of the claim is reasonably disputed, it can be bad faith not to pay
the portion that is (or should be) undisputed pending resolution of the dispute. (See § 5.05)
Presumably some amount would have been undisputed had there been no coverage question, so
failure to pay that amount might have supported a bad faith finding.123 On the other hand, New

120 103 N.M. at 483–84.
121 103 N.M. at 485 (emphasis original).
122 The conclusion that there was no showing of malice, fraud, oppression, or similar misconduct seems
entirely appropriate.
123 See, e.g.,

versus replacement cost as to destroyed barn—presented triable issue of fact, so summary judgment on
coverage was improper, precluding any possibility of bad faith on that issue; however, insurer’s failure to
Mexico may have been applying the *Anderson* standard on bad faith\(^{124}\) (see § 5.03[2]), so the court might have been ruling that the record could not support the necessary finding that the insurer knew or recklessly disregarded the fact that its basis for denial was not reasonable.

The availability of summary judgment, in appropriate cases, despite the insurer’s failure to discover evidence favorable to the insured is further supported by *Szumigala v. Nationwide Mutual Insurance Co.*\(^{125}\) This case involved an uninsured motorist claim. The insured was riding a bicycle when Cambre, a motorcyclist, struck him at an intersection. Both were killed. There were no witnesses to the accident itself. The police report concluded that the insured had disregarded a stop sign giving Cambre the right of way, that Cambre was not speeding, and that obstructions to vision meant that Cambre had no realistic ability to avoid the accident. The insurer

pay amounts concededly due for clean up costs, personal property losses, and actual cash value of barn could support jury’s finding of bad faith);

*Louisiana*: *Guitreau v. State Farm Mut. Auto. Ins. Co.*, 540 So. 2d 1097, 1102 (La. Ct. App. 1989) (once liability of uninsured motorist and existence of coverage are clear, insurer must tender amount of undisputed damages, despite dispute as to full amount of damages);

*Mississippi*: *Cossitt v. Federated Guar. Mut. Ins. Co.*, 541 So. 2d 436, 445 (Miss. 1989) (insurer was not only reasonable but correct in denying uninsured motorist benefits and in delaying medical payments benefits until insured made proper proof of loss, but its failure to pay $1,000 in medical payments benefits promptly upon receipt of such proof might support submission of bad faith issue to jury).

\(^{124}\)The requirements for establishing bad faith in New Mexico are not entirely clear, as most of the cases concentrate primarily on the requirements for recovery of punitive damages once bad faith has been found. See, e.g, *Jessen v. National Excess Ins. Co.*, 108 N.M. 625, 627 (1989). When the bad faith tort was recognized, it was said to lie for “any frivolous or unfounded refusal to pay.” *State Farm Gen. Ins. Co. v. Clifton*, 86 N.M 757, 759 (N.M. 1974). That formulation might not require any subjective culpability if the insurer’s conduct was objectively unreasonable. A recent case, however, provides some clarification:

“Unfounded” in this context does not mean “erroneous” or “incorrect;” it means essentially the same thing as “reckless disregard,” in that the insurer “utterly fail[s] to exercise care for the interests of the insured in denying or delaying payment on an insurance policy.” It means an utter or total lack of foundation for an assertion of nonliability—an arbitrary or baseless refusal to pay, lacking any arguable support in the wording of the insurance policy or the circumstances surrounding the claim. It is synonymous with the word with which it is coupled: “frivolous.”

*Jackson Nat’l Life Ins. Co. v. Recceconi*, 113 N.M. 403, 419 (1992) (*quoting Jessen v. Nat’l Excess. Ins. Co.*, 108 N.M. 625, 628 (1989)) (emphasis original in *Jackson*) (citation omitted). While this clarification fails to resolve the issue completely, the requirement of recklessness may place New Mexico among those states embracing the intentional tort concept of bad faith. But the requirement of subjective culpability may only apply to an award of punitive damages. *See Sloan v. State Farm Mut. Auto. Ins. Co.*, 135 N.M. 106, 113 (2004) (“In failure-to-pay claims, therefore, a plaintiff … might make a proper showing that the insurer acted unreasonably in denying or delaying a claim, entitling the plaintiff to compensatory damages, without having made a prima facie showing that the refusal to pay was frivolous or unfounded.”)

denied the claim, and the trial judge rendered summary judgment in its favor on bad faith. At trial of the contractual claim, an accident reconstructionist persuaded the jury that Cambre was negligent and bore 10 ten percent of the fault, producing a judgment requiring payment of policy limits. The insured’s parents (and personal representatives) appealed the summary judgment on bad faith, arguing that the insurer was unreasonable in failing to conduct further investigation and discover that the uninsured motorist was liable.

The Fifth Circuit affirmed. It began by noting that an insured seeking to impose liability based upon a deficient investigation must show a “level of negligence … such that a proper investigation by the insurer ‘would easily adduce evidence showing its defenses to be without merit.’”126 Without passing on whether the insurer should have undertaken further investigation, the court found the summary judgment proper because it found “nothing Nationwide could have uncovered by further investigation that would have undermined at least the arguable merit in Cambre’s, and hence its own, defenses.”127 While plaintiffs were able to find an expert who convinced a jury to find liability, that did not show bad faith “when paucity of fault actually found is coupled with the weight of the evidence contrary to even this minimal finding.”

[e] Circumstantial Case Must Be Judged as Whole

[i] Illustrative Case—State Farm Fire & Casualty Co. v. Simmons

Where an insurer relies on circumstantial evidence to deny a claim, special problems may be presented, as illustrated by State Farm Fire & Casualty Co. v. Simmons.128 State Farm had denied a claim for fire damage to the Simmons home on the ground that the insureds had committed arson. It set out to prove this circumstantially by showing the “arson triangle” of (1) incendiary origin of the fire, (2) opportunity to set the fire, and (3) motive for doing so.129 Incendiary origin was clear, and the Simmons’s’ opportunity to set the fire reasonably so.130 Thus the apparent issue was motive.

State Farm claimed that the Simmonses had financial problems that provided a motive for them to set the fire.131 For reasons explained below, the court apparently concluded that the jury could have found it unreasonable for State Farm to believe that the Simmonses had a motive to burn the house.

On the surface, this would suggest that the insured showed that the asserted reasonable basis for denial failed to create a bona fide dispute. The fire loss to the Simmons home was recognized by all. Because arson is an affirmative defense, their prima facie case required no more. If the “arson triangle” could not provide a reasonable basis for denying the claim—because no motive could be reasonably asserted—then State Farm’s only articulated basis would seem to fail. Under this view, the debate between the majority and the dissents about the allegedly deficient investigation would be a side issue, not critical to the result. (See § 17.03[4][d][iv]–[v])

126 853 F.2d at 280 (quoting Merchants Nat’l Bank v. Southeastern Fire Ins. Co., 751 F.2d 771, 777 (5th Cir.1985)).
127 853 F.2d at 281.
128 State Farm Fire & Cas. Co. v. Simmons, 963 S.W.2d 42 (Tex. 1998).
129 963 S.W.2d at 45 & n. 1.
130 963 S.W.2d at 44.
131 963 S.W.2d at 46.
The evidence on motive can be summarized as follows. The Simmonses were behind on their mortgage payments and under significant financial pressure.\textsuperscript{132} State Farm initially made a mistake in analyzing their financial condition, thinking it far worse than it was, and may not have fully reconsidered the issue upon discovering the truth.\textsuperscript{133} In fact, the Simmonses were not much worse off than was normal for them and they were managing their problems adequately, although they were never far from going under.\textsuperscript{134} The insurance was not even enough to pay their mortgage, so a fire would destroy their home without removing the burden of the debt.\textsuperscript{135} They had made extensive improvements to the home and would be far worse off after a fire than before.\textsuperscript{136} Viewing all of the evidence in the light most favorable to the Simmonses, it is apparent that they had no reason to burn the house and every reason no to do so. State Farm’s contrary position arguably could be found unreasonable, and thus the “arson triangle” would collapse.

While that interpretation is plausible, and may well reflect the underlying basis of the affirmance of the bad faith finding,\textsuperscript{137} it misses deeper issues about circumstantial proof that should have concerned the court. For the “arson triangle” is not the only way to find circumstantial proof of arson, and an alternate analysis provides a seemingly substantial basis for State Farm’s decision to “test the claim in court.”

The issue is one of general importance. Arson is a particularly serious type of insurance fraud, of significant concern to both insurers and government agencies.\textsuperscript{138} If its impact on

\textsuperscript{132} 963 S.W.2d at 46.
\textsuperscript{133} 963 S.W.2d at 46–47. State Farm asserted that it had discovered and corrected the initial error before denying the claim and that, even after the correction, a motive to commit arson remained. But the court concluded that the jury could have found this mere “post hoc rationalization.” Id. at 47.
\textsuperscript{134} 963 S.W.2d at 46.
\textsuperscript{135} 963 S.W.2d at 46.
\textsuperscript{136} 963 S.W.2d at 43, 46.
\textsuperscript{137} See Provident Amer. Ins. Co. v. Castañeda, 988 S.W.2d 189, 198 (Tex. 1998) (stating that basis of Simmons was insurer’s unreasonable disregard of evidence that Simmonses had no motive for arson).
\textsuperscript{138} All states recognize the seriousness of arson and consider it a crime. See, e.g.,

\textit{California:} \textsc{Cal. Penal Code} § 451.1; \textsc{Fla. Stat. Ann.} § 806.01;


\textit{Texas:} \textsc{Tex. Penal Code Ann.} § 28.02.

Indeed, some states even increase the criminal punishment if the arson was committed for insurance fraud or other, similar profit motives. See

\textit{Pennsylvania:} \textsc{Pa. Cons. Stat. Ann.} § 3308. Most states also explicitly recognize the importance of finding and punishing arsonists and give insurance companies who are likely to have such information immunity from a civil action for reporting that information to the prosecuting authorities. See

\textit{Massachusetts:} \textsc{Mass. Gen. Laws Ann.} ch. 148, § 32 (no person such as an insurance investigator who furnishes information about suspected arson to the appropriate governmental agency can be held liable for damages in a civil action). Because arson is such a serious crime, an insurer who has facts warranting a
insurance costs is to be controlled, insurers must rely on circumstantial evidence to detect and deny fraudulent arson claims, and they must do so at the risk of occasionally denying the claim of an innocent insured.

In the appellate briefing of Simmons, the parties divided the circumstantial evidence into two categories: opportunity and motive.\textsuperscript{139} Consistent with the “arson triangle” metaphor, they apparently assumed that both must be shown to make out an arson defense. While this division is useful for some purposes, it is artificial.

The ultimate issue on the contract claim was whether the circumstantial evidence, taken as a whole, was strong enough to make it more probable than not that the Simmonses were the arsonists.\textsuperscript{140} If the evidence in one category was strong enough, it might not matter whether evidence in the other category was weak or equivocal. In particular, if it could be shown that the Simmonses and only the Simmonses had the opportunity to set the fire, then it would not matter if one thought they lacked a motive to do so. As Sherlock Holmes often remarked, “when you have eliminated the impossible, whatever remains, however improbable, must be the truth.”\textsuperscript{141}

On that front, the briefs indicate that State Farm had a solid case, one not apparent from the opinions. The fire was set shortly after 2:00 a.m. By their own sworn statement, the Simmonses left the house (to drive to Louisiana to visit a relative) between 1:30 and 2:00, and probably closer to 2:00.\textsuperscript{142} If their account was falsified or simply imprecise, their departure might have been even later.

Mr. Simmons locked up before leaving.\textsuperscript{143} The fire was set at two separate places inside the house.\textsuperscript{144} So either the Simmonses did it just before they left, or someone else entered the house to set it almost immediately after they left. There was no evidence of theft, though the fire itself might have concealed such evidence.\textsuperscript{145}

The facts that the fire started at just about the time the Simmonses left the house, that it

belief that the insured committed arson will be shielded from bad faith liability for failure to pay the claim. See, e.g.,


\textsuperscript{139} See Simmons, Reply to Application for Writ of Error, 21–23; Petitioner’s Reply Br. 6–7 & Appendices A–B; Response to Petitioners’ Reply Br. 4–12.

\textsuperscript{140} See State Farm Fire & Cas. Ins. Co. v. Vandiver, 970 S.W.2d 731, 736, 738 (Tex. App. 1998) (circumstantial evidence must be considered in totality and is probative of fact if inferences arising from the circumstances are not equally consistent with nonexistence of that fact; circumstantial evidence of arson provided reasonable basis for denial of claim).

\textsuperscript{141} ARTHUR CONAN DOYLE, The Sign of (the) Four, in THE COMPLETE SHERLOCK HOLMES (1988).

\textsuperscript{142} See Simmons, 963 S.W.2d at 44; State Farm Br. at 21.

\textsuperscript{143} 963 S.W.2d at 44.

\textsuperscript{144} 963 S.W.2d at 44; State Farm App. at 24.

\textsuperscript{145} 963 S.W.2d at 44; State Farm Br. at 21.
was set from inside, and that the house was generally secured show that they had an easy opportunity to set the fire, and that one has to assume a number of unusual circumstances for someone else to have had that opportunity without their connivance. This evidence points to their culpability, just as the oversized footprint near the body of Nicole Brown Simpson pointed in the direction of O.J. Simpson, even though it is not impossible that another person with feet of a similar unusual size committed the murder.

Even if an enemy or a vandal was inclined to burn the house (apparently without bothering to steal anything), it seems quite extraordinary that he or she would pick this particular time to do so. There is no indication that the Simmonses’ impending one-day absence was known widely outside their family, and their own account indicates that the time of departure was not what they had planned. So either the hypothetical enemy/vandal simply happened by at 2:00 a.m. and seized the unexpected opportunity to enter and set a fire, or s/he lay in wait for them to leave and entered essentially as they were pulling out of the driveway. The improbability of these assumptions again points to the Simmonses.\(^{146}\)

The lack of a motive to commit arson, and even the existence of a strong motive not to do so, does not preclude the possibility that the Simmonses committed arson. After all, people sometimes do stupid things, because they don’t think them through. None of the briefs or opinions in *Simmons* offers any reason why the evidence on opportunity did not suffice to warrant “testing the claim in court,” even if the motive evidence clearly favored the Simmonses. That is understandable, as the analysis presented here was not offered until two months after the case was argued in the supreme court.\(^{147}\) One hopes that future courts will not similarly overlook the complexity of the problems presented by circumstantial evidence.

**[ii] Simmons on Deficient Investigation**

The *Simmons* court’s opinion is also extremely critical of State Farm’s investigation. The jury might have found that State Farm did not try very hard to pursue the possibility that others might have set the fire.\(^ {148}\) In particular, it did not locate and interview those whom the Simmonses identified as having grudges against them.\(^ {149}\) Combined with the arguably unreasonable contention that the Simmonses had a strong motive to burn the house, this led the court to characterize the investigation as “outcome-oriented,” designed solely to support the accusation against the Simmonses.\(^ {150}\)

While the dissents viewed the investigation less negatively than the majority, they focused

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\(^ {146}\) A Texas lawyer has suggested to me that an “enemy” might have driven by as the Simmonses were loading the car and then awaited their departure. This would render the hypothesis less implausible than the text assumes. Because the briefs describe the lot as wooded, I had assumed the driveway would not be clearly visible from the street. But even if it were visible, this still strikes me as sufficiently improbable to create a jury issue on the identity of the arsonist. Under the analysis advanced here, existence of a jury issue on coverage would defeat any bad faith claim.

\(^ {147}\) Some of the analysis in this section was developed for use in an amicus brief on the merits in *Simmons* (filed by the National Association of Independent Insurers); that analysis differed from what the parties argued.

\(^ {148}\) 963 S.W.2d at 45.

\(^ {149}\) 963 S.W.2d at 45.

\(^ {150}\) 963 S.W.2d at 45.
on the absence of any evidence that the alleged defects in the investigation had caused any harm.\textsuperscript{151} The majority responded that requiring the Simmonses to submit such evidence would "turn [the] duty [to investigate] on its head."\textsuperscript{152}

Taken in isolation, this last point might suggest that deficient investigation could itself support bad faith liability, without any proof of resulting harm.\textsuperscript{153} But other cases reject liability for mere bad faith conduct, in the absence of harm resulting from that wrong. (See § 5.04[3][c]) And the burden of showing harm from any mishandling of the claim (including deficient investigation) would seem part of the burden of establishing the tort.

If proof of resulting harm is to be excused in any circumstances, it should be limited to cases, like \textit{Simmons}, where the insurer asserts an affirmative defense instead contesting the insured’s ability to prove a covered loss. With the insurer bearing the burden of proof on its defense, one might also shift to it some burden of producing evidence that no harm had resulted from its defective investigation.

Precisely because proof of harm to the protected interest in contractual benefits is so fundamental to the law of bad faith, \textit{Simmons} should not be read to undermine that requirement when it appears to rest primarily on lack of any reasonable basis for reliance on a supposed motive to commit arson.

Nor ought the characterization of an investigation as “outcome-oriented” itself be regarded as evidence of bad faith. (See also § 5.04[2][c][ii]) There is nothing inherently wrong with an investigator forming a preliminary opinion as to the likely outcome of the investigation and seeking evidence to confirm that opinion. Arguably, it is impossible to conduct an investigation without some sort of hypothesis to help sort significant evidence from insignificant. In any case, claims investigators are human, and humans commonly draw preliminary conclusions from incomplete evidence and then look for confirmation. Being human is not bad faith. And insurers are surely entitled to look as hard as they want for evidence of fraud, even if the circumstances are less suspicious than the ones here.

It is wrong (and bad investigative technique) to fail to look for evidence which might contradict one’s hypothesis, if there are obvious places where such evidence might be found. It is even more wrong to fail to take account of such evidence if it is found. In particular, the duty of good faith demands that insurers look for (and take account of) evidence supporting coverage, because they will be chargeable with knowledge if it turns out to exist and to be reasonably discoverable.

But the focus, for bad faith purposes, should not be on the quality of the investigation, in the abstract, but rather should be on the evidence favorable to the insured that the deficient investigation missed. That focus avoids penalizing insurers for failing to pursue every line of inquiry that an insured can dream up (after the fact if necessary). But it will still provide incentives to pursue inquiries that appear to have reasonable prospects of uncovering truly significant information.

\textsuperscript{151} 963 S.W.2d at 50–52 (Enoch, J., dissenting), 48–50 (Hecht, J., dissenting).

\textsuperscript{152} 963 S.W.2d at 47.

The Simmons court suggested that one piece of evidence against State Farm was its failure to conform to the investigatory standards which it had set for itself. But an insurer does not set the standards to which it must conform to act in good faith. The law sets those standards. An insurer sets standards by which it seeks to assure compliance with the law (possibly including a margin for error) and to implement what it regards as good business practices, which will generate and maintain customer goodwill. The violation of such internal standards does not constitute bad faith. At most, an insurer’s standards may tend to show what investigation it regards as reasonable. This could provide some support for charging the insurer with knowledge of facts that went undiscovered because it failed to satisfy its internal standards.

While the court does not mention it, the Simmonses also argued that the arson defense must not have been fairly debatable, because State Farm chose not to debate it with them before reaching a decision. But the issue is not whether the claim was “fairly debated” before it was denied. The issue is whether it was one State Farm could fairly demand that the Simmonses debate in court. If so, State Farm might prefer not to preview its entire case before the litigation even started, perhaps giving the Simmonses an opportunity to fabricate evidence to meet that case (as arsonists might be tempted to do).

What State Farm lost by failing to explain its position in more detail before denying the claim was the opportunity to learn of its own misunderstandings that the Simmonses could have corrected, and of any exculpatory evidence it had not previously elicited. As the jury at least might have concluded that such a discussion would have been a reasonable investigative step, State Farm thus would have become chargeable with the information it could have learned by so doing. The risk of being so charged provides a significant incentive for insurers to discuss their positions with their insureds whenever there is any apparent possibility that such a discussion might yield significant information.

[f] If Policy Must Be Reformed Before any Coverage Is Due, That May Preclude Bad Faith Claims

In R & B Auto Ctr., Inc. v. Farmers Group, Inc., R & B was a used car dealer seeking coverage for liability under California’s Lemon Law for a title-branded used car. Farmers refused to defend or indemnify, because the plain language of the policy limited Lemon Law coverage to new cars. R & B alleged that it had told the agent who sold the policy that it only sold used cars and specifically inquired whether the policy would cover Lemon Law liability for a title-branded used car. Allegedly, the agent assured R & B that it would. R & B sued for, misrepresentation, reformation, bad faith, and violation of an unfair practices statute. By way of motions in limine, the superior court granted what amounted to a summary judgment to Farmers.
The court of appeal found triable claims in theory for reformation and bad faith. But it held that, because there was no coverage under the policy as written, there could be no claim for bad faith:

before an insurer can be found to have acted tortiously (i.e., in bad faith), for its delay or denial in the payment of policy benefits, it must be shown that the insurer acted unreasonably or without proper cause. Generally speaking, “the reasonableness of the insurer’s decisions and actions must be evaluated as of the time that they were made ….” When an insured submits a claim to an insurer and there is no potential for coverage of that claim under the policy, the insurer has no duty to defend and it may reasonably deny the claim. Since it is reasonable to deny the claim at the time, if the policy is later reformed to provide retroactive coverage, the insurer may not be held liable for bad faith for failing to have the foresight to know that the policy would be reformed.

Stated as a pure proposition of law, this seems questionable. R & B presumably asserted its reformation claim in the claim-handling process. Farmers would then have been obliged to investigate the facts alleged by R & B. If investigation showed that R & B was entitled, without any genuine dispute, to reformation, then there could be a basis for a bad faith claim. The possibility that this might have been true receives some support from the fact that, when sued, Farmers tendered payment for what it claimed were R & B’s costs of defending and settling the Lemon Law claim, with interest. On the other hand, R & B does not appear to have contended that it was entitled to summary judgment on reformation, and any genuine factual dispute would have precluded a bad faith claim. So the decision appears correct, even if the legal point might be overstated.


[a] Overview

While the existence of a genuine issue of fact on the issue of coverage ordinarily should preclude liability for bad faith, such an issue is not essential to the ability of an insurer to obtain summary judgment on bad faith. To repeat, “when a claim is ‘fairly debatable,’ the insurer is entitled to debate it, whether the debate concerns a matter of fact or law.” Thus, even if the facts are undisputed, an insurer may conclusively establish good faith if it had a reasonable legal argument that it need not pay the claimed benefits. As a result, it is possible for a court to

156.3 140 Cal. App. 4th at 336–49.
156.4 140 Cal. App. 4th at 354. (See 5.04[1][b], above.) For essentially the same reason, it found the statutory unfair practices claim properly dismissed. 140 Cal. App. 4th at 354–56.
156.5 140 Cal. App. 4th at 335–36. The tender was refused. 140 Cal. App. 4th at 336.
158 Conversely, a reasonable dispute as to a factual issue will not preclude bad faith if, even on the insurer’s view of the facts, there was no reasonable legal argument for refusing to pay. See, e.g., LaHaye v. Allstate
render summary judgment for the insured on coverage and for the insurer on bad faith if it finds the insurer’s view of the law mistaken, but nonetheless reasonable.

Case law does not establish a bright-line rule (like the directed-verdict rule, see §§ 17.03[4][a]–[c]) for determining whether a legal position qualifies as reasonable. Many cases simply declare in a conclusory fashion that the position taken was reasonable, even though ultimately rejected by the court. However, there are a few clear guidelines. For example, reasonable reliance on a state insurance regulation, even one whose validity was challenged, could not constitute bad faith.

[b] Reasonableness of Insurer Position Can Often Be Demonstrated

[i] Favorable Judicial Rulings on Coverage Can Establish Existence of Reasonable Basis To Test Claim in Court

[A] Many Cases Have So Held

As the Iowa Supreme Court has explained:

“Perhaps the most reliable method of establishing that the insurer’s legal position is reasonable is to show that some judge in the relevant jurisdiction has accepted it as correct. The favorable decision need not have been available to the insurer at the time it acted on the claim. After all, if an impartial judicial

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159 When a court finds an insurer’s position unreasonable, a basis for that conclusion usually is discernible from its reasoning in rejecting the position. Decisions with only conclusory statements that the insurer’s position was reasonable include.

US/California: Franceschi v. American Motorists Ins. Co., 852 F.2d 1217, 1220 (9th Cir.1988);


160 Occasionally, courts will uphold the insurer’s coverage position and then separately reject a bad faith claim on the seemingly self-evident basis that the insurer’s meritorious position was reasonable. See, e.g.,


officer, informed by adversarial presentation, has agreed with the insurer’s position, it is hard to argue that the insurer could not reasonably have thought that position viable.\textsuperscript{160.2}

Examples of this point abound. When a trial court has rendered judgment for the insurer on coverage, an appellate reversal on coverage is commonly accompanied by a ruling that the legal position is fairly debatable and, as a result, precludes any bad faith claim on remand.\textsuperscript{161} Similarly, a showing of division among judges considering the question (in other cases or in the same case in another court) ordinarily precludes bad faith exposure.\textsuperscript{162} Even acceptance of the question for review by the state supreme court will show that the position was tenable and that


\textit{Pennsylvania}: Jones v. Nationwide Prop. & Cas. Ins. Co., 2010 PA SUPER 90, ¶¶ 15–16 (favorable decision need not have been available to the insurer at the time it acted on the claim).

\textit{US/Alabama}: St. Paul Fire & Marine Ins. Co. v. Tinney, 920 F.2d 861, 864 (11th Cir.1991);

\textit{US/Mississippi}: Starkville Mun. Separate Sch. Dist. v. Continental Casualty Co., 772 F.2d 168, 170 (5th Cir.1985) (relying on district court’s acceptance of insurer’s position to show its reasonableness);

\textit{Alabama}: Badners v. Prudential Life Ins. Co., 567 So. 2d 1242, 1244 ( Ala. 1990);

\textit{Louisiana}: Soniat v. Travelers Ins. Co., 538 So. 2d 210, 216 (La. 1989);


\textit{Alaska}: Hillman v. Nationwide Mut. Fire Ins. Co., 855 P.2d 1321, 1325–26 (Alaska 1993) (two members of supreme court and a respectable minority of other jurisdictions had agreed with insurer’s coverage argument);


\textit{See also}

there is sufficient doubt to justify continued assertion of the position despite prior rejection by lower courts.\textsuperscript{163}

Sometimes a holding based on this reasoning is expressed in a manner that looks like the court was considering a factual dispute. For example, in \textit{John Hancock Mutual Life Insurance Co. v. Poss}\textsuperscript{164} the court reasoned that bad faith was precluded because the trial court had found that there was a significant factual issue as to the insurer’s liability under the policy and sent that question to the jury.\textsuperscript{165} However, the appellate court had concluded that the insured was entitled to coverage as a matter of law, so summary judgment should have been rendered for the insured on coverage. Thus, submission of the case to the jury was actually relevant to show that the trial court had agreed with the insurer that the legal standard required resolution of the factual question, rather than, as would be the case under the directed-verdict rule, to show that the factual question itself created a reasonable ground for dispute.

Of course, a legal position once defensible on this basis does not remain reasonable once later decisions (of the same court or a higher one) have clearly repudiated that position.\textsuperscript{166} Pendency of a proceeding for appellate review of such a rejection is of no consequence if there was no reasonable basis for seeking review.\textsuperscript{167} A reported decision adverse to the insurer by a

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\textit{Georgia}: First Fin. Ins. Co. v. Rainey, 401 S.E.2d 490, 491–92 (Ga. 1991);


\textit{See also}

\textit{US/Mississippi}: Larr v. Minnesota Mut. Life Ins. Co., 924 F.2d 65, 67 (5th Cir.1991) (law sufficiently doubtful that Fifth Circuit had resorted to certifying question to state court). The \textit{Rago} court indicated that the reasonableness of the insurer’s position also was supported by a supreme court decision on another issue that had raised doubts about an earlier lower appellate court decision adverse to the insurer’s position. 355 Pa. Super. at 218.


\textsuperscript{165} 154 Ga. App. 279.

\textsuperscript{167}

\textit{Georgia}: International Indem. Co. v. Coachman, 181 Ga. App. 82, 84 (1986) (once supreme court had decided issue, insurer was subject to penalties if it failed promptly to process open files in accordance with that decision, though it need not reopen closed files absent request to do so);

\textit{Kentucky}: Kentucky Farm Bureau Mut. Ins. Co. v. McQueen, 700 S.W.2d 73, 74 (Ky. Ct. App. 1985) (initial appellate decision favorable to insurer’s position, though never formally overruled, clearly had been superseded by contrary decision; insurer subject to penalty);

\textit{see}


\textsuperscript{167} \textit{International Indem. Co. v. Coachman}, 181 Ga. App. 82, 91 (Ga. Ct. App. 1986) (request for review of state court’s decision by United States Supreme Court did not justify delay in compliance when request did
federal court applying state law cannot operate as a repudiation of even unreported state trial court decisions to the contrary, for federal courts can only predict state law, not make that law. Even a reasonable legal argument against coverage will not support further delay in payment after the insurer has stipulated not to raise that argument.

Another example of this doctrine is a coverage question in Texas affecting hundreds of cases involving damage to a home’s foundation allegedly caused by plumbing leaks. The standard all risk homeowner’s policy in Texas had been changed and a question arose as to whether this damage was covered or excluded under the new policy. Once cases went to litigation, insurers began raising this legal question as a defense and litigating the issue. A federal district court and the Fifth Circuit agreed with the insurer’s position that this type of damage was excluded under the unambiguous language of the policy, and that there was no applicable exception to the exclusion for damage to the dwelling. Subsequently, however, the Texas Supreme Court disagreed and found coverage for the loss. The courts wisely recognized in subsequent decisions that (although the Supreme Court ultimately ruled there was coverage), at the time the issue was litigated, the law was unclear, and the insurer’s position was a reasonable one to take, especially considering that the Fifth Circuit agreed.

A Pennsylvania court has inverted this reasoning to say that once an appellate court has rendered decision on a particular issue, failure to comply is unreasonable per se and entitles the insured to attorneys’ fees as a penalty. This seems wrong. At least when the insurer has not yet had an opportunity to present to the appellate court its own arguments, based on a proper record of its own creation, it ought to be able to litigate without penalty so long as it has reasonable arguments not yet adequately presented by another insurer. The prior adverse decision may call for close scrutiny of the alleged distinctions between the arguments previously rejected and those sought to be litigated and of their substantiality in light of the prior decision, but further litigation should not be penalized if truly reasonable new arguments remain. This is especially true where the court which has rejected the position is only one of several intermediate courts, others have not yet ruled, and there is out-of-state authority supporting the insurer’s position.


A California appellate decision in Filippo Industries, Inc. v. Sun Insurance Co. rejected the rule that a favorable trial court decision on coverage precludes a finding of bad faith and allowed jury imposition of tort liability where the jury deemed the insurer’s position not raise any colorable issue of federal law).

172 See 972 S.W.2d at 741–42; see also Oram v. State Farm Lloyds, 977 S.W.2d 163, 167 (Tex. App. 1998).
unreasonable, even though the insurer’s position had initially been accepted by the trial court.

Filippo Industries, a distributor of women’s clothing, had purchased inventory (some imported and some domestic), which it stored in a warehouse, pending resale to retailers. Filippo purchased a $650,000 open marine cargo policy from Sun Insurance in 1990, increasing the limit to $1.5 million in the spring of 1992. A fire occurred on May 14, 1992, destroying over $1.7 million worth of clothing, almost half of it domestic goods. Filippo had been in the habit of submitting required inventory reports late and the last report before the fire was for December, declaring goods worth $647,000. In December 1992, Filippo filed a report showing an inventory for May exceeding $1.5 million. While investigating the loss, Sun made advances totaling $650,000 by September 1992. On January 28, 1993, Sun declined to make any further payments, taking the position that domestic goods were not covered and that the maximum amount payable was the $647,000 shown by the last pre-fire inventory report. Since Sun had already paid $650,000, it said nothing more was due.

Filippo sued, but Sun obtained summary judgment that the last pre-fire inventory report fixed the maximum amount due. The court of appeals reversed, finding that the late inventory reports affected only collection of the appropriate premium, not the amount payable. Sun then paid an additional $225,876 for the imported goods not covered by its advances, but continued to dispute coverage for the domestic goods. A jury found that the entire policy limit, including $624,124 for domestic goods, was due by January 1, 1993, and that failure to pay the full amount had been in bad faith. It awarded $4,125,000 in consequential damages for the failure of Filippo’s business and $750,000 in punitive damages.

Among Sun’s arguments on appeal from the resulting judgment was the claim that its initial victory on summary judgment established that its reliance on the inventory report had not constituted bad faith. Sun relied particularly on an analogy to the law of malicious prosecution that had been drawn in Dalrymple v. United Services Automobile Association.

Dalrymple, a military officer, had resisted efforts to hospitalize her for mental illness by barricading herself in her quarters and shooting at all who attempted to enter. Before she

175 74 Cal. App. 4th at 1432–1433.
176 74 Cal. App. 4th at 1433.
177 74 Cal. App. 4th at 1433.
178 74 Cal. App. 4th at 1433.
179 74 Cal. App. 4th at 1435.
180 74 Cal. App. 4th at 1435.
181 74 Cal. App. 4th at 1435.
182 74 Cal. App. 4th at 1435.
184 Filippo II, 74 Cal. App. 4th at 1436.
185 74 Cal. App. 4th at 1436.
186 74 Cal. App. 4th at 1436. The jury also awarded $1.5 million in punitive damages against McGee, Sun’s managing agent in the United States, but the court of appeal reversed that award. 74 Cal. App. 4th at 1436.
188 40 Cal. App. 4th at 504.
surrendered, she shot a police officer in the leg.\textsuperscript{189} A court martial determined that she was not criminally responsible for the incident because she was unable to appreciate the nature and quality or wrongfulness of her conduct.\textsuperscript{190}

The policeman sued for his injuries and Dalrymple demanded a defense from USAA, her homeowner’s insurer.\textsuperscript{191} While disputing coverage on the basis that the shooting was not an “occurrence” (i.e. accident), USAA defended under a reservation of rights.\textsuperscript{192} USAA also brought an action seeking a declaration that there was no coverage. The trial court found coverage and USAA then indemnified Dalrymple against the subsequent tort judgment for the policeman.\textsuperscript{193}

Dalrymple initially was awarded attorneys fees incurred in the coverage action, but the court of appeal found that she could not recover such fees without establishing bad faith.\textsuperscript{194} That issue was tried to a jury, with expert testimony on whether USAA had acted reasonably.\textsuperscript{195} The jury found bad faith, but the court of appeal reversed.

The court reasoned that establishing lack of proper cause for contesting coverage was similar to showing lack of probable cause in a malicious prosecution action.\textsuperscript{196} Any dispute as to the facts the insurer had before it, like disputes about the facts known to the instigator of a prosecution, would create a jury issue.\textsuperscript{197} But where the facts known to the insurer were undisputed, the bad faith issue, like the issue in a malicious prosecution case, was whether a legally tenable basis for litigation existed.\textsuperscript{198} That issue “is clearly not a matter within the scope of experience of a lay jury. Rather, the trial court is best equipped to assess whether the insurer had proper cause to seek a ruling on coverage under the particular circumstances.”\textsuperscript{199}

In Dalrymple, there was no dispute about the evidence available to the insurer.\textsuperscript{200} While the claim was pending, the insurance law was evolving and uncertain on the relevance of an insured’s mental impairment to negate the effect of an intent to injure.\textsuperscript{201} Given that state of the law, “there was a genuine issue as to coverage under this policy and USAA had proper cause at each stage of the proceedings to pursue a coverage determination.”\textsuperscript{202}

\textsuperscript{189} 40 Cal. App. 4th at 504.
\textsuperscript{190} 40 Cal. App. 4th at 505–506.
\textsuperscript{191} 40 Cal. App. 4th at 505.
\textsuperscript{192} 40 Cal. App. 4th at 505.
\textsuperscript{193} 40 Cal. App. 4th at 507.
\textsuperscript{194} See 40 Cal. App. 4th at 507.
\textsuperscript{195} 40 Cal. App. 4th at 507.
\textsuperscript{196} 40 Cal. App. 4th at 515.
\textsuperscript{197} 40 Cal. App. 4th at 516.
\textsuperscript{198} 40 Cal. App. 4th at 516.
\textsuperscript{199} 40 Cal. App. 4th at 516–17. While Dalrymple itself involved a coverage dispute turning on a purely legal issue, the court’s analysis was not limited to disputes of that sort. It applies equally to questions of whether the particular information available to an insurer creates a legally tenable basis to dispute coverage.
\textsuperscript{200} 40 Cal. App. 4th at 518–19.
\textsuperscript{201} 40 Cal. App. 4th at 521.
\textsuperscript{202} 40 Cal. App. 4th at 523.
The *Filippo II* court rejected the analogy to malicious prosecution, distinguished *Dalrymple*, and affirmed the bad faith verdict. On the analogy, it reasoned that:

Malicious prosecution is a disfavored remedy, is a second law suit arising from the same facts, follows a prior resolution in the party’s favor, is potentially susceptible of other forms of redress, and necessarily involves legal knowledge in the evaluation of the defendant’s act (the filing of the underlying suit). Nothing disfavors a finding in favor of insurance coverage; it has not been preceded by litigation arising on the same facts; the insured has gained nothing from prior litigation; the insured has no other potential redress; legal knowledge is not necessarily required to evaluate the reasonableness of an insurer’s actions in denying coverage.\(^\text{203}\)

The court also drew an analogy to the rule governing a liability insurer’s duty to defend, which it may not refuse to do merely because it believes (even correctly) that the facts are such that no indemnity coverage is due.\(^\text{204}\) Just as an insurer may not rely on hindsight to defeat the duty to defend, the court thought it could not do so to defeat bad faith.

Finally, the court reasoned that allowing the trial court’s coverage decision to shield the insurer from bad faith claims would effectively deny the insured its right to appeal that decision. It felt this especially inappropriate “in the insurance coverage context, where legal knowledge is not a prerequisite.”\(^\text{205}\) The court expressed “great faith in the sagacity and reasonableness of trial judges, but we decline to impute infallibility to any court … Mistakes happen, but … a mistake should [not] automatically result in depriving an insured of its right to appeal the dismissal of its claim of bad faith.”\(^\text{206}\)

**[C] *Filippo* Is Unsound**

The *Filippo Industries* court’s reasoning fails to distinguish between (1) an insurer’s contractual obligation to provide the benefits promised by its policy, and (2) its tort obligation of good faith and fair dealing in determining whether payment is due. It is true that a finding of coverage is not disfavored. (*See § 5.02[2] above.*) But deterring an insurer from challenging a questionable claim is disfavored. Procedurally, bad faith litigation is part of the same suit as the coverage determination, but the two are distinct issues with the same relation as between an underlying suit and a malicious prosecution action. (Indeed, coverage is often bifurcated and determined before any bad faith trial proceeds.) (*See § 18.03 below.*) Moreover, treating the trial court’s coverage ruling as dispositive of the bad faith claim does not deny the insured the right to appeal the coverage denial or to obtain full redress for any breach of contract.

The issue is whether, in addition to recovering full contractual remedies under the insurance policy, the insured is also entitled to the extraordinary tort remedy granted to protect


\(^{204}\) 74 Cal. App. 4th at 1441.

\(^{205}\) 74 Cal. App. 4th at 1441.

\(^{206}\) 74 Cal. App. 4th at 1441–1442.
against insurer abuse in claim handling. Strong reasons of public policy, parallel to those operative in defining the malicious prosecution tort, require protection of an insurer’s right to challenge questionable claims. (See § 5.02[2] above.)

In *Crescent City Live-Stock Landing & Slaughter-House Co. v. Butchers’ Union Slaughter-House & Live-Stock Landing Co.*, the United States Supreme Court held that a judgment in favor of a plaintiff, though later reversed, conclusively established that the plaintiff had probable cause to bring suit (unless fraud in procuring the judgment were shown). This reflected the “dignity and authority” of the initial judgment and the “an invincible presumption of the law that the judicial tribunal, acting within its jurisdiction, has acted impartially and honestly.” An impartial and honest judgment in favor of the underlying plaintiff could not be impugned by a collateral finding that the judgment was unreasonable, even if that judgment had been reversed. This remains the prevailing rule.

Similarly, a trial court’s conclusion, after adversarial presentation, that an insurance claim lacks merit is, at a minimum, powerful evidence that the insurer had reasonable grounds to think that a court might so conclude. It is important to remember that the issue in *Filippo Industries* was whether Sun’s legal position on the proper interpretation of the contract was tenable. The jury would not have been permitted to pass on whether Sun’s construction was correct, and there is no reason to allow it to sit in judgment (based on conflicting expert testimony) on the reasonableness of the trial court’s prior decision.

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206.2 120 U.S. at 159.
206.3 W. PAGE KEETON ET AL., PROSSER & KEETON ON TORTS § 120 at 894 (5th ed. 1984) (“A recovery by the plaintiff in the original action usually is regarded as conclusive evidence of the existence of probable cause, even though it is subsequently reversed, unless it can be shown to have been obtained by fraud or other imposition upon the court.”);

**Kansas:** Vanover v. Cook, 260 F.3d 1182, 1190 (10th Cir. 2001).

**Indiana:** Freidline v. Shelby Ins. Co., 774 N.E.2d 37, 42–43 (Ind. 2002) (while agreeing with court of appeals that trial court’s denial of coverage was incorrect, court pointed to that denial in support of its holding that the insurer had not acted in bad faith).

*Filippo Industries* is particularly troubling because the jury was not permitted to learn that the trial court had ruled in Sun’s favor. See *Filippo Indus., Inc. v. Sun Ins. Co.*, 74 Cal. App. 4th 1429, 1441–42 (1999); Appellant’s Opening Brief, 14, 45–49; (asserting this as error); Respondent’s Brief, 45–48 (arguing that offer of this evidence was not properly renewed and that its exclusion was proper); Appellant’s Reply Brief, 40–43 (quoting in limine ruling excluding this evidence and replying to arguments that exclusion was proper). The court of appeal ruled that even an evidentiary presumption based on that ruling would unduly burden the insured. See *Filippo Indus.*, 74 Cal. App. 4th at 1441–42. The court of appeal was also troubled by the possibility that the trial court’s summary judgment decision might not have been fully considered and, so ought not to be accorded conclusive weight on bad faith. 74 Cal. App. 4th at 1441–42. But the remedy for oversights of the sort suggested is the litigant’s right to point out those oversights on a motion for reconsideration. There is neither need nor reason to substitute later tort litigation for that remedy.

208 The malicious prosecution analogy and its implications for division of authority between judge and jury is further discussed in § 17.04[2][b].
The supposed analogy to the duty to defend ignores differences between the two issues. A duty to defend is triggered by a mere potential for indemnity coverage, and the existence (at the time a defense was required) of such a potential is not defeated by the fact that no need for actual indemnification develops. And the test is not, as it would be in a bad faith case, whether it was reasonable to believe that indemnity coverage might not be required. Rather, the test is whether there was any possibility that indemnity coverage might be required. Because the substantive standards are almost opposite, no procedural analogy is proper.

Apart from its failure to distinguish properly between the insurer’s contractual duties and its tort duties, the *Filippo Industries* court erred in failing to understand the balance struck by bad faith law between assuring payment of claims that are clearly due and assuring that questionable claims may be challenged. Other courts ought not to follow that decision.

[D] Possible Exception

One premise of the argument for regarding a prior finding of no coverage as preclusive of bad faith is that the court making that ruling was fully and accurately informed on coverage. If the plaintiff can show that, through no fault of the plaintiff, the court which previously ruled in favor of the insurer on coverage was not presented with evidence or argument which would have had a reasonable probability of altering its ruling, that would justify a fresh consideration of whether, in light of all that the insurer knew or should have known at the time it delayed or denied payment, it had a reasonable basis for doing so. Even more clearly, if the plaintiff can show that the prior ruling was obtained by presentation of false evidence, then that ruling ought not to preclude fresh consideration of bad faith.

[ii] Authority from Other Jurisdictions

Absent relevant precedent in the jurisdiction controlling the claim in question, an insurer should be able to establish that its legal position is reasonable by pointing to favorable decisions in other jurisdictions, at least assuming that the law in those jurisdictions is materially similar

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**US/Mississippi:** Dunn v. State Farm Fire & Cas. Co., 927 F.2d 869, 874 (5th Cir. 1991) (Mississippi had not decided whether innocent coinsured could recover in arson case, and other jurisdictions were split, so issue was fairly debatable);

**US/California:** Clemco Indus. v. Commercial Union Ins. Co., 665 F. Supp. 816, 830 (N.D. Cal. 1987) (while exposure trigger of liability coverage for silicosis was increasingly popular, it was not bad faith for insurer to apply manifestation trigger, which was supported by some authority in other jurisdictions and not yet clearly rejected by California; insurer had no obligation to yield to apparent trend so long as room existed for intelligent disagreement), aff’d mem., 448 F.2d 1242 (9th Cir.1988);

**California:** Griffin Dewatering Corp. v. Northern Ins. Co., 176 Cal. App. 4th 172, 202 (2009) (while California Supreme court ultimately rejected insurer’s construction of pollution exclusion, fact that many courts in other jurisdictions had accepted that construction showed it was reasonable);

**Illinois:** State Farm Fire & Cas. Co. v. Miceli, 164 Ill. App. 3d 874, 883–884 (Ill. App. Ct. 1987) (some jurisdictions would have upheld denial, and prior adverse Illinois authority was arguably distinguishable based on possible differences in policy language), appeal denied, 522 N.E.2d 1257 (Ill. 1988);
to that in the controlling jurisdiction\textsuperscript{210} and the insured cannot establish that the court(s) in question were not presented with some evidence or argument which would have had a reasonable probability of altering their rulings. Where there are multiple rulings favoring the insurer, each of them must be shown to be inadequately informed in this way to avoid the conclusion that they show the insurer’s action in accordance with those rulings to be reasonable.

One court has called into question an insurer’s ability in some circumstances to establish the reasonableness of its position simply by relying on out-of-state authority, though the decision is no longer citable as precedent.\textsuperscript{211} 

\textit{Gourley v. State Farm Mutual Automobile Insurance Co.}\textsuperscript{212} arose out of an uninsured motorist claim. The insured was not wearing a seat belt at the time of the accident. The insurer contended that her recoverable damages were limited to the harm she would have suffered had she been wearing a seat belt. Accordingly, it offered only $25,000 and rejected demands for the $100,000 policy limit and $60,000. The insurers conceded that the claim was worth $60,000 absent the seat belt defense. An arbitrator later awarded $88,137, which State Farm promptly paid. Gourley then sued for bad faith. A jury awarded $15,765 in actual damages and $1,576,500 in punitive damages, to which the trial court added prejudgment interest.\textsuperscript{213} The California Court of Appeal affirmed. In response to State Farm’s claim that decisions in other states supported its defense, the court responded that the jury might have found otherwise.\textsuperscript{214} The court further reasoned:

\begin{quote}
[W]e do not believe good faith is established merely because a defense is “tenable.” As noted, a major purpose of insurance is to provide peace of mind through prompt payment. That purpose is frustrated where the insurer consciously decides to try out an untested legal argument against its own insured.\textsuperscript{215}
\end{quote}

\textit{Iowa:} Amco Ins. Co. v. Stammer, 411 N.W.2d 709, 713 (Iowa Ct. App. 1987);

\textit{Louisiana:} Carney v. American Fire & Indem. Co., 371 So. 2d 815, 819 (La. 1979) (relying on cases in other jurisdictions favorable to insurer’s position);

\textit{Utah:} Larsen v. Allstate Ins. Co., 857 P.2d 263, 266 (Utah Ct. App. 1993) (relying on cases in other jurisdictions favorable to insurer’s position, even though those cases involved different statutory wording and differences led court to different result).

\textsuperscript{210}For example, Maryland does not construe ambiguities against the insurer as strongly as most jurisdictions do. Cheney v. Bell Nat’l Life Ins. Co., 315 Md. 761, 766–767. Thus, a Maryland decision favoring an insurer on policy construction may not establish the reasonableness of an insurer’s reliance, in a more stringent jurisdiction, on that same construction.

\textsuperscript{211}As will be seen, the California Supreme Court granted review, albeit limited to another point. Under California practice, a grant of review prevents publication in the official reports, which precludes citation of the appellate opinion as precedent. Cal. R. of Ct., R. 8.1115.


\textsuperscript{213}265 Cal. Rptr. at 637.

\textsuperscript{214}The suggestion that this issue was one for a jury to resolve based on expert testimony is rather startling. There appear to be no significant discussions in bad faith cases of whether such issues are for court or jury, but virtually all of the cases treat the issue as one for the court. Moreover, there would seem to be no proper basis on which a jury could find untenable a legal position upheld by other jurisdictions. (See § 17.04[2])

\textsuperscript{215}265 Cal. Rptr. at 638 (citation and footnote omitted).
This is unsound. The limitation placed on an insurer by the duty of good faith is a prohibition of withholding payment without some legitimately arguable basis for doing so. If there is a basis to dispute the claim, the insurer is not required to dissipate its assets by paying the claim and others like it pending adjudication of a similar issue arising in a third-party case. In the absence of contrary precedent in the controlling jurisdiction, the existence of favorable precedent in other states should establish as a matter of law the debatability of the position, thereby precluding any bad faith liability.

[iii] Open Issues of Law—Illustrative Case

Many courts have found insurer legal positions reasonable, even in the absence of clear supporting authority, because the issue was an open one or one of first impression in the controlling jurisdiction. Courts find this conclusion especially appropriate when existing authority is complex, confused, or points in different directions. However, the mere absence of

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US/Mississippi: Gorman v. Southeastern Fid. Ins. Co., 775 F.2d 655, 659 (5th Cir. 1985);

Hawaii: Colonial Penn Ins. Co. v. First Ins. Co., 71 Haw. 42, 44 (1989);

Idaho: Squire v. Exchange Ins. Co., 116 Idaho 251, 253 (1989);


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US/Georgia: Shipes v. Hanover Ins. Co., 884 F.2d 1357, 1361 (11th Cir. 1989) (no authoritative precedent on point, and dicta in two cases on other subjects assumed method of calculation different from that adopted by court in rejecting insurer’s argument);

US/Illinois: Pohrer v. Title Ins. Co., 652 F. Supp. 348, 355 (N.D. Ill. 1987) (some case law on other subjects arguably supported insurer’s construction of its exclusion, and case required resolution of ambiguities in both contract language and state law);

US/Oklahoma: Duckett v. Allstate Ins. Co., 606 F. Supp. 728, 731 (W.D. Okla. 1984) (authority relied upon in rejecting insurer’s position “does not mandate that result; the case is inapposite factually and the language relied on, while persuasive, is mere dicta”);

Georgia: Johnson v. Nat’l Union Fire Ins. Co., 177 Ga. App. 204, 207 (Ga. Ct. App. 1985) (issue one of first impression in Georgia, and insurer’s position was reasonable despite its knowledge of contrary decisions in other states under different statutory schemes);

Louisiana: Fay v. Willis, 577 So. 2d 1147, 1152 (La. Ct. App.) (statutory language and a postclaim supreme court decision both gave some support to insurer’s rejected argument), writ denied, 584 So. 2d 1159 (La. 1991);

a case specifically rejecting the insurer’s position does not make that position reasonable if it is contrary to clear statutory or policy language or to authority that provides adequate guidance to resolve the issue.\(^{219}\)

A particularly strong statement of the latter point is found in *Verbaere v. Life Investors Insurance Co. of America*,\(^ {220}\) in which the Illinois Appellate Court upheld an award of attorney fees and a statutory penalty for “vexatious and unreasonable” failure to pay a disability insurance claim. The plaintiffs, Angela and Peter Verbaere, had purchased a credit disability policy to cover indebtedness secured by their home and motor home. In December 1978 Peter suffered severe head injuries that left him permanently disabled. Two other disability insurers made lump-sum payments, thereby reducing the indebtedness. Life Investors commenced $125 monthly payments, as provided in the policy.

In March 1982 the Verbaeres sold their residence and, to obtain release of the mortgage, substituted a cash deposit as collateral for the loan. When the sale was completed and the mortgage released, the bank improperly seized the cash collateral and applied it to retire the loan.\(^ {221}\)

When the bank notified Life Investors that the loan had been repaid, Life Investors terminated its payments, invoking a contractual provision specifying that the insurance would be

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Washington: *Starczewski v. Unigard Ins. Group*, 61 Wn. App. 267, 273 (insurer’s position was reasonable even though 1927 case it relied upon was distinguishable because it involved more explicit policy language), *review denied*, 117 Wn. 2d 1017 (1991).

Georgia: *State Farm Fire & Casualty Co. v. Martin*, 174 Ga. App. 308, 310 (1985);

Oklahoma: *Buzzard v. Farmers Ins. Co.*, 824 P.2d 1105, 1112 (Okla. 1991) (though not directly foreclosed by precedent, asserted requirement that tortfeasor’s limits be exhausted before underinsured motorist benefits were due was contrary to clear statutory policy).

Arkansas: *Shepherd v. State Auto Property & Casualty Ins. Co.*, 312 Ark. 502, 513 (1993) (no case law existed on validity of offsets to underinsured motorist coverage, but existing case law on uninsured motorist coverage was so analogous as to render insurer’s position unreasonable);


Louisiana: *Guitreau v. State Farm Mut. Auto. Ins. Co.*, 540 So. 2d 1097, 1102 (La. Ct. App. 1989) (“where sufficient jurisprudence exist to give guidance … in determining whether a claim should be denied, the risk of erroneous interpretation falls on the insurer”);


\(^{221}\) The propriety of this seizure was at issue in *Verbaere v. Community Bank*, 148 Ill. App. 3d 249 (Ill. App. Ct. 1986) (“Verbaere I”), *appeal denied*, 505 N.E.2d 363 (1989). The litigation with the bank settled after the decision in *Verbaere I*. 
cancelled and a partial refund issued “[i]f through prepayment, renewal, refinancing, or otherwise, the indebtedness in connection with which this insurance is written is discharged prior to its scheduled maturity date.” 222 The insurer’s refusal to pay the remaining benefits due as of the time the collateral was seized was found improper on a prior appeal. 223 As the court explained, the provision upon which Life Investors relied related to cancellation of the insurance (and partial refund of premium) when payment of the loan prior to disability eliminated the hazard insured. A more relevant provision, dealing with beneficiaries, called for payment to the creditor, to the extent of its interest, with any remaining balance due to the insured. This accorded with the indication in Vogelsang v. Credit Life Insurance 224 that benefits vested with the onset of disability.

The sole issue in the subsequent appeal concerned the award for “vexatious and unreasonable” denial. The court approvingly quoted the trial court’s conclusion that the insurer’s position had been taken “in the teeth” of Vogelsang. 225 Moreover, it found it “noteworthy … that Life Investors has never offered even a colorable explanation as to why the beneficiary provision does not govern the facts before the court.” 226 Further, the error of its position was at least implicitly established in Verbaere I, although that was not the precise issue before the court. Especially in light of this precedent, a penalty clearly was appropriate:

We do not understand why Life Investors—which underwrote the risk of disability, fixed the premium, and provided for a partial refund of the premium in the event of early discharge of the loan—appears to have difficulty understanding the nature of credit disability insurance and its own clearly worded beneficiary provision. Nor do we find persuasive Life Investors’ attempt to minimize the precedential value of Vogelsang as an excuse for pursuing an obtuse legal theory based on the cancellation clause in its policy. Vogelsang’s reasoning strongly discredits the position Life Investors takes here, as do the comments in Verbaere I. 227

With specific reference to the point under discussion here, prior precedent adverse to the insurer’s position was not necessary to support the penalty:

[C]ase law will not always exist to aid in issues of policy construction, and an insurance company should not prop up an unreasonable interpretation with the fortuity that no court has yet squarely ruled on the precise position it takes. Lack of case precedent may be attributable to the possibility that other insurance companies faced with the same situation as exists in the pending case would not have attempted to defend on the grounds asserted by Life Investors. As the court noted in

222 226 Ill. App. 3d at 294.
225 Verbaere III, 226 Ill. App. 3d at 295.
226 226 Ill. App. 3d at 296.
227 226 Ill. App. 3d at 298.
Vogelsang, the insurer in that case agreed that the insured’s payment of the underlying debt did not bar the cause of action for credit disability insurance.

The policy provisions excerpted in this opinion are not highly technical, obscure, or conflicting. They are not ambiguous. There are no disputed factual issues involved. Life Investors has persisted in a plainly unreasonable interpretation of its policy and we conclude that the trial court did not abuse its discretion in awarding sanctions.228

Thus, insurers asserting positions not supported by precedent at least must be sure that they have a reasonable basis in policy language and are not effectively foreclosed by closely analogous precedent.

[iV] Special Considerations Regarding Policy Interpretation and Ambiguity

When the insurer’s legal position is based on a disputed interpretation of its own policy language, special considerations apply. Ordinarily, the insurer is solely responsible for the drafting of the contractual language employed.229 When this is the case, all jurisdictions will construe ambiguities against the insurer, and most jurisdictions will do so quite strongly.230 Thus, the mere fact that the policy language is capable of having the meaning that the insurer urges cannot be enough to shield the insurer absolutely from bad faith liability. As one court has observed:

If the insurer’s interpretation of its own contract as excluding coverage could render an insured’s claim “fairly debatable,” then insurers would be encouraged to write ambiguous insurance contracts, secure in the knowledge that an obscure portion of the policy would provide an absolute defense to a claim of bad faith.231

Notably, some courts in Louisiana appear to have embraced the opposite extreme:

“An insurer must take the risk of misinterpreting its policy provisions. If it errs in interpreting its own insurance contract, such error will not be considered as a reasonable ground for delaying the payment of benefits, and it will not relieve the

228226 Ill. App. 3d at 298–299 (emphasis original).
229Occasionally, policy language is not drafted by either party to the contract, but is negotiated with a large insured or trade association or prescribed by statute.
231Sparks v. Republic Nat’l Life Ins. Co., 132 Ariz. 529, 539 (Sup. Ct.), cert. denied, 459 U.S. 1070 (1982). Arizona permits bad faith liability only when the insurer knows its position has no basis or fails to determine whether its position is tenable. Rawlings v. Apodaca, 151 Ariz. 149, 160 (Sup. Ct. 1986). Accordingly, the insurer’s subjective belief in the validity of its interpretation is a defense to liability, but the existence of that belief ordinarily is a jury question. Sparks, 132 Ariz. at 539.
The very case on which these courts have relied (directly or indirectly), however, refutes this seemingly absolute rule. Despite construing policy language unfavorably to the insurer, the court in Carney v. American Fire & Indemnity Co. held that penalties could not be awarded because the insurer’s position was amply supported by authority from other states. Other Louisiana cases indicate that a reasonable policy interpretation, even if rejected, will preclude penalties. Courts in other states uniformly take that view.

The correct rule is that the insurer must take due account of the applicable rules calling for construction of ambiguities against it when it denies a claim based on a disputed policy interpretation. It must have reasonable grounds to contend that the policy is unambiguous and that it refutes the interpretation urged by the insured. It should not matter if one or more courts have found the policy ambiguous on the point in question if reasonable minds could differ on the issue of ambiguity. As long as that is true, the matter remains fairly debatable.

The issue was examined in Griffin Dewatering Corp. v. Northern Insurance Co. The insurer there had denied a duty to defend on a basis widely accepted in other jurisdictions (and by some local appellate decisions) but which was ultimately rejected by the California Supreme Court. The court concluded, as a matter of law, that the insurer’s action had reasonable basis.

The general rule is that “in asserting a contractual position, an insurance company must take a reasonable position under rules of contract interpretation, which rules generally favor policyholders. For example, if there is an ambiguity in an insurance policy provision, the insurance company must interpret the ambiguity in favor of the policyholder.” But the

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234 371 So. 2d at 819.


236 E.g.,


236.2 176 Cal. App. 4th at 208 (emphasis original).
question of whether there is ambiguity is different, governed by a rule that

The question of whether an insurance contract is, in context, ambiguous at all, is one where the insurance company may, if reasonable, take a position that “benefits its own interest.” Otherwise, a liability insurance company would lose every time the policyholder could find a court—anywhere, in any jurisdiction (even if that court was having a bad day)—that took the policyholder’s side of a given question of law over the interpretation of contract language, and even if that court employed a rationale that would be generally at odds with California rules regarding interpretation of policy language. It would mean that an insurance company could never argue in favor of its side in a pure question of law if there were some court somewhere that had taken the opposite view.236.3

Nor does the fact that different courts have disagreed about the meaning of a policy provision establish that it is ambiguous.237

In Pedicini v. Life Insurance Co. of Alabama,237.1 the Sixth Circuit held that the relevant language in a medical insurance policy was ambiguous and further held that the insurer had acted in bad faith by refusing to recognize that ambiguity. In 1990, Pedicini purchased a supplemental cancer insurance policy from Life Insurance Co. of Alabama (“LICOA”). Effective October 1, 2001, he replaced that policy with a more restrictive one to lower his premiums. The newer policy provided for payment of “actual charges” for chemotherapy and radiation received as treatment for cancer; it defined “actual charges” as “actual charges made by a person or entity furnishing the services treatment or material.” In 2007, Pedicini was diagnosed with cancer. After he began receiving qualifying chemotherapy and radiation treatments, LICOA made payments based on the discounted amounts the providers agreed to accept from Medicare, rather than the amounts billed. (The actual bills were paid by Medicare and a Medicare supplemental policy, so Pedicini had no out-of-pocket cost, but this policy allowed for possible double payment.) Pedicini sued.237.2

Discovery revealed that, until eight months before selling the newer policy to Pedicini, LICOA had paid benefits under policies using the same language as Pedicini’s based on the amount billed, rather than on the discounted amount accepted. LICOA said this was a response to changes in medical billing practices. But it gave no notice to policyholders of the change, even though it significantly reduced payments.237.3

In Pedicini’s suit, the district court gave summary judgment for Pedicini on the contract claim, holding the policy language ambiguous. But it concluded that this issue was fairly debatable, so it gave summary judgment to LICOA on the bad faith claim. The Sixth Circuit

236.3 176 Cal. App. 4th at 208 (emphasis original).
237.1 Pedicini v. Life Ins. Co. of Ala., 682 F.3d 522 (6th Cir. 2012).
237.2 682 F.3d at 524–25.
237.3 682 F.3d at 524–25.
affirmed as to the contract but reversed on bad faith, remanding for further proceedings. 237.4

LICOA relied on a district court decision that upheld its interpretation of the language. The Sixth Circuit relied instead on more recent decisions by the Fourth and Fifth Circuits finding the language ambiguous, particularly in light of the fact that the insurers, like LICOA, had previously interpreted the same language differently. The Sixth Circuit distinguished a case where the Eleventh Circuit had interpreted the phrase “actual charges incurred” to mean the discounted amount accepted. 237.5 The Sixth Circuit concluded it would have been unnecessary for that policy to add the word “incurred” had “actual charges” been unambiguous.

It summarized its contractual holding as follows:

As evidenced by the decisions of our sister circuits, the thoughtful arguments presented by both parties, and LICOA’s shift in its benefit-payment practices, it is clear that “a reasonable person would find [the term “actual charges”] susceptible to different or inconsistent interpretations” thus making it ambiguous under Kentucky law. We agree with the Fifth Circuit that dictionary definitions are unhelpful, as “real” and “existing” charges could just as reasonably refer to the billed amount as well as to the amount accepted as full payment. Moreover, the fact that LICOA paid benefits equal to the amount billed for approximately twenty years prior to February 2001 seriously undermines its position that the term “actual charges” unambiguously means the amount accepted as full payment. While perhaps LICOA is uncannily altruistic, it is more likely that the change in its benefit-payment practices reflects LICOA’s own struggles with the ambiguous terms of its policies. Because the term is ambiguous, it must be construed in favor of Pedicini as a matter of Kentucky law. 237.6

Under Kentucky law, proof of bad faith required Pedicini to establish, in addition to a right to payment of the claim, that LICOA lacked a reasonable basis in law or fact to deny the claim and that it knew or recklessly disregarded the lack of a reasonable basis. As to the first of these requirements, the Sixth Circuit concluded that

An objective assessment of the legal landscape evidences that LICOA lacked a reasonable basis in law for disputing Pedicini’s claim to benefits according to his interpretation of “actual charges.” Under clearly established Kentucky law, ambiguous contractual terms are construed in favor of the insured. The term “actual charges” is “patently ambiguous,” the use of the term in the supplemental policy is hopelessly circular, as the term

237.4 682 F.3d at 524.
237.7 Pedicini, 682 F.3d at 528 (citation omitted).
“actual charges” even appears within its own definition in the policy. Moreover, for twenty years prior to February 2001, LICOA had paid benefits equal to the amount billed by medical providers, inspiring expectations among its policyholders regarding the value of their benefits. In light of these facts, LICOA should have realized that unilaterally altering its definition of “actual charges” was likely to result in legal claims against it by its policyholders and that, under Kentucky law, LICOA would lack a reasonable basis for denying those policyholders relief. LICOA points to no legal authority contemporaneous with its February 2001 policy change suggesting otherwise. The opinions that LICOA cites as “recognized authorities” in support of its position all post-date February 2001 and thus could not have informed LICOA’s determination of the reasonableness of its action at that time. As a result, it is difficult to see how LICOA can maintain that the proper resolution of its dispute with Pedicini is “fairly debatable as a matter of law.”

There were factual issues as to LICOA’s knowledge or reckless disregard of the lack of a reasonable basis, and the court remanded for further proceedings on that issue.²³⁷.⁹

LICOA relied on the holding that “where there is a legitimate first-impression coverage question for purposes of Kentucky law and recognized authorities support the insurer’s position in denying coverage, the insured’s claim is fairly debatable as a matter of law and will not support a claim of bad faith.”²³⁷.¹⁰ LICOA’s problem was that the only authority it could find to support its position was a single district court decision that had since been rejected by two appellate decisions, in addition to being contrary to LICOA’s own twenty-year practice.

Thus, insurers asserting positions not supported by precedent at least must be sure that they have a reasonable basis in policy language and are not effectively foreclosed by closely analogous precedent or by their own prior practices.

[v] Advice of Counsel or Industry Custom

Courts occasionally cite an insurer’s compliance with the advice of counsel or industry custom as positive factors in rendering summary judgment on bad faith.²³⁸ The general view is

²³⁷.⁸ 682 F.3d at 529 (citations omitted).
²³⁷.⁹ 682 F.3d at 529–30.
²³⁷.¹⁰ Empire Fire & Marine Insurance Co. v. Simpsonville Wrecker Service, Inc., 880 S.W.2d 886, 891 (Ky. 1994).
²³⁸

US/California: Hanson v. Prudential Ins. Co., 783 F.2d 762, 767 (9th Cir.1985);
that these are relevant factors in defense at trial, but they are not absolute defenses of the sort that can be the basis for summary judgment. (See §§ 8.09–8.10 above.)

In jurisdictions requiring a subjective element to establish bad faith, sincere reliance on advice of counsel sought in good faith presumably is a complete defense to bad faith.\footnote{239} However, the sincerity of the belief and the good faith in seeking the advice (e.g., from a lawyer who will give a real answer, as opposed to finding any way at all to give the desired answer) often will be questions for the trier of fact.

[c] Claims of Bad Faith Denial of Duty To Defend Require Special Consideration Because Legal Standard for Duty To Defend Is Different from Other Coverage Standards

Overview

Existence of a duty to defend depends primarily on whether the complaint against the insured alleges any liability that, if proven, could result in a covered judgment. (See §§ 3.02[1]–[3] above.) So long as the insurer’s decision is made solely on that basis, it is involves a pure legal issue, which would be determined by the court if litigated. As such, the relevant test for any claim of bad faith denial of the defense is whether there was a reasonable legal argument for the insurer’s position. (See also § 3.08[3] above.) Of course, any such argument must take account of the very pro-insured standard for determining coverage. (See § 17.03[5][b][iv] above.) But the law on the issue need not be settled, so long as the insurer can make a reasonable argument that there is no duty to defend.\footnote{240} The standard for what constitutes a reasonable basis to deny coverage is the same on duty to defend as in ordinary first-party cases.\footnote{241}

Many jurisdictions require the insurer to consider extrinsic facts (ones not alleged in the complaint) which the insurer knows (or, in some cases, should have learned) that may establish a

\textit{Utah:} Larsen v. Allstate Ins. Co., 857 P.2d 263, 266 (Utah Ct. App. 1993);
\textit{cf.}

duty to defend not evident from the allegations of the complaint. (See § 3.02[4][a] above.) In such cases, there may be factual disputes about what the evidence in question established, and there may be a question about whether doubtful evidence can create a duty to defend. Factual disputes about what the evidence establishes might be subject to the directed-verdict rule, unless the relevant law holds that doubtful evidence can create a duty to defend. That question itself might create a genuine legal dispute.

Some jurisdictions permit the insurer, under some circumstances, to consider some types of extrinsic facts which defeat coverage. (See § 3.02[4][b] above.) Any denial of a defense based on such evidence must respect the limits and evidentiary standards imposed by local law. For example, California allows an insurer, where a defense is otherwise called for by the allegations of the complaint, to decline to defend based on extrinsic facts only if those facts are undisputed. (See § 3.02[4][b][vii] above.) Accordingly, in contrast to the usual rule that a genuine issue of fact on coverage defeats a bad faith claim, a genuine issue of extrinsic fact would require a defense and preclude a good faith refusal to defend.  

In Fire Insurance Exchange v. Oltmanns,¹ a concurring opinion argued that an entirely different standard should be applied to claims of bad faith failure to defend. The court did not address that argument for procedural reasons, but the concurrence has significant flaws. Oltmanns was sued by his brother-in-law for injuries sustained while Oltmanns was towing him in Oltmanns’ Honda F-12 Aquatrax personal watercraft. Oltmanns tendered to Fire, his homeowners' insurer. Fire filed a DJ, asserting that coverage was barred by an exclusion for liability resulting from ownership maintenance or use of "jet skis and jet sleds." The district court granted summary judgment for Fire, but the court of appeals found ambiguity and reversed. Fire then settled the claim against Oltmanns for policy limits and reimbursed Oltmanns' defense costs. But Fire refused to reimburse Oltmann's expenses for litigation of the DJ. Oltmanns contended that the refusal to defend and filing of the DJ had been in bad faith and sued to recover damages. ²

The district court, the court of appeals, and the Utah Supreme Court all agreed that Fire's challenge to the demand for a defense had been "fairly debatable." All agreed that this supported summary judgment for Fire on bad faith.³ The concurrence argued that a different standard should have applied, but that Oltmanns had waived his claim under that standard.⁴ Based on the arguments actually presented by Oltmanns, the court concluded that it was inappropriate to

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² 2018 UT 10, ¶¶ 1-6.
³ 2018 UT 10, ¶¶ 6, 8-12.
⁴ 2018 UT 10, ¶¶ 24-26 (concurring op.).

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²⁴² This point was made in Delgado v. Interinsurance Exchange of the Automobile Club, 152 Cal. App. 4th 671, 692–693 (2007), rev’d on other grounds, 47 Cal. 4th 302 (2009). The grant of review precludes citation in California of the court of appeal opinion in Delgado. See Cal. R. of Ct., R. 8.1115. The genuine dispute doctrine in context of a bad faith breach of the duty to defend was briefly discussed in two other decisions, but both courts declined to rule on the issue because the insurer failed to show how it was applicable under the circumstances of the case. Century Surety Co. v. Polisso, 139 Cal. App. 4th 922, 951 (2006); Perez v. Fire Ins. Exch., No. F043931, 2005 Cal. App. Unpub. LEXIS 11088, at *59–60 (Cal. Ct. App. 5 Dist. Nov. 30, 2005). Thus, although unreported, Delgado is the only California decision that has substantively addressed application of the doctrine to bad faith cases involving breach of the duty to defend.
address the concurrence’s proposed standard.\textsuperscript{5} The concurrence chose to address its proposed standard lest other courts conclude that the “fairly debatable” standard applies to claims for bad faith failure to defend.\textsuperscript{6} The concurrence began from the proposition that “[t]he relationship between the insurer and its insured [in a first-party context] is fundamentally different than in a third-party context.”\textsuperscript{7} Both first- and third-party insurers “have, at minimum, the same implied ‘duty of good faith and fair dealing implied in all contracts and . . . a violation of that duty gives rise to a claim for breach of contract.’”\textsuperscript{8} But, in the concurrence’s opinion, “[i]n third-party cases, there is not only the implied duty of good faith performance that inheres in any insurance contractual relationship, but there is an extended duty because ‘the insurer acts as an agent for the insured with respect to the disputed claim.’”\textsuperscript{9}

But, while Utah cases have characterized the insurer’s duty as fiduciary, that duty differs from a traditional fiduciary duty. The traditional duty “require[s] that the fiduciary ‘give priority to his beneficiary's best interests whenever he acts on the beneficiary's behalf.’”\textsuperscript{10} In the third-party insurance situation, however,

“the insurer must act in good faith and be as zealous in protecting the interests of the insured as it would be in regard to its own.” This is a lower standard than that required of a typical fiduciary relationship where the fiduciary must place the interests of the beneficiary above its own.\textsuperscript{11}

As the concurrence read Utah law,

an insurer has a duty to defend against a potentially viable third-party liability claim ”unless relief is obtained by way of a declaratory judgment.” Thus, when there is a non-frivolous claim and there is a question as to whether the insurer will have to pay the claim, the insurer should defend the insured until it obtains a declaratory judgment holding that there is no coverage for the loss under the policy.\textsuperscript{12}

Oltmanns sought to recover fees for litigating the declaratory judgment action, and the general rule is that “[w]here an insurer files a declaratory judgment action to determine its responsibilities in a third-party claim . . ., the insured is not entitled to attorney fees unless they are provided for in the insurance contract.\textsuperscript{13} “However, the right to bring a declaratory judgment

\begin{footnotes}
\footnotetext{5}{2018 UT 10, ¶¶ 13-21.}
\footnotetext{6}{2018 UT 10, ¶ 26 (concurring op.). Most of the opinion speaks in the first-person plural, suggesting that it was written as a majority opinion but failed to gather any adherents.}
\footnotetext{8}{2018 UT 10, ¶ 34 (concurring op.), quoting Beck, 701 P.2d at 798.}
\footnotetext{9}{2018 UT 10, ¶ 34 (concurring op.), quoting Beck, 701 P.2d at 799.}
\footnotetext{10}{2018 UT 10, ¶ 43 (concurring op.), quoting Douglas R. Richmond, Trust Me: Insurers Are Not Fiduciaries to Their Insureds, 88 Ky. L.J. 1, 1 (2000).}
\footnotetext{11}{2018 UT 10, ¶ 45 (concurring op.), quoting Beck, 701 P.2d at 799 (citation to Beck omitted).}
\footnotetext{13}{2018 UT 10, ¶ 58 (concurring op.).}
\end{footnotes}
action to determine a coverage question does not relieve the insurer of the duty to defend during the pendency of the declaratory judgment action if there is a potentially viable third-party liability claim. 14

Here, Fire investigated the claim and brought a declaratory judgment action, but it never provided a defense. The concurrence appears to say that failure to defend while seeking the declaratory judgment was bad faith, but that Oltmanns waived that claim by not making that argument in response to the summary judgment motion. 15

The concurrence correctly sees a difference between first-party bad faith and third-party bad faith. The latter seeks to protect the insured from excess judgments resulting from unreasonable failure to settle third-party claims. (See § 2.03[1], above) The former protects the insured from denial or delay of benefits when the insured’s entitlement to those benefits is not subject to fair debate. (See § 5.02-.03, above) They do have different standards, reflecting the different risks they address. (Compare § 2.03[2], above, with § 5.03, above) But the third-party bad faith standard applies only to failure to settle and has never been applied to failure to defend. Failure to defend does not risk an excess judgement unless the injuries at issue are sufficiently severe to support such a judgment. If the injuries are that severe, the insured’s protection is in the right to consequential damages for breach of the duty to defend. (See § 1.04[3], above) Bad faith breach of the duty to defend is actionable, but under the same standards as delay or denial of any other first-party benefit.

All of the concurrence’s references to a fiduciary duty (even the less onerous version of such a duty described in Beck) are beside the point. 16 Those references deal with situations in which the putative fiduciary acts on behalf of the putative beneficiary. In general, they address an insurer’s duties when considering possible settlement of claims brought against the insured, but it can be assumed, arguendo, that an insurer’s actions in conducting the insured’s defense would also be governed by such a duty. But an insurer that refuses to defend is not acting on behalf of the insured in any way, so there is no occasion to impose fiduciary or even quasi-fiduciary duties.

Moreover, even the concurrence’s more specific argument does not support a bad faith claim where refusal to defend is “fairly debatable,” though it might support a conclusion that the refusal in Oltmanns was not “fairly debatable.” Insofar as the concurrence relies on Fire’s failure to defend while pursuing the declaratory judgment action, that point depends on whether, as the concurrence claims, Utah law required Fire, before withholding a defense, to obtain a declaratory judgment that the Honda F-12 Aquatrax personal watercraft constituted a “jet ski” within the meaning of the policy. If that were clearly so, that could establish that the refusal to defend was not “fairly debatable,” even if the underlying coverage question was. But jurisdictions differ on when an insurer is permitted to rely on extrinsic evidence to deny the duty to defend without first obtaining a declaratory judgment. (See § 3.02[4][b], above) And the court says that Utah law on that point is “unsettled” and rejects the concurrence’s claim to the contrary. 17 Thus, like the underlying question of what constitutes a “jet ski,” the question of whether a declaratory judgment was necessary before the defense could properly be withheld appears to have been

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14 2018 UT 10, ¶ 59 (concurring op.).
15 2018 UT 10, ¶¶ 71-75 (concurring op.).
16 It is also inaccurate to describe the Beck duty as “fiduciary,” precisely because it is less demanding than a traditional fiduciary duty. It is more accurately described as “quasi-fiduciary.” (See § 1.08, above)
Washington Variation

Washington holds that “[t]he insurer is entitled to investigate the facts and dispute the insured’s interpretation of the law, but if there is any reasonable interpretation of the facts or the law that could result in coverage, the insurer must defend.”243 Contrary to the law elsewhere (see § 3.02[3] above), this apparently includes giving the insured the benefit of at least some doubts regarding the interpretation of the insurance policy. When an insurer denies a defense “based on arguable legal interpretation of its own policy” and fails to “avail itself of legal options such as proceeding under a reservation of rights or seeking declaratory relief,” it can be found in bad faith as a matter of law.244 Again, the existence of a genuine issue on coverage may create, rather than preclude, bad faith.

This rule derives from *Woo v. Fireman’s Fund Insurance Co.*244.1 Woo was a dentist; he agreed with a surgical assistant, Alberts, to replace two of her teeth with implants. This required installing temporary partial bridges called “flippers” until permanent implants were installed. When he ordered the flippers for Alberts, he also ordered a second set shaped like boar tusks. While Alberts was under anesthesia, as a practical joke, he installed the boar-tusk flippers, took pictures, removed them, and installed the proper flippers. When shown the pictures, Alberts was not amused; she quit and sued for outrage, battery, invasion of privacy, nonpayment of overtime wages, retaliation for requesting payment of overtime wages, medical negligence, lack of informed consent, and negligent infliction of emotional distress. Woo sought a defense under his policy, which included professional liability, employment practices liability, and general liability. Fireman’s Fund refused to defend, on the ground that the actions in question did not arise out of the practice of dentistry, did not fall within any of the defined offenses covered for employment practices liability, and, for purposes of general liability were intentional and not part of any business activity. Woo settled with Albert for $250,000, and sued Fireman’s Fund.244.2

A jury found Fireman’s Fund liable for bad faith in violation of Washington’s Consumer Protection Act (see § 10.04[2][j][i], above) and awarded $750,000. The court of appeals reversed, finding no duty to defend.244.3 The Washington Supreme Court reversed, finding that Woo’s claims arose out of the practice of dentistry and that Alberts’ claims at least might have alleged unexpected injury within the general liability coverage.244.4 It also found bad faith, even though Fireman’s Fund had obtained an opinion of counsel that it had no duty to defend and even though the court of appeals had agreed with Fireman’s Fund on that.

Characterizing counsel’s opinion, which acknowledged a lack of clear precedent, as “equivocal,” the court declared that reliance on that opinion

244 168 Wash. 2d 398, ¶ 20.
244.2 161 Wn. 2d. 43, ¶¶ 4–9.
244.3 161 Wn. 2d. 43, ¶¶ 9–12.
244.4 161 Wn. 2d. 43, ¶¶ 17–33.
flatly contradicts one of the most basic tenets of the duty to defend. The duty to defend arises based on the insured’s potential for liability and whether allegations in the complaint *could conceivably* impose liability on the insured. An insurer is relieved of its duty to defend only if the claim alleged in the complaint is “clearly not covered by the policy.” Moreover, an ambiguous complaint must be construed liberally in favor of triggering the duty to defend.

Fireman’s is essentially arguing that an insurer may rely on its own interpretation of case law to determine that its policy does not cover the allegations in the complaint and, as a result, it has no duty to defend the insured. However, the duty to defend requires an insurer to give the insured the benefit of the doubt when determining whether the insurance policy covers the allegations in the complaint. Here, Fireman’s did the opposite—it relied on an equivocal interpretation of case law to give itself the benefit of the doubt rather than its insured.244.5

The court also upheld the jury’s finding of bad faith, though with little explanation.244.6

The bad faith implications of *Woo* were developed in *American Best Food, Inc. v. Alea London, Ltd.*244.7 This case arose from a nightclub altercation. George Antonio confronted Michael Dorsey in American Best’s club, Cafe Arizona. Club security escorted Antonio from the building. He was later allowed to return and again confronted Dorsey. Both were escorted outside, at which point Antonio pulled a gun and shot Dorsey nine times. Dorsey staggered back into the club, where employees were instructed to remove him, allegedly “‘dump[ing] him on the sidewalk.’”244.8

Dorsey sued alleging failure to take reasonable precautions to protect him against injury and, in an amended complaint that the security guards exacerbated his injuries by dumping him on the sidewalk. Alea denied coverage based on an exclusion for injuries or damages “arising out of” assault or battery. Cafe Arizona’s counsel protested, pointing to the allegations of post-assault negligence and to out-of-state authority supporting coverage on that basis. Alea stuck with its denial, based on its reading of a Washington case. When Cafe Arizona sued, the superior court found no duty to defend and dismissed the case. The court of appeals found a duty to defend and remanded for further proceedings on bad faith.244.9

The supreme court agreed that there was a duty to defend, reasoning that “[t]he duty to indemnify exists only if the policy *actually covers* the insured’s liability. The duty to defend is triggered if the insurance policy *conceivably covers* allegations in the complaint.”244.10 "The

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244.5 161 Wn. 2d. 43, ¶¶ 36–37 (emphasis original). This rule regarding the scope of the duty to defend is criticized in § 3.02[3], *above*.
244.6 161 Wn. 2d. 43, ¶¶ 60–61
244.8 168 Wash. 2d 398, ¶ 2.
244.9 168 Wash. 2d 398, ¶¶ 3–4.
244.10 168 Wash. 2d 398, ¶ 6 (emphasis original).
insurer is entitled to investigate the facts and dispute the insured’s interpretation of the law, but if there is any reasonable interpretation of the facts or the law that could result in coverage, the insurer must defend."

On bad faith, Alea argued that its legal interpretation was at least reasonable, even if not correct. It relied on *Leingang v. Pierce County Medical Bureau, Inc.*, where an insurer was held not in bad faith where its position, though ultimately found to be incorrect, had been reasonable and supported by some authority. But the court distinguished that case as involving medical benefits and the duty to indemnify. Moreover, it reasoned that Alea put its own interest ahead of those of its insured

when it denied a defense based on an arguable legal interpretation of its own policy. Alea failed to follow well established Washington State law giving the insured the benefit of any doubt as to the duty to defend and failed to avail itself of legal options such as proceeding under a reservation of rights or seeking declaratory relief. Alea’s failure to defend based upon a questionable interpretation of law was unreasonable and Alea acted in bad faith as a matter of law.

Curiously, the court denied “the dissent’s suggestion, [that its rule] presume[d] that a breach of the duty to defend is per se bad faith.” But it seems that the only way to avoid bad faith is to have relied on clear authority that is now overruled. And even in that situation, one must wonder whether the ultimate result will not be deemed “conceivable” in hindsight.

This rule of bad faith law was applied in *Xia v. ProBuilders Specialty Insurance Co.* Xia purchased a home from ProBuilders’ insured. After moving in, she began to feel ill, and it was discovered that an incorrectly installed exhaust vent of her hot water heater was discharging carbon monoxide directly into her basement. When she sued the insured, ProBuilders denied coverage based on an absolute pollution exclusion and a townhouse exclusion. In coverage and bad faith litigation, the superior court found the townhouse exclusion applicable. The court of appeals disagreed on that exclusion but found the absolute pollution exclusion applicable. The supreme court agreed that the carbon monoxide discharged here was a pollutant subject to the absolute pollution exclusion. But it found that negligent installation was the efficient proximate cause of the claimed loss and not excluded.

The efficient proximate cause had formerly been employed exclusively in first-party property insurance, not in liability insurance. The application in *Xia* was not only unprecedented, it was a bolt of lightning from the blue. Nonetheless, the court appears to have held that failure to anticipate it was bad faith:

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244.11 *168 Wash. 2d 398*, ¶ 7 (emphasis added).
244.13 *American Best Food*, 168 Wash. 2d 398, ¶ 20 (footnote omitted).
244.14 *168 Wash. 2d 398*, ¶ 19 n.5.
244.15 *Xia v. ProBuilders Specialty Ins. Co.*, 188 Wn. 2d 171 (2017).
244.16 *188 Wn. 2d 171*, ¶¶ 1–38.
244.17 *188 Wn. 2d 171*, ¶¶ 1–38.
In sum, the efficient proximate cause rule remains an important part of Washington insurance law. Although we have never before applied the rule to a case with facts such as these, we see no reason to depart from the policies underpinning the rule’s function. The allegations of Xia’s complaint provided a reasonable and conceivable basis to believe that the negligent installation of the hot water heater, itself a covered occurrence under the policy provisions, set in motion a causal chain wherein the venting of exhaust lowered the oxygen content of the room such that a normally nonpolluting appliance began discharging toxic levels of carbon monoxide fumes. The record suggests that prior to declining coverage, neither ProBuilders nor NBIS conducted any investigation into Washington law that might have alerted them to the rule of efficient proximate cause and this court’s unwillingness to permit insurers to write around it. Accordingly, ProBuilders wrongfully refused to defend its insured after receiving Xia’s complaint.244.18

While not expressly finding bad faith, the court remanded for “further proceedings regarding damages for Xia’s breach of contract and bad faith claims, as well as the remaining questions of material fact relating to Xia’s CPA and IFCA claims.”244.19 No further proceedings on liability for bad faith were contemplated. If a decision this startling is deemed to have been “a reasonable and conceivable basis” to believe there was a duty to defend, it is hard to imagine circumstances in which breach of the duty to defend will not be considered bad faith.

[d] Unless Insurer’s Legal Position Is Sanctionable, That Argues Against First-Party Bad Faith

This review of the law governing summary judgment in legal disputes and its juxtaposition with the review of the directed-verdict rule suggests that there may be an analogue applicable in determining when an insurer’s legal position regarding a claim can subject it to bad faith exposure. Rule 11 of the Federal Rules of Civil Procedure (like similar rules and statutes in many states) requires an attorney (or an unrepresented party) filing a pleading to certify that it “is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law.”245 This rule subjects an attorney signing such a pleading to sanctions if there is no reasonable basis on which the pleading could have been so certified.246 Thus, a legal position that would subject an attorney to sanctions if asserted in a pleading at the time the insurer relies upon that position appears to be necessary to subject an insurer to bad faith liability.

244.18 *Xia*, 188 Wn. 2d 171, ¶ 39.
244.19 188 Wn. 2d 171, ¶ 41.
246 See *Dura Sys., Inc. v. Rothbury Invs.*, Ltd., 886 F.2d 551, 556 (3d Cir.1989).
There May Be Special Problems When Basis for Denial Implicates Insurer’s Own Handling of Policy—Illustrative Cases

[i] Gulf Atlantic Life Insurance Co. v. Barnes

A number of cases demonstrate that courts are especially critical of legal justifications offered for denial of claims when the problem was created, wholly or in significant part, by the insurer’s own handling of the policy or of the claim. An example is Gulf Atlantic Life Insurance Co. v. Barnes.247 The plaintiff in this case apparently was a poor and ill-educated single mother of seven248 who purchased life insurance on her own life and those of her children. By arrangement among her employer, the insurer, and a credit union, the premiums were advanced by the credit union (which remitted them directly to the insurer), and the credit union was repaid by weekly payroll deductions (in this case $4 per week).

The policy for which the plaintiff applied would have provided benefits of $9,683 on her death and $1,000 on the death of any child. As issued, the policy provided for benefits of $7,437 on the death of the plaintiff and $7,000 on the death of any child, but the application was attached to and made a part of the policy. A child died in September 1978, and the insurer initially drew a check for $7,000. The agent to whom the check was sent for delivery to the plaintiff pointed out that the amount did not correspond to the application. An executive of the insurer determined that there had been an error in processing the application and that the policy should be corrected and a $1,000 death benefit paid in accordance with the corrected policy. This was done in November 1978. The jury might have found that no explanation was ever provided to the plaintiff,249 though she and her neighbors who orally questioned the amount of the payment were assured that it was correct and one neighbor was told there had been an unspecified clerical error.

On June 7, 1979, an attorney for the plaintiff wrote to the insurer. On June 22, 1979, he filed suit for bad faith. On June 28, before receiving service, the insurer attempted to contact the attorney to offer the $6,000 difference between the benefits claimed and the amount previously paid. When it reached the attorney after service, he rejected that offer and demanded more.250 The insurer then counterclaimed for reformation of the contract to conform to the application, alleging the mistake in the specification of death benefits in the policy as issued. However, in discovery the insurer simultaneously asserted mistaken issuance and conceded that the failure to pay the stated benefit was mistaken.251

248 The opinion does not indicate whether the insured had a husband in the household, but the extensive factual recitation makes no mention of one and gives a clear impression that the insured was the sole support of herself and her children.
249 No written explanation was provided, and plaintiff never made a written request for one. The insurer maintained that the selling agent was supposed to explain when he delivered the check, but the plaintiff denied receiving any explanation. 405 So. 2d at 922–23.
250 The plaintiff allegedly suffered emotional distress due to her difficulty in paying a large funeral bill. 405 So. 2d at 922. She took the policy, as initially issued, to the funeral home and assigned the benefits to the funeral home. 405 So. 2d at 919. One suspects that the expense of the funeral resulted in part from reliance on the ostensible $7,000 death benefit, but the court does not note any evidence so indicating or point out the possibility. However, while such detrimental reliance on the contract, as written, presumably would be a defense to reformation, the insurer had no notice of it in advance of suit, so it would not seem to provide support for a claim of bad faith.
251 405 So. 2d at 923. These two positions were inconsistent, though the insurer does not appear to have
The jury awarded policy benefits of $6,000 plus interest and undifferentiated “compensatory and punitive damages” of $1,100,000. The Alabama Supreme Court found the extracontractual award excessive and reduced it to $100,000, but otherwise affirmed. In particular, the court concluded that the jury might have found issuance of the policy deviating from the application to be a counteroffer, accepted by the plaintiff (presumably by payments on the premium note without protest of the discrepancy).

Undisputed evidence supported the insurer’s claim that the policy as issued was the product of a computerized scrivener’s error. Under the standard practices for the policy form in question, purchase of one unit of children’s coverage insured each of the policyholder’s children, however numerous, for $1,000, at a cost of $7.50 per year. The death benefit for the plaintiff specified on the application was the amount that could be purchased for the $4 weekly payment after allowing for the premium for one unit of children’s coverage. The insurer’s personnel who processed the policy were not familiar with the form and thought that the plaintiff’s seven children called for seven units of children’s coverage. The computer then calculated a premium of $52.50 for $7,000 coverage per child and reduced the plaintiff’s death benefit in accordance with the $45 reduction in premium available for that coverage. No one, insurer or insured, appears to have noted the discrepancy between policy and application until after the child’s death.

Based on this undisputed factual scenario, the insurer would seem to have had a tenable legal argument that the policy should be reformed and that, once this was done, only $1,000 was due. Dissenting members of the court, while rejecting this argument as a basis for reversal of the award of benefits, would have found it sufficient to preclude bad faith:

In order for the tort of bad faith to arise, it must be established that there was no question as to the terms, conditions or obligations of the parties under the contract. Since there was a variance between the $1,000 children’s rider benefit amount on the application, and the face amount of the policy, there was a justiciable controversy between the parties as to the correct amount due and owing .... Under all the facts of this case, it is plain that a valid and subsisting dispute existed between the insured and the insurer as to the amount of insurance payable under the children’s rider, and that this dispute was not finally resolved until today, when this Court affirmed the judgment entered upon a jury verdict that found in favor of the policyholder on this issue. Because of this valid and subsisting dispute, I believe that the company had a lawful basis upon which to refuse to pay the $6,000 until the matter was resolved by the parties themselves or in a court proceeding such as was

realized that. Moreover, if the insurer actually was conceding that the benefits were due, it should have paid them unconditionally rather than offering them only in settlement and then withholding them until the bad faith case was resolved. Of course, pleading rules permit inconsistent pleading.

252 405 So. 2d at 926.
253 405 So. 2d at 926.
254 405 So. 2d at 920–21.
filed in this case.\textsuperscript{255}

The majority, however, seized on the trial court’s failure to find an arguable basis for denial and the insurer’s “concession” of the coverage issue:

If a lawful basis for refusal had existed, the insurance company would have valiantly argued that fact. Instead, after plaintiff filed suit, the insurer offered to pay the remainder of the face value of the policy \ldots . After reviewing the evidence, we find that the jury could reasonably have concluded that the insurer tried to cover its “mistake” without any existing debatable reason. The policy was valid from the date of its issuance and the insurer never had any lawful basis for refusing to pay the face value.\textsuperscript{256}

Because the position was one of law, not fact, the “admission” in discovery would not seem binding in a context in which the insurer simultaneously asserted that the initial policy (as opposed to the failure to pay) was mistaken. Moreover, because the issue was one of law, its legitimacy would not seem to present a jury question at all. Thus, the dissent seems to have the better of the argument.\textsuperscript{257}

However, apart from conceding error on the claim payment, the insurer may have made another critical error. Upon discovering the mistake in the issuance of the policy, the insurer undertook to “correct” it unilaterally without informing the insured and seeking either her consent or judicial reformation of the policy. In other contexts insurers sometimes face judicial hostility to what is perceived as reliance on inertia to bolster their positions.\textsuperscript{258} When the insurer seeks to repudiate the provisions of a duly-issued policy on the basis of its own unilateral mistake in reducing the agreed terms to writing, the basis for such hostility would seem at a maximum, especially if the insurer knows it is dealing with a poor and unsophisticated policyholder. Had the insurer directly confronted the issue and, if necessary, sought reformation, it might have avoided the bad faith exposure. (Of course, for a policy of this size, seeking judicial reformation might have been more expensive than paying the claim. The insurer’s immediate offer of payment on learning of plaintiff’s retention of counsel suggests this was true. But by waiting until the insured had challenged its action to offer payment, the insurer may have created bad faith exposure.)

\textsuperscript{255} 405 So. 2d at 926–27 (Maddox, J., concurring in part and dissenting in part).
\textsuperscript{256} 405 So. 2d at 925–26 (opinion of the court) (emphasis original).
\textsuperscript{257} It is possible that the disagreement did not relate to the law of bad faith, but reflected differing views on the tenability of the argument for reformation. While the dissent seems correct in regarding that argument as a reasonable one, the court’s position would have no troubling implications for other cases if this point were the bone of contention.
\textsuperscript{258} For example, in some jurisdictions an insurer that disputes coverage under a liability insurance policy risks loss of its defenses to indemnification (if it erred in denying a defense) unless it either defends under reservation of rights or files a declaratory judgment action. (See § 3.08[2] above.) Because seeking adjudication prevents imposition of the penalty, even if a defense is due, the effect is to discourage inactivity based on the hope that the insured will not pursue the matter. While this approach seems clearly unsound (see § 3.08[2]), the point at issue in text does not depend on the soundness of the rule described in this footnote.
Another case implicating the insurer’s handling of the policy is *Southern United Life Insurance Co. v. Caves.* This case involved a $12,000 credit life insurance certificate issued in 1982 in connection with the purchase of a car. There was no application, and the insured, Caves, was asked no questions about his health. A normal underwriting investigation would not have inquired about health. The insurer, Southern, had given agents no guidelines about insurability, but simply directed them to use their judgment. However, a policy condition required that the insured be in insurable health at the time the policy took effect.

Caves had a heart attack in 1974 and had been under a doctor’s care ever since. At the time the policy was issued, Caves was taking three different medicines and collecting Social Security disability benefits. He was in pain and had been diagnosed as having a progressively worsening disease. The agent was aware of the heart attack and subsequently sold other credit life policies to Caves.

Caves died of a heart attack before making the first monthly payment on the loan. The policy reserved the insurer’s right to require evidence of insurability within thirty-one days of issuance and to decline risks it found not insurable. However, the policy was to be effective in the event the debtor died within that period if the insurer would have accepted the risk under its normal underwriting practices. Because the normal underwriting practices did not include any inquiry about health, the latter provision precluded simple declination of the risk.

Upon ascertaining Caves’s precarious health at the time of issuance, Southern invoked the insurable health condition and tendered only a premium refund. Caves’ widow sued, alleging that the agent’s acceptance of the premium with knowledge of the prior heart attack waived the condition. Southern responded that the master policy limited authority to waive or change its provisions to company officers, thereby denying such authority to soliciting agents. It also asserted that the agent was not aware of the advanced progression of Caves’ illness even though she knew of the heart attack. The trial court granted summary judgment for the widow on the policy claim, and a jury awarded $10,000 in punitive damages for bad faith.

In affirming, the Mississippi Supreme Court noted that the provision of the master policy attempting to restrict authority to waive or modify was not available to Caves at the time he purchased the policy. More fundamentally, a Mississippi statute precluded restriction of the authority of soliciting agents. Thus, the agent’s knowledge and her conduct in accepting the premium were imputable to Southern.

Moreover, because Southern made no health inquiries, gave agents no guidelines for acceptance of risks, and ordinarily accepted all applications they submitted (unless credit investigation disclosed a problem not related to health), it could not rely on postclaim discovery of health problems:

> Where an insurance company makes no effort to establish clear and meaningful guidelines to assist its agents in discerning persons eligible for coverage, but merely relies on the agents’

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259 *So. United Life Ins. Co. v. Caves, 481 So. 2d 764 (Miss. 1985).*
260 481 So. 2d at 766.
261 481 So. 2d at 766–67.
judgment to select those persons appearing to be healthy, that company by its actions manifests an intention to “insure the world.” In this case, there is ample evidence that Southern was liable for the policy and the court below acted quite properly in rendering summary judgment for the appellees.262

As a basis for finding liability on the policy, this reasoning is clearly defensible. However, at least the latter point might have seemed, prior to this decision, to be debatable, so the contrary legal argument might have provided a sufficient basis for denial to preclude bad faith. However, the Mississippi Supreme Court did not see it that way. As it viewed the record:

Southern knew or should have known that as a matter of law, it had no arguable or legitimate reason for refusal. Furthermore, even after the claim arose, Southern made no attempt to contact its agent to determine what imputable knowledge she had. Southern merely proceeded to investigate the medical history of the decedent which was not its usual practice, in order to avoid liability.263

It went on to suggest a “reverse Dutton” rule, reasoning:

In the great majority of cases, where the insured is not entitled to a directed verdict on his underlying contract claim, it follows that the bad faith punitive damages issue should not be submitted to the jury. Conversely, where the insured is entitled to a directed verdict or, its functional equivalent, summary judgment, it will often follow that the insured is entitled to have the jury consider the bad faith claim. It is this latter situation with which we are presented today.264

The court thus concluded that the case before it fit the purpose of allowing punitive damages for bad faith:

“If an insurance company could not be subjected to punitive damages it could intentionally and unreasonably refuse payment of a legitimate claim with veritable impunity. To permit an insurer to deny a legitimate claim, and thus force a claimant to litigate with no fear that claimant’s maximum recovery could exceed the policy limits plus interest, would enable the insurer to pressure an insured to a point of desperation enabling the insurer to force an inadequate settlement or avoid payment entirely.”265

As already demonstrated, however, a “reverse Dutton” rule is inappropriate because it

262 481 So. 2d at 768.
263 481 So. 2d at 768.
264 481 So. 2d at 769 (citation omitted). Because the court said only that the jury would “often” be permitted to consider bad faith, it did not actually adopt a “reverse Dutton” rule.
265 481 So. 2d at 768 (quoting Standard Life Ins. Co. v. Veal, 354 So. 2d 239, 248 (Miss. 1978)).
disregards the right of the insurer to rely on tenable legal theories that would preclude coverage on the undisputed facts. (See § 17.03[5][a] above.) Nor should failure to inquire of the agent matter if she did not know the facts (regarding the advanced stage of the disease) relied upon for denial. (See § 17.03[4][d][iv] above.) Nor does the fact that an insurer rarely finds it worthwhile to investigate health on small policies (despite the policy condition apparently supporting its right to do so) necessarily render it improper to do so when circumstances brought to its attention suggest that investigation would be productive. However, the Caves court clearly found the singling out of a few insureds for postclaim health investigations to be unfair to those investigated, and evidently felt that this unfairness should have been sufficiently obvious to Southern to obviate any basis for disputing the claim.

[iii] **Intercontinental Insurance Co. v. Lindblom**

A third case in which the dispute implicated the propriety of the insurer’s handling of the policy is *Intercontinental Insurance Co. v. Lindblom.* This too was a life insurance case. The issue was whether the policy had lapsed for nonpayment of premium. As is customary, the policy allowed a thirty-one-day grace period after a premium payment was due, during which time the policy would remain in force. Intercontinental had an undisclosed internal practice of allowing an additional informal fourteen-day grace period and, if that expired on a weekend or holiday, an additional period ending on the next business day. Premiums could be paid at twelve, six, three, or one month intervals.

Lindblom was the beneficiary and owner of a $10,000 policy insuring the life of Rodenberry. Initially, Lindblom paid quarterly premiums covering the months through November 1983. In December 1983 she decided to switch to monthly payments. On January 1, 1984, she notified Intercontinental of her decision to do so and sent a payment specifically designated for December and promising a January payment when she received notice from Intercontinental (which never replied). At the time she made the payment, the formal grace period already had expired, but the check was received within the informal period and applied to the December premium, maintaining the policy in force, albeit with an overdue January premium.

Lindblom made payments early in the month from February 1984 through August 1985, almost all outside the formal grace period for the overdue premium of the prior month but within the informal grace period. Accordingly, each was accepted and back-applied to the prior month’s premium, keeping the policy in force, but always with an overdue premium.

The next payment was a check dated September 15, which Intercontinental did not receive until after expiration of the informal grace period for the overdue August 1985 premium. Intercontinental’s computer rejected this payment on the ground that the policy had lapsed. While Intercontinental was reacting to this development, Lindblom sent a payment in early October 1985, which also was collected.

On October 11, 1985, Intercontinental wrote to Lindblom and informed her of the lapse. She could not understand the reason for the notice and presented copies of her recent cancelled checks to her agent. The agent told her that he would take care of the matter and, upon receiving a copy of the cancelled October 1985 check, assured her that the policy was still in force. On

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266 *Intercont’l Ins. Co. v. Lindblom, 571 So. 2d 1092 (Ala. 1990).*

267 Intercontinental claimed to have sent prelapse notices, but Lindblom denied receiving them. This dispute could not preclude bad faith. (See § 17.03[3][b][i] above.)
October 23 Rodenberry died.

Intercontinental denied the claim on the basis that the policy had lapsed for nonpayment of the August 1985 premium. It initially did not offer to refund the payments, but eventually did so. Lindblom sued, and a jury awarded $3,012,400. The Alabama Supreme Court found the award excessive, but affirmed conditional on a remittitur to $2,012,400.

The court first found that Intercontinental’s acceptance of premiums beyond the stated grace period operated as a waiver of strict adherence to the payment schedule stated in the policy, precluding it from enforcing any lapse resulting from the late August 1985 payment. The court first denied any significance to the fourteen-day informal grace period:

This additional extended grace period is not mentioned anywhere in the policy, nor was it ever revealed to Ms. Lindblom. In our review of this case and of the insurance contract, we cannot give any validity to this extended, unwritten grace period, as it is not part of the written contract and never became part of the contract. The “extended grace period” argument, under the facts of this case, appears to be merely a convenient way for Intercontinental to justify its acceptance of premium payments outside of the 31-day grace period, insure continued payments, and keep the policy in force, all without the knowledge of the insured or the beneficiary. 268

The court’s description of the effect of the informal grace period suggests a nefarious scheme to lure policyholders into making additional payments. Any policyholder who no longer desired the insurance would simply have stopped paying, but lapse would have been seriously detrimental to any policyholder desiring the insurance. Thus, the grace period clearly was beneficial to all policyholders, including Lindblom, whose policy otherwise would have lapsed as of December 1, 1983, potentially requiring purchase of a new insurance at a higher price reflecting the insured’s greater age. Moreover, the benefit of the additional grace period was something to which the policyholders had no right. Intercontinental provided it as a gratuity.

The problems resulted from Lindblom’s carelessness regarding the payments, the impact of which arguably was magnified by the lack of any notice of the precarious situation into which she had fallen. But Intercontinental had no duty to protect her from the consequences of her carelessness on this point, and the informal grace period would never have impacted her had she complied with the terms of the policy.

In any event, the court articulated two alternate theories under which acceptance of the overdue premiums constituted a waiver. First, it reasoned:

Because Intercontinental set up a practice whereby it continuously back-applied some 20 or more payments it received outside the 31-day grace period and made no attempt to treat the policy as lapsed, it could not arbitrarily cease this practice and treat the policy as lapsed in August 1985 by claiming that

268 571 So. 2d at 1096 (emphasis original).
payment was not made within the 31-day grace period.\textsuperscript{269}

As an alternative, the court concluded:

\textquoteright{}[A] plausible … reading of the evidence could indicate that the policy actually lapsed in January 1984 when Ms. Lindblom informed Intercontinental that she would remit the January payment as soon as she received notice. Because Intercontinental never notified her as to the change in payment plans, her next check was dated February 2, 1984, and Ms. Lindblom made each subsequent payment on time, including the August and September 1985 payments. We conclude that Intercontinental waived its right to lapse the policy by not doing so when the January payment was overdue and by accepting payments past the 31-day grace period.\textsuperscript{270}

Essentially, in the latter approach the court treats the January 1984 payment as never made, with every subsequent payment applied to the current month’s premium and the right to lapse for nonpayment of the omitted premium waived (at least absent a demand). While one might argue with the latter analysis, it is at least a defensible basis for imposing liability.

Turning to the issue of bad faith, the court began by noting that the Dutton rule was no obstacle to bad faith liability, as Lindblom would have been entitled to a directed verdict on contractual liability had she moved for one.\textsuperscript{271} The court also criticized the insurer’s initial claim processing, which relied solely on the computer record that the policy had lapsed on August 1 without investigating the payment history and determining the nature of the problem, and the insurer’s failure to investigate the payment problem during the nearly two years it continued.\textsuperscript{272} This was held to be an intentional failure to investigate whether there was a proper ground for denial.\textsuperscript{273}

The Lindblom court did not explain what Intercontinental should have done had it promptly ascertained the complete facts upon presentation of the claim. Accepting the conclusion that policy benefits were due, was the legal analysis leading to that result so clear that Intercontinental was obliged to pay the claim rather than litigating? Or can it be said that Intercontinental would then have been persuaded to pay the claim? Neither proposition is necessarily true, and if neither is true, any deficiencies in the investigation caused no harm and leave unaffected the existence of a reasonable legal basis for the insurer’s denial. (See § 7.03[4][d][iv]–[v] above.) And the implicit conclusion that the facts showed the sort of fraud, malice, or oppression sufficient to support punitive damages seems clearly wrong.

\textsuperscript{269} 571 So. 2d at 1096. The court further observed that “[a]llowing such a practice gives Intercontinental virtually absolute power over the contract and leaves persons such as Mrs. Lindblom helpless.” 571 So. 2d at 1096. Of course, a failure of timely performance of a material obligation by one party ordinarily gives the other party “absolute power” to terminate the contract.

\textsuperscript{270} 571 So. 2d at 1096.

\textsuperscript{271} 571 So. 2d at 1097. This is correct, though absence of a Dutton defense to bad faith does not itself establish bad faith. (See § 17.03[4][a]) The court does not suggest that it does.

\textsuperscript{272} 571 So. 2d at 1099.

\textsuperscript{273} 571 So. 2d at 1099.
The best argument in support of *Lindblom* seems to be that Intercontinental’s handling of the prelapse late payments breached its duty to inform Lindblom of what she must do to maintain her rights under the policy. (See § 5.07 above.) Arguably, her continuing failure to make timely payments in accordance with the terms of the policy should have put Intercontinental on notice that she needed such information, and it had to know that she was ignorant of the informal grace period that was protecting her from the consequences of her defaults. On the other hand, in a world of mechanized billing and payment processing it seems questionable to expect anyone at Intercontinental ever to be aware of the situation. Failure to provide for an “alarm” and special notice to the policyholder when payment patterns activated the informal grace period might have been negligent, but this is not enough for bad faith liability under the intentional tort approach followed in Alabama. 274 Thus, even this explanation of *Lindblom* seems inadequate to support liability.

**[iv] Republic Insurance Co. v. Martin**

The three cases just discussed all involve problems arising from the preclaim handling of the insurance policy. But similar issues can arise from postclaim conduct of the insurer. *Republic Insurance Co. v. Martin* 275 arose out of a fire insurance claim on the former home of a now-divorced couple. The named insured, the husband, was obligated under the divorce decree to transfer the home to the wife, though he remained obligated on the mortgage debt. He had executed a quitclaim deed, but it had not been recorded or delivered to the wife. The agent had been instructed to transfer the policy into the wife’s name, had given assurances that this would be done, but had not yet done it.

When the house burned, the insurer, Republic, obtained nonwaiver agreements from husband, wife, and their daughter (who was living in the home at the time of the fire and later received an assignment of her mother’s rights to any insurance proceeds). Republic paid the mortgage and took an assignment of the note. It conducted a prolonged investigation and then denied the claim on the bases that the husband had no insurable interest in the property and the wife was not an insured under the policy (presumably because no longer married to or residing with the husband). The couple and their daughter sued, seeking bad faith penalties because Republic had lulled them into believing it would pay until the policy’s one-year suit limitation ran, then denied the claim. 276

The jury awarded $26,000 in contractual damages, a $6,500 bad faith penalty, and $4,780 in attorneys’ fees. The Georgia Court of Appeals affirmed. It found that all plaintiffs had insurable interests (and that the trial court had correctly directed a verdict on this point) and that the agent’s undertaking to transfer the policy created contractual rights in the wife. It did not sustain the bad faith award by characterizing Republic’s legal position as unreasonable, though one could read the opinion to indicate that the rejection of that position was clearly compelled by precedent. Instead, it reasoned as follows:

The evidence … shows that the insurer had knowledge

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276 182 Ga. App. at 390. There is no indication in the opinion that Republic ever relied on the suit limitation as a defense to payment, though the nature of the suit suggests that it might have been mentioned in the denial letter.
immediately after the fires of the potential insurable interests of
the mother, father, and daughter; it procured their signatures on
non-waiver agreements. The insurer made no effort to attempt to
refund any premiums if indeed it believed that for some time it
had no contractual obligation to Martin for lack of an insurable
interest. It gave no reasonable explanation for not following
through on its representation that it would change the named
insured on the policy. Nor did it inform any of the parties that it
would not pay the claim until well past the time for filing suit
under the policy. In fact, the evidence supports the finding that
the insurer alternately led the father and daughter, who inquired
frequently about the status of the claim, to believe that the claim
would be paid, until 1982, and thus lulled them into forbearing
suit to protect their interests.277

It is questionable whether mere failure to deny until after expiration of the suit limitation,
which is all that is described, is sufficient to constitute “lulling” the insured into the belief that the
claim would be paid. The court however, clearly was disturbed by the totality of the insurer’s
conduct, including its failure to honor the preloss instructions to transfer and its failure to act
consistently with its ultimate legal position by tendering a premium refund.

Regardless of whether these cases are analytically correct, they clearly teach that courts
are likely to be hostile to claim denials based on what they perceive to be technicalities and when
the insurer’s mistaken or questionable handling of the policy or claim had a substantial role in
creating the situation giving rise to the “technical” defense. Thus, in evaluating such cases for
summary judgment, one must look for support much more solid than the merely nonfrivolous
legal argument ordinarily necessary to protect against bad faith.

§ 17.04 Unless There Is Some Question About What the Insurer
Knew or Should Have Known, Existence of First-Party Bad Faith in
Most Jurisdictions Is Ordinarily a Question of Law, Not a Question of
Fact

[1] Burdens of Production and Persuasion in First-Party Bad Faith
Cases

[a] Overview

Any discussion of summary judgment or judgment as a matter of law on bad faith must
grapple with the question of when and to what extent existence of bad faith can be resolved by the
court as a question of law and when it presents a question of fact, requiring resolution (if either
party so demands) by a jury. Before tackling that subject directly, it is useful to delineate with
some precision who has what burdens, of production and persuasion, at the trial of a first-party
bad faith case. The cases have not stated these burdens explicitly, and failure to understand them
can complicate or obscure analysis of when questions of fact are presented.

277 182 Ga. App. at 394.
For example, the Texas Supreme Court once experienced difficulty delineating standards for appellate review of sufficiency of the evidence in bad faith cases. (See § 17.02[1].) Justice Hecht attributed some of the difficulties with the law of bad faith and the proper application of “no evidence” review to a burden of proof which, if actually imposed, would be impossible to meet: “[i]f … a judgment for bad faith must be supported by evidence negating the existence of any reasonable basis, then no judgment can survive review. No plaintiff can disprove every reasonable basis conceivable for denying or delaying a claim.” If that were indeed the burden, it would create the problems described. But that is not the real burden.

The burden Justice Hecht describes is imposed only on one group of litigants: those mounting equal protection (or similar constitutional) attacks on statutes. Under that extraordinary procedural regime, a court may uphold a statute if the court can conceive of a basis that the challenger has failed to negate, even if that purpose was never advanced either in the legislature or at trial. But that framework is designed to afford maximum protection to the broad power of the legislature against possible encroachment by the courts. Private litigants like insurers are entitled to no such protection.

Clarifying the real burdens is the first step in analysis of what questions can be resolved by the court.

[b] The Insured Must Present Prima Facie Evidence That the Claim Was Payable and That the Insurer Had Notice of the Claim and Access To Evidence Sufficient To Support the Claim

In the contract phase of the suit, the insured has the initial burden to prove he has a covered claim. The insurer then has the burden to prove any exclusions that apply, or other reasons that the policy does not provide coverage. Once that is accomplished, the burden may then switch back to the insured to prove any exceptions to the exclusions that apply.

An insurer can be required, through discovery, to specify every allegedly reasonable basis for withholding payment on which it relies to defeat the bad faith claim. An insured then seeks to show that none of the bases so identified provided a sufficient ground to withhold payment. If successful in this, the insured has made out a prima facie case, unless there is a question about what the insurer knew or should have known.

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4 See 7 J. INS. REG. at 136–39.
5 See JEFFREY E. THOMAS, THE NEW APPLEMAN ON INSURANCE LAW, LIBRARY EDITION § 18.01[2][a].
6 See JEFFREY E. THOMAS, THE NEW APPLEMAN ON INSURANCE LAW, LIBRARY EDITION § 18.01[2][a].
7 See JEFFREY E. THOMAS, THE NEW APPLEMAN ON INSURANCE LAW, LIBRARY EDITION § 18.01[2] (describing division of authority on burden of proving exceptions to exclusion).
8 See, e.g., FED. R. CIV. P. 34.
9 See §§ 5.04, 17.03[4][d]. See also Michael Sean Quinn, Insurer Bad Faith—Sic et Non-Texas Style, 19 INS. LITIG. RPRTR. 485, 494–95 (1997).
Even without reliance on the availability of discovery, a manageable framework can be established by proper allocation of evidentiary burdens. Of course, the burden of proof is ultimately on the insured who asserts the bad faith claim. But that does not mean that the insurer has no evidentiary burden once coverage has been established. Instead, the insurer’s burden has escaped notice, because the practicalities of defending a bad faith claim induce insurers to shoulder that burden without any court ever saying that it exists. Making the burden explicit helps clarify both the law of bad faith and the application of appellate review or summary judgment to bad faith claims.10

In general, every bad faith claim depends on the existence of a valid claim for insurance benefits. (See § 5.06 above.) The insured bears the burden of proving the existence of coverage.11 In considering a claim presented by an insured, an insurer is entitled (after conducting a reasonable investigation) to insist that this burden be met.

Absence of enough evidence to establish coverage would be a reasonable basis to withhold benefits, at least until the missing evidence were found (or would have been found with a reasonable investigation).12 So an insured cannot make out a prima facie case of bad faith without presenting evidence sufficient, if believed, to establish two things: (1) existence of coverage and (2) withholding of payment even after enough information to show coverage was available to the insurer. For this purpose, evidence is “available” if the insurer either actually knew of it or would have known of it had it conducted a reasonable investigation. (See § 5.04) Thus, an insured establishes a prima facie case of bad faith by presenting evidence of entitlement to coverage and presenting evidence that all of the necessary facts were or should have been known to the insurer.

[c] The Insurer Must Articulate One or More Bases for Challenging the Validity of the Claim

Once the insured has made a prima facie case, the insurer then has a burden of articulating one or more grounds for withholding payment. The insurer may do this, for example, by offering a legal argument that the evidence presented by the insured does not establish coverage because the policy, a governing statute, or a rule means something different from what the insured now

10 The burdens described here are analogous to those utilized in employment discrimination law, pursuant to McDonnell Douglas Corp. v. Green, 411 U.S. 792 (1973); Furnco Construction Corp. v. Waters, 438 U.S. 567 (1978); and Texas Department of Community Affairs v. Burdine, 450 U.S. 248 (1981). The insurer’s burden is one of producing evidence in response to a prima facie case, not of persuasion. But the evidence produced by the insurer frames the issues for the insured’s proof. Arguably the initial McDonnell Douglas burdens do little or no work, because they are easy to satisfy and have little or no role in structuring the inquiry at the final stage. See George Rutherglen, Reconsidering Burdens of Proof: Ideology, Evidence, and Intent in Individual Claims of Employment Discrimination, 1 VA. J. SOC. POLICY & L. 43, 56–60 (1993). In contrast, the burdens at the first two stages of the bad faith proof structure articulated here have real substance and the third stage is structured by what is produced in the second.

11 See Leo Martinez, Marc S. Mayerson, & Douglas R. Richmond, New Appleman Insurance Law Practice Guide § 3.07(1).

asserts, or that it did at the time payment was withheld. (See §§ 5.02[2], 5.03[1]–[2], 17.03[5] above.) The insurer may do this by explaining that it contends that some of the evidence necessary to support coverage is of doubtful credibility or arguably supports different inferences than those drawn by the insured. (See §§ 5.02[2], 5.03[1]–[2], 17.03[4] above.) And the insurer may do this by producing evidence of its own, which, if believed, contradicts essential evidence offered by the insured or avoids its effect. (But production of evidence avails an insurer nothing if the evidence it adduces provides no basis for a finding against the insured, even if the evidence itself is accepted.) A common method of avoiding the effect of evidence showing coverage is presentation of evidence supporting application of an exclusion, such as the one for arson.

In the ordinary case, the insurer can, and usually does, satisfy any production burden by introducing its claim file (or key parts of that file) if the insured has not already done so. The claim file ordinarily constitutes undisputed evidence of what investigation occurred, what the insurer knew, and when it knew it. If the insurer can point to portions of the file supporting its decision to “test the claim in court,” that satisfies its burden. Of course, the insurer is free, in most jurisdictions, to supplement the claim file with additional evidence that its action was proper, even though it did not have that evidence in its possession when it denied the claim. (See § 17.03[4][d][iii] above.)

[d] The Insured Has the Burden of Proving That None of the Articulated Grounds Constituted a Reasonable Basis for Delaying or Denying Payment

The insured then has the burden of showing that none of the grounds asserted by the insurer gives rise to a bona fide dispute that warranted testing the claim in court. This cannot be

13 See, e.g., Arnold v. National County Mut. Fire Ins. Co., 725 S.W.2d 165 (Tex. 1987) (insurer relied on (1) facts which led it to suspect possible speeding or intoxication but did not support either conclusion and (2) the belief that jurors would be unfairly prejudiced against motorcyclists).

14 Delaware: Bennett v. USAA Cas. Co., 2017 Del. LEXIS 105, *9–11 (insureds’ burden to prove lack of a reasonable basis included burden of producing evidence on that point);

Mississippi: James v. State Farm Mut. Auto. Ins. Co., 743 F.3d 65, 70 (5th Cir. 2014) (“The initial burden placed on the insurer is low: it ‘need only show that it had reasonable justifications, either in fact or in law’ for its actions. Once an insurance company articulates an arguable or legitimate reason for its payment delay, the insured bears the burden of demonstrating that the insurer had no arguable reason. ‘The plaintiff’s burden in this respect likewise exists at the summary judgment stage where the insurance company presents an adequate prima facie showing of a reasonably arguable basis for denial so as to preclude punitive damages.’ ”).

Texas: See Universe Life Ins. Co. v. Giles, 950 S.W.2d 48, 81 (Tex. 1997) (Enoch, J., concurring). (noting that the insurer will normally “put forth some purportedly reasonable basis for denial or delay in payment” and concluding that the insured would have the burden … to put before the factfinder some evidence that no reasonable insurer would have relied on the information before the insurer to deny or delay payment, or that the insurer’s proffered reasons were a pretext or a sham or that the information before the insurer at the time it denied coverage was
done merely by presenting evidence contradicting the insurer’s evidence, for conflicts in the evidence are precisely the reason why it is proper to test the claim in court.\textsuperscript{15} (See §§ 5.02[2], 5.03[1]–[2], 17.03[4] above.)

Absence of a bona fide dispute can be proven, as it was in Giles, by showing that the insurer relied on an interpretation of the evidence which the source of that evidence had disclaimed and that the insurer knew or should have known of the disclaimer.\textsuperscript{16} As Giles also shows, it can be proven by showing that some of the evidence relied upon by the insurer was erroneous, and that the insurer knew of the error.\textsuperscript{17} And showing that the information on which the insurer relies “was known or should have been known to be unreliable can prove it.”\textsuperscript{18} For example, if the testimony of a witness on whom the insurer relies is a pure fabrication and the insurer knows that (or is deemed to know that because the lying witness is an insurer employee), that testimony cannot create a bona fide dispute. (See § 17.03[4][b][i] above.)

But the term “unreliable” in the foregoing statement must be understood in the narrow sense of something unworthy of reliance, something that does not warrant “testing the claim in court.” (See §§ 17.03[4][b][ii]–[iv] above.) It is not enough for the insured to show that the insurer’s evidence (or the inference it seeks to draw from the evidence) is subject to question and impeachment if, despite that, a fact finder might reasonably find it worthy of sufficient credence to defeat the insured’s claim. (After all, the insured’s claim may itself rest upon questionable evidence). Evidence which might reasonably be found sufficient to defeat the claim warrants “testing the claim in court,” and reliance on such evidence is not improper, even if the evidence is subject to impeachment or an argument for a different inference than the insurer seeks.

In light of this allocation of evidentiary burdens, appellate review of a bad faith finding would proceed as follows (with summary judgment procedure being analogous (compare

\textsuperscript{known or should have been known to be unreliable.})

\textbf{Texas:} 950 S.W.2d at 81 (“the plaintiff may not parse through the information before the insurer and pull out only the information showing coverage to prove bad faith”); Lyons v. Millers Cas. Ins. Co., 866 S.W.2d 597, 601 (Tex. 1993);

\textbf{California:} Blake v. Aetna Life Ins. Co., 99 Cal. App. 3d 901, 924 (Cal. Ct. App. 1979) (failure of evidence provided to or discovered by insurer to rule out suicide created reasonable ground to withhold accidental death benefit);

\textbf{Wisconsin:} Anderson v. Continental Ins. Co., 85 Wisc. 675, 691 (Wis. 1978) (“when a claim is ‘fairly debatable,’ the insurer is entitled to debate it, whether the debate concerns a matter of fact or law”).

\textsuperscript{15}See Giles, 950 S.W.2d at 56–57 (Spector, J., announcing the judgment) (explaining that insured’s supposed “positive history of heart disease” was only a family history, not a personal history); 950 S.W.2d at 82 (Enoch, J., concurring) (same); 950 S.W.2d at 79 (Hecht, J., concurring) (agreeing with other justices on lack of basis for denying claim).

\textsuperscript{16}See 950 S.W.2d at 57 (Spector, J., announcing the judgment) (noting that correction of transcription error removed alternate basis for claiming pre-existing personal history of heart disease). \textit{See also} 950 S.W.2d at 81 (Enoch, J., concurring) (insured may prove that “the insurer’s proffered reasons were a pretext or a sham”).

\textsuperscript{17}950 S.W.2d at 81; \textit{see also} Provident Am. Ins. Co. v. Castaneda, 988 S.W.2d 189, 194 (Tex. 1998).
§ 17.02[1] with § 17.02[2] above. First, the appellate court would determine what information should be deemed available to the insurer. Any question as to what the insurer knew or would have learned from reasonable investigation is a fact issue, subject to jury determination if there is any probative evidence to support a finding for the insured. So, for purposes of appellate review, one would assume the view most favorable to the verdict and also consistent with whatever evidence is undisputed. (See § 17.02[1] above.)

Then the court would examine the evidence with respect to each of the grounds for withholding payment articulated by the insurer (unless the ground is an argument of law, not requiring evidentiary support). Existence (as opposed to correctness) of whatever evidence allegedly supports the insurer’s position will often be undisputed, but if the existence of that evidence (e.g., a disputed oral admission) is in question, that too is an issue of fact, on which the jury’s verdict would be binding if supported by any probative evidence. As to each ground for which it is undisputed that some evidence supporting the insurer exists, the insured must have offered evidence sufficient to support a finding that there was no bona fide dispute as to the insured’s right to payment.

In a point of considerable significance here, any inquiry into the adequacy of the insurer’s investigation has only limited relevance on appellate or summary judgment review of the existence of a genuine dispute. Adequacy of the investigation is generally relevant only to the extent that it bears on whether the insurer should be charged with knowledge of facts it did not actually discover. (See §§ 5.04[3][a], 17.03[4][d] above.) After all, one does not investigate for the sake of investigating. One investigates to find useful information. If further investigation would not have revealed anything useful, it should make no difference that such investigation was not done. (See §§ 5.04[3], 17.03[4][d] above.)

Once the court determines what the insurer knew (actually or constructively), it must determine whether those facts created a “bona fide dispute” as to coverage. Even one bona fide dispute as to the right to payment justifies “testing the claim in court.” So, unless the insured has presented probative evidence of the absence of a bona fide dispute on every ground relied upon by the insurer, there is no evidence to support an actual or putative verdict. But deciding whether there is a bona fide dispute, even on a factual point, does not require weighing the evidence: the issue is simply whether a reasonable person, in possession of the information available to the insurer, would have been justified in “testing the claim in court.”

19 Inadequacies in investigation would have greater relevance in jurisdictions that require a showing of subjective culpability. (See § 5.03[2] above.) Obvious deficiencies in investigation might support an inference of conscious indifference to the rights of the insured.
First-Party Bad Faith Law Generally Does Not Call for Factfinders To Make Value Judgments About Whether Particular Claims Should Have Been Paid

[a] Unlike Negligence Law, Which Calls for Case-by-Case Balancing, Bad Faith Law Employs Categorical Balancing To Specify Legal Standard

[i] Bad Faith Law Uses Categorical Balancing

To many observers, a determination of what is reasonable (and, therefore, what constitutes a reasonable basis to challenge a claim) sounds like a question of fact, requiring a jury determination (if a jury has been demanded). Reasonableness is a fact question in its most common context, namely negligence law. There the issue is whether the defendant acted unreasonably in not taking greater precautions, given the safety risks of his conduct. That sort of fact-bound balancing is inextricably intertwined with judgments about what further precautions would have prevented the harm to the plaintiff, how burdensome it would have been to take them, and how much risk was created by failure to take them. Rather than require detailed findings on subordinate facts where achieving unanimity would be difficult, the jury is permitted to treat the entire complex of judgments as a single question, requiring agreement on only the bottom line.

But bad faith law does not call for balancing of that sort. The insurer’s right to “test the claim in court” does not vary with the harm that the insured may suffer if the claim is denied or with the size of the amount claimed by the insured. The issue is whether a qualitative threshold requirement is satisfied. If there is a bona fide dispute, then the insurer may challenge the claim; if not, it must pay without requiring the insured to sue. (See §§ 5.02[2], 5.03[1]–[2], 5.05 above.)

Whether a reasonable prosecutor (or a reasonable juror) could take a particular view on the basis of specified evidence is a question of law, and it is so treated in the law of malicious prosecution. (See § 17.04[2][b] below.) The question of whether specified evidence created a bona fide dispute warranting “testing the claim in court” is analogous. So for purposes of “no evidence” review in bad faith cases, a reviewing court is ordinarily required to defer to jury factfinding only on the question of what the insurer knew (actually or constructively) when it decided to deny the claim. 20

Those asserting that bad faith includes a greater role for the fact finder have not explained why they believe this or what that role should be. They may believe that the fact finder is entitled to make some sort of individualized value judgment, analogous to that in negligence cases, about whether it was reasonable to withhold payment, even if there was a fairly debatable question about the right to payment. 21 If so, they are mistaken; bad faith law neither does nor should allow

20 James v. State Farm Mut. Auto. Ins. Co., 743 F.3d 65, 70 (5th Cir. 2014) (“whether an insurer possessed an arguable or legitimate reason is a question of law”).

In theory, there could be another factual issue. If the jury could have found that the insurer missed significant information favorable to the insured, it might be arguable that finding that information would have persuaded the insurer to pay, even though a legitimate question about coverage might remain. See § 17.03[4][d][v][A] above). Such a contention are rarely, if ever, made by insureds. So the possibility remains largely a theoretical curiosity.

21 That was the explicit position of the court of appeals in State Farm Fire & Cas. Co. v. Simmons, 857
such value judgments.

[ii] Use of Case-by-Case Balancing Would Deny Insurers Necessary Freedom To Contest Debatable Claims

To explain why this is so, consider problems that appeared to have been created by the new Texas formulation of the bad faith standard adopted in *Universe Life Insurance Co. v. Giles*, under which an insurer acts in bad faith if it fails to pay when its liability has become “reasonably clear.” On its face, that formulation seemed to encourage juries to believe that they are entitled to make the sort of value judgments just rejected. Thus, far from clarifying the standard, that formulation seemed to confuse it. A majority of the Texas court held that the substance of the standard is unchanged, yet the old standard did not authorize juries to make such value judgments. This reformulation appeared likely to have practical consequences that illustrate the theoretical undesirability of allowing such value judgments under any formulation.

We agreed with Michael Sean Quinn that “[a]lthough the court intend[ed] its tinkering to be merely semantic, its intention [seemed] likely to be frustrated by the realities of pre-trial and trial practice.” Unless very clearly instructed to the contrary, jurors would be likely to feel that liability can be “reasonably clear” even though there remains a bona fide dispute. In particular, “a juror who believes insurers should err on the side of paying a claim will think the failure to do so unreasonable.” That would force insurers to pay some claims that they might have been defeated if permitted to “test the claim in court.” Consequently, it would deny insurers the latitude necessary to question doubtful claims, latitude which decisions recognizing and defining the bad faith tort have always sought to preserve. See § 5.02[2] above. In turn, that would necessarily inflate insurance costs. (In fact, these fears for the development of Texas law apparently proved groundless, as the old substantive standard continued to be applied under the new formulation. Nonetheless, those fears illustrate the flaws of allowing juries to engage in case-by-case balancing about whether an insurer should have paid.)

S.W.2d 126 (Tex. Ct. App. 1993), aff’d without addressing this point, 963 S.W.2d 42 (Tex. 1998). It is also the position taken in Phil Hardberger, Juries Under Siege, 30 St. Mary’s L.J. 1, 39–44 (1998). It is unclear, however, how the jury is supposed to make such a judgment or why a judgment is thought either necessary or appropriate.


See §§ 5.02[2], 5.03[1]–[2] above. For a more detailed exposition of prior Texas law on this point, see William T. Barker, Evidentiary Sufficiency in Insurance Bad Faith Suits, 6 Conn. Ins. L.J. 82, 92–109 (1999–2000). In contrast to the suggestion that courts must defer to some jury determinations about the reasonableness of an insurer’s assessment of the evidence on factual issues, it seems quite clear under Texas law that courts were to make their own independent evaluation of whether an insurer’s legal arguments could be reasonably supported. See United States Fire Ins. Co. v. Williams, 955 S.W.2d 267, 268 (Tex. 1997).


Giles, 950 S.W.2d at 59 (Hecht, J. concurring).

Of that possibility, it has been said, “[i]f it is right, then the liability-has-become-reasonably-clear standard spells ‘trouble with a capital T’ and should not have been adopted.” Quinn, 19 Ins. Litig. Rptr. at 496. “[T]he locution reasonably clear brings the tort closer to the law of negligence,” and “we can expect counsel to seek a jury charge assimilating insurer bad faith to negligence and, more significantly, to argue the case to the jury as though insurer bad faith is a form of negligence, whatever instruction the court gives.” 19 Ins. Litig. Rptr. at 496–97.

Nor is this the only flaw of the reformulated standard. The statute whose language the court has grafted onto the bad faith tort proscribes failure “to attempt in good faith to effectuate a prompt, fair and equitable settlement of a claim with respect to which the insurer’s liability has become reasonably clear.”\(^\text{28}\) If “reasonably clear” means, as the Texas court has since held, that there is no reasonable basis to withhold payment, then this would require insurers to do no more than promptly pay claims which are due.\(^\text{29}\) That would mirror the requirements of pre-*Giles* bad faith law.\(^\text{30}\) But a requirement to “attempt to effectuate a … settlement” might lead jurors to believe that insurers are obliged to offer to compromise doubtful claims, and that the jury is authorized to decide how “fair” the insurer has been in any settlement negotiations.

Bad faith liability for denying claims that are not subject to bona fide dispute is a manageable risk. Exposing insurers to second-guessing of their handling of *questionable* claims would be disastrous. Even if the claim were defeated, an insured might argue that it had enough merit that the insurer should have offered a compromise. If the claim succeeds, the existence of a bona fide dispute would not preclude the contention that a generous compromise should have been offered, so as to save the insured the expense, delay, and anxiety of litigating the claim.\(^\text{31}\)

The latter hazard could be avoided by using a formulation that does not suggest an obligation to compromise. But the problem of forcing insurers to pay claims that are subject to

\(^{28}\) *TEX. INS. CODE ANN.*, art. 21.21, *See Giles*, 950 S.W.2d at 55 (quoting statute and proposing to adopt it as the standard for common law bad faith).

\(^{29}\) *Boyd*, 177 S.W.3d at 922.

\(^{30}\) Justice Hecht’s opinion construed the statutory language that way. [*See Universe Ins. Co. v. Giles*, 950 S.W.2d 48, 69–70 (Tex. 1997).] Justice Enoch must have agreed in order to conclude that the change in the common law formulation left the substantive standard unaltered. [*See id.* at 80] (Enoch, J., concurring).

\(^{31}\) Even the technical problems in application of any standard requiring compromise are daunting:

[H]ow much of an attempt must a carrier make to effectuate a settlement in order for it to be a good faith attempt? In what spirit must the carrier act? Is a letter whereby the carrier offers to pay what it thinks it owes sufficient to avoid liability? What if the carrier is right that it owes some money but wrong about how much it owes? Since a carrier has the right to be wrong, if it makes a good faith error as to the amount it owes, then there should be no liability. Further an almost universally employed negotiation style is to offer less than you think you owe and to demand more than you think you can get. Is an insurance company barred from utilizing this negotiation style, once its liability for some amount has become reasonably clear? … What is the difference between *fair* and *equitable* when it is said that an insurance company must ‘effectuate a prompt, fair and equitable settlement of a claim’? What is the force of the word ‘settlement’? That term connotes the possibility of free-wheeling negotiation. But the whole thrust of bad faith law is to induce insurance companies to pay what they owe, as opposed to trying to negotiate themselves better deals than they deserve.

Quinn, 19 INS. LITIG. RPTR. at 496.
legitimate question is inherent in any standard allowing fact finders to make individualized judgments. No judgment is necessary if the claim is beyond question. Any judgment would have to be based on some balancing of the burden to the insured of having to sue for payment against the benefit to the insurer of requiring a suit. Because the typical insured may be seriously impacted by an insured loss, while the insurer is able to pay any individual claim, fact finders are likely to require insurers to call even substantial doubts in favor of insureds.

Fact finders are also likely to create inequalities between insureds whose claims are subject to similar doubts. If some form of balancing of benefits and burdens is allowed, doubts will be called more strongly in favor of more vulnerable insureds. Either the poor must be charged more for similar risks or the rich will be forced to pay an equal amount for what, in practice, will be lesser coverage. Neither of these effects has any relevance to the purposes justifying the bad faith tort.

Moreover, no court or commentator has ever provided any explanation of what inquiry the jury is supposed to make in determining whether an insurer acted unreasonably or without a reasonable basis. An insurer is supposed to be free to challenge questionable claims, but there has been not even a hint of guidance of how one is to determine which claims that (after full investigation) present a genuine dispute of material fact or a bona fide legal issue are not sufficiently questionable that an insurer must risk bad faith liability to challenge them. Unless and until insurers and juries are provided guidance on that issue, insurers ought to be shielded from bad faith liability for challenging any claim that presents a bona fide litigable issue on coverage.

To say that insurers should be legally free to deny all questionable claims is not to say they will actually do so. They must also take account of business issues. An insurer can build valuable goodwill by giving insureds the benefit of the doubt in cases where any dispute is marginal. Also, litigating a claim is frequently more expensive than paying it, even if the insurer expects to win. That is even more true if the insurer expects to lose, as losing will require it to pay, not only the claim, but also possibly the legal fees on both sides and penalty interest.

But there are some claims that the insurer may find should be resisted regardless of expense and risk of loss. This would be especially likely for possibly fraudulent claims. It might also be true of a claim that the insurer sees as part of a pattern that it regards as dubious claims (especially large ones, like those for foundation damage). The insurer might well conclude failure to put such claims to the test whenever possible will only inflate costs by encouraging even more dubious variants.

Forcing insurers to call legitimate doubts in favor of insureds would limit the ability of insurers to resist such claims, if they also realize that a jury might well accept those claims. By definition, fraudulent claims have their infirmities concealed, and the concealment may fool the fact finder (who may call doubts in favor of the insured in determining contract liability). Insureds generally have a strong interest in not funding payment of fraudulent claims, and anything that weakens the ability to challenge such claims is likely to increase their frequency. If

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33 See Alan O. Sykes, “Bad Faith” Breach of Contract by First-Party Insurers, 25 J. LEGAL STUD. 405, 425–29 (1996) (arguing that forcing insureds to sue when the insurer develops reasonable suspicions of fraud may be the most efficient way to sort out valid claims which generate such suspicions from those in which the suspicions are justified).
there is a bona fide dispute as to the insured’s right to payment, the insurer should be entitled to “test the claim in court” even if it is pessimistic about its prospects before a jury. Jurors might not permit this if they were allowed to decide that the insurer ought to have disregarded a genuine question about the bona fides of a claim.

We have grown accustomed to juries making individualized judgments in negligence cases, where they are unavoidable. But nothing inherent in the right to jury trial requires that the legal standard for other causes of action, like malicious prosecution and insurance bad faith, be defined to require or permit such judgments. For the reasons previously stated, the law of bad faith has been defined in a way that does not require or permit them. Defining the legal standard that way was correct, because (as just explained) broader fact finder discretion would impair the proper operation of the insurance mechanism. (See also §§ 17.03[5][b][i][a] & (c) above.)

[b] In Bad Faith Law, Reasonable Basis for Denial, Like Probable Cause in Law of Malicious Prosecution, Presents Question of Law Once Underlying Facts Are Determined

In Dalrymple v. United Services Automobile Association, a California court reasoned that establishing lack of proper cause for contesting coverage was similar to showing lack of probable cause in a malicious prosecution action. Any dispute as to the facts the insurer had before it, like disputes about the facts known to the instigator of a prosecution, would create a jury issue. But where the facts known to the insurer were undisputed, the bad faith issue, like the issue in a malicious prosecution case, would be whether a legally tenable basis for litigation existed. That issue “is clearly not a matter within the scope of experience of a lay jury. Rather, the trial court is best equipped to assess whether the insurer had proper cause to seek a ruling on coverage under the particular circumstances.”

The common law in most states has extended the cause of action for malicious prosecution from unjustifiable criminal proceedings to wrongfully initiated civil suits. An essential element of that tort is want of probable cause. The RESTATEMENT says that probable cause exists so long as the party initiating the civil proceeding:

- reasonably believes in the existence of the facts on which the claim is based and either
  - (a) correctly or reasonably believes that under those facts the claim may be valid under applicable law, or
  - (b) believes to this effect in reliance upon the advice of counsel, sought in good faith and given after full disclosure of all relevant

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35 40 Cal. App. 4th at 515.
36 40 Cal. App. 4th at 516.
37 40 Cal. App. 4th at 516.
38 40 Cal. App. 4th at 516. While Dalrymple itself involved a coverage dispute turning on a purely legal issue, the court’s analysis was not limited to disputes of that sort. It applies equally to questions of whether the particular information available to an insurer creates a legally tenable basis to dispute coverage.
40 150 Wn. 2d at 912; RESTATEMENT, § 674(b).
facts within his knowledge and information.\textsuperscript{41}

Assuming that the defendant does not rely on advice of counsel, the requirement of reasonable belief in the existence of the alleged facts and the possible legal validity of the claim does indeed appear to be parallel to what is necessary to establish good faith in denying a claim.\textsuperscript{42} So, the substantive law analogy appears strong.

This division of functions between court and jury is described as follows in the \textsc{Restatement}, which notes that they differ from those in negligence actions:

The respective functions of court and jury in actions for malicious prosecution differ in one important particular from their respective functions in other actions of tort in which, as in actions for negligence, the liability of the defendant depends upon the unreasonable character of his conduct. In passing upon this question someone must determine what the defendant did or failed to do and the circumstances under which his act or omission occurred; and someone, either court or jury, must determine whether, in the light of these circumstances, his conduct measured up to the standard of a reasonable man. In actions for negligence and other tort actions in which the liability of a defendant depends upon the unreasonable character of his conduct, both of these matters are determined by the jury … .

In actions for malicious prosecution, however, upon the issues of favorable termination and probable cause, the jury has only the function of finding the circumstances under which the defendant acted. The court determines whether, under those circumstances, the termination was sufficiently favorable to the accused, and whether the defendant had or had not probable cause. If there is no conflict in the testimony as to what the circumstances were, the court has no need for a finding of the jury. The jury is not called upon to act unless there is a conflict in the testimony that presents an issue of fact for its determination.\textsuperscript{43}

Accordingly, the reasonableness of the basis for bringing the claim under the circumstances (either undisputed or found by the jury) presents an issue for the court. By the same token, the reasonableness of a particular interpretation of an insurance policy should be a question of law for the court in a bad faith case. (See also §§ 17.03[b][i][B]–[C] above.)

\textsuperscript{41} \textsc{Restatement (second) of Torts} § 675 (1977).
\textsuperscript{42} Advice of counsel as a defense to bad faith is discussed in § 8.09 above.
\textsuperscript{43} \textsc{Restatement}, § 673, cmt. e. This limited view of the jury’s function in a malicious prosecution action is taken in a strong majority of jurisdictions. C.C. Marvel, Annotation, \textit{Probable Cause or Want Thereof, in Malicious Prosecution Action, as Question of Law for Court or Fact for Jury}, 87 A.L.R.2d 183.
Whether Insurer’s Legal Position Was Reasonable Presents Question of Law

Proximate Cause in Cases of Legal Malpractice on Appeal, Turns on Legal Analysis Appropriate for Courts, Rather than Expert Witnesses and Juries

Where an insurer’s defense to a bad faith action asserts existence of a reasonable legal argument for challenging the claim, the issue is whether reasonable minds could differ on the coverage determining law. (See § 17.03[5] above.) As the California Court of Appeal has explained:

“We recognize there are numerous cases reciting that ‘reasonableness’ of a defendant’s conduct is a factual question for the jury. However, the reasonableness of the legal position taken by [the insurance company here] depends entirely on an analysis of legal precedent and statutory [or contractual] language. Those are matters of law, not facts which can effectively be ascertained by lay jurors.”44

The Restatement of the Law of Liability Insurance agrees at least as to finding insurer legal positions unreasonable:

What [“reasonable basis,” “fairly debatable,”] and other similar expressions … have in common is that the insurer must have a sufficient basis for any refusal to perform. An insurer has a sufficient basis if it takes a legal position that a reasonable insurer might take, or acts as a reasonable insurer might in the circumstances. Because a reasonable insurer is knowledgeable about and follows liability insurance coverage law, a coverage position that lacks a fairly debatable basis in the law of the jurisdiction—a determination that can be made by the court as a matter of law—would not be fairly debatable.44.1

But a court that can properly determine whether a legal position is reasonable can make that determination regardless of whether it favors the insurer or the insured.

Another area of civil liability that sometimes turns on legal analysis is legal malpractice, notably, malpractice in failing to take, perfect, or properly present an appeal. In such a case, there is no damage to the client unless the appellate court would have reversed or modified the judgment below. Decisions have consistently recognized that determinations of whether review would have been granted (if discretionary) and whether the appellate court would have rendered a more favorable judgment “are within the exclusive province of the court, not the jury, to

44.1 RESTATEMENT OF THE LAW OF LIABILITY INSURANCE § 49, cmt. b (Prop. Final Dr. No. 2 April 13, 2018).
As the Washington Supreme Court explained:

The rationale for these decisions is clear. The overall inquiry is whether the client would have been successful if the attorney had timely filed the appeal. The determination of this issue would normally be within the sole province of the jury. Underlying the broad inquiry, however, are questions bearing legal analysis. The determination of whether review would have been granted and whether the client would have received a more favorable judgment depends on an analysis of the law and the rules of appellate procedure. Clearly, a judge is in a much better position to make these determinations.

The Texas Supreme Court has elaborated on the greater competence of courts to decide such issues:

The question of whether an appeal would have been successful depends on an analysis of the law and the procedural rules. Millhouse’s position that the jury should make this determination as a question of fact would require the jury to sit as appellate judges, review the trial record and briefs, and decide whether the trial court committed reversible error. A judge is clearly in a better position to make this determination. Resolving legal issues on appeal is an area exclusively within the province of judges; a court is qualified in a way a jury is not to determine the merits and probable outcome of an appeal. Thus, in cases of appellate legal malpractice, where the issue of causation hinges on the possible outcome of an appeal, the issue is to be resolved by the court as a question of law.

As to factual issues presented in the underlying case, the malpractice jury determines the probable outcome of proper presentation of those issues “by substituting its own judgment for that of the factfinder in the earlier case.” But “the jury cannot decide a disputed question of law

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45 Daugert v. Pappas, 104 Wash. 2d 254, 258 (1985) (collecting cases); RONALD E. MALLEN & JEFFREY M. SMITH, LEGAL MALPRACTICE § 30.52, at 1259 (2005) (noting that most courts regard this as a question of law).

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Washington: 104 Wash. 2d at 258–59. Geer v. Tonlon, 137 Wash. App. 838, 844–45 (2007) (following Daugert on this issue and declaring that same rule applies to “other attorney actions or omissions” involving legal questions); Halvorsen v. Ferguson, 46 Wn. App. 708, 713 (1987) (where lawyer alleged not to have made the best arguments, court decides whether different arguments would have produced different results).

Illinois: Governmental Interins. Exch. v. Judge, 221 Ill. 2d 195, 210–212 (2006);


47 Millhouse v. Wiesenthal, 775 S.W.2d 626, 628 (Tex. 1989).

on the testimony of lawyers.”

“[i] Insurer’s Misjudgment About Legal Position Is Also Analogous to that of Judgmental Immunity in Legal Malpractice

The law of legal malpractice provides another, even closer, analogy to the law of bad faith, though one where the roles of judge and jury are less well defined. Under the law of first-party bad faith, an insurer has a “right to be wrong” about the legal position it takes without being subject to liability, so long as that position was fairly debatable. (See § 5.02[2] above.) Under the law of legal malpractice, a lawyer has a similar right:

In general, mere errors in judgment … do not subject an attorney to liability for legal malpractice. This rule has found virtually universal acceptance when the error involves an uncertain, unsettled or debatable proposition of law.

As one commonly quoted court has put it, there is no liability for a judgmental error regarding a proposition of law “which has not been settled by a court of last resort in the State and on which reasonable doubt may be entertained by well-informed lawyers.” “An attorney is not negligent … when he exercises judgment in a matter of doubtful construction.”

A leading treatise explains the rationale for this rule:

The professional is distinguished from other skilled and knowledgeable individuals because undertakings usually require the exercise of judgment to resolve issues that are uncertain and subject to disagreement even among the most learned. Of all professionals, however, lawyers are the most vulnerable to an error revealed in hindsight. The essence of the legal system portends a high frequency of errors. Unlike any other profession, the practice of law often involves a process by which attorneys must take positions inconsistent to those of their clients’ adversaries, antagonists or competitors. Usually, only one side will prevail.

While a lawyer must exercise care in forming any judgment, including the conduct of any necessary research, “[i]f the law is truly debatable or unsettled, research will not necessarily lead an attorney to a correct conclusion,” if correctness is judged by what a court later decides the law to be. Of course, “even on doubtful matters, attorneys are expected to perform sufficient

49 280 Ore. at 573.
50 Charles Reinhart Co., 444 Mich. at 601 (emphasis original).
55 RONALD E. MALLEN & JEFFREY M. SMITH, LEGAL MALPRACTICE § 19:6, at 1204. Where the law is unsettled, a lawyer should not rely solely on an attempt to predict how the question will be resolved if it is
research to enable them to make an intelligent and informed judgment for their clients.”

The exercise of judgment, however, may not require that every issue be researched:

Lawyers build their knowledge and experience over a legal lifetime. Lawyers gain recognition because [of] their ability to provide answers quickly, without conducting research on every point. Thus, exercise of legal judgment involves: (1) consideration of the issue; and (2) a decision to research if the lawyer’s understanding is uncertain.

Like providing legal advice, insurance claim handling has an adversarial aspect, as insurers must be vigilant to detect unfounded claims and have the right to challenge those that are legally questionable, even realizing that some of the questioned claims will be found legally meritorious. Thus, the reasons for judgmental immunity in legal malpractice cases are much like those for limiting insurer liability in bad faith cases. There are strong parallels between the two areas of law. Just as lawyers must exercise judgment whether research is necessary, claim personnel must decide whether it is necessary to seek a legal opinion, or whether the policy language is adequately clear that legal advice is unnecessary.

Case law on the functions of judge and jury regarding judgmental immunity is limited. Courts have found lawyers immune as a matter of law when they rendered what turned out to be erroneous advice regarding law that was then unclear. And, once again, the court is more competent than a jury to determine whether the law really was unclear at the time the lawyer gave the advice. Nor should a lawyer’s judgment be subject to attack as uninformed unless the plaintiff can identify some important consideration the lawyer overlooked. Even if some such consideration is identified, a leading treatise argues that no liability should be permitted with respect to the lawyer’s judgment about what research was necessary:

Both policy and practical considerations dictate that an attorney who exercises an informed judgment should not be liable for the possible “to advise a client to follow [a] reasonably prudent course of action in light of the uncertainty.”


Ronald E. Mallen & Jeffrey M. Smith, Legal Malpractice § 19:6, at 1205.

Ronald E. Mallen & Jeffrey M. Smith, Legal Malpractice § 19:6, at 1203.

California: Sprague v. Morgan, 185 Cal. App. 2d 519, 523 (1960) (lawyer not liable for taking view of law supported by a dissent);

Minnesota: Meagher v. Kalvi, 256 Minn. 54, 60–61 (1959) (same);


adequacy of his or her research, investigation, and thought processes. Imposing liability for advising on an unsettled or debatable proposition of law is likely to abrogate the error of judgment rule.

A problem is that a lawyer’s judgmental decisions invariably are challenged in hindsight. The standard usually is a subsequent judicial decision that has clarified the law or decided the proposition. That decision establishes the criteria that a client’s expert witness in a legal malpractice suit can use to explain the thought processes the lawyer should have followed, and the research and investigation methods that should have been undertaken. No lawyer who reached a different conclusion could have complied with such a standard of care. Those who fail to pass the test of hindsight may face a legal malpractice claim. Thus, although the choice among unsettled alternatives may be protected, that protection will be lost if the lawyer did not use the research techniques advocated by the plaintiffs expert witness. Such an exception threatens to destroy the protection of the rule.61

But Clark County Fire District No. 5 v. Bullivant Houser Bailey, P.C.,62 treated judgmental immunity as presumptively a jury issue, though subject to resolution as a matter of law if reasonable minds could not differ.63 It opined that, “[u]nder the attorney judgment rule a plaintiff can avoid summary judgment on breach of duty for an error in judgment in one of two ways.”64 One of these focused on the proposition that

to avoid liability under the attorney judgment rule the attorney’s judgment must be an informed one. In other words, even if the decision itself was within the reasonable range of choices, an attorney can be liable if he or she was negligent based on how that decision was made .... [I]f sufficient evidence of such negligence exists, the jury must decide the issue.65

That is consistent with the analysis here, though one would have liked a more specific discussion of the need to show that the attorney failed to discover or consider something that would lead to a different conclusion.

But, on the actual legal judgment, the court also deemed that a possible subject for jury decision. A plaintiff could avoid summary judgment by showing that

63 2014 Wash. App. LEXIS 977, ¶ 34.
64 2014 Wash. App. LEXIS 977, ¶ 35.
65 2014 Wash. App. LEXIS 977, ¶ 36 (citation omitted).
the attorney’s exercise of judgment was not within the range of reasonable choices from the perspective of a reasonable, careful and prudent attorney in Washington. Merely providing an expert opinion that the judgment decision was erroneous or that the attorney should have made a different decision is not enough; the expert must do more than simply disagree with the attorney’s decision. The plaintiff must submit evidence that no reasonable Washington attorney would have made the same decision as the defendant attorney. If there is a genuine issue as to whether the attorney’s decision was within the range of reasonable choices, the jury must be allowed to decide the issue.\textsuperscript{66}

But it makes no more sense to have a jury determine the reasonableness of a legal judgment than it would to have it determine whether an appellate argument would have succeeded. That is an issue outside a jury’s competence and at the core of the court’s competence.

For much the same reasons that lawyer’s judgmental immunity ordinarily should be a matter of law, so should the question of whether an insurer’s legal position was fairly debatable. There is a strong public interest in protecting the right of insurers to challenge questionable claims, and the court is more competent than a jury to assess the state of the law at the time the insurer made its claim decision.

§ 17.05 First-Party Bad Faith Law in Some States May Limit Availability of Judgment as a Matter of Law

[1] Arizona

[a] \textbf{Zilisch v. State Farm}: Even if Claim Is Fairly Debatable, It Must Be Fairly Debated

In \textit{Deese v. State Farm Mutual Automobile Insurance Co.},\textsuperscript{1} the Arizona Supreme Court held that the law of bad faith protects an insured’s intangible interest in fair handling of a first-party claim, such that there could be liability for use of improper procedures (there, a biased peer review system), even in the absence of coverage. (See § 5.06[2] above.) Nonetheless, liability turned on whether “the claim’s validity [was] ‘fairly debatable’ after an adequate investigation.”\textsuperscript{2} As such, summary judgment and judgment as a matter of law were available essentially on the basis described in §§ 17.03[4]–[5] above. But that changed with the decision in \textit{Zilisch v. State Farm Mutual Automobile Insurance Co.}\textsuperscript{3}

\textit{Zilisch} arose from a UIM claim. Zilisch was seriously injured while a passenger. The tortfeasors were drag racing.\textsuperscript{4} She collected $146,500 in benefits from the tortfeasors’ insurers,

\textsuperscript{66} See § 17.03 above.
\textsuperscript{2} \textit{Rawlings v. Apodaca}, 151 Ariz. 149, 156 (Sup. Ct. 1986).
\textsuperscript{4} According to Zilisch’s lawyer, Calvin Thur, Zilisch’s fiancee was killed in the accident and the drag-racing tortfeasors plead guilty to second-degree murder. Calvin Thur, \textit{Letter to the Publisher}, 16 \textit{BAD
exhausting at least one of the policies. On December 19, 1991, Zilisch’s lawyer demanded the $100,000 policy limit under her own State Farm UIM coverage. He declared that he did not want a counter offer, but only the full limit.  

Zilisch’s primary injury was to her left eye. She was examined by several doctors, including Dr. Hoyt, a leading neuro-opthamologic surgeon, who advised that the injury was permanent and uncorrectible. Scott Chan, State Farm’s claim representative, interviewed Zilisch and reported that she appeared to have the problem she described. He requested medical records, including those of Dr. Hoyt. Initially, he was told that Dr. Hoyt had no records, but, on January 20, 1992, Dr. Hoyt orally confirmed that the injury was permanent, and a consultant retained by Chan agreed after speaking with Dr. Hoyt. Dr. Hoyt eventually submitted a written report on June 30, 1992.  

In July, Chan reported the case to his supervisor, suggesting that the tort settlements fully compensated Zilisch. The file was then reassigned to Donald Neu. According to the court of appeals, a check of verdict reporters showed no similar injuries and that eye injuries produced highly variable damages. In light of this check, Neu estimated the claim to be worth $15,000–20,000 more than the tort settlements (i.e. a total of $160,000–165,000). After attending Zilisch’s examination under oath in September 1992, Neu increased his estimate of the total value to $200,000–225,000. He obtained authority to offer $55,000–75,000, and offered $55,000. Zilisch rejected this.  

In preparing for arbitration, State Farm ordered an IME, which confirmed permanency. An internal memo recommended not increasing the offer because Zilisch had ruled out anything less than limits. The arbitrators awarded $387,500, and State Farm paid the $100,000 limit.  

Zilisch sued for bad faith, recovering $460,000 in compensatory damages and $540,000 in punitive damages. The trial court found no basis for punitive damages, but entered judgment for compensatory damages. The Arizona Court of Appeals directed that judgment be rendered for State Farm. Zilisch had attacked State Farm’s handling of her claim by showing other acts of bad faith by State Farm and practices allegedly designed to underpay claims. State Farm’s appeal focused on her claim, arguing that its value was fairly debatable. The court agreed that, on the facts here, fair

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5 196 Ariz. 234, ¶¶ 2–3, 12.  
6 196 Ariz. 234, ¶ 4–7.  
7 196 Ariz. 234, ¶ 8–9.  
8 Zilisch v. State Farm Mut. Auto. Ins. Co., 194 Ariz. 34, 36 (Ct. App. 1998). Some of the facts set forth here are found in the opinion of the court of appeals, which the supreme court reversed. But nothing in the supreme court’s opinion suggests that the court of appeals inaccurately described the record, or that facts it found undisputed were actually in dispute. The two opinions will be cited as “Zilisch (Sup.)” and “Zilisch (App.).”  
9 Zilisch (Sup.) 196 Ariz. 234, ¶¶ 9–11.  
10 196 Ariz. 234, ¶ 12.  
12 Zilisch (App.), 194 Ariz. 34, ¶ 35.
debatability is an issue of law, reviewable de novo by it.\textsuperscript{13}

As it viewed the record, reasonable minds could not differ that Zilisch’s injuries, while serious, were not catastrophic. She had vision problems, but retained substantial vision. Cosmetic problems had resolved. Her emotional upset was not unusually great. And it concluded there was no indication of any impact on her earning capacity.\textsuperscript{14} There was no contention that State Farm could or should have done more investigation of this unique injury.\textsuperscript{15} Zilisch’s expert supported a high valuation of her claim, but did so in a conclusory manner, with little factual support. Moreover, his views were highly colored by his disapproval of State Farm’s claim handling practices, both generally and in this case. Because, in the view of the court of appeals, fair debatability is a threshold question, other aspects of the claim handling are irrelevant in determining it.\textsuperscript{16}

The Arizona Supreme Court reversed on that issue and remanded for consideration of other issues.\textsuperscript{17} In its view, even when a claim is fairly debatable, “an insurer must exercise reasonable care and good faith.”\textsuperscript{18} It viewed fair debatability as a question implicating the insurer’s reasonable belief, rather than a purely objective determination based on the facts of the claim.\textsuperscript{19} The insured has a right to “‘honest and fair treatment,’ ” and “if an insurer acts unreasonably in the manner in which it processes a claim, it will be held liable for bad faith ‘without regard to its ultimate merits.’ ”\textsuperscript{20}

The court of appeals had erred in “focus[ing] exclusively on the amount ultimately offered by the carrier.”\textsuperscript{21} The insurer should investigate adequately and quickly, evaluate reasonably, and act promptly. “It should not force an insured to go through needless adversarial hoops to achieve

\textsuperscript{13} 194 Ariz. 34, ¶¶ 15–19.
\textsuperscript{14} 194 Ariz. 34, ¶¶ 21. In responding to a commentary published right after the supreme court’s Zilisch decision, Zilisch’s counsel, Calvin Thur, stated that State Farm knew that she was at risk to lose her job because of her injuries and she in fact was removed from certain job responsibilities. Calvin Thur, Letter to the Publisher, 16 BAD FAITH L. REP. 133, 134 (2000). Assuming this is true, it does not appear from the opinion that she lost her job or suffered decreased income. The risk may have increased her emotional distress, but there apparently was no economic loss other than medical expenses. Mr. Thur also disputes the court of appeals’ account, primarily suggesting that the impact of the injury on Zilisch’s life was greater than the court of appeals indicated. 16 BAD FAITH L. REP. at 134.
\textsuperscript{15} Zilisch (App.), 194 Ariz. 34, ¶ 22.
\textsuperscript{16} 194 Ariz. 34, ¶ 23–27. One of the court’s points was that the clear liability of the drag-racing tortfeasor was irrelevant to determination of the amount of damages. 194 Ariz. 34, ¶ 26. Mr. Thur argues that juries regularly award higher damages in cases of clear or outrageous misconduct (a point State Farm’s claim manual recognized). 16 BAD FAITH L. REP. at 134. While that is true, the court of appeals pointed out that the liability facts in Zilisch should not even be presented in a trial whose only issue would be damages. Moreover, increased emotional distress awards based on outrageous conduct are an informal form of punitive damages. A UM/UIM insurer has no need to be deterred and cannot properly be punished for the tortfeasor’s misconduct.
\textsuperscript{17} Zilisch (Sup.) 196 Ariz. 234, ¶ 26.
\textsuperscript{18} 196 Ariz. 234, ¶ 19.
\textsuperscript{19} 196 Ariz. 234, ¶ 20. “While an insurer may challenge claims which are fairly debatable, its belief in fair debatability “is a question of fact to be determined by a jury.” Id. (citation omitted).
\textsuperscript{21} 196 Ariz. 234, ¶ 21.
its rights under the policy. It cannot lowball claims hoping the insured will settle for less.”

According to the court, there was evidence that State Farm set arbitrary goals for the reduction of claims paid, and that salaries and bonuses were influenced by achievement of those goals. The jurors could have concluded that the insistence in seeing a report Dr. Hoyt had not yet prepared was “a pretext to drag out the claims process.” State Farm took nearly ten months to respond to the initial policy limits demand, four months after receiving Dr. Hoyt’s report. Nor did State Farm ask for an IME until after it had made its initial offer of $55,000.

According to the supreme court, State Farm’s evaluation during the time before it made its offer went from zero to $15,000–20,000 to $55,000–75,000, without receiving any new information after Dr. Hoyt’s report. “Even after State Farm’s lawyer recommended offering $75,000, State Farm refused to offer more than $75,000.”

[b] Critique of Zilisch

The significance of the facts stated by the supreme court is mystifying. Strikingly, the supreme court did not comment on Zilisch’s expert testimony asserting that the claim was worth more than the policy limit, evidence the court of appeals found conclusory and inadequate. If the supreme court had disagreed on that point, it could simply have said so and held that State Farm’s offer was too low. If that had been clearly true, then the verdict could have been affirmed without the various innovative points made by the court. But the court chose instead to say that the adequacy of the offer did not dispose of the bad faith claim. Implicitly, the court seems to have accepted the objective reasonableness of the offer. It certainly never says that the jury could have found that State Farm should have offered the policy limit.

Nor does it seem strange that, having evaluated the claim at $55,000–75,000, State Farm chose to make an initial offer of $55,000. It is certainly a common negotiating technique to offer something less than one is willing to pay, expecting to increase the offer if the other party shows any willingness to negotiate. But the offer of less than the maximum amount State Farm was then willing to pay seems the only conduct even arguably describable as “lowballing.” Regardless, the

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22 196 Ariz. 234, ¶ 21.
23 196 Ariz. 234, ¶ 23.
24 196 Ariz. 234, ¶¶ 23–24. While Dr. Hoyt had orally confirmed permanency, the court of appeals reports that he had also opined that Zilisch seemed to be doing well. Zilisch (App.) ¶ 9. Because the issue on valuation included not only permanency, but severity, that would seem an arguable reason for wanting a report. And his actual report described her condition as “not a significant disability” and one that could be compensated, if needed, with reading glasses.” Id. ¶ 10. Mr. Thur asserts that Dr. Hoyt’s report “was not even mentioned or relied upon when State Farm did its evaluation four months after receiving the report,” and refers to other evidence indicating greater severity. Calvin Thur, Letter to the Publisher, 16 BAD FAITH L. REP. 133, 134 (2000). But what State Farm actually relied upon would seem to relate to the subjective element (knowledge or reckless disregard of the lack of a basis) rather than to the distinct question of whether, objectively speaking, the claim was fairly debatable.
25 Zilisch (Sup.), 196 Ariz. 234, ¶ 23.
26 196 Ariz. 234, ¶ 24. According to the court of appeals, the first increase followed adjuster Neu’s check of verdict reporters, which is surely new information, albeit information equally available to the predecessor adjuster. The second increase followed Neu’s attendance at Zilisch’s examination under oath, which seems clearly to be new information.
27 196 Ariz. 234, ¶ 24.
amount of the offer seemingly caused no harm. Zilisch had declared disinterest in anything less than policy limits and neither opinion reports evidence that she would have taken anything less.\(^{28}\) Seemingly it would have made no difference had State Farm offered $75,000.

And even if State Farm took longer than it should have to make the offer, it is unclear that the delay caused any harm. Had State Farm made the $55,000 offer sooner, it still would have been necessary to arbitrate the claim, as Zilisch presumably would still have rejected that offer. It might be that a quicker evaluation would have gotten the parties to arbitration sooner, but neither opinion says so. In particular, State Farm might have been entitled to some sort of report from Dr. Hoyt as evidence for the arbitration, even if negotiations had reached an early impasse. Finally, even if State Farm should have evaluated instantly, that would at most have saved ten months in getting $100,000 to Zilisch. It is very difficult to imagine how such a delay could have caused $460,000 in compensatory damages.

\textit{Zilisch} appears to allow liability so long as the jury could find something objectionable about the claim handling, without requiring any proof that the supposed mishandling harmed the insured. Moreover, the conduct it says the jury could have found to constitute bad faith does not seem so unreasonable as the court says the jury could have found it. So, it is hard to see any principled basis for the decision.

Even if the record showed unsavory practices, those practices do not seemed to have harmed Zilisch. The insurance commissioner might wish to act against such practices. But an insured ought not to have a tort claim absent a showing of injury to that insured caused by those practices.\(^{29}\) Apart from the usual requirements of tort law, it will be possible for an insured to point out real or imagined imperfections in the handling of many, perhaps most claims. If any such imperfection can support a bad faith action, even without any showing of resulting injury, the potential volume of litigation boggles the mind, especially if every claim opens the way to try the insurer’s practices in handing other claims (as \textit{Zilisch} apparently allowed).

Of particular significance here, the court seems to eliminate the formerly separate requirement of objectively unreasonable conduct and to focus primarily on the insurer’s state of mind. In short, bad attitude, standing alone, now seems to be actionable, and jurors may be given great license to find bad attitude. To be safe, insurer will likely have to pay claims and parts of claims that are subject to significant dispute, lest a jury find some misstep in the claim handling. In the end, such a rule will necessarily inflate insurance costs to confer benefits that would not be due if entitlement were tested in court. That is exactly the result that courts in other states have shaped bad faith law to avoid.

The \textit{Zilisch} court offers no justification for the legal rules it announces. Other courts ought not to follow those rules.

[c] Consequences of \textit{Zilisch}

Review of the reported Arizona cases (state and federal) does not reveal changes in case

\(^{28}\) Nor did Mr. Thur’s letter to the publisher report any such evidence. And it is easy for a plaintiff to declare after the fact, if it is true, that she would have taken some amount had that only been offered.

\(^{29}\) The Arizona court is in a small minority that have allowed bad faith liability in the absence of any injury to an interest of the insured more concrete than the intangible right to “honest and fair treatment.” (\textit{See} § 5.06[2] \textit{above}.\))
results as dramatic as Zilisch’s language seemed (and still seems) to portend. Of course, Zilisch’s impact may be more clearly reflected in settlements and unreported trial court opinions, both of which are invisible to the outside observer.

Insurers still get at least some summary judgments, though sometimes in cases where they appear to have gone many arguably extra miles and the court is prepared to characterize a demand that they go further as unreasonable.30 Courts have sometimes been willing to say that, while an insurer had misinterpreted the relevant law, its interpretation was objectively reasonable and precluded bad faith liability.31 One federal court has suggested that the novel rules announced by Zilisch may apply only where the issue is the amount of the injury, rather than existence of coverage.32

Other cases have denied summary judgment when it might well have been denied under the law before Zilisch:

• a jury might be permitted to find that an insurer acted unreasonably in failing to include general contractor’s overhead & profit in its computations of actual cash value, where the court concluded that it could not be categorically excluded, Arizona Supreme Court dicta had cast doubt on the propriety of failing to include it, the insurer did not seek a legal opinion on the issue, and the facts bearing on whether it should have been included on the particular claim were not well developed;33

• a jury might be permitted to find that an insurer acted unreasonably where insurer changed its interpretation of key language adversely to insureds after the policy in suit was issued, court finds that language ambiguous, and the relevant Arizona legal principles at least cast doubt on any genuine dispute as to insurer’s interpretation;34

• jury could find that expert was not provided with all relevant information and that it was bad faith to rely on his inadequately informed estimate.35

But some cases do appear to have been resolved differently under Zilisch than they would have been before:

• even if an insurer’s legal position was fairly debatable, a jury might find bad faith “‘if the evidence shows its employees could not or did not reasonably believe that [the claimant’s demand] could be rejected within the bounds of the law;’”36

jury might find that insurer’s repeated changes of position, finding new reasons to deny claim involved “setting up a series of ‘needless adversarial hoops;’” insurer also took arguably unreasonable amount of time to evaluate the claim.  


[i] The Case

[A] Overview

Lennar Corp. v. Transamerica Insurance Co., 38 held that a later-reversed trial court summary judgment that there was no coverage did not preclude claims that the denial had been in bad faith. It also extended certain unusual principles of Arizona bad faith law in new directions. This subsection examines and criticizes that holding and some of the unusual features of Arizona bad faith law which affected availability of summary judgment on bad faith in Lennar. But it offers a reading that suggests a possible extension of bad faith law that might be reconcilable with traditional principles.

[B] Facts  

Lennar (actually a group of related companies) developed 105 homes in a project called Pinnacle Hill. Homeowners complained of construction defects and eventually filed multiple suits against Lennar. In December, 1998, Lennar tendered these to its insurers, which filed an action in October, 2000 seeking a declaration that there was no duty to defend and no coverage because, inter alia, the defects did not constitute an “occurrence” within the meaning of the policies. The superior court agreed and granted summary judgment, but the court of appeals reversed as to the duty to defend. 40 By 2003, Lennar had settled all of the homeowners’ claims, 41 but litigation continued over coverage and bad faith.

Lennar did not perform any of the actual construction of the homes, subcontracting all of that work to others. Before construction began, Lennar obtained a geotechnical evaluation of the soils, which reported that the soils were subject to expansion and settlement if exposed to excessive moisture, but Lennar represented otherwise to permitting authorities, who issued a public report to that effect. The homes were completed between December 1993 and September 1995. 42

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40 Lennar II, 256 P.3d 635, ¶¶ 2–6, describing decision in Lennar I.
42 Lennar I, 214 Ariz. 255, ¶ 2.
Homeowners soon began complaining of problems including cracking drywall. In September 1998, a suit was filed alleging that Lennar negligently oversaw construction and negligently allowed construction on expansive soil, complaining of wall cracks, tile grout cracks and separation, baseboard separation, and sticking doors. Additional suits were filed and consolidated with the first, collectively referred to as the “Pinnacle Hill lawsuit.” The complaints were amended to add claims for fraud. Lennar tendered these suits to its insurers and those of subcontractors whose work was implicated, under whose policies Lennar was an additional insured.43

Both Lennar and the plaintiffs commissioned investigations of the cause of the problems:

Lennar hired Roel Consulting Group to investigate the problems at Pinnacle Hill, determine the cause of the property damage and implement a remediation plan to prevent further damage to the homes. After inspection and testing, Roel and its consultants concluded that the primary cause of damage to the Pinnacle Hill homes was deficient work by various subcontractors. Of relevance to this appeal, it concluded that Wheeler, the rough grader, failed to properly compact fill soil, provide adequate draining and build non-expansive building pads. It further concluded that Morrison, the framing subcontractor, inadequately secured the exterior walls, improperly fastened the interior walls, and failed to install adequate backing for the stucco and drywall, and that Metro Drywall, the drywall subcontractor, failed to attach the drywall to an adequate backing and concealed the deficiencies of other subcontractors’ work.

In October 1999, the Pinnacle Hill plaintiffs disclosed that they had retained an expert, Randy Marwig, who had evaluated the soils at Pinnacle Hill and discovered that the soils were expansive. One month later, Marwig acknowledged in his deposition that his initial report, in which he had attributed the property damage to soil subsidence, had assumed that the homes were constructed in accordance with the plans and specifications. Marwig further stated that he now believed that not to be the case and that this could potentially cause him to reassess whether the problems were “the result of expansive soil movements or the result of construction deficiencies or structural inadequacies ….” He explicitly stated that there may be “specific deficiencies which may be either made worse or created by the construction deficiencies … even in the absence of soil movement.”44

Lennar presented this information to its insurers. They continued to deny coverage but filed a coverage action, seeking a declaration that they owed no coverage. Lennar counterclaimed for bad faith.45 One insurer began providing a defense in September, 2001.46

43 214 Ariz. 255, ¶¶ 3–4 & n.1.
44 214 Ariz. 255, ¶¶ 5–6 (footnote omitted).
45 214 Ariz. 255, ¶¶ 7–8.
The Coverage Ruling

The superior court granted summary judgment in favor of all insurers. On appeal, Lennar argued that at least the negligent construction claims were covered. The insurers responded by arguing that:

even the negligent construction count does not trigger their duty to defend because: (1) faulty workmanship cannot constitute an occurrence under Arizona law; (2) the natural consequences of faulty workmanship cannot constitute an occurrence; (3) the workmanship, whether faulty or not, does not constitute an occurrence because an occurrence must be an accident and the subcontractors intended to accomplish the work in the way that they did; (4) the complaint did not allege negligence in the work of specific subcontractors sufficient to create a duty for insurers of that subcontractor’s scope of work to provide a defense to Lennar; and (5) if there were “occurrences,” they happened before some or all of the policies were in effect.

The court of appeals rejected these arguments. While faulty workmanship, standing alone, is not an occurrence, damage to other property resulting from faulty workmanship can be. Arizona law does not preclude the unintended natural consequences of faulty construction from constituting an occurrence. Even if the construction was done exactly as the subcontractors intended, any property damage resulting from that deficient construction could still be accidental. While the complaints did not allege deficiencies in the work of any particular subcontractor, the investigation results, known to the insurers, identified particular subcontractors and required their insurers to respond. While the allegedly faulty construction occurred before the inception of some of the policies at issue, there may have been ongoing damage during the policy periods. Accordingly, there had been a possibility of covered liability and a duty to defend.

For purposes of bad faith analysis, it is significant that the court recognized that there is authority in other jurisdictions for the proposition that the natural consequences of faulty construction, even if unintended, do not constitute an occurrence. But it rejected that authority as a minority position and, in its view, contrary to the plain language of the policies. The court cites no prior Arizona authority on that issue and the principal briefs reveal none.

47 Lennar I, 214 Ariz. 255, ¶ 16.
52 214 Ariz. 255, ¶ 30–33.
54 214 Ariz. 255, ¶ 21.
55 214 Ariz. 255, ¶ 22.
56 There was a great deal of briefing on the coverage issue, and we have examined only what one of the lawyers in the case identified as the principal briefs.
The Bad Faith Ruling

After the appellate ruling on duty to defend, the insurers moved for summary judgment on the bad faith claims, arguing that the superior court ruling in their favor, though later reversed, established as a matter of law that they had a reasonable basis for denying coverage. The superior court agreed and granted summary judgment. The court of appeals again reversed.

Most jurisdictions recognizing a first-party bad faith claim follow the standard enunciated in *Anderson v. Continental Insurance Co.*: “To show a claim for bad faith, a plaintiff must show the absence of a reasonable basis for denying benefits of the policy and the defendant’s knowledge or reckless disregard of the lack of a reasonable basis for denying the claim.” (See § 5.03[2]) Arizona adopted that formulation. Arizona has imposed the following gloss on that standard, as summarized by the *Lennar II* court:

The covenant of good faith and fair dealing requires an insurer “to play fairly with its insured.” The insurer owes the insured “some duties of a fiduciary nature,” including “[c]onideration, fairness and honesty.”

Our supreme court … described some of the obligations the duty of good faith imposes on an insurer:

The carrier has an obligation to immediately conduct an adequate investigation, act reasonably in evaluating the claim, and act promptly in paying a legitimate claim. It should do nothing that jeopardizes the insured’s security under the policy. It should not force an insured to go through needless adversarial hoops to achieve its rights under the policy. It cannot lowball claims or delay claims hoping that the insured will settle for less. Equal consideration of the insured requires more than that.

The court of appeals rejected the argument that an erroneous summary judgment establishes that, as a matter of law, the argument accepted by the superior court was fairly debatable. It went on to conclude that there were material issues of fact precluding summary

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56 *Lennar II*, 256 P.3d 635, ¶ 5.
57 256 P.3d 635, ¶ 32.
60 *Lennar II*, 256 P.3d 635, ¶¶ 8–9 (citations omitted).
61 256 P.3d 635, ¶¶ 14–17, citing *EOTT Energy Operating Ltd. P’ship v. Certain Underwriters at Lloyds’ of London*, 59 F. Supp. 2d 1072, 1080 (D. Mont. 1999); *Filippo Indus., Inc. v. Sun Ins. Co. of New York*, 74 Cal. App. 4th 1429, 88 Cal. Rptr. 2d 881, 889 (1991) (“We certainly have great faith in the sagacity and reasonableness of trial judges, but we decline to impute infallibility to any court, trial or appellate.”); *Robinson v. State Farm Fire & Cas. Co.*, 583 So. 2d 1063, 1066 (Fla. Dist. Ct. App. 1991) (“It makes no sense that an insurer who asserts a coverage issue that, for any reason, withstands summary judgment, but ultimately fails, would be excused from all of the good faith obligations imposed on the insurer who admits coverage.”).
judgment in *Lennar II*. While both the superior court decision and the court of appeals reversal would be relevant evidence on whether the coverage issue was fairly debatable, the court concluded that other evidence would also be relevant:

Whether the reasonableness of an insurer’s coverage position may be determined as a matter of law depends on the nature of the dispute and other factors, including whether extraneous evidence bears on the meaning of the contested policy language. The fair debatability of the insurers’ coverage positions in this case turns in large part on the interpretation of standard language in the form policies the insurers issued to Lennar. The interpretation of an insurance contract generally is a question of law for the court. But when the policy is reasonably susceptible to more than one meaning, the court may allow extrinsic evidence, and when that evidence “establishes controversy,” the question properly is given to the jury.\(^\text{62}\)

Moreover, “[w]hen, as here, the policies are written on a standard industry form, evidence of how these insurers, other insurers and other courts have interpreted the policy language in other cases may bear on whether these insurers acted reasonably in disputing coverage.”\(^\text{63}\) In the court’s view, “whether the insurers acted reasonably in challenging Lennar’s claims based on the meaning of “occurrence” in the policies was a question for the jury to resolve,” considering all of the relevant evidence.\(^\text{64}\)

To establish a bad faith claim, Lennar would need to prove both that the coverage issue was not “fairly debatable” (i.e., that the insurers had no reasonable basis to deny coverage) and that the insurers either knew that or recklessly disregarded it. What the insurers believed is normally a jury issue. The court commented as follows on the evidence which might bear on that issue:

In responding to the insurers’ motion for summary judgment, Lennar offered evidence that some of the insurers knew homebuilders that bought their commercial general liability policies intended to obtain coverage for damages resulting from construction defects. On remand, this evidence may bear on the insurers’ subjective belief in the reasonableness of the coverage positions they took. Also relevant may be evidence of prior positions these insurers have taken in similar cases and these insurers’ knowledge of judicial interpretations of the policy language in other cases and their knowledge of positions other insurers or industry groups have taken in other similar cases.\(^\text{65}\)

In most states, establishing that a claim was fairly debatable would preclude any bad faith

\(^{62}\) 256 P.3d 635, ¶ 19 (citations omitted).

\(^{63}\) 256 P.3d 635, ¶ 20 (citation omitted).

\(^{64}\) 256 P.3d 635, ¶ 21.

\(^{65}\) 256 P.3d 635, ¶ 22.
But, under Arizona law,

“[w]hile fair debatability is a necessary condition to avoid a claim of bad faith, it is not always a sufficient condition. The appropriate inquiry is whether there is sufficient evidence from which reasonable jurors could conclude that in the investigation, evaluation, and processing of the claim, the insurer acted unreasonably and either knew or was conscious of the fact that its conduct was unreasonable.”

Lennar complained that, despite compelling evidence of problems due to causes other than expansive soils, the insurers conducted no investigation of the causes of the damage complained of, continued to insist that all of the alleged damages were caused by soil problems, and offered no contributions toward settlement, and that (with one exception) they offered no payments toward defense costs.

In the court’s view, the evidence created genuine issues of material fact as to the insurers’ good faith in handling the claim.

The case was remanded for further proceedings on bad faith.

[i] Analysis

[A] Key Components of the Lennar II Ruling Are Questionable, At Least Under Generally Accepted Principles of Bad Faith Law

The bad faith ruling had three components. First, the court held that “an erroneous grant of summary judgment does not conclusively establish that coverage is fairly debatable.” Second, it held that, in the circumstances there, the issue of fair debatability was a jury question. Third, it held that, even if coverage had been fairly debatable, the insurers might still have breached their duty to fairly handle the claim. Each of these holdings addresses an important issue, and each is questionable. To varying degrees, each may rest on peculiar features of Arizona law. This discussion will analyze each holding in terms of both principles of bad faith law accepted elsewhere and under the sometimes divergent law of Arizona.

As shown in § 17.03[5][b][i] above, insurer-favorable judicial rulings on coverage can establish the existence of a reasonable basis to test the claim in court. Under that principle, the superior court’s ruling would ordinarily seem to preclude a finding of bad faith. But, as explained in § 17.03[5][b][i][D] above, if the plaintiff can show that, through no fault of the plaintiff, the court which previously ruled in favor of the insurer on coverage was not presented with evidence or argument which would have had a reasonable probability of altering its ruling, that would

66 See § 17.03, above.
68 256 P.3d 635, ¶¶ 26–28 & n.5.
69 256 P.3d 635, ¶ 31.
70 256 P.3d 635, ¶ 32.
71 256 P.3d 635, heading before ¶ 14 (capitalization omitted).
justify a fresh consideration of whether, in light of all that the insurer knew or should have known at the time it delayed or denied payment, it had a reasonable basis for doing so. Even more clearly, if the plaintiff can show that the prior ruling was obtained by presentation of false evidence, then that ruling ought not to preclude fresh consideration of bad faith. The facts in Lennar II may have made the latter principles applicable. (See § 17.05[1][d][2][b] above.)

Unless there is some question about what the insurer knew or should have known, existence of first-party bad faith in most jurisdictions is ordinarily a question of law, not a question of fact. (See § 17.04) No prior Arizona case has suggested otherwise. Insofar as Lennar II suggested that evaluation of the reasonableness of an insurer’s conduct might be a jury question, that suggestion seems highly questionable. However, the opinion indicates that there were questions regarding the insurers’ knowledge of certain facts that the court deemed relevant to the reasonableness of that decision. The relevance of some of those facts may be questioned (see § 17.05[1][d][ii][B] below, but if they were relevant, the state of the insurers’ knowledge could be a jury question, even under the analysis offered here. The opinion is unclear as to exactly what question or questions would be before the jury. So, it is hard to determine whether the opinion is consistent on that point with the analysis here.

In most jurisdictions, showing that a claim was fairly debatable would preclude bad faith liability, as long as the insurer did not injure any interest independent of the insured’s rights under the policy. (See §§ 5.06, 17.03 above.) But Arizona does not limit bad faith liability to cases where there is coverage or where noninsurance interests are injured. (See § 5.06[2][b][i] above.) Moreover, Zilisch v. State Farm Mutual Automobile Insurance Co. holds that fair debatability of a claim is not a complete defense to bad faith liability. (See § 17.05[1][a] above.) Even if analytically questionable, these decisions were binding in Lennar II.

In the wake of Zilisch, some courts took the view that its principles applied only where the existence of coverage was clear but there was a dispute as to the value of the claim. That would greatly limit the most questionable implications of Zilisch and would largely preserve the analytical framework established by Noble.

While the analysis here would indicate that such a reading of Zilisch would be desirable, Lennar II clearly does not accept that reading.

[B] The Facts in Lennar II Might Support a Deviation from the Usual Rules

Putting aside the summary judgment ruling in favor of the insurers, they would seem to have had a fair argument that out-of-state authority, acknowledged in Lennar I, supported a genuine dispute regarding their claim that the natural consequences of an intentional act did not constitute an occurrence. While that was a minority rule, there was apparently no Arizona authority bearing on that issue. So, it could be a subject of fair debate in Arizona. While that was

74 E.g., Young v. Allstate Ins. Co., 296 F. Supp. 2d 1111, 1121 n.14 (D. Ariz. 2004);
76 There might have been other issues that could also be said to be fairly debatable, but the acknowledgement in Lennar I regarding this issue makes it the easiest issue to analyze.
not the basis for the summary judgment ruling, a correct decision may be affirmed on any
ground.\textsuperscript{77}

But one must take account of the evidence described relating to the subjective
expectations or beliefs of various parties regarding the meaning of the policy language. The
significance of that evidence seems to flow from Arizona’s rules for the interpretation of
standardized or adhesion contracts, including insurance contracts. In particular,

“Although customers typically adhere to standardized
agreements and are bound by them without even appearing to
know the standard terms in detail, they are not bound to
unknown terms which are beyond the range of reasonable
expectation … [An insured who adheres to the [insurer’s]
standard terms does not assent to a term if the [insurer] has
reason to believe that the [insured] would not have accepted the
agreement if he had known that the agreement contained the
particular term. Such a belief or assumption may be shown by
the prior negotiations or inferred from the circumstances. Reason
to believe may be inferred from the fact that the term is bizarre
or oppressive, from the fact that it eviscerates the non-standard
terms explicitly agreed to, or from the fact that it eliminates the
dominant purpose of the transaction.”\textsuperscript{78}

That principle applies even if the unexpected provision unambiguously negates coverage
for particular claims. Presumably, it could be bad faith to rely on such a provision if the insurer
knew or recklessly disregarded the fact that the provision was unenforceable.

While that principle is directly applicable to contractual terms that were unknown to the
insured, it might also have some application to unexpected interpretations of terms that the
insured knew were part of the contract, even if a court would hold that interpretation to be
unambiguously correct. The evidence relied upon by the \textit{Lennar II} court might have been taken to
show that (1) Lennar (and other contractors) would never have agreed to buy the policies if they
had known that the insurers might contend that the policies did not cover liability for construction
defects that were the unintended but natural consequences of intended actions, (2) that the
contractors’ expectation of coverage was reasonable, and (3) that the insurers knew of this
reasonable expectation at the time they sold the policies. On this basis, it might be seen as
unreasonable (under Arizona law) to deny coverage on a basis contrary to the known reasonable
expectations of the insureds, despite some authority supporting such a denial, based on what that
court considered to be the unambiguous meaning of the policy.

While that would be a novel extension of bad faith law, it might be reconcilable with the
underlying basis for traditional principles. Lennar would argue that, if the facts asserted by
plaintiffs were true, the insurers were obliged to take account of the above principle of Arizona

\textsuperscript{77} \textit{Phoenix v. Geyler}, 144 Ariz. 323, 330, 697 P.2d 1073, 1080 (Ariz. 1985) (“If such grounds are apparent
in the record, then we should affirm, even though the trial court may have reached the right result for the
wrong reason.”).

\textsuperscript{78} \textit{Darner Motor Sales v. Universal Underwriters Ins. Co.}, 140 Ariz. 383, 391–92 (Sup. Ct. 1984), \textit{quoting
Co.}, 154 Ariz. 266. 271–73 (Sup. Ct. 1987) (applying rule to override unambiguous contractual language).
insurance coverage law and to recognize that, based on those facts, the insurers’ coverage argument was not fairly debatable in Arizona, even though some other jurisdictions accept that argument. The facts that Lennar sought to prove regarding the expectations of insureds and the knowledge of the insurers are fairly extreme, so that extension of traditional principles, even if accepted, would have fairly narrow application, even in jurisdictions that accept the insurance coverage principle articulated above. That application would be narrow (and not all jurisdictions would agree with Arizona on taking account of subjective expectations). So, it would not be surprising that no other case has passed on such a situation.

On that reading of Lennar II, and assuming that similar considerations applied to all of the insurers’ other arguments, denial or delay of benefits could have been in bad faith once any self-insured retentions were exhausted. While any need for jury interpretation of the contract was obviated by finding that its terms unambiguously favored Lennar, a finding of ambiguity or a finding that the language (on its face) unambiguously favored the insurers might then have presented a jury issue on whether the evidence called for interpretation of the contract in Lennar’s favor. Such a determination might be a necessary part of determining whether denial of coverage was bad faith (at least during the period before the superior court had ruled against coverage).

This reading would also provide an explanation why, on the facts in Lennar II, the superior court’s ruling on coverage did not establish, as a matter of law, that coverage was fairly debatable. Lennar had been precluded, during the coverage phase of the case, from developing the evidence described by the Lennar II court on the reasonable expectations of insureds and the insurers’ knowledge of those expectations. Thus the court was, at a minimum, not fully informed regarding the impact those expectations might have had on coverage. Given the Lennar I finding of coverage even without that evidence, a court might conclude that the evidence on that point would have had a reasonable probability of changing the ruling. On that basis, the ruling would not have been a reliable basis to preclude a finding of bad faith. (See § 17.03[5][b][i][D] above.)

That would still leave it unclear why it mattered that the insurers did not conduct further investigation (which would seem unnecessary if their claim decisions assumed the truth of the evidence presented by the insureds) or why (if they had good grounds to test the coverage issue in court) the insurers were subject to criticism for refusal to contribute to defense costs or settlement. On the other hand, Lennar may have been an insured who could have reimbursed insurer advances, had it been determined that nothing had been due. If so, the insurer might have mitigated any bad faith risk by offering some payments if Lennar would agree to reimbursement of any amounts determined not to have been due.

[2] [Reserved]

[3] Florida

Florida applies a unique “totality of the circumstances” standard (for both first-party and third-party claims) that is not readily susceptible to summary judgment or judgment as a matter of law. (See § 5.03[4] above.)

80 Lennar contended that the court had also relied on a false affidavit submitted by Auto-Owners. Lennar II, Appellants’ Opening Brief, 10–17.
Kentucky protects the right of an insurer to dispute fairly debatable claims. (See § 10.04[2][c][ii][B] above.) But there may be a requirement, of uncertain content, that any debate be conducted fairly. (See § 10.04[2][c][ii][C] above.)

Under Montana law, “[a]n insurer may not be held liable … if the insurer had a reasonable basis in law or in fact for contesting the claim or the amount of the claim, whichever is in issue.” But this does not yield the same results as similarly worded standards do in other states because the question whether an insurer’s view of the facts will be considered reasonable is generally one for the jury, not the court. But an insurer that has a defense to coverage as a matter of law will not be liable, and the reasonableness of an insurer’s legal arguments is a question for the court. (See § 10.04[2][g] above.)

[6] Rhode Island

[a] Skaling v. Aetna: First-Party Bad Faith Unbound?
Rhode Island was formerly a strong adherent of the principles espoused here and of the Dutton rule. But the judicial climate has changed markedly. Rhode Island recently became the first state in the country to hold that a liability insurer is strictly liable if it suffers an excess judgment after turning down an offer to settle the claim against its insured within policy limits. A similar spirit as to first-party bad faith was reflected in Skaling v. Aetna Insurance Co.

The case involved a UIM claim. Skaling was injured when he fell from a railroad trestle while attempting to rescue Matty Webber, a passenger in a jeep that had been negligently operated by Shaun Menard. Skaling suffered severe and permanent injuries requiring two months of hospitalization and medical expenses exceeding $50,000. Menard’s auto insurer paid Skaling its $25,000 limit, having concluded that Menard had created a dangerous condition by parking his car on the trestle. Aetna denied UIM benefits on the basis that the injuries did not

81 MONT. CODE § 33-18-242(5).
83 Redies v. Attorneys Liab. Prot. Soc’y, 2007 MT 9, ¶¶ 29–35 (reasonableness is for the court when it depends entirely on analysis of legal authority); Bartlett v. Allstate Ins. Co., 280 Mont. 63, 70 (1996) (plaintiff had no insurable interest in the insured property, so insurer necessarily had reasonable basis to contest claim); Watts v. Westland Farm Mut. Ins. Co., 271 Mont. 256, 630 (1995) (because no applicable policy was in force at the time of the loss, insurer had reasonable basis to contest claim).
85 Asermely v. Allstate Ins. Co., 728 A.2d 461 (R.I. 1999). (See § 2.03[2][e][iii])
87 799 A.2d at 1001.
arise from the ownership, maintenance or use of the Menard vehicle.\textsuperscript{88}

The facts of the accident are fully described in a prior opinion on the coverage case.\textsuperscript{89} It was beyond question that the intoxicated Menard was at fault for driving the jeep onto the trestle, from which Skaling fell. The coverage issue posed by Aetna was whether the presence of the jeep on the trestle was the proximate cause of Skaling’s injuries. The jeep was over 70 inches wide and the trestle only 86 inches wide, and the jeep was stopped at an angle, leaving only a very narrow space in which to try to pass it.\textsuperscript{90} Skaling fell when trying to walk past the jeep, as did one of the firefighters called to the scene; another firefighter avoided falling only by grabbing the steering wheel through a window.\textsuperscript{91} Aetna’s argument was that, because Skaling could not describe exactly how he fell, he could not show that the position of the car was the cause of his injuries, which the supreme court rejected because a plaintiff is not required to show every step of the causal chain.\textsuperscript{92}

On the contract claim, a jury found Menard’s negligence to be the proximate cause of Skaling’s injuries, assessed 10% fault against Skaling, and fixed his recoverable tort damages (after reduction for his own fault) at $1,174,500. Judgment was entered for the UIM policy limit of $300,000.\textsuperscript{93} The trial court granted Aetna summary judgment on bad faith,\textsuperscript{94} and the supreme court reversed.

On the bad faith claim, Aetna argued that the 10% assessment of fault to Skaling showed that the claim was fairly debatable. The court properly rejected this argument, observing that Skaling would have been entitled to recover the policy limit even if his fault had been as great as 75%.\textsuperscript{95}

Moreover, Aetna had never considered the doctrine that one who creates a dangerous condition is liable for injuries suffered by nonreckless attempts at rescue. The court found that Aetna had failed to investigate by researching Rhode Island law (or any other law) on the meaning of the relevant policy language.\textsuperscript{96} In fact, proximate causation is not necessary to show that injuries arise out of the ownership, maintenance or use of an underinsured motor vehicle.\textsuperscript{97} Only “some nexus” is required.\textsuperscript{98}

Aetna also failed to properly determine the facts, notably the narrowness of the space in

\textsuperscript{88} 799 A.2d at 1001.
\textsuperscript{90} 742 A.2d at 286.
\textsuperscript{91} 742 A.2d at 286, 288.
\textsuperscript{92} 742 A.2d at 288. One wonders why so much turned on the precise position of the car on the trestle. The rescue was necessitated by Webber’s presence in the jeep on the trestle, and Skaling would not have been on the trestle but for her being in that location. That chain of causation does not seem so attenuated as to require resort to the position of the car. But the court treated the position of the car as critical.
\textsuperscript{93} Skaling II, 799 A.2d at 999–1000, 1014.
\textsuperscript{94} 799 A.2d at 999.
\textsuperscript{95} 799 A.2d at 1015.
\textsuperscript{96} 799 A.2d at 1013.
\textsuperscript{97} 799 A.2d at 1015.
\textsuperscript{98} 799 A.2d at 1013.
which Skaling had tried to get past the jeep. Moreover, the adjuster claimed that Skaling had never told her the position of the jeep had anything to do with his fall and believed he was past the jeep when he fell. She agreed that the case would have looked much different had she known that Skaling fell while trying to pass the jeep. Skaling, however, claimed that he had told her that was exactly where he fell.

So, even assuming that proximate causation was a triable issue, there does not seem to have been a bona fide dispute as to causation sufficient to support coverage, at least so long as one accepts Skaling’s account of what he told the adjuster. As the court observed, “[t]his is precisely the sort of disputed oral conversation that defies application of the directed verdict/JML on the contract claim standard as a measure of the existence of bad faith.”99 Accordingly, the reversal of the summary judgment easily could have been justified on the principles advocated here. But the court wrote far more broadly, and Rhode Island courts are unlikely to characterize its statements as mere dicta, even though none of the broader statements was necessary to its result.

The court extensively discussed the Alabama law of “abnormal” bad faith (see § 5.03[3]), and the potential for liability for failure to adequately investigate or subject findings to “cognitive evaluation.”100 It approvingly discussed Zilisch v. State Farm Mutual Automobile Insurance Co.101 and the language in Farmland Mutual Insurance Co. v. Johnson,102 that, divorced from its factual context, can be read as endorsing Zilisch.103 It noted that Florida has entirely rejected the principle that existence of grounds for fair debate precludes bad faith, though it declined to go that far at this time.104 It repudiated the Dutton rule and cited a statute saying that bad faith is an issue of fact.105 It limited the evidence usable to establish good faith to that gathered before the claim was denied.106 It declared that “an intentional failure on the part of the insurer to determine whether there is a lawful basis to deny the claim, standing alone, is bad faith.”107 It agreed with Zilisch that fair debatability would not always preclude liability for bad faith.108

Finally, the Skaling court did something that no other court has ever done in the context of first-party bad faith. It held that, even where a claim is fairly debatable, the insurer is obliged to offer a compromise “in an effort to relieve the insured from the burden and expense of litigation.”109 Its conduct will be judged by the reasonableness of its settlement behavior.110

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99 799 A.2d at 1014. (See § 17.03[4][b][ii] above.)
100 799 A.2d at 1007–08.
103 799 A.2d at 1009.
105 799 A.2d at 1010. The statute long antedated the cases that had adopted the Dutton rule. It is possible that the Dutton rule was repudiated simply because inconsistent with the rule excluding consideration of evidence not in the insurer’s possession at the time the claim was denied. See Dakota, M. & E.R.R. v. Acuity, 2009 SD 69, ¶¶ 26–29. If so, an adapted form of the Dutton rule might still be applicable.
106 Zilisch, 799 A.2d at 1010–11. (See § 17.03[4][d][iii] above.)
107 799 A.2d at 1011.
108 799 A.2d at 1011.
109 799 A.2d at 1011.
To this it added the admonition, based on its prior holding in the context of the duty to settle third-party claims, that “‘an insurance company has a “fiduciary obligation to act in the “best interests of its insured”’.”¹¹¹ Because denial of a claim is always contrary to the interests of the insured, the court did not explain how it could be true that “not every refusal to pay amounts to insurer bad faith.”¹¹²

In sum, the purported survival of the rule that an insurer is free to dispute claims that are fairly debatable appears undermined by many pro-plaintiff doctrines announced in Skaling. In particular, an insured who prevails on a coverage claim will almost always be able to argue that the insurer was insufficiently generous in its offers to settle what the jury will be told was a meritorious claim.

[b] Critique of Skaling

The Skaling court, even more than the Zilisch court, has lost all sight of the strong public interests in allowing insurers to challenge claims subject to genuine disputes and to litigate such challenges to judgment, if no settlement is reached. It fails to consider that insurers already have substantial motivation to compromise disputed claims, both to avoid their own litigation costs and to avoid the risk of losing.

Courts in other jurisdictions have consistently protected those public interests by preserving strong protections against bad faith claims when the underlying contractual claims are subject to bona fide dispute. Such courts should reject the limits which Zilisch and Skaling place on those protections.

Interestingly, Skaling appears to have had little visible effect in subsequent reported cases in Rhode Island. In Imperial Casualty & Indemnity Co. v. Bellini,¹¹³ the Rhode Island court affirmed a summary judgment for the insurer on bad faith, holding that coverage had been fairly debatable. The policy apparently provided no coverage, but Imperial inadvertently extended coverage by demanding and accepting payment of a $250 deductible when undertaking a defense under reservation of rights.¹¹⁴ In a case on prejudgment interest on uninsured motorist claims, the court supported starting the running of interest before determination of the tortfeasor’s liability by citing Skaling for the proposition that insurers must investigate and review claims before refusing to pay.¹¹⁵ As yet, no reported decision has relied on any of the statements in Skaling identified as problematic in § 17.05[6][b].

[7] South Dakota

South Dakota continues to adhere to the requirement that “[f]or proof of bad faith, there must be an absence of a reasonable basis for denial of policy benefits [or failure to comply with a duty under the insurance contract] and the knowledge or reckless disregard [of the lack] of a

¹¹⁰ 799 A.2d at 1011.
¹¹¹ 799 A.2d at 1011. (But see § 1.08 above.)
¹¹² 799 A.2d at 1011.
reasonable basis for denial,’ “116 But it has recently quoted approvingly some of the expansive language from Zilisch v. State Farm Mutual Automobile Insurance Co.,117 Farmland Mutual Insurance Co. v. Johnson,118 and Skaling v. Aetna Insurance Co.119 With one exception (see § 17.03[4][d][iii]), South Dakota does not yet appear to have adopted any of those principles. But it is worth examining why those principles were not implicated.

Dakota, Minnesota, & Eastern Railroad Co. v. Acuity120 involved a complicated claim. Julian Olson, an employee of DM&E, was seriously injured in a motor vehicle accident in the scope and course of his employment. He was driving a car equipped with a Hy-Rail System which allowed it to be driven on railroad tracks. He sued DM&E under the Federal Employers Liability Act for negligent maintenance of the Hy-Rail System, ultimately settling with DM&E. Acuity was found to provide no coverage for that liability.121

But DM&E had uninsured motorist (“UM”) coverage with Acuity, applicable to the accident, and Olson claimed the accident was caused, in part, by a negligent “phantom motorist” who had cut him off and whose car never made contact with his.122 The UM coverage required independent corroboration of the facts of any such accident.123 Shortly after the accident, three independent witnesses told DM&E that there had been an unusually slow moving vehicle ahead of Olson as he entered the interstate highway, and one expressed the belief that this vehicle had probably caused the accident.124 When the UM claim was presented, Acuity hired a lawyer, Gary Thimsen, to investigate the claim and provide a coverage opinion; Acuity did no investigation of its own.125 Thimsen recommended that the claim be denied for want of independent corroboration.126

DM&E obtained an order compelling Thimsen’s deposition, but the deposition was deferred pending resolution of the coverage question.127 DM&E prevailed on coverage and that judgment was affirmed. DM&E then requested Thimsen’s deposition, and Acuity moved for summary judgment on bad faith, arguing that the coverage trial showed that coverage had always been fairly debatable. The circuit court granted the motion, without addressing DM&E’s request for delay to take Thimsen’s deposition. The supreme court reversed.

120 2009 SD 69.
121 2009 SD 69, ¶¶ 2–3.
122 2009 SD 69, ¶ 5.
123 2009 SD 69, ¶ 5 n.3 (“[i]f the hit-and-run vehicle does not hit an insured, a covered auto, or a vehicle an insured is occupying, the facts of the accident must be corroborated by competent evidence provided by an independent and disinterested person and not by the insured or any person occupying the same vehicle as the insured.’ ” (emphasis original)).
124 2009 SD 69, ¶ 6.
125 2009 SD 69, ¶¶ 7–8.
126 2009 SD 69, ¶ 5
127 2009 SD 69, ¶ 9.
Only if Acuity had properly investigated and evaluated the claim could it reasonably deny the claim, and only evidence in Acuity’s possession when it denied coverage could be used to defend that denial.\textsuperscript{128} Without knowing what investigation Thimsen had made and what facts he had discovered, it was “unclear what facts were available to suggest that the claim was fairly debatable when Acuity denied the claim.”\textsuperscript{129} That lack of information precluded summary judgment, because “Acuity [had] the initial burden to ‘clearly show an absence of any genuine issue of material fact and an entitlement to judgment as a matter of law.’”\textsuperscript{130} The existence of a genuine dispute at trial could not support summary judgment, because that may have included evidence Acuity did not have when it denied the claim.\textsuperscript{131}

All of that analysis (except for the refusal to consider information obtained after denial) is fully consistent with the analysis here and none of it depends on the problematic portions of \textit{Zilisch, Farmland}, and \textit{Skaling}. To support the proposition that existence of a genuine dispute depended in part on the adequacy of the insurer’s investigation, the court did cite \textit{Zilisch, Farmland}, and \textit{Skaling}, with parenthetical quotations that, standing alone, could be troublesome.\textsuperscript{132} But the proposition those quotations were used to support is not troublesome, and the court did not adopt any of those quotations as South Dakota law. The court also cited the rejection by those cases of the directed verdict rule, but premised its own rejection of that rule on the need to exclude evidence not in the insurer’s possession at the time of the denial.\textsuperscript{133} That leaves room for an appropriately adapted rule reflecting that exclusion. At least for now, South Dakota does not appear to have adopted any of the rules suggested by \textit{Zilisch, Farmland,} and \textit{Skaling} (except for the refusal to consider information obtained after denial).

\textbf{[8] Washington}

\textbf{[a] Washington Bad Faith Law Is Uncertain on Authority of Court Versus That of Jury}

The analysis here indicates that if the historical facts about what evidence was available to the insurer are undisputed and there is no issue as to inadequate investigation missing material facts supportive of the claim, determination of whether the insurer had a reasonable basis to deny or delay payment ordinarily constitutes a question of law for the court. (See § 17.04[1]–[2] above.) At one time, under \textit{Ellwein v. Hartford Accident & Indemnity Co.}, Washington bad faith law was relatively clear and very supportive of that position.\textsuperscript{134} \textit{Ellwein} was partially overruled by \textit{Smith v. Safeco Insurance Co.}\textsuperscript{135} and \textit{American States Insurance Co. v. Symes of Silverdale, Inc.}\textsuperscript{136} There is language in \textit{Smith} that could be read to make the determination of reasonableness a jury question, if reasonable minds could differ on that question. One recent case in the court of

\begin{footnotes}
\item[128] 2009 SD 69, ¶¶ 21–27.
\item[129] 2009 SD 69, ¶ 26.
\item[130] 2009 SD 69, ¶ 26.
\item[131] 2009 SD 69, ¶ 27.
\item[132] 2009 SD 69, ¶ 27.
\item[133] 2009 SD 69, ¶ 28.
\item[136] \textit{Am. States Ins. Co. v. Symes of Silverdale, Inc.}, 150 Wash. 2d 462 (2003).
\end{footnotes}
appeals, *American Best Food, Inc. v. Alea London, Ltd.*, has read that language that way. However, the Washington Supreme Court found that the bad faith question in *Alea London* was one of law, albeit one that it resolved against the insurer. So, the court of appeals opinion no longer appears authoritative on that point.

The particular aspect of bad faith law addressed by *Symes* and *Smith* is the ability of an insurer to obtain a summary judgment that there was no bad faith. But, because availability of summary judgment reflects the content of the underlying substantive law, the underlying structure of that law bears strongly on the interpretation of those cases.

*Symes* provides a current authoritative statement of Washington bad faith law on first-party claims (those where the insured is seeking benefits for the insured’s own losses):

An insurer has a duty of good faith to its policyholder, and violation of that duty may give rise to a tort action for bad faith. To prove bad faith the policyholder must show the insurer’s breach of the insurance contract was unreasonable, frivolous, or unfounded. Whether an insurer acted in bad faith is a question of fact. Accordingly, an insurer is entitled to a directed verdict or a dismissal on summary judgment of the policyholder’s bad faith claim only if there are no disputed material facts pertaining to the reasonableness of the insurer’s conduct under the circumstances and the insurer is entitled to prevail as a matter of law.

The emphasized language sets a high threshold for bad faith liability. What it leaves uncertain is what standard is to be applied in determining whether an insurer’s incorrect action (as it is later determined to be) was “unreasonable, frivolous, or unfounded.” Of equal importance, it leaves uncertain who decides that question: the court, as a matter of law, or the trier of fact (typically a jury).

*Smith* directly addresses the division of functions between court and jury in bad faith cases. While, as shown in §17.05[8][c] & [e] [ii] below, *Smith* addresses an issue somewhat different from that in a first-party bad faith case, the court did not recognize that difference, and its comments are presumably authoritative in first-party cases.

*Smith*, like *Symes*, began with the rule that “an insurer has a duty of good faith to all of its policyholders, and to succeed on a bad faith claim, a policyholder must show the insurer’s breach of the insurance contract was unreasonable, frivolous, or unfounded . . . . Part of this inquiry is whether the insurance company did have a cognizable reason to deny coverage.” The court then addressed the application of the substantive law in the context of summary judgment:

Whether an insurer acted in bad faith remains a question of fact.

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139 *Symes*, 150 Wash. 2d at 469–70 (emphasis added, citations omitted). Application of that standard to insurer refusals to provide a defense is different, because the coverage standard differs. (See §17.03[5][c] above (discussing *Alea London*).)
140 *Smith*, 150 Wash. 2d at 485 (emphasis original).
A motion for summary judgment is properly granted where “there is no genuine issue as to any material fact and … the moving party is entitled to a judgment as a matter of law.” All facts and reasonable inferences are viewed in the light most favorable to the nonmoving party. Questions of fact may be determined on summary judgment as a matter of law where reasonable minds could reach but one conclusion. But a court must deny summary judgment when a party raises a material factual dispute. The legal inquiry shapes what is a material fact ….

If the insured claims that the insurer denied coverage unreasonably in bad faith, then the insured must come forward with evidence that the insurer acted unreasonably. The policyholder has the burden of proof.

The insurer is entitled to summary judgment if reasonable minds could not differ that its denial of coverage was based upon reasonable grounds. If, however, reasonable minds could differ that the insurer’s conduct was reasonable, or if there are material issues of fact with respect to the reasonableness of the insurer’s action, then summary judgment is not appropriate. *If the insurer can point to a reasonable basis for its action, this reasonable basis is significant evidence that it did not act in bad faith and may even establish that reasonable minds could not differ that its denial of coverage was justified. However, the existence of some theoretical reasonable basis for the insurer’s conduct does not end the inquiry.* The insured may present evidence that the insurer’s alleged reasonable basis was not the actual basis for its action, or that other factors outweighed the alleged reasonable basis. ¹⁴¹

To the extent inconsistent with these principles, the Court overruled *Ellwein.*¹⁴² But the extent of the overruling is not otherwise specified.

The most troublesome aspect of *Smith* is the emphasized language. It may simply mean that the insurer cannot rely in defense to a bad faith claim on a theoretical basis that was not among the grounds of its decision. But, if one parses the court’s language carefully, there is a suggestion that even reliance on a reasonable ground might be found, in some sense, not to be reasonable, because “reasonable minds could differ that the insurer’s conduct was reasonable,” and that this might happen even in the absence of “material issues of fact with respect to the reasonableness of the insurer’s action.” If that suggestion were correct, then the reasonableness of the insurer’s conduct might be determined by a jury, as a factual question.

[b] Background: *Ellwein v. Hartford*

Because much of the importance of *Smith* and *Symes* is their partial overruling of *Ellwein*

¹⁴¹ 150 Wash. 2d at 485–86 (emphasis added).
¹⁴² 150 Wash. 2d at 486.
v. Hartford Accident & Indemnity Co.,\textsuperscript{143} that case must be reviewed to determine how much was overruled.

Ellwein involved an underinsured motorist claim against Hartford. Ellwein’s car was hit at an intersection by a car driven by Gleason. There were two eyewitnesses, Shultz and McDougal, the latter of whom suffered minor damage to his car. Gleason was insured by Allstate and McDougal by Safeco. Allstate and Safeco made subrogation demands on Hartford. Hartford hired an accident reconstruction expert, Cooper, who provided a report based on statements of Shultz and McDougal, concluding that Gleason was speeding and ran a red light. Based on this, Hartford took the position with the other insurers that Ellwein was not negligent. But it also began preparing to defend a potentially large UIM claim, noting internally that Cooper’s report could be used to argue that Ellwein was also negligent.\textsuperscript{144}

After collecting Gleason’s $100,000 policy limit from Allstate, Ellwein made a UIM demand on Hartford, which had a $1,000,000 UIM limit. Hartford provided Cooper with additional evidence (in existence before his report but not reviewed by him). Much of this “new” evidence implicated Ellwein as the cause of the accident. Cooper now concluded that Gleason entered the intersection on a yellow light, not a red light, and had no reason to expect that Ellwein would not yield to him. Ellwein hired another expert who reached conclusions consistent with Cooper’s prior report.\textsuperscript{145}

Defense counsel evaluated the case at $600,000–700,000. Hartford reduced this by 50% based on comparative negligence, and offered $300,000 ($800,000 gross damages, reduced by 50%, less $100,000 already recovered). The arbitrator found Gleason solely at fault and awarded gross damages of $929,803.39.\textsuperscript{146}

Ellwein sued for bad faith. The superior court granted summary judgment to Hartford. The supreme court affirmed in part and reversed in part\textsuperscript{147} an issue of no concern to here. But it affirmed the summary judgment that it was not bad faith for Hartford to have asserted 50% comparative negligence, and to make settlement offers based on that assertion.\textsuperscript{148} This is the point of significance here.

In light of the rule that a bad faith plaintiff has the burden of proving that an insurer’s actions were “unreasonable, frivolous, or unfounded,” the court reasoned that, in a summary judgment context

\begin{itemize}
  \item an insurer is ordinarily entitled to summary judgment dismissal of a bad faith claim unless the insured shows there was no reasonable basis for the insurer’s actions. Stated another way, where there is no real dispute that an insurer had a reasonable basis for its actions, dismissal of the bad faith claim on summary
\end{itemize}

\textsuperscript{144} 142 Wash. 2d at 768–70.
\textsuperscript{145} 142 Wash. 2d at 770–71.
\textsuperscript{146} 142 Wash. 2d at 771–72.
\textsuperscript{147} 142 Wash. 2d at 778–83.
\textsuperscript{148} 142 Wash. 2d at 774–78.
judgment is appropriate.\textsuperscript{149}

The court noted that this "‘fairly debatable’ standard for determining bad faith … is followed in the vast majority of jurisdictions,"\textsuperscript{150} quoting approvingly the following language:

An insurer is entitled to dispute claims so long as it has a reasonable basis. If reasonable minds could not differ on the coverage-determining facts, a verdict should be directed or summary judgment rendered on coverage. If that cannot be done, it ordinarily must follow that the insurer had reasonable grounds to dispute the facts, precluding any possibility of bad faith.\textsuperscript{151}

The court applied this standard to conclude that summary judgment had been properly granted on Hartford’s settlement practices:

Hartford, as a UIM insurer, had a general right to assert a comparative fault defense. Furthermore, the ambiguous and somewhat conflicting eyewitness reports alone created an issue as to whether Gleason entered the light on the yellow. Had Gleason entered the light on the yellow, Mrs. Ellwein would have been at least partially responsible for the accident by breaching in her statutory duty to yield. Consequently, even absent Cooper’s revised report, this claim of bad faith was properly dismissed because of Hartford’s legitimate basis for asserting comparative fault.\textsuperscript{152}

However, the Ellwein court introduced its analysis with a short summary that does not correctly track the analysis that followed:

RCW 48.01.030 imposes a duty to act in good faith upon insurers, and violation of that duty may give rise to a tort action for bad faith. Claims of bad faith, however, are not easy to establish; insureds must meet a “heavy burden.” \textit{Insureds must prove bad faith as a matter of law.} “Ordinarily, if the evidence produced by either side creates a fact issue with regard to the validity of the claim and, thus, the legitimacy of the denial thereof, the tort claim must fail ….”\textsuperscript{153}

The italicized sentence incorrectly states the standard. The correct statement is that the bad faith plaintiff must prove \textit{coverage} as a matter of law. Alas, that incorrect sentence created problems in \textit{Smith} and \textit{Symes}.

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\textsuperscript{149} 142 Wash. 2d at 776.  
\textsuperscript{150} 142 Wash. 2d at 776. (footnote omitted).  
\textsuperscript{152} \textit{Ellwein}, 142 Wash. 2d at 777–78.  
\textsuperscript{153} 142 Wash. 2d at 776, quoting Nat’l Sav. Life Ins. Co. v. Dutton, 419 So.2d 1357, 1362 (Ala.1982). (citations omitted).
Smith v. Safeco

Smith arose in the context of a third-party liability claim. In April, 1997, Smith was injured when her car was rear-ended by one driven by Bryce. Bryce was insured by Safeco and Smith had underinsured motorist (UIM) coverage with Farmers. Smith initially provided Safeco no information about her injuries. On February 24, 1999, a “claims specialist” employed by Smith’s counsel told a Safeco adjuster on the phone that Smith had suffered a closed head injury, and loss of memory and had incurred medical bills close to $20,000, in addition to past and future wage loss. Starting in August, 1998, Smith’s counsel repeatedly demanded to be told Bryce’s liability limits. In the absence of consent by Bryce, Safeco declined to provide this information without any documentation of Smith’s injuries sufficient to show a claim exceeding the policy limit.

On March 29, 1999, Smith sued Bryce. On May 17, 1999, Smith’s counsel asserted out-of-pocket damages of $612,000 and demanded the full policy limits, if less than $1.5 million. On May 26, Safeco disclosed that Bryce’s limit was $100,000. On July 30, Safeco paid that amount to Smith. Smith then settled with Bryce, giving a covenant not to execute in return for Bryce’s agreement to a “partial judgment” for $100,000 and an assignment of all of Bryce’s rights under the insurance policy. Safeco sought a declaratory judgment that it had no liability for failure to disclose the limits earlier, because disclosure often results in an inflated demand not supported by the facts, something not in the insured’s interest. Smith counterclaimed for bad faith, both in her own right and as Bryce’s assignee. The trial court granted summary judgment for Safeco.

The court of appeals affirmed. It first concluded that Safeco owed no duty to Smith herself. The duty to Bryce was to attempt to protect her against exposure in excess of her limits and includes “an affirmative duty to make a good faith effort to settle.” The court of appeals then discussed Ellwein as providing the summary judgment standard and rejected an argument that Ellwein was limited to UIM cases. It then concluded that there was no absolute duty to the insured to disclose limits to the claimant, because this might sometimes be harmful to the insured.

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155 112 Wash. App. at 649.
156 112 Wash. App. at 650.
157 112 Wash. App. at 651.
158 112 Wash. App. at 651 & n.29.

Factors bearing on breach include but are not limited to “the strength of the injured claimant’s case on the issues of liability and damages[,]” the adequacy of the insurer’s investigation and evaluation; the adequacy of the insured’s policy limits and the consequent “risk to which each party [insurer and insured] is exposed in the event of a refusal to settle[,]” willingness or refusal to negotiate and the resulting “climate for settlement;” and any other action by the insurer “demonstratin[ng] greater concern for the insurer’s monetary interest than [for] the financial risk attendant to the insured’s predicament. “[112 Wash. App. at 651.]
As it saw the duty,

[i]n the absence of a statute or rule requiring disclosure, and assuming that the insured does not direct otherwise, the insurer must disclose the insured’s policy limits if a reasonable person in the same or similar circumstances would believe that disclosure is in the insured’s (as opposed to the claimant’s) best interests. Conversely, the insurer need not disclose if a reasonable person would believe that disclosure is not in the insured’s best interest, or if a reasonable person would not know, after reasonably marshalling the facts and evaluating the claim, whether disclosure was or was not in the insured’s best interests.¹⁵⁹

In Smith, the facts bearing on any such duty were fully developed and essentially undisputed. There was no claim of deficient investigation and Smith’s refusal to provide information to Safeco meant that it had very little information about her injuries. Accordingly, Smith could not show and a rational trier of fact could not find, as Ellwein would require, that Safeco’s failure to disclose was so “unreasonable, frivolous, or unfounded” as not to be “fairly debatable.” A reasonable person in Safeco’s shoes would have deemed himself or herself to lack any reliable information on the nature of Smith’s injuries or the size of her claim; such a person would not have relied on undocumented information asserted over the telephone, and he or she would have had nothing else. Lacking any reliable information, a reasonable person in Safeco’s shoes would not have believed that disclosure of Bryce’s policy limits would serve Bryce’s (as opposed to Smith’s) interests. On the contrary, a reasonable person in Safeco’s shoes simply would not have known whether the disclosure of Bryce’s policy limits would help or hurt Bryce’s interests. Smith cannot show that “there was no reasonable basis for [Safeco’s] actions[,]” and the trial court did not err by granting summary judgment.¹⁶⁰

The supreme court reversed, holding that application of the Ellwein standard was error. It ruled that the proper standard was:

If the insured claims that the insurer denied coverage unreasonably in bad faith, then the insured must come forward with evidence that the insurer acted unreasonably. The policyholder has the burden of proof. The insurer is entitled to summary judgment if reasonable minds could not differ that its denial of coverage was based upon reasonable grounds. If, however, reasonable minds could differ that the insurer’s conduct was reasonable, or if there are material issues of fact with respect to the reasonableness of the insurer’s action, then

¹⁵⁹ 112 Wash. App. at 653 (emphasis original, footnotes omitted). The court assumed, without holding, that an insurer must comply with an insured’s direction whether to disclose limits, a point that did not matter in the absence of a directive from Bryce. 112 Wash. App. at 653 n.33.
¹⁶⁰ 112 Wash. App. at 654 (emphasis original, footnotes omitted).
summary judgment is not appropriate. If the insurer can point to a reasonable basis for its action, this reasonable basis is significant evidence that it did not act in bad faith and may even establish that reasonable minds could not differ that its denial of coverage was justified. However, the existence of some theoretical reasonable basis for the insurer’s conduct does not end the inquiry. The insured may present evidence that the insurer’s alleged reasonable basis was not the actual basis for its action, or that other factors outweighed the alleged reasonable basis. To the extent that Ellwein is inconsistent with these principles, it is overruled.  

This is the partial overruling whose extent must be determined.

[d] **American States v. Symes of Silverdale**

*American States Insurance Co. v. Symes of Silverdale, Inc.* was an arson coverage case. Symes was a corporation operating a family restaurant and sports bar and was insured by American States. It filed a chapter 11 bankruptcy reorganization proceeding. No trustee was appointed, and Symes continued to operate as debtor-in-possession. Symes renewed its insurance and increased the policy limit. The property was severely damaged by fire, which state investigators found to have been caused by arson and American States alleged to have been set by Thomas LePre, president of Symes. The day after the fire, the bankruptcy court granted a creditor’s motion to convert the bankruptcy to a chapter 7 liquidation, appointing Kathryn Ellis as trustee. She sued to collect the insurance on the property, saying that coverage for the bankruptcy estate would not have been impaired even if LePre had set the fire. She also alleged bad faith. The Trustee moved for summary judgment on coverage, and American States moved for summary judgment on bad faith, arguing that it had at least a sufficient ground for contesting coverage to defeat any bad faith claim. The trial court denied both motions.

On discretionary review, the court of appeals agreed that proof of arson by LePre would defeat the Trustee’s claim for coverage and, pursuant to Ellwein, held that the existence of reasonable grounds to assert this defense precluded any claim for bad faith. The supreme court majority held that, as a matter of bankruptcy law, arson by LePre could not defeat coverage for the bankruptcy estate. It remanded for unspecified further proceedings (presumably on bad faith).

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163 150 Wash. 2d at 465.
165 150 Wash. 2d at 468.
166 150 Wash. 2d at 470.
[e] Analysis of *Smith* and *Symes*

[i] *Symes*

*Symes* was a first-party claim governed by the rule that “fairly debatable” claims may be debated (by denying them). As the court of appeals had viewed the case, there was a genuine issue of fact whether LePre had committed arson and coverage would be defeated if he had. That established a reasonable basis to deny the claim, as the Trustee was not entitled to summary judgment on coverage. But the Supreme Court concluded that the Trustee was, after all, entitled to that summary judgment. The focus of inquiry would then shift to whether American States had a reasonable basis for arguing that arson by LePre (if proven) would defeat coverage. That does not turn on any factual issue, but on assessment of whether the legal argument against coverage was “unreasonable, frivolous, or unfounded.” On that point, neither *Dutton* nor *Ellwein* has anything to say. So a remand on that point says nothing about the continued viability of *Ellwein*’s adoption of the *Dutton* rule.

The remand is troubling, though, because it seems pointless. All three judges of the court of appeals and four of the nine justices of the supreme court agreed with American States on the merits of its legal position. On the analysis here (see §§ 17.03[5][b][i][A] & [C] above), the fact that American States’ coverage argument was accepted, after full adversarial presentation, by some impartial judges (and especially a majority of the judges who addressed the issue) should establish as a matter of law that the denial of coverage was not “unreasonable, frivolous, or unfounded.” But there is no indication that point was ever argued, so it may not have occurred to the court. Be that as it may, it has nothing to do with the *Ellwein* holding, which remains fully consistent with *Symes*.

That said, the seemingly senseless remand would have been required if reasonableness of the insurer’s interpretation of the policy is a jury issue.

[ii] *Smith*

*Smith* was not a first-party case, but was a case involving protection of the insured from excess judgments in favor of a third-party claimant. The substantive standard for such cases is different, requiring case-by-case balancing of the interests of the insured in settling against the interests of the insurer in not paying more than the claim is truly worth. (See § 2.03[2] above.) Many jurisdictions say that this requires the insurer to act as if it alone would be liable for the entire judgment. (See § 2.03[2][d] above.) In contrast, the standard in first-party cases establishes a minimum threshold for what constitutes a reasonable basis, with the balancing having been done in formulating the rule, rather than case-by-case. (The latter type of balancing may be described as “categorical balancing.”) (See § 17.04[2][a] above.)

Because the *Ellwein* standard is based on the substantive law governing first-party cases, that standard could not properly be transferred into the context of a third-party claim. Unfortunately, the argument made for distinguishing *Ellwein* did not make that point. The

167 The trial court’s reasoning is not stated in the appellate opinions, but it granted summary judgment on bad faith. So it seems likely that it, too, agreed with American States that arson by LePre would bar coverage.

168 *Smith v. Safeco Ins. Co.*, 112 Wash. App. 645, 652 n.29 (2002) (“In a motion for reconsideration, Smith contends that *Ellwein* applies only to UIM claims, and thus that *Ellwein* does not apply here”).
court of appeals then analogized bad faith cases to employment cases and read *Ellwein* as a broad rule applicable to all bad faith cases:

*Ellwein* clearly does apply whenever, as here, it is known that the [insurer] performed (or refrained from performing) a *discretionary act*, and the question is whether the insurer *abused its discretion*. In the latter situation, the trier of fact must defer to the defendant’s exercise of discretion, “much as an appellate court refers to a trial court’s findings of fact on appeal.”

Under this reading, *Ellwein* would have established a broad special summary judgment rule for bad faith cases that would have protected insurers on third-party claims so long as they had some basis to think that refusal to settle would be reasonable. That would have imported into bad faith analysis a test rooted in the much different law of at-will employment. It would have changed the substantive law applicable to third-party claims, eliminating the need for case-by-case balancing by the factfinder. The supreme court properly rejected such a broad special rule, holding that “the existence of some theoretical reasonable basis for the insurer’s conduct does not end the inquiry.”

Putting aside the special summary judgment rule, the issue in *Smith* was whether it had been bad faith to refuse disclosure of Bryce’s liability limit. As the substantive standard was articulated by the court of appeals (and not altered by the supreme court), that turned on whether a reasonable person in the position of the insurer would have believed that Bryce’s interests called for such disclosure. That inquiry is entirely suited for case-by-case balancing, as opposed to the categorical balancing used by the court of appeals. It is that which the supreme court directed in remanding “to the trial court for proceedings consistent with this decision, which may include summary judgment and/or trial.” On the facts, it seems entirely plausible that the trial court could conclude (as several justices did) that no rational finder of fact could find bad faith. But the analysis would be totally different from that employed by the court of appeals, and a fresh review of the evidence would be required.

[iii] Implications of *Smith* and *Symes*

The supreme court’s insistence in *Smith* on preserving case-by-case balancing on third-party claims should not require such balancing on first-party claims, where categorical balancing had established a threshold rule permitting “fairly debatable” claims to be denied. (*See § 17.04[1]–[2]*)

*Ellwein* strongly endorsed the *Dutton* rule and clearly rejected case-by-case balancing in

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169 112 Wash. App. 645, 652 n.29 (emphasis original, citation omitted).
171 *See* 112 Wash. App. at 653. The court assumed, without holding, that an insurer must comply with an insured’s direction whether to disclose limits, a point that did not matter in the absence of a directive from Bryce. 112 Wash. App. at 653 n.33.
172 150 Wash. 2d at 487–88.
173 150 Wash. 2d at 487 (opinion concurring in part and dissenting in part). This opinion decries what it characterizes as the majority’s conclusion that there was an issue of fact precluding summary judgment. 150 Wash. 2d at 487. But the majority expressly leaves open the possibility that that summary judgment might again be entered. So the majority simply chose not to decide whether there was an issue of fact.
first-party bad-faith cases. *Ellwein* was a unanimous decision, and was in accord with preexisting law (in Washington and almost everywhere else) on that point. Had the new decisions been understood as overturning *Ellwein* on this central point, one would expect that at least some of those who joined in *Ellwein* would have dissented (or concurred specially, to disclaim that result) or, at least, that someone would have offered an explanation of the reasons for change. The lack of any of these thus supports a reading that only rejects *Ellwein*’s erroneous paraphrase of the *Dutton* rule and the lower courts’ erroneous extension of *Ellwein* to third-party cases. The categorical balancing in first-party cases would simply be unaffected by the partial overruling on the other points. On the other hand, the remand in *Symes* could be read to require case-by-case balancing of some sort.

[f] Implications of Unchanged Washington Bad Faith Standard

As the Washington Supreme Court reaffirmed in *Symes*, “[t]o prove bad faith the policyholder must show the insurer’s breach of the insurance contract was unreasonable, frivolous, or unfounded.”

The use of the three terms together suggests that they are intended to convey a single concept. While they probably are not intended to be synonyms, they are closely related. The pre-*Ellwein* cases had consistently read them that way. Thus, the Supreme Court itself had said that “[a] denial of coverage based on a reasonable interpretation of the policy is not bad faith, and even if incorrect, does not violate the Consumer Protection Act if the insurer’s conduct was reasonable” and that existence of authority in other jurisdictions that would support denial of coverage precluded a finding of bad faith.

The court of appeals had indicated that an insurer’s denial of a claim was reasonable if the insurer had “‘probable cause to pursue its defense’” or when there was a “‘legitimate controversy’” about the insured’s right to benefits.

There was no bad faith where “there was a legitimate issue as to the law” or if the court was “unable to find … that Unigard’s arguments thoroughly lacked legal justification”

“[M]ere denial of coverage due to a debatable question of coverage is not bad faith.” Bad faith could not be found where “there was a bona fide dispute over the existence and extent of old damage.”

Bad faith thus involved denial of coverage where there was no debatable question or bona fide dispute about the insured’s right to benefits that the insurer failed to provide. The circumstances had to be such that the insurer lacked probable cause to pursue a challenge to the insured’s right to those benefits. And the plaintiff had the burden of proving that this was so.

The only case to discuss the standard is *Phil Schroeder, Inc. v. Royal Globe Ins. Co.* In that case, Royal Globe denied coverage for carpet damaged by a cleaning machine, based on an

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exclusion for damage to property in the insured’s care, custody or control. The superior court
concluded, and the Supreme Court agreed, that the employees operating the machine were not
themselves insureds and, accordingly, the exclusion did not apply. But the Supreme Court
reversed an award of attorneys’ fees. For this purpose, the question was whether Royal Globe had
breached its duty of good faith and fair dealing. It rejected the views of jurisdictions that had held
that such a breach required culpable intent. It quoted a treatise:

Generally the insurance company must have a reasonable and
valid ground on which to oppose payment of the claim to avoid
the application of penalties and attorney fees.

The insurer is subject to the statutory penalty where it refuses to
make payment for a reason which has by prior cases been held
invalid.183

In Phil Schroeder, Royal Globe had relied on two cases in other jurisdictions that
supported its position and there were no Washington cases to the contrary. There were two that
had denied coverage, but did not indicate whether the employees qualified as insureds. In these
circumstances, the Supreme Court “[could not] say Royal Globe breached its good faith fiduciary
duty in refusing to extend coverage in the absence of litigation.”184 Stated otherwise, bad faith
denial of coverage is the act of forcing the insured to litigate to obtain benefits when there is no
reasonable basis to resist the claim. (See §§ 5.02[1]–[2], 17.03) The logic of that unchanged legal
standard supports the conclusion that bad faith can be ruled on as a matter of law under the
standards described in § 17.04. The analogies to malicious prosecution and to causation and
judgmental immunity in legal malpractice are all supported by Washington law. (See
§ 17.04[2][b]–[c])

No cases in either the state or federal courts, except the court of appeals’ opinion in
American Best Food, Inc. v. Alea London, Ltd.,185 have treated this issue as one of fact when the
analysis here would treat it as one of law. For reasons set forth in § 17.05[8][a], the court of
appeals’ opinion in Alea London does not appear to be authoritative on that point. But even if it
were authoritative, its authority would be questionable in light of the analysis here.

[9] Utah

[a] Jones v. Farmers Insurance Exchange

In Jones v. Farmers Insurance Exchange,186 the Utah Supreme Court held that the district
court had erred in granting summary judgment that the insurer’s denial of coverage was “fairly
debatable” and, thus, not bad faith. Upon examination, however, this does not appear to call for
any different analysis than that offered here.

Jones was an underinsured motorist claim on which, ultimately the only disputed aspect
was dental treatment for cracked teeth. The court summarizes the facts and Farmers’ investigation

183 99 Wash. 2d at 74, quoting G. Couch, Insurance § 58:165 (2d ed. 1966) (emphasis by the court).
184 99 Wash. 2d at 74.
as follows:

Mr. Jones visited Richard Hughes, D.M.D., about four years after the accident. Dr. Hughes submitted a report to the insurance company stating that Mr. Jones required extensive dental repair including porcelain onlays to restore five teeth due to fractures; a root canal due to exposure; and six crowns due to premature wear, likely from stress or an altered bite. Dr. Hughes’s record states, “These fractures/breaks could have been caused by traumatic force. It was reported by the patient that he was in an automobile accident 4 years ago and injured his mouth. He was aware that he had broken his tooth but was involved with several medical procedures that took precedence.”

Farmers sent a letter to Dr. Hughes stating the record “obviously leaves us to question causation.” The letter continued, “The purpose of this letter is to get your professional opinion on the cause of Mr. Jones’s teeth damage and to get the following questions answered.” The included questions addressed Mr. Jones’s dental history, his ability to mitigate damages, and the total cost of the recommended procedures. Farmers’ claim summary log documents Dr. Hughes’s reply, noting that Dr. Hughes “[s]tates the teeth were cracked during the accident and are still cracked requiring the same treatment regardless of time frame. Approximate cost for recommended treatment is $14,000.” According to the log, Dr. Hughes “basically relates [Mr. Jones’s] problems to this accident, stating that he would have needed the treatment whether he did it 4 years ago or today.” After Farmers discussed Mr. Jones’s claim at a meeting, the claim summary activity log states,

We have no support, other than the insured’s statement, that the damage to his teeth resulted from this loss. Insured makes no mention of his teeth until he sees the dentist 4 years after the accident; there is no facial trauma noted in the ER report, Dr. Gordon’s report or the PT reports. His mouth problems could just have likely been caused by something other than this accident, we don’t have enough support to include the $14,000 in future treatment. Will evaluate without.

The log contains an entry the following month noting that Farmers “would have expected multiple fractured teeth to cause some pain or discomfort during the 4 years.”

Farmers offered Jones $5,000 and Jones demanded the policy limit of $30,000. Arbitrators awarded $18,500, an amount the court notes was sufficient to cover the disputed dental bill. Jones sued for bad faith and the district court granted summary judgment to Farmers, concluding that Farmers’ position was fairly debatable.

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187 2012 UT 52, ¶ 2–3.
188 2012 UT 52, ¶ 4–5.
While noting that review of a summary judgment ordinarily entails no deference to the district court’s conclusions, Utah views the “fairly debatable” question as a special one:

“Whether an insured’s claim is fairly debatable under a given set of facts is also a question of law. However, because of the complexity and variety of the facts upon which the fairly debatable determination depends, the legal standard under which this determination is made conveys some discretion to trial judges. Therefore, although we will carefully review a trial court’s conclusion that an insured’s claim is or is not fairly debatable, we will grant the trial court’s conclusion some deference.”

The court summarized the relevant law on bad faith as follows:

an insurer’s “implied obligation of good faith performance contemplates, at the very least, that the insurer will diligently investigate the facts to enable it to determine whether a claim is valid, will fairly evaluate the claim, and will thereafter act promptly and reasonably in rejecting or settling the claim.” But “when an insured’s claim is fairly debatable, the insurer is entitled to debate it and cannot be held to have breached the implied covenant [of good faith] if it chooses to do so.” This is because the duties imposed by the implied covenant of good faith “plainly indicate that the overriding requirement imposed … is that insurers act reasonably, as an objective matter, in dealing with their insureds.” Therefore, an insurer cannot be held to have breached the covenant of good faith “on the ground that it wrongly denied coverage if the insured’s claim, although later found to be proper, was fairly debatable at the time it was denied.”

Farmers argued that “‘if an insured cannot establish that [he] is entitled to summary judgment on the merits of his [bad faith] claim, that means the claim is fairly debatable.’” The court disagreed, noting that such a rule, if accepted, would require that the “fairly debatable” issue always be resolved on summary judgment, and that was not the law in Utah. The court pointed to Billings ex rel. Billings v. Union Bankers Ins. Co., a case where it had affirmed judgment on a jury verdict of bad faith, even though it had affirmed denial of summary judgment.

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190 2012 UT 52, ¶ 7, quoting Billings, 918 P.2d at 465.
191 2012 UT 52, ¶ 8. It may be that the court’s bracketed insertion of the words “bad faith” misinterpreted Farmers’ argument. The rule on which Farmers relied says that the bad faith claim must fail if the insured is not entitled to summary judgment on the contract claim. Even if the court misstated Farmers’ argument, neither its own reasoning nor the result appears to be based on that possible error.
on the contract claim.\textsuperscript{193} The court also noted that other jurisdictions had rejected the rule advocated by Farmers.\textsuperscript{194}

The court explained that

There is a notable distinction between a factual dispute about the validity of the underlying insurance claim and a factual dispute about what information the insurance company used to deny the claim. Mr. Jones alleges in his case that, based on the information Farmers indisputably had, it should have granted his claim or conducted further investigation before denying it. There is little dispute about what information Farmers used to deny Mr. Jones’s claim. The disputed facts, therefore, involve the question of whether Farmers’ conduct measured up to the required standard of good faith and fair dealing.\textsuperscript{195}

Such a question need not be resolved on summary judgment.

When making the determination of whether a claim is fairly debatable, a judge should remain mindful of an insurer’s implied duties to diligently investigate claims, evaluate claims fairly, and act reasonably and promptly in settling or denying claims. Only when “there [is] a legitimate factual issue as to the validity of [the insured’s] claim,”\textsuperscript{196} such that reasonable minds could not differ as to whether the insurer’s conduct measured up to the required standard of care, should the court grant judgment as a matter of law.

Farmers argued that Dr. Hughes’ statements about causation were based on misrepresentations by Jones, whose credibility was undermined by his apparent failure to complain earlier about injury to his mouth. The court agreed that this raised questions, but did not destroy his credibility completely. The issue was whether what Farmers considered common sense justified rejecting Dr. Hughes’ opinion, and the court held that

Reasonable minds could differ as to whether this reasoning is consistent with Farmers’ duties to conduct a diligent investigation and evaluate claims fairly. Insurers are entitled to use common sense, but in this case the insurer’s common sense conflicted with the only medical opinion it possessed relating to Mr. Jones’s teeth … . Dr. Hughes replied to Farmers’ inquiries by stating that “the teeth were cracked during the accident and are still cracked.” After such a response from a medical expert, a jury could find that Farmers should not have considered it obvious that a person with multiple injuries would seek

\textsuperscript{193} \textit{Jones}, 2012 UT 52, ¶ 8–9.
\textsuperscript{195} 2012 UT 52, ¶ 11 (footnote omitted).
\textsuperscript{196} 2012 UT 52, ¶ 12 (footnote omitted).
treatment for cracked teeth without delay.\textsuperscript{197} Accordingly, the court remanded for further proceedings.\textsuperscript{198}

[b] Billings Is Consistent with the Directed-Verdict Rule

In \textit{Billings ex rel. Billings v. Union Bankers Ins. Co.},\textsuperscript{199} Billings had purchased a catastrophic health insurance contract providing for payment of hospital in-patient treatment and certain out-of-hospital expenses. He was in a motorcycle accident in which he sustained traumatic brain injury. Union Bankers paid his expenses while hospitalized. Billings was transferred from the hospital to Tangram Rehabilitation Network, and Union Bankers refused to pay for his care there, causing Billings to discontinue that treatment. Billings sued for breach of contract and bad faith. The district court denied summary judgment on coverage, concluding that there were factual issues arising from differing interpretations of the insurance contract. The Utah Supreme Court affirmed the denial of summary judgment because “‘the record before us … failed to adequately demonstrate the nature of the treatment received at Tangram.’”\textsuperscript{200} The case was then tried, and Union Bankers moved for directed verdict at the close of the evidence on the ground that coverage was “fairly debatable.” The district court denied that motion, and the jury found both a breach of contract and bad faith, awarding $1.8 million in damages, to which the district court added $110,651 as a reasonable attorney’s fee. The Utah Supreme Court affirmed judgment on the verdict but remanded for recalculation of the fees.\textsuperscript{201} The court concluded that “[w]hether an insured’s claim is fairly debatable on a given set of facts is … a question of law,” but that Billings’s claim was not fairly debatable.\textsuperscript{202} It noted that it had previously held that “when confronted with a claim for benefits by a first-party insured, the insurer must ‘diligently investigate the facts …, fairly evaluate the claim, and … act promptly and reasonably in rejecting or settling the claim.’”\textsuperscript{203} But the affirmance of the denial of summary judgment had not been based on the existence of a factual question as to coverage, but rather on the inadequacy of the record to allow the court to reach that issue. And the verdict on bad faith was sustained.\textsuperscript{204} (The court provided no further analysis of the coverage issue or why it was not fairly debatable.)

\textit{Billings} is easily reconciled with the directed-verdict rule (see § 17.03[4][a]). As previously noted (see § 17.03[4][a][i]), that rule does not require that the insured obtain a directed verdict on coverage, only that the insured have been entitled to one. Had the denial of summary judgment been made on a complete record, that would have indicated that Billings would not

\textsuperscript{197} 2012 UT 52, ¶ 16.
\textsuperscript{198} 2012 UT 52, ¶ 18.
\textsuperscript{199} \textit{Billings ex rel. Billings v. Union Bankers Ins. Co.}, 918 P.2d 461 (Utah 1996)
\textsuperscript{200} 918 P.2d at 462–63, quoting \textit{Billings v. Union Bankers Ins. Co.}, 819 P.2d 803, 805 (Utah 1991) (“\textit{Billings I}”).
\textsuperscript{201} 918 P.2d at 463–64, 468.
\textsuperscript{202} 918 P.2d at 464.
\textsuperscript{203} 918 P.2d at 465, quoting \textit{Beck v. Farmers Insurance Exchange}, 701 P.2d 795, 801 (Utah 1985) (emphasis by the \textit{Billings} court). “[W]hether an insurer has acted reasonably is an objective question to be determined without considering the insurer’s subjective state of mind.” 918 P.2d at 465 n.2.
\textsuperscript{204} 918 P.2d at 465–66.
have been entitled to a directed verdict. But the record presented on summary judgment had been inadequate to resolve the coverage issue, and the record at trial did allow that to be resolved. Only if that resolution required fact-finding by the jury would there have been a fairly debatable factual dispute. While the coverage issue was submitted to the jury, the ultimate result indicates that the issue did not require submission and that Billings would have been entitled to a directed verdict.

[c] Jones Is Consistent with the Modified Directed-Verdict Rule

In Jones, Farmers had elicited a medical opinion from Dr. Hughes that Jones’s dental injuries resulted from the accident. Farmers did not obtain another medical opinion, nor did it inquire whether Dr. Hughes had any basis for that conclusion other than Jones’s own statements to that effect. Its premise was that Dr. Hughes’s conclusion was so obviously dubious that laymen could properly reject it. The ability of laymen to reject a medical opinion is unusual, to say the least. Moreover, further investigation (at least an inquiry to Dr. Hughes) was arguably necessary before his opinion could properly be rejected, even if that were otherwise possible. If there was some medical reason that at least bolstered Jones’s statements, lay claims personnel could not even evaluate the opinion without understanding that. Judgments about what a reasonable investigation requires are ordinarily ones for a jury. And analysis of whether a claim was fairly debatable must take account of all evidence the insurer should have found, as well as what it actually knew.

That question regarding further investigation might have been avoided if the summary judgment record established that further investigation would not have aided Jones’s claim. But there is no indication that this evidence had been developed. In that respect, the record may have been incomplete, as it had been in Billings. And, if a complete record provided additional support for Jones’s claim, that additional evidence could allow the jury to conclude that the claims personnel’s unsupported lay opinions were not worthy of reliance.

Accordingly, a remand for further proceedings was proper under the modified directed-verdict rule.

[d] Cases in Other Jurisdictions That Appear To Reject Even the Modified Directed Verdict Rule Are Inconsistent with the Premises of the Utah Law Reaffirmed in Jones

There are states that appear to reject all forms of a directed-verdict rule. Notably, Florida is committed to a unique “totality of the circumstances” standard for first-party bad faith, and Montana holds that a jury must determine whether an insurer’s view of the facts constitutes bad faith. Arizona holds that, at least in some circumstances, a jury may properly find bad faith based on the improper way in which a claim was handled, even if there were, ultimately, a genuine dispute as to the amount due and Rhode Island has agreed. But all of these cases are inconsistent with the rule, reaffirmed in Jones, that “[w]hether an insured’s claim is fairly

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205 State Farm Mut. Auto. Ins. Co. v. Laforet, 658 So. 2d 55, 63 (Fla. 1995). (See §§ 5.03[4], 17.05[3].)
debatable under a given set of facts is ... a question of law.’”

Utah remains in the mainstream of jurisdictions that firmly protect the right of an insurer to dispute any claim that is fairly debatable (based on all information that a reasonable investigation would have developed). In such jurisdictions, the modified directed-verdict rule continues to indicate when summary judgment will be available in cases involving factual disputes as to coverage.

[10] Colorado


Sanderson v. American Family Insurance Co. affirmed summary judgment for an insurer on the issue of bad faith, but asserted that the fact that the claim was “fairly debatable” was not (as the trial court had thought) a threshold defense. As explained in §§ 17.03–.04, above, that “defense” is fundamental to the structure of a bad faith claim under the law in most jurisdictions. The court’s assertion about the role of that “defense” was dictum but later cases have followed it. Nonetheless, Sanderson can be reconciled with the analysis here, because the court only rejected a misunderstood version of the “defense” and its analysis is fully consistent with recognition of the properly understood rule. This subsubsection examines Sanderson, the next subsubsection examines the cases that have followed it, and the last subsubsection of this subsection critiques that line of cases.

Leonard Sanderson was injured in an accident with Brian Pierce, who had bodily injury liability coverage of $25,000. After a year of litigation, Sanderson settled with Pierce’s insurer for the policy limit. Sanderson had $100,000 in underinsured motorist insurance with American Family (“AFI”), and demanded the $75,000 difference between Pierce’s limit and his own UIM limit. He also demanded arbitration. AFI offered $30,000, noting that (1) Sanderson had suffered no loss of past or present income, (2) he had a preexisting degenerative neck condition, and (3) AFI had paid and was continuing to pay medical expenses under PIP coverage. The arbitrators found Sanderson 15% at fault and awarded $357,387.80, after offsetting the $25,000 tort settlement. AFI promptly paid its limits plus arbitration costs and prejudgment interest. Sanderson sued for bad faith.

The district court held that AFI’s defenses were “fairly debatable” and, therefore, granted summary judgment to AFI. Sanderson argued, and the court of appeals agreed, that “although fair debatability is part of the analysis of a bad faith claim, it is not necessarily sufficient, standing alone, to defeat such a claim.” That court stated the basis for what it described as the “fairly debatable” defense as follows:

When an insured sues his or her insurer for bad faith breach of an insurance contract, the insured must prove that (1) the insurer acted unreasonably under the circumstances, and (2) the insurer either knowingly or recklessly disregarded the validity of the

211 251 P.3d at 1215-16.
212 251 P.3d at 1217.
insured’s claim. The reasonableness of the insurer’s conduct must be determined objectively. Thus, if a reasonable person would find that the insurer’s justification for denying or delaying payment of a claim was “fairly debatable” (i.e., if reasonable minds could disagree as to the coverage-determining facts or law), then this weighs against a finding that the insurer acted unreasonably. This is true even if the insurer’s defense ultimately proves to be unsuccessful, because resort to a judicial forum does not necessarily evince bad faith or unfair dealing, regardless of the outcome of the proceeding.\(^{213}\)

Nonetheless, the court viewed fair debatability as only part of the necessary analysis, agreeing with the Arizona Supreme Court’s statement in *Zilisch v. State Farm Mutual Automobile Insurance Co.*,\(^{214}\) that “‘[w]hile it is clear that an insurer may defend a fairly debatable claim, all that means is that it may not defend one that is not fairly debatable. But in defending a fairly debatable claim, an insurer must exercise reasonable care and good faith.’”\(^{215}\) (See § 17.05[1][a], above)

However, in *Sanderson* itself, the court of appeals agreed with the district court that no reasonable jury could find that AFI acted in bad faith in contesting relative fault, which might have defeated liability altogether, if Sanderson had been at least 50% at fault. “Sanderson presented no evidence that AFI had contested liability in bad faith or without any reasonable basis for doing so.”\(^{216}\) Sanderson instead focused on the magnitude of his damages. Similarly, AFI’s (unsuccessful) argument that it was entitled to an offset for the personal injury protection (“PIP”) benefits it had paid and was paying was not shown to be made in bad faith.

But Sanderson also complained about AFI’s claim handling:

Specifically, Sanderson points to the evidence presented in his experts’ reports, which tended to show, among other things, that AFI had improperly (1) failed to follow prevailing industry investigation standards; (2) substituted the nonmedical opinions of its claims attorney and claims adjuster for those of Sanderson’s doctors; (3) failed to explain why Sanderson’s claim was being delayed and denied; and (4) made a low settlement offer of $30,000, never explained the basis for that offer, and stubbornly refused to move from that offer.\(^{217}\)

The court of appeals concluded that the fact that the defenses previously discussed were fairly debatable did not obviate the need to consider claim processing issues, agreeing with *Zilisch* that

“while fair debatability is a necessary condition to avoid a claim

\(^{213}\) 251 P.3d at 1217 (citations omitted).


\(^{215}\) *Sanderson*, 251 P.3d at 1218, quoting *Zilisch*, 196 Ariz. at ¶ 19.

\(^{216}\) 251 P.3d at 1218.

\(^{217}\) 251 P.3d at 1219.
of bad faith, it is not always a sufficient condition. The appropriate inquiry is whether there is sufficient evidence from which reasonable jurors could conclude that in the investigation, evaluation, and processing of the claim, the insurer acted unreasonably and either knew or was conscious of the fact that its conduct was unreasonable.\textsuperscript{218}

However, the court of appeals concluded that no reasonable jury could have found bad faith based on the claim handling in \textit{Sanderson}. There could be no liability for delay while Sanderson litigated with Pierce, because Colorado law then required exhaustion of the tortfeasor’s limits before any UIM payment was due.\textsuperscript{219} All of the evidence Sanderson relied upon to show the existence of material issues on bad faith actually pertained to material issues in the UIM arbitration and did not show lack of good faith by AFI in disputing the UIM claim.\textsuperscript{220} Sanderson made no showing that better investigation by AFI “would have altered its analysis of the liability and offset issues, … defenses, which, if successful, could have absolved AFI from liability altogether.”\textsuperscript{221} Accordingly, “as a matter of law, … AFI was entitled to pursue its defenses to liability.”\textsuperscript{222}

While Sanderson claimed that AFI had not timely informed him of its basis for contesting liability, the court found that he was well aware of that basis and had ample opportunity to explore it in the arbitration. AFI’s $30,000 settlement offer was “made in the context of an adversarial arbitration in which AFI was asserting multiple defenses that, if successful, could have reduced its liability to $30,000, if not entirely.”\textsuperscript{223} Under the circumstances, “AFI had no duty to negotiate at all during the arbitration,” let alone to explain its offer.\textsuperscript{224} Moreover, AFI did explain its basis; “[t]he fact that Sanderson did not agree with this explanation does not support a bad faith claim.”\textsuperscript{225}

Accordingly, there was no basis on which a jury could have found bad faith.

The question whether a claim was “fairly debatable” is not really a defense, but is a fundamental aspect of what must be established in order to impose bad faith liability. But, as the \textit{Sanderson} court failed to understand, the determination of whether a claim was fairly debatable must take account, not only of the information the insurer knew, but also of what it should have discovered had it properly investigated.\textsuperscript{226} (See § 5.04, above) If, taking account of all of that

\begin{footnotesize}
\textsuperscript{218} 251 P.3d at 1219, \textit{quoting Zilisch}, 196 Ariz. at ¶ 22.
\textsuperscript{219} 251 P.3d at 1220.
\textsuperscript{220} 251 P.3d at 1220.
\textsuperscript{221} 251 P.3d at 1220.
\textsuperscript{222} 251 P.3d at 1220.
\textsuperscript{223} 251 P.3d at 1220.
\textsuperscript{225} 251 P.3d at 1221.
\textsuperscript{226} Indeed, the statute provides that the jury may be instructed that wilfull conduct of the sort described in
information, the claim is fairly debatable, it ought not to be possible to find bad faith liability. (See §§ 17.03–17.04, above.) The only reason Sanderson gives for rejecting a threshold defense that a claim was fairly debatable is that “there may be instances in which a poor investigation might preclude an insurer from obtaining summary judgment on the basis of an allegedly viable defense (e.g., where a proper investigation might have revealed that the insurer’s superficially viable defense would not succeed).” That is certainly correct, but fully consistent with the true rule shielding an insurer’s right to challenge fairly debatable claims. One possible reading of Sanderson is that what it meant by a “threshold defense” was one that could obviate any need for discovery. If that was the meaning, the court was correct in saying that discovery might be needed into the adequacy of the insurer’s investigation and what it would have found had it investigated further. But the focus would be on what information supporting the claim the insurer missed and whether a reasonable investigation would have uncovered that information. (See § 17.03[4][d], above.)

In any event, all of the Sanderson court’s comments on whether it is a “threshold defense” to bad faith that a claim was fairly debatable were dicta. Affirmance was proper whether or not there was a “threshold defense,” because there was no injury to Sanderson from any improper claims handling (if there had been any of that). Accordingly, it ought not to have much precedential weight. Nonetheless, other courts have found it persuasive.

[b] Cases Following Sanderson

[i] Colorado Court of Appeals

Many of the cases following Sanderson, like Sanderson itself, can be reconciled with the analysis offered here. Thus, in Vaccaro v. American Family Insurance Co., the insurer denied UIM benefits because it refused to accept the diagnosis and recommendations of the insured’s medical expert, whom it regarded as “retained only for litigation.” But it “did not present any evidence at trial, relying instead on plaintiff’s prior statements to paramedics and treating physicians that he was not seriously injured in the auto accident and was not in severe pain.” One cannot get summary judgment or directed verdict that an issue is fairly debatable without presenting evidence sufficient to create a genuine factual issue. (See § 17.03[4], above.)

the unfair claim practices statute “is prohibited and may be considered if the delay or denial of the claimed injury, damage, or loss was caused by or contributed to by such prohibited conduct.” COLO. REV. STAT. § 10-3-1113(4). Among the practices thus proscribed is denying claims without conducting a reasonable investigation, COLO. REV. STAT. § 10-3-1104(1)(h)(IV). This confirms that lack of information that would have been discovered had a reasonable investigation been conducted cannot provide a reasonable basis for delay or denial of a claim.

There are a few jurisdictions that hold that an insurer can be liable for bad faith even if no benefits were due under the contract. See § 5.06, above. In such jurisdictions, the rule stated in the text may not hold. But even in such jurisdictions, it is difficult to see what damages the bad faith claim handling would cause, unless some collateral interest of the insured is injured by the claim handling.

227 Sanderson, 251 P.3d at 1220.
228 § 10-3-1104(1)(h)(IV).
230 2012 COA 9M, ¶ 33.
231 2012 COA 9M, ¶ 46.
evidence the insurer relied on, both in adjusting and at trial, does not appear sufficient to create a genuine factual issue regarding the doctor’s diagnosis and recommendations: contrary medical evidence would be required. Thus, even under the analysis offered here, Vaccaro would seem to have correctly concluded that the evidence permitted a finding of bad faith.232

Another factor affecting Vaccaro is that Colorado now has a statute supplementing the common law cause of action. Under the common law, “an insurer acts in bad faith in delaying the processing of or denying a valid claim when the insurer’s conduct is unreasonable and the insurer knows that the conduct is unreasonable or recklessly disregards the fact that the conduct is unreasonable.”233 Under the statute, “[a] first-party claimant … whose claim for payment of benefits has been unreasonably delayed or denied may … recover reasonable attorney fees and court costs and two times the covered benefit.”234 For purposes of the statute, “an insurer’s delay or denial was unreasonable if the insurer delayed or denied authorizing payment of a covered benefit without a reasonable basis for that action.”235 Thus, the common-law requirement that the insurer know of, or recklessly disregard, its lack of a reasonable basis does not apply under the statute.

But if the claim is fairly debatable, we would conclude that this indicates that the insurer had a reasonable basis. So, while liability under the statute is broader (with no requirement of subjective culpability), the summary judgment analysis should not differ as between the statute and the common law.

The Vaccaro court seemingly disagreed with this approach, distinguishing between the common law and statutory standards, in part on the ground that

the “fairly debatable” defense goes as much to the knowledge or recklessness prong of common law bad faith as it does to unreasonable conduct. By contrast, the only element at issue in the statutory claim is whether an insurer denied benefits without a reasonable basis.236

We would argue that if, after full investigation, the right to benefits is fairly debatable that fact impacts both prongs of the common-law analysis. That fact necessarily shows existence of a

234COLO REV. STAT. § 10-3-1116(1).
235COLO REV. STAT. § 10-3-1116(2).
reasonable basis. It also supports a finding that the insurer did not know or recklessly disregard the fact that it lacked such a basis. But the latter impact is the weaker one: even where a reasonable basis existed, the insurer might have mistakenly believed otherwise.

A more complex problem was presented in *Hansen v. American Family Insurance Co.* That was an underinsured motorist claim by Jennifer Hansen, who was injured while a passenger in her boyfriend’s car, which he was driving. But the declaration pages for the policy, from its inception showed her parents as the named insureds and, at least at the time of the accident, Jennifer did not reside with them. So, American Family denied the claim, on the ground that Jennifer was not an insured. But Jennifer owned the insured car and asserted that she had always been a named insured. This claim was supported by lienholder statements issued by the insurance agency, which also described themselves as “declaration pages.” After Jennifer filed suit, American Family elected to reform the policy to designate her as a named insured and eventually paid the $75,000 UIM limits. The trial court concluded that the lienholder statement rendered the policy ambiguous as a matter of law and so instructed the jury. As to the common-law claim, the jury found that American Family neither unreasonably denied the claim nor knew or recklessly disregarded any unreasonableness. But, on the statutory claim, it found that American Family denied the claim without a reasonable basis, that this caused Jennifer damages, but that it did not cause denial or delay of any of the UIM benefits without a reasonable basis. The trial court awarded a penalty of twice the covered benefit ($150,000) plus $199,683.28 in attorney’s fees and costs.

The court of appeals affirmed. Because the jury found for American Family on the common law claim, the court found the issue of evidentiary sufficiency moot. As to the statutory claim, it simply quoted *Sanderson* and *Vaccaro*, declared itself persuaded by their analysis, and said that “even assuming coverage here was ‘fairly debatable’ because the policy was arguably unambiguous as to the named insured, the insurance company is not entitled to judgment as a matter of law on the claimant’s statutory claim.” It did not explain how American Family could be found to lack a reasonable basis for its action if, indeed, the policy was arguably unambiguous as to the named insured. (On the analysis we favor, the result in *Hansen* might be supportable on the ground that, given the facts in the case, ambiguity was not fairly debatable. But that was not the basis chosen by the court.) The Colorado Supreme Court reversed: it found no ambiguity in the insurance policy, extrinsic evidence could not be consulted, and the insurer acted reasonably reasonable in relying on the policy. As a result, the court did not address the impact of a determination that the claim was “fairly debatable” or the relation of that determination to whether the insurer’s denial was reasonable.

*Schuessler v. Wolter* consolidated claims for medical malpractice and insurance bad faith in connection with a work injury. (The medical malpractice claims are not relevant here.) The workers’ compensation insurer, Pinnacol, denied benefits on the ground that a work injury had not been established. An administrative law judge awarded benefits, which Pinnacol paid.

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238 2013 COA 173, ¶¶ 3-20, 28–32.
240 2013 COA 173, ¶ 43.
Schuessler sued for bad faith delay. A jury found Pinnacol liable, awarding $50,000 in economic damages and $325,000 in noneconomic damages.\textsuperscript{243}

Schuessler had medical insurance through Kaiser Foundation Health Plan. Wolter, a neurosurgeon working for Kaiser, diagnosed multiple degenerative disc changes and possible herniation of one disc. He performed a diskectomy and fusion, which was successful but resulted in side effects.\textsuperscript{244} Pinnacol relied on the opinion of another doctor that “Schuessler’s injury might not be work related because (1) Schuessler delayed in reporting the injury; (2) his medical condition was more consistent with chronic degenerative changes than with an acute injury; and (3) the symptom spectrum was inconsistent with established disease patterns.”\textsuperscript{245}

Pinnacol argued that Schuessler’s entitlement to benefits was fairly debatable, and that this defeated the bad faith claims. Based on Sanderson and Vaccaro, the court reasoned that fair debatability did not defeat the bad faith claim and pointed to the facts that three other doctors had opined that Schuessler suffered a work injury and that this was corroborated by evidence from the employer.\textsuperscript{246}

It is possible that Pinnacol’s evidence was insufficient to establish fair debatability. The doctor it relied upon seems only to have opined that Schuessler might not have suffered a work-related injury, not that, in fact, his symptoms resulted only from chronic degeneration. Nor is it clear that Pinnacol’s doctor considered and rejected the opinions of the other doctors. But the court at least assumed that the evidence did establish fair debatability, and held that a jury might nonetheless find that Pinnacol lacked a reasonable basis. As with the other cases, it does not explain the basis on which that could be found.

In Vignola v. Gilman,\textsuperscript{247} a Nevada district court rejected cross-motions for summary judgment on bad faith in handling a Colorado UIM claim by Auto-Owners Insurance Co.\textsuperscript{248} The insured, Nancy Oullet, was killed on June 22, 2010 in an auto accident caused by Charles Gilman. Louis Vignola reported this to an agent for Auto-Owners. Vignola initially described himself as Oullet’s ex-husband, but later claimed they were still married, but separated. Her death certificate said she was divorced. Vignola produced evidence of the marriage, but (despite numerous requests from Auto-Owners) never provided evidence that they were still married nor (so far as the opinion reflects) any explanation for the indications that they were divorced. Auto-Owners investigated but found no evidence of a divorce.\textsuperscript{249}

Plaintiffs in the bad faith case were Oullet’s minor children (through their father, Vignola, as guardian ad litem) and the administrator of Oullet’s estate. By late 2010, there were only two obstacles to payment of the $500,000 UIM limit. Plaintiffs had not exhausted the limits of Gilman’s insurance, as required by a provision in the Auto-Owners policy (the validity of which

\begin{thebibliography}{99}
\bibitem{243} 2012 COA 86, ¶¶ 2–5.
\bibitem{244} 2012 COA 86, ¶¶ 3–4.
\bibitem{245} 2012 COA 86, ¶ 41.
\bibitem{246} 2012 COA 86, ¶¶ 39–42.
\bibitem{248} There was also a claim for destruction of the motorcycle that Oullet was riding. 2013 U.S. Dist. LEXIS 176723, at *5. It does not appear to have been significant to the bad faith suit.
\bibitem{249} 2013 U.S. Dist. LEXIS 176723, at *2–4, *8–9.
\end{thebibliography}
plaintiffs disputed). And Auto-Owners had not determined the proper recipients, given the uncertainty about the status of Vignola’s marriage to Oulet. But no payment was made until December 2011, when the UIM claim was settled by payment of $250,000 to each of the children, with a release of any claim by Vignola. The settlement reserved claims for bad faith delay.\textsuperscript{250}

The court held that the policy provision requiring exhaustion of the tortfeasor’s limits was unenforceable, but concluded that whether Auto-Owners’ reliance on that provision was fairly debatable presented a jury question and that, even if it were fairly debatable, a jury could find that reliance unreasonable.\textsuperscript{251} A jury might also find that Auto-Owners could have resolved the identity of the proper payees by filing an interpleader or in other ways offered by plaintiffs.\textsuperscript{252}

On the analysis offered here, that ruling was problematic both in allowing a jury to decide whether a legal position was fairly debatable (see § 17.04[2], above) and in holding fair debatability would not defeat the bad faith claim.

[ii] Tenth Circuit

In the absence of a decision by the Colorado Supreme Court on the issue, the Tenth Circuit has chosen to follow these decisions. \textit{Home Loan Investment Co. v. St. Paul Mercury Insurance Co.}\textsuperscript{253} arose from a fire loss claim. Home Loan held a deed of trust on property known as “White Hall.” The owner had stopped making payments and offered a deed in lieu of foreclosure. Home Loan instead elected to work with the owner to try to sell the property, so it could be paid from sale proceeds. St. Paul had a relationship with Home Loan through which it provided coverage for foreclosed property. When Home Loan sought coverage for White Hall, St. Paul, it received a questionnaire asking it to state the nature of its interest, offering the following options:

\begin{itemize}
  \item a) Bank has actual title to the property.
  \item b) Bank is holding the property during the statutory period of redemption.
  \item c) Bank is the mortgagee in possession of real property with the agreement or consent of the borrower.
  \item “d) Bank is in the process of foreclosing—formal proceedings have been started and papers have been filed in the proper legal jurisdiction.”\textsuperscript{254}
\end{itemize}

None of those statements was literally true, but Home Loan answered “c.” St. Paul then issued a policy of foreclosed property protection, defining “foreclosed property” as

\textsuperscript{250}2013 U.S. Dist. LEXIS 176723, at *2–14.
\textsuperscript{251}2013 U.S. Dist. LEXIS 176723, at *23–25.
\textsuperscript{252}2013 U.S. Dist. LEXIS 176723, at *25–28.
\textsuperscript{253}Home Loan Inv’t Co. v. St. Paul Mercury Ins. Co., 827 F.3d 1256 (10th Cir. 2016).
\textsuperscript{254}827 F.3d at 1258.
“any building or structure that you:

- acquire by legal enforcement of a lien through a foreclosure proceeding;
- acquire by obtaining a deed in lieu of foreclosure; or
- hold as a mortgagee in possession.”

The policy defined “mortgagee in possession” as “a mortgagee of a building or structure who is in possession of it or who has assumed the care, custody, or control of such building or structure on behalf of the mortgagor with the agreement or assent of the mortgagor.” But it did not define “possession” or “care, custody, or control.”

The property was then nearly destroyed by fire. In processing the claim, St. Paul asked who had possession of the property or care, custody and control of it. Home Loan responded with the name of the owner. St. Paul then denied the claim, because the property did not meet the definition of “foreclosed property,” and sent a check to refund the premium payment.

Home Loan sued, alleging breach of contract and statutory bad faith. St. Paul’s motions for summary judgment were denied and a jury found for Home Loan on both claims. St. Paul appealed, challenging only the finding of bad faith.

St. Paul’s lead argument was that Home Loan’s claim was, at best, “fairly debatable,” and that this established that its position was not unreasonable. The Tenth Circuit did not itself analyze the merits of that argument, instead deferring, in the absence of a decision by the Colorado Supreme Court, to the “well reasoned” decisions of the court of appeals.

St. Paul also argued that the bad faith statute governed only unreasonable conduct in claims handling not in underwriting. But the Tenth Circuit looked to the breadth of the unfair insurance practices statute of which the bad faith statute was a part, which reached all unfair practices in the business of insurance. It reasoned that:

The sweeping language of these statutes makes clear Colorado’s intent to capture all aspects of the insurance relationship and to impose liability for both bad faith breach of the obligation to indemnify—underwriting—and bad faith breach of the obligation to pay a specified or ascertainable amount—claims handling. Under the plain language of section 10-3-1115 and related statutes, a plaintiff may recover whether a claim is unreasonably delayed or denied because the insurer believes the policy should never have been issued or because of some issue related to the claim itself. So long as the jury is convinced the

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255 827 F.3d at 1259.
256 827 F.3d at 1259.
257 827 F.3d at 1259.
258 827 F.3d at 1260.
259 827 F.3d at 1260–62.
claim was unreasonably delayed or denied, the plain language of section 10-3-1115 provides a remedy. Accordingly, we hold liability under sections 10-3-1115 and 10-3-1116 is not limited to claims-handling conduct. 260

A dissent argued that the evidence was insufficient to show that St. Paul acted unreasonably. 261 But the court found that St. Paul had not properly presented and preserved a general challenge to the sufficiency of the evidence, because its argument, both before submission to the jury and after the verdict focused entirely on the argument about inapplicability of the statute to underwriting issues; moreover, St. Paul did not argue general sufficiency of the evidence in its opening brief on appeal. 262

A few days later, a similar conclusion on the significance of fair debatability was reached in Etherton v. Owners Insurance Co. 263 This concerned a UIM claim. Etherton’s car had only minor damage, but he underwent three back surgeries to repair disk damage in his spine. The other driver’s insurer settled with Etherton for a $250,000 policy limit. Etherton had UIM coverage of $1 million and demanded the difference. After months of seeking additional information, Owners offered $150,000, stating that there was a serious question of causation by the accident. Etherton sued a few months later. 264

As trial approached, Owners moved to exclude Etherton’s expert witness, and the judge then assigned to the case granted the motion. Etherton moved for reconsideration and the judge recused. The new judge granted reconsideration and allowed the expert to testify. The jury found damages of $1,382,000 and bad faith refusal to pay. Owners filed a motion for new trial and JMOL, arguing that the expert testimony was inadmissible and that, without that testimony, Etherton had not proved causation. The court disagreed and entered judgment for $2,250,000 ($750,000 in benefits and twice that in penalties). Owners appealed. 265

The Tenth Circuit concluded that the district court had not abused its discretion in allowing the expert. 266 The court also agreed with Hansen that the fact that the claim was fairly debatable does not conclusively establish that denial or delay was reasonable. But it also criticized Owners for rejecting Etherton’s evidence of causation (which apparently did not include a medical conclusion on that issue) without any contrary evidence. 267 This suggests that Owners did not then have evidence sufficient to render causation fairly debatable. (That might

260 827 F.3d at 1262–63. The dissent found it unnecessary to decide that issue, because the conduct at issue (denial of the claim) was not underwriting conduct. 827 F.3d at 1275. (Apparently, Home Loan argued that St. Paul had engaged in post-claim underwriting. See § 8.08[3], above.).

261 827 F.3d at 1270-77. Specifically, the dissent argued that, even if the jury could have properly found that Home Loan had possession, custody, or control of White Hall, it could not have found it unreasonable for St. Paul to contest that issue. 827 F.3d at 1275-76. Of course, that bad faith question is closely connected to, if not the same as, whether the coverage issue was fairly debatable.

262 827 F.3d at 1265-70.


264 829 F.3d at 1214–15.

265 829 F.3d at 1215–16.

266 829 F.3d at 1219–23.

267 829 F.3d at 1226–27.
have sufficed to permit delay while seeking such evidence, but not refusal to pay.) On that basis, the result could be correct, even if the assessment of the significance of a claim being fairly debatable was not.

[c] Critique of *Sanderson* and Its Progeny

The Colorado Supreme Court recognized the tort of first-party bad faith and defined its elements in *Travelers Insurance Co. v. Savio*. It held that an insured “who asserts that an insurer has failed to pay a claim in bad faith must establish that the insurer acted unreasonably and with knowledge of or reckless disregard for the fact that no reasonable basis existed for denying the claim.”

This formulation suggests that the court intended that an insurer ought to be held to have “acted unreasonably” only when “no reasonable basis existed for denying the claim.”

The court emphasized that “[t]he insurer … must be accorded wide latitude in its ability to investigate claims and to resist false or unfounded efforts to obtain funds not available under the contract of insurance.” It looked to *Anderson v. Continental Insurance Co.*, in which the Supreme Court of Wisconsin recognized the peculiar characteristics of first-party insurance claims and concluded that the appropriate standard for determining the presence or absence of bad faith dealing by an insurer with regard to a claim of its insured consisted of two parts: “the absence of a reasonable basis for denying benefits of the policy and the defendant’s knowledge or reckless disregard of the lack of a reasonable basis for denying the claim.”

That formulation would be exactly equivalent to the one adopted in *Savio*, if the *Savio* formulation is read as suggested above.

Moreover, the *Savio* court quoted approvingly from *Anderson*: “‘Under these tests of the tort of bad faith, an insurance company … may challenge claims which are fairly debatable and will be found liable only where it has intentionally denied (or failed to process or pay) a claim without a reasonable basis.’” Strikingly, even *Schuessler*, which followed *Sanderson*, recognized that the *Savio* standard means that “[u]nder Colorado law, it is reasonable for an insurer to challenge claims that are ‘fairly debatable.’”

Insofar as *Sanderson* and its progeny allow an insurer to be held liable for bad faith failure

\[269\] 706 P.2d at 1274.
\[270\] 706 P.2d at 1274.
\[272\] *Savio*, 706 P.2d at 1275.
\[273\] See also *COLO. REV. STAT.* § 10-3-1116(2) (“an insurer’s delay or denial was unreasonable if the insurer delayed or denied authorizing payment of a covered benefit without a reasonable basis for that action.”).
\[274\] 706 P.2d at 1275, quoting *Anderson*, 271 N.W.2d at 377 (emphasis added).
to pay a claim that, after proper investigation, is fairly debatable, those cases cannot be reconciled with *Savio*.*276 Accordingly, they ought not to be considered authoritative under Colorado law.

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276 In *American Family Mutual Insurance Co. v. Allen*, 102 P.3d 333 (Colo. 2004), the court remanded for trial of a coverage issue as to ownership of the insured car, but directed that the damage award (including tort damages for bad faith) stand if coverage were found. 102 P.3d at 345. While existence of a triable issue of fact on coverage would seem to provide a basis for fair debate and preclude any finding of bad faith, that argument was not made on appeal. Instead, the insurer argued as to the issue of bad faith only that expert testimony on industry standards was required to find liability, an argument the court rejected. 102 P.3d at 342–45.