A THREE-PART FIELD GUIDE

How Insurers Use Biased Experts to Deny Claims, and How to Fight Back

The complete arc, from the duty to the discovery, and why the correction requires no new law.

Guide 1	**The Duty of Good Faith & Fair Dealing**	*Why denying a claim on a bought opinion is illegal.*
Guide 2	**Standards, Factors & Presumptions**	*How to prove the opinion was bought.*
Guide 3	**Defeating the Discovery Objections**	*How insurers bury the proof, and the answer to each objection.*

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Christopher L. Dion, Consulting Attorney · expertbiasreport.substack.com · Commentary, not legal advice.

THE FOUNDATION SERIES · FIVE PARTS

The Duty of Good Faith & Fair Dealing

Why an insurer that denies a claim on a bought expert opinion breaches its duty, on every duty at once.

> **THE GAP NO ONE ELSE IS FILLING**
>
> For forty years, insurers have denied and underpaid claims on opinions from experts who make their living from the industry. The doctrine that forecloses the practice is settled California law, yet almost no one litigates it as a breach of the good-faith duty itself. This guide states that duty, in full, from the controlling authority.

I. The covenant, and where it comes from

1. **Read into every contract.** The implied covenant of good faith and fair dealing is a term the law reads into every contract: neither party may do anything to destroy the other's right to receive the benefits of the agreement. Its natural habitat is discretion, wherever a contract gives one party power over the other's stake.
2. **Insurance was present at the creation.** The conventional lineage starts too late. The doctrine's most durable language was written about an insurer, *Brassil v. Maryland Casualty Co.*, 210 N.Y. 235 (1914), two decades before the covenant had its general name. California's own adoption ran through at least six decisions before *Comunale v. Traders & General Ins. Co.*, 50 Cal.2d 654 (1958), fused it to the insurance relationship.
3. **The covenant disciplines discretion.** The covenant is violated when a party exercises a discretionary right in an unreasonable manner. *Carma*'s test is disjunctive: a party breaches if it subjectively lacks belief in the validity of its act **or** its conduct is objectively unreasonable. The objective prong operates "regardless of the actor's motive." *Carma Developers v. Marathon Development*, 2 Cal.4th 342 (1992).

II. Why insurance is different

4. **The tort's confinement is its proof.** California built the bad-faith tort (*Comunale, Crisci, Gruenberg, Egan*), then deliberately declined to extend it to employment (*Foley*) and lending (*Price*). The confinement is the evidence: *Foley*'s distinctions are affirmative holdings about insurance: the insured cannot return to the market after the loss, protection *is* the product, and insurer and insured are financially at odds at the moment of performance. *Foley v. Interactive Data Corp.*, 47 Cal.3d 654 (1988).
5. **"Special," and exploited.** The relationship is special, not fiduciary: duties "akin to" fiduciary duties arising from "the unique nature of the insurance contract." *Vu v. Prudential*, 26 Cal.4th 1142 (2001). Because the insurer is permitted a genuine dispute, it has every incentive to manufacture the appearance of one, and the bought expert is that device.

III. What the duty requires

6. **A full, fair, and thorough investigation.** Seek the facts that support coverage, not only those that defeat it (*Wilson*, quoting *Mariscal*); investigate every basis (*Jordan*); interview the witnesses (*Frommoethelydo*). The duty is nondelegable (*Hughes; Major*), judged under the totality of the circumstances with no checklist safe harbor. *Wilson v. 21st Century*, 42 Cal.4th 713 (2007).

7. **Equal consideration, and no scienter.** On undisputed facts of a one-sided investigation, breach is established as a matter of law; no scienter is required (the breach lives in the process, not the mental state), and the insurer cannot insulate itself through its org chart. *Egan v. Mutual of Omaha*, 24 Cal.3d 809 (1979). That last principle reads directly onto vendor-intermediated expert practice.

8. **Honesty, including by silence.** No affirmative misrepresentation (*Fletcher*); no implied misrepresentation by strategic silence (*Davis; Sarchett*); no misrepresenting the purpose of the insurer's own procedures (*Tomaselli*). Silence about how an expert was selected, paid, and how often he reaches the same result operates as an implied representation that the opinion is independent.

IV. The biased expert, squarely

9. **Honest selection required.** An insurer "cannot insulate itself from liability for bad faith conduct by the simple expedient of hiring an expert for the purpose of manufacturing a 'genuine dispute.'" *Chateau Chamberay v. Associated Int'l*, 90 Cal.App.4th 335 (2001).

10. **One test, not two.** A dispute is "genuine" only if the insurer's position is reasonable under the totality of the circumstances; stated grounds may be found "a pretext or rationalization." *Wilson*, 42 Cal.4th at 722–23.

11. **Financial dependence runs to the industry, not one insurer.** An expert may be retained by a given insurer only once, for a single large case, so a demand for that expert's "routine" outcomes *for that insurer* misframes the inquiry. A substantial likelihood of bias is shown by convergence: the expert's financial dependence on the insurance industry as a whole, the procedural and methodological irregularities in this claim's report, and the insurer's failure to adopt reasonable measures to keep the evaluation neutral, the *Demer*-type facts. Retention frequency for a single insurer is neither necessary nor sufficient.

12. **Identical under ERISA, except the remedy.** Both regimes distrust the conflicted decisionmaker (*Firestone; Glenn; Abatie; Nord*; in California, *Egan* and *Wilson*), and the *Demer* framework crosses the ERISA line in both directions. What differs is the remedy: preemption (*Pilot Life; Davila*) strips the tort, punitive damages, and the jury, so the one surviving lever, the bias inquiry, carries the most weight where the claimant has the fewest tools.

ANCHORING AUTHORITIES

Brassil (1914) · *Comunale* (1958) · *Egan* (1979) · *Foley* (1988) · *Carma* (1992) · *Chateau Chamberay* (2001) · *Vu* (2001) · *Wilson* (2007) · *Demer* (9th Cir. 2016) · 29 C.F.R. § 2560.503-1(b)(7).

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Standards, Factors & Presumptions

How to prove a bought opinion: the operational architecture for assessing insurer-retained expert bias.

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>
> The genuine-dispute doctrine lets an insurer defeat a bad-faith claim with almost any facially credible expert report. The only route past that shield is to attack the expert's *neutrality* rather than the expert's conclusion. Until this framework was built out, that route existed mostly as an argument in a single 2024 article. This is the only operational build of it: a standard, four factors, and a presumption, each already recognized in law.

I. The standard

1. **Inference of bias.** Not proof of a corrupt motive, but a fair probability, drawn from an expert's financial relationship and pattern of opinions, that bias shaped the result. It is a century-old rule about who may judge, borrowed from *Tumey v. Ohio*, 273 U.S. 510 (1927), and *Commonwealth Coatings v. Continental Casualty*, 393 U.S. 145 (1968): a decisionmaker with a financial stake is disqualified by the structure of the arrangement, guilty mind or not.
2. **A continuum, not a switch.** Bias runs from appearance to substantial likelihood to constitutionally intolerable risk; ERISA courts have applied a version of it under the name "weighing" for years. *Bagramyan v. GEICO* (Cal. Ct. App. 2023) was the first California appellate decision to name inference-of-bias as the operative test, on a record where the insurer conceded it did not track how often it retained its expert, or how often that expert's findings supported denial.

II. The four factors: how the standard is tested against a record

3. **Factor one: relational metrics.** Compensation and assignment volume: the cheapest evidence in a bias case, often no more than an invoice. *Valley Bank of Nevada v. Superior Court* (1975), the case insurers cite to wall off the numbers, protects third-party *customer* records, not an expert's own compensation.
4. **Factor two: reputational metrics.** The pattern lives in other insureds' claim files (the reports, the outcomes, the recurring reasoning), not in any claimant's identity. *Colonial Life & Accident Ins. Co. v. Superior Court* (1982) opened those files to discovery more than forty years ago. *Shirley v. Allstate* (S.D. Cal. 2019) is the cautionary case: a claimant who demanded seventy-two other insureds' names lost the request as a fishing expedition, and lost the case twenty-seven days later.
5. **Factor three: flawed principles and theories, and procedural irregularities.** The earliest bias evidence needs no discovery; it sits in the report. Facial tells (no stated methodology, no competing hypotheses, boilerplate recycled across claims) and process irregularities (paper-only review, questions narrowed until the answer arrived). The tell almost always overlooked is the expert who states a governing principle and cites no source for it, a gap *Sargon Enterprises v. USC* gives courts the tools to test.

6. **Factor four: measures to ensure expert reliability and neutrality.** This factor targets omission. It asks what the insurer never built to keep evaluations fair before the claim arrived. *Glenn* supplies the standard (a conflict shrinks where an insurer takes real, outcome-blind steps); *Demer* supplies the correction insurers rely on to evade it (a walled-off claims department does nothing to cure a financially dependent outside reviewer). *Fessenden v. Reliance Standard* is the paper-safeguards playbook at full strength.

III. The presumption

7. **The burden shifts.** Once a claimant makes a modest showing on the first factor, the burden shifts to the insurer to come forward with evidence that its expert was actually neutral. Silence, where the insurer could have kept records and did not, is not treated as neutral. *Demer v. IBM Corp. LTD Plan*, 835 F.3d 893 (9th Cir. 2016).
8. **The order is the case.** Most losing bias cases lose on order, not on facts: establish the standard before reaching for the evidence. The open frontier is the sharper procedural question: how much evidence survives summary judgment when an insurer's expert manufactures a "genuine dispute."
9. **The jurisdictional gift.** *Demer* is an ERISA case, decided in a body of law with no bad-faith tort and no independent duty to investigate fairly. First-party claimants have both, plus California's regulatory mandate of a "thorough, fair, and objective" investigation (Cal. Code Regs. tit. 10, § 2695.7(d)). If the burden-shift holds in the more constrained ERISA setting, it holds with at least as much force outside it.

ANCHORING AUTHORITIES

Tumey (1927) · *Commonwealth Coatings* (1968) · *Valley Bank* (1975) · *Colonial Life* (1982) · *Glenn* (2008) · *Sargon* (2012) · *Demer* (9th Cir. 2016) · *Fessenden* · *Bagramyan* (Cal. Ct. App. 2023) · Cal. Code Regs. tit. 10, § 2695.7(d).

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Defeating the Discovery Objections

How insurers bury the proof of bias, and the answer to each objection, already written in the case law.

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> The proof of expert bias lives almost entirely inside the insurer's files: compensation, assignment volume, and the pattern of outcomes across other claims. Insurers keep it buried with a familiar repertoire of objections. Most are more reflexive than sound, and each can be answered. This guide works the twelve principal objections, one at a time.

I. Relevance & nexus (Part 1)

1. **Plead the pattern, then harvest it.** Pattern discovery follows pattern pleading, not the reverse. Allege the systematic retention of outcome-oriented experts as a practice; the complaint is where relevance is manufactured, the requests only harvest it.
2. **Key to the person.** All reports by this expert; all claims this doctor evaluated for this insurer. The same-professional key establishes the nexus on the face of the request and narrows scope in the same stroke.
3. **"Fishing expedition" has no content.** California's highest court held decades ago that the fishing accusation is never, standing alone, a valid objection; elsewhere the epithet has no content beyond specificity. Supply it and nothing is left. Plead the parties' relative access to information by name: you have none of the evidence, the insurer has all of it.

II. Scope & proportionality (Part 2)

4. **Overbreadth concedes relevance.** Overbreadth and proportionality dispute *how much* and *at what cost*, never "none." The court's remedy for genuine overbreadth is narrowing, on whichever party's terms are on the table; keep terms of yours there.
5. **Build the boundaries in.** Factual-pattern, geographic, temporal (three-to-five years is the norm), the professional key, document-type, and, as a last resort, a numerical cap or sampling offer. Requests that carry their own limits turn the scope objections into surplusage.
6. **Graduated sequence.** Aggregates and dispositions come first (logs, summaries, cheap by anyone's math), but they are drawn from the underlying files, which are produced with third-party identities protected. What is deferred until specific cause is shown is the personally identifiable information alone, not the files. The sequence is a proportionality argument in structural form.

III. Burden & the mini-trial (Part 3)

7. **Split the two faces.** Search-and-production cost is a mechanics question with a demanding evidentiary discipline; the "mini-trial" is an imagined proceeding pattern discovery has never produced. Hold each to its own law.

8. **Burden is quantified or conceded.** The showings that sustained the objection named the systems, the search limits, and the per-file review time; the showings that failed were adjectives. Demand the declaration, category by category.

9. **Turn the burden around.** If the insurer's systems cannot retrieve claims by expert or outcome, the burden of looking is the insurer's own product (self-induced burden), and the incapacity is itself affirmative evidence that no one was monitoring the experts.

10. **Kill the mini-trial fiction.** Pattern evidence is used as statistics (retention counts, finding rates, payment totals), never as relitigated claims. No jury re-decides anyone else's file; the inference runs from the aggregate to the process.

IV. Privacy, privilege & the residue (Parts 4–5)

11. **Concede away the legitimate; keep the data.** Stipulate the protective order first; take production unredacted under it (mass redaction is where the cost lives); never request the third-party identities you do not need. Quote the whole privacy statute: the judicial-order and permitted-by-law exceptions are what the objection omits; consent is a pathway, not a precondition.

12. **Business records are not legal advice.** Compensation data, retention counts, invoices, and ordinary-course instructions are claims-administration records. Demand the privilege log and treat blanket assertions as forfeitures. Define "the insurer" to include its vendors, TPAs, and affiliates so a possession objection cannot hide the data behind an intermediary.

A wall of reflexive, unsupported objections becomes proof of the bad faith itself.

ANCHORING AUTHORITIES

Cal. Civ. Discovery Act · *Fed. R. Civ. P.* 26(b)(1), 34 · *Valley Bank* (1975) · *Colonial Life* (1982) · *Demer* (9th Cir. 2016) · and the meet-and-confer record built across all five parts.

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