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REGULATORY LIMITS ON CLAIMS HANDLING

Timing for Responses and Determinations

The Fair Claims Settlement Practice Regulations set forth the relevant time limits for claims handling responses and determinations. The most important time limits are: 15 days to acknowledge receipt of claim (10 Cal. Code Reg., § 2695.5(e)(1)); 15 days to respond to communications from claimant, regarding a claim, to which reply is expected (10 Cal. Code Reg., § 2695.5(b)); 40 days after proof of loss to accept or deny claim, or notify that more time is needed (10 Cal. Code Reg., § 2695.7(b)).

As to the requirement to reply within 15 days after receipt of any communication from a claimant that suggests a reply is expected, the response must be complete and based upon the facts as then known. This requirement ends when there is receipt of notice of legal action. Note that as to the 40 day requirement, it is triggered by proof of claim, which means evidence or documentation in the possession of the insurer, whether submitted by the claimant or obtained by the insurer in the course of its investigation, showing any evidence of the claim and reasonably supporting the magnitude or amount of the claimed loss. If an insurer requires more than 40 days to make a claims determination, the insurer must provide the claimant with written notice that additional time is required to make a determination and specify what further information is required and the continuing reasons for the inability to make a determination.

Standards for Determination and Settlements

Claims handling standards are set forth in Insurance Code section 790.03, and the above regulations. Violations of Insurance Code section 790.03 can only be enforced by the Insurance Commissioner. (See Cal. Ins. Code, § 790.04.) However, although no private right of action exists for violation of the statute or regulations (*Moradi-Shalal v. Fireman's Fund Ins. Cos.* (1988) 46 Cal.3d 287, 304), violation of the regulations is admissible evidence of the tortious breach of the implied covenant of good faith and fair dealing. (*Jordan v. Allstate Ins. Co.* (2007) 148 Cal.App.4th 1062, 1078.)

PRINCIPLES OF CONTRACT INTERPRETATION

An insurance policy is a binding, legal contract between the insurer and the insured under which the insurer agrees to defend and indemnify the insured against loss, damage, or liability arising from a contingent or unknown event in exchange for payment of a premium by the insured. (Cal. Ins. Code, §§ 22–23; *Fraser-Yamor Agency, Inc. v. County of Del Norte* (1977) 68 Cal.App.3d 201, 213.) There must be a meeting of the minds of the parties as to the essential terms of the insurance contract. (*Long v. Keller* (1980) 104 Cal.App.3d 312, 321 (providing essential terms including the subject matter to be insured, the hazards covered, the policy term, and others).)

An insurance policy should generally be interpreted under the same rules governing the interpretation of any contract. (*State Farm Mutual Auto. Ins. Co. v. Eastman* (1984) 158 Cal.App.3d 562, 566.) If an insurance policy's terms are clear, the terms are given the plain meaning that a layman would ordinarily attach to them. (*Reserve Ins. Co. v. Pisciotta* (1982) 30 Cal.3d 800, 807.) As to terms of the policy that are ambiguous or uncertain, those terms are resolved by giving effect to the insured's objectively reasonable expectations, or, if this fails, by construing the ambiguous language against the insurer. (*E.M.M.I. Inc. v. Zurich Am. Ins. Co.* (2004) 32 Cal.4th 465, 470.)

In determining whether the circumstances give rise to an exception to the general rule that ambiguous language is construed against the insurer, courts have examined the size, sophistication, and bargaining strength of the insured, as well as other factors. Such other factors include, among others: the insured's ability to negotiate policy changes (*Advanced Micro Devices, Inc. v. Great American Surplus Lines Ins. Co.* (1988) 199 Cal.App.3d 791, 801); representation and assistance of insurance brokers or risk managers, or both, on behalf of the insured (*Fireman's Fund Ins. Co. v. Fibreboard Corp.* (1986) 182 Cal.App.3d 462, 468); and whether the policy was a manuscript policy negotiated and prepared specifically for the insured, rather than a standardized form (*Garcia v. Truck Ins. Exch.* (1984) 36 Cal.3d 426, 438).

In interpreting an insurance policy, a court's fundamental goal is to give effect to the parties' intent at the time of contracting. (*Bank of the West v. Superior Court* (1992) 2 Cal.4th 1254, 1265.) Some courts have held that relevant extrinsic evidence can assist in interpreting the policy if such evidence can establish the intent of the parties at the time of contracting. (See *Gribaldo, Jacobs, Jones & Assoc. v. Agrippina Versicherunges A.G.* (1970) 3 Cal.3d 434, 443 (testimony allowed on how deductible on errors and omissions indemnity policy operated); *Heston v. Farmers Ins. Group* (1984) 160 Cal.App.3d 402, 412 (insurer's statements about "contract value" provisions held admissible).) Extrinsic evidence of the intent of the parties can be admitted only if the evidence is relevant, and the language in the policy is fairly susceptible to either of two interpretations. (*Gribaldo, Jacobs, Jones & Assoc.*, supra, at p. 443.)

For example, extrinsic evidence of "the type of information sought upon application for such a policy and the relatively small premiums charged" was admissible to show that the parties never intended coverage. (*Herzog v. National American Ins. Co.* (1970) 2 Cal.3d 192, 197.) Extrinsic evidence of the circumstances surrounding the making of a contract may also be admissible. (E.g., Heston, supra, at p. 412 (express representations on status as "independent businessman" made during negotiations are clearly relevant to determining meaning of ambiguous contract).)

Additionally, the Insurance Code includes a broad variety of regulations that affect the formation, interpretation, and coverage of an insurance contract. For example, the concealment or misrepresentation in the formation of contract of material facts by the insured or insurer is prohibited (Cal. Ins. Code, §§ 330–331, 359); and a violation of a material warranty or other material provision of a policy, on the part of either party, entitles the other to rescind (Id. § 447).

In *Lat v. Farmers New World Life Ins. Co.* (2018) 29 Cal.App.5th 191, the court held that the notice-prejudice rule precluded a denial of life insurance benefits based on the insured's failure to give notice of disability as required under a disability premium waiver rider. Absent proof of actual prejudice, the insured was entitled to the benefit of the premium waiver and the policy remained in force despite the lack of payment.

CONTRACT INTERPRETATION
Common Issues

1. Faulty Workmanship as an "Occurrence"

California courts have demonstrated a willingness to enforce "faulty workmanship" exclusions in commercial general liability policies (commonly the "j(5)" and j(6)" exclusions. Notably, the Court in *Clarendon America Ins. Co. v. General Security Indemnity Co. or Arizona* (2011) 193 Cal.App.4th 1311, 1325 ("*Clarendon*"), held that those exclusions "preclude coverage for deficiencies in the insured's work." In reaching this conclusion, the court cited the rationale of an older decision, *Maryland Casualty Co. v. Reeder* (1990) 221 Cal.App.3d 961, 967, which had concluded that general liability policies are not intended to provide contractors with coverage for claims their work is inferior or defective.

The *Clarendon* Court went on to hold that the contractor bears the risk of repairing or replacing faulty workmanship while the insurer bears the risk of damage to the property of others.

The *Clarendon* ruling was recently reinforced by the California Court of Appeal, Second District, in *Letgolts v. David H. Pierce & Associates, PC* (2021) 71 Cal.App.5th 272, 281-282, in which the Court of Appeal interpreted a manuscript policy as precluding coverage for faulty workmanship where an insured sought to enforce the carrier's duty to *defend*. The decision explained that insuring against faulty workmanship creates a "moral hazard" of tempting contractors to cut corners wherever possible with the recognition that if their work is faulty or defective, they will not face monetary consequences – their insurance would instead be responsible.

In sum, under standard commercial general liability policies, there can be no coverage for faulty workmanship unless and until there is evidence of "property damage" (as defined in the policy) beyond the defective work.

2. Does Your State Have an Anti-Indemnity Statute?

Yes. California Civil Code §§ 2782 applies to "construction contracts" entered after January 1, 2013. It applies to both private and public contracts, and voids indemnity agreements which purport to require indemnity for a contracting party's "sole negligence or willful misconduct" or for "defects in design furnished by those persons…."

CHOICE OF LAW

The interpretation process of a policy begins with a determination of which jurisdiction's law should be applied. If all contacts involving the action have occurred in California, a choice of law issue does not arise, and California law applies. When out-of-state contacts exist, however, and the laws of the other state(s) and those of California differ, a choice of law analysis must be applied. Litigation over insurance contracts can involve complicated choice of law issues, often because insurance contracts do not include a choice of law provision and the insurer and insured are from different states. For example, determination of whether an excess policy provides coverage may require a choice of law analysis, which may result in the application of the law of a jurisdiction other than California. This issue is important because the applicable state law may determine issues such as the insurability of punitive damages or the existence of a bad faith tort.

California courts have adopted the governmental interest test for choice of law problems in both contract and tort cases. (Kearney v. Salomon Smith Barney, Inc. (2006) 39 Cal.4th 95, 100; Robert McMullan & Son, Inc. v. United States Fid. & Guar. Co. (1980) 103 Cal.App.3d 198, 204 (contract issue); Offshore Rental Co. v. Continental Oil Co. (1978) 22 Cal.3d 157, 161 (tort issue).) The governmental interest test is a three-step analysis: (1) determine whether the laws of the various states that have contacts with the action conflict on the issue to be interpreted (Offshore Rental Co., supra, at p. 161); (2) if the laws conflict, assess whether the states each have an interest in having their own state law applied by examining the relative interests of the litigants and states involved (e.g., the place of contracting, negotiation, and performance; location of subject matter; and domicile, residence, place of incorporation of parties (Robert McMullan & Son, Inc., supra, at p. 204–05); and (3) if both (or two or more) states have an interest in having their own law applied, there is a true conflict, and the comparative impairment analysis must be applied, i.e., the court must determine which state's interest would be more impaired if its law were not applied (Zimmerman v. Allstate Ins. Co. (1986) 179 Cal.App.3d 840, 846).

In performing the comparative impairment analysis, a court examines the history and current status of the conflict laws, as well as the function and purpose of those laws. (Kearney, supra, at p. 123–24.) For example, if a state's law is outmoded and infrequently applied when compared with the law of another state, the interests of the state with the newer law will generally prevail. (E.g., Offshore Rental Co. v. Continental Oil Co. (1978) 22 Cal.3d 157, 169; Rosenthal v. Fonda (9th Cir. 1988) 862 F.2d 1398 (holding that New York's law on breach of an oral employment contract applied because its statute of frauds was stricter than California's, thereby demonstrating that New York had a stronger interest in protecting people).) Another factor to consider is California Civil Code section 1646, which provides, "A contract is to be interpreted according to the law and usage of the place where it is to be performed; or, if it does not indicate a place of performance, according to the law and usage of the place where it is made." (Arno v. Club Med Inc. (9th Cir. 1994) 22 F.3d 1464, 1468 n.6 (noting there is a difference of opinion as to whether the governmental interest test or Civil Code section 1646 applies, but holding that under either test, California law applied).)

DUTIES IMPOSED BY STATE LAW

Duty to Defend

1. Standard for Determining Duty to Defend

The duty to defend (implied in all liability insurance policies unless clearly excluded) is broader than the duty to indemnify. (Certain Underwriters at Lloyd's of London v. Superior Court (2001) 24 Cal.4th 945, 958; Gray v. Zurich Ins. Co. (1966) 65 Cal. 2d 263.) "[T]he insured need only show that the underlying claim may fall within policy coverage; the insurer must prove it cannot." (Montrose Chemical Corp. v. Superior Court (1993) 6 Cal. 4th 287, 300 (emphasis in original).) Additionally, the insurer must consider facts extrinsic to the complaint. (See Ibid. ("The duty to defend is determined by reference to the policy, the complaint, and all facts known to the insurer from any source." (emphasis in original); Gray, supra, 65 Cal. 2d at p. 276 ("[C]ourts do not examine only the pleaded word but the potential liability created by the suit.").) The duty to defend arises as soon as tender is made and continues until the action concludes. (Aerojet-General Corp. v. Transport Indem. Co. (1997) 17 Cal. 4th 38, 58.) An "insurer has a duty to defend the entire 'mixed' action imposed by law in support of the policy: 'To defend meaningfully, [it] must defend immediately. [Citation.] To defend immediately, it must defend entirely.'" (Id. at pp. 59–60 (emphasis in original) (citations omitted).)

In Crawford v. Weather Shield Mfg. Inc., (2008) 44 Cal.4th 541, the California Supreme Court addressed the contractual duty to defend in a non-insurance context. The issue was whether a contract under which a subcontractor agreed "to defend any suit or action" against a developer "founded upon" any claim "growing out of the execution of the work" required the subcontractor to provide a defense to a suit against the developer even if the subcontractor was not negligent. (Id. at p. 551.) The California Supreme Court answered this question in the affirmative, ruling that the contractual defense obligation in an indemnity provision of a construction subcontract operates in the same manner as the defense obligation of a general liability policy. (Id. at p. 568.) The contractual duty to defend is prospective or prophylactic in nature and arises on the tender of defense. Further, the duty to defend is triggered by allegations of damage embraced by the indemnity agreement, regardless of whether the subcontractor is ultimately found negligent.

2. Issues with Reserving Rights

The insurer has the obligation to defend lawsuits that could potentially result in covered damages. Thus, coverage questions do not excuse the insurer's duty to furnish a defense: "The court in the third party suit does not adjudicate the issue of coverage . . . the only question there litigated is the insured's liability." (*Gray v. Zurich Ins. Co.* (1966) 65 Cal.2d 263, 279.)

A reservation of rights is a method for providing defense of a claim while preserving coverage defenses. (*ICW v. Haralambos Beverage Co*. (1987) 195 Cal.App.3d 1308.) Conversely, conducting a defense without a reservation of rights can waive any coverage defenses. (*Miller v. Elite Ins. Co.* (1980) 100 Cal.App.3d 739, 755.)

An insurer may unilaterally reserve its rights to invoke coverage defenses (*Blue Ridge Insurance. Co. v. Jacobsen* (2001) 25 Cal.4th 489, 497–98) and seek reimbursement of defense costs expended on claims not potentially covered under the policy. (*Buss v. Superior Court* (1997) 16 Cal.4th 35, 50 ("As to the claims that are not even potentially covered, however, the insurer may indeed seek reimbursement for defense costs.") The insurer may also seek reimbursement of uncovered amounts paid to reasonably settle claims. Where an insurer adequately reserves its rights to seek reimbursement of settlement costs for claims which are not covered, the insured's *promise* to reimburse reasonable settlement amounts paid in settlement is implied in law. (*Blue Ridge,* supra, 25 Cal.4th at pp. 503–04.)

By itself, a general reservation of rights does not give rise to a conflict triggering the duty to provide independent counsel. (*Federal Ins. Co. v. MBL, Inc.* (2013) 219 Cal.App.4th 29, 44.) A conflict of interest may arise, however, which creates a duty on an insurer to provide independent counsel (i.e., *Cumis* counsel) for the insured, when an insurer reserves its rights on a given issue, and the outcome of that coverage issue can be controlled by counsel retained by the insurer for the defense of the claim. (See Cal. Civ. Code § 2860(a)-(b); *San Diego Federal Credit Union v. Cumis Insurance Society, Inc.* (1984) 162 Cal.App.3d 358 (superseded by Cal. Civ. Code § 2860); *Buss*, supra, 16 Cal. 4th at pp. 59–60 ("Civil Code section 2860 simply 'clarifies and limits' *San Diego Federal Credit Union*. . . .").) But the conflict must be real and actual; the insured cannot manufacture a conflict by speculating about hypothetical or potential conflicts that may arise in the course of the litigation. (*Centex Homes v. St. Paul Fire & Marine Ins. Co.* (2015) 237 Cal.App.4th 23.

State Privacy Laws; Insurance Regulatory Issues; Arbitration/Mediation

The Insurance Information and Privacy Protection Act (Cal. Ins. Code, § 791.01 et seq.) creates a statutory right of privacy for an insured and claimants for information maintained by insurance companies, including claims files. Disclosure of the information can be compelled in discovery; however, any order allowing discovery of such information must be conditioned on the written consent of the affected parties in response to a court-approved request form. (Cal. Ins. Code, § 791.13; *Mead Reinsurance Co. v. Superior Court* (1986) 188 Cal. App. 3d 313, 321–22. Cf. Federal HIPAA law.)

In addition, claims files may contain privileged communications made in the course of an attorney-client relationship, or documents that are work-product of either the insurer or the insurer. (See infra, Part VI.D.)

In *Strawn v. Morris, Polich & Purdy* (2019) 30 Cal. App. 5th 1087, the court held that policyholders could state a claim for invasion of privacy against an insurer's coverage counsel and law firm, where the counsel had disseminated inadvertently produced tax returns to forensic accountants while evaluating coverage.

1. Criminal Sanctions

The Insurance Commissioner is authorized to bring enforcement actions against insurers or insurance producers. (Cal. Ins. Code, sec. 12921.1.) Violation of any law or regulation relating to the business of insurance may be prosecuted through an enforcement (or "noncompliance") action. (10 Cal. Code Reg., §2591.1.) Referrals on suspected insurance fraud are handled by the California Department of Insurance, Enforcement Branch Headquarters Intake Unit, 9342 Tech Center Drive, Suite 100, Sacramento, CA 95826, and may be prosecuted as a felony. Punishment for committing insurance fraud ranges from probation, fines, community service, restitution, and imprisonment.

2. The Standards for Compensatory and Punitive Damages

Extracontractual compensatory damages recoverable in insurance "bad faith" actions include economic losses; resulting emotional distress; certain types of attorney fees; and, in some cases, prejudgment interest. Extracontractual damages are available on proof that the insurance company's withholding of benefits was unreasonable. (Progressive West Ins. Co. v. Yolo County Superior Court (2005) 135 Cal.App.4th 263, 278.) Except as otherwise provided by law, a plaintiff is entitled to compensatory damages on proving the elements of a cause of action by a preponderance of the evidence. (Cal. Evid. Code §115.) Punitive damages are awarded on proof by clear and convincing evidence that the defendant is guilty of oppression, fraud, or malice. (Cal. Civ. Code §3294.)

3. Insurance Regulations to Watch

California Code of Civil Procedure Section 999 through 999.5 – Effective January 1, 2023, the California Code of Civil Procedure was modified to specifically address Policy Limits Demands in the Pre-Litigation Context. It outlines the specific requirements by which a "policy limits demand" must meet in order to effectively "open the policy" if the carrier rejects the offer or fails to respond within the requisite time period. It also outlines the requirements imposed upon an insurer who receives such a demand. To the extent an insurance company receives a "policy limits demand" during the pre-litigation claims period – adhering to the stringent requirements of this new code section will be critical in avoiding extra-contractual exposure.

SB 793 – This proposed bill seeks to codify the requirement that insurance institutions or their agents must provide clear and conspicuous privacy notices to customers on an annual basis, including a requirement of notifying customers of the right to submit a written request to access, correct, amend, or delete their personal information.

AB 336 – This proposed bill is particularly applicable to the construction insurance world. It seeks to modify the requirements for contractors (licensed by the Contractors State License Board) seeking to re-certify their satisfaction of workers' compensation insurance requirements imposed by the Board. Specifically, the bill would require contractors submitting certification of compliance with the workers' compensation insurance requirements to identify the specific classification codes endorsed on the policy.

4. State Arbitration and Mediation Procedures

The rules for arbitration in California are governed by the California Arbitration Act, set forth in California Code of Civil Procedure sections 1280 to 1284.4. See also the California Rules of Court, Rule 3.823. In Los Angeles Unified Sch. Dist. v. Safety National Casualty Corp. (2017) 13 Cal. App. 5th 471, the court held that the Federal Arbitration Act does not preempt California's procedural provision that allows a court to deny a motion to compel arbitration where there is a possibility of conflicting rulings in pending litigation with third parties.

Mediation protocol is set forth in California Evidence Code sections 703.5, and 1115 to 1129, inclusive. All communications by mediation participants are considered confidential. Attorneys are required to obtain their client's signature on a separate printed disclosure form confirming that the client understands the proceedings to be confidential to the full extent provided in Evidence Code section 1119.

5. State Administrative Entity Rule-Making Authority

The California Department of Insurance (CDI) regulates the insurance market in California, and is led by the California Insurance Commissioner. The state's legislature authorizes the Insurance Commissioner to conduct evidentiary hearings on a wide variety of insurance related matters. The Administrative Hearing Bureau serves as a neutral forum and conducts hearings in accordance with the Administrative Procedures Act, the California Insurance Code, and Title 10 of the California Code of Regulations. In 1988 the voters adopted Proposition 103 (Cal. Ins. Code, sections 1861.01 et seq.) regulating rates for certain classes of insurance, including private passenger auto insurance. Under the law, insurers offering these classes of insurance cannot set or change rates without the Commissioner's approval and without the opportunity for public participation in the rate setting process. (*California Auto. Assigned Risk Plan v. Garamendi* (1991) 232 Cal.App.3d 904, 909-910.)

EXTRACONTRACTUAL CLAIMS AGAINST INSURERS: ELEMENTS AND REMEDIES

Bad Faith Claim Handling/Bad Faith Failure to Settle Within Limits

3. First Party

To recover for breach of the implied covenant of good faith and fair dealing, an insured must show that the insurer's conduct was not only improper but also unreasonable. Where there is no coverage, there can be no bad faith. (Samson v. Transamerica Ins. Co. (1981) 30 Cal.3d 220, 240; see Waller v. Truck Inc. Exch. (1995) 11 Cal.4th 1, 15 (concluding that plaintiff's alleged emotional and physical distress flowed from noncovered economic loss, so there was no potential for coverage and no duty to defend the plaintiff in the underlying lawsuit; thus, it could not be found liable for statutory bad faith or breach of the implied covenant of good faith and fair dealing for its denial of a defense).)

The opinions in Chateau Chamberay Homeowners Assoc. v. Associated International Ins. Co. (2001) 90 Cal.App.4th 335, 346; Fraley v. Allstate Ins. Co. (2000) 81 Cal.App.4th 1282, 1292; and Guebara v. Allstate Ins. Co. (9th Cir. 2001) 237 F.3d 987, 992, reiterate the long-standing principle that bad faith hinges on reasonableness. It is not bad faith for an insurer adjusting a first party claim to delay or refuse payment of disputed benefits where there exists a "genuine issue" over the existence or scope of the insurer's obligation for policy benefits. Thus, an insurer that denies benefits reasonably, but incorrectly, will be liable only for damages flowing from the breach of contract, i.e., the policy benefits. (Morris v. Paul Revere Life Ins. Co. (2003) 109 Cal.App.4th 966, 977.)

The Chateau Chamberay court elaborated on factors that could support bad faith, including whether the insurer: (1) misrepresented the nature of its investigatory activity, (2) provided any false documents or testimony, (3) did not honestly select independent experts to make the appropriate loss evaluations, (4) relied upon expert reports that were not reasonable or, (5) failed to conduct a thorough investigation." (Id. at 349.) Note that the court in FEI Enterprises, Inc. v. Kee Man Yoon (2011) 194 Cal.App.4th 790, refused to apply both an objective and subjective standard, finding: " The majority view is that in determining whether the dispute is 'reasonable,' the proper test to apply is an objective one. An insurer's subjective state of mind is immaterial."

Under current California law, only insureds have original standing to bring a bad faith claim. In addition, even though typically each party in California bears his or her own attorney's fees, if an insured sues for bad faith and wins, attorney's fees incurred in pursuing contract benefits can be recovered. (Brandt v. Superior Court (1985) 37 Cal.3d 813, 819 ("The fees recoverable, however, may not exceed the amount attributable to the attorney's efforts to obtain the rejected payment due on the insurance contract".)

When an insured assigns a bad faith cause of action against an insurer, the assignee also receives the right to recover the policy benefits in full, plus the right to Brandt fees. (Essex Ins. Co. v. Five Star Dye House, Inc. (2006) 38 Cal.4th 1252, 1255.)

A plaintiff who proves bad faith is entitled to recover under tort law all damages proximately caused by the insurer's conduct, including punitive damages. (Crisci v. Security Ins. Co. (1967) 66 Cal.2d 425, 433.)

4. Third-Party

The implied covenant of good faith and fair dealing runs between the insurer and the insured, not the third party claimant. Therefore, the third party claimant cannot sue for breach of the implied

covenant of good faith and fair dealing if the insurer refuses to settle. (Murphy v. Allstate Ins. Co. (1976) 17 Cal.3d 937, 944.) However, under certain circumstances, an insured may assign its bad faith rights to a third party claimant in exchange for a covenant not to execute, thereby eliminating the insured's personal exposure to an excess judgment. (Hamilton v. Maryland Casualty Co. (2002) 27 Cal.4th 718, 732.)

In 2008, a California Court of Appeal ruled that the "genuine dispute" rule does not bar a complaint for bad faith where the insured alleges, in detail, that the insurer knowingly conducted a biased and incomplete investigation for the specific purpose of minimizing the insured's claim. (See Brehm v. 21st Century Insurance Co. (2008) 166 Cal.App.4th 1225, 1239–40.)

Under the made-whole doctrine, an insurer that does not participate in an underlying third party tort action by its insured is obligated to reimburse its insured for a prorata share of attorneys' fees spent in pursuing a third party tortfeasor. (Century Ins. Co. v. Superior Ct. (Quintana) (2008) 47 Cal.4th 511.)

Personal rights, such as recovering for emotional distress or collecting punitive damages, cannot be assigned and therefore are not recoverable by a third party. (Murphy v. Allstate Ins. Co. (1976) 17 Cal.3d 937, 942 ("[B]ecause a purely personal tort cause of action is not assignable in California, it must be concluded that damage for emotional distress is not assignable.").)

Fraud

Under the California Civil Code, the term "fraud" encompasses independent causes of action for a number of types of claims, including intentional or negligent misrepresentation, concealment, or false promise. (Cal. Civ. Code, §§ 1709-1710.) To recover, "There must be (1) a *false representation* or concealment of a material fact (or, in some cases, an opinion) susceptible of knowledge, (2) made with *knowledge* of its falsity or without sufficient knowledge on the subject to warrant a representation, (3) with the *intent* to induce the person to whom it is made to act upon it; and such person must (4) act in *reliance* upon the representation (5) to his *damage*." (*South Tahoe Gas Co. v. Hofmann Land Improvement Co.* (1972) 25 Cal.App.3d 750, 765 (emphasis in original).)

Common examples of fraud in the context of insurance include: improperly denying claims; misrepresenting to claimants certain facts or insurance policy provisions; and improperly denying coverage.

In *Tenet Healthsystem Desert, Inc. v. Blue Cross of California* (2016) 245 Cal.App.4th 821, the court held that a health insurer's preauthorization for emergency services following an auto accident, without notice of a coverage limitation for injuries sustained when driving while intoxicated, not only estopped the insurer from relying on the exclusion, but constituted fraud and negligent misrepresentation.

Although generally punitive damages cannot be awarded for breach of contract (Cal. Civ. Code, § 3294), punitive damages are available in fraud causes of action, such as in the context of insurance bad faith.

Intentional or Negligent Infliction of Emotional Distress

An action for intentional infliction of emotional distress may be an alternative theory of recovery in a bad faith action against an insurer for mishandling a claim. (See *Fletcher v. Western National Life Ins. Co.* (1970) 10 Cal.App.3d 376, 394.) To prevail, an insured must show: (1) extreme and outrageous conduct by the insurer directed at the insured; (2) the insurer's intent to cause severe emotional distress to the insured thereby, or reckless disregard of the probability that such distress will result; and (3) the insured's severe emotional distress

proximately caused by the insurer's conduct. (*Christensen v. Superior Ct. (Pasadena Crematorium*) (1991) 54 Cal.3d 868, 903.) Courts tend to apply these requirements strictly. (Ibid.)

However, to recover emotional distress as a component of damages in an action for tortious breach of the implied covenant, plaintiff need not plead or prove outrageous conduct, "severe" emotional distress, or an intent on the part of the insurer to cause emotional distress. Provided the bad faith conduct has caused economic loss, emotional distress damages are recoverable in a bad faith action independent of the tort of intentional infliction of emotional distress. (*Gruenberg v. Aetna Ins. Co.* (1973) 9 Cal.3d 566, 580.)

Similarly, an action for negligent infliction of emotional distress may be available as an alternative to a bad faith action. But because of the restrictive treatment accorded emotional distress claims generally and the lack of authoritative precedent, the viability of a negligent infliction action against an insurer is presently unclear. (See *Bates v. Hartford Life & Acc. Ins.* (C.D. Cal. 2011) 765 F.Supp.2d 1218, 1222; *Bogard v. Employers Cas. Co.* (1985) 164 Cal.App.3d 602, 618 (denying recovery for negligent infliction of emotional distress); *Krupnick v. Hartford Accident & Indem. Co.* (1994) 28 Cal. App. 4th 185, 209 (same).) Further, as a general rule, negligence is not among the theories generally available against insurers. (*Sanchez v. Lindsey Morden Claims Services, Inc.* (1999) 72 Cal.App.4th 249, 254.)

State Consumer Protection Laws, Rules and Regulations

California's Unfair Competition Law (UCL), Business and Professions Code sections 17200 et seq., allows recovery for "any unlawful, unfair or fraudulent business act or practice and unfair, deceptive, untrue or misleading advertising." (Cal. Bus. & Prof. Code § 17200.) By prohibiting "unlawful" business practices, the UCL borrows violations of other laws and makes a violation of those laws a per se violation of the UCL. Until recently, there was a split in authority over whether a UCL action could be brought against an insurer for unfair settlement practices in violation of the Unfair Insurance Practices Act (UIPA). (Cf. *Safeco Ins. Co. v. Superior Court* (1990) 216 Cal.App.3d 1491 (affirming dismissal of UCL claim based on unfair settlement practices); *State Farm Fire & Cas. Co. v. Superior Court* (1986) 45 Cal.App.4th 1093 (holding that a cause of action against an insurer was properly brought under the UCL by a group of insured homeowners whose homes were damaged in an earthquake, based on the insureds' allegations of fraudulent deceit and breach of the covenant of good faith implied in their policies), overruled by *Cel-Tech Communications, Inc. v. Los Angeles Cellular Telephone* (1999) 20 Cal.4th 163, 184–87 (disapproving *State Farm's* definition of "unfair" for purposes of section 17200).)

The California Supreme Court resolved this split in authority in *Zhang v. Superior Court* (2013) 57 Cal.4th 364. In *Zhang*, the Court held that alleged false advertising was a proper basis for a civil cause of action against the insurer under the UCL. But the Court acknowledged that UCL actions based solely on violations of the UIPA are precluded.

The statute "piggybacks" onto some underlying offense or pattern of offenses. In *Tenet Healthsystem Desert, Inc. v. Blue Cross*, supra, the court held that a health insurer's preauthorization of services, coupled with a failure to give notice of a coverage exclusion, not only constituted fraud, but also supported a cause of action for violation of the UCL, because "An unfair business practice includes anything that can properly be called a business practice and that at the same time is forbidden by law."

DISCOVERY ISSUES IN ACTIONS AGAINST INSURERS

Discoverability of Claims Files Generally

Claim files ordinarily are considered relevant and discoverable in a bad faith action. (*Aetna Cas. & Sur. Co. v. Superior Court* (1984) 153 Cal.App.3d 467, 477 (although attorney-client privilege and work product doctrine may limit otherwise discoverable information).) Moreover, the claim files of other insureds may be discoverable if relevant to show other instances of misconduct. (*Colonial Life & Acc. Ins. Co. v. Superior Court* (1982) 31 Cal.3d 785, 790.) However, insurers may object on the grounds that such discovery is unduly burdensome, and the files may only be released upon prior consent of the affected insureds. (Cal. Ins. Code, § 791.13; *Mead Reinsurance Co. v. Superior Court* (1986) 188 Cal.App.3d 313, 321–22.)

Discoverability of Reserves

Reserve information is generally considered relevant and discoverable in a third party bad faith case to prove the insurer's awareness of facts triggering a duty to defend and the insurer's unreasonable exposure of its insured to an excess judgment risk. (*Lipton v. Superior Court* (1996) 48 Cal.App.4th 1599, 1614.) With respect to first party cases, such information may be deemed irrelevant because the insured's liability is not at issue. (*American Protection Ins. Co. v. Helm Concentrates, Inc.* (E.D. Cal. 1991) 140 F.R.D. 448, 449–50.) It is a standard practice for defense counsel in both first and third party cases to object to such discovery, thus placing the burden on plaintiff to move for production.

Discoverability of Existence of Reinsurance and Communications with Reinsurers

The California statute authorizing discovery of insurance information does not permit discovery of whether the defendant's liability insurer has reinsured the risk with another insurer. Reinsurance is a contract of indemnity made for the benefit of the liability insurer, with no relevance in an underlying tort action brought against an insured. (*Catholic Mut. Relief Soc. v. Sup.Ct. (Roman Catholic Archdiocese of San Diego)* (2007) 42 Cal.4th 358, 368.)

Reinsurance correspondence and communications between insurer and reinsurer, not otherwise privileged, may be relevant and discoverable in a bad faith action to the extent the correspondence or communication addresses "liability, exposure, the likelihood of a verdict in excess of policy limits or coverage issues." (*Lipton*, supra, 48 Cal.App.4th at pp. 1617–18.)

Attorney/Client Communications

An attorney hired by the insurance carrier to defend an action against one of its insureds represents two clients, the insurer and the insured, and owes duties of care to both under the rules of professional conduct and tort law. (*Lysick v. Walcom* (1968) 258 Cal.App.2d 136, 146.) The "triangular aspect" of the representation has been described as "a coalition for a common purpose – a favorable disposition of the claim – with the attorney owing duties to both clients." This is known as the tripartite relationship. (*Purdy v. Pacific Auto. Ins. Co.* (1984) 157 Cal.App.3d 59, 76.) Insofar as the insured is concerned, the attorney retained by an insurer "owes him the same obligation of good faith and fidelity as if he had retained the attorney personally." (*Lysick v. Walcom,* supra.)

Thus, the insurer and insured become joint clients for purposes of the attorney-client privilege. Both the insurer and the insured are entitled to disclosure of confidences from the other. Neither party may use the privilege as a shield in litigation between insurer and insured. (Cal. Evid. Code § 962; *American Mutual Liability Ins. Co. v. Superior Court* (1974) 38 Cal.App.3d 579, 591–92.)

In a bad faith action, reasonable reliance on the advice of counsel is a valid defense but waives the attorney-client privilege. (*Transamerica Title Ins. Co. v. Superior Court* (1987) 188 Cal.App.3d 1047, 1053 ("Generally, too, the deliberate injection of the advice of counsel into a case waives the attorney-client privilege as to communications and documents relating to the advice.").)

Note that for defense counsel, compliance with insurer guidelines, directives, and billing limitations could pose a potential for conflicts, such as disclosure of information that may harm the client's right to coverage. (See ABA publication, Ethical Obligations of a Lawyer Working Under Insurance Company Guidelines and Other Restrictions, February 16, 2001.)

DEFENSES IN ACTIONS AGAINST INSURERS

Misrepresentations/Omissions: During Underwriting or During Claim

Generally, the rules of rescinding a contract on a non-consensual basis are codified in Civil Code section 1689, subdivision (b). The Insurance Code also provides that a policy of insurance may be rescinded on the following grounds: (1) where the insured has misstated or concealed a material fact in the application for insurance, even if unintentional (Cal. Ins. Code, §§ 331 et seq.); (2) where a mistake exists (Cal. Civ. Code § 1689(b)(1)); or (3) where the insured's breach of a policy provision or warranty materially affects the risk (Cal. Ins. Code, § 447).

Where the application for insurance contains misstatement or concealment of material facts, even if unintentional, the insurer is entitled to rescind the policy. The question of materiality is to be tested subjectively. "The most generally accepted test of materiality is whether or not the matter misstated could reasonably be considered material in affecting the insurer's decision as to whether or not to enter into the contract, in estimating the degree or character of the risk, *or in fixing the premium rate thereon*." (*Old Line Life Ins. Co. v. Superior Court* (1991) 229 Cal.App.3d 1600, 1604 (emphasis in original) (citations omitted).)

Generally speaking, "[m]ateriality is determined solely by the probable and reasonable effect which truthful answers would have had upon the insurer. . . . The fact that the insurer has demanded answers to specific questions in an application for insurance is in itself usually sufficient to establish materiality as a matter of law." (*Imperial Cas. & Indem. Co. v. Sogomonian* (1988) 198 Cal.App.3d 169, 179 (citations omitted).) A material misrepresentation made by an insured during the course of a claim's submission not only bars the portion of the loss that relates to the misrepresentation but also voids the entire policy. (*Cummings v. Fire Ins. Exch.* (1988) 202 Cal.App.3d 1407, 1418–19.)

Failure to Comply with Conditions

"An insurer may assert defenses based upon a breach by the insured of a condition of the policy such as a cooperation clause, but the breach cannot be a valid defense unless the insurer was substantially prejudiced thereby." (*Campbell v. Allstate Ins. Co.* (1963) 60 Cal.2d 303, 305.) Furthermore, California follows a "notice prejudice rule" with respect to notice of claims under occurrence-based liability policies. Under the notice

prejudice rule, the insurer must show actual prejudice resulting from untimely notice. *Northwestern Title Sec. Co. v. Flack* (1970) 6 Cal.App.3d 134, 141-142 ("With respect to the insurer's burden of establishing substantial prejudice from the breach of a cooperation or notice clause, the holding in *Campbell* has been interpreted to mean that such burden is not carried by a showing of possibility of prejudice to the insurer. Rather, actual prejudice must be shown.").) The notice prejudice rule does not apply to claims submitted under claims made and reported policies. (*Pacific Employers Ins. Co. v. Superior Court* (1991) 221 Cal.App.3d 1348, 1358–59.)

Challenging Stipulated Judgments: Consent and/or No-Action Clause

Most liability policies seek to bar collusive settlements by prohibiting an action on the policy until there has been a judgment or a settlement approved by the carrier. "The 'no action' clause gives the insurer the right to control the defense of the claim—to decide whether to settle or to adjudicate the claim on its merits. [] When the insurer provides a defense to its insured, the insured has no right to interfere with the insurer's control of the defense, and a stipulated judgment between the insured and the injured claimant, without the consent of the insurer, is ineffective to impose liability upon the insurer." (*Safeco Ins. Co. v. Superior Court* (1999) 71 Cal.App.4th 782, 786–87.)

Although generally punitive damages cannot be awarded for breach of contract (Cal. Civ. Code, § 3294), punitive damages are available in fraud causes of action, such as in the context of insurance bad faith.

Preexisting Illness or Disease Clauses

A preexisting condition provision excludes coverage for charges or expenses incurred during a specified period following the enrollee's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage. (Health & Saf. Code, § 1357.50(c).) Regulation of preexisting condition exclusions in individual and small group health insurance plans is left to the individual states as a result of the McCarran-Ferguson Act of 1945, 15 U.S.C. sections 1011–1015.

In 2010, Congress enacted and the President signed into law the Patient Protection and Affordable Care Act in order to increase the number of Americans covered by health insurance and decrease the cost of health care. One key provision is the individual mandate, which requires most Americans to maintain "minimum essential" health insurance coverage. On June 28, 2012, the Supreme Court rendered a final decision to uphold most provisions of the health care law, including the individual mandate. (*National Federation of Independent Business v. Sebelius* (2012) 132 S. Ct. 2566.) Starting in 2014, the Affordable Care Act guaranteed that all Americans, regardless of their health status or preexisting conditions, will have access to quality, affordable coverage.

As of January 2019, the Affordable Care Act remains intact.

In *Zubillaga v. Allstate Indemnity Company* (2017) 12 Cal.App.5th 1017, the court held that an insurer's continued reliance on its expert's original opinions as the basis for disputing the medical necessity or reasonable value of treatments, despite awareness of further treatments, additional medical records and physician recommendations, posed triable issues of fact regarding the reasonableness of the insurer's coverage denial..

Statutes of Limitations and Repose

The statute of limitations in an insurance coverage action depends upon whether the plaintiff asserts a cause of

action based upon contract or tort theories. Actions based upon breach of contract are subject to a four-year limitations period (see Cal. Code Civ. Proc., § 337), while actions based upon tort (i.e., bad faith breach of the implied covenant of good faith) are subject to a two year limitations period. (E.g., *Richardson v. Allstate Ins. Co.* (1981) 117 Cal.App.3d 8, 13.)

The limitations period generally begins to run once the insurer has unconditionally denied the insured's claim. (See *State Farm Fire & Cas. Co. v. Superior Court* (1989) 210 Cal.App.3d 604, 609 (action to recover policy benefits).) A contractual limitations period may be "equitably tolled from the time the insured files a timely notice, pursuant to policy notice provisions, to the time the insurer formally denies the claim in writing." (*Prudential-LMI Commercial Ins. v. Superior Court* (1990) 51 Cal.3d 674, 678.) However, an insurer's offer of an optional appeal process does not toll running of the statute of limitations following an unequivocal written denial. (*Vishva Dev, M.D., Inc. v. Blue Shield of Cal.* (2016) 2 Cal.App.5th 1218.)

TRIGGER AND ALLOCATION ISSUES FOR LONG-TAIL CLAIMS

Trigger of Coverage

The term "trigger of coverage" is a term of convenience used to describe that which, under the specific terms of an insurance policy, must happen in the policy period in order for the potential of coverage to arise. "The issue is largely one of timing—what must take place within the policy's effective dates for the potential of coverage to be 'triggered'?" (*State of Cal. v. Continental Ins. Co.* (2012) 55 Cal.4th 186, 196.) With respect to liability coverage, if injury or damage is continuous or progressive throughout several policy periods, coverage is triggered under all policies in effect during those policy periods. (*Montrose Chem. Corp. v. Admiral Ins. Co.* (1995) 10 Cal.4th 645, 655 (adopting the continuous injury trigger of coverage for claims of continuous or progressively deteriorating damage or injury under third party CGL policies).) But the courts continue to apply a "manifestation trigger" in first party cases. (*Prudential-LMI Commercial Ins. Co. v. Superior Court* (1990) 51 Cal.3d 674, 678–79 ("[I]n a first party property damage case (i.e., one involving no third party liability claims), the carrier insuring the property at the time of manifestation of property damage is solely responsible for indemnification once coverage is found to exist.").)

Allocation Among Insurers

There is no bright line rule for determining how a court will apportion a loss among multiple insurers on the risk. Generally, the court will apportion costs of defense on "varying equitable considerations . . . depend[ing] upon the particular policies of insurance, the nature of the claim made, and the relation of the insured to the insurers . . . ." (*CNA Casualty v. Seaboard Sur. Co.* (1986) 176 Cal.App.3d 598, 619.) Factors can include time on the risk, policy limits, number of insureds, extent of damage in the policy period, or any combination of the foregoing. Nevertheless, each insurer has an independent duty to the insured to pay the claim in full, subject to policy limits, applicable exclusions, other insurance clauses. (*Armstrong World Indus. v. Aetna Cas. & Sur. Co.* (1966) 45 Cal.App.4th 1.) In addition, there is generally no allocation to the insured for uninsured or self-insured periods. (See, e.g., *Aerojet*, supra, 17 Cal.4th at 72, 77.)

CONTRIBUTION ACTIONS

Claim in Equity vs. Statutory

With regard to tort law, contribution is a claim brought by one tortfeasor against another tortfeasor to recover some or all of the money damages the first tortfeasor owes to an injured plaintiff, as a result of a settlement or judgment in favor of the plaintiff. A good explanation of the law of equitable contribution between insurers is found in *Scottsdale Ins. Co. v. Century Surety Co.* (2010) 182 Cal.App.4th 1023, 1031, where the court stated:

> "In the insurance context, the right to contribution arises when several insurers are obligated to indemnify or defend the same loss or claim, and one insurer has paid more than its share of the loss or defended the action without any participation by the others. Where multiple insurance carriers insure the same insured and cover the same risk, each insurer has independent standing to assert a cause of action against its coinsurers for equitable contribution when it has undertaken the defense or indemnification of the common insured. Equitable contribution permits reimbursement to the insurer that paid on the loss for the excess it paid over its proportionate share of the obligation, on the theory that the debt it paid was equally and concurrently owed by the other insurers and should be shared by them pro rata in proportion to their respective coverage of the risk. The purpose of this rule of equity is to accomplish substantial justice by equalizing the common burden shared by coinsurers, and to prevent one insurer from profiting at the expense of others."

As to statutory contribution among tortfeasors, in California a joint tortfeasor's liability may be joint, several, or joint and several. (Cal. Civ. Code, § 1430.) An obligation imposed on several tortfeasors is presumed to be joint (Cal. Civ. Code, § 1431), with the exception of noneconomic damages. Thus, in any action based on principles of comparative fault, liability is several only with respect to non-economic damages, including pain, suffering, inconvenience, mental illness, emotional distress, loss of society and companionship, loss of consortium, injury to reputation, and humiliation. In such cases, a defendant's liability for non-economic damages is several only, and his liability to the claimant is determined by reference to his percentage of fault. California Civil Code section 1432 specifically provides that a party who satisfies more than its share of a claim may require a proportionate contribution from all the parties joined with it. (See also, *American Motorcycle Ass'n v. Superior Court of Los Angeles County* (1978) 20 Cal.3d 578.)

Moreover, as a general rule, a settling tortfeasor is freed from all liability in contribution, provided the settlement is found by the court to have been in good faith. (Cal. Code Civ. Proc., § 877, subd. (b).) The settling tortfeasor's share is not counted when dividing the remaining fault among the other defendants to determine how much of the judgment each is responsible for.

But note that settlement of a covered claim by one of several liability insurers insuring the same loss (e.g., successive insurers covering a continuous and progressive loss) is not subject to "good faith" determination under Code of Civil Procedure section 877.6. Liability insurers are not "joint tortfeasors"; nor are they "co-obligors" because their obligations arise out of separate contracts (policies); and their liability to each other rests upon principles of equitable contribution rather than comparative fault. Thus, despite an order confirming the "good faith" of a settlement between the insured and one of its insurers, the settling insurer may still be forced to contribute a proportionate share of whatever the nonsettling insurer is ultimately obliged to pay under its policy. (*Topa Ins. Co. v. Fireman's Fund Ins. Cos.* (1995) 39 Cal.App.4th 1331, 1338.)

On the other hand, a liability insurer who covers one of several tortfeasors may be barred from obtaining

contribution from another tortfeasor by a good faith settlement determination. The insurer is subrogated to its insured's rights and thus may ordinarily seek equitable contribution from the other tortfeasors. (*Mid-Century Ins. Exch. v. Daimler–Chrysler Corp.* (2001) 93 Cal.App. 4th 310, 315.) But because a determination that a settlement was made in good faith bars the nonsettling defendant from asserting equitable indemnity claims against the settling tortfeasor, its liability insurer is likewise barred since it "stands in the shoes" of the insured.

The result is different for contractual indemnity claims. A good faith settlement order does not, however, bar a nonsettling tortfeasor (or its liability insurer) from seeking indemnification from the settling tortfeasor based on an express contract (e.g., an indemnification provision in a construction contract): "Because an insurer stands in the shoes of its insured, the insurer can pursue a cause of action against the settling tortfeasor for breach of an express contractual indemnification clause." (*Interstate Fire & Cas. Ins. Co. v. Cleveland Wrecking Co.* (2010) 182 Cal.App.4th 23, 32-22.)

Note also that a defendant's liability insurer is not a "joint tortfeasor" or "co-obligor" with its insured. Thus, the insured's settlement with the injured party is not subject to "good faith" determination under Code of Civil Procedure section 877.6 and not binding in a subsequent action by the insured against the insurer for failure to defend the claim. (*Hartford Acc. & Indem. Co. v. Sup.Ct.* (1995) 37 Cal.App.4th 1174.)

Elements

The general elements of contribution are that: (1) another tortfeasor was negligent or at fault; and (2) that negligence or fault was a substantial factor in causing plaintiff's harm.

The determination of the right to equitable contribution depends less on specific elements, and more on which method of allocation will produce the most equitable results, which is subject to judicial discretion. (*Scottsdale Ins.,* supra, 182 Cal.App.4th 1023, 1031.) The courts have expressly declined to formulate any definitive rules for allocating defense costs among carriers, because of the varying equitable considerations which may arise, and which affect the insured and the carriers, and which depend upon the particular policies of insurance, the nature of the claim made, and the relation of the insured to the insurers.

There are various ways for the courts to apportion the burden among multiple insurers:

- apportionment based upon the relative duration of each primary policy as compared with the overall period of coverage during which the 'occurrences' 'occurred' (the 'time on the risk' method);
- apportionment based upon the relative policy limits of each primary policy (*'policy limits' method*);
- apportionment based upon both the relative durations and the relative policy limits of each primary policy, through multiplying the policies' respective durations by the amount of their respective limits so that insurers issuing primary policies with higher limits would bear a greater share of the liability per year than those issuing primary policies with lower limits (*'combined policy limit time on the risk' method*);
- apportionment based upon the amount of premiums paid to each carrier (*'premiums paid' method*);
- apportionment among each carrier in equal shares up to the policy limits of the policy with the lowest limits, then among each carrier other than the one issuing the policy with the lowest limits in equal shares up to the policy limits of the policy with the next-to-lowest limits, and so on in the same fashion until the entire loss has been apportioned in full (*'maximum loss' method*) ; and
- apportionment among each carrier in equal shares (*equal shares' method*). (*Scottsdale Ins.,* supra, at p.

1032.)

Notably, questions as to whether the non-participating insurer breached the duty of good faith and fair dealing toward its insured or otherwise acted tortiously are not at issue in an equitable contribution action. Equitable contribution does not depend on fault; it is based on an equitable apportionment of contractual undertakings.

DUTY TO SETTLE

"[T]he implied obligation of good faith and fair dealing requires the insurer to settle in an appropriate case although the express terms of the policy do not impose such a duty." (*Comunale v. Traders & General Ins. Co.* (1958) 50 Cal.2d 654, 659.) Tort liability is imposed for wrongful refusal to settle a liability claim against the insured within policy limits. (*Crisci v. Security Ins. Co.* (1967) 66 Cal.2d 425, 429–30.) The insurer must give the insured's interests at least as much consideration as its own in evaluating the "reasonableness" of a settlement demand from the injured party. (*Comunale*, supra, 50 Cal.2d at p. 659; *Crisci*, supra, 66 Cal.2d at p. 429 ("In determining whether an insurer has given consideration to the interests of the insured, the test is whether a prudent insurer without policy limits would have accepted the settlement offer").)

Note, however, that in *Reid v. Mercury Insurance Co.* (2013) 220 Cal.App.4th 262, the court held that "[i]n the absence of a settlement demand or any other manifestation the injured party is interested in settlement, when the insurer has done nothing to foreclose the possibility of settlement, . . . there is no liability for bad faith failure to settle."

The court in *Boicourt v. Amex Assur. Co.* (2000) 78 Cal.App.4th 1390, expressly declined to set a bright-line rule regarding the extent of an insurer's duty to communicate with its insured in responding to a settlement inquiry from a claimant. In *Madrigal v. Allstate Indemnity Co.* (9th Cir. 2017) 697 Fed.Appx. 905, the court held that whether an insurer acted reasonably in attempting to fulfill conditions accompanying a policy limit demand was a question of fact for the jury.

In the recently published decision of *Planet Bingo, LLC v. Burlington Insurance Company* (2021) 62 Cal.App.5th 44, the Court of Appeal found a triable issue of fact existed as to whether a carrier is liable for bad faith failure to settle after it failed to respond to a subrogation demand letter, holding that summary judgment entered for the insurer was inappropriate. The *Planet Bingo* court reasoned that at a minimum, the *Boicourt* holding recognized the existence of an opportunity to settle within the policy limits can be shown by evidence other than a formal settlement offer. Applying this principle to the facts of the case, the *Planet Bingo* court noted the significance of a subrogation demand letter and expert testimony that a subrogation demand letter "offers a clear invitation to negotiate a settlement for less than that amount," as well as testimony that it is a well-known industry custom to accept policy limits for a full release of the insured. The *Planet Bingo* court held this testimony raised a triable issue of fact as to whether the subrogation letter represented an opportunity to settle within policy limits and as such, the insured had made a prima facie case that Burlington was liable for failure to settle.

LH&D BENEFICIARY ISSUES

Change of Beneficiary

As a general rule, California requires a change to a beneficiary designation to be made in accordance with the

terms of the policy. (*Moss v. Warren* (1975) 43 Cal.App.3d 651, 655.) A change in beneficiary cannot be accomplished by mere intent. (*Wicktor v. Los Angeles County* (1956) 141 Cal.App.2d 592, 596.)

Effect of Divorce on Beneficiary Designation

Where one spouse is named as beneficiary in a policy of insurance on the life of another, such spouse is entitled to the proceeds of the policy, even though the parties were divorced, in the absence of any terms in the policy to the contrary. (*Thorp v. Randazzo* (1953) 41 Cal.2d 770, 773–74; *Dierdorff v. Homesteaders Life Ass'n* (1941) 47 Cal.App.2d 674, 678; *Jenkins v. Jenkins* (1931) 112 Cal.App. 402.) There are three well-recognized exceptions to this general rule: "(1) where the insurance company has waived strict compliance with its own rules and pursuant to the request of the insured to change the beneficiary has issued a new certificate; (2) where it is beyond the power of the insured to comply literally with the regulations; and (3) where the insured has pursued the ways indicated by the laws of the company and has done all in his or her power to change the beneficiary but before the new certification is actually issued he or she dies." (*Moss*, supra, at pp. 15–16.) Furthermore, California demands that substantial steps be taken to actually change a beneficiary before the formal requirements of the contract may be ignored. (Id. at p. 17.)

The date that the change becomes effective is typically designated in the policy itself.

INTERPLEADER ACTIONS

Availability of Fee Recovery

Insurers can often find themselves dealing with claimants competing for the same funds. A common example is life insurance benefits held by an insurer where conflicting claims are made by the named beneficiary and someone else. An interpleader allows a stakeholder that fears the prospect of multiple liability to file suit, deposit the property with the court, and withdraw from the proceedings. By statute in California, "[a]ny person, firm, corporation, association or other entity against whom double or multiple claims are made, or may be made, by two or more persons which are such that they may give rise to double or multiple liability, may bring an action against the claimants to compel them to interplead and litigate their several claims." (Cal. Civ. Proc. Code, § 386, subd. (b).) The purpose of interpleader is to prevent a multiplicity of suits and double vexation. (*Farmers New World Life Ins. Co. v. Rees* (2013) 219 Cal.App.4th 307, 315.)

Code of Civil Procedure section 386, subdivision (a), allows the neutral stakeholder to seek reimbursement for its costs and reasonable attorney fees. The stakeholder may commence an interpleader action, deposit the funds into court, and obtain a discretionary fees/costs recovery by the court from the amount deposited. Thus, with respect to attorney fees and costs, a party to an action who follows the procedure for interpleader set forth in Code of Civil Procedure section 386 may insert in the motion, petition, complaint, or cross-complaint a request for allowance of costs and reasonable attorney fees incurred in the action. The court may, in its discretion, award a party the costs and reasonable attorney fees from the amount in dispute which has been deposited with the court. (Cal. Civ. Proc. Code, § 386.6.) No attorney fees are awardable unless the interpleader procedure in section 386 is closely followed.

For example, in *Farmers New World*, supra, the court held that an award of attorney fees and costs to the interpleading party was permitted where the life insurance benefits were in dispute due to the beneficiary's

status as a suspect in the death of the insured. The wife's death had been investigated as a homicide because the husband was the sole beneficiary on the wife's life insurance policy. The appellate court determined that the policy benefits were indeed in dispute, in light of the ongoing criminal investigation of the matter as a possible homicide. The court also noted that a party who seeks to challenge a fee award on the ground the interpleader action is improper, must contest the propriety of the interpleader action during the initial phase of the proceeding. Failure to do so results in a waiver of the objection.

Differences in State vs. Federal

Under federal law, interpleader is authorized by 28 U.S.C. section 1335 and Fed. R. Civ. P. 22, and governed by equitable principles. As in California, federal interpleader enables a person holding funds or property to which others are making conflicting claims to join them and require them to litigate who is entitled to the funds or property. (*Libby, McNeill & Libby v. City Nat'l Bank* (9th Cir. 1978) 592 F.2d 504, 507.)

There are two types of federal interpleader actions, each having distinct jurisdictional requirements and procedural characteristics: (1) statutory interpleader (28 U.S.C. § 1335), which authorizes interpleader actions in federal courts and contains special provisions for jurisdiction, venue, and service of process; and (2) Rule 22 interpleader (Fed. R. Civ. P. 22), which permits interpleader in any action that meets the normal jurisdiction requirements in federal court (e.g., amount in controversy exceeds $75,000).

As with California interpleader, federal courts have discretion to award attorney fees and costs to a disinterested stakeholder. Under federal interpleader, however, the authority is the court's equitable discretion, not by statute.

There are several major differences between the state and federal remedies. Under California law, the stakeholder must be a truly disinterested party. Under federal interpleader, however, the stakeholder may be liable to one or more of the parties; interpleader is available to protect the stakeholder from multiple claims on the same liability. Additionally, under California law, the court's power to stay is more limited. As a matter of comity, state courts are usually reluctant to enjoin proceedings pending outside the state, so California interpleader may be only partially effective.

Nonetheless, sometimes only California interpleader is available because there is no federal jurisdiction (i.e., stakeholder and all claimants are citizens of the same state and no federal question is involved). But when both are available, the same factors affecting choice of forum generally apply (e.g., different pleading requirements, discovery rules, summary judgment standards, jury issues). Interpleader defendants served in state court should not overlook the possibility of removing the action to federal court if the matter could originally have been brought in that forum.