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REFERENCE GUIDE TO AZ LAW

VERSION 26

Published 2022

Our Reference Guide covers many areas of Arizona law, highlighting the most common issues associated with civil litigation. This resource is intended to provide a general overview of the subject matter, and is a supplement to the personal service we provide to our clients. It should not be relied upon as the sole source of information, and should not be substituted for competent professional legal advice for a particular situation. Should you have any questions, we encourage you to contact the authors listed at the end of each chapter or any JSH attorney.

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CHAPTER 7: INSURANCE COVERAGE AND BAD FAITH

INSURER'S DUTIES TO ITS INSURED

Generally, liability insurers owe three separate duties to their insureds. These are: (1) the duty to defend; (2) the duty to indemnify and pay claims against the insured that are covered by the policy; and (3) the duty to act in good faith and deal fairly with the insured. ***Arizona Prop. & Cas. Ins. Guar. Fund v. Helme***, 153 Ariz. 129, 735 P.2d 451 (1987).

Duty to Defend and Indemnify

Standard liability policies require the insurer to defend the insured against all actions brought against the insured which are, judging by the allegations in the complaint, potentially within coverage of the policy. As a starting point, the insurer is obligated to defend only if it would be bound to indemnify the insured if the injured person prevailed upon the allegations of the complaint. ***Paulin v. Fireman's Fund Ins. Co.***, 1 Ariz. App. 408, 410-11, 403 P.2d 555, 557-58 (1965), *overruled on other grounds* by ***Kepner v. W. Fire Ins. Co.***, 109 Ariz. 329, 509 P.2d 222 (1973). However, an insurer's duty to defend the insured is independent of and not limited by the insurer's duty to indemnify. The duty to defend is much broader and may be triggered even though ultimately the insurer is relieved of its duty to indemnify (i.e., actually pay the claims brought against the insured). Generally, a liability insurer has only three options when requested to defend an insured. The insurer can defend unconditionally and without reservation of rights. The insurer can defend under a reservation of rights, i.e., agree to provide a defense, while reserving its right to deny coverage depending upon policy language and ultimate resolution of the claims. The third option is for the insurer to refuse to defend the insured entirely. As will be discussed below, an insurer that chooses to defend under a reservation of rights, or chooses not to defend the insured at all, incurs risks.

Once an insurer accepts and assumes the duty to defend the insured, even if done mistakenly or voluntarily, the insurer must carry out the duty competently, diligently and in good faith. An insurer that voluntarily assumes the defense of an insured can be sued for deficiencies in that defense even when there is no actual coverage for the claims under the policy. ***Lloyd v. State Farm Mut. Auto. Ins. Co.***, 176 Ariz. 247, 250, 860 P.2d 1300, 1303 (Ct. App. 1992), ***appeal after remand***, 189 Ariz. 369, 943 P.2d 729 (Ct. App. 1996). In *Lloyd*, the insured was driving a race car when the plaintiff was injured. Although State Farm covered other of the insured's vehicles, this particular race car was not insured under the policy. When the insured was sued, State Farm initially provided a defense to the insured but subsequently withdrew its representation when it determined that no coverage existed. The court held that State Farm's initial acceptance of the defense, although gratuitous, created an obligation to act with good faith and fair dealing during its defense, even though there was no coverage under the policy. Consequently, a liability insurer

can be found liable for bad faith even when the policy does not require the insurer to defend or indemnify the insured.

In some circumstances, multiple insurance companies can share the duty to defend. An insurer that has a duty to defend, but fails to do so, can be compelled to contribute its share of defense costs. ***Home Indem. Co. v. Mead Reinsurance***, 166 Ariz. 59, 61-62, 800 P.2d 46, 48-49 (1990).

Although the language of many insurance policies suggests that the tender or exhaustion of policy limits relieves the insurer of the duty to defend, Arizona case law holds otherwise. The mere fact that a primary insurer has paid or tendered its policy limits does not extinguish the insurer's duty to defend the insured, nor does it relieve the insurer of its responsibility for continuing defense costs. ***California Cas. Ins. v. State Farm Mut. Auto. Ins. Co.***, 185 Ariz. 165, 168, 913 P.2d 505, 508 (1996). Rather, an insurer's duty to defend terminates when the insurer tenders the policy limits **and** obtains from the claimant either a complete release or a covenant not to execute against the insured's assets. *Id.* Likewise, an insurer's tender of policy limits does not end the duty to defend in the absence of a judgment, settlement, or release completely protecting the personal assets of the insured. ***Cont'l Cas. Co. v. Farmers Ins. Co. of Ariz.***, 180 Ariz. 236, 883 P.2d 473 (1994) (Farmers properly discharged its duty to defend, and owed no share of defense costs because Farmers had paid policy limits and secured release of all claims except claims covered by the excess carrier).

The federal district court in Arizona addressed whether an insurer could obtain reimbursement of defense fees incurred defending non-covered claims. While this is not a controlling state court decision, it is the federal court's prediction as to how the Arizona Supreme Court would "likely" rule on the issue. In ***Great American Assurance Company v. PCR Venture of Phoenix LLC***, 161 F. Supp. 3d 778 (D. Ariz. 2015), Great American sought to recover the defense fees it paid in defending its insured in an underlying matter, after establishing that coverage did not exist. Great American defended pursuant to a reservation of rights while the coverage issue was litigated. A California decision, ***Buss v. Superior Court***, 16 Cal.4th 35, 939 P.2d 766 (1997), supported the request for reimbursement. But the district court declined to follow *Buss* based, in part, on the distinction between the duties to defend and indemnify. The duty to defend is broader, and by allowing recovery of fees in defending claims ultimately deemed "non-covered," the duty to defend would *only* exist where coverage under the policy also existed. This would make the two duties coextensive, contrary to Arizona law. Further, the court held there was nothing in the policy language permitting such reimbursement, and it was not proper to read provisions into the contract to permit reimbursement against the insured's interest.

Damron Agreements

In Arizona, if an insurer refuses to defend the insured, the injured plaintiff and the insured might enter into a Damron agreement. This is an agreement whereby the plaintiff and insured stipulate to a judgment against the insured, the plaintiff agrees not to execute the judgment, and the insured assigns his or her rights against the insurer to the plaintiff. The agreement is named for

Damron v. Sledge, 105 Ariz. 151, 460 P.2d 997 (1969). The claimant then pursues the insured's bad faith claim against the insurance company.

The claimant/injured party can obtain a judgment against the insured in one of several different ways. First, the insured can withdraw his answer and simply allow a default judgment to be entered against him. Alternatively, the claimant/injured party and the insured can agree to a stipulated judgment. Yet another alternative is for the parties to conduct a "damages" trial where the insured does not contest liability or damages. In *Damron*, the insured simply withdrew his answer and permitted a default judgment to be entered against him.

When the claimant/injured party seeks to collect the judgment from the insurer, the battle becomes a coverage dispute. The injured party seeks to prove that there is coverage under the policy and that the insurer was wrong in denying coverage to its insured. If the injured party prevails on the coverage issue, he seeks to collect from the insurer the judgment he obtained against the insured. If the insurer was wrong in refusing to defend the insured, the insurer may be liable for the amount of the judgment, up to the policy limits. If the insurer previously received and rejected a policy limits demand, the insurer's liability could exceed the policy limits. ***State Farm Mut. Auto. Ins. Co. v. Paynter***, 122 Ariz. 198, 204, 593 P.2d 948, 954 (Ct. App. 1979). In *Paynter*, the court of appeals indicated that the decisive factor in extending liability beyond the policy limits was not the insurer's refusal to defend, but rather its rejection of an offer to settle within policy limits.

Although the trial court may refuse to enforce collusive agreements, Damron agreements in and of themselves are not collusive. Collusion does not exist merely because an insured allows a default to be taken in order to escape liability and financial risk by assigning his/her claims against his/her insurer to the plaintiff. An insured, however, cannot enter into a Damron agreement with an injured plaintiff in every case. Only when his or her insurer breaches its contractual obligations (express or implied) to the insured is the insured excused from his or her obligations under the cooperation clause of the insurance policy. ***State Farm Mut. Auto. Ins. Co. v. Peaton***, 168 Ariz. 184, 192, 812 P.2d 1002, 1010 (Ct. App. 1990). Thus, an insured cannot settle with an injured plaintiff simply because the insurer declines to pay more than the amount of coverage that the insured purchased. *Id.* In *Peaton*, coverage was completely voided because the insured breached the policy's cooperation clause under these circumstances.

If an insurer refuses to defend its insured, and the insured enters into a Damron agreement with the plaintiff, the insurer might be able to intervene in the underlying action to contest the damages or judgment sought by the injured plaintiff. ***H.B.H. v. State Farm Fire & Cas. Co.***, 170 Ariz. 324, 823 P.2d 1332 (Ct. App. 1991) (insurer defending under reservation of rights may intervene and participate in damages hearing set by plaintiff's and insured's Damron agreement where insurer had upheld its duty to defend). An insurer loses its right to intervene in a damage hearing, however, if the insurer has breached its contractual duty to defend its insured. ***Purvis v. Hartford Accident & Indem. Co.***, 179 Ariz. 254, 877 P.2d 827 (1994). In *Purvis*, the insurer had not defended because it never received a tender. The court allowed the insurer to intervene at the damages hearing following the insured's entry into a Damron agreement, because the insurer

had not breached its duty to defend the insured. An insurer breaches its contractual duty to defend its insured if the insured made an unequivocal and explicit demand to the insurer to undertake the defense. A demand for indemnification is not necessarily an expressed demand to defend.

Other Circumstances Where Damron Agreements are Allowed

Damron agreements between a contractor, its excess carrier, and plaintiff are valid. In ***Colorado Cas. Ins. Co. v. Safety Control Co., Inc.***, 230 Ariz. 560, 288 P.3d 764 (Ct. App. 2012), a subcontractor's insurer challenged a Damron agreement between the contractor, its excess carrier, and the plaintiff, alleging that the agreement was procured through fraud and collusion because it improperly shifted liability. The court held that a contractor and its excess carrier can validly enter into a Damron agreement with a plaintiff, assigning their rights against the subcontractor's primary insurer who refused to defend the contractor as an additional insured. But the primary carrier was not *automatically* bound to the amount of the stipulated judgment, because the stipulated judgment did not indicate that the subcontractor was liable, nor did it provide any facts that would indicate the loss was covered by the primary insurer's policy.

In ***Botma v. Huser***, 202 Ariz. 14, 39 P.3d 538 (Ct. App. 2002), the court of appeals held that, in keeping with Arizona's prohibition of the assignment of a legal malpractice claim, such a claim could not be assigned when packaged with the assignment of a bad faith claim against an insurance carrier. The court reasoned that while allowing assignment of legal malpractice claims in Damron-type situations, or in any situation, would result in more compensation for some individual plaintiffs, permitting such assignments would cause immeasurable damage to the attorney-client relationships, the tort system, the court system, and the public's sense of justice. The court did hold, however, that plaintiff's malpractice claim did survive the invalid assignment. In other words, the malpractice claim could not be validly assigned, but its original owner still had the right to bring it himself.

An insurer is bound to facts stipulated to under a Damron agreement except when the stipulated facts are determinative of coverage. ***Quihuis v. State Farm Mut. Auto. Ins. Co.***, 235 Ariz. 536, 538, 334 P.3d 719, 721 (2014). In *Quihuis*, the insured entered into a Damron agreement after the insurer refused to defend on the grounds that the insured did not own the vehicle involved in an accident. The Damron agreement stipulated the insured owned a vehicle and negligently entrusted that vehicle to a negligent driver. Because ownership of the vehicle was determinative of both liability and coverage, the Arizona Supreme Court held the insurer was not precluded from litigating ownership of the vehicle exclusively for coverage purposes.

Morris Agreements

A Morris agreement is like a Damron agreement, but it is entered into when the insurer has agreed to defend under a reservation of rights (rather than refused to defend entirely). The standard liability policy contains a cooperation clause which requires the insured to cooperate with the insurer and aid the insurer in defense of plaintiff's claim. So long as the insurer performs

its obligations, i.e., meets its duty to defend and indemnify, the cooperation clause remains in full force. Accordingly, the insured is prohibited from making his or her own settlement with the injured plaintiff, or entering into any type of Morris or Damron agreement. Such action by the insured constitutes a breach of the insurance policy. ***United Serv. Auto. Ass'n v. Morris***, 154 Ariz. 113, 741 P.2d 246 (1987); *see also* ***State Farm Mut. Auto. Ins. Co. v. Peaton***. However, the cooperation clause prohibits the insured from independently settling a case without the insurer's involvement only when the insurer unconditionally assumes the duty to defend and indemnify. When an insurer defends under a reservation of rights, the insured is relieved from his or her obligations under the cooperation clause, and the insured is free to enter into a Morris agreement with the injured plaintiff.

Munzer v. Feola, 195 Ariz. 131, 985 P.2d 616 (Ct. App. 1999), emphasizes that the insured may enter into a Morris agreement only with respect to those counts or claims that the insurer is defending under a reservation of rights. If the insurer admits coverage and defends the insured without reservation as to a claim, while defending the insured under reservation of rights on a different claim in the same action, the insured may enter a Morris agreement only as to the claim defended under reservation of rights. In *Munzer*, Smith & Feola was sued for malpractice; Admiral defended it under a reservation of rights. The reservation pertained only to damages for attorney's fees. Admiral recognized coverage for other counts, claims and damages under the policy, and fully defended on those claims. But Smith & Feola entered into a Morris agreement with the plaintiff and allowed judgment to be entered against it for $389,000 on all claims. The court ruled that Smith & Feola breached the cooperation clause of the policy because the stipulated judgment was not limited to damages relating to the "non-covered" counts. The Morris agreement voided the insurance coverage for the general damages portion of the case.

The plaintiff and insured also cannot use a Morris agreement to establish facts necessary to obtain coverage. In other words, they cannot decide, stipulate or set forth facts pertinent to resolution of the coverage dispute with the insurer. Morris agreements are limited to admitting facts essential to determining the insured's liability to the injured plaintiff in the underlying tort action.

Our courts recognize the danger that an insured being defended under a reservation of rights might settle with the injured plaintiff for an inflated amount, or might agree to an adverse judgment in a frivolous case, merely to escape personal financial exposure or annoyance. Consequently, in the Morris context, the amount of damages to which the insured and plaintiff agree is binding on the insurer only if the insured or injured plaintiff can show that the settlement terms and damages are "reasonable and prudent." This involves evaluating the facts bearing on the insured's liability and the injured plaintiff's damages, as well as the risks of going to trial, and trying to answer "what a reasonably prudent person in the insured's position would have offered to settle the case on its merits." *See Morris, supra*.

An insured and an insurer cannot join in a Morris agreement to avoid the insurer's obligation to pay policy limits and pass liability in excess of those limits on to other insurers. ***Leflet v. Redwood Fire & Cas. Ins. Co.***, 226 Ariz. 297, 247 P.3d 180 (Ct. App. 2011). In *Leflet*, the court held that such

agreements are invalid because the agreements fall outside the scope and protection of Morris. The overarching goal of Morris is to permit the insured and the insurer to balance their competing interests in an atmosphere of fairness and defined risk – not to promote the transformation of the underlying contract and tort claims into bad faith claims at inflated values. The court found the settlement in this case unusual because it involved multiple layers of insurance, and an insurer was a party to the agreement. The insurers who participated in the settlement paid less than their policy limits despite the fact that the stipulated judgment exceeded their contribution by more than twentyfold. The clear intent and effect of the agreement was to favor these insurers and burden the subcontractors' insurers.

Pueblo Santa Fe Townhomes Owners' Ass'n v. Transcon. Ins. Co., 218 Ariz. 13, 178 P.3d 485 (Ct. App. 2008), addressed an insurer's delay and resulting in prejudice to the insured in a Morris context. There, the insurer did not issue a reservation of rights letter until 18 months after the notice of claim. In the interim, the court in this construction defect suit set various deadlines to include completion of testing and ordered that consultants not appearing at the testing would be unable to conduct other testing. The insured was never informed of this deadline and no one attended on behalf of the insured. Damages against the insured were estimated at $2.1 million. Prior to the construction defect trial, the insured entered into a Morris agreement with the plaintiff and stipulated to a $1.1 million judgment. The court of appeals found that due to the insurer's delay and resulting prejudice to the insured, the insurer was estopped from asserting any coverage defenses against the claimant. *See also* ***Penn-America Ins. Co. v. Sanchez***, 220 Ariz. 7, 202 P.3d 472 (Ct. App. 2008) (issue of fact regarding whether the issuance of a reservation of rights 10 months after agreeing to defend resulted in prejudice so that the coverage defenses were deemed waived); ***Wilshire Ins. Co. v. Yager***, 2018 WL 5801537 at *8 (D. Ariz. Nov. 5, 2018) (finding no prejudice resulting from insurer's delay in sending a reservation of rights letter to Defendant and granting summary judgment to insurer on issues of waiver and estoppel).

In ***Mora v. Phoenix Indem. Ins. Co.***, 196 Ariz. 315, 996 P.2d 116 (Ct. App. 1999), the court addressed the insurer's right to intervene in a Morris context. The plaintiff made a policy limits demand against defendant's insurer. The insurer failed to respond in a timely manner, and did not offer the policy limits until after the deadline had passed. Consequently, the insured entered into a Morris agreement with the injured plaintiff. The insured agreed to allow a default judgment to be entered against her, and the injured plaintiff agreed not to execute the judgment against the insured's personal assets. The insured assigned her claim against the insurance company to the injured plaintiff. The injured plaintiff scheduled a damages hearing with the court. The insurer, having been notified of the Morris agreement, sought to intervene in the damages hearing. The injured plaintiff objected, contending that the insurer forfeited its right to intervene by failing to offer the policy limits by the deadline, and by failing to give equal consideration to the rights of its insured. The trial court denied the insurer's motion to intervene, but the Court of Appeals reversed, vacated the judgment, and remanded for another damages hearing. Because the insurer had defended the insured, it still had the right to intervene and participate in the damages hearing to contest reasonableness of plaintiff's damages. An insurer does not forfeit the right to intervene if it breaches the duty to give due consideration to settlement offers.

If the insurer at least meets the duty to defend, it is normally entitled to a comprehensive "reasonableness" hearing to contest the fairness of the stipulated amount. ***Himes v. Safeway Ins. Co.***, 205 Ariz. 31, 66 P.3d 74 (Ct. App. 2003). In the reasonableness hearing, the insured has the burden of proving, by a preponderance of the evidence, that the settlement amount (or requested amount, if no set dollar amount was stipulated in the Morris agreement) would be reasonable after an arm's length negotiation between adverse parties on the merits of the case. The evidence at the reasonableness hearing should help the court in "evaluating the facts bearing on the liability and damages aspects of claimant's case, as well as the risks of going to trial."

The language of *Morris* and *Mora* provides an uncertain guarantee. In ***Associated Aviation Underwriters v. Wood, et al.***, 209 Ariz. 137, 98 P.3d 572 (Ct. App. 2004), the court limited the insurer's right in the "reasonableness" hearing. There, the insurer had fully defended on a reservation of rights, but also filed a declaratory action seeking a ruling that there was no coverage. The insureds then entered a Morris agreement, specifying $35 million in damages, and the trial court entered judgment for that amount. However, in the damages hearing, and then in the related declaratory action, the court refused to hear evidence regarding the insured's underlying liability, which evidence had strong bearing on the coverage question. The trial court declared that the causation issues were "subsumed" in the underlying judgment based on the Morris agreement, and thus that evidence on that issue would not be allowed in the reasonableness hearing on damages. The ruling was also applied to the declaratory action, thus effectively eliminating the insurer's ability to demonstrate the absence of coverage, although it had defended the insured in the underlying action. Thus, after ***AAU v. Wood***, the carrier's right to intervene in a reasonableness hearing has been compromised.

In ***Arizona Prop. & Cas. Ins. Guar. Fund v. Martin***, 210 Ariz. 478, 113 P.3d 701 (Ct. App. 2005), the insured entered a Morris agreement, and a default judgment was entered. The insurer brought a declaratory judgment action, though, and was allowed to offer evidence there, which undermined the factual bases for the Morris agreement. Although the insured argued that *Morris* and ***AAU v. Wood*** called for a different ruling, the court of appeals upheld the trial court's decision to allow the evidence, which resulted in summary judgment for the carrier in the declaratory action. Thus, the extent to which an insurer may present evidence at a reasonableness hearing remains unclear.

In ***Monterey Homes Arizona, Inc. v. Federated Mut. Ins. Co.***, 221 Ariz. 351, 212 P.3d 43 (Ct. App. 2009), the court addressed whether the insured could extinguish the insurer's subrogation rights when settling with the plaintiff and agreeing to "no indemnity or defense payments." There, Federated was defending under a reservation of rights and did not consent to the settlement. Federated sought to intervene in order to be subrogated for its defense fees. The court remanded to determine if plaintiff could show Federated had notice of settlement and that it was reasonable. If so, Federated's subrogation claim was extinguished by its insured's settlement with plaintiff.

As with Damron agreements, the policy limits are an insurer's maximum exposure, provided that the insurer continues to provide a defense (even under a reservation of rights) and has not

rejected a policy limits demand or acted in bad faith. If the insurer acts in bad faith, it might be liable for paying any settlement or judgment in excess of the policy limits, as well as punitive damages, for committing the tort of bad faith.

VALIDITY OF POST-LOSS ASSIGNMENTS

Typically, an insured cannot assign the rights, benefits, or protections of their insurance policy unless the insurer explicitly consents. This non-assignment rule is based on the insurer's right to choose whom it insures. In *Farmers v. Udall*, however, the Arizona Court of Appeals held that this non-assignment rule does not apply to "*post-loss* assignments." *Farmers Ins. Exch. v. Udall*, 245 Ariz. 19, 424 P.3d 420 (Ct. App. 2018). Because post-loss assignments "do not grant [assignees] any rights greater than those held by the insureds-assignors," the court reasoned, the typical rule against assignment is inapplicable. There, Farmers insured several homeowners against potential water damage. The insureds' policies each contained a clause stating that their "interest in this policy [could] not be transferred to another person without [Farmers'] written consent." Nonetheless, after several policyholders suffered water damage to their homes, they quickly signed an agreement that transferred their "rights, benefits, proceeds, and causes of action" to EcoDry, an Arizona home-restoration company. EcoDry, after repairing the insureds' water-damaged homes, submitted its invoices directly to Farmers; and in each case, Farmers refused to pay the full amount of the invoice, arguing that EcoDry had expended unreasonable, unusual, or non-customary charges. After failing to recover the full amount of their invoices, EcoDry – standing in the shoes of the original policyholders – sued Farmers under the terms of the policies. Farmers moved to dismiss EcoDry's complaint, arguing their insureds' post-loss assignments were invalid and that EcoDry lacked standing to enforce the terms of the policies. The Court of Appeals affirmed the trial court's denial of Farmers' motion to dismiss, holding that Arizona law allows policyholders to freely assign their rights, benefits, and causes of action *after* the loss has occurred. However, because EcoDry only asserted a claim for breach of contract, the Court did not decide whether a potential bad faith claim is assignable.

DUTY OF GOOD FAITH AND FAIR DEALING (BAD FAITH)

Definition

The basis of the tort of bad faith is breach of the covenant of good faith and fair dealing implied in every contract. According to ***Rawlings v. Apodaca***, 151 Ariz. 149, 153, 726 P.2d 565, 569 (1986), "neither party will act to impair the right of the other to receive the benefits which flow from their agreement or contractual relationship." If there is such an impairment, the aggrieved party may seek not only contractual but also tort damages.

Bad faith actions are generally classified as either first-party or third-party bad faith claims. The classifications depend on the type of insurance coverage at issue.

First-Party Bad Faith Claims

First-party claims arise when insurers contract to pay benefits directly to an insured, e.g., health, accident, homeowners, fire, disability, UM, UIM, med-pay, collision, etc. The plaintiff/insured claims that the insurer acted in bad faith in denying him coverage or refusing to pay him benefits.

Third-Party Bad Faith Claims

Third-party claims occur when an insurer contracts to defend and indemnify an insured against a claim by a third party. An insured can bring a third-party claim in the event he is subjected to excess liability by reason of an insurer's bad faith refusal to settle. Likewise, a third party bad faith claim can be brought by an assignee of the insured (such as the injured plaintiff in the underlying action) who obtains a right to bring a bad faith claim against the insurer.

Workers' Compensation Bad Faith

Per ***Hayes v. Cont'l Ins. Co.***, 178 Ariz. 264, 872 P.2d 668 (1994), worker's compensation carriers are subject to liability for common law bad faith claims separate and apart from any statutory penalties contained within the Arizona Workers' Compensation statutes.

Because the Industrial Commission has exclusive jurisdiction to determine whether an injured worker is entitled to benefits and the amount of those benefits, the worker must first seek a compensability determination from the Industrial Commission before pursuing a claim of bad faith. In ***Merkens v. Fed. Ins. Co.***, 237 Ariz. 274, 349 P.3d 1111 (Ct. App. 2015), plaintiff failed to challenge Federal's decision to terminate her benefits with the Industrial Commission and instead sued Federal for bad faith. The trial court granted Federal's motion for summary judgment on the ground that plaintiff failed to exhaust her administrative remedies. The court of appeals affirmed. It held that the Industrial Commission has exclusive jurisdiction to adjudicate a claim for denial of benefits. The superior court only had jurisdiction to consider allegations of bad faith claim handling since this did not arise out of Plaintiff's employment.

In ***Doneson v. Farmers Ins. Exch.***, 245 Ariz. 484, 431 P.3d 198 (Ct. App. 2018), the Arizona Court of Appeals upheld an exclusion precluding med pay benefits "if workers' compensation benefits are required," despite the insured's reimbursement of the workers' compensation insurer. In *Doneson*, Plaintiff was injured in a car accident. Part of Plaintiff's medical bills were paid by workers' compensation, but he had to repay that amount, per the workers' compensation statute, when he recovered from the third-party tortfeasor. Plaintiff then sought medical payment from his own carrier, Farmers. Farmers denied the claim because its med pay provision excluded "bodily injury…during the course of employment if workers' or workmen's compensation benefits are required." Plaintiff argued that because he had to repay the benefits he received from workers' compensation, they were not "required." The Court of Appeals found in favor of Farmers, finding that the policy language was not reasonably susceptible to Plaintiff's interpretation.

Surety Bad Faith

In ***S&S Paving & Construction, Inc. v. Berkley Regional Ins. Co***., 239 Ariz. 512, 372 P.3d 1036 (Ct. App. 2016), the court of appeals held that a surety on a public bond issued under the Little Miller Act cannot be sued for bad faith. The City of Prescott retained Spire Engineering ("Spire") as a general contractor for a public construction project. Berkley issued a payment bond for the project. S&S was a subcontractor for Spire and notified Berkley that it had not been paid for its work. When Berkley refused to pay S&S because the claim was untimely, S&S sued Berkley for breach of contract and bad faith. The statute of limitations barred the contract claim. The trial court also dismissed S&S's bad faith claim concluding there was no contractual relationship or special relationship for the claim to survive. S&S appealed. The court of appeals affirmed. Arizona adopted the Little Miller Act ("Act") in A.R.S. § 34-221. The Act requires contractors on public works projects to furnish payment bonds to protect claimants who supply labor and materials on a public project. And the statutory scheme for recovery under that bond is the claimant's exclusive remedy. The court would not graft a common law remedy onto a statutory scheme that includes complete relief and specific conditions precedent to recovery. This result was consistent, said the court, with the way private project claimants are treated under the state's mechanic's lien laws.

STANDING TO ASSERT A BAD FAITH CLAIM

Generally, the named insured under the policy and any individual who becomes a "covered person" under the policy's provisions can assert a claim for bad faith. The injured plaintiff in a third-party tort action does not have standing to bring a bad faith action against a defendant's insurance company, absent an assignment of rights from the insured**.**

In ***Fobes v. Blue Cross and Blue Shield of Arizona, Inc.***, 176 Ariz. 407, 861 P.2d 692 (1993), the court held an insured's wife could not bring a bad faith action against the insurer for the denial of health benefits that led to the death of her husband, because she was not a covered person under the provisions of his policy. The insurer issued the health insurance policy solely to the husband, and the wife had her own separate policy. Accordingly, the wife had no standing to bring an action for bad faith.

In ***Enyart v. Transamerica Ins. Co.***, 195 Ariz. 71, 985 P.2d 556 (Ct. App. 1998), the court ruled that under specific circumstances, the injured plaintiff in a tort action can become a "covered person" and have standing to bring a bad faith action. In *Enyart*, plaintiff was a third-party tort claimant. Plaintiff entered into a settlement agreement with the defendants and their insurers whereby plaintiff was to receive $375,000 from an annuity as part of a structured settlement agreement. The settlement agreement called for the defendants' insurance company to obtain a back-up annuity policy as a guarantee against the insolvency of the primary annuity company. The insurer never obtained the backup annuity and, as luck would have it, the primary company became insolvent. The plaintiff then sued the defendants' insurance company that was supposed to purchase the backup annuity policy. The court held that the structured settlement agreements created a "special relationship" between the plaintiff and the "guarantor" insurance company.

In ***Leal v. Allstate Ins. Co.***, 199 Ariz. 250, 17 P.3d 95 (Ct. App. 2000), the court held that Allstate's gratuitous offer to treat the Leals as "customers" did not equate to a promise to give equal consideration to the Leals' interest. The Leals were involved in a minor-impact accident with an Allstate insured. Allstate advised the Leals they did not need to retain an attorney and they were considered "customers." Allstate further promised them good customer service, including a promise that Allstate would discuss fair payment of their claim. Allstate made a settlement offer which the Leals rejected. Subsequently the Leals hired an attorney. The case was arbitrated and appealed and the Leals received $23,000 at trial. The Leals sued Allstate, claiming Allstate breached its assumed or implied duty of good faith and fair dealing, and that Arizona mandatory liability law created a duty for Allstate to negotiate their claims fairly and in good faith.

The court found that Allstate's offer to treat the Leals as customers did not create any sort of "special relationship" from which the duty of good faith and fair dealing could be implied. There was no special contract between the Leals and Allstate. The court also rejected the Leals' argument that this duty was imposed by law since accident victims are the intended beneficiaries of insurance statutes. The court held accident victims are not the intended beneficiaries of every policy provision, and mandatory insurance laws do not require an insured to pay a third-party claimant until a judgment is entered.

STATUTE OF LIMITATIONS

Bad faith claims are subject to a two-year statute of limitations. In a first party claim for bad faith, the statute of limitations does not begin to run until the insurer intentionally denies, fails to process, or fails to pay a claim without a reasonable basis. ***Ness v. W. Sec.***, 174 Ariz. 497, 851 P.2d 122 (Ct. App. 1992). According to ***Thompson v. Property & Casualty Ins. Co. of Hartford***, 2015 WL 1442795 (D. Ariz. March 30, 2015), an unpublished decision, the statute begins to run on the date of the original denial for coverage, even if the insurance company is asked to reconsider. There, Plaintiff claimed his home was burglarized between July 24, 2009 and July 31, 2009. After submitting a claim and sitting for an examination under oath, Hartford denied his claim on May 3, 2011, after it determined that Plaintiff intentionally concealed or misrepresented material facts and circumstances regarding his claim. Thereafter, Plaintiff's counsel wrote to Hartford requesting a revised decision. On September 11, 2012, Hartford sent Plaintiff's counsel another letter confirming its original denial. Thereafter, on October 29, 2013, Plaintiff sued for breach of contract and bad faith. Hartford moved for summary judgment because Plaintiff had not filed his bad faith claim within two years from the date of the original denial letter, May 3, 2011. Plaintiff's counsel argued the statute of limitations should begin on the date of Hartford's second letter, September 11, 2012. The court agreed with Hartford, and held the statute of limitations ran from Hartford's first denial letter because it had unequivocally denied Plaintiff coverage under the policy. After Hartford had completed its investigation, it determined there was no coverage. The court stated there was no room for ongoing negotiation in this statement.

In a third-party bad faith failure-to-settle claim, the statute of limitations does not begin to run until the underlying judgment becomes final and non-appealable. ***Taylor v. State Farm Mut. Auto. Ins. Co.***, 185 Ariz. 174, 179, 913 P.2d 1092, 1097 (1996).

STANDARDS FOR IMPOSING LIABILITY FOR BAD FAITH CLAIMS

First-Party Bad Faith Standard – "Fairly Debatable" or "Reasonable Basis"

For years, Arizona courts would not hold an insurer liable for bad faith if the insurer challenged a first party claim that was fairly debatable or if it denied a claim so long as the insurer had a reasonable basis for its action. ***Filasky v. Preferred Risk Mut. Ins. Co.***, 152 Ariz. 591, 734 P.2d 76 (1987); ***Clearwater v. State Farm Mut. Auto. Ins. Co.***, 164 Ariz. 256, 792 P.2d 719 (1990). Even if ultimately wrong in questioning a claim, the insurer could not be held liable in bad faith if a reasonable basis existed for denying the claim. ***Aetna Cas. & Sur. Co. v. Superior Court***, 161 Ariz. 437, 778 P.2d 1333 (Ct. App. 1989). Whether a claim is fairly debatable, however, depends upon the particular facts of the case.

A few significant decisions have held that an insurer might still be held liable for bad faith even if a claim is "fairly debatable," and even if the insurer might have had a reasonable basis for its decision. Likewise, the fact that the insurer may have ultimately paid the contract benefits due under the insurance policy does not shield the insurer from a claim for bad faith. An insurer may be liable for bad faith not because of the ultimate decision it reached, but because of the manner and method it utilized in reaching its decisions. *Rawlings, supra*.

In ***Zilisch v. State Farm Mut. Auto. Ins. Co.***, 196 Ariz. 234, 995 P.2d 276 (2000), the Arizona Supreme Court significantly limited the "fairly debatable" defense. After an automobile accident, Zilisch made a claim for underinsured motorist benefits. State Farm initially made no offer to settle the UIM claim, questioning whether Zilisch's injuries and damages were significant enough to trigger UIM benefits. State Farm contended that the value of Zilisch's UIM claim was fairly debatable. However, the Supreme Court held that even if a claim is fairly debatable, an insurer has the obligation to immediately conduct an adequate investigation, act reasonably in evaluating the claim, and act promptly in paying a legitimate claim. This obligation exists regardless of whether a claim is fairly debatable. Thus, an insurance carrier may be liable for bad faith on a fairly debatable claim if it did not act in good faith or act promptly in evaluating and investigating the claim. *See also* ***Twin City Fire Ins. Co. v. Burke***, 204 Ariz. 251, 63 P.3d 282 (2003).

Knoell v. Metro. Life Ins. Co., 163 F. Supp. 2d 1072 (D. Ariz. 2001), held that the issue of whether a claim is fairly debatable is not always a question for the jury. In *Knoell*, the insured sued a disability insurer for delay in paying disability benefits, alleging breach of contract and bad faith and seeking punitive damages. The carrier, in processing the claim, had had a round table discussion where more than one person evaluated the status of the claim. The district court held that under Arizona law, the total disability insurance claim was fairly debatable, and thus delay in payment while the insurer investigated was not bad faith conduct. The court noted that when a claim is fairly debatable, the insurance company cannot be liable for acting in bad faith by declining to pay such claim immediately, citing ***Lasma Corp. v. Monarch Ins. Co.***, 159 Ariz. 59, 764 P.2d 1118, 1122 (1988). The court also held that the company keeping statistics on resolution of claims and looking to their "bottom line" were reasonable internal procedures that did not

constitute bad faith. This was particularly true given the fact that plaintiff offered no evidence that the carrier's behavior ever resulted in the denial of a legitimate claim.

Young v. Allstate Ins. Co., 296 F. Supp. 2d 1111 (D. Ariz. 2003), held that generally when an insurer challenges claims that are fairly debatable, its belief in fair debatability is a question of fact to be determined by the jury under Arizona law. However, if an insured offers no significantly probative evidence that calls into question the insurer's belief in fair debatability, the court may rule on the issue as a matter of law.

In ***Lennar Corp. v. Transamerica Ins. Co.***, 227 Ariz. 238; 256 P.3d 635 (Ct. App. 2011), an insurer filed a complaint seeking a declaratory judgment that it owed no duty to defend or indemnify. The insurer prevailed on summary judgment but the judgment was reversed on appeal. In a subsequent bad faith action, the insurers again moved for summary judgment, arguing that the trial court's initial grant of summary judgment (though later reversed) established that the insurer had a reasonable basis to deny the claim, that the claim was "fairly debatable" as a matter of law, and automatically defeated the insured's bad faith claim. The court refused to hold as a matter of law that the erroneous granting of summary judgment in the insurers' favor created a reasonable basis to deny coverage, and held that whether the insurers acted reasonably in challenging the claims was a question for the jury.

In ***Deese v. State Farm Mut. Auto. Ins. Co.***, 172 Ariz. 504, 838 P.2d 1265 (1992), the Arizona Supreme Court held that an insurer may be found liable for bad faith even if it did not breach the contractual provisions of the policy. A breach of an express covenant of the policy is not a prerequisite to the tort of bad faith. In *Deese*, the insurer paid the contractual benefits to which plaintiff was entitled. However, the plaintiff also proved that the insurer systematically reduced claims through the deliberate use of selected chiropractors who predictably recommended a reduction of chiropractic expenses. Plaintiff contended that the insurer's claims review process regarding chiropractic care was a sham. The court held that even though the insurer did not breach its contractual duty to pay benefits, the insured/plaintiff was still entitled to receive the security of knowing that she would be dealt with fairly and in good faith. *Deese* stands for the proposition that even when an insurer pays all contractual benefits due under a policy, the company can still be found in bad faith based upon **the manner** in which any coverage or payment decision was made.

Failing to conduct an adequate investigation may constitute bad faith if further investigation would have disclosed other relevant facts or would have influenced the decision-making process. *See* ***Aetna Cas. & Sur. Co. v. Superior Court***, 161 Ariz. 437, 778 P.2d 1333 (Ct. App. 1989). An insurer's subjective bad faith may be inferred from a flawed investigation or an improper investigation. However, to establish a claim for bad faith or unreasonable failure to investigate, the plaintiff must demonstrate an unreasonable action in processing a claim.

Insurance companies can also be found liable for bad faith if they fail to properly advise their insureds of relevant, beneficial insurance policies. ***Nardelli v. Metro. Group Prop. & Cas. Ins. Co.***, 230 Ariz. 592, 277 P.3d 789 (Ct. App. 2012). In *Nardelli*, plaintiffs sued defendant insurer when the insurer insisted on repairing, instead of totaling, plaintiffs' heavily damaged vehicle. At trial

plaintiffs argued that the defendant was liable for bad faith because the insurer failed to alert plaintiffs to two beneficial provisions in the insurance policy, including one for appraisal. The plaintiffs produced evidence that the insurer had internally discussed invoking the appraisal clause but decided against it. The court ruled that this was sufficient for bad faith and held that while an insurer does not have an obligation to explain every fact and provision in a policy, insurers do have a duty to "inform the insured about the extent of coverage and his or her rights under the policy" in a way that is not misleading.

Recently, the Arizona Supreme Court accepted review and is considering the issue of whether it is proper to allow the jury to consider a contract defense such as a waiver to undermine the plaintiff's showing of bad-faith elements. ***Cavallo v. Phoenix Health Plans, Inc***., 250 Ariz. 525, 482 P.3d 404 (Ct. App. 2021). There, plaintiffs alleged that the defendant health plan unreasonably denied Mr. Cavallo's claim for a drug he needed to prevent his MS from relapsing. The health plan argued, in part, that Mr. Cavallo waived the claim by canceling the prior authorization request after it was made and because his provider failed to provide necessary information to initiate and process the claim. The court of appeals upheld the waiver instruction the trial court gave, which told the jury that, "by accepting performance known to be deficient, a party has waived the right to reject the contract on the basis of that performance. If Mr. Cavallo has waived a promised performance, then [Phoenix Health] is no longer bound to perform on that promise and Mr. Cavallo is not entitled to damages for that particular non-performance," and that the health plan had the burden of proving waiver. Plaintiffs argued such an instruction had no place in a case alleging breach of the covenant of good faith and fair dealing. The health plan argued contract defenses like waiver can apply in bad faith cases and that the instruction did not mislead the jury in to believing that the covenant of good faith and fair dealing could be waived or that waiver constituted an absolute defense. Review was granted on March 1, 2022, and a Supreme Court decision is expected in due course.

Third-Party Bad Faith Standard – "Equal Consideration"

In ***Farmers Ins. Exch. v. Henderson***, 82 Ariz. 335, 313 P.2d 404 (1957), the court established the "equal consideration" test for determining whether an insurance company is liable for bad faith in failing to settle third-party claims against its insured. To be in good faith, an insurer must consider its insured's interests equally with its own in making a decision whether to settle within policy limits. Failure to settle in good faith renders an insurer liable for the full amount of the judgment, even in excess of the policy limits.

An insurer must "evaluate[] a claim without looking to the policy limits[,] as though it alone would be responsible for the payment of any judgment rendered on that claim, it views that claim objectively, and in doing so renders 'equal consideration' to the interests of itself and the insured." ***General Accident Fire & Life Assurance Corp. v. Little***, 103 Ariz. 435, 442 P.2d 690, 697 (1968).

No intentional or fraudulent motive is necessary for a finding that the insurer has failed to give the required equality of consideration to the interests of the insured. ***State Farm Auto Ins. Co. v.***

Civil Serv. Employees Ins. Co., 19 Ariz. App. 594, 509 P.2d 725 (1973). The insurer "will be liable to its insured for any judgment subsequently entered against the insured in excess of policy limits unless the insurer shows that an application of the equality of consideration test would not have required acceptance of the settlement offer."

The insurer's duty to give equal consideration to the interest of its insured may arise even absent a demand or request to settle on the claim if there is a high probability that the recovery could exceed the policy limits. ***Fulton v. Woodford***, 26 Ariz. App. 17, 545 P.2d 979 (Ct. App. 1976). In *Fulton*, the court held the duty to give equal consideration arises when a conflict of interest exists between the insurer and the insured. A conflict of interest normally arises when an offer is made by the claimant to settle within policy limits. In the absence of a demand or a request to settle within policy limits, or within the financial means of the insured plus the policy limits, a conflict of interest exists giving rise to the duty to give equal consideration to the interest of the insured where there is a high probability of claimant recovery, and a high probability that such a recovery will exceed policy limits.

Often, third-party claimants (or their attorneys) threaten an insurer with bad faith if the insurer does not respond to a demand within a limited period of time. In ***Miel v. State Farm Mut. Auto. Ins. Co.***, 185 Ariz. 104, 912 P.2d 1333 (Ct. App. 1995), the court of appeals held that an insurer who does not respond to a settlement demand within the prescribed time limit does not necessarily act in bad faith. Certain factors must be considered in determining whether the insurer acted in bad faith. The reasonableness of the insurer's conduct must be judged in light of all the facts surrounding the demand. The length of time that elapsed after the deadline and the reasons plaintiff insisted on a compliance deadline are relevant factors to be weighed in determining whether the insurer acted reasonably. The court also emphasized that there is no cause of action for mere negligence against an insurer who mishandles a file or makes mistakes in handling the file. Liability lies only if the insurer's conduct amounts to bad faith.

Recently, the Arizona Supreme Court held that under a policy without a contractual duty to defend, the objective reasonableness of the insurer's decision to withhold consent is assessed from the perspective of the insurer, not the insured. The insurer must independently assess and value the claim, giving fair consideration to the settlement offer, but need not approve a settlement simply because the insured believes it is reasonable. ***Apollo Educ. Grp., Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA***, 250 Ariz. 408, 409–10, 480 P.3d 1225, 1226–27 (2021). There, a directors and officers policy contained no duty to defend, and thus imposed no duty on the insured to cooperate with the insurer's defense. Instead, the company was to defend itself against any claims. A class action was filed and a settlement reached. The insurer refused to consent to the settlement. The company entered into the settlement, paid out of pocket, then sued the insurer for breach of contract and bad faith. The district court granted the insurer summary judgment. The company appealed. The Ninth Circuit certified to the Arizona Supreme Court the question of how to analyze the breach of contract claim. The Supreme Court answered that the policy language spoke in terms of the insurer's perspective. It explained that "where the insurer has no control over the litigation, it is more reasonable that the insurer's perspective, which necessarily includes consideration of the strength of the underlying claim in accord with

its interest in avoiding unnecessary payment, should prevail. Of course, the converse would be true where the insurer has control over the defense. The terms as agreed to by these parties reflects this reasonable understanding of the overall nature and context of the contract." The court explained the insurer's obligation as follows:

> To act reasonably, the insurer is obligated to conduct a full investigation into the claim. The Court has described the insurer's role as "an almost adjudicatory responsibility." To carry out this responsibility, the insurer "evaluates the claim, determines whether it falls within the coverage provided, assesses its monetary value, decides on its validity and passes on payment." Id. The company may not refuse to pay the settlement simply because the settlement amount is at or near the policy limits. Rather, the insurer must fairly value the claim. The insurer may, however, discount considerations that matter only or mainly to the insured—for example, the insured's financial status, public image, and policy limits—in entering into settlement negotiations. The insurer may also choose not to consent to the settlement if it exceeds the insurer's reasonable determination of the value of the claim, including the merits of plaintiff's theory of liability, defenses to the claim, and any comparative fault. In turn, the court should sustain the insurer's determination if, under the totality of the circumstances, it protects the insured's benefit of the bargain, so that the insurer is not refusing, without justification, to pay a valid claim.
>
> Under this formulation, an insurer has every incentive to act prudently, both for itself and its insured. An insurer is unlikely to reject a settlement if the objective value of the claim is commensurate with the settlement, for it will likely have to pay out regardless. Should the insurer act unreasonably in rejecting the settlement, the insured may challenge that determination, and may file a bad-faith tort action if circumstances warrant, as Apollo is pursuing here.

250 Ariz. at 414-15, 480 P.3d at 1231-32 (internal citations omitted).

When an insurer is faced with multiple claims in excess of its policy limits, the insurer may meet its duty to equally consider settlement offers by interpleading the limits of the policy. ***McReynolds v. Am. Commerce Ins. Co.***, 225 Ariz. 125, 235 P.3d 278 (Ct. App. 2010). In *McReynolds*, the injured plaintiff filed a $25,000 offer of judgment, which was equivalent to the amount of the insured's policy limit. After the carrier unsuccessfully attempted to resolve lien issues with plaintiff's medical providers, the offer lapsed, and the carrier interpleaded the $25,000 limits, naming the plaintiff and the lienholders as defendants. At trial, the plaintiff

obtained a $469,110 judgment. After trial, the insured assigned any potential claims against the carrier to the plaintiff in exchange for a covenant not to execute. The plaintiff sued the carrier for failing to give equal consideration to the insured's interests by failing to accept the offer of judgment. The trial court granted summary judgment in favor of the carrier and plaintiff appealed. The court of appeals upheld summary judgment, holding that "when an insurer is faced with multiple claims in excess of its policy limits . . . an insurer satisfies its duty in such situations when it promptly and in good faith interpleads its policy limits into court, naming all known claimants in the action, and continues to provide a defense to the insured."

Insurers should still use caution when relying on the interpleader opinion. An interpleader is not a guarantee of a full release of the insured (although it should always be requested). The interpleader satisfies the insurer's obligation to indemnify and releases the insurer from liability, but does not necessarily release the insured. The insured might still face personal exposure as to all claims not fully satisfied through the interpleader. Finally, an interpleader does not relieve the insurer of its obligation to defend.

LIABILITY FOR BAD FAITH LITIGATION CONDUCT

An insurer that objects to coverage may not use that as an excuse to disregard its claims-handling responsibilities pending resolution of the coverage issue. ***Lennar Corp. v. Transamerica Ins. Co.***, 227 Ariz. 238, 245, 256 P.3d 635 (Ct. App. 2011); *see also* ***Tucson Airport Auth. v. Certain Underwriters at Lloyd's, London***, 186 Ariz. 45, 918 P.2d 1068 (Ct. App. 1996). While Arizona recognizes a "continuing" duty of good faith and fair dealing through the course of litigation, Arizona has not directly addressed whether litigation conduct may be introduced at trial as evidence of bad faith. Courts in many jurisdictions have prohibited the introduction of litigation conduct at trial as evidence of bad faith. *See, e.g.,* ***Timberlake Constr. Co. v. U.S. Fid. & Guar. Co.***, 71 F.3d 335 (10th Cir. 1995); *but see* ***White v. W. Title Ins. Co.***, 40 Cal. App. 3d 870, 886, 221 Cal. Rptr. 509, 517, 710 P.2d 309, 317 (1985), superseded by statute. Some courts have admitted such evidence in unique situations. In the jurisdictions that have admitted evidence of post-filing conduct, the evidence was limited to extremely egregious conduct, settlement negotiations, or the *insurer's* conduct rather than the attorney's litigation conduct. Given this unsettled area of the law in Arizona, insurers and their attorneys should use caution once litigation commences, particularly when it comes to settlement negotiations, as this might be later admitted as evidence of bad faith.

DISCOVERY OF MEDICAL EXPERT'S PREVIOUS REPORTS

In ***Cheatwood v. Christian Brothers Services,*** 2018 WL 287389 (D. Ariz. Jan. 4, 2018), a bad faith case arising from a health benefits claim, the Arizona District Court quashed portions of the Insureds' subpoena to a medical expert which sought: (a) all medical review reports prepared by the medical expert during the last five years, and (b) the number of medical necessity reviews the expert performed for plaintiffs versus defendants during the last five years. The court reasoned that, although evidence of bias may be relevant to a bad faith claim, the expert's past reviews were irrelevant because "they involve[d] facts and circumstances different than the facts

and circumstances involved in this case." Further, it would be unsurprising if the expert's reviews were favorable to the insurer because insurers likely seek medical necessity reviews only on questionable claims. Lastly, the number of reviews the expert conducted on plaintiffs versus defendants was irrelevant, according to the court, because the expert did know, at the time he was doing a review, whether it was for a defendant or plaintiff.

INSURER LIABILITY FOR ACTS OF INDEPENDENT ADJUSTING AGENCY

An independent agency hired by an insurance company to investigate a claim owes no independent duty to the insured, and consequently, the independent adjusting agency cannot be held liable to the claimant for bad faith. Instead, the independent adjustor's conduct is imputed to the insurance company, and the insurance company remains liable to the claimant on the basis of the conduct of the independent adjuster. If the independent adjuster mishandles the claim, the insurance company has the same liability for bad faith as if an employee of the insurance company had mishandled the claim. ***Meineke v. GAB Bus. Servs., Inc.***, 195 Ariz. 564, 991 P.2d 267 (Ct. App. 1999). As the court stated in ***Walter v. Simmons***, 169 Ariz. at 236, 818 P.2d at 221 (Ct. App. 1991), an insurer's duty of good faith is non-delegable, and consequently, the insurer remains vicariously liable for the claims processing performed by an independent adjuster.

TPA AND ADJUSTER LIABILITY FOR AIDING AND ABETTING INSURER BAD FAITH

Insureds may not assert bad faith aiding and abetting claims against a TPA (third party administrator) or its adjusters because the duty of good faith and fair dealing arises from the insurance policy (contract), and neither the TPA nor its adjuster has privity of contract with the insured. ***Centeno v. Am. Liberty Ins. Co***., 2019 WL 4849548 (D. Ariz. Oct. 1, 2019). *Centeno* arises from a workers' compensation claim. The claim was initially accepted and then American Liberty denied the claim because of conflicting information on whether the injury arose from a work accident. Centeno filed an industrial claim and eventually the Industrial Commission of Arizona ruled in her favor and found the claim compensable. Subsequently she sued American Liberty and the TPA for bad faith, and raised aiding and abetting claims against the TPA and its adjuster. The court agreed dismissed the bad faith and aiding and abetting claims against the TPA and adjuster because no contractual relationship existed between the TPA, its adjuster and the insured. The court did note, however, that properly pled, such claims could survive against entities that have no contractual relationship. A viable claim requires an allegation of "some action . . . separate and apart from the facts giving rise" to the bad faith claim against the insurer. In this case, Centeno failed to plead facts separate and apart from those alleged against American Liberty. In the future, plaintiffs' counsels will certainly heed the court's warning and plead facts to defeat a motion to dismiss.

PHYSICIAN LIABILITY FOR AIDING AND ABETTING INSURER BAD FAITH

A physician performing an independent medical exam (IME) cannot be held liable for aiding and abetting an insurance carrier in committing bad faith if the physician had no actual or inferred knowledge of the carrier's intent to commit bad faith. ***Federico v. Maric***, 224 Ariz. 34, 226 P.3d 402 (Ct. App. 2010). In *Federico*, the insurer retained Dr. Maric to conduct an IME of plaintiff. Dr. Maric found no objective evidence of physical injury or pain and suggested plaintiff was malingering. The insurer denied the plaintiff's claim. The plaintiff sued Dr. Maric, alleging he aided and abetted the insurer's bad faith denial of plaintiff's claim. The trial court granted Dr. Maric summary judgment, and the court of appeals affirmed. To show that Dr. Maric aided and abetted the insurer in committing bad faith, plaintiff had to prove the following elements: (1) the insurance company must commit a tort that causes the plaintiff injury; (2) the defendant must know the primary tortfeasor's conduct constitutes a breach of duty; and (3) the defendant must substantially assist or encourage the primary tortfeasor in the achievement of the breach. Even assuming the truth of plaintiff's allegation that Dr. Maric performed an inadequate IME and knew his report would adversely affect the outcome of plaintiff's claim, there was no evidence that Dr. Maric knew the insurer intended to act in bad faith, nor any evidence of a strategy to assist the insurer in acting in bad faith.

FAILURE TO PAY UNACCEPTED SETTLEMENT OFFER AMOUNT

In a first party case, when there is no dispute as to liability and coverage is not contested, but the amount of the loss is disputed, insurance companies have a duty to promptly pay the undisputed amount of the claim. ***Borland v. Safeco Ins. Co., of Am.***, 147 Ariz. 195, 709 P.2d 552 (1985); *see also* ***Filasky v. Preferred Risk Mut. Ins. Co.***, 152 Ariz. 591, 734 P.2d 76 (1987). Failure to do so could constitute bad faith. However, an insurer does not breach the covenant of good faith and fair dealing when it fails to pay, in advance, the amount of an unaccepted settlement offer for personal injuries prior to arbitration and prior to obtaining a complete release. ***Voland v. Farmers Ins. Co. of Ariz.***, 189 Ariz. 448, 943 P.2d 808 (Ct. App. 1997). In *Voland*, the claimant made a claim for uninsured benefits. Claimant had more than $100,000 in UM coverage, but the insurer determined that the fair value of the claim was between $30,000 and $40,000. It made an offer of $30,000. Although claimant's counsel believed the claim far exceeded $30,000, he demanded that the insurer immediately pay $30,000 as the "undisputed amount" and further requested that the matter proceed to arbitration over the "disputed value." The insurer refused, and in response, claimant filed a bad faith claim. The court of appeals held that the insurer did not become legally obligated to immediately pay the amount offered for settlement, unless the insured accepts that amount as full and final settlement. An insurer can make a "fair value" offer and not be obligated to tender the amount of that offer merely as a "partial settlement."

The *Voland* court distinguished first party claims that can be "accurately appraised without great difficulty or difference of opinion," from those personal injury claims that are "unique and generally not divisible or susceptible to relatively precise evaluation or calculation." The court

explained that the pain and suffering/general damage elements of a personal injury claim, for example, are inherently flexible and subject to differing and potentially changing evaluations based on various factors. In short, evaluating personal injury claims, and particularly the general damage component is far from an exact science. Oftentimes it is no more precise or predictable than throwing darts at a board.

DISCOVERY OF CLAIMS FILE IN BAD FAITH LAWSUITS

For a complete overview of discovery issues, see Chapter 8.

An insurer's files are critical to the plaintiff in establishing a bad faith claim. Conversely, an insured's files may also be critical in establishing a defense to a bad faith claim. Accordingly, it is crucial that all notations in the file, including phone messages, e-mails and interoffice memos, reflect fairness. It is important to avoid notations that contain sarcastic or derogatory comments. To the extent possible, notations should be kept to factual information, and any analytical comments should demonstrate that they are based on facts, not conjecture, and that the insurer has also considered the claimant's interest and arguments. The attorney-client privilege might not apply, or alternatively, it might be waived in a bad faith action. If an insurer intends to defend the bad faith claim by asserting "advice of legal counsel," the attorney-client privilege is waived. Accordingly, before an insurer defends a bad faith action by claiming "advice of counsel," the insurer should first know and understand what attorney-client communications are being waived. In some cases, disclosure of attorney-client communications can cause more harm than good, and therefore, "advice of legal counsel" might not be the proper defense to the bad faith action.

Where the litigant claiming an attorney-client privilege relies on a subjective and allegedly reasonable evaluation of the law, which necessarily incorporates information the litigant learned from its lawyer, a communication is discoverable and admissible. ***State Farm Mut. Auto. Ins. Co. v. Lee***, 199 Ariz. 52, 13 P.3d 1169 (2000) (what State Farm knew about the law included what it learned from its attorneys, and allowing State Farm to assert the privilege would improperly allow it to use the privilege as both a sword and a shield). Before the court will imply a waiver, it must find that the litigant affirmatively put the privileged materials at issue. The mere denial of the allegations in the complaint, or an assertion that the denial was in good faith, would not amount to an implied waiver.

In ***Twin City Fire Ins. Co. v. Burke***, 204 Ariz. 251, 63 P.3d 282 (2003), the liability carrier refused to settle a claim within its million-dollar-limits when it had opportunities to do so, and it rejected a specific demand from the excess carrier that it accept plaintiff's offer below the million-dollar-limit. The jury subsequently awarded plaintiff $6 million and the excess carrier settled the claim for $5.4 million. The excess carrier then sued the liability carrier for bad faith. Based on ***State Farm Mut. Auto. Ins. Co. v. Lee***, the trial Judge ordered the excess carrier to produce its privileged files regarding the underlying claim. The excess carrier filed a special action arguing that it had not waived the attorney-client privilege. The Supreme Court held that the attorney-client privilege protected the excess carrier's communications with its counsel. Distinguishing *Lee*, the

court held that the privilege had not been waived because the excess carrier never injected the advice it had received from its counsel into the bad faith case. Moreover, the excess carrier's conduct was not relevant because the primary carrier's limit had not been exhausted and the excess carrier had not interfered in the underlying case.

In ***Assyia v. State Farm Mut. Auto. Ins. Co.***, 229 Ariz. 216, 273 P.3d 668 (Ct. App. 2012), a passenger in a vehicle hit by an uninsured motorist was allowed to recover her attorney's fees in a breach of contract case, despite the fact that the insurer eventually paid the policy limits. The insurer had initially denied the insured's claim for policy limits, but as new information became available during litigation the insurer re-evaluated the claim and tendered the policy limits. The trial court awarded the insured attorney's fees based, in part, on A.R.S. § 12-341.01 which allows the recovery of attorney's fees in "any contested action arising out of a contract." The court of appeals affirmed, noting that the action was contested even though the insurer willingly paid the policy limits. The court held that a matter is contested as long as the defendant "has appeared and generally defends against the claims." As a result of this decision, some plaintiffs have begun making policy limit demands with a time deadline that does not allow for adequate investigation. If the insurer denies the claim, the plaintiff will bring a breach of contract and bad faith suit, disclose new information, and threaten attorney's fees. Thus, insurers must be careful to document requests for additional information necessary to evaluate a claim.

A self-insured corporation also implicitly waives the attorney-client privilege by asserting that its claim adjusters acted reasonably and in the employee's best interest in handling a workers' compensation file. This defense necessarily implicates any advice the corporation receives from defense counsel. ***Mendoza v. McDonald's Corp.***, 222 Ariz. 139, 213 P.3d 288 (Ct. App. 2009).

EXPERT OPINION REGARDING INSURER'S STATE OF MIND SHOULD BE EXCLUDED

In ***Hunton v. American Zurich Ins. Co.***, 2018 WL 1182550 (D. Ariz. Mar. 7, 2018), an insurance bad faith case arising from a workers' compensation claim, the Arizona District Court excluded an insured's expert opinion that the insurer's alleged "claims handling failures" were "pervasive enough to support the conclusion that upper management had to have known of, and approved, the [alleged] deficient staffing levels, inadequate training, inadequate oversight by middle management, and the ethics-related lapses related to the financial incentives granted to employees." The court reasoned that to allow this expert testimony would be to substitute the expert's opinion for that of the jury, and that the jury was capable of determining whether an insurer acted knowingly for the purposes of a bad faith claim.

PRACTICE TIPS/SUGGESTIONS TO MINIMIZE RISK OF BAD FAITH

An insurer's investigation must be prompt, thorough and reasonable. The insurer must consider facts favorable to the insured's position as well as those facts not favorable to the insured's position. If the insurer fails to perform a balanced and even-handed investigation, it increases the risk of a claim for bad faith. If the insured does not supply the required or requested information, the insurer is not absolved of the duty to fairly investigate the matter.

- Don't jump to conclusions.
- Look at the entire picture.
- Evaluate in an impartial manner.
- Do not rely on unsubstantiated opinion or hearsay.
- Review facts, policy provisions and the law.
- Retain experts, if necessary, and supply them with all material (good and bad) so that their opinions are well based.
- Obtain the advice of counsel for any legal questions.
- Keep an open mind and be willing to conduct further investigation if warranted.

DAMAGES RECOVERABLE IN A BAD FAITH CLAIM

For a complete overview on damages, see Chapter 2.

Contract Damages

Damages for injuries proximately caused by the insurer's conduct are recoverable whether those injuries should have been anticipated or not. ***Rawlings v. Apodaca***, 151 Ariz. 149, 726 P.2d 565 (1986). Consequential damages are "those damages caused by a breach of contract...that can reasonably be supposed to be within the contemplation of the parties." ***Walter v. Simmons***, 169 Ariz. at 236, 818 P.2d at 221 (Ct. App. 1991) (quoting ***Seekings v. Jimmy GMC of Tucson, Inc.***, 130 Ariz. 596, 638 P.2d 210, 215 (1981)). Plaintiff has the burden of proving consequential damages with "reasonable certainty" and if he does not prove them with "precision" a court may refuse them. *See Walter*, 169 Ariz. at 236, 818 P.2d at 221.

Compensatory Damages

Emotional Distress

When an insured buys coverage, he or she is seeking peace of mind. Breach of a covenant by the insurer breaches that peace of mind and an award for emotional distress is allowed. ***Rawlings v. Apodaca***, 151 Ariz. 149, 726 P.2d 565 (1986).

Emotional distress damages may be awarded in bad faith cases even though the defendant did not intentionally cause the distress and even though the distress was not severe. ***Farr v. Transamerica Occidental Life Ins. Co. of Cal.***, 145 Ariz. 1, 699 P.2d 376 (Ct. App. 1984).

Economic Loss

Economic damages may include those business or personal losses proximately resulting from an insurer's wrongdoing. In addition, attorney's fees may be awarded in first-party bad faith actions pursuant to A.R.S. § 12-341.01. ***Dodge v. Fid. & Deposit Co.***, 161 Ariz. 344, 778 P.2d 1240 (1989); ***Schwartz v. Farmers Ins. Co***., 166 Ariz. 33, 800 P.2d 20 (Ct. App. 1990). Attorney's fees can also be awarded in third-party claims. Though attorney's fees may not be awarded as an item of

consequential damages, the Legislature provides for their recovery in A.R.S. § 12-341.01. ***Ponderosa Plaza v. Siplast***, 181 Ariz. 128, 888 P.2d 1315 (Ct. App. 1993). *See also* ***Sparks v. Republic Nat'l Life Ins. Co.***, 132 Ariz. 529, 647 P.2d 1127 (1982).

Lost future profits that flow from a breach of contract are recoverable. ***McAllister v. Citibank***, 171 Ariz. 207, 829 P.2d 1253 (Ct. App. 1992). However, such an award cannot be based on speculation or conjecture. *Walter*, *supra*.

Workers' Compensation Case

A plaintiff in a workers' compensation bad faith case is entitled to seek pain and suffering, lost earnings and decrease in future earning capacity, and future medical expenses as long as she can show the injuries resulted from the defendant's bad faith conduct (i.e., delay) and not the original injury. ***Mendoza v. McDonald's Corp.***, 222 Ariz. 139, 213 P.3d 288 (Ct. App. 2009).

Punitive Damages

An insurer's breach of covenant of good faith and fair dealing does not automatically entitle the insured to punitive damages. There must be "something more." ***Linthicum v. Nationwide Life Ins. Co.***, 150 Ariz. 326, 723 P.2d 675, 679 (1986); ***Rawlings v. Apodaca***, 151 Ariz. 149, 726 P.2d 565 (1986). The "something more" required for punitive damages is evidence "that defendant either (1) intended to injure the plaintiff ... or (2) consciously pursued a course of conduct knowing that it created a substantial risk of significant harm to others. This standard is satisfied by evidence that defendant's wrongful conduct was motivated by spite, actual malice or intent to defraud. Defendant's conscious and deliberate disregard of the interests and rights of others also will suffice." ***Gurule v. Illinois Mut. Life & Cas. Co.***, 152 Ariz. 600, 734 P.2d 85 (1987); *Walter*, *supra*.

Punitive damages should be restricted to "only those limited cases of consciously malicious or outrageous acts of misconduct in which punishment and deterrence is both paramount and likely to be achieved." *Linthicum*. There must be both an "evil mind" and "aggravated and outrageous" conduct. A plaintiff must show that the defendant intended to interfere with plaintiff's rights "consciously disregarding the unjustifiably substantial risk of significant harm to [the plaintiff]."

A plaintiff must prove punitive damages by clear and convincing evidence. *Linthicum*; *Rawlings*. Clear and convincing evidence means "that which may persuade that the truth of the contention is highly probable." ***Thompson v. Better-Bilt Aluminum Prods. Co.***, 171 Ariz. 550, 557, 832 P.2d 203, 210 (1992). A mere inadequate investigation does not alone support a claim for punitive damages. ***Filasky v. Preferred Risk Mut. Ins. Co.***, 152 Ariz. 591, 734 P.2d 76 (1987).

The 14th Amendment due process clause prohibits states from imposing grossly excessive punishment – i.e., punitive damage awards – against a tortfeasor. ***BMW of North America, Inc. v. Gore***, 517 U.S. 559 (1996). The factors to consider in determining whether an award of punitive damages is appropriate include: (1) the degree of reprehensibility of the defendant's conduct or defendant's culpability; (2) the relationship between the penalty and the harm to the victim

caused by the defendant's action; (3) the relation between the plaintiff's compensatory damages and the amount of the punitive damages; (4) the difference between civil punitive damages and the criminal sanction which could be imposed for comparable misconduct; and (5) the sanctions imposed in other cases for comparable misconduct. *See also*, ***Cooper Indus. Inc. v. Leatherman Tool Group, Inc.***, 532 U.S. 424 (2001).

In ***State Farm Mut. Auto. Ins. Co. v. Campbell***, 538 U.S. 408 (2003), the Supreme Court held that out-of-state conduct dissimilar from the acts upon which liability is premised, cannot serve as a basis for punitive damages. A defendant should be punished for the conduct that harmed the plaintiff, not for being an unsavory individual or business. A state cannot punish a defendant for conduct that may have been lawful where it occurred. Nor, as a general rule, does a state have a legitimate concern in punishing a defendant for unlawful acts committed outside the state's jurisdiction.

A plaintiff can also recover punitive damages for improper company-wide practices. ***Nardelli v. Metro. Group Prop. & Cas. Ins. Co.***, 230 Ariz. 592, 277 P.3d 789 (Ct. App. 2012). In *Nardelli*, plaintiffs sued the defendant insurer when the insurer decided to repair plaintiffs' heavily damaged vehicle instead of totaling it. At trial, plaintiffs presented evidence of the insurer's aggressive profits campaign in their claims department that urged employees to save money on claims. This campaign included incentive payments based on an adjuster's "claims balance scorecard." The court stated that this profits campaign was evidence that the insurer "acted with conscious disregard of [the plaintiff's] rights and the injury that might result."

Arellano v. Primerica Life Ins. Co., 235 Ariz. 371, 332 P.3d 597 (Ct. App. 2014), potentially increases punitive damages to a 5:1 ratio when an insurer's actions falls in the "middle to high level of reprehensibility." There, a wife sought to obtain life insurance for her husband. At trial, a jury found that Primerica engaged in the following acts: (1) Primerica accepted the plaintiff's application without her signature; (2) the Primerica insurance agent's assured the plaintiff the policy was effective from the time she tendered her initial premium payment and application; (3) the Primerica agent failed to provide the plaintiff with a copy of the insurance application; (4) a Primerica agent forged the plaintiff's initials without her consent to lower the policy amount in an effort to ensure the application's approval; (5) Primerica failed to return the plaintiff's initial premium payment after canceling plaintiff's application. The jury awarded the plaintiff over $1 million in punitive damages, which constituted a 13:1 ratio. The Arizona Court of Appeals found the 13:1 ratio violated due process. The court, however, found a 5:1 ratio appropriate based on what it described as Primerica's middle to high level of reprehensibility.

Arellano is also significant because it held that A.R.S. § 20-1108 applies to verbal contracts for insurance. Section 20-1108 prohibits the admission of a life or disability insurance application unless the application is attached or made part of the policy. During trial, the court excluded Arellano's insurance application, holding that a verbal contract existed between the plaintiff and Primerica. The court of appeals affirmed the trial court's ruling, rationalizing that, while the contract in *Arellano* was based on verbal assurance, Primerica could have easily satisfied the requirements of § 20-1108 by providing the plaintiff with a copy of the application.

McClure v. Country Life Ins. Co., 326 F. Supp. 3d 934 (D. Ariz. 2018), *aff'd* 795 F. App'x 548 (9th Cir. 2020), continues the trend of awarding punitive damage awards in multiples of compensatory damages. In McClure, Country Life issued a disability policy. The insured suffered a concussion while walking at a mall and claimed he could no longer work. He then developed psychiatric problems and was hospitalized after a suicide attempt. Country Life paid benefits for over a year and then terminated the benefits based on an inconclusive psychological evaluation. The insured was thereafter hospitalized again for suicidal ideations. After the insured filed suit, County Life reinstated benefits to the date of the second hospitalization. The jury awarded 1.3 million in compensatory damages and $5 million in punitive damages.

CLAIMS SETTLEMENT PRACTICES

Arizona has a statute entitled the "Unfair Claims Settlement Practices Act." A.R.S. § 20-461, together with regulations adopted by the Arizona Department of Insurance, impose significant obligations on insurance carriers doing business in the state.

Both the statute and the regulation are nominally directed at actions committed or performed "with such a frequency to indicate as a general business practice." They prohibit claims practices such as:

* * *

2. Failing to acknowledge and act reasonably and promptly upon communications with respect to claims arising under an insurance policy.

* * *

4. Refusing to pay claims without conducting a reasonable investigation based on all available information.
5. Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed.
6. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear.

* * *

14. Failing to promptly settle claims if liability has become reasonably clear under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

* * *

15. Failing to promptly provide a reasonable explanation of the basis in the insurance policy relative to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

Importantly, the statute specifically provides that it does not create a civil cause of action and is designed solely as an administrative remedy. At least one court has held that the statute and Insurance Department regulations could not be included as a jury instruction in a bad faith case. ***Melancon v. USAA Cas. Ins. Co.***, 174 Ariz. 344, 849 P.2d 1374 (Ct. App. 1992). There is, however, nothing to stop a plaintiff's expert from testifying that the insurer's "standard of care" is based upon the very same principles as set forth in the Act.

The Director of Insurance is empowered to collect fines and civil penalties for violations. The Department also has the related authority to investigate complaints, and an insurer receiving an inquiry from the Department of Insurance should handle that inquiry with the highest priority, even if the complaint is undeniably without merit.

The rules adopted by the Insurance Department go further than the statute. In addition to further defining the obligations under the unfair claims settlement practices statute, the Department also adopted certain time limits for responding to claims and inquiries. For instance, R20-6-801(E)(1) requires an insurer to acknowledge receipt of the claim within 10 working days unless payment is made within that time. Ten working days are generally the limit for responding to other communications from a claimant "which reasonably suggest that a response is expected." R20-6-801(E)(3). The insurer is required to complete the investigation of a claim within 30 days after notification, unless the investigation cannot be reasonably completed within that time. R20-6-801(F).

An insurer is required to accept or deny a claim within 15 days after receipt of a properly executed proof of loss and the denial of a claim based upon a specific policy provision or exclusion must be given in writing to the claimant and kept in the claim file. R20-6-801(G)(1)(a).

If the insurer requires more time to determine whether a first party claim should be accepted or denied, the insurer must notify the first party claimant within 15 days after the receipt of the proofs of loss, giving reasons why more time is needed. Every 45 days thereafter, the insurer must send the claimant a letter setting forth the reasons additional time is needed for investigation. R20-6-801(G)(1)(b).

Where negotiations are underway between an insurer and a claimant who is not an attorney nor represented by an attorney, the insurer must give the claimant written notice of the pending expiration of the time limit within 30 days for first party claimants and 60 days for third-party claimants prior to the date on which the limitations period expires. In no event may the insurer continue negotiations during the period the limitations is about to expire without having given such written notice. R20-6-801(G)(4).

On September 20, 2000, the Director of the State Department of Insurance issued Circular Letter 2000-11. The Circular Letter was a response to an ethics opinion issued by the State Bar of Arizona in June of 1999, Opinion No. 99-07, which concluded that an attorney could not ethically negotiate with a non-lawyer public adjuster (licensed adjuster) if that adjuster was not supervised by a lawyer. The letter recognized that a licensed adjuster's authority was limited to that granted by the Legislature under A.R.S. §§ 20-281 and 20-312. The Circular Letter identified certain general activities that a licensed adjuster is authorized to perform on behalf of an insured, including the gathering of facts relevant to a claim, documenting and measuring damages, determining repair and replacement costs, evaluating coverage and valuation issues, preparing a proof of loss, engaging in settlement negotiations with an authorized representative of the insurer, advising the insured whether to accept an insurer's offer of settlement and assisting in completing ordinary settlement documentation. The Circular Letter specifically stated that

licensed adjusters were not authorized to initiate or defend court proceedings, prepare or submit pleadings or motions, engage in discovery, or present evidence or legal arguments.

The regulations provide specific obligations for handling first party automobile total losses, replacement automobiles, cash settlements, and subrogation.

The regulations also provide that an insurer, upon receipt of an inquiry from the Department of Insurance respecting a claim, must respond within 15 working days of receipt of the inquiry and furnish the Department with an adequate response to the inquiry. R20-6-801(E)(2). Although the claims settlement statute and the accompanying regulations are aimed at general business practices, several similar complaints against the same insurer, or a particularly difficult case, may result in an investigation by the Department of other files processed by the insurer. For this reason, adequate training on the requirements of the Unfair Claims Settlement Practices Act and adequate documentation of the claim file offers the best opportunity to avoid problems with the insurance department.

EQUITABLE SUBROGATION

Equitable subrogation is a principle of law that permits indemnity, even in the absence of a contract for indemnity, when justice demands that there be such recovery. The principles of equitable subrogation can apply between co-insurers as well as primary and excess insurers. For example, if Joe, insured by ABC Insurance Company, rents a car and allows Tom, insured by XYZ Insurers, to drive the car, Tom might be a permissive user of the car under Joe's policy. Tom would also have coverage under his own policy. Therefore, if Tom was involved in an accident for which he was at fault, both insurers would likely provide coverage for the loss. Assuming the injured person's damages exceeded the minimum limits provided by the rental company, the rental company would then be entitled to tender the driver's defense to the next layer of coverage. If one of the insurers refused to defend and provide indemnification, the insurer providing a defense and indemnification would be entitled to recover its indemnity payments and defense costs in accordance with its pro rata share or in accordance with some other equitable method a court chooses to apply.

Such equitable principles can apply in primary and excess situations. If the primary coverage is $100,000 and the lawsuit has a value greatly in excess of that amount, the primary and excess insurers should work together in an equitable manner toward the common goal of defending the insured. If they do not, a court could do it for them. Insurers thus should work together to minimize the amount of indemnification required as well as the amount of fees and costs incurred. Otherwise, the court will apply equitable principles in dividing indemnity payments and defense costs between insurers with applicable coverage.

The doctrine of equitable subrogation has been present in Arizona for a number of years. In ***Busy Bee Buffet v. Ferrell***, 82 Ariz. 192, 310 P.2d 817 (1957), the Arizona Supreme Court permitted a "passive" tortfeasor to recover from an "active" tortfeasor the amounts the passive tortfeasor had to pay the injured third person. There, plaintiff Ferrell fell through an open trap door in a

hallway jointly shared by the Busy Bee Buffet and co-tenant Steve Pastis. Pastis had left the trap door to the basement open while he went to find a flashlight. As joint tenants of the hallway, both Busy Bee and Pastis owed a duty to Ferrell to safely maintain the premises. However, as between Busy Bee and Pastis, Pastis was "actively" negligent while Busy Bee was only "passively" negligent. Thus, Busy Bee was entitled to recover from Pastis the full amount of the damages awarded to Ferrell.

INA Ins. Co. of North America. v. Valley Forge Ins. Co., 150 Ariz. 248, 722 P.2d 975 (Ct. App. 1986), followed *Busy Bee* in the insurance context. INA insured an agent who sold a Valley Forge homeowners policy. The homeowner sued the agent for negligently failing to provide sufficient coverage and sued Valley Forge for various theories including breach of contract. The agent tendered his defense to Valley Forge who refused the tender on the grounds that the agent was independently negligent. INA defended the agent who was subsequently dismissed from the suit.

INA then sought to recover its fees and costs incurred in defending the agent from Valley Forge. Valley Forge maintained that it had no obligation to indemnify INA, because the homeowner's complaint alleged the agent's independent negligence. The court held that the complaint's allegations of independent wrongdoing do not control the right to indemnity. It is the actual wrongdoing or lack of it that determine the right to indemnification. Because Valley Forge had to indemnify the agent, it also had to indemnify INA, standing in the shoes of the insured agent, for the fees and costs expended to defend the agent.

In ***Hartford Accident & Indem. Co. v. Aetna Cas. & Sur. Co.***, 164 Ariz. 286, 792 P.2d 749 (1990), an excess insurer was allowed to maintain a bad faith claim against a primary insurer for the latter's failure to settle within policy limits. Aetna was the primary carrier with policy limits of $25,000. Although it had an opportunity to settle the underlying lawsuit for $15,000, Aetna refused. Subsequently, the case went to trial, resulting in a jury verdict of $140,000. The court held that Hartford, the excess insurer, was subrogated to the rights of the insured, and had a cause of action against the primary insurer for bad faith failure to settle within the policy limits.

The court said an excess insurer is also committed to indemnifying the insured. As such, the excess insurer "steps into the shoes" of the insured for purposes of the existing contractual relationship with the primary insurer. Thus, the excess insurer has standing to sue the primary insurer for any bad faith conduct in the handling of the insured's case.

> An excess insurer should not have to pay a judgment if the primary insurer caused the excess judgment by a bad faith failure to settle within primary limits. We hold, therefore, that an excess carrier is subrogated to the rights of the insured and has a cause of action against the primary insurer for bad faith failure to settle within policy limits. This right is derivative of the contract between the insured and the primary carrier.

Id. at 291, 792 P.2d at 754. Allowing such an action, said the court, serves an important public policy of encouraging settlements. Otherwise, the primary insurer would have little incentive to settle when an excess insurer is available to cover any amount of the primary insurance limits

without fear of recourse. *See also* ***Twin City Fire Ins. Co. v. Burke***, 204 Ariz. 251, 63 P.3d 282 (2003).

An excess carrier's equitable subrogation claim will fail, however, if the primary insurer's conduct did not amount to bad faith. Additionally, a judgment in excess of the primary policy limits will not automatically result in an excess carrier's right to recover from the primary carrier unless the excess carrier can prove bad faith on the part of the primary carrier.

In *Knightbrook Ins. Co. v. Payless Car Rental System Inc.*, 243 Ariz. 422, 409 P.3d 293 (2018), the Arizona Supreme Court held that Arizona's equitable indemnity law does not incorporate the First Restatement of Restitution § 78, which conflicts with Arizona's general equitable indemnity principles. Arizona indemnity law requires that an insurer *actually owe* the discharged duty to recover from a third party under equitable indemnification. In contrast, § 78 requires the "mere *justifiable belief* that [the insurer] faced a 'supposed obligation' for which [the indemnitor] bore the greater responsibility." In so ruling, the Court noted that it was "troubled that § 78 could preclude an indemnitor from raising viable defenses to the underlying claim.

EQUITABLE CONTRIBUTION BETWEEN INSURERS

Equitable contribution is similar to equitable subrogation. While equitable subrogation usually occurs between excess and primary carriers, claims for equitable contribution arise between two or more carriers providing the same or similar layer of coverage. In ***American Cont'l Ins. Co. v. American Cas. Co. of Reading, PA***, 183 Ariz. 301, 903 P.2d 609 (Ct. App. 1995), the court held that one insurer may recover its contribution to the plaintiff's damages from another insurer whose insured was never named as a party in the underlying lawsuit, provided that the insurer seeking contribution is able to establish the negligence of the mutual insured.

In *American Continental*, a hospital nurse improperly administered injections to a patient which rendered the patient a quadriplegic. The patient filed a medical malpractice action against the hospital and the hospital's "employees and/or agents," though the nurse was never specifically named as a defendant. American Continental Insurance Company, Inc. (ACIC) issued a hospital liability insurance policy to the hospital. Under this policy, the term "insured" included the hospital and its employees. The policy obligated ACIC to defend and indemnify all insureds against medical malpractice claims. The individual nurse who committed the negligent act also had her own personal professional liability policy issued by American Casualty Company (American). The ACIC policy and the American policy both provided primary coverage and contained "other insurance" clauses which allocated liability between insurance companies when concurrent coverage existed.

ACIC defended the hospital and the nurse, and it invited American to also participate in the defense and settlement of the suit. American refused because the nurse was not specifically named as a defendant to the lawsuit. ACIC eventually settled the underlying action and then sued American for recovery for a portion of the defense costs and settlement payment. American

argued that it was not obligated to contribute any defense costs or settlement money to ACIC because American's named insured, the nurse, was never sued in the underlying action.

The court rejected this argument and held that equitable contribution between insurers is available and permissible, even if the mutually named insured is not actually named as a party in a lawsuit. Although a claim for indemnity might require that the mutual insured be named a party in the lawsuit, the same is not true for equitable contribution. Equitable contribution is based upon the relationship of two insurers insuring the same risk. Three elements must be satisfied to establish a claim for equitable contribution: (1) the two insurers must insure the same risk; (2) neither insurer can be the primary insurer; and (3) the loss sustained must be caused by the risk insured against. *See also* ***Mutual Ins. Co. of Ariz. v. American Cas. Co. of Reading, Penn***., 189 Ariz. 22, 938 P.2d 71 (Ct. App. 1996), *superseded by statute on other grounds*, *as stated in* ***Jangula v. Ariz. Prop. And Cas. Ins. Guar. Fund***, 207 Ariz. 468, 88 P.3d 182 (Ct. App. 2004).

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