Brehm v 21st Century Insurance Company

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Covenant of good faith and fair dealing; Genuine dispute rule

Plaintiff was injured in a 2003 car accident. He and his parents were each injured and the defendant driver carried a minimum limits, $15,000/30,000 policy. Each of them recovered $10,000 from the underinsured motorist's carrier. Plaintiff then presented an underinsured motorist claim to his own carrier, 21st Century. The policy carried UIM limits of $100,000 per person, plus medical benefits of $5,000. Plaintiff made a statutory 998 demand for the balance of $85,000, plus the $5,000 for medical bills.

21st Century rejected the demand, based on the opinion of its medical expert. It offered $5,000 plus the medical payments. Its physician indicated plaintiff had only subjective complaints and no objective evidence of injury. Plaintiff then went to a "highly credentialed, board certified orthopedic surgeon" for another opinion. The new specialist opined plaintiff had an injury to his right shoulder that in all probability would require surgery.

Plaintiff then made a new demand for the balance of the policy limits. He provided his new doctor's records and report. He agreed to continue the November 2004 arbitration. The defendant carrier again offered $5,000 plus the medical benefits. On March 26, 2005, the plaintiff received an arbitration award for $91,186. 21st Century paid the $85,000 plus $5,000 shortly thereafter. Plaintiff then sued his carrier for unreasonably failing to make a good faith effort to resolve his UIM claim after its liability for payment of benefits was clear.

In his second amended complaint, plaintiff alleged the medical evidence in his carrier's possession at the time it rejected his demand showed its offer to settle was extremely unrealistic, and further, it knew that he was entitled to the full policy limits. He alleged 21st Century made an unreasonably low offer to delay paying his legitimate claim in the hope of compelling him to accept less than the full amount he was due.

The plaintiff also alleged the medical expert used by the defendant was a non-practicing professional expert witness, known to the insurance industry to be biased in favor of the defense. He claimed the doctor was retained not to objectively and fairly evaluate the 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."

The trial court sustained 21st Century's demurrer without leave to amend on the basis plaintiff had simply alleged a classic "genuine dispute" as to the value of a UIM claim. Under *Chateau Chamberay Homewoners Assn. v Associated Internat. Ins. Co.* (2001) 90 Cal.App.4th 335, an insurer denying or delaying benefits under a genuine dispute with its insured cannot be liable in bad faith. Because the defendant carrier had relied on the opinion of its expert, the offer was reasonable. The court further indicated that since there was no breach of the insurance contract, there could be no breach of

the implied covenant of good faith and fair dealing. The case was dismissed and this appeal followed.

California law recognizes in every contract, including insurance policies, an implied covenant of good faith and fair dealing. (*Wilson v 21st Century Ins. Co.* (2007) 42 Cal.4th 713) The covenant is implied as a supplement to the express contractual covenants, to prevent a contracting party from engaging in conduct that frustrates the other party's rights to the benefits of the agreement. (*Waller v Truck Ins. Exchange, Inc.* (1995) 11 Cal.4th 1) Breach of a specific provision of the contract is not a necessary prerequisite to a claim for breach of the implied covenant of good faith and fair dealing...Even an insurer that pays the full limits of its policy may be liable for breach of the implied covenant if improper claims handling causes detriment to the insured. (*Schwartz v State Farm Fire & Casualty Co.* (2001) 88 Cal.App.4th 1329)

A delay in payment of benefits due under an insurance policy gives rise to tort liability only if the insured can establish the delay was unreasonable. (*Frommoethelydo v Fire Ins. Exchange* (1986) 42 Cal.3d 208) The genuine dispute rule cannot be invoked to protect an insurer's denial or delay in payment of benefits unless the insurer's position was both reasonable and reached in good faith. A genuine dispute exists only where the insurer's position is maintained in good faith and on reasonable grounds. An expert's testimony will not automatically insulate an insurer from a bad faith claim based on a biased investigation. (*Chateau Chanberay*, supra, 90 Cal.App.4th at 348)

Unlike the recent Supreme Court case of *Wilson v 21st Century*, the carrier did have the insured examined by a medical doctor, and it was the doctor who asserted the claimant did not need surgery. But because this is a demurrer under review, the Justices looked to the allegations of the complaint, stating: "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."

21st Century argues the offer and the underlying settlement covered the projected medical expenses and could not have been made in bad faith as a matter of law. Brehm argues the offer provided nothing for past expenses, lost earnings or pain and suffering. The Appellate Court noted the reasonableness of the insurer's offer at the time it was made is simply not a question that can be resolved at the pleading stage. It is ordinarily a question of fact to be determined by the jury. (*Walbrook Ins. Co. v Liberty Mutual Ins. Co.* (1992) 5 Cal.App.4th 1445)

The defendant carrier also argued it had a contractual right to arbitrate the UIM claim. The implied covenant of good faith and fair dealing cannot prohibit a contracting party from doing that which is expressly permitted by the agreement itself. The Justices indicated that by making lack of agreement as to value of the claim an express precondition to demanding arbitration, the policy itself contemplates the parties will first

make an affirmative effort to resolve their dispute. In effect, this creates a contractual duty to discuss the claim to which the implied covenant of good faith and fair dealing properly attaches. The covenant imposes on a contracting party not only a duty to refrain from acting in a manner that frustrates performance of the contract, "but also the duty to do everything that the contract presupposes theat he will do to accomplish its purpose."(*Pasadena Live LLC v City of Pasadena* (2004) 114 Cal.App.4th 1089) The express right to arbitrate is not inconsistent with the implied obligation to attempt in good faith to reach agreement prior to arbitration.

Finally, 21st Century contended that Insurance Code section 11580.26 provides broad immunity to an insurer, permitting it to avoid bad faith liability arising from its pre-arbitration handling of a UM or UIM claim simply by requesting arbitration. The Second DCA found the argument flawed, noting it disregarded additional language in the same statute obligating the insurer to attempt to reach an agreement with its insured before it may invoke arbitration as a means of resolving any disagreement. The duty to attempt to agree before arbitrating, clearly imposed by the Legislature, invokes a corresponding duty to do so in good faith. (See *Wilson*, at p. 720; Insurance Code section 790.03(h)(5))

The Justices concluded that section 11580.26(b) means a bad faith action **may not** be based simply on the fact that, after failing to resolve a UM/UIM dispute, the insurer lost the arbitration or the insured recovered an award greater than the insurer's final settlement offer. Thus the statute precludes evaluating whether an insurer acted in good faith in attempting to resolve the dispute by considering, after-the-fact, the results of the arbitration proceeding. What it does not mean is that the insurer is relieved of its obligation to act reasonably in attempting to settle any disagreement with its insured concerning a UM/UIM claim or its duty not to withhold unreasonably payments due under a policy. (*Pilimai v Farmers Ins. Exchange Co.* (2006) 39 Cal.4th 133) Breaching those duties is not simply "guessing wrong" but acting tortiously.

The order of dismissal is reversed and remanded. Plaintiff is to recover costs on appeal.