Filed 5/14/02; reposted to correct file date

**CERTIFIED FOR PARTIAL PUBLICATION***

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FIFTH APPELLATE DISTRICT

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| JONATHAN NEIL & ASSOCIATES, INC.,<br>Plaintiff and Appellant,<br>v.<br>FREDDIE JONES,<br>Defendant, Cross-complainant and Appellant;<br>MILDRED JONES et al.,<br>Cross-complainants and Appellants.<br>CAL-EAGLE INSURANCE,<br>Cross-defendant and Appellant;<br>JOHNSEY INSURANCE COMPANY,<br>Cross-defendant and Respondent. | F029400 & F030300<br><br>(Super. Ct. No. 0512318-7)<br><br>**OPINION** |

APPEAL from a judgment of the Superior Court of Fresno County. Franklin P. Jones, Judge.

* Pursuant to California Rules of Court, rules 976(b) and 976.1, this opinion is certified for publication with the exception of parts II and III.

Fried, Frank, Harris, Shriver & Jacobson, Richard A. Brown and E. Randol Schoenberg; Greines, Martin, Stein & Richland, Irving H. Greines, Robin Meadow, Tyna Thall Orren and Peter O. Israel for Plaintiff and Appellant and Cross-defendant and Appellant.

McCormick, Barstow, Sheppard, Wayte & Carruth, James P. Wagoner and Wendy S. Loyd for Defendant, Cross-complainant and Appellant Freddie Jones and Cross-complainants and Appellants Mildred Jones and Fred Jones Trucking, Inc.

Emerson Corey & Barsotti for Cross-defendant and Respondent.

This appeal and cross-appeal follow a judgment in favor of a trucking company and its owners, and against the company's assigned-risk liability insurer. We find the facts do not support a *tort* cause of action for breach of the duty of good faith and fair dealing and that the trial court erred when it failed to stay proceedings while the parties exhausted administrative remedies before the Insurance Commissioner. As a result of these conclusions, the judgment must be reversed and the matter remanded for further proceedings.

## FACTS AND PROCEDURAL HISTORY

### *The Trucking Company and Its Liability Insurance*

In 1990 and 1991, Freddie and Mildred Jones owned a trucking company, known as Fred Jones Trucking. In August of 1992, the Joneses formed a corporation, Fred Jones Trucking, Inc., and assigned to it all of their interest in Fred Jones Trucking. We will refer to the Joneses' individual and corporate identities as "the Joneses," unless the particular context requires a further distinction. The Joneses operated under the

authority of the California Public Utilities Commission (PUC).[1] They performed both contract and job-lot hauling consisting mostly of day trips of less than 200 miles.

The Joneses owned two tractor units and five trailers. Of their gross receipts of about $680,000 per year in 1991, about $365,000 was paid to subhaulers. Subhaulers are individual owner-operators who have their own PUC certificates of authority and their own liability insurance, required as a condition of certification by the PUC.

The PUC also requires the insurer of any regulated trucker to cover any injury or damage to third parties caused by any PUC-regulated vehicle used in the trucker's business, although this coverage permits the insurer to seek reimbursement from its insured if the risks have not been disclosed to the insurer. Thus, because the Joneses were themselves holders of a PUC certificate for their trucking company and subhaulers held their own certificates, two insurance companies could be responsible for payment if a subhauler had an accident while hauling for the Joneses.

The Joneses had liability insurance for the 1990 policy year with Edison Insurance. Edison went out of business and the Joneses needed to find a new insurer. Their insurance agent, Johnsey Insurance Company (Johnsey), suggested they obtain insurance through the state's assigned risk plan because it might save the Joneses some money. The Joneses agreed.

Johnsey obtained an application for the assigned risk plan. The application contained a statement to the effect that any policy issued as a result of the application would be subject to the rules and regulations of the assigned risk program: "This application shall be evidence of temporary insurance subject to the following

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[1] In 1996, regulatory authority was shifted to the Department of Motor Vehicles and the Highway Patrol (see Veh. Code, § 34600 et seq.).

conditions: [¶] … [¶] 4. The insurance afforded hereunder shall be subject to all the terms and conditions of the Plan and of the policy form prescribed for use."

The Joneses' application was assigned to Cal-Eagle Insurance Company (Cal-Eagle) by the assigned-risk program office. Cal-Eagle issued a policy in a form required by the Department of Insurance. It charged the Joneses an initial estimated annual premium of $14,088, based on the Joneses' use of their own, specified vehicles in the business. (Cal-Eagle added the minimum permissible premium of $299 for the PUC endorsement coverage, based on the information set out in the Joneses' application.) Over the term of the policy, Cal-Eagle assessed additional premiums as the Joneses added equipment to their fleet. The total of premiums charged and paid during the policy year was $21,752.

The Cal-Eagle policy issued to the Joneses included the following language:

> **"1. Premium Changes**
>
> "The premium for this policy is based on information we have received from you or other sources. You agree:
>
> "a. that if any of this information material to the development of the policy premium is incorrect, incomplete or changed, we may adjust the premium accordingly during the policy period.
>
> "b. to cooperate with us in determining if this information is correct and complete, and to advise us of changes in this information.
>
> "Any adjustment of your premium will be made using the rules in effect at the time of the change. Premium adjustment may be made as a result of a change in:
>
> "a. autos insured by the policy ….
>
> "b. drivers, driver's age or driver's marital status.
>
> "c. coverages or coverage limits.
>
> "d. rating territory.
>
> "e. eligibility for discounts or other premium credits."

After the policy expired, Cal-Eagle did a routine audit of the Joneses to make sure all of the vehicles used in the business had been accounted for in the calculation of premiums. The audit took place pursuant to the following provision of the policy: "The estimated premium for this Coverage Form is based on the exposures you told us you would have when this policy began. We will compute the final premium due when we determine your actual exposures."

The auditor discovered the Joneses' extensive use of subhaulers, and Cal-Eagle assessed the Joneses (under old Rule 23, explained below) another $111,523 in insurance premiums for the coverage period that had just expired. This additional premium was subsequently adjusted to $51,294 under new Rule 23, also explained below.

The Joneses declined to pay the additional premium. Cal-Eagle assigned its claim to Jonathan Neil & Associates, Inc., a collection agency, which sued Freddie Jones for the balance due on the premium. The Joneses responded with a cross-complaint, initially for bad faith and subsequently amended to state other tort causes of action.

***The Commercial Automobile Insurance Procedure (CAIP)***

*The Basic Assigned Risk Program*

Section 11620 of the Insurance Code requires the Insurance Commissioner to "approve or issue a reasonable plan" to provide liability insurance for those "who are in good faith entitled to but are unable to procure that insurance through ordinary methods." In general, the plan assigns such insureds to the various companies who write insurance in California and regulates the premiums that can be charged to such insureds. This assigned-risk insurance is generally issued at the minimal levels required by the financial responsibility law. (See Ins. Code, § 11622.)

Prior to adoption by referendum in 1988 of Proposition 103, the assigned risk plan was operated by a governing committee formed by the insurers, "subject to review

by the Insurance Commissioner." (See former Ins. Code, § 11623, repealed by Stats. 1990, ch. 1132, § 1.) This committee is known as the CAARP committee, an acronym reflecting the name of the program it administers, the California Automobile Assigned Risk Program.

After 1990, the CAARP committee became advisory to the Insurance Commissioner (see Ins. Code, § 11623, subd. (a)). The Insurance Commissioner is required to "consult with the advisory committee on a regular basis on policy matters affecting the operation of the plan." (Ins. Code, § 11623, subd. (a).) Nevertheless, the committee "with the approval of the commissioner shall appoint a manager to carry out the purposes of this article, employ sufficient personnel to provide services necessary to the operation of the plan, and contract for the provision of statistical and actuarial services." (*Ibid*.) The CAARP committee apparently has contracted with an organization called AIPSO to manage the plan. AIPSO is a nationwide operator of such plans; AIPSO provides policy and endorsement forms, as well as interpretive advice.

The CAARP committee is, by statute, composed of eight employees of insurance companies that write assigned-risk policies, four public members, two representatives of insurance agencies, and the Insurance Commissioner or his/her designee. (Ins. Code, § 11623, subd. (a).) Curiously, "[n]otwithstanding this act, which changes the status of the governing committee to that of an advisory committee, the committee shall have the right to retain counsel of its choice … and the right and necessary standing to bring and defend actions in judicial and administrative proceedings related to the plan in the name of the plan …." (Ins. Code, § 11623, subd. (b).)

*The Commercial Assigned Risk Procedure.*

There are certain classes of vehicle users whose financial exposure (and potential danger to the public) is much greater than is contemplated by the ordinary assigned-risk placement. Among these is the class of commercial truckers. In order to accommodate these higher risk vehicle users, the Insurance Commissioner in 1978 promulgated (by

regulation at Cal. Code Regs., tit. 10, § 2432 et seq.) the Commercial Automobile Insurance Procedure (CAIP). The assigned risk plan for truckers is also administered by the CAARP committee (of which there is a separate CAIP subcommittee that handles policy issues arising from truckers' insurance).

CAARP hires two "servicing carriers" (Cal. Code Regs., tit. 10, § 2432, subd. (e)), who provide all of the insurance policies issued under CAIP. These carriers have a contract with CAARP by which they are paid a percentage of the premium as a fee for their services. They turn all premiums over to CAARP and charge all claims to CAARP, which then distributes the charges among automobile liability carriers in California. Thus, the servicing carriers are not typical insurance companies in the sense of a company putting its own assets at risk through its underwriting and premium practices. Instead, risk is borne by the insurance industry at large, underwriting and premium practices are specified by CAARP and the Department of Insurance (DOI), and the servicing carrier is paid a commission for implementing and administering the program.

Cal-Eagle became one of the servicing carriers on March 6, 1991, and it issued the Joneses a one-year policy for a term beginning March 27, 1991.

*Rule 23.*

CAARP and DOI promulgated a "California Commercial Automobile Assigned Risk Plan Manual of Rules and Rates" for servicing carriers' use in determining premiums and otherwise administering the commercial assigned-risk plan. Of primary importance in the present case is rule 23, in both its original form and as revised by DOI in 1992.

There was testimony to the effect that the manual was created by AIPSO, the national organization that CAARP had hired to manage CAIP. The testimony indicated that California was somewhat unique in issuing PUC certificates directly to subhaulers, with the attendant requirement that the subhauler have its own insurance. In other

states, according to the testimony, only the primary trucking company had insurance and the hired carriers were covered under that insurance. In its original form, California rule 23 was the generic, nationwide rule published by AIPSO. Because of the unique requirement that subhaulers have their own insurance, there had long been controversy and uncertainty concerning the way rule 23 applied in California -- if it applied at all. At the very least, it can be said that the original rule 23 did not, in its language, take account of the California situation.

The provision relevant to the present discussion is subdivision C of rule 23 as it existed during the term of the insurance policy and the initial audit. Subdivision C, written in the form of a directive to the servicing carriers, stated in an initial, unnumbered paragraph: "Premium Determination: Rate automobiles transporting exclusively for one concern on the same basis as though owned by such concern for both territory and classification."

The rule then provided two alternatives. In subparagraph 1, the rule said truckers may be "written on a specified car basis according to the Trucks, Tractors and Trailers Classifications Rule." The Classifications Rule, rule 22, provided the basis on which Cal-Eagle calculated the premiums for the trucks and trailers owned and operated by the Joneses directly. If Cal-Eagle had applied this portion of the rule to the Joneses' subhaulers, it would have resulted in a listing in the Joneses' policy of each tractor and trailer used by any of their subhaulers -- and assessment of the full rated premium for each truck.

Rule 23 provided an alternative: "2. Cost of Hire Basis. Truckers may be written on the cost of hire basis to cover their liability because of a contract involving the hire of trucks, tractors and trailers." In order to determine the premium on this basis, the servicing carrier was required to first determine the average premium for *listed* tractors and trailers under the policy (as determined from application of rule 22), then multiply that average rate by .0033 to obtain the "cost of hire rate." The servicing

carrier was then to determine the insured's total cost of hiring the subhaulers and compute the insurance premium by "multiplying each $100 of the total amount estimated for the cost of hire … by the cost of hire rate." Nowhere in the rule was the word "subhauler" used; the relevant portion of the rule referred only to a "contract involving the hire of trucks, tractors and trailers."

Rule 23 was rewritten by DOI after a two-year period of study and consultation with the insurance industry. The revised rule specifically applied to exposure based on a "subhauling agreement involving the hauling of goods on behalf of an insured trucker by a hired carrier."

The revised rule recognized that in some circumstances the primary trucker's insurance would be called upon only to provide excess coverage if a claim exceeded the limits of liability of the subhauler's insurance. Thus, the revised rule stated at subparagraph C.2.a(2): "The insured trucker may request and the CAIP Servicing Carrier shall provide coverage for the hired carrier exposure on an excess basis where an insured trucker demonstrates at the time of application or upon renewal that all of the following criteria are satisfied and such criteria remain satisfied throughout the policy period[.]" The five criteria address both the form and the substance of the relationship between the trucker and the subhauler; the criteria are set forth in the margin.[2] The

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[2] The criteria listed in revised rule 23 are:

"(a) Any hired carrier with whom the insured trucker contracts to carry or subhaul must operate under its own California PUC operating authority.

"(b) No written lease or oral rental agreement shall exist between the insured trucker and the hired carrier; however, a separate, written subhaul agreement which complies with California PUC requirements shall be executed between the insured trucker and the hired carrier. This subhaul agreement shall make the hired carrier's insurance primary, make the hired carrier responsible for all claims and/or liabilities, name the insured trucker as an additional insured on the hired carrier's policy, provide that the hired carrier's insurer will notify the insured trucker if the hired carrier's policy

premium applicable if the insured trucker is able to satisfy all criteria is 4 percent of the otherwise-applicable premium.

The revised rule also modified the otherwise-applicable premium. Although the premium was based on cost of hiring the subhaulers, as had been the premium under the original rule 23, the base multiplier was reduced from .0033 to .0011. The revised rule required that "the total cost of hiring" was to be calculated on the basis that each subhauler's vehicle was hired for a minimum of $60,000 of work per year.

As the revised rule was implemented from September of 1992 forward, certain problems revealed themselves. Some of the problems occurred because DOI required the carriers to implement the rule on a retroactive basis if requested by insureds. Most insureds -- including the Joneses -- did not have the detailed records readily available to

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is canceled, and require minimum limits of not less than the applicable California PUC-required minimum limits.

"(c) The insured trucker shall have on file copies of all subhaul agreements for audit by the CAIP Servicing Carrier.

"(d) The insured trucker shall not dispatch or exert any control over the means by which the hired carrier fulfills the obligations of the subhaul agreement; the hired carrier shall exercise independent control over the equipment operated and the drivers or persons operating that equipment.

"(e) The insured trucker shall maintain a separate subhaul register which complies with California PUC requirements. This register shall be made available for audit and/or review by the CAIP Serving Carrier, the Plan, and/or the California Insurance Commissioner.

"(f) The CAIP Servicing Carrier, the California Insurance Commissioner, and the Plan shall have access to the insured trucker's books and records for a period of three years after the date of cancellation or non-renewal of the policy to audit and determine compliance with the requirements of this section. If upon audit it is determined that there has not been compliance with the requirements of this section, the premium for the hired carrier exposure will be recomputed in accordance with the provisions of paragraph C.2.b. below."

satisfy the five criteria for excess coverage. Further, smaller truckers like the Joneses did not use any particular subhauler for anywhere near $60,000 of work per year.

Through oral and written interpretations, written instruction letters in particular cases, and written directives, DOI over time shaped the application of the rule to try to achieve a fair and reasonable premium commensurate with the risks against which CAIP insured. In particular, DOI eventually decided substantial compliance with the five criteria was sufficient to permit reduction of the premium to the excess-insurance rate and it decided that the minimum charge per subhauler should be prorated on a daily basis.

The evidence was conflicting concerning when and how DOI implemented the postrevision interpretations of rule 23.

***The Insurance Application Form***

The application for assigned-risk insurance filed by the Joneses was a form specified by DOI and made available to insurance agents. There was a section in which the applicant listed all "operators that usually drive" specifically insured vehicles and a section in which the applicant provided detailed information concerning all tractors and trailers covered by the policy.

Another section entitled "HIRED CAR COVERAGE" said, "Check here if desired. Cost of Hire Section must be completed." This section of the application inquired whether the Joneses used in their business nonowned vehicles that would be covered under the PUC endorsement. The Joneses, through their insurance agent, checked the box desiring such coverage and entered "-0-" in a box headed "Estimated Annual Cost of Hire."

The next page of the application had a section called "Cost of Hire," containing two subparts. Part (i) was for automobiles (including trucks) "leased or hired on a long term basis (over 6 mos.)." Such vehicles (which the Joneses did not utilize) were required to be "specifically insured … as an owned automobile." Part (ii), critical to the

parties' approach to the present case, required the following of the applicant: "Indicate the total Cost of Hire including wages, for automobiles, which are *not* specifically insured by the applicant as an owned automobile." This is referred to as "short term cost of hire." The application contained blanks for insertion of the cost of hire for the current year and the first through fourth prior years. The Joneses left this section of the application completely blank.

The Joneses spent some $360,000 each year on subhaulers. If these subhaulers were considered "hired cars," the relevant figures for the current and prior years should have been entered in the "short term cost of hire" section. Cal-Eagle would have been entitled to assess an estimated premium for this coverage based on the formula in rule 23, and it would have established the actual premium through an audit of or report by the insured at the end of the policy term.

Interpreting the applicability of rule 23 to the premiums that could be assessed for the use of subhaulers and the relationship between the language of the application form and rule 23, the trial court concluded: "[T]he Joneses' subhaulers are not within the cost of hire provision because the subhaulers' trucks are not hired vehicles." The next day, the court explained this ruling further: "[I]n spite of all the testimony and the possible ambiguities and conflicting arguments subhaulers aren't within the cost of hire provision.… [¶] Cost of hire is a word of art I guess by this time in the insurance industry and so is a hired -- the term hired -- the hire of autos another word of art or term of art, and I concluded that neither of those terms include subhaulers." In instructions to the jury, the court stated: "Subhaulers' trucks are not hired vehicles for the purpose of this action …."

***The Bureaucratic Players***

Although the statute provides that CAARP will directly operate the plan, and although Cal-Eagle's contract nominally was with CAARP, DOI (on behalf of the Insurance Commissioner) also considered itself to have direct supervisory authority

over the servicing carriers, including Cal-Eagle. The servicing carrier contract between Cal-Eagle and CAARP provided that Cal-Eagle will "comply … with all written bulletins, directives or interpretations [of the Procedures] issued by the Commissioner …" Nevertheless, DOI personnel testified they had authority under the contract to direct that Cal-Eagle take specific actions. Further, they testified, at one point, DOI threatened to cancel Cal-Eagle's servicing carrier contract.

Former and current DOI employees testified that the department, in its normal role of regulator of the insurance industry, maintains a consumer complaint office. That office has the power to seek resolution of complaints and to institute administrative enforcement proceedings if informal resolution is not possible. DOI has administrative hearing officers and an appeal process.

Additionally, former and current DOI employees testified CAARP has an appeal process specific to assigned risk insureds. The committee has the authority to hold hearings and issue decisions, which are subject to review by the Insurance Commissioner. On occasion, CAARP referred complaints to DOI for initial hearing.

The Joneses filed a complaint with the DOI consumer affairs office after Cal-Eagle issued the adjusted bill for $51,000, complaining that Cal-Eagle demanded too many records. DOI responded that Cal-Eagle was correct to ask for these records and that the Joneses should try to provide them. DOI invited the Joneses to recontact DOI if, upon providing the records, they got no relief from Cal-Eagle. (In its response to DOI inquiries investigating the Joneses' complaint, Cal-Eagle failed to disclose that the Joneses already had asked for extra time to "recreate" the necessary records, and that Cal-Eagle's auditor had refused on the basis that the audit had to review only the records "now in existence.") The Joneses did not pursue the matter through DOI.

Although Cal-Eagle had a general policy to inform its insureds about administrative appeals through CAARP, it did not inform the Joneses about the availability of such an appeal when the Joneses' insurance agent and their lawyers

complained to Cal-Eagle about the additional premium. The Joneses did not file an appeal with CAARP.

***Proceedings in the Trial Court***

Cal-Eagle moved for summary judgment on two bases: that the Joneses failed to state a tort cause of action for bad faith and that they had failed to exhaust their administrative remedies. The trial court denied the motion. Cal-Eagle petitioned this court for writ relief. This court summarily denied the petition.

The trial was divided into three phases. Phase I was a trial to the court without a jury on certain matters of interpretation of statutes, regulations, rules, and policy language. Phase II was the trial to the jury of the complaint and cross-complaint. Phase III was the trial to the jury concerning the amount of punitive damages to be awarded. The jury found the Joneses owed no additional premiums on Jonathan Neil's complaint, awarded the Joneses $2,027,167 in compensatory damages from Cal-Eagle and assessed punitive damages against Cal-Eagle in the amount of $11,445,714.23. In posttrial proceedings the trial court conditioned its denial of a new trial motion on remittitur of the punitive damages award to $4,350,887. While preserving their right to cross-appeal, the Joneses consented to the remittitur.

Cal-Eagle and Jonathan Neil & Associates, Inc. filed timely notices of appeal, as did the Joneses. Cal-Eagle and Jonathan Neil & Associates, Inc. subsequently filed a notice of appeal from the order on costs (F030300); that appeal was consolidated with this case by order of the court.

## DISCUSSION

Cal-Eagle's appeal raises issues of jurisdiction and standing, failure to state a cause of action, trial and instructional error, and substantive issues concerning the award of damages and attorney fees. The Joneses' cross-appeal challenges the trial court's reduction of the jury's punitive damages award, certain substantive and evidentiary rulings during the trial, and certain rulings concerning attorney fees.

We conclude the trial court committed two fundamental errors that require reversal of the judgment. As a result of our holdings on these two issues, any retrial of this matter will have a wholly different texture and many or most of the substantive and procedural issues raised by the parties will not recur on retrial. Accordingly, we have addressed only the issues we consider dispositive of this appeal. Those issues are whether the Joneses have stated a tort cause of action for bad faith and whether judicial consideration of this case is precluded by the doctrine of exhaustion of administrative remedies.

## I.

## The Facts of this Case Do Not Support a Tort Cause of Action for Bad Faith.

After Cal-Eagle's motion for summary judgment was denied, it filed a petition for writ of mandate in this court. In addition to the exhaustion of remedies issue, the petition contended the Joneses had failed to state a tort cause of action for insurance bad faith. This court summarily denied the writ.

On this appeal from the judgment, Cal-Eagle does not renew, in the same terms, the argument that the Joneses failed to state a tort cause of action for bad faith. Instead, it raises the issue in the context of instructional error: "The trial court instructed the jury that incorrect billing statements may deprive an insured of an insurance 'benefit' and may breach the covenant of good faith and fair dealing…. This was prejudicial error." (Record citation and fn. omitted.) We perceive this as essentially the same argument raised in the writ petition.

The Joneses perceive the argument in the same manner. In response, they state: "a number of decisions have confirmed that a claim for breach of the covenant of good faith and fair dealing may be predicated solely on the insurer's conduct causing a higher premium." In a footnote, they list seven cases and state: "This same conclusion was

presumably reached by this court in denying CAL-EAGLES's Petition for Writ of Mandate …."

The Joneses' presumption is incorrect. Our summary denial of the writ petition was neither an adjudication of the issues nor did it reflect any view of this court concerning the issues presented. (See *Kowis v. Howard* (1992) 3 Cal.4th 888, 897.) In considering the issue for the first time on this appeal, we conclude the circumstances of the present case do not give rise to a tort cause of action for insurance bad faith.

The common-law tort of breach of the duty of good faith and fair dealing has a venerable history in California, but that doctrine has enjoyed relatively broader and narrower application over the years. The cases finally appear to have settled on a relatively narrow application of the doctrine; as a result, earlier cases that contain dicta that might support the expansion of the doctrine as proposed by the Joneses are an unreliable guide to the law as it must be applied to the current facts. We will begin by summarizing the familiar principles established in the seminal cases.

"There is an implied covenant of good faith and fair dealing in every contract that neither party will do anything which will injure the right of the other to receive the benefits of the agreement." (*Comunale v. Traders & General Ins. Co.* (1958) 50 Cal.2d 654, 658.) "This principle applies equally to insurance policies, which are a category of contracts." (*Kransco v. American Empire Surplus Lines Ins. Co.* (2000) 23 Cal.4th 390, 400.)

The covenant of good faith and fair dealing "is implied as a supplement to the express contractual covenants, to prevent a contracting party from engaging in conduct that frustrates the other party's rights to the benefits of the agreement." (*Waller v. Truck Ins. Exchange, Inc.* (1995) 11 Cal.4th 1, 36.) The covenant is reciprocal, binding both the insurer and the insured. (*Commercial Union Assurance Companies v. Safeway Stores, Inc.* (1980) 26 Cal.3d 912, 918.) In *Gruenberg v. Aetna Ins. Co.* (1973) 9 Cal.3d

566, 573, the court stated in broad terms that the breach of the covenant "sounds in both contract and tort."

In the insurance context, the early cases arose primarily in the context of a breach of the insurer's "duty to accept reasonable settlements" and the duty to act reasonably in investigating and paying the claims of its insured, "two different aspects of the same duty." (*Gruenberg v. Aetna Ins. Co.*, *supra*, 9 Cal.3d at p. 573.) Tort liability for an insurer's bad faith is centered on these aspects of the insurer's duty under the insurance contract. "The parties are bound by a reciprocal obligation of good faith and fair dealing, but the particular duties differ given the differing performance due under the contract of insurance. A fundamental disparity exists between the insured, which performs its basic duty of paying the policy premium at the outset, and the insurer, which, depending on a number of factors, may or may not have to perform its basic duties of defense and indemnification under the policy. [Citation.] An insured is thus not on equal footing with its insurer -- the relationship between insured and insurer is inherently unequal, the inequality resting on contractual asymmetry. An insurer's tort liability for breach of the covenant is thus predicated upon special policy factors inapplicable to the insured." (*Kransco v. American Empire Surplus Lines Ins. Co.*, *supra*, 23 Cal.4th at pp. 404-405.)

Outside the insurance context, the "bad faith" tort -- that is, a tort action for breach of the duty of good faith and fair dealing -- was initially recognized in a variety of circumstances. Court of Appeal cases held, and Supreme Court cases suggested in dicta, that bad faith breach of an employment contract or of any contract in which the parties enjoyed a "special relationship" would give rise to a tort cause of action. (*Foley v. Interactive Data Corp.* (1988) 47 Cal.3d 654, 685-691.) The Supreme Court held that a tort cause of action would arise from bad faith denial of the *existence* of a contract. (*Seaman's Direct Buying Service, Inc. v. Standard Oil Co.* (1984) 36 Cal.3d 752, 769, overruled in part by *Freeman & Mills, Inc. v. Belcher Oil Co.* (1995) 11 Cal.4th 85, 88.)

In *Koehrer v. Superior Court* (1986) 181 Cal.App.3d 1155, the Court of Appeal "broached the possibility of obtaining tort damages for the breach of any term of a contract whether for employment or otherwise." (*Foley v. Interactive Data Corp., supra,* 47 Cal.3d 654, 689, disapproving *Koehrer v. Superior Court, supra,* 181 Cal.App.3d 1155.)

*Koehrer*, however, probably represents the high tide line for the tort of bad faith in California. In a series of decisions beginning with *Foley v. Interactive Data Corp., supra,* 47 Cal.3d 654, the Supreme Court began a dramatic restriction of the applicability of the bad faith tort. In *Foley*, the court held that tort damages were unavailable for bad faith breach of an employment contract. (*Id*. at p. 700.) In *Hunter v. Up-Right, Inc.* (1993) 6 Cal.4th 1174, 1180-1182, the court held that tort damages were unavailable when an employer had used misrepresentations to induce termination of employment. In *Applied Equipment Corp. v. Litton Saudi Arabia Ltd.* (1994) 7 Cal.4th 503, 515, the court held that tort damages were not available when a contracting party conspired with another to interfere with his own contract. Finally, in *Freeman & Mills, Inc. v. Belcher Oil Co., supra,* 11 Cal.4th at page 103, the court overruled *Seaman's Direct Buying Service, Inc. v. Standard Oil Co, supra,* 36 Cal.3d 752, and held that tort damages were not available for bad faith denial of the existence of, or denial of liability under, a contract. *Freeman & Mills* established "a general rule precluding tort recovery for noninsurance contract breach, at least in the absence of violation of 'an independent duty arising from principles of tort law' [citation] other than the bad faith denial of the existence of, or liability under, the breached contract." (*Freeman & Mills, Inc. v. Belcher Oil Co., supra,* 11 Cal.4th at p. 102.) More recently, the Supreme Court reiterated that it has "cautioned courts to exercise great care in considering whether to extend 'the exceptional approach taken in [the insurance cases]' to 'another contract setting.'" (*Cates Construction, Inc. v. Talbot Partners* (1999) 21 Cal.4th 28, 46.)

Thus, the cases from *Foley* through *Freeman & Mills* and to the present indicate an unmistakable insistence that judicial creation of the bad faith tort not stray beyond the "insurance cases." Nevertheless, in *Freeman & Mills*, the court emphasized that "nothing in this opinion should be read as affecting the existing precedent governing enforcement of the implied covenant in insurance cases." (*Freeman & Mills, Inc. v. Belcher Oil Co., supra,* 11 Cal.4th at p. 103.)

We turn now to the question of what is meant by the "insurance cases." Does this refer to every aspect of an insurance contract, to the limited issues of bad faith payment of claims and unreasonable failure to settle, or to some range of issues between those two poles?

In the recent case of *State Comp. Ins. Fund v. Superior Court* (2001) 24 Cal.4th 930, the Supreme Court considered a complaint in which the insured alleged facts quite analogous to those before us. The complaint alleged the insurer had misstated financial information received from the insured in order to cause the rating bureau to classify the insured at a higher risk level, thereby producing higher premiums for the insurer. (*Id*. at p. 937.) After the trial court refused to grant the insurer's motion for judgment on the pleadings based on an issue of statutory immunity, the Supreme Court considered the matter on a petition for review from the appellate court's denial of a writ of mandate. (*Id*. at p. 932.)

In considering the issue of immunity, the court discussed in detail *Security Officers Service, Inc. v. State Compensation Ins. Fund* (1993) 17 Cal.App.4th 887, and many of the other workers' compensation cases upon which the Joneses have relied in the present appeal. In those cases, the insured typically alleges the insurer handled claims in bad faith in order to assess higher insurance premiums against the insured. (We discuss these cases in some detail at a later point in this opinion.) Although approving the rule of law established by those cases, and even though concluding State Compensation Insurance Fund was not immune from suit, the court stated: "We

emphasize that in reaching this result we are not asked to and do not reach any conclusion as to whether Schaefer [the insured employer] has stated a valid cause of action against SCIF. We merely determine whether a civil suit based on Schaefer's allegations is precluded by [the statutory] immunity." (*State Comp. Ins. Fund v. Superior Court*, *supra*, 24 Cal.4th at p. 944.)

As noted above, the facts of *State Comp. Ins. Fund v. Superior Court*, *supra*, 24 Cal.4th 930, are analytically very similar to those of the present case. And, as noted, the Supreme Court discussed with approval the line of workers' compensation bad-faith cases upon which Cal-Eagle relies in the present case. From these two facts, Cal-Eagle concludes "there is no analytically logical distinction" between those workers' compensation bad-faith cases and cases such as the present one and *State Comp. Ins. Fund v. Superior Court*, *supra*, 24 Cal.4th 930. Were this so, there would have been no reason for the Supreme Court to "emphasize" that it was not deciding whether the complaint in *State Comp. Ins. Fund v. Superior Court*, *supra*, 24 Cal.4th 930, stated a cause of action. Reserving an issue, clearly, is not deciding an issue; nevertheless, reserving an issue in these circumstances is a recognition that, however the issue is ultimately decided, the workers' compensation bad-faith cases are sufficiently different that the facts before the Supreme Court required a separate analysis of the cause-of-action issue.

In *State Comp. Ins. Fund v. Superior Court*, *supra*, 24 Cal.4th 930, the Supreme Court was not required to decide the open question whether the tort of insurance bad faith should be extended beyond the claims and settlement area. In the present case, we are asked to and are required to determine whether to do so. We turn to that task.

We are satisfied the "insurance cases" exception preserved in *Freeman & Mills* does not extend to *every* breach of an insurance contract. As noted above, the covenant of good faith and fair dealing is reciprocal, binding both the insurer and the insured. (*Commercial Union Assurance Companies v. Safeway Stores, Inc.*, *supra*, 26 Cal.3d at

p. 918.) Nevertheless, an *insured* is not guilty of the tort of bad faith when the insured breaches the covenant; in those circumstances the insurer is limited to contract remedies. (*Kransco v. American Empire Surplus Lines Ins. Co., supra,* 23 Cal.4th at pp. 404-405.) Accordingly, we may reject any interpretation of the preserved "insurance cases" exception in *Freeman & Mills* that would permit a tort action for *every* bad faith breach of an insurance contract.

In addition, however, the logic and language of *Foley* and other Supreme Court cases persuades us that not every instance of bad faith conduct by an insurer gives rise to a tort cause of action. In particular, we perceive that the general administration of an insurance policy "is not sufficiently similar" to the duties involved in investigating, defending, and settling claims to justify imposition of tort liability on an insurer who acts in bad faith. (See *Foley v. Interactive Data Corp., supra,* 47 Cal.3d at p. 693.) Rather, in the performance of such contract administration duties, the obligations of the insurer are much closer to the normal contract duties of the insured -- present in many policies -- to pay premiums, provide information to the insurer, and maintain adequate records to facilitate administration of the contract. (See *Kransco v. American Empire Surplus Lines Ins. Co., supra,* 23 Cal.4th at pp. 404-405.)

The Supreme Court has taken care to qualify the particular nature of the relationship between an insurer and its insured that justifies imposition of tort liability: "We explained in *Gruenberg v. Aetna Ins. Co.* (1973) 9 Cal.3d 566[, 575] …, that '[t]he duty [to comport with the implied covenant of good faith and fair dealing] is immanent in the contract whether the company is attending [on the insured's behalf] to the claims of third persons against the insured or the claims of the insured itself. Accordingly, when the insurer unreasonably and in bad faith withholds payment of the claim of its insured it is subject to liability in tort.'" (*Foley v. Interactive Data Corp., supra,* 47 Cal.3d at p. 684, brackets in original.)

When an insurer is called upon to act as an insurer -- that is, to defend, settle, or pay a claim -- three aspects of its relationship with its insured are most distinctive. First, the insurer has virtually sole control of the proceedings, including the decision to settle third-party claims (see *Crisci v. Security Ins. Co.* (1967) 66 Cal.2d 425, 430-431) and the decisions to investigate and pay claims by its own insured (see *Egan v. Mutual of Omaha Ins. Co.* (1979) *supra,* 24 Cal.3d at 809, 816-817, 819). Second, the insured is subject to financial pressures that the insurance was intended to mitigate. (See *McLaughlin v. National Union Fire Ins. Co.* (1994) 23 Cal.App.4th 1132, 1158.) Third, the insured must initiate action against the insurer in order to obtain the benefits of the insurance policy. The insurer may simply refuse action unless the insured has the financial resources and the perseverance to force the insurer's hand; the insured cannot just go out into the marketplace and purchase replacement coverage for a loss that has already occurred. (See *Foley v. Interactive Data Corp., supra,* 47 Cal.3d at p. 692.)

None of these factors is present in the case of a premium dispute such as the one in the present case. In this case the insured can do nothing and make the insurer prove its entitlement to additional premiums in litigation initiated by the insurer (see *Old Republic Ins. Co. v. FSR Brokerage, Inc.* (2000) 80 Cal.App.4th 666, 688) or, in the alternative, the insured can present its records in comprehensible form to the insurer and the Insurance Commissioner for resolution of the dispute. The insured cannot be pressured by the loss of coverage, since the policy term has expired already. While the insured is under the financial pressure shared by any potential litigant with an inchoate claim on the horizon, the insured has not suffered the "calamity" of property or income loss or of a third-party trying to collect a large judgment against it. (See *ibid.*; see also *Crisci v. Security Ins. Co., supra,* 66 Cal.2d at p. 428-429.) Further, as to the disputed premium, the insured has a fast and affordable administrative remedy before an agency that has both formal and informal control over the insurer.

We do not question that an insurer's abuse of its rights to audit the financial records of its insured and to collect an additional premium under an approved rate structure may constitute a breach of the covenant of good faith and fair dealing. Such a breach, however, is fully remediable in a contract action with damages measured according to traditional contract principles.

Nor does protection of the public support allowing tort damages in this type of insurance case. Normally, the motivation of a party in breaching a contract is immaterial; the law of contract normally awards "those damages within the contemplation of the parties at the time [the contract is made] or at least reasonably foreseeable by them at that time." (*Cates Construction, Inc. v. Talbot Partners* (1999) 21 Cal.4th 28, 61; see Civ. Code, § 3300.) By contrast, it would be highly relevant in an administrative proceeding before the Insurance Commissioner that the commissioner's chosen provider for commercial assigned-risk insurance was engaging in predatory practices. (See Cal. Code Regs., tit. 10, § 2694.) Given the availability of effective administrative oversight as a means of implementing the public policy favoring good faith and fair dealing in assessing insurance premiums, there is no compelling need to extend the bad faith tort beyond the area of breach of the duties to defend, settle, and pay claims, and into the area of ordinary premium disputes. (See *Foley v. Interactive Data Corp., supra,* 47 Cal.3d at p. 693.)

The Joneses assert that policyholders do not enter into insurance contacts "seeking to gain a commercial advantage but rather are only seeking protection against calamity," citing *Egan v. Mutual of Omaha Ins. Co., supra,* 24 Cal.3d at page 819, and *Cates Construction, Inc. v. Talbot Partners, supra,* 21 Cal.4th at page 44. From this premise, they conclude that "California courts have long recognized that tort actions against insurers for breach of the covenant of good faith and fair dealing are not limited to those based on policy provisions promising payment of a claim, but instead may be predicated on violation of other policy provisions as well."

Although there certainly is language in earlier cases that supports the Joneses' contention, we do not believe that language withstands scrutiny in the light of the more recent Supreme Court cases. These more recent cases include, for example, *Cates Construction, Inc. v. Talbot Partners, supra,* 21 Cal.4th at page 44, where the court recites the distinctions drawn in the cases between "insurance contracts" generally and "most other contracts for goods or services." Then the court adds: "In addition, we have observed that the tort duty of a liability insurer ordinarily is based on its assumption of the insured's defense and of settlement negotiations of third party claims.… *The assumption of those responsibilities* obligates the insurer to give at least as much consideration to the welfare of its insured as it gives to its own interests so as not to deprive the insured of the benefits of the insurance policy." (*Ibid*., italics added.) This focus on the duties to defend and settle does not support a broad application of tort law to all bad faith breaches of an "insurance contract."

We have reviewed carefully the cases upon which the Joneses rely for a broad application of the tort of bad faith. Those cases largely fall into two categories. In the first group, cases employ language that was a part of the initial tide of enthusiasm for a universal tort of bad faith, the very tide *Foley* and its progeny sought to turn. The second group involves the unique field of workers' compensation insurance, where concepts of "experience factor" and "reserve rating" cause the insurers' bad-faith claims settlement practices to result in higher premiums; that is, the higher premiums are a collateral -- albeit, intended -- result of the underlying bad faith in handling claims.

*A. The "Universal" Bad Faith Tort Cases.*

The Joneses rely on *Spindle v. Travelers Ins. Companies* (1977) 66 Cal.App.3d 951. In that case, a medical malpractice insurer had a master contract with a regional association of physicians. According to the allegations of the complaint, the insurer wanted to raise rates for individual doctors by an amount that exceeded the increases permitted by the master contract. When the medical society resisted, the insurer

canceled the plaintiff's insurance in order to coerce and intimidate the medical society into permitting the rate increases. (*Id*. at pp. 954-955.)

In the course of concluding that this complaint stated a tort cause of action for bad faith, the *Spindle* court made the statements upon which the Joneses rely: "'There is an implied covenant of good faith and fair dealing in *every contract* … . This principle is applicable to policies of insurance' [Citation omitted; emphasis added by the *Spindle* court.] … [¶] We are unable to discern any logical basis for distinguishing between an insurer's conduct in settling a claim made pursuant to the policy and that involved in an insurer's cancelling a policy if bad faith conduct is the basis for the cancellation. … No plausible reason exists why cancellation provisions of a contract should be treated differently from other contractual provisions insofar as application of the implied covenant of good faith and fair dealing is concerned." (*Spindle v. Travelers Ins. Companies, supra,* 66 Cal.App.3d at p. 958.)

The problem with this analysis from *Spindle* is the same problem identified and criticized in *Foley*: While the court correctly concluded the insurer's conduct was a breach of the covenant of good faith and fair dealing, the *Spindle* court "did not, however, focus on the fact that traditionally such a finding justified only contract damages." (*Foley v. Interactive Data Corp., supra,* 47 Cal.3d at p. 689, discussing *Khanna v. Microdata Corp.* (1985) 170 Cal.App.3d 250.)

The logic of *Spindle* proceeds from the facts that an insurance contract is just like any other contract and that *all* contracts include an implied covenant of good faith and fair dealing. (See *Spindle v. Travelers Ins. Companies, supra,* 66 Cal.App.3d at p. 958.) Accordingly, *Spindle* concludes, every provision of an insurance contract should be subject to enforcement through the bad faith tort, just as is every provision of every contract, consistent with "the evolvement of the doctrine of the implied covenant of good faith and fair dealing [which] *is* an expression of *public policy* in our state." (*Id*. at p. 959, italics in original.)

The problem is, of course, that what may have seemed like an evolving, generalized bad faith tort in 1977 can no longer be viewed in that manner after *Foley* and its progeny.

The Joneses also rely on *Johnson v. Mutual Ben. Life Ins. Co.* (9th Cir. 1988) 847 F.2d 600 for the proposition that "incorrect billing statements and termination notices, sent over a two-year period, arguably deprive[]" an insured of the bargained-for "peace of mind" that is one of the benefits an insured seeks by obtaining insurance. (See *id*. at p. 603.) Once again, however, the Ninth Circuit's *Johnson* opinion preceded the California Supreme Court's decision in *Foley*, and *Johnson* fails to anticipate the restrictive interpretation of the bad faith tort espoused in *Foley* and the subsequent cases.

We agree with *Johnson* and the Joneses to this extent: in one sense, the "peace of mind" afforded by an insurance policy uniquely supports the availability of tort damages in the insurance context. That uniqueness arises, however, precisely from the claims-resolution functions of an insurance policy. An insured derives peace of mind from knowing that when accident, disability, or death (or whatever other risk is insured) occurs, and it is otherwise too late to protect himself or herself against the financial burden of the calamity, the insurance will mitigate the degree of harm.

In many other ways, however, the peace of mind involved in buying insurance is the kind common to consumer and commercial transactions of every sort. The householder gains peace of mind from the "contract" for the purchase of groceries to stock the family pantry; the business owner gains peace of mind from a distribution contract with a supplier or manufacturer of goods, who in turn gains peace of mind from the contract that assures a ready outlet for its product; an insured gains peace of mind knowing he or she has gotten the best possible "deal" on insurance or that he or she has been able to obtain the necessary insurance required to engage in a regulated business, such as trucking.

In all of these common instances the desire for peace of mind is a primary motivation for the contracting parties to enter the marketplace in the first instance. A focus on the broad concept of peace of mind as a benefit of any particular contract does not provide an analytical basis on which to impose tort liability for the bad faith deprivation of that benefit.

Instead, as *Foley* requires, the analysis must be based upon an evaluation of the manner in which the proposed application of the bad faith tort is supported by the reasons particular to the application of the bad faith tort in the areas of insurance claims, settlement, and duty to defend. (See *Foley v. Interactive Data Corp.*, *supra,* 47 Cal.3d at pp. 690, 693; see also *New Plumbing Contractors, Inc. v. Nationwide Ins. Co.* (1992) 7 Cal.App.4th 1088, 1096-1097 [contrasting "marketplace aspect" of the insurance relationship with the "fiduciary-type relationship which pertains only to the receipt of benefits under the insurance policy"].)

In sum, we conclude the pre-*Foley* cases do not provide a sufficient analysis to make them useful as precedent in the present circumstances. At most, the cases stand for the proposition that the present facts may have constituted a cause of action in an earlier era.

The Joneses rely on one post-*Foley* case, *Helfand v. National Union Fire Ins. Co.* (1992) 10 Cal.App.4th 869, 903, for the broad proposition that the insurer can be liable in tort for bad faith concerning any clause in an insurance contract. That case, however, was on appeal from a trial court's order, in effect, requiring specific performance of an insurance policy, the third year of which the insurer sought to cancel in bad faith. (*Id*. at

pp. 906-907.) Because it involved only a contract remedy, statements in *Helfand* concerning tort remedies are dictum.[3]

Further -- and of even greater importance -- the purpose of the cancellation of the directors' and officers' liability policy in *Helfand* was to avoid payment of claims that were certain to arise after the company filed for bankruptcy protection. (*Helfand v. National Union Fire Ins. Co., supra,* 10 Cal.App.4th at p. 904.) Claims which were "reasonably foreseeable at the policy's inception" had become "imminent and unavoidable on the part of the prepaid insured at the time of cancellation." (*Id*. at p. 906.) Accordingly, the bad faith actions of the insurer in *Helfand* involved the core duties to defend and settle claims arising under the policy; cancellation of the policy was simply the means by which the insurer sought to accomplish its repudiation of those duties. (See also *McLaughlin v. National Union Fire Ins. Co., supra*, 23 Cal.App.4th at p. 1157.)

*B. The Workers' Compensation Cases*

In their reliance on workers' compensation cases for the principle that bad faith assessment of premiums constitutes tortious bad faith, the Joneses confuse the breach of the duty of good faith and fair dealing with the damages resulting from that breach. The

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**3** Similarly, the post-*Foley* case of *Williams v. State Farm Fire & Casualty Co.* (1990) 216 Cal.App.3d 1540, 1544, footnote 4, does not address whether tort or contract damages would be appropriate for bad faith cancellation of a policy during an initial 60-day cancellation period reserved to the insurer in the policy. The court merely notes that "the insurer's right to cancel is also limited by the covenant of good faith and fair dealing implied in every insurance contract." (*Ibid*.) As we have stated repeatedly in this opinion, we do not question in any way the applicability of the covenant to each and every aspect of a party's conduct in discharging its duties under a contract; the issue before us is whether a *tort* cause of action arises from breach of the covenant in particular circumstances. The brief statement in *Williams* does not address the issue before us.

matter is summarized clearly in one of the cases the Joneses cite, *Security Officers Service, Inc. v. State Compensation Ins. Fund, supra,* 17 Cal.App.4th 887. "Does the implied covenant of good faith and fair dealing require a workers' compensation insurer *to defend and resolve claims* with due regard to the impact of outstanding claims and reserves on the premiums the insured will be assessed and on policy dividends it may receive?" (*Id*. at pp. 898-890, italics added.) The case authorities "clearly instruct that the implied covenant of good faith and fair dealing imposes limits on the insurer's latitude in discharging its contractual *right or duty to defend, investigate and settle claims*. … The question presented here is whether such standards, imposed by the implied covenant, govern not only the insurer's freedom to accept or reject settlement offers, but also its discretion in leaving claims unresolved and outstanding, and in fixing monetary reserves to account for the future resolution." (*Id*. at p. 895, italics added.)

In other words, in workers' compensation insurance, the premium is directly tied to the insured's claims experience, and that claims experience is controlled in significant part by the insurer's exercise of discretion in settling claims (or not). Thus, in the workers' compensation setting the insurer's bad-faith motivation in handling claims is alleged to be the establishment of a basis for charging higher premiums (*Security Officers Service, Inc. v. State Compensation Ins. Fund, supra,* 17 Cal.App.4th at p. 893); in the traditional insurance setting, the insurer's motivation for a bad faith claims-handling policy is to save money. Nevertheless, in both instances, the operative exercise of discretion by the insurer is in the narrow area of settling claims and defending its insured.

Typical of the cited cases is the introductory paragraph from *Tricor California, Inc. v. State Compensation Ins. Fund* (1994) 30 Cal.App.4th 230, 233: "Tricor alleged SCIF engaged in bad faith claims handling resulting in Tricor's paying unjustified higher premiums and wrongly being denied dividends. … We hold that Tricor properly

could present evidence of negligent claims handling as evidence of bad faith and breach of contract by SCIF …."

As we have seen, these are precisely the areas in which policy considerations articulated by the Supreme Court (see *Foley v. Interactive Data Corp., supra,* 47 Cal.3d at p. 684) have countenanced the "exceptional approach" taken in the traditional insurance bad faith situation. (*Id*. at p. 690; see *Kransco v. American Empire Surplus Lines Ins. Co., supra,* 23 Cal.4th at pp. 404-405.) We conclude the workers' compensation cases cited by the Joneses, most of which involve minor variations on the type of claim made in *Security Officers Service, Inc. v. State Compensation Ins. Fund, supra,* 17 Cal.App.4th 887, do not support the establishment of a tort of bad faith when the only dispute between the parties involves assessment of premiums, without the involvement of the insurer's underlying duty to pay, settle, and defend the insured against claims. [4]

Consistent with the Supreme Court's admonition to exercise great caution in extending the bad faith tort beyond the traditional setting of defending and settling claims under an insurance contract, we conclude that there are no reasons of policy or precedent that support introduction of a tort remedy for an insurer's bad faith actions in non-claims administration of a liability insurance policy.

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[4] Two of the cases cited by the Joneses involve only the issue of State Compensation Insurance Fund's claim of immunity from suit. (See *Maxon Industries, Inc. v. State Compensation Ins. Fund* (1993) 16 Cal.App.4th 1387; *Courtesy Ambulance Service v. Superior Court* (1992) 8 Cal.App.4th 1504.) The other cases cited by the Joneses all involve claims handling and loss reserve practices of the insurer, as those practices affect the insured's premiums. (See *MacGregor Yacht Corp. v. State Comp. Ins. Fund* (1998) 63 Cal.App.4th 448; *Lance Camper Manufacturing Corp. v. Republic Indemnity Co.* (1996) 44 Cal.App.4th 194; *Tricor California, Inc. v. State Compensation Ins. Fund, supra,* 30 Cal.App.4th 230; *Mission Ins. Group, Inc. v. Merco Construction Engineers, Inc.* (1983) 147 Cal.App.3d 1059.)

## II.*

## The Joneses Must Exhaust Their Administrative Remedies.

We hold above that the facts of this case do not give rise to a tort action for bad faith breach of the insurance contract. There remain, however, contract causes of action asserted by Cal-Eagle on its premium claims and by the Joneses on their *contract* bad faith claims. We now turn to the issues of whether, and to what extent, these contract-based claims are subject to the doctrine of exhaustion of administrative remedies.

*A. Cal-Eagle's Cause of Action for Additional Premiums.*

There is no claim in this case that the Insurance Commissioner has an administrative procedure insurers may invoke to collect premiums due under an insurance contract. To the extent such premiums are authorized under commissioner-approved rate structures, collection of those premiums is a matter for the courts.

By way of defense, however, the Joneses effectively alleged that the premiums were not authorized by the approved rate structures. When a party to a civil action asserts a defense that is otherwise within the exclusive jurisdiction of an administrative agency, the trial court is required to stay judicial proceedings and refer the administrative issues to the appropriate agency. (*Styne v. Stevens* (2001) 26 Cal.4th 42, 58-59.) We will discuss below our conclusion that the defensive issues the Joneses sought to raise were within the exclusive jurisdiction of the Insurance Commissioner.

*B. The Joneses' Cross-Complaint.*

The Joneses' cross-complaint, to the extent it states a contract cause of action for breach of the duty of good faith and fair dealing against Cal-Eagle, alleges in net effect that Cal-Eagle discharged its duties as a servicing carrier in a manner that did and was intended to cause harm to the Joneses.

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* See footnote on page 1, *ante*.

The revised second amended cross-complaint alleges Cal-Eagle breached the covenant of good faith and fair dealing "by among other things:

> "a. Conducting so-called premium 'audits' which [were] not authorized under the terms of the policy or under the law;
>
> "b. Conducting so-called premium 'audits' in bad faith;
>
> "c. Asserting that the JONESES owe CAL-EAGLE additional sums by way of premium, even though the policy does not require the payment of any additional premium and even though CAL-EAGLE did not incur any additional risk;
>
> "d. Misrepresenting the terms and conditions of the policy and their effect;
>
> "e. Acting contrary to the terms of the policy by attempting to adjust the premium after the policy expired;
>
> "f. Failing to respond adequately or fully to inquiries made on behalf of cross-complainants;
>
> "g. Taking the position that additional sums are due and assigning the matter to a collection agency for handling;
>
> "h. Not giving the JONESES the benefit of revised rule 23 effective immediately and retroactive to October, 1990, thereby causing a $111,523 bill to be sent to the JONESES on September 16, 1992 and a $115,689 bill to be sent to the JONESES in December of 1992, contrary to the terms of the policy, the directives of the Department of Insurance and the California Auotmobile Assigned Risk Plan, and the terms of CAL-EAGLE's Servicing Carrier Agreement with the Department of Insurance;
>
> "i. Not determining premiums based on 'actual exposures' with respect to the JONESES sub-hauling operations as to which the actual exposure was on an excess basis in view of the existence of primary insurance covering the sub-haulers;
>
> "j. Adding vehicles to the policy that were found on the JONESES' premises during an audit even though CAL-EAGLE knew that the vehicles were not owned by the JONESES;

"k. Making false statements to Gary Richards of JOHNSEY regarding the justification for adding vehicles to the policy;

"l. Refusing to implement even the primary rate under the revised rule 23 and instead requiring an audit and then instructing its auditors to look for other ways to increase premiums;

"m. Determining the JONESES' 'actual exposure' for cost of hire on the first audit to be $369,482 while on the second audit, based on the exact same records as the first audit, determining the JONESES' cost of hire exposure to be $726,689, and in so doing employing an artificial $5,000 per month minimum contrary to the Department of Insurance directives and the terms of the policy;

"n. Finding on the second audit that the JONESES' Sub-Haul Agreements were not in compliance with PUC requirements and that the JONESES did not have copies of the sub-hauler's Public Utilities Commission certificates or copies of the policies, all of which were contrary to specific findings made based on the very same records during the first audit;

"o. Falsely finding during the second audit that the JONESES' Sub-Haul Agreements did not require that FRED JONES TRUCKING, INC. be named as an additional insured under the sub-haulers' policies when a simple reading of any one of the Agreements would show exactly to the contrary;

"p. Asserting that the JONESES did not have Certificates of Insurance for 10 of the 44 sub-haulers although the Certificates had been sent to CAL-EAGLE two months earlier;

"q. Inventing criteria requiring actual Certificates of Insurance although Revised Rule 23 only required that the Sub-Haul Agreements require Certificates of Insurance, not that the insured provide the Certificates themselves;

"r. Asserting that the insured's sub-haul register was not in compliance with the PUC without any investigation with the PUC and even though the PUC, upon conducting their inspections, never had any problems with the JONESES' records;

"s. Refusing to accept the JONESES' offer to recreate their records contrary to CAL-EAGLE's own policy and practice of accepting

later acquired information and contrary to the directive from the Assigned Risk Plan to accept such later provided information;

"t. Sending the JONESES a bill for $96,972 on April 6, 1993, even after CAL-EAGLE had sent bills of $51,294 twice during the two preceding weeks, thus leaving the JONESES uncertain, when they were contacted by plaintiff JONATHAN NEIL & ASSOCIATES herein, demanding $51,294, what the ultimate amount would be that CAL-EAGLE would claim;

"u. Filing the present action after having Insurance Code § 11580.9 and applicable case law pointed out and ignoring the same, and falsely proclaiming its right and duty to charge the amounts claimed;

"v. Failing to provide the insured with notice of the alleged right of appeal, contrary to CAL-EAGLE's own policy and practice and contrary to the covenant of good faith and fair dealing;

"w. Causing this suit to be maintained following decisions from the Department of Insurance in other cases directly contrary to the position taken in the present case."

We must determine whether the Joneses were required to raise and pursue these claims in available administrative proceedings.

*C. The Administrative Appeal Process.*

In order to provide automobile liability insurance to those "who are in good faith entitled to but are unable to procure such insurance through ordinary methods," the Legislature has directed the Insurance Commissioner to "approve or issue" an assigned risk insurance plan. (Ins. Code, § 11620, subd. (a).) As described in some detail above, the plan is to be administered through an advisory committee and by a manager hired by the committee. The Legislature has prescribed that the plan shall contain, among other provisions, procedures "for appeal to the commissioner by persons who believe themselves aggrieved by operation of the plan." (Ins. Code, § 11624, subd. (b); see also Ins. Code, §§ 12921.1-12921.4 [requiring Insurance Commissioner to establish procedure for administrative complaints of insurer wrongdoing].)

The Insurance Commissioner has adopted regulations establishing an appeal procedure for the assigned risk plan. Section 2495 of title 10, California Code of Regulations, provides: "Any applicant, insured or insurer under the plan who is affected by any act, ruling, decision or order of an insurer, the manager or the committee, and believes such act, ruling, decision or order to be in conflict with or not authorized by the provisions of the plan or by the law," may appeal to the advisory committee.

"The committee shall review all evidence and consider all statements, arguments, and contentions at a hearing upon not less than five days' notice to the parties to the matter, and within 10 days thereafter shall notify such parties of its decision which shall be binding upon all parties subject to appeal to the commissioner. [¶] If any party … is dissatisfied with the decision of the committee upon such appeal, he may appeal to the commissioner who shall hear the parties, review the matter and render a decision which shall be binding upon all parties." (Cal. Code Regs., tit. 10, § 2495.)

The regulation also contains a mechanism to replace with a neutral representative any member of the advisory committee who is employed by an insurer whose actions are the subject of the appeal. (Cal. Code Regs., tit. 10, § 2495.)

*D. Exhaustion.*

The requirement for exhaustion of administrative remedies, where applicable, is jurisdictional: the trial court has no jurisdiction over the claim until "'the administrative process has run its course.'" (*Farmers Ins. Exchange v. Superior Court* (1992) 2 Cal.4th 377, 390, quoting from *United States v. Western Pac. R. Co.* (1956) 352 U.S. 59, 63.) "Jurisdictional" is here used in the broad sense, not the fundamental sense, thus implying that trial courts' actions in disregard of the requirement of exhaustion of administrative remedies may be addressed through the writ of prohibition. (*Abelleira v. District Court of Appeal* (1941) 17 Cal.2d 280, 293.)

The exhaustion requirement is generally applicable in three instances. First, "[t]he rule is that where a right is given and a remedy provided by statute, the remedy so provided must ordinarily be pursued." (*Rojo v. Kliger* (1990) 52 Cal.3d 65, 83.) Second, where the Legislature has, by adoption of a pervasive and self-contained system of administrative procedure, indicated an intent that a matter be handled exclusively by the administrative agency, exhaustion of the prescribed administrative procedure will be required. (*Id*. at pp. 87-88.) Finally, when a matter involves resolution of complex or technical issues particularly requiring the expertise of the administrative agency, exhaustion of available administrative remedies will be required. (*Ibid*.; see *Styne v. Stevens, supra,* 26 Cal.4th at p. 58; *Farmers Ins. Exchange v. Superior Court, supra*, 2 Cal.4th at p. 396.)

The present case, we believe, falls within the third category. This court summarized the relevant considerations in *McKee v. Bell-Carter Olive Co.* (1986) 186 Cal.App.3d 1230, 1244-1245: "[I]t is necessary to keep in mind the underlying policies which are advanced by the exhaustion of administrative remedies doctrine. In *Kane v. Redevelopment Agency* [(1986)] 179 Cal.App.3d 899, the court noted: '... "[T]he major factors that affect an exhaustion decision may be easily identified. Pulling away from requirement of exhaustion are combinations of such factors as irreparable injury to a party from pursuing the administrative remedy, clear absence of agency jurisdiction, clear illegality of the agency's position, a dispositive question of law peculiarly within judicial competence, the futility of exhaustion, and expense and awkwardness of the administrative proceeding as compared with inexpensive and efficient judicial disposition of the controversy. [¶] Pulling toward requirement of exhaustion are combinations of such factors as need for factual development, importance of reflecting agency's expertise or policy preferences in the final result, probability that the agency will satisfactorily resolve the controversy without judicial review, protection of agency processes from impairment by avoidable interruption, conservation of judicial energy by

avoiding piecemeal or interlocutory review, and providing the agency opportunity to correct its own errors." [Citation.]' [Citation.] Virtually all of these factors reflect recognition that many agencies have developed special expertise within that area the agency has been created to serve. When this is so, and when a comprehensive procedural framework exists satisfying the requirements of due process and is available to resolve controversies arising in that area, the efficacy of an administrative proceeding, gauged by a weighing of these factors, is obvious." (The *McKee* court found exhaustion was not required.)

The Legislature has delegated to the Insurance Commissioner the sole authority to adopt, implement, and regulate CAIP. In establishing and administering CAIP, the Insurance Commissioner necessarily has made policy choices -- in particular, as concerns the present case, in the areas of the reasonable premium for coverage of derivative liability under the PUC endorsement and the records reasonably necessary to establish the right to a lower-tier premium for such coverage. The Insurance Commissioner has employed the expertise of his staff in establishing a detailed rating process for truckers and for ensuring the integrity of the administration of the program through detailed reporting by and review of the actions of CAARP and the servicing carriers. (See Cal. Code Regs., tit. 10, §§ 2492-2494.5, 2496.) To the extent the carriers err in the application of the Insurance Commissioner's rules and policies, the commissioner is fully empowered under the terms of the commercial assigned risk plan to cause the carriers to remedy their errors. Consistent application of the plan rules and policies is of great importance and can be achieved only through a requirement that aggrieved parties first take their grievances to the Insurance Commissioner through the established procedures. All of these considerations militate in favor of requiring exhaustion in this case.

In retrospect, it might have been preferable if this court had addressed the petition for writ of mandate in this case on the merits. The lengthy trial might well have

been avoided. Still, the trial that did occur unmistakably demonstrates why administrative exhaustion is necessary.

First, several present and former employees of the DOI were called as witnesses for the parties. They testified about interpretation of the CAIP manual by prior carriers and explained the policy considerations involved in amendments to and application of the manual. The net effect of this testimony was that individual employees informally exercised the discretion of the Insurance Commissioner by stating to the trial court their own views of department policy, intent, procedure, and practice. In one critical example, an attorney with DOI testified that the consumer services division of DOI had interpreted old rule 23 to not apply to subhaulers if they had their own insurance, but that "the legal division and as far as I know the [C]ommissioner[']s office never really interpreted old Rule 23."[5]

Second, in order to try the case in a comprehensible manner, the parties stipulated the court would conduct a "phase I" trial, in which the parties, in essence, educated the trial court about the policies and practices of the Insurance Commissioner in administering CAIP, and then invited the court to provide its interpretation of the insurance application, the standard CAIP insurance policy, the CAIP manual and rules contained therein, and the California Code of Regulations pertaining to CAIP. While the interpretation of written documents is a judicial function unless they are of a "complex or technical nature beyond the usual competence of the judicial system" (*Rojo*

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[5] The attorney also testified that the "servicing carriers felt that if they were going to be applying [old rule 23] in a manner that they felt, uh, was not the manner that they read the rule to, the have been written that they needed direction from the department to do that." With respect to the servicing carriers' interpretation of old rule 23 before the consumer services division began issuing advisory letters in individual cases in late 1990, the attorney testified that she did not view the carriers' interpretation as "outlandish" or "an unreasonable interpretation."

*v. Kliger, supra,* 52 Cal.3d at p. 88), the issue in the present case was how all of those various items should be interpreted to create a viable commercial assigned risk program for truckers. That determination required the expertise and discretion of the Insurance Commissioner and his staff, exercised in a formal manner capable of uniform application throughout CAIP.

As part of the phase I trial, the parties jointly submitted nine issues for the trial court to resolve. While the statement of these issues is not entirely self-explanatory, a listing of the issues will shed light on the scope of the trial court's exercise of what, in our view, should be the exclusive initial jurisdiction of the Insurance Commissioner. The statement of these issues in the pretrial order is as follows:

> "1. The following legal issues shall be tried to the court prior to the impanelment of the jury:
>
> "(a) Whether Cal-Eagle was entitled to change the policy premium after the policy period.
>
> "(b) Whether Cal-Eagle had the right under the Joneses' policy to conduct premium audits after the policy period.
>
> "(c) Whether any change in premium could be made based on reasons other than the five enumerated reasons set forth in the Cal-Eagle policy.
>
> "(d) Whether Cal-Eagle was entitled to charge a premium based on factors other than 'actual exposure.'
>
> "(e) Whether any change in premium on or after September 16, 1992 had to be based on the rules in effect at the time of the change.
>
> "(f) Whether Cal Auto Assigned Risk Plan ('CAARP') Rule 23 and Revised Rule 23 governed premium rate calculation for hired carrier coverage.

> "(g) Whether there is a conflict between the policy and CAARP Rules, and if so, whether Cal-Eagle was required to follow the policy or CAARP Rules.
>
> "(h) Whether communications from the Department of Insurance regarding complaints of individual insureds constituted 'written bulletins, directives, and interpretations thereof issued by the commissioner or the plan' within the meaning of Cal-Eagle Servicing Agreement with CAARP.
>
> "(i) Whether Insurance Code section 11580.9 applies to this action."

Resolution of these issues involves core functions of administrative discretion and expertise specifically assigned to the Insurance Commissioner by the Legislature when it authorized the assigned risk program and directed the Insurance Commissioner to establish CAIP. Determination of these issues on a case-by-case basis by courts, in the first instance, will undermine the ability of the Insurance Commissioner to administer CAIP on a uniform basis state-wide.

The trial court relied and the Joneses on appeal rely on *Hightower v. Farmers Ins. Exchange* (1995) 38 Cal.App.4th 853 for the proposition that exhaustion was not required in the present case because the present case is merely a dispute between the insured and the insurer and does not involve any matter regulated under CAIP. As the trial court stated the matter: "[J]urisdiction over the setting of [assigned risk] rates is not equivalent to jurisdiction over a dispute concerning the adjusting of the premium after the policy has expired."

*Hightower* was a bad faith claim filed by an insured against her insurer after the insurer unreasonably failed to settle an uninsured motorist claim in a timely manner. (*Hightower v. Farmers Insurance Exchange, supra,* 38 Cal.App.4th at p. 857.) The only connection to CAARP whatsoever was that the insurance policy had been issued by the insurer pursuant to the assigned risk program. Apart from the general CAARP requirement that assigned risk claims be treated just like the claims of voluntary

customers (see Cal. Code Regs., tit. 10, § 2431.3, subd. (c)(2)), nothing in the CAARP program regulated the insurer's handling of the uninsured motorist claim. The *Hightower* court stated -- correctly, in our view -- that the "administrative remedy found in the CAARP regulations extends solely to matters regulated by the CAARP, not to all disputes involving persons who happen to be insured under the CAARP. … Clearly, the CAARP committee has jurisdiction over matters such as the issuance of an assigned risk policy, the setting of rates for the purchase of such policies, and the manner in which risks are assigned to insurers." (38 Cal.App.4th at p. 860.)

Equally clearly, the dispute in the present case concerns actions taken by a CAIP servicing carrier in a complex and evolving area directly under the supervision of the Insurance Commissioner. Requiring exhaustion of administrative remedies in the present case is entirely consistent with the views expressed in *Hightower v. Farmers Insurance Exchange, supra,* 38 Cal.App.4th 853.

In summary, we conclude that review of the servicing carrier's actions in auditing, determining supplemental premiums, and charging those premiums against its insured must rest, in the first instance, within the exclusive jurisdiction of the Insurance Commissioner, subject to judicial review of the final agency action. If, after that final agency action, the Joneses have suffered cognizable harm that was not remedied in the administrative proceeding, they will be able to amend their cross-complaint in the present action to assert those damages. (See *Karlin v. Zalta* (1984) 154 Cal.App.3d 953, 980; see also *Farmers Ins. Exchange v. Superior Court, supra,* 2 Cal.4th at p. 400.)

The parties have contended at various times that the Joneses already have invoked their administrative remedies. The Joneses did file a complaint with the DOI consumer services division. That division did a superficial review of the situation and told the Joneses to try to cooperate with Cal-Eagle, then to contact DOI again if they were not satisfied with Cal-Eagle's response. Although the Joneses now assert that DOI did not understand the extent to which Cal-Eagle had frustrated their prior attempts to

cooperate, the Jones did not attempt to further address the matter with DOI. Instead, they abandoned their DOI appeal before the process reached any sort of finality.

The Joneses did not invoke the alternative administrative process by filing a complaint with CAARP. There is a dispute whether they knew, at the time of the audits and the erroneous bills, that the alternative process existed. Undisputed, however, is the fact that the Joneses were entitled to an opportunity to assert through the CAARP process the substance of their defense in the collection action when they raised the defense that the premiums were not authorized by law or by the contract. We conclude the Joneses were not only entitled to pursue this remedy, they were required to do so as a condition to pursuing the defense in judicial proceedings.

At the phase I trial, an attorney with DOI testified that it was the department's policy that an insured who has exhausted the consumer-services appeal process is not required by the department to start again through the CAARP administrative appeal process. Her rationale was that because both appeal routes end in review by the Insurance Commissioner, seeking relief through both processes is duplicative. In the present case we are not required to determine the relationship between the DOI and the CAARP administrative routes; in particular, we are not required to determine whether an insured who pursued the DOI route to finality would have any right or obligation to pursue the CAARP appeal process, since the Joneses did not pursue either route to finality. On the present facts, the Jones are required to pursue the CAARP appeal process to its conclusion.

As a final point, we briefly address Cal-Eagle's alternate contention that the trial court abused its discretion in failing to refer this matter to the Insurance Commissioner under the doctrine of primary jurisdiction, even if formal exhaustion of administrative remedies was not required. We have concluded exhaustion was required; nevertheless, even if this were not so, we agree with Cal-Eagle that the trial court abused its

discretion by failing to refer core issues to the Insurance Commissioner for initial resolution.

The doctrine of primary jurisdiction is a relatively recent judicial creation in California. (See *Farmers Ins. Exchange v. Superior Court*, *supra*, 2 Cal.4th at p. 402 (dis. opn. of Mosk, J.).) "As explained by our Supreme Court, [a stay in a civil action while an agency addresses certain issues] may be justified under the doctrine of 'primary jurisdiction' when there is a 'paramount need for specialized agency review.' (See *Farmers Ins. Exchange v. Superior Court* (1992) 2 Cal.4th 377, 401 … .) Under that doctrine, a trial court may avail itself of the specialized expertise of an administrative agency before hearing a matter--the agency in effect becomes a kind of special master for the trial court." (*Miller v. Superior Court* (1996) 50 Cal.App.4th 1665, 1669.)

*Farmers Ins. Exchange* involved a challenge by the Attorney General to an insurer's alleged failure to implement the good driver discounts required by Proposition 103. (2 Cal.4th at p. 398.) The court stated: "Inevitably, analysis of the People's claim will require 'a searching inquiry into the factual complexities of [automobile] insurance ratemaking and the conditions of that market during the turbulent time here involved.' [Citation.] To address the People's claim, one must inquire into the insurer's ratemaking process in order to determine what the rate would be for a given driver without the discount. Thereafter one must discern whether the rate offered on a given Good Driver Discount policy is 20 percent below what the insured would otherwise have been charged. As we have observed, the question of insurance rate regulation has 'traditionally commanded administrative expertise applied to controlled industries.' [Citation.] [¶] There is no reason to conclude otherwise in the present case; we think it is plain that a court attempting to determine whether a given Good Driver Discount policy meets the statutory 20 percent discount requirements should have the benefit of the Insurance Commissioner's expert assessment of that issue." (*Id*. at p. 399.)

In the present case, the trial court permitted the Joneses to attempt to instill the necessary expertise both in the court itself and in the jury. That was an abuse of discretion. (See *Farmers Ins. Exchange v. Superior Court*, *supra*, 2 Cal.4th at pp. 390-391 [application of primary jurisdiction doctrine an exercise of judicial discretion].) The expertise is invested by statute in the Insurance Commissioner (see Ins. Code, § 12900 et seq.) and that officer must be permitted to bring his expertise and statutory authority to bear on the issues involved in the present case, if not through application of an exhaustion requirement, then most certainly through invocation of the commissioner's primary jurisdiction. (See *Wise v. Pacific Gas & Electric Co.* (1999) 77 Cal.App.4th 287, 298 [requiring referral to PUC of issues in fraud and unfair competition civil action].)

## III.*

## The Appeal of the Johnsey Judgment.[6]

In net effect, the trial court instructed the jury that the Joneses did not owe any additional premium and that there were no material misstatements or omissions in the insurance application filled out on their behalf by Johnsey. We have concluded that the trial court should have deferred to the Insurance Commissioner on those issues under the doctrine of administrative exhaustion; we express no opinion whether the trial court's instructions were correct or incorrect. The court's instructions, right or wrong, were fundamental to the judgment in favor of Johnsey on the Joneses' cross-complaint.

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***** See footnote, *ante*, page 1.

**6** The cross-complaint included a negligence claim against the Joneses' insurance agency, cross-defendant and respondent Johnsey. The jury returned a verdict in favor of Johnsey and against the Joneses. The Joneses' cross-appeal includes a conditional appeal of the Johnsey judgment, seeking reversal and a new trial if we reverse the judgment against Cal-Eagle.

At this point, the judgment must be reversed as to Johnsey as well as the other parties to this appeal. After the administrative process has run its course, the trial court will be in a position to determine whether to reinstate the judgment, grant a new trial on the negligence count, or enter some other order consistent with this opinion and the state of affairs in existence after administrative finality.

**DISPOSITION**

The judgment is reversed. The matter is remanded to the trial court with directions that the trial court direct the Joneses to pursue to finality an administrative complaint under title 10, section 2495, California Code of Regulations. The court shall stay proceedings in the present case until and unless either party petitions for dissolution of the stay based on the final administrative outcome, at which time the trial court shall conduct further proceedings consistent with the views expressed herein. Cal-Eagle Insurance Company and Jonathan Neil & Associates, Inc., are awarded costs on appeal from the Joneses. Johnsey Insurance Company shall bear its own costs on appeal.

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VARTABEDIAN, Acting P. J.

WE CONCUR:

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BUCKLEY, J.

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WISEMAN, J.