

# Knocking Down the Bad Faith Set-Up

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# Knocking Down the Bad Faith Set-Up

Insurance, *n.* An ingenious modern game of chance in which the player is permitted to enjoy the comfortable conviction that he is beating the person who keeps the table.

Ambrose Bierce *The Devil's Dictionary*

## I. Rules of the Game

Once upon a time, civil litigation centered on efforts to make a person (or business entity) “whole” after that person or company was harmed by the tort, or contractual breach, of another. Today, the central goal of civil litigation often seems not so much based on establishing the value of a purported victim’s harm, but instead, on the policy limits of the alleged wrongdoer’s liability insurance policy.

The reality of modern litigation is that the existence of an insurance policy—and its limits—very often influences the scope, strategy, and tactics employed by the counsel engaged in the battle. The availability of “extra-contractual” damages that can be imposed upon insurance carriers for purported breaches of insurance contract based duties to defend or to settle claims against policyholders can often prove to be an enticing distraction for both counsel for policyholders and for claimant, who may find that by switching their focus from “who did what wrong and how much is it worth?” in the original dispute to “how does the insurance carrier’s conduct add value?” to the dispute, they can present their clients with promises of much bigger returns.

When the liability contestants on the field of play conspire to set up the inattentive insurance carriers off to the side, the results can be devastating if the insurance carrier personnel are not vigilant and attentive to everything unfolding on the field. This article explains the basic rules of insurance in the context of liability disputes and seeks to inform insurance carrier personnel exactly how crafty counsel can manipulate events so that the field of play engulfs the carriers on the sidelines.

### A. The Duty (and Right) to Defend (and the Consequences for Not Doing So)

The standard comprehensive or commercial general liability insurance policy not only establishes a duty on the part of the insurer to indemnify the insured for those sums that the insured becomes legally obligated to pay as damages for any covered claim, but the policy also creates a duty (and a *right*) to defend the insured in any action brought against it seeking damages for any covered claim. *Buss v. Superior Court*, 16 Cal. 4th 35, 46–47 (1996); *Hartford Cas. Ins. Co. v. New Hampshire Ins. Co.*, 417 Mass. 115, 628 N.E.2d 14, 17 (1994); Va. Code §38.2 209.

An insurer’s duty to indemnify runs to claims that are actually covered, in light of the facts proved, but it does not technically arise until liability is established. By contrast, the duty to defend is broader and applies to claims that are merely potentially covered, in light of facts alleged or otherwise disclosed, and the duty arises as soon as tender is made. *Buss*, 16 Cal. 4th at 46.

In California, as elsewhere, this duty of an insurance carrier to provide its insured with a defense is practically absolute. “The duty of an insurer to provide a defense is broad and applies when there is only a potential for coverage even if no covered loss is ultimately incurred.” *Presley Homes v. American States Ins. Co.*, 90 Cal. App. 4th 571, 574 (4th Dist. 2001). This duty to defend arises even if only one of several claims against an insured is potentially covered, and can be said not to arise only when none of the claims alleged against an insured are potentially covered under the policy. *Buss*, 16 Cal. 4th at 47. Even in “mixed” actions, where some of the claims are potentially covered and some of the claims are not, public policy requires the insurance carrier

to defend the entirety of the action, because, “To defend meaningfully, the insurer must defend immediately. To defend immediately, it must defend entirely.” *Id.* at 49.

The effect and application of these principles are demonstrated in *Presley Homes v. American States Insurance Co.*, 90 Cal. App. 4th 571. Whereas “duty to defend” precepts were developed in instances involving insurance carriers being tasked with defense of suits for insureds who had paid premiums in exchange for “peace of mind,” in *Presley*, the court held that the broad, and oftentimes practically unlimited duty to defend claims extended even to “additional insureds,” persons who paid no premiums to the insurance carriers asked to carry the defense of their burden. In *Presley*, the plaintiff homebuilder required its subcontractors name it as an “additional insured” on the subcontractors’ liability insurance policies. When a homeowner sued plaintiff for a construction defect, plaintiff tendered its defense to—among others—the defendant insurance carrier that had insured two of the subcontractors. *Id.* at 574. Defendant carrier initially agreed to share in plaintiff’s defense, but it proposed the retention of separate counsel on certain structural issues and discussed the possibility of paying only a percentage of plaintiff’s defense costs based on the subcontractors’ work on the residence in question. *Id.* When the parties could not agree on defense apportionment, the plaintiff-homebuilder demanded a “full and complete” defense and that the carrier “acknowledge its obligations to [plaintiff] by its immediate agreement to reimburse [plaintiff] for its attorney’s fees and costs incurred. . . in this action.” *Id.* The carrier asserted the position that it had a duty to defend plaintiff only against those claims specifically relating to the subcontractors’ work. *Id.*

The underlying litigation settled, with the subcontractors personally contributing funds, the homebuilder incurring legal fees, and the carrier contributing what it believed was its share of those defense costs that were attributable to the subcontractors’ work. *Id.* The homebuilder then sued the carrier for its defense costs.

The court of appeal held that the carrier’s action “to limit its defense obligation to the portion attributable to [the subcontractors’] potential exposure, and the delay in providing a defense while the parties attempted to reach a mutually acceptable percentage, highlights the very reason the Supreme Court requires an insurer to provide a complete defense even where the underlying lawsuit includes both covered and uncovered claims.” *Id.* at 576–77. The insurer’s obligation was to provide a complete and unqualified defense, and its remedy was to seek “contribution from other insurers obligated to defend the claim against plaintiff.” *Id.* at 577. This decision reflects the current state of an insurer’s duty to provide its insured, even an “additional insured,” with a full defense, even if only a minority of the causes of action levied against it are potentially covered by the policy.

## **B. The Duty to Settle (and the Consequences for Not Doing So)**

In the area of insurance contracts, the covenant of good faith and fair dealing has taken on a particular significance because of the special relationship between the insurer and the insured. The insurer, when determining whether to settle a claim, must give at least as much consideration to the welfare of its insured as it gives to its own interests. *Jonathan Neil & Assoc., Inc. v. Jones*, 33 Cal. 4th 917, 937 (2004). However, an insurer need not elevate the interests of its insured above its own or that of its shareholders. *Morris v. Paul Revere Life Ins. Co.*, 109 Cal. App. 4th 966, 973 (4th Dist. 2003). The applicable standard is whether a prudent insurer would have accepted the settlement offer if it alone were to be liable for the entire judgment. *Jonathan Neil & Assoc., Inc.*, 33 Cal. 4th at 937. The standard is premised on the insurer’s obligation to protect the insured’s interests in defending the latter against claims by an injured third party. *Id.* A breach of this duty of reasonable settlement gives rise to tort damages. *Id.* at 937–38. See also *Guaranty Nat’l Ins. Co. v. George*, 953 S.W.2d 946 (Ky. 1997).

Punitive damages are often available for a sufficiently egregious failure to settle third party claims where it results in an excess judgment against the insured. *O’Neill v. Gallant Ins. Co.*, 329 Ill. App. 3d 1166, 1176, 769 N.E.2d 100, 109 (2002); *Hart v. Republic Mut. Ins. Co.*, 152 Ohio St. 185, 87 N.E.2d 347 (1949).

These duties are not created simply by judicial fiat; even under statutory law, a party must prove that the liability insurer failed to settle a tort claim against its insured under circumstances when it could and should have done so had it acted fairly and honestly toward its insured. Fla. Stat. 624.155(1)(b)(1).

### **C. Third Party Access to an Insured's Policy Benefits**

The general rule is that third parties are not party to the insurance contract and neither are they intended beneficiaries; therefore, an insurer owes no duties to a third party claimant because of a lack of contractual or fiduciary privity. Generally, this precludes meritorious third party actions for claims of bad faith and breach of contract. But see *Kremen v. State Auto Ins. Fund*, 363 Md. 663, 673, fn. 9, 770 A.2d 170 (2001) (third party bad faith case in Maryland sounds in tort). However, there are certain means by which a third party is able to state causes of action directly against a carrier based on its coverage of an insured.

Like many states (see *Clegg v. Butler*, 424 Mass. 413, 418, 676 N.E.2d 1134, 1139 (1997)), California has codified the right of a “judgment creditor” to initiate a direct action against an insurance carrier to collect the proceeds of a judgment it has obtained against an insured. California Insurance Code section 11580(b)(2) requires that no policy be issued in the state that purports to cover a loss for liability unless it also includes:

A provision that whenever judgment is secured against the insured or the executor or administrator of a deceased insured in an action based upon bodily injury, death, or property damage, then an action may be brought against the insurer on the policy and subject to its terms and limitations, by such judgment creditor to recover on the judgment.

This statutory basis for a third party to bring an action against an insurer is recognized in the language of most insurance policies themselves, as contained in the typical “No Action” policy provision:

No action shall be brought against us until the obligation of the insured has been determined by final judgment [after an actual trial] or agreement signed by us.

But when is a judgment “final”? If the insured simply agrees to settle the case with a third party claimant, and in so doing executes a covenant with the third party not to collect the judgment against the insured's own assets, what are the insured's real liabilities? And how can a carrier avoid the effects of collusion between the two?

#### **1. When a tender of defense is denied**

Once an accident occurs, the insured is sued, and a defense of that suit is tendered to a carrier, the decision of whether or not to provide a defense of the insured in large measure shapes the carrier's ability to shield itself from any potentially collusive agreements reached between the insured and the third party filing suit.

In *Pruyn v. Agricultural Insurance Co.*, 36 Cal. App. 4th 500 (2d Dist. 1995), for example, a stipulated judgment of liability against an insured with a covenant not to execute the judgment against the insured—but to instead go after the carrier for the sums—was held to be presumptive evidence of the legitimacy of the damages claim. In *Pruyn*, plaintiff filed suit against a community association for damages as a result of diminution in value of her home's value due to landslides allegedly caused or exacerbated by the association's negligent maintenance of the area. *Id.* at 509–10.

The association's many insurance carriers all denied the tender of defense, and the insured association negotiated a settlement with plaintiff in which it stipulated to judgment of \$650,000 and assigned all of its rights against the insurers in exchange for a covenant not to execute. *Id.* at 511. Plaintiff and the association moved for and received an order determining that the settlement was made in good faith, pursuant to California Code of Civil Procedure section 877.6 (which is used to protect one settling tort-feasor from indemnification claims of nonsettlers). Plaintiff then filed suit under Insurance Code section 11580(b)(2) as a “judgment

creditor,” the carriers moved for judgment on the pleadings that such an agreement could not bind them, and the trial court granted their motions and dismissed the case. *Id.* at 512.

The court of appeal reversed and held that if the carriers had *wrongfully refused to defend the insured* (which fact was not actually decided on appeal), the insured defendant had a right to settle with plaintiff on the best terms possible, and this settlement raised an evidentiary presumption as to the existence and amount of the insured’s liability. *Id.* at 509. Although the hearing at the good faith determination did not contain sufficient safeguards to ensure due process and alone could not bind an insurer, the determination was further evidence of the insured’s liability, and it would fall upon the insurer to demonstrate that the agreement was actually the product of fraud or collusion, which would render it void. *Id.* at 518–19.

However, it is not always enough, by itself, to provide a defense of the insured in order to avoid a third party claimant from stating a claim for bad faith against an insured’s carrier. Once a third party “claimant” becomes a third party “judgment creditor” under the terms of California Insurance Code section 11580, the third party can enjoy a heightened status. In *Hand v. Farmers Insurance Exchange*, 23 Cal. App. 4th 1847 (2d Dist. 1994), the insured was involved in an automobile accident that injured plaintiff. *Id.* at 1851. The insured tendered, and the carrier provided, a defense to the suit that was filed, participating in settlement discussions, offering amounts to settle the case, and admitting policy limits of \$500,000 during discovery. *Id.* at 1851–52. No settlement was reached, the matter went to trial, and plaintiff obtained a jury verdict for \$234,000. *Id.* The carrier first denied any payment, then, five months after the judgment, took the position for the first time that the insured was covered only for \$15,000 and refused to pay anything above that. *Id.* Plaintiff sued the insurer under section 11580 and further alleged claims for bad faith and intentional infliction of emotional distress, praying for punitive damages. *Id.* The trial court granted the plaintiff’s motion for summary judgment on the right to collect the full judgment based on section 11580, but dismissed her claims for bad faith. *Id.* at 1852–53.

The court of appeal affirmed the section 11580 judgment but reversed the dismissal of plaintiff’s cause of action for bad faith, reasoning that once plaintiff had become a *bona fide* “judgment creditor” under the terms of section 11580, she enjoyed the status and rights of a “third-party beneficiary” to the contract, and the covenant of good faith and fair dealing ran equally to her. *Id.* at 1860–61.

This case is a favorite of plaintiffs’ bar, but it should be understood in the narrow factual context of the case itself. The court of appeal itself limited its holding to “the limited circumstances of this case,” and ruled “with due regard, indeed concern, for the widespread general understanding that bad faith claims against insurers are not assertable by ‘third-party claimants.’” *Id.* at 1860. The real lesson for an insurer is that if you defend your insured, admit coverage, conduct settlement negotiations without success, bring the case to trial, and receive a verdict against your insured that is under policy limits—pay the judgment.

## II. The Game So Far

More recently, courts have gone back and forth on the issue of what it takes in order for a third party to be granted the kind of standing an insured would possess, allowing it to claim the benefits of the covenant of good faith and fair dealing. Counsel for third parties, keeping abreast of these decisions and keen to the prospect of punitive damages, can often work with insureds to find creative ways of minimizing the insured’s own potential for any personal liability while simultaneously conferring the status of a fiduciary upon the third party.

The most recent pronouncement from the California Supreme Court on a third party claimant’s attempt to circumvent the general prohibition against a third party assuming the full rights of a contractually insured came in *Hamilton v. Maryland Casualty Co.*, 27 Cal. 4th 718 (2002), which has potentially constricted application of *Pruyn* and other past holdings. In *Hamilton*, the insured tendered defense to the insurer, who *accepted* tender,

a settlement was discussed (below policy limits), but the insurer refused settlement demands, instead choosing to press a defense through trial. *Id.* at 722–23. Meanwhile, the insured and the plaintiff entered into a stipulated agreement, without the carrier’s participation, whereby plaintiff would dismiss all claims against the insured in exchange for a stipulated judgment in excess of policy limits, a covenant not to execute the judgment against the insured, and an assignment to the third party plaintiff of the insured’s cause of action for breach of the good faith duty to accept a reasonable settlement demand. *Id.* at 723. The trial court then approved the settlement and determined that it was made in good faith pursuant to Code of Civil Procedure section 877.6, and the third party then instituted suit against the carrier for contractual damages based on the carrier’s failure to accept previous settlement offers. *Id.* The trial court granted the third party’s motion for summary judgment against the insurer, but the court of appeal reversed, holding that, *where an insurer provides a defense*, a claim for breach of the duty to settle cannot be brought until judgment has been rendered after an actual trial. *Id.* at 723–24.

The California Supreme Court unanimously affirmed this decision, concluding that:

[W]here the insurer has accepted defense of the action, no trial has been held to determine the insured’s liability, and a covenant not to execute excuses the insured from bearing any actual liability from the stipulated judgment, the entry of a stipulated judgment is insufficient to show, even rebuttably, that the insured has been injured to *any* extent by the failure to settle, much less in the amount of the stipulated judgment.

*Id.* at 726.

Crucial to this holding was the carrier’s provision of a defense to its insured, which granted it the right to control the litigation and seek to obtain a more favorable judgment at trial than the one stipulated to by its insured and the third party. This was so despite the *imprimatur* of the settlement’s “good faith” determination by the trial court, because such hearings are designed to test whether a settling tort-feasor is paying less than its fair share of a settlement, not whether the settling insured is agreeing to a settlement that exposes its insurer to a judgment in excess of policy limits. *Id.* at 729–30. “A defending insurer cannot be bound by a settlement made without its participation and without any actual commitment on its insured’s part to pay the judgment, even where the settlement has been found to be in good faith for purposes of section 877.6,” even if there is no evidence of collusion or fraud. *Id.* at 730.

Courts have subsequently applied these principles to deny the effect of a bankruptcy court’s determination of the value of a third party’s claim against a bankrupt insured, despite the bankruptcy trustee’s assessment that the agreement was made in good faith. In *Wolkowitz v. Redland Insurance Co.*, 112 Cal. App. 4th 154 (2d Dist. 2003), plaintiff in the underlying litigation was injured in an automobile accident that he claimed was caused by a defective “lift kit” installed by the insured, he sued the insured, the carrier accepted tender of the defense, the injured plaintiff then made a policy-limits demand of \$500,000, the carrier declined to settlement offer, and the insured then filed for bankruptcy. *Id.* at 157–58.

After a spate of litigation related to the bankruptcy filing, the trustee for the bankrupt insured then entered into an agreement with the plaintiff that expressly provided that the plaintiff had a \$26,225,000 claim against the insured’s bankruptcy estate as a general unsecured claim. *Id.* at 158–59. It further provided that plaintiff would not seek any recovery from the insured, but would look solely to proceeds to be recovered from the carrier. *Id.* The agreement was subject to the approval of the bankruptcy court, but both the trustee and the plaintiff would work to obtain this approval. *Id.* Needless to say, this agreement was reached without the participation of the carrier. *Id.*

After giving notice to all parties, including the carrier, the trustee then moved the bankruptcy court for approval of the settlement, which the court did approve after the motion went unopposed (the carrier likely

would not have standing to appear and oppose, and, if it did, it could be accused of breaching its fiduciary duty to its insured). *Id.* at 159. The trustee then filed suit against the carrier, alleging breach of contract and breach of the implied covenant of good faith and fair dealing. *Id.* The trial court concluded that the bankruptcy court's approval of the settlement was not the equivalent of a final judgment, and, therefore, the insured had not actually suffered any damages as a result of the carrier's failure to settle, a necessary element to any claim, and dismissed the case. *Id.* at 160.

In affirming the trial court's judgment, the court of appeal relied heavily on *Hamilton, supra*, in focusing on the requirement that an insured actually suffer an adverse judgment above policy limits, actual damages, before it has a cause of action against a *defending* carrier for breach of the duty to settle. *Id.* at 162–64. The bankruptcy court's hearing on the settlement agreement, like the good faith determination in *Hamilton*, was not truly an adversarial process and could not act as a reliable measure of the plaintiff's damages in the alternative to a trial and could not bind the insurer. *Id.* at 165–66. The court of appeal expressly extended the holding of *Hamilton* to apply not just to breach of contract cases but also to tortious bad faith cases as well. *Id.* at 164.

*Hamilton* and *Wolkowitz*, read in combination, provide strong support for the proposition that once an insurer accepts the tender of defense of its insured, its right to govern the litigation—while subjecting it to possible extra-policy payments if it refuses to settle and does worse at trial—shields it from settlements made between its insured and third parties where there is a covenant not to execute against the insured, even if the settlement is approved in a judicial setting that is not at heart adversarial. See also *Mercado v. Allstate Ins. Co.*, 340 F.3d 824 (9th Cir. 2003) (insurer not obligated to pay a stipulated judgment where the insurer was tendering a defense, the insured would suffer no damage from the stipulated judgment, and the insurer did not participate in the settlement). But see *Weber v. Indemnity Ins. Co. of N. Am.*, 345 F. Supp. 2d 1139 (D.Haw. 2004) (endorsing such agreements when insureds have “defense within limits” or “cannibalizing” policies; noting similar case law in Alaska, Washington, Minnesota, and Arizona).

But unusual cases continue to arise whereby counsel for a third party claimant exhibits knowledge of the law and is able to navigate the case law to gain access directly to the policy. One such example is *National Union Fire Insurance Co. v. Lynette C.*, 27 Cal. App. 4th 1434 (3d Dist. 1994), which involved policy coverage for a foster mother who negligently failed to prevent her husband from sexually molesting a foster child. As trial approached, the carrier was concerned about the egregious nature of the case becoming public, and the carrier-retained counsel for the defendant-insured foster mother initiated a proposed settlement with counsel for the foster child, and there was a *tentative* agreement to settle for \$1,250,000 on the eve of trial. *Id.* at 1440. However, the foster child's attorney recognized that a stipulated agreement, in which the insured would not be required to personally contribute and that would not result in an actual trial, might not be binding upon the insurer, so he proposed an “uncontested court trial” whereby only plaintiff would present evidence on liability and damages and the court judge would “make up his mind on those issues.” *Id.*

After the foster mother's *Cumis* counsel (separate counsel for an insured provided by an insurer when there is a reservation of rights) intervened and approved of the agreement, the insured's other counsel (who also represented the carrier) expressed the belief that he faced a conflict of interest, stated that he had never had the carrier's final approval for the stipulated judgment, and remained “neutral” as to whether the carrier endorsed the uncontested proceeding. *Id.* at 1441. The uncontested trial proceeded, and plaintiffs' counsel alone presented evidence in the form of depositions, a sheriff's report, and depositions of various experts. *Id.* The judge returned with findings of fact that the insured and her husband were negligent, jointly and severally liable for damages of \$1,250,00, and judgment was entered for the plaintiff foster child. *Id.* at 1441–42.

In the carrier's action for declaratory relief, in which the plaintiff intervened with its own cause of action under section 11580 as a judgment creditor, the trial court determined that the policies issued by the

carrier were available to satisfy the judgment, and the carrier appealed, contesting the issue of whether the judgment arising from an uncontested court proceeding was sufficient to meet the “actual trial” requirement in the “no action” clause in the carrier’s policy with the insured. *Id.* at 1442–43.

The court of appeal affirmed that the judgment was binding on the insurer, noting that in other cases where stipulated agreements between an insured and a third party claimant were not binding, there had been a lack of judicial oversight. “Here, there was no such agreement and the trial court did not act simply as an administrative ‘rubber stamp.’” *Id.* at 1445. Despite the fact that the only evidence presented in the court trial was put on by the plaintiff, the court held that “a trial does not have to be adversarial to be considered an ‘actual trial’ under the ‘no action’ clause to be considered binding against the insurer in a section 11580 proceeding.” *Id.* at 1449. The court acknowledged legitimate concerns about a stipulated judgment with a covenant not to execute against an insured and the potential for fraud and collusion, but, in light of the facts of the case before it, concluded there was no abuse, fraud, or collusion in the proceeding that occurred. *Id.*

Had the carrier’s counsel provided a more thorough defense and vigorously opposed the uncontested proceedings, which it made a strategic decision not to do in light of the sensational aspects of the case and its potential effect on other pending cases against the same insured, the result in the court of appeal might have been different. But this is an example of how a plaintiffs’ lawyer, armed with knowledge of the requirements of section 11580 and like statutes, can gain direct access to an insured’s policy, even when a defense is provided.

Even after an insurer has paid full policy limits before being sued, creative insureds have been able to obtain damages based on claims of bad faith where they were once considered unrecoverable. In *Schwartz v. State Farm Fire and Casualty Co.*, 88 Cal. App. 4th 1329, 1333 (2d Dist. 2001), the insured and his passenger sustained injuries in an automobile accident with an uninsured motorist, and each made claims under the uninsured motorist provisions of the insured’s primary and excess policies. The primary policy provided coverage of \$500,000 per person and \$1 million per accident, while the excess umbrella policy afforded straight coverage limits of \$2 million. *Id.* Both the insured and the passenger made separate demands for arbitration of their claims by different arbitrators to the carriers, and each received \$500,000 under the primary policy, though the passenger managed to do so eight months before the insured. *Id.* at 1333–34. The passenger’s arbitration hearing on the excess policy came before the named insured’s, and he obtained an arbitration judgment of \$1,528,040, which the excess carrier paid one month later. *Id.* at 1333. A few months thereafter, the named insured received his \$500,000 from the primary insurer and provided the excess carrier with documentation verifying that the primary had exhausted its policy limits in making a partial payment on the claim, and the excess insurer then paid the \$471,960 that remained from the original \$2 million to the named insured who had actually procured the policy. *Id.* at 1335.

The insured filed suit against the excess insurer for bad faith, asserting that the excess insurer knew with a reasonable certainty that the combined claims of the named insured and the passenger would consume all of both the primary and excess policies, that the excess carrier took no steps to reserve a proportionate \$1 million share of the \$2 million policy for the insured, and that the excess carrier failed to notify the insured before releasing the proceeds to the passenger. *Id.* at 1334. The excess carrier successfully moved for summary judgment on the basis that it properly paid out policy claims as they became payable and that its knowledge that the named insured’s claims might eventually exceed policy limits was not relevant because there was no obligation owed to the insured until the primary policy was exhausted and the umbrella excess policy was triggered. *Id.*

The court of appeal reversed, finding that the implied covenant of good faith required that the excess carrier not injure the insured’s right to receive full benefits under the policy and that the legal principle that an insurer cannot be in bad faith “unless policy benefits are due” refers only to the policy’s *eventual* coverage of the claim, not the exact date that the policy proceeds are due. *Id.* at 1335. In summation, the court stated:

Therefore, payment of full benefits to one insured, with knowledge of the other insured's competing claim to the same limited pool of insurance funds, may breach the insurer's implied covenant not to impair its other insured's right to receive benefits under the contract, and summary judgment for [the excess carrier] was inappropriate.

*Id.*

Creativity is the lifeblood of more than just the liberal arts, as the foregoing cases demonstrate, but recognition of the common hallmarks of the bad faith setup still goes a long way towards circumventing one.

### **III. The Game Continues...**

If insurance is “an ingenious modern game of chance,” it is one where the rules are not always as certain as they appear, and plaintiffs' counsel are always searching for ways to amend those that are. An exposed insured may be all too willing to stack the deck against its carrier by agreeing to settle with a third party claimant on terms that absolve it of all liability—at the potential expense of the carrier. Vigorous exercise of the insurer's right to conduct and control the defense of its insured in third party liability cases remains the surest way to circumvent new schemes hatched by creative third party counsel before they arise—and to enable a carrier to stand before a court and argue persuasively that it should not be bound by them when they do.