CASE STUDY PREPARED FROM ORIGINAL PUBLISHED OPINION

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Ted Maslo v Ameriprise Auto & Home Insurance 6/27/14

Insurance Bad Faith; Genuine Dispute Rule; Ins. Code section 790.03(h)(5)

Plaintiff Ted Maslo was the insured on an automobile insurance policy issued by respondent Ameriprise Auto and Home Insurance. After sustaining bodily injuries as a result of an accident caused by an uninsured motorist, Maslo filed a claim seeking the $250,000 limit on the policy's uninsured motorist coverage and was awarded $164,120.91 by the arbitrator.

On October 9, 2012, plaintiff/appellant filed a first amended complaint for damages against his insurer, alleging one cause of action for breach of the covenant of good faith and fair dealing. According to the complaint, appellant was an insured on an automobile insurance contract that provided up to $250,000 in coverage for injuries and damages resulting from the negligence of an uninsured motorist. During the policy term, an uninsured motorist struck appellant's vehicle from the rear, forcing it to collide with a third vehicle. The complaint further alleged that on or about September 3, 2008, the accident was investigated by the Los Angeles Police Department (LAPD), which prepared a traffic collision report. The report concluded the uninsured motorist was the sole cause of the accident.

As a result of the accident, appellant suffered numerous bodily injuries, including a severe injury to his shoulder. Appellant was referred to an orthopedic surgeon, and an MRI revealed an "internal derangement of the left

shoulder; a SLAP lesion of the left shoulder; a split tear of the superior rotator cuff; and downsloping of the acromion and impingement syndrome." Appellant underwent two surgeries to repair his shoulder.

The complaint further alleged that appellant reported the accident to his insurer on September 3, 2008, and provided a statement about the accident the following day. The insurer also received a copy of the LAPD traffic collision report. On August 13, 2009, appellant supplied his insurer with copies of all his medical records and billing statements regarding his treatment. In that letter, appellant sought settlement of the uninsured motorist claim in the amount of the policy limit of $250,000. The insurer did not respond to the settlement demand.

On January 22, 2010, appellant renewed his demand and requested a response. On February 2, the insurer asked for an extension of time to respond, which appellant granted. On February 26, the insurer retained counsel for an arbitration proceeding on appellant's uninsured motorist claim. The complaint alleged that although appellant had offered to mediate his claim, the insurer "refused to participate in the Mediation process, refused to make any offer of settlement to Plaintiff, and refused to respond to Plaintiff's policy limits demand."

The parties stipulated that appellant's medical expenses totaled $64,120.91. At the conclusion of the arbitration, the arbitrator awarded appellant that amount in medical damages and $100,000 in general damages, for a total award of $164,120.91.

The insurer filed a demurrer to the first amended complaint. It argued that the complaint failed to state a cause of action for breach of the covenant of good faith and fair dealing, as allegations in the complaint established the existence of a "genuine dispute" over the amount of payment due under the insurance policy. As the damages in the instant case did not plainly exceed $250,000, the

insurer argued that the superior court should sustain the demurrer. In the alternative, the insurer argued that the complaint failed to adequately allege causation. According to the insurer, "it was not the insurer's failure to make a settlement offer that resulted in the need for arbitration; rather, it was appellant's overvaluation of his claim that was the cause of the delay in resolution of his claim."

The superior court sustained the demurrer with leave to amend. The court determined that causation was not supported by sufficient factual allegations. Appellant then filed his second amended complaint and the insurer filed a demurrer, repeating the same argument regarding causation and relying upon the same legal authorities. The insurer further contended that causation on an insurance "bad faith" claim could be shown only where the arbitrator determined that the claim was worth more than the initial demand made by the insured.

After another hearing, the trial court issued an order sustaining the demurrer without leave to amend. The court found that appellant could not allege causation, as the facts did not show that appellant's damages "plainly exceeded the uninsured motorist coverage policy limits." A judgment dismissing the complaint was entered March 26, 2013. Plaintiff/appellant timely noticed an appeal to the Second Appellate District, Division Four.

Appellant contends his complaint alleged facts sufficient to state a cause of action for breach of the covenant of good faith and fair dealing against his insurer. "The law implies in every contract, including insurance policies, a covenant of good faith and fair dealing. 'The implied promise requires each contracting party to refrain from doing anything to injure the right of the other to receive the agreement's benefits. To fulfill its implied obligation, an insurer must give at least as much consideration to the interests of the insured as it gives to its own interests. When the insurer unreasonably and in bad faith withholds

payment of the claim of its insured, it is subject to liability in tort.'" (*Wilson v. 21st Century Ins. Co*. (2007) 42 Cal.4th 713, 720, quoting *Frommoethelydo v. Fire Ins. Exchange* (1986) 42 Cal.3d 208, 214-215) Thus, "an insurer's obligations under the implied covenant of good faith and fair dealing with respect to first party coverage include a duty not to unreasonably withhold benefits due under the policy. An insurer that unreasonably delays, or fails to pay, benefits due under the policy may be held liable in tort for breach of the implied covenant." (*Rappaport-Scott v. Interinsurance Exchange of the Automobile Club* (2007) 146 Cal.App.4th 831, 837)

Moreover, "while an insurance company has no obligation under the implied covenant of good faith and fair dealing to pay every claim its insured makes, the insurer cannot deny the claim 'without fully investigating the grounds for its denial.'" (*Wilson*, at 42 Cal.4th at pp. 720-721) "By the same token, denial of a claim on a basis unfounded in the facts known to the insurer, or contradicted by those facts, may be deemed unreasonable. '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.'" (*Wilson*, at p. 721, quoting *Mariscal v. Old Republic Life Ins. Co*. (1996) 42 Cal.App.4th 1617, 1623.)

The Second DCA noted the appellant alleged (1) that the insurer was apprised that appellant, its insured, had suffered bodily injuries resulting from the negligence of an uninsured motorist; (2) that the insurer knew the LAPD traffic collision report had concluded the uninsured motorist was solely at fault; (3) that appellant made a demand for payment of the $250,000 policy limit on his uninsured motorist coverage; (4) that appellant submitted his medical records and billing statements; (5) that the insurer rejected the demand without an adequate investigation, as the insurer failed, among other things, to conduct a defense medical examination or interview appellant's treating physicians; (6) that despite clear evidence of liability, the insurer made no offer of settlement; (7) that the insurer agreed to pay the claim only after the arbitration, which was more

than three years after the accident and more than two years after the insurer had all appropriate medical documentation in its possession; and (8) that as a result of the insurer's refusal to investigate and evaluate his claim, appellant was compelled to incur the costs of an arbitration necessitated solely by the insurer's intransigence.

In California, "to fulfill its implied obligation of good faith and fair dealing, an insurer must give at least as much consideration to the interests of the insured as it gives to its own interests." (*Wilson*, *supra*, 42 Cal.4th at p. 720) Moreover, under section 790.03, subdivision (h)(5) of California's Insurance Code, it is an unfair claim settlement practice not to "attempt in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear." That statutory provision applies to "all . . . persons engaged in the business of insurance." (See § 790.01.) Thus, in California, an insurer has the same duty to act in good faith in the uninsured motorist context as it does in any other insurance context.

The insurer next contends that on the facts alleged in the complaint, it may avoid liability for an insurance bad faith claim under the "genuine dispute" rule. The "genuine dispute" rule is "a close corollary" to the principle that "an insurer's denial of or delay in paying benefits gives rise to tort damages only if the insured shows the denial or delay was unreasonable." (*Wilson*, *supra*, 42 Cal.4th at p. 723.) Under the rule, "'an insurer denying or delaying the payment of policy benefits due to the existence of a genuine dispute with its insured as to the existence of coverage liability or the amount of the insured's coverage claim is not liable in bad faith even though it might be liable for breach of contract.'" (*Chateau Chamberay Homeowners Assn. v. Associated Internat. Ins. Co*. (2001) 90 Cal.App.4th 335, 347) Pointing to the fact that appellant's initial demand was $250,000 and the arbitrator ultimately awarded roughly $164,000, the insurer contends that a genuine dispute necessarily existed.

"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." (*Wilson*, *supra*, 42 Cal.4th at p. 723.) Here, the insurer cannot rely upon the genuine dispute rule, as the complaint alleged that the insurer failed to comply with its common law and statutory obligations to thoroughly and fairly investigate, process, and evaluate appellant's claim.

Specifically, the complaint alleged that the insurer was promptly apprised of the claim, provided with the LAPD traffic collision report showing the uninsured motorist was solely responsible for the accident, and provided with medical documentation of the injuries sustained by appellant and the nature and cost of his medical treatment. The complaint further alleged that the insurer neither interviewed appellant's treating physicians, nor conducted its own medical examination or review. The complaint alleged that despite being provided with "all documents concerning liability and damages . . . needed to fully and fairly evaluate the case," the insurer failed to promptly and properly investigate and handle appellant's claim. Specifically, it failed to respond in good faith to appellant's settlement demand, made no settlement offer, failed to provide a reason for withholding payment, refused appellant's offer to participate in mediation, and provided appellant no opportunity to negotiate a settlement. The California Supreme Court has made clear that there can be no genuine dispute in the absence of a thorough and fair investigation. (See *Wilson*, *supra*, 42 Cal.4th at p. 723) As the complaint alleged an inadequate investigation and dilatory claim handling procedures, the genuine dispute rule provides no basis for sustaining the demurrer.

The insurer further contends that an insurer's failure to investigate, evaluate, or attempt in good faith to settle its insured's claim does not constitute bad faith except under limited circumstances, as an insurer has a statutory right to arbitrate disputes over the amount of damages. According to the insurer, it

may be liable only where the damages plainly exceed the policy limits. In all other circumstances, the insurer contends, when faced with a claim for which liability is shown with reasonable certainty, it may refuse to investigate, evaluate or even respond to its insured, force the insured to incur the costs of arbitration, and avoid liability for breaching its common law and statutory duties so long as the ultimate award is less than the insured's initial demand. The Justices fount this position is at odds with California common law and the statutory requirements of the Insurance Code.

Recognizing that an insurer has a statutory right to binding arbitration when the insurer and insured disagree over the existence or extent of coverage, the Justices referenced *Hightower v Farmers Insurance Exchange* (1995) 38 Cal.App.4th 853, where the court held that the adoption of that statutory provision did not abrogate the insurer's duty of good faith in handling uninsured motorist claims. Rejecting the position now advanced by the defendant, the *Hightower* court observed: "Under the insurer's interpretation of the statute, an insurer could 'stonewall' uninsured motorist claimants in every case but avoid bad faith liability through the simple act of requesting arbitration and refusing to pay until ordered to do so by an arbitrator." The court refused to ascribe such intent to the Legislature. The court further stated: "Where there is no issue reasonably to be resolved by arbitration, as in a case where the insured's damages plainly exceed policy limits and the liability of the uninsured motorist is clear, the failure to attempt to effectuate a prompt and fair settlement violates the insurer's statutory duties (Ins. Code, § 790.03, subd. (h)(5)) and gives rise to tort liability.

Thus, the DCA reaffirms that an insurer may be liable for bad faith in failing to attempt to effectuate a prompt and fair settlement (1) where it unreasonably demands arbitration, or (2) where it commits other wrongful conduct, such as failing to investigate a claim. An insurer's statutory duty to attempt to effectuate a prompt and fair settlement is not abrogated simply

because the insured's damages do not plainly exceed the policy limits. Nor is the insurer's duty to investigate a claim excused by the arbitrator's finding that the amount of damages was lower than the insured's initial demand. Even where the amount of damages is lower than the policy limits, an insurer may act unreasonably by failing to pay damages that are certain and demanding arbitration on those damages. Here, the DCA held the amended complaint adequately stated a bad faith insurance cause of action, as it alleged that the insurer breached its statutory and common law duties to its insured by failing to adequately investigate, evaluate, and process the insured's claim, and by failing to attempt to settle the claim even after liability became reasonably clear.

Finally, the insurer argues that its alleged failure to investigate, evaluate, or process appellant's claim could not, as a matter of law, be the legal cause of appellant's damages. Specifically, it contends that in the absence of an allegation that the appellant would have settled for anything less than his initial demand, arbitration was inevitable. The Justices pointed out, however, that it was not the plaintiff's initial demand that made arbitration inevitable, but the insurer's alleged refusal to investigate and process his claim. Even in the face of reasonably certain damages, the insurer offered nothing. Thus, as alleged, it was not appellant's conduct, but the insurer's that precluded any possible settlement and made arbitration inevitable. In short, the the complaint adequately alleged causation by asserting that the insurer's conduct was the direct and proximate cause of appellant's damages, including unnecessary costs and fees incurred for the arbitration.

There can be no serious dispute that an insurer is required to thoroughly and fairly investigate, process, and evaluate its insured's claim. The complaint alleged facts sufficient to state a tort claim for the insurer's breach of the duty of good faith and fair dealing under common law and for failure to attempt to effectuate a prompt and fair settlement under the Insurance Code. It further adequately alleged that the insurer's breach of its duty of good faith and its

failure to attempt to effectuate a prompt and fair settlement directly and proximately caused appellant to suffer damages, including incurring unnecessary costs and fees of arbitration.

Accordingly, the trial court erred in sustaining the demurrer and dismissing the second amended complaint with prejudice. The judgment is reversed, and the matter is remanded with directions to the trial court to vacate its order sustaining the demurrer to the complaint and to enter a new order overruling the demurrer. Appellant is awarded his costs on appeal.

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