

“FIRST PARTY” INSURANCE BAD FAITH CLAIMS:
MOORING PROCEDURE TO SUBSTANCE

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Since the seminal California appellate decision in *Fletcher v. Western National Life Insurance Co.* was decided in 1970,¹ the judicially created form of redress for first party insurance bad faith—centrally, a contract- or tort-based damages remedy for an insurance company’s unreasonable refusal to provide policy benefits due its insured—has grown from being the subject of a few published appellate opinions a year to what some perceive as its own cottage industry, with armies of specialist lawyers for both insurance companies and policyholders as well as annual seminars, professional legal journals, treatises, and websites all devoted to the topic of insurance company bad faith. Whatever the cause of the increase in the number of claims of first party insurance bad faith,² the courts have noticed their burgeoning

1. *Fletcher v. W. Nat’l Life Ins. Co.*, 89 Cal. Rptr. 78 (Ct. App. 1970).

2. For an incisive business and economic explanation for the increased number of first party bad faith claims, see Richard E. Stewart and Barbara D. Stewart, *The Loss of the Certainty Effect*, 4 RISK MGMT. & INS. REV. 29, 33 (2001) (“From an insurer’s point of view, resisting large claims has become an effective, perhaps even necessary, competitive strategy.”). The Stewarts’ article is an important contribution to the discussion of insurance company bad faith—and in particular the implications for the insurance industry itself. It is also available at <http://www.stewarteconomics.com/publicat.htm> (accessed May 30, 2003).

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dockets,³ and one judicial response has been to develop tools to weed out bad faith claims on summary judgment.

One of the principal tools used by some courts to summarily reject bad faith claims that are based on unreasonable coverage determinations is the “directed verdict” rule, which I argue below loses sight of the applicable law and distorts the substantive legal rules governing an insurance company’s duty to deal with its policyholders fairly. After two decades, the directed verdict rule is losing sway, as illustrated by the recent thoughtful opinion of the Rhode Island Supreme Court reconsidering its own views on the subject.⁴ This mixed rule of substance and procedure should be abandoned as it is not focused on the governing question of whether the denial of coverage was unreasonable *vel non*.

I also discuss here a cousin to the directed verdict rule, the so-called “genuine issue” or “genuine dispute” summary judgment doctrine, whose major vice is precisely its elevation to the status of a separate doctrine. Correctly understood, it is nothing more than a recharacterization of the plaintiff’s burden of proof and offers no independent vitality as a true “defense” to a bad faith claim. As with the directed verdict rule, the conflation of procedural rhetoric with the substantive legal standards governing insurer conduct leads to confusion doctrinally and, more important, to error in concrete cases.

Part I traces the development of the concept of an actionable first party insurance bad faith remedy for the unreasonable denial of coverage. Part II discusses the “directed verdict” rule, whose essence is that, unless the policyholder is entitled to a directed verdict on its coverage claim, the insurer is automatically insulated from bad faith as a matter of law. I argue that the directed verdict rule is inconsistent with the substantive law of first party insurance bad faith and sacrifices policyholders that have been treated in bad faith on the altar of the judiciary’s own institutional fretting over taking questions away from juries.

Part III reviews the “genuine issue” doctrine whereby an insurance company may defeat the bad faith claim against it by showing that it denied

3. See *Employees’ Benefit Ass’n v. Grissett*, 732 So. 2d 968, 978 (Ala. 1998) (“[O]nce thought to be a rarely applicable remedy, recovery for the tort of an insurer’s bad faith failure to pay a claim appears now with great frequency.”). Bad faith claims are classified commonly, although somewhat artificially, as either “third party” or “first party.” Third party bad faith claims involve an insurer’s unreasonable refusal to settle a case that it is or should have been defending for its policyholder, even though a settlement was available within its policy limits, thus exposing the policyholder to an uninsured excess of policy limits judgment that could have been avoided had the carrier reasonably settled the case in the first place. The recognized landmark case in this area is *Comunale v. Traders & Gen. Ins. Co.*, 328 P.2d 198 (Cal. 1958). First party bad faith claims, to some extent in contrast, involve an insurer’s unreasonable refusal to provide policy benefits owing to the insured or other insurer conduct incommensurate with its duty to treat its insured fairly and in good faith.

4. *Skaling v. Aetna Ins. Co.*, 799 A.2d 997 (R.I. 2002).

coverage on a basis constituting a genuine issue as to coverage. Recent decisions have begun to confront the substantive issues and summary judgment context in more nuanced ways.⁵ I argue that the genuine issue “doctrine” is properly used by an insurance company only in defense to its policyholder’s motion for summary judgment on bad faith; the same showing is insufficient when the insurance company moves on offense for summary judgment against its policyholder. As a practical matter, the insurance company’s burden of production and persuasion on its offense motion is to provide the court a record that is nearly as factually laden as that which would exist at the close of the plaintiff’s case at trial. Only on such a record may a court conclude that inferences otherwise drawn in favor of the non-moving party/policyholder as a matter of course (particularly as to the insurer’s motive and intent) would not be reasonable. In such an event, the insurer can argue on its offense motion that no substantial dispute of fact is presented for jury resolution impeding a summary determination that the policyholder’s bad faith claim fails as a matter of law.

Finally, Part IV recapitulates the proper legal standards, differing evidentiary records, and respective burdens on both policyholders and insurance companies in connection with dispositive motions in first party insurance bad faith cases.

I. THE DEVELOPMENT OF THE FIRST PARTY BAD FAITH REMEDY

Over the three decades’ ebb and flow of the development of first party bad faith legal doctrine, the courts have articulated a number of grounds supporting the first party bad faith remedy, and as cases presented themselves the courts have given further flesh to the way in which the covenant of good faith needs to be instituted into practice by insurance companies.⁶

5. See, e.g., *Smythe v. Safeco Ins. Co. of Am.*, No. 01–55475, 2002 WL 506116, at *5 (9th Cir. Mar. 28, 2002); *Smith v. Safeco Ins. Co.*, 50 P.3d 277, 281 (Wash. Ct. App. 2002); *Chateau Chamberay Homeowners Ass’n v. Associated Int’l Ins. Co.*, 108 Cal. Rptr. 2d 776 (Ct. App. 2001).

6. The development of the first party bad faith remedy has not been monopolized by the judicial branch; in each state, executive-appointed or independently elected insurance commissioners and state legislatures have influenced (and in some cases preempted) the development of the standards of practice and legal rules (and consequent remedies) with which insurance companies are to comport themselves in their dealings with citizens of the particular state. E.g., GA. CODE ANN. § 33–6–34; see also *Peiffer v. State Farm Mut. Auto. Ins. Co.*, 940 P.2d 967, 970–71 (Colo. Ct. App. 1997); *Kraeger v. Nationwide Mut. Ins. Co.*, No. Civ. A. 95–7550, 1997 WL 109582, at *1 (E.D. Pa. Mar. 7, 1997) (permitting expert to use insurance statute as evidence of “standards to which insurance companies must adhere”); *Dees v. Am. Nat’l Fire Ins. Co.*, 861 P.2d 141, 149–52 (Mont. 1993); *Heyden v. Safeco Title Ins. Co.*, 498 N.W. 2d 905, 911 (Wis. 1993) (using state unfair claims practices statute to support punitive damages claim). A state statute may be applied to afford a bad faith remedy even if the contract terms are governed by another state’s law, subject only to constitutional constraints; this is because the applicability of a statute depends on its terms and the scope of legislative power rather than on questions of the judicially created doctrine of choice of law. See generally *Watson v. Employers Liab. Assurance Corp., Ltd.*, 348 U.S. 66 (1954).

Natural divergences in emphasis among the state courts have produced somewhat differing articulations, but they share the same core first party bad faith precepts. However clothed, the first party bad faith doctrine rests fundamentally on the principle that an insurance company has a separately enforceable duty not to withhold benefits unreasonably and that the rubric for imposing that duty is the contractually derived covenant of good faith and fair dealing.⁷

Until the first party bad faith remedy was introduced in the 1970s, for really “bad” insurer conduct, an insured had few available legal claims—generally, a fraud claim, which in addition to the high burden of proof requires the insured to show that at the time of contracting the carrier never had an intention to perform, or an intentional infliction of emotional distress claim, which also has difficult elements of proof and may not compensate economic harm stemming from the unreasonable coverage denial (and may not be available to businesses and corporations, which form a large component of the insurance-buying public).⁸ As a result, the courts were unable to police various types of unacceptable conduct by insurers or provide effective redress for policyholders.⁹ Consequently, led principally by the California courts in *Fletcher*¹⁰ and *Gruenberg v. Aetna Insurance Co.*,¹¹ and soon by other jurisdictions such as Wisconsin in *Anderson v. Continental Insurance Co.*,¹² most jurisdictions adopted the first party insurance bad faith remedy.¹³

The remedy stems from the unique nature of insurance contracts: One side, the policyholder, has generally fully performed, and the other side,

7. Compare *Gruenberg v. Aetna Ins. Co.*, 510 P.2d 1032 (Cal. 1973), with *Anderson v. Cont'l Ins. Co.*, 271 N.W.2d 368 (Wis. 1978); see generally STEPHEN ASHLEY, BAD FAITH ACTIONS: LIABILITY AND DAMAGES § 2.13, at 2–38 (2d ed. 1997) (“Whether one can postulate a set of actions that would constitute bad faith for purposes of *Gruenberg* but would escape liability under *Anderson* is debatable.”).

8. See generally H. Walter Croskey, *Bad Faith in California: Its History, Development and Current Status*, 26 TORT & INS. L.J. 561, 562–63 (1991); ASHLEY, *supra* note 7, § 2.11, at 2–32, 2–33.

9. Further driving the need for development of a first party remedy is the fact that every successful policyholder litigant ends up receiving less in compensation than the value that prompt and full performance would have conferred; this is true because of the “American rule” governing payment of attorneys’ fees, limitations on prejudgment interest recoveries, and an arguably unreasonable judicial bias against awarding full consequential damages in contract and specifically insurance contract cases. See generally Croskey, *supra* note 8; see also Tom Baker, *Constructing the Insurance Relationship: Sales Stories, Claim Stories, and Insurance Contract Damages*, 72 TEX. L. REV. 1395, 1423–25 (1994).

10. *Fletcher v. W. Nat'l Life Ins. Co.*, 89 Cal. Rptr. 78 (Ct. App. 1970). Another important early case is *Sukup v. State*, 227 N.E.2d 842, 844 (N.Y. 1967).

11. 510 P.2d 1032 (Cal. 1973).

12. 271 N.W.2d 368 (Wis. 1978).

13. In the Supreme Court of Canada’s recent landmark decision in *Whiten v. Pilot Ins. Co.*, 209 D.L.R. (4th) 257 (Can. 2002), the court held that “a breach of the contractual duty of good faith is independent of and in addition to the breach of contractual duty to pay the loss. It constitutes an ‘actionable wrong’ [for which punitive damages may be awarded].” *Id.* ¶ 79.

the insurer, will perform only should certain circumstances arise.¹⁴ Because the insurer already collected the premium, any payment on a claim by the insurer diminishes the insurer’s resources, i.e., claim payments (actual or reserved) directly reduce profit shown to shareholders.¹⁵ As a result, at the point of claim the relationship of the insurance company to the policyholder is fundamentally adverse economically.¹⁶ The central purpose and function of the first party bad faith remedy is to provide a counterweight to the structural adversity of economic interest that an insurance company has to its own policyholder.¹⁷

The courts’ recognizing an insurance company’s unreasonable failure to perform as separately actionable also grows out of another *sine qua non* of insurance relationships: What insurers sell is protection to their policyholders,¹⁸ and an essential element of the value of the insurance contract is lost if the carrier’s performance is anything but immediate.¹⁹ Insurance

14. Such a promise of performance is called “aleatory.” See generally 3A ARTHUR L. CORBIN, CORBIN ON CONTRACTS § 728 (1960) (“An aleatory promise is one the performance of which is by its own terms subject to the happening of an uncertain and fortuitous event or upon some fact the existence or past occurrence of which is also uncertain and undetermined.”); see also *id.* § 731 (“Insurance as an Aleatory Contract”).

15. See generally Stewart and Stewart, *supra* note 2, at 31.

16. See *Foley v. Interactive Data Corp.*, 765 P.2d 373, 396 (Cal. 1988) (“In the insurance relationship, the insurer’s and insured’s interest are financially at odds. If the insurer pays a claim, it diminishes its fiscal resources.”); cf. *Ellwein v. Hartford Accident & Indem. Co.*, 15 P.3d 640, 647 (Wash. 2001) (“the relationship between a UIM insurer and its insured is by nature adversarial and at arm’s length”) (quotation omitted); *Beck v. Farmers Ins. Exch.*, 701 P.2d 795, 798 (Utah 1985).

17. See *Kransco v. Am. Empire Surplus Lines Ins. Co.*, 2 P.3d 1 (Cal. 2000); *Grand Sheet Metal Prods. Co. v. Prot. Mut. Ins. Co.*, 375 A.2d 428, 430 (Conn. Super. Ct. 1977) (economic power imbalance in insurance relationships is a “paramount consideration” in adopting first party bad faith remedy). In *Kransco*, the court held:

A fundamental disparity exists between the insured, which performs its basic duty of paying the policy premium at the outset, and the insurer, which, depending on a number of factors, may or may not have to perform its basic duties of defense and indemnification under the policy. An insured is thus not on equal footing with its insurer—the relationship between insured and insurer is inherently unequal, the inequality resting on contractual asymmetry. An insurer’s tort liability for breach of the covenant is thus predicated upon special policy factors inapplicable to the insured.

Kransco, 2 P.3d at 11 (citations omitted).

18. Insureds are not seeking commercial advantage vis à vis the insurance company when entering into an insurance contract. *E.g.*, *McCorkle v. Great Atl. Ins. Co.*, 637 P.2d 583, 588 (Okla. 1981) (“[O]ne of the primary reasons a consumer purchases any type of insurance (and the insurance industry knows this) is the peace of mind and security that it provides in the event of loss.”); *Crisci v. Sec. Ins. Co. of New Haven*, 426 P.2d 173, 179 (Cal. 1967) (“[P]laintiff did not seek . . . commercial advantage but to protect herself against the risks of accidental losses, including the mental distress which might follow from the losses. Among the considerations in purchasing liability insurance . . . is the peace of mind and security it will provide in the event of an accidental loss. . . .”); see also *Whiten*, 209 D.L.R. (4th) 257, ¶ 129 (“The obligation of good faith dealing means that the [insured’s] peace of mind should have been [the insurer’s] objective. . . .”). See generally *Baker*, *supra* note 9.

19. As an example, specific performance of the duty to defend has been ordered because

companies inculcate the image of coming to the insured's rescue in the time of need, a standard of performance that in the minds of purchasers of insurance forms a material part of the insurance company's consideration.²⁰ When an insurance company wrongly fails to perform, whether that failure is due to the claims person's error, negligence, or malice, the policyholder is deprived of the benefit of the insurer's core promise of prompt protection that in fact was owed.

Indeed, to be a reliable contracting party that will provide prompt performance across the broad class of its policyholder customers, the insurance company makes what might be termed an "institutional" promise that it will organize itself in such a fashion to get the coverage question right not just most of the time, but virtually every time. Otherwise, the promptness of performance so vital to the value of the insurance contract would be destroyed as to large groups of policyholders. The insurance company's promise of protection entails its ensuring that its claims people are well trained, properly investigate claims and apply the contract, treat insureds consistently and fairly, and most important, pay insureds' covered claims promptly.²¹ In effect, the promise of insurance protection—which by def-

"[o]ne purpose of purchasing CGL insurance is to obtain peace of mind that the carrier will defend against third party lawsuits which potentially seek damages within the coverage of the policy. . . . The right to seek reimbursement and to sue for breach of contract are inadequate remedies as a matter of law." *Montrose Chem. Corp. v. Am. Motorist Ins. Co.*, 16 Cal. Rptr. 2d 516, 533 (Ct. App. 1993) (uncitable in California) [the author was counsel to one of the policyholders in this case]; see also *McGinnis v. Employers Reinsurance Corp.*, 648 F. Supp. 1263, 1271 (S.D.N.Y. 1986); Marc S. Mayerson, *Insurance Recovery of Litigation Costs: A Primer for Policyholders and Their Counsel*, 30 TORT & INS. L.J. 997, 1012–14 (1995). Because insurance contracts promising security are unlike, for example, commercial contracts involving the sale of goods (cf. *Crisci*, 426 P.2d at 179), when an insurer breaches, an insured cannot reasonably "cover" and seek alternative performance from another source (and then sue the breaching insurer for the net difference). See *Wallis v. Superior Court*, 207 Cal. Rptr. 123, 128 (Ct. App. 1984), *overruled on other grounds*, *Foley v. Interactive Data Corp.*, 765 P.2d 373 (Cal. 1988).

20. See *State Farm Fire & Casualty Co. v. Nicholson*, 777 P.2d 1152, 1156 n.6 (Alaska 1989); *C&J Fertilizer, Inc. v. Allied Mut. Ins. Co.*, 227 N.W.2d 169, 178–79 (Iowa 1975) ("We would be derelict in our duty to administer justice if we were not to judicially know that modern insurance companies have turned to mass advertising to sell 'protection.'"); *D'Ambrosio v. Pa. Nat'l Mut. Casualty Ins. Co.*, 396 A.2d 780, 785 (Pa. Super. Ct. 1978) ("The insurer's promise to the insured to 'simplify his life,' to put him 'in good hands,' to back him with 'a piece of the rock' or to be 'on his side' hardly suggests that the insurer will abandon the insured in his time of need."); see generally *Free v. Sluss*, 197 P.2d 854 (Cal. App. Dep't Super. Ct. 1948) (sales of soap). Insurers actively market to and profit from a policyholder's desire both to transfer the risk of loss and to secure the help of an experienced partner in a time of need. See generally *Baker*, *supra* note 9, at 1403–07. Especially in the context of mass tort situations, one unfortunate consequence of the current coverage environment is that insurers are not coming to the aid of their corporate policyholders to help them efficiently manage what for them is perhaps a once-in-a-lifetime situation, forcing companies to reinvent the wheel in terms of systems, management, and strategies while their insurers "run for cover instead of coverage." See Marc S. Mayerson, *The Coverage Wars*, TEX. LAW., Feb. 23, 1998, at 34.

21. The primacy of immediate performance is such that, for a promptly paying carrier, a court may excuse carrier conduct that otherwise might well be actionable—essentially on a

inition requires that the insurance company promisor reliably perform—includes a necessary covenant to perform promptly or to deny coverage only where the insurance company has proper cause and a reasonable basis to do so.²² Unlike other contracts, the notion of efficient breach, or of the policy contract providing the insurance company with the option to perform or pay damages, is (or certainly should be) entirely alien to insurance relationships.²³

When the institutional “reliability” promise—that is, the insurer’s promise to pay promptly or deny reasonably and in good faith—itself is breached, the insurance company’s paying damages coextensive with the benefits owed (plus interest) does not compensate the policyholder for this separate violation.²⁴ Presumptively, the damages flowing from an unrea-

theory that the breach of fair dealing in the circumstances is *damnum absque injuria*. See *Love v. Fire Ins. Exch.*, 271 Cal. Rptr. 246, 254–56 & n.10 (Ct. App. 1990); compare *Robinson v. N.C. Farm Bureau Ins. Co.*, 356 S.E.2d 392 (N.C. Ct. App. 1987) (full, but untimely, performance does not preclude bad faith claim).

22. *E.g.*, *Chateau Chamberay Homeowners Ass’n v. Associated Int’l Ins. Co.*, 108 Cal. Rptr. 2d 776, 784 (Ct. App. 2001) (“unreasonably or without proper cause”); *Nicholson*, 777 P.2d at 1152; *Travelers’ Ins. Co. v. Sheppard*, 12 S.E. 18, 23 (Ga. 1890) (“any defense not manifesting such reasonable and probable cause would expose the [insurance] company to the imputation of bad faith”); *Zoppo v. Homestead Ins. Co.*, 644 N.E.2d 397 (Ohio 1994). As the California Court of Appeal has explained: “If an insurer were free of such special duties [of good faith and fair dealing] and could deny or delay payment of clearly owed debts with impunity, the insured would be deprived of the precise benefit the contract was designed to secure (i.e., peace of mind) and would suffer the precise harm (i.e., lack of funds in times of crisis) the contract was designed to prevent.” *Love*, 271 Cal. Rptr. at 252.

23. See *Stewart and Stewart*, *supra* note 2, at 34–40 (evaluating the reliability of performance question through the lenses of option theory, asymmetric information theory, and prospect theory); cf. *Zapata Hermanos Sucesores, S.A. v. Hearthside Baking Co.*, 313 F.3d 385, 389–90 (7th Cir. 2002). (Posner, J.). It is well established that the custom and practice in the insurance industry sets a floor, not a ceiling, for determining what is reasonable conduct by insurance companies; an industry-wide race to the bottom will not shield each insurer from being found to have breached its duty of good faith and fair dealing. See *Sparks v. Republic Nat’l Life Ins. Co.*, 647 P.2d 1127, 1336–37 (Ariz. 1982); *Silberg v. Cal. Life Ins. Co.*, 521 P.2d 1103, 1108 n.3 (Cal. 1974) (ruling as a matter of law that insurer committed bad faith, notwithstanding that there was no prior case law on point or relevant industry custom and practice).

24. In *Wallis*, the California court held:

A further very important characteristic of the insurance contract is that ordinary contract damages are inadequate to protect the insureds’ rights. In the first place, they offer no motivation whatsoever for the insurer *not* to breach. If the only damages an insurer will have to pay upon a judgment of breach are the amounts that it would have owed under the policy plus interest, it has every interest in retaining the money, earning the higher rates of interest on the outside market, and hoping eventually to force the insured into a settlement for less than the policy amount.

207 Cal. Rptr. at 128. Compensating insureds separately for their damages from unreasonable claim denials is consistent with imposing the costs of externalities on the party best in the position to avoid the unreasonable conduct in the first place: As between the insurance company and an innocent policyholder whose claim was improperly denied, the costs imposed by the claims handler’s unreasonable withholding of benefits more properly are borne by the

sonable denial of coverage would include the policyholder's costs of prosecuting the coverage case,²⁵ because it would be entirely speculative for the insurer to contend that, had it not denied coverage *unreasonably*, it would have denied coverage reasonably, such that the policyholder would have had to sue it to get coverage for the policy benefits that the insurer incorrectly withheld.²⁶

Moreover, the courts are loath to permit a policyholder's transaction costs in accessing judicial redress itself to create an economic space within which an insurance company can get away with rendering less than what it promised when collecting the policyholder's premium,²⁷ and the first party bad faith remedy helps ensure that the insurer's promise and contractual duty to perform promptly in the time of need is not desiccated to a legal right to sue the insurance company for breach later.²⁸

insurance company employer. This is especially true for benefits unreasonably withheld pursuant to company policy or approval by management. *See Hudson Universal, Ltd. v. Aetna Ins. Co.*, 987 F. Supp. 337, 342 n.4 (D.N.J. 1997) ("The Court cautions, however, that an insurer may not 'create' a debate by denying coverage on an issue for which it consistently declines coverage as a matter of policy."). Ordinarily, such would provide the basis for the imposition of punitive damages against the insurance company in many states. *See generally* *Trinity Evangelical Lutheran Church and School-Freistadt v. Tower Ins. Co.*, N.W.2d No. 01-1201, 2003 WL 21205367 (Wis. May 23, 2003); *Neal v. Farmers Ins. Exch.*, 582 P.2d 980 (Cal. 1978).

25. *See Ingersoll Milling Mach. Co. v. M/V BODENA*, 829 F.2d 293, 309-10 (2d Cir. 1987); *Polito v. Cont'l Cas. Co.*, 689 F.2d 457, 465 (3d Cir. 1982); *Brandt v. Superior Ct.*, 693 P.2d 796, 800-01 (Cal. 1985); *Pugh v. N. Am. Warranty Servs. Inc.*, 1 P.3d 570, 574 (Utah Ct. App. 2000). *But see Burnside v. State Farm Fire & Cas. Co.*, 528 N.W.2d 749, 753 (Mich. Ct. App. 1995). The policyholder may have other damages as well. *See generally* *Mead v. Johnson Group, Inc.*, 615 S.W.2d 685, 687 (Tex. 1981); *Fletcher v. W. Nat'l Life Ins. Co.*, 89 Cal. Rptr. 78, 93-95 (Ct. App. 1970). The damages to which a policyholder is entitled arising from a "good faith" breach are not capped by the policy limit (plus interest) per se, but instead are the nonbreaching party's actual damages; the contract limit forms the principal basis for an insured's expectation damages, but the policy limit does not itself form a shield or establish a cap to recoverable breach of contract damages. *See generally* *Beck v. Farmers Ins. Exch.*, 701 P.2d 795 (Utah 1985).

26. No doubt some courts appear reluctant to impose separate liability on insurance companies for erroneous claim denials resulting from "ordinary" or "simple" negligence, but what the courts seem to be saying is that ordinary breaches of contract stemming from human error and frailty are not the stuff of bad faith. *See, e.g., Griffin v. Allstate Ins. Co.*, 29 P.3d 777, 783 (Wash. Ct. App. 2001) ("As long as the insurance company acts with honesty, bases its decision on adequate information, and does not overemphasize its own interests, an insured is not entitled to base a bad faith claim or [statutory] claim against its insurer on the basis of a good faith mistake."), quoting *Coventry Assocs. v. Am. States Ins. Co.*, 961 P.2d 933, 937-38 (Wash. 1998); *Rawlings v. Apodaca*, 726 P.2d 565, 573 (Ariz. 1986). Although it can be said perhaps that the insured assumes the risk of an inaccurate coverage determination produced by the sloppiness of ordinary human beings trying to do their jobs as best they can, there is no justification to compound the deprivation that the insured suffers from an incorrect coverage denial by further forcing the insured to bear the costs of pursuing coverage negligently denied or otherwise failing to compensate the insured for its full damages resulting from the wrongful denial of coverage. *See Ingersoll Milling*, 829 F.2d at 309-10; *Beck*, 701 P.2d at 800-01.

27. *Bibeault v. Hanover Ins. Co.*, 417 A.2d 313, 318 (R.I. 1980); *Rawlings*, 726 P.2d at 570.

28. *Nobel v. Nat'l Am. Life Ins. Co.*, 624 P.2d 866, 868 (Ariz. 1981) ("whole purpose of insurance is defeated" when payments are withheld or delayed in bad faith); *Hayseeds, Inc.*

Some courts further have justified judicial scrutiny of the fairness of how insurance companies treat their policyholders because of the special legal protections afforded insurers in view of the perceived "public" nature of their business²⁹ and the fact that, at least for liability policies, the insurance companies operate (and make their money) in conjunction with the civil court system by helping to adjust private disputes in our society.³⁰

Yet, in the doctrinal development of the first party insurance bad faith remedy, the courts concurrently have expressed countervailing concerns, perhaps the most important of which is the idea that sometimes the insurance company should be able to lose the coverage case but not also be found automatically to have acted in bad faith.³¹ The rhetoric of the Wisconsin (i.e., *Anderson*) "fairly debatable" rule is illustrative: "[W]hen a claim is 'fairly debatable,' the insurer is entitled to debate it, whether the debate concerns a matter of fact or law."³² As one court observed: "This 'fairly debatable' standard is premised on the idea that when an insurer denies coverage with a reasonable basis to believe that no coverage exists, it is not guilty of bad faith even if the insurer is later held to have been wrong."³³ The Indiana courts, for example, have recognized what they term an insurer's "privilege to disagree" without the insurer being subject to bad faith liability. As the Indiana Supreme Court explained:

It is evident that the exercise of this right [to disagree] may directly result in the intentional infliction of temporal damage, including the damage of interference with an insured's business (which an insured will undoubtedly consider to be oppressive). The infliction of this damage has generally been regarded as privileged, and not compensable, for the simple reason that it is worth more

v. State Farm Fire & Cas., 352 S.E.2d 73, 79 (W. Va. 1986) ("[W]hen an insured purchases a contract of insurance, he buys insurance—not a lot of vexatious, time consuming, expensive litigation with his insurer.").

29. See, e.g., McCarran Ferguson Act of 1945, 15 U.S.C. § 1011 (2000); *German Alliance Ins. Co. v. Lewis*, 233 U.S. 389, 406, 414–15 (1914). The Supreme Court of Canada in its recent landmark decision in *Whiten v. Pilot Ins. Co.* justified the award of punitive damages to the policyholder on the ground that "[o]ver compensation of a plaintiff is given in exchange for this socially useful service" of deterring wrongful conduct of insurance companies. 209 D.L.R. (4th) 257 (Can. 2002), ¶ 37.

30. See generally *Travelers Ins. Co. v. Savio*, 706 P.2d 1258, 1273 (Colo. 1985); *Grand Sheet Metal Prods. Co. v. Prot. Mut. Ins. Co.*, 375 A.2d 428, 430 (Conn. Super. Ct. 1977); *Hoskins v. Aetna Life Ins. Co.*, 452 N.E.2d 1315, 1321 (Ohio 1983); *Egan v. Mut. of Omaha Ins. Co.*, 620 P.2d 141, 146 (Cal. 1979).

31. Otherwise, insurance companies alone would be exempted from the American rule governing attorneys' fees. Another important constraint in the development of first party bad faith law has been to ground the bad faith remedy (and corresponding obligations) on a basis unique to insurance companies so as not to open up all contracting parties to bad faith claims. See generally *White v. W. Title Ins. Co.*, 710 P.2d 309, 327–28 (Cal. 1985) (Kaus, J., concurring and dissenting).

32. *Anderson v. Cont'l Ins. Co.*, 271 N.W.2d 368, 376 (Wis. 1978).

33. *Hudson Universal, Ltd. v. Aetna Ins. Co.*, 987 F. Supp. 337, 341 (D.N.J. 1997).

to society than it costs, *i.e.*, the insurer is permitted to dispute its liability in good faith because of the prohibitive social costs of a rule which would make claims nondisputable. Insurance companies burdened with such liability would either close their doors or increase premium rates to the point where only the rich could afford insurance.³⁴

So as not to unduly burden insurers' "privilege to disagree," some courts have sought to limit the presentation and prosecution of first party insurance bad faith claims by policyholders through the development of special motion-related doctrines for such cases that mix substantive law and procedural rules—most notably, the directed verdict rule and the genuine issue doctrine, which are discussed separately in the next two sections.³⁵

II. THE DIRECTED VERDICT RULE

The Alabama Supreme Court is credited with formulating the "directed verdict" rule, the essence of which is that, unless the policyholder is entitled to a directed verdict on its coverage claim, the insurance company's denial of coverage cannot constitute bad faith as a matter of law.³⁶ The two-decades-old directed verdict rule edifice presently is crumbling; even in those states where it applies the courts have been constrained to develop numerous

34. *Vernon Fire & Cas. Ins. Co. v. A.W. Sharp*, 349 N.E.2d 173, 181 (Ind. 1976).

35. Without abandoning first party bad faith claims altogether, some courts have developed one substantive limitation on the scope of bad faith that has gained some traction nationwide, *viz.*, if there is no covered contract claim, as a matter of law an insurer can never be found in bad faith. This rule treats the covenant of good faith as dependent upon the antecedent contract claim. Of course, those jurisdictions adopting this rule insulate bad faith conduct that otherwise would be inconsistent with the insurers' legal duties to their insureds. Although the policyholder may not have significant damages for breach of good faith where there is no coverage, that issue should be separate from the question whether a violation occurred.

By ruling that there is no bad faith in the absence of coverage, courts close their doors to other remedies, such as equitable or declaratory remedies or even, if appropriate, punitive damages. Implicitly, the courts are applying an assumption of risk theory from the insured's submission of an uncovered claim. But insulating all bad faith conduct simply because the claim was not covered is too blunt an instrument to separate out those claims where there are real departures from the norms of insurer conduct and real damages suffered by the policyholder (although not sufficient to state a claim of intentional infliction of emotional distress, a tort fashioned with respect to noncontracting parties) and those claims that may not rise above the level of *damnum absque injuria*.

The courts adopting this view solecistically import the no harm, no foul rule in tort to the contractual context of bad faith claims with the carrier—a contracting partner (not a stranger as in tort) with a covenant of good faith and fair dealing; the carrier's good faith obligation is an abiding one contractually (*see Gruenberg v. Aetna Ins. Co.*, 510 P.2d 1032, 1037–38 (Cal. 1973)), knowingly assumed by insurers in every state today, that should be actionable whether or not there is coverage. *See Deese v. State Farm Mut. Auto. Ins. Co.*, 838 P.2d 1265, 1270 (Ariz. 1992); *Best Place, Inc. v. Penn Am. Ins. Co.*, 920 P.2d 334, 336 (Haw. 1996); *Tornetta v. Allstate Ins. Co.*, 973 P.2d 8, 12 (Wash. Ct. App. 1999).

36. *Nat'l Sav. Life Ins. Co. v. Dutton*, 419 So. 2d 1357 (Ala. 1982); *see also Pickett v. Lloyd's*, 621 A.2d 445, 453–54 (N.J. 1993).

exceptions,³⁷ and some courts, like the Rhode Island Supreme Court, are on the verge of abandoning their previous embrace of the doctrine.³⁸

The directed verdict rule as formulated by the Alabama Supreme Court in *Dutton* states: “In the normal case . . . to make out a prima facie case of bad faith refusal to pay an insurance claim, the proof offered must show that the plaintiff is entitled to a directed verdict on the contract claim and, thus, entitled to recover . . . as a matter of law.”³⁹ A pair of insurer-side lawyers have argued:

The logic of the *Dutton* rule is simple. An insurer is entitled to dispute claims so long as it has a reasonable basis. If reasonable minds could *not* differ on the coverage determining facts, a verdict should be directed or summary judgment rendered on coverage. If that cannot be done, it ordinarily must follow that the insurer had reasonable grounds to dispute the facts, precluding any possibility of bad faith.⁴⁰

But *Dutton* ignores the overarching rule that an insurance company has a *duty* to pay the claim if it is reasonable to do so.⁴¹ If reasonable minds could differ about the facts or whatever is the essence of the coverage dispute, then an insurer’s adopting the coverage denying construction—far from insulating it from bad faith liability—should go a long way toward establishing bad faith liability against the carrier. The reason that this is true—and indeed must be true—is that as a matter of substantive insurance law, insurance companies are required to construe ambiguous policy language in favor of coverage and to construe the facts and circumstances in the light most favorable to coverage.⁴²

37. See Stephen D. Heninger and Nicholas W. Woodfield, *A Practitioner’s Guide to Alabama’s Tort of Bad Faith*, 57 ALA. LAW. 277, 281 (Sept. 1996).

38. *Skaling v. Aetna Ins. Co.*, 799 A.2d 997 (R.I. 2002). Of course, several states have expressly refused to adopt the directed verdict rule. See *id.* (citing cases).

39. *Dutton*, 419 So. 2d at 1362.

40. William T. Barker and Paul E.B. Glad, *Use of Summary Judgment in Defense of Bad Faith Actions Involving First Party Insurance*, 30 TORT & INS. L.J. 49, 56 (1994), quoted in *Ellwein v. Hartford Accident & Indem. Co.*, 15 P.3d 640, 645 (Wash. 2001) (sans the first sentence quoted here).

41. *E.g.*, *Fleming v. Safeco Ins. Co. of Am., Inc.*, 206 Cal. Rptr. 313, 318 (Ct. App. 1984) (“The first and primary duty of the insurer is to pay a claim to its insured if such payment would be reasonable under all the circumstances. . .”).

42. See 2 ERIC MILLS HOLMES & MARK S. RHODES, *HOLMES’S APPLEMAN ON INSURANCE*, 2D § 6.1, at 147 (1996) (“If any question of the meaning of policy terms arises, it should be liberally construed in favor of the insured pursuant to the ‘contra proferentem’ rule of construction.”); *Lucas v. State Farm Fire & Cas. Co.*, 963 P.2d 357 (Idaho 1998) (factual record must be construed in favor of coverage). That insurers are to give the benefit of any honest doubt to the policyholder also grows out of the reliability promise and the primacy of the insurer’s promptly performing, both in individual instances and overall. See generally *Sonoco Bldgs., Inc. v. Am. Home Assurance Co.*, 877 F.2d 1350, 1353 (7th Cir. 1989) (Insurance policies are to be construed to effectuate “the predominate purpose of the policy, which is to indemnify the insured for loss.”).

Insurance companies are importantly different from most other contract litigants (whose contracts, should they contain ambiguities, will be construed against them in court) because insurance companies themselves must apply the various procoverage doctrines—on pain of exposure to bad faith damages for failing to do so. As the U.S. Court of Appeals for the Tenth Circuit incisively explained:

Insurers are obviously well aware of this “familiar rule” [that uncertain policy language is to be construed in favor of coverage], but Prudential’s argument would allow them to ignore it with impunity. Under Prudential’s argument, an insurer could intentionally insert an ambiguous term into a policy and continually deny coverage based on that term, despite contrary court decisions or its own doubts about the meaning of the term. The insurer could lose coverage cases (though many insureds would not litigate and would accept the insurer’s denial of coverage), but would never face a bad faith claim because its ambiguous term would create a “legitimate dispute.” Such actions by an insurer would not be in good faith and could not be countenanced. Thus, mere ambiguity cannot, as a matter of law, create a valid defense to a bad faith claim.⁴³

If reasonable minds could differ about the claim, so long as one reasonable construction leads to coverage, the carrier must adopt it.⁴⁴

Dutton and the courts adopting the directed verdict rule also typically do not consider that the standard for a directed verdict (including the residuum of discretion to deny and then enter a j.n.o.v. later) turns importantly on questions concerning the proper role of the judge and jury.⁴⁵ The rules governing a judge’s directing a verdict take into account the antidemocratic nature of the exercise of judicial power and the constitutional questions concerning the right to a jury trial that judicial summary resolution implicates.⁴⁶

43. *Wolf v. Prudential Ins. Co. of Am.*, 50 F.3d 793, 800 (10th Cir. 1995). The reasons for requiring insurance companies themselves to construe the language in favor of coverage or apply against themselves other maxims of policy construction include the facts that, unlike other contracting parties who make something in the world and use contracts to memorialize some exchange of value, insurance companies are professional contract manufacturers, whose business is the production of contracts, and are professional litigants who owe a duty to the court system not to engage in litigation that they should know will result in the application of these pro-coverage doctrines.

44. See generally *HOLMES & RHODES*, *supra* note 42, at 137–42 (“[I]f the meaning of the words employed is doubtful or uncertain, or if for any reason an ambiguity exists either in the policy as a whole or in portions thereof, the insured should have the benefit of a favorable construction in such instance.”) (footnotes omitted).

45. See *Baltimore & Carolina Line, Inc. v. Redman*, 295 U.S. 654, 659–61 (1935); *cf. Slocum v. New York Life Ins. Co.*, 228 U.S. 364, 376–88 (1913).

46. See *Neely v. Martin K. Eby Constr. Co.*, 386 U.S. 317, 321–22 (1967) (j.n.o.v. does not violate Seventh Amendment); *Galloway v. United States*, 319 U.S. 372, 389–90 (1943) (directed verdict does not violate Seventh Amendment); see also *Gibson v. City of Cranston*,

A party has no “entitlement” to have a judge resolve a matter summarily, and in many ways things are loaded to err on the side of going to the jury.⁴⁷ These institutional concerns, quite obviously, have nothing to do with regulating the legal relationship between policyholders and their insurers. There is no justification for denying an insured’s otherwise proper bad faith claim because of various judge/jury issues bound up in any motion for summary judgment.⁴⁸

The institutional concerns at issue on a motion for directed verdict also curtail what and how evidence is considered on the motion, an evidentiary basis that is almost diametrically opposite to how insurers are required to evaluate their policyholders’ claims. Given the procedural context, a policyholder’s motion for directed verdict on the coverage claim is considered on a record not construing inferences in favor of coverage (and in some states coverage favorable evidence is disregarded).⁴⁹ But in evaluating the policyholder’s claim for coverage, although the insurer is not required to disregard coverage-negating facts, it is required to consider all of the evidence that supports its policyholder’s claim for coverage and to construe that evidence in favor of coverage. A carrier would be found to have acted in bad faith if it drew all inferences against its own policyholder and disregarded coverage-favorable evidence, as if it were a judge evaluating a directed verdict motion.⁵⁰

37 F.3d 731, 735 (1st Cir. 1994); *Henson v. Falls*, 912 F.2d 977, 978–79 (8th Cir. 1990); *Etalook v. Exxon Pipeline Co.*, 831 F.2d 1440, 1447 (9th Cir. 1987); *cf. Dairy Queen, Inc. v. Wood*, 369 U.S. 469, 470, 473 (1962) (jury issues should be tried first before bench trial at equity).

47. For example, generally denials of motions for summary judgment are not reviewable after trial. *See, e.g., Lama v. Borrás*, 16 F.3d 473, 476 n.5 (1st Cir. 1994) (denial of summary judgment overtaken by full dress trial and adverse jury verdict); *W. Heritage Ins. Co. v. Green*, 54 P.3d 948, 951 (Idaho 2002) (“This Court has adopted the general rule that an order denying a motion for summary judgment is not reviewable on appeal from a final judgment.”); *see also Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255 (1986) (district court may deny summary judgment in a case “where there is reason to believe that the better course would be to proceed to a full trial”); *Montgomery Ward & Co. v. Duncan*, 311 U.S. 243, 253–54 (1940) (losing party may appeal judgment on merits after denial of motion for directed verdict).

48. Since appellate courts have permitted bad faith claims notwithstanding the trial court’s (erroneous) acceptance of the carrier’s no coverage argument (*see Filippo Indus., Inc. v. Sun Ins. Co. of N.Y.*, 88 Cal. Rptr. 2d 881 (Ct. App. 1999)), a trial court’s decision merely to permit the coverage question to go to the jury, which in no way casts doubt on the validity of the policyholder’s claim (and implicitly confirms its substantiality), likewise should not impale the insured’s bad faith claim as a matter of law.

49. *See Reeves v. Sanderson Plumbing Prods., Inc.*, 530 U.S. 133 (2000) (although inferences are construed in favor of nonmoving party, under Fed. R. Civ. P. 50 the court is to consider the full evidentiary record); *Miller v. Elite Ins. Co.*, 161 Cal. Rptr. 322, 332 (Ct. App. 1980) (on motion for directed verdict, the court should consider only the evidence favoring nonmoving party and construe all inferences in its favor so as not to deprive it of the right to jury trial).

50. *E.g., Lucas v. State Farm Fire & Cas. Co.*, 963 P.2d 357 (Idaho 1998); *Aetna Life Ins. Co. v. Lavoie*, 505 So. 2d 1050 (Ala. 1987) (insurer’s failure to consider portion of medical

Finally, why should other bad insurer conduct be immunized simply because the claim was fairly debatable? As the Rhode Island Supreme Court recently observed:

It makes little sense that an insurance company may deny a claim, assert a coverage issue in a reckless and oppressive fashion, fail to timely respond to its obligations, or otherwise behave in a manner inconsistent with its implied duties of fair dealing and be insulated from tort liability for its bad faith conduct because it fortuitously survives a motion for judgment as a matter of law, yet is ultimately found to have breached the insurance contract.⁵¹

And using this logic in part, a number of states have rejected the directed verdict rule.⁵²

The rejection of the directed verdict rule does not mean that insurance companies cannot receive summary judgment in their favor on bad faith claims, as Part IV shows. The question is not whether the contract claim is “directed verdictable.” It is instead the reasonableness of the insurer’s decision to breach its contract by wrongly denying coverage.

III. THE GENUINE ISSUE DOCTRINE

As they did in the formulation of the first party bad faith remedy itself, the California courts, and the U.S. Court of Appeals for the Ninth Circuit purporting to construe California law, have led in the development of the “genuine issue” or “genuine dispute” doctrine, the essential idea of which is that an insurer cannot be found to have acted in bad faith if there was a genuine issue as to coverage. As one California court stated, “A court can conclude as a matter of law that an insurer’s denial of a claim is not unreasonable, so long as there existed a genuine issue as to the insurer’s liability.”⁵³ Most importantly, the courts—in California and elsewhere—have used the “genuine issue” doctrine as a vehicle for granting summary judg-

records favorable to insured evidenced bad faith); *Delgado v. Heritage Life Ins. Co.*, 203 Cal. Rptr. 672 (Ct. App. 1984) (bad faith for carrier to consider only evidence tending to deny coverage and to ignore coverage-favorable evidence).

51. *Skaling v. Aetna Ins. Co.*, 799 A.2d 997, 1005 (R.I. 2002); *see also* *Robinson v. State Farm Fire & Cas. Co.*, 583 So. 2d 1063, 1066 (Fla. Dist. Ct. App. 1991) (“It makes no sense that an insurer who asserts a coverage issue that, for any reason, withstands summary judgment, but ultimately fails, would be excused from all of the good faith obligations imposed on the insurer who admits coverage.”); *Riverside Ins. Co. v. Pedigo*, 430 N.E.2d 796, 806–08 (Ind. Ct. App. 1982).

52. *E.g.*, *Zilisch v. State Farm Mut. Auto. Ins. Co.*, 995 P.2d 276, 279–80 (Ariz. 2000); *Farmland Mut. Ins. Co. v. Johnson*, 36 S.W.3d 368, 375 (Ky. 2000); *State Farm Mut. Auto. Ins. Co. v. Laforet*, 658 So. 2d 55, 62 (Fla. 1995); *Brewer v. Am. & Foreign Ins. Co.*, 837 P.2d 236, 238 (Colo. Ct. App. 1992).

53. *Fraley v. Allstate Ins. Co.*, 97 Cal. Rptr. 2d 386, 391 (Ct. App. 2000) (quotation omitted).

ment for insurance carriers; indeed, the Ninth Circuit seems to have expressly endorsed this as the doctrine's objective.⁵⁴

But what is this "doctrine" exactly? Is it an affirmative defense to bad faith that an insurance company may plead and prove?⁵⁵ Insurance companies have argued the matter this way, so that, if any ground for denying coverage provided a "genuine issue" as to coverage, then the policyholder's bad faith claim fails. But this approach to the genuine issue doctrine surely is misconceived.

The existence of one sincerely disputable ground for denying coverage does not provide the carrier with a license to commit bad faith.⁵⁶ Nor does one sincerely disputable ground excuse a carrier's asserting numerous frivolous grounds or engaging in other conduct inconsistent with its duty of good faith and fair dealing.⁵⁷ An insurer cannot throw out a bunch of policy provisions in the hope that one of them turns out to provide a disputable ground.⁵⁸ At all times, an insurer is supposed to have an adequate factual and contractual basis for refusing to provide policy benefits.

The genuine issue doctrine is properly understood, not as an affirmative defense, but rather as a contention that the plaintiff has failed to carry the burden of demonstrating a right to judgment on the bad faith claim. The error in present doctrine or in how the doctrine is often understood lies in transplanting an argument appropriate in defense to a motion for summary judgment by the policyholder and instead using the same argument

54. *Guebara v. Allstate Ins. Co.*, 237 F.3d 987, 992 (9th Cir. 2001) (observing that the "Ninth Circuit has affirmed the dismissal of bad faith claims in numerous cases over the past 17 years because of genuine issues about liability under California law").

55. See William A. Daniels, *Hard to Tell: Counsel Must Rely on the Facts When Distinguishing Between Unfair Dealings and Mistaken Judgment by Insurance Companies*, LOS ANGELES DAILY J., Mar. 29, 2002, at 6, 11 (Verdicts & Settlements) ("the genuine dispute doctrine takes on the nature of an affirmative defense to bad faith").

56. *E.g.*, *Skaling*, 799 A.2d at 1011.

57. In *Gruenberg v. Aetna Ins. Co.*, 510 P.2d 1032 (Cal. 1973), the pivotal California Supreme Court decision adopting the first party bad faith remedy, the central question concerned the carrier's obligations in view of the insured's failure to provide a sworn statement within the time specified by the policy. The bare facts would have permitted the carrier to invoke an exclusion and on that basis deny coverage, but the court held that the duty of fair dealing fettered the carrier's discretion to invoke the exclusion:

While it might be argued that defendants would be excused from their contractual duties (e.g., obligation to indemnify) if plaintiff breached his obligations under the policies, we do not think that plaintiff's alleged breach excuses defendants from their duty, implied by law, of good faith and fair dealing. In other words, the insurer's duty is unconditional and independent. . . .

Id. at 1040.

58. Whether the insured may collect damages for the assertion of frivolous grounds or other conduct depends on the (im)materiality of the breach involved and the nature of the damages claimed. In *Opsal v. United Servs. Auto. Assoc.*, for example, the claim denial letter was incomprehensible; while the court found that the letter was inconsistent with the insurer's obligations, the breach was immaterial. 10 Cal. Rptr. 2d 352, 359 (Ct. App. 1991).

as the basis for a motion on offense by the insurer. Although the genuine issue idea in offense motions by insurance companies may play a role, the requisite showing for them to prevail (as discussed below) may not dispose of the policyholder's bad faith claims as efficiently as current doctrine often seems to indicate.

This point can be clarified by considering the salience of a genuine issue as to coverage more concretely in the context of motion practice. Where the policyholder moves for summary judgment on the bad faith claim (after prevailing on the coverage question), the policyholder must show that the undisputed evidence establishes that the carrier denied the claim unreasonably.⁵⁹ In response, the insurer may contend that there is a dispute of material fact as to its *lack* of a reasonable basis for denying coverage and show as a factual matter that it denied coverage on a basis (even if erroneous) that was sincere and substantial.

On the other hand, when the insurer moves pretrial for summary judgment on the bad faith claim, the court first must assume that whatever ground relied on by the carrier to show the absence of bad faith is non-meritorious (i.e., that there is coverage).⁶⁰ The carrier then must argue that the ground that it relied on provided it a substantial basis for its (presumed erroneous) coverage determination. The question presented by the motion, for which the insurer bears the burden of persuasion,⁶¹ is that, based on the undisputed record (including the presumed erroneous coverage denial), no reasonable jury could conclude that the carrier denied coverage unreasonably or without proper cause.

In response, as with any opposition to a motion for summary judgment, the policyholder can show a genuine dispute with respect to any of these material facts, which will defeat the insurer's motion. As one California trial court recently explained:

Where there is a factual dispute as to the sincerity and genuineness of the purported bases for denying coverage and the reasonableness of the insurer's overall conduct in wrongly denying the claim, "an insurer's bad faith is ordi-

59. Whether the policyholder also has other elements of proof in his or her prima facie case, such as bad intent, recklessness, or the like, does not matter as the point here focuses only on the reasonableness factor that is universally applied in first party bad faith cases, either alone or in conjunction with other elements.

60. This follows from two rules: the substantive legal rule that there is no bad faith in the absence of coverage and the procedural rule that all inferences are construed in favor of the nonmoving party. Consequently, the defense proffered by the insurer starts out at a level of less than 50% validity (because of the procedural posture and because the existence of coverage is ordinarily a predicate for the policyholder's bad faith claim such that the court must adopt the inference that coverage existed under the contract).

61. *E.g.*, *Aguilar v. Atl. Richfield Co.*, 24 P.3d 493, 506 (Cal. 2001) ("[F]rom commencement to conclusion, the party moving for summary judgment bears the burden of persuasion that there is no triable issue of material fact and that he is entitled to judgment as a matter of law.").

narily a question of fact to be determined by a jury considering the evidence of motive, intent and state of mind.” “Whether an insurer’s denial of a claim is unreasonable is dependent upon the facts in each case. The issue remains a question of fact unless only one inference may be drawn from the evidence.” [The insurance company’s] motion thus fails because whether [its] grounds for denying coverage were “reasonable and legitimate” is materially disputed and is thus a question for the jury. In addition, the grounds which [the insurance company] does cite for denying coverage arguably would not excuse [its] other bad faith conduct as alleged in the complaint.⁶²

A recent California appellate decision, on which the above trial court opinion relies, highlights the type of record and argument that an insurance company should present to prevail on a motion for summary adjudication of the policyholder’s bad faith claim:

When it moved for a summary adjudication of HOA’s bad faith cause of action, AIIC [the insurer] presented evidence of the existence of a legitimate dispute with HOA as to just what was due under the policy. . . . That declaration [of the claim adjuster] spelled out in considerable detail the entire adjustment process as it unfolded. . . .

Indeed, AIIC presented substantial evidence justifying its position. In opposing AIIC’s motion, HOA essentially offered only a two page declaration of its expert who claimed to have read the claim files and, based thereon, expressed the *conclusionary* opinions that AIIC (1) had not conducted an adequate and thorough investigation of HOA’s loss, (2) had engaged in dilatory claims handling and unreasonable adjusting practices, (3) had arrived at an inadequate initial scope of loss for the structural damage and (4) had failed to obtain all necessary engineering inspections and reports. . . . HOA argues that such “evidence” is sufficient to raise a triable issue of fact. We disagree.

Although an insurer’s bad faith is ordinarily a question of fact to be determined by a jury by considering the evidence of motive, intent and state of mind, “[t]he question becomes one of law . . . when, because there are no conflicting inferences, reasonable minds could not differ. . . . Thus, the issue of bad faith may, in specific instances, be treated as an issue of law.” . . . Given the record we have before us, we find that this case falls within the ambit of the foregoing principles. We are not called upon to determine whether AIIC’s view as to the proper outcome of the adjustment process was correct. It is only necessary for us to determine that, *in light of the record as a whole*, its position with respect to the disputed points was *reasonable* or that AIIC had *proper cause* to assert the positions that it did.

62. *Montrose Chem. Corp. of Cal. v. Canadian Universal Ins. Co.*, No. C 594 148 (lead case) (Cal. Super. Ct. Nov. 29, 2001) (citations omitted), *reprinted in* 16 MEALEY’S LIT. REP. (INS.) § C, at C-3 (Jan. 15, 2002) (citations omitted by ellipses). [The author was counsel for the policyholder in this matter.] *See also Griffin v. Allstate Ins. Co.*, 29 P.3d 777, 785 (Wash. Ct. App. 2001) (“When a question of material fact exists as to whether the insurer’s coverage position was ‘fairly debatable’ or its actions reasonably justified, summary judgment [in the insurer’s favor] is not permitted.”).

... only one inference can be drawn from this record. AIIC had a reasonable and legitimate basis for questioning HOA's claim.⁶³

The court denied the bad faith claim and affirmed entry of summary adjudication in favor of the insurance company. *Chateau Chamberay* is particularly interesting because the policyholder sought to create a fact issue by proffering an expert affidavit, whose opinion the court discarded, just as it might do in considering whether plaintiff's case on bad faith goes to the jury at the close of evidence.⁶⁴

Even though the plaintiff-policyholder bears the burden of proof at trial on the unreasonableness of the coverage denial, on the insurer's motion a court ordinarily will construe factual inferences in favor of finding the coverage denial unreasonable.⁶⁵ Consequently, as in *Chateau Chamberay*, on its motion the insurer should seek to lay a factual foundation establishing that drawing such inferences would be unreasonable in the circumstances and that the policyholder has not satisfied its burden of showing that a reasonable jury could find in its favor.⁶⁶ The insurer prevails not by showing that there was a genuine dispute supporting its coverage denial, but rather by demonstrating that the policyholder cannot show, on the record presented, that the insurer denied coverage unreasonably or without proper cause (or, more precisely, that no reasonable jury could so find).⁶⁷

63. *Chateau Chamberay Homeowners Ass'n v. Associated Int'l Ins. Co.*, 108 Cal. Rptr. 2d 776, 786-87 (Ct. App. 2001) (citations omitted). The court made clear that, if the facts themselves were disputed, the court could not resolve that dispute; however, if the factual story is undisputed and permits only one inference, then the court can determine whether the insurance company breached its duty of good faith and fair dealing. *See id.* at 785 n.7.

64. *See* Fed. R. Civ. P. 50(a), Advisory Comm. Note (1991) ("The court may, as before, properly refuse to instruct a jury to decide an issue if a reasonable jury could on the evidence presented decide that issue in only one way."). *See generally* *Paulfrey v. Blue Chip Stamps*, 197 Cal. Rptr. 501, 504 (Ct. App. 1983) ("In [two prior cases] the courts made their holdings a matter of law because the evidence was so strong in each case concerning the reasonableness of the insurer in the handling of the insured's claim.")

65. This follows from (i) the fact that the policyholder is the nonmoving party and (ii) the policyholder's evidentiary burden at trial under Fed. R. Evid. 104(b) and its state counterparts that one must proffer only enough evidence from which a jury reasonably *could* find the factual proposition proffered to be true.

66. *Cf. Smith v. Safeco Ins. Co.*, 50 P.3d 277, 281 (Wash. Ct. App. 2002) ("When an insurer moves for summary judgment . . . , it necessarily claims that a rational trier of fact could not find . . . the insurer breached its 'affirmative duty to make a good faith effort to settle.' To support such a claim, the insurer must show the reasons why it did what it did."); *see generally* *Sip-Top, Inc. v. Ecko Group, Inc.*, 86 F.3d 827, 830 (8th Cir. 1996) (court may not accord party "benefit of unreasonable inferences or those at war with the undisputed facts") (quotation omitted); *Duckett v. Allstate Ins. Co.*, 606 F. Supp. 728, 731 (W.D. Okla. 1985) ("A jury question arises only where the relevant facts are in dispute or where the undisputed facts permit differing inferences as to the reasonableness of the insurer's conduct.")

67. *See generally* *Squire v. Exchange Ins. Co.*, 775 P.2d 143 (Idaho Ct. App. 1989); *Verrastro v. Middlesex Ins. Co.*, 540 A.2d 693, 699 (Conn. 1988) (bad faith requires case-by-case anal-

IV. PRETRIAL DISPOSITION OF FIRST PARTY INSURANCE BAD FAITH CLAIMS

With respect to unreasonable denials of coverage (as opposed to, e.g., claims handling malfeasance⁶⁸), the trier of fact confronts an evidentiary record on the bad faith claim that differs in one crucial respect from that on the coverage claim: Whereas the contract claim generally is adjudicated based on all evidence discovered and adduced, including expert evidence at the time of trial, the only proper evidence to defeat the bad faith claim (with respect to the question of coverage *vel non*) is the record before the insurer at the time that it determined not to perform.⁶⁹ This difference in the evidentiary record simply reflects the substantive legal question presented on the bad faith claim, which is the reasonableness of the insurer's refusal to provide benefits promptly to its insured.⁷⁰

ysis). A useful comparison to *Chateau Chamberay* is the recent *Smythe* decision by the U.S. Court of Appeals for the Ninth Circuit, notable in part because the Ninth Circuit has led in the development of the genuine dispute doctrine:

[B]ecause the issue [in the case] is "what was said," the telephone application was not recorded, and the written application was never sent to the Smythes for their review, there is not any independent "physical" evidence that corroborates one side or the other. . . . [V]iewing the evidence in the light most favorable to the Smythes, a reasonable trier of fact could find Safeco acted unreasonably. The Smythes' "story" is that after Safeco determined the loss was legitimate, it immediately began looking for a pretext to deny the claim. For example, Safeco never took the exam under oath of Lorelei Smythe, even though she was the owner of and in possession of the furs when they were stolen. Instead, Safeco filed a submission with the California Department of Insurance accusing both Smythes of fraud. In sum, this case involves one of those factual disputes that is inappropriate for application of the "genuine disputes" doctrine.

Smythe v. Safeco Ins. Co. of Am., No. 01-55475, 2002 WL 506116, at *5 (9th Cir. Mar. 28, 2002).

68. Where policy benefits are due, "delayed payment based on inadequate or tardy investigations, oppressive conduct by claims adjusters seeking to reduce the amounts legitimately payable and numerous other tactics may breach the implied covenant because it frustrates the insured's *primary* right to receive the benefits of his contract—i.e., prompt compensation for losses." *Love v. Fire Ins. Exch.*, 271 Cal. Rptr. 246, 256 (Ct. App. 1990); *see also Stewart v. Gulf Guar. Life Ins. Co.*, No. 2000-CA-01511, 2002 WL 1874826 (Miss. Aug. 15, 2002) (post-claim underwriting is bad faith); *J.B. Aguerre, Inc. v. Am. Guarantee & Liab. Ins. Co.*, 68 Cal. Rptr. 2d 837, 842 (Ct. App. 1997) (breach of first party bad faith alleged where insurer unreasonably coerced insured into contributing to settlement of underlying liability case). The focus of this article is not on those types of claims.

69. *E.g.*, *Erwin v. State Farm Fire & Cas. Co.*, 618 F. Supp. 1040, 1042 (E.D. Mo. 1985) (reasonableness of carrier's decision is judged by "the facts as they appeared at the time of the refusal to pay"); *Amato v. Mercury Cas. Co.*, 61 Cal. Rptr. 2d 909, 914 (Ct. App. 1997) (an insurer "cannot rely on hindsight").

70. Due to the crucial importance of promptness and reliability of performance, "the first and primary duty of the insurer is to pay a claim to its insured if such payment would be reasonable under all the circumstances." *Fleming v. Safeco Ins. Co. of Am., Inc.*, 206 Cal. Rptr. 313, 318 (Ct. App. 1984) (the court continued by observing that such performance was due "even though the payment of that claim would obviously reduce the assets of the carrier and the interest of its stock holders").

But when an insurance coverage dispute is brought to a court's doorstep, because insurance policies are in the form of legal contracts, ultimately courts have little choice but to enforce them according to their legal form. As a consequence, as in any contract case, whether contractual performance is owed will be based on what the "true facts" were, as opposed to what the parties understood the facts to be (unless the contract terms indicate otherwise).⁷¹ Consequently, evidence postdating the refusal to perform—including merits expert testimony first developed for the litigation—properly may be admissible in disproving breach of contract (or in proving no coverage).⁷² But such evidence will not be admitted for purposes of disproving a bad faith claim, because there the question is the reasonableness

Because carriers are supposed to pay claims promptly in the ordinary course, the quality of proof that the insured presents at the time of claim obviously is not the same as the quality of proof that it would present at trial. The significance of this observation is that in the claims process (that is, before lawyers get involved) insurance companies not only pay claims, but also do so on a fairly generalized or limited factual record. In addition to the reasonable decision of the claims person that the cost of acquiring information exceeds the value of refining its detail (especially when considered against a portfolio of claims), that the "softer" proof of the claim is sufficient to trigger the insurer's mature obligation to perform follows from the insurer's promises of promptness and reliability of performance.

Insurance law recognizes that the insurer's reasonable claim payment on a limited record is performance owed pursuant to the terms of the insurance contract itself and not an ex gratia payment (which would not be covered under the reinsurance otherwise applicable to indemnify the insurance company (cedant) for the claim payment made to its policyholder), even where the policyholder's claim, if litigated, might be found to be outside of coverage. See *ReliaStar Life Ins. Co. v. IOA Re, Inc.*, 303 F.3d 874 (8th Cir. 2002) (follow-the-fortunes clause requires reinsurers to pay the cedant unless the cedant's payment was made in bad faith); cf. *Uniroyal, Inc. v. Home Ins. Co.*, 707 F. Supp. 1368, 1379 (E.D.N.Y. 1988) (reasonable settlement binds insurer even without proof of actual injury). If such everyday payments were considered ex gratia payments for which the insurance company would never get reimbursed from its own reinsurers, the entire system would grind to a halt.

71. Cf. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 112 (1989) ("As they do with contractual provisions, courts construe terms in trust agreements without deferring to either party's interpretation.")

72. ERISA cases provide an interesting perspective on the question of judicial review of benefits determinations under a de novo standard of review. In a recent decision by the U.S. Court of Appeals for the Tenth Circuit, the court held that, although evidence other than that before the plan administrator was admissible before the trial court, the district court is required to exercise discretion in deciding whether to admit the evidence because otherwise the "goal of not making district courts' substitute plan administrators" would be undermined. See *Hall v. UNUM Life Ins. Co. of Am.*, 300 F.3d 1197 (10th Cir. 2002). The ERISA basis for the *Hall* court's ruling implies that the default non-ERISA rule in a de novo review context (such as when a court evaluates whether there is coverage under an insurance policy) is to admit evidence relevant to proving whether the claim in fact is covered at the time of trial, even if not before the insurer (which is what the district court in *Hall* relied on in reaching its later reversed ruling):

[J]ust because it's ERISA doesn't make this all that much different from the recovery on an insurance policy and that is whether the defendant insuring company is in accord with the promises of its coverage and that really depends on a factual determination of the plaintiff's condition as of the time of termination. . . .

...

of the insurer’s failure to perform at that time, whether that failure stemmed from a misconstruction of the policy, the facts, or both.

For example, the U.S. Court of Appeals for the Fifth Circuit precluded a carrier from defending against its policyholder’s bad faith claim by relying on a ground for denying coverage that provided a sufficient factual conflict to require jury resolution, because it had not relied on that ground when it refused to perform.⁷³ The court recognized that, with regard to the contract claim, state law permitted the carrier to assert later-identified grounds unless the insured could establish waiver or estoppel. The court found, however, that a later-identified ground was not admissible in the bad faith case in evaluating the reasonableness of the insurer’s refusal to perform. In part, this holding followed from the fact that under the relevant state law there was no bad faith in the absence of coverage. As a consequence, only if the jury rejected the later-asserted ground for coverage would the bad faith question be presented. Thus, even if the ground would otherwise provide a well-disputable basis to refuse to perform, *ex hypothesi* the jury will reject the disputable ground, meaning that the ground never applied in the first place. In other words, there was coverage all along and prompt performance was owed, and there is no reason to insulate the carrier from bad faith liability where it unreasonably denied coverage simply because the carrier later “gets lucky” and finds a disputable—but in truth inapplicable—basis to refuse to perform.⁷⁴

Given the evidentiary record differences, and in view of the arguments above, what is the proper relationship between the contract claim and the bad faith claim, and how can and should courts resolve bad faith claims summarily?

If the policyholder moves for summary judgment or a directed verdict on its coverage or contract claim and prevails, the policyholder automatically may be entitled to a favorable finding of bad faith against the insurance company. As one leading commentator has recognized,

[t]he converse of the [*Dutton*] directed verdict rule should also be true: if the insured is entitled to a directed verdict on the policy claim (i.e., if reasonable minds could not disagree as to the insured’s entitlement to policy proceeds), the insured should also receive a directed verdict on his bad faith claim [for wrongful denial of coverage].⁷⁵

... I don’t care what’s in [the insurance company’s] record. What I’m looking at is does the plaintiff have evidence to come into this room and prove disability?

Id. at 1204 (quoting district court ruling).

73. *Sobley v. S. Natural Gas Co.*, 210 F.3d 561 (5th Cir. 2000).

74. *Id.* On the second appeal, the Fifth Circuit found that there was no substantial evidence to support the bad faith claim. *See Sobley v. S. Natural Gas Co.*, 302 F.3d 325 (5th Cir. 2002).

75. *See ASHLEY*, *supra* note 7, § 5:04, at 5–21; *see also* *S. United Life Ins. Co. v. Caves*, 481 So. 2d 764 (Miss. 1985); *Mixson, Inc. v. Am. Loyalty Ins. Co.*, 562 S.E.2d 659 (S.C. Ct. App. 2002).

By prevailing on summary judgment, the policyholder would have established that there was no genuine dispute of material fact and that it was entitled to be paid as a matter of law (even considering, contra insurance law principles, the evidence in a light favorable to the (nonmoving) insurer)—a strong foundation for a bad faith claim. Similarly, by prevailing on a motion for directed verdict at the close of the defendant insurance company's case, on which the court will construe facts and inferences in favor of the insurance company,⁷⁶ the policyholder will have established that on the factual record most favorable to the insurer no reasonable jury could not have found in favor of coverage. However, the precise bad faith question is the reasonableness of the carrier's conduct, given the state of the record at the time that the carrier refused to perform, even though—after full discovery with compulsory legal process—the whole factual record confirms that coverage should have been provided all along.⁷⁷

When the insurer moves for summary judgment in its favor on the coverage claim, its motion can be based on either of two (nonmutually exclusive) propositions: (i) an argument that the policyholder cannot establish its *prima facie* case for coverage; or (ii) an argument that an exclusion or condition applies for which the carrier bears the burden of proof. Denial of either form of motion, coupled with a policyholder trial victory on the coverage claim, provides a powerful basis for the policyholder's bad faith claim.

In the first type of motion, an insurer's contention that the policyholder failed to set forth a *prima facie* case for coverage, the question presented is whether a reasonable jury could find coverage for the policyholder on the contract claim. Where the court denies the insurer's motion, it does so based on the conclusion that the hypothesized jury considering the record at the time of the motion reasonably could conclude that there was coverage. The "bad faith" question then becomes why the carrier did not reach the same conclusion on the record before it when it denied coverage and refused to perform.

76. The court may enter a directed verdict "only when, disregarding conflicting evidence and giving to (the opposing parties) evidence . . . every legitimate inference which may be drawn from that evidence, the result is . . . no evidence of sufficient substantiality to support a verdict in favor of the (opposing party). . . ." *Miller v. Elite Ins. Co.*, 161 Cal. Rptr. 322, 332 (Ct. App. 1980).

77. Evidence subsequent to the carrier's coverage determination may be relevant to prove motive, intent, pattern, and practice, or an unreasonable persistence in denying coverage, *e.g.*, *McIlravy v. N. River Ins. Co.*, 653 N.W.2d 323 (Iowa 2002); *Ingalls v. Paul Revere Life Ins. Group*, 561 N.W.2d 273, 280 (N.D. 1997); *Southerland v. Argonaut Ins. Co.*, 794 P.2d 1102, 1106 (Colo. Ct. App. 1990); *Home Ins. Co. v. Owens*, 573 So. 2d 343, 344 (Fla. Dist. Ct. App. 1990); *Spadafore v. Blue Shield*, 486 N.E.2d 1201, 1203-04 (Ohio Ct. App. 1985), but the record defending the coverage go/no go decision is limited to that which was the actual basis for the insurer's decision. *Cf. Harbor Ins. Co. v. Cont'l Bank Corp.*, 922 F.2d 357, 362-65 (7th Cir. 1990) (Posner, J.) (addressing mend-the-hold doctrine as applied to insurance contracts).

In the second type of motion whereby the carrier moves for summary judgment based on the application of an exclusion or condition, if the court denies the motion by rejecting the carrier’s coverage-defeating construction of the policy language, then the carrier adopted a position (i) at odds with the plain meaning of the policy or (ii) that was at best one of two reasonable constructions, meaning that the carrier failed to adopt a reasonable construction of the policy that would have provided coverage.⁷⁸ On the other hand, where the court denies the motion on the ground of material factual disputes, then the carrier sought to deny coverage based on a construction of the factual record that reasonably could be construed to be within coverage. Either result on the insurer’s unsuccessful summary judgment motion, or directed verdict motion, provides a substantial basis for the policyholder’s bad faith claim.⁷⁹

If the policyholder moves for summary judgment on the contract claim and loses, because of the judge/jury issues involved in such motions, the denial does not necessarily establish that the carrier’s coverage denial was reasonable. On such a motion the judge is not to weigh the facts and is directed to construe inferences in favor of the nonmoving party. One cannot infer from the denial of the motion that the choice of inferences favoring coverage would not also have been reasonable at the time that performance was due (which, because of the substantive insurance law background, the insurer—as opposed to a judge later at motions practice—would have been required to adopt).

If the policyholder moves for summary judgment on the bad faith claim, the insurance company can defend against that motion by showing the existence of a genuine dispute as to coverage, which will put at issue for trial the policyholder’s contention that the insurer did not have proper cause to deny its claim.

Finally, the insurer can move for summary judgment on the policyholder’s bad faith claim, although to prevail, it will need to proffer a record

78. The insurer bears the burden of ambiguous drafting (e.g., *Safeco Ins. Co. of Am. v. Robert S.*, 110 Cal. Rptr. 2d 844 (Cal. 2001)), and courts should not permit carriers to insert ambiguous language in their policies as a shield to bad faith liability. See *Wolf v. Prudential Ins. Co. of Am.*, 50 F.3d 793, 799–800 (10th Cir. 1995); *Employees’ Benefit Ass’n v. Grissett*, 732 So. 2d 968, 976 (Ala. 1998) (“[I]n a ‘normal’ case, the insurer cannot use ambiguity in the contract as a basis for claiming a debatable reason not to pay the claim.”); *Sparks*, 647 P.2d at 1137.

79. See *Mixson*, 562 S.E.2d at 659 (although no legal precedent on point, the common meaning of the disputed term reasonably applied such that a fact question was presented on the bad faith claim as to whether the carrier should have adopted it); see also *Lucas v. State Farm Fire & Cas. Co.*, 963 P.2d 357, 361 (Idaho 1998) (Where one medical expert clearly supported claim for coverage, “[d]rawing every reasonable inference in favor of coverage [as the insurer should have done] [the court concluded] that Dr. Smith’s diagnosis is sufficient to support [the insured’s] contention that his claim was not reasonably in dispute.”); *Palmer v. Farmers Ins. Exch.*, 861 P.2d 895, 902–03 (Mont. 1993) (insurer’s denial of coverage based on account of unreliable witness supported bad faith claim).

that negates the reasonableness of any inference that the insurer denied coverage in anything but good faith. The insurer therefore must show on its motion that its basis for denying coverage at the time was substantial, sincere, and genuine,⁸⁰ which requires showing that the insurer reasonably construed the policy terms and the factual record (the carrier having first informed itself reasonably as to the facts)⁸¹ and that the defenses to coverage were not advanced for an improper purpose. It would be advisable for the insurer to show that (i) the insurer considered the full factual record, construing it favorably to its insured,⁸² and (ii) the insurer applied a fair interpretation of the policy, giving due regard to the rules favoring coverage.⁸³ On such a foundation, the insurer has a strong basis to say that, even if it erred in denying coverage, no reasonable jury could find that it denied coverage unreasonably or without proper cause.

V. CONCLUSION

Developing tools to aid in the swift resolution of insurance coverage cases is a laudable objective, and complex insurance coverage disputes in particular present formidable case management challenges.⁸⁴ But the directed verdict rule is not an appropriate tool and instead distorts the substantive law by placing a judicial thumb on the scales in favor of insurance companies, all seemingly dressed up in the “neutral” rhetoric of procedure.⁸⁵ In contrast, the genuine dispute doctrine—properly applied—provides a

80. See, e.g., *Griffin v. Allstate Ins. Co.*, 29 P.3d 777, 783 (Wash. Ct. App. 2001) (“As long as the insurance company acts with honesty, bases its decision on adequate information, and does not overemphasize its own interests, an insured is not entitled to base a bad faith claim or [statutory] claim against its insurer on the basis of a *good faith* mistake.”), quoting *Coventry Assocs. v. Am. States Ins. Co.*, 961 P.2d 933 (Wash. 1998).

81. *Rawlings*, 726 P.2d at 572; *Egan v. Mut. of Omaha Ins. Co.*, 620 P.2d 141 (Cal. 1979).

82. *Delgado v. Heritage Life Ins. Co.*, 203 Cal. Rptr. 672 (Ct. App. 1984).

83. *Beck v. State Farm Mut. Auto. Ins. Co.*, 126 Cal. Rptr. 602, 606–07 (Ct. App. 1976). In a related context, insurer counsel in an article wrote:

The correct rule is that the insurer must take due account of the applicable rules calling for construction of ambiguities against it when it denies a claim based on a disputed policy interpretation. It must have reasonable grounds to contend that the policy is unambiguous and that it refutes the interpretation urged by the insured.

See Barker and Glad, *supra* note 40, at 90.

84. See Marc S. Mayerson, Stephen A. Klein, and Donald R. McMinn, “Pretrial Scheduling and Pretrial Orders,” *Law and Practice of Insurance Coverage Litigation* § 20.1 (West Group & ABA 2000); Marc S. Mayerson, *Managing Complex Insurance Coverage Disputes*, 32 TORT & INS. L.J. 53 (1996).

85. In reviewing the State of New Jersey bad faith law since the New Jersey analog of *Dutton—Pickett v. Lloyd’s*, 621 A.2d 445 (N.J. 1993)—was adopted, a proinsurer article crows: “Since *Pickett* was decided in 1993, the reported cases in New Jersey demonstrate that the courts are generally applying the *Pickett* standard consistently and that most bad faith cases are being dismissed before trial.” Jeffrey Winn & Maria Orecchio, *Legal Standards of Insurance Bad Faith in New York and New Jersey*, 5 J. INS. COV. 17, 22 (2002)

basis for evaluating whether the policyholder’s claim of unreasonable coverage denial gets to trial, and the detailed factual showing that the case law requires insurers to make on their motions for summary judgment is no more than what reasonably should be expected from insurance companies that both promise and are required to pay claims promptly unless there is proper cause not to do so.

