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ARBITRATION

Crowley Maritime Corp. v. Boston Old Colony Ins. Co. (Jan. 11, 2008) 158 Cal.App.4th 1061

Where Liability Insurers Indemnified Insured, Then Sued Third-Party Insurers for Equitable Contribution, The Contribution Claim Did Not Arise from Insurance Contracts Between Insured and Third-Party Insurers. Thus, Contractual Arbitration Clause Did Not Apply.

Facts:

Plaintiff Crowley Maritime Corporation ("Crowley") is a tugboat company. Crowley settled lawsuits claiming asbestos exposure and received indemnification from Boston Old Colony Insurance Company ("Boston") and Glen Falls Insurance Company ("Glen Falls") for the settlements. Boston and Glen Falls sued for equitable contribution from Crowley's other insurers, West of England Ship Owners Mutual Insurance Association ("West of England") and The United Kingdom Mutual Steam Ship Assurance Association Limited ("UK Mutual"), both based out of the country and managed in London.

West of England and UK Mutual petitioned to compel arbitration of the equitable contribution claim based on their arbitration agreement with their insured, Crowley, to resolve all disputes in arbitration under English law.

Holding:

In affirming the trial court's decision denying arbitration, the Court of Appeal noted West of England and UK Mutual confused equitable contribution with equitable subrogation. These two insurers argued that Boston and Glen Falls were seeking to "stand in the shoes" of the insured and should be required to fulfill Crowley's contractual arbitration obligations. The Court of Appeal rejected West of England and UK Mutual's argument.

In the insurance context, equitable subrogation involves the substitution of the insurer in the position of its insured to seek reimbursement from responsible third parties. In equitable subrogation, the insurer "stands in the shoes" of the insured. Equitable contribution, on the other hand, is the right to seek contribution when, for instance, multiple insurers cover the same loss and one insurer pays more than its share to the insured. Boston and Glen Falls were not standing in the shoes of Crowley, but were seeking equitable contribution for paying more than their share of a collectively insured risk. The right of equitable contribution did not arise from contract because Crowley's multiple insurers who may share responsibility for the same loss did not contract with each other.

West of England and UK Mutual also argued Boston and Glen Falls may be compelled to arbitrate despite being non-signatories to the arbitration agreements under California law and the Federal Arbitration Act ("FAA"). West of England and UK Mutual invoked the FAA because they are foreign insurers and their contracts with Crowley involved international commerce.

The Court of Appeal noted that under California law, a non-signatory can be compelled to arbitrate under two circumstances: (1) where the non-signatory is a third party beneficiary of the contract containing the arbitration agreement; or (2) where a preexisting relationship existed between the non-signatory and one of the parties to the arbitration agreement. Neither of these exceptions applied.

Under the FAA, a non-signatory may be bound to an arbitration agreement pursuant to ordinary principles of contract law, such as incorporation by reference, assumption and agency, among others. Non-signatories can also enforce arbitration agreements as third party beneficiaries. However, the Court of Appeal held to compel a party to arbitration under the FAA, the reluctant party must be claiming direct benefits under the contract containing the arbitration agreement.

Here, Boston and Glen Falls were not suing for direct benefits under Crowley's insurance contracts with West of England and UK Mutual. Rather, Boston and Glen Falls sued for equitable contribution, a claim based on equity, not contract. Thus, West of England and UK Mutual could not use the FAA to compel arbitration of Boston and Glen Falls' claim for equitable contribution.

Lambert v. Carneghi (Jan. 11, 2008) 158 Cal.App.4th 1120

The Appraisal Process under Insurance Code §2071 Is an Arbitration Proceeding Entitling the Appraiser to Arbitral Immunity. The Litigation Privilege Does Not Protect an Expert from Negligence Claims Brought by the Party That Retained Him.

Facts:

Appellants Winston and Elaine Lambert's ("Appellants") home was completely destroyed by an accidental fire in March 1995. The damage was covered by a policy issued by Fire Insurance Exchange ("FIE"), which provided "guaranteed replacement cost coverage," as well as a "'building ordinance or law coverage' endorsement." The coverage pays the full replacement cost to replace or repair the home in conformity with applicable laws. FIE hired two appraisers and paid Appellants based on the appraisers' reports.

It took four years for Appellants to obtain permits to replace their homes. They incurred substantial costs, including rent, architectural, legal, surveying and engineering. Appellants and FIE did not agree on replacement value to rebuild Appellants' home. Appellants sought an appraisal pursuant to the terms of their insurance policy and section 2071. Appellants hired attorneys who retained Robert Dailey "to define, describe and estimate the replacement cost" of Appellants' home. Appellants also hired Chris Carneghi "to provide appraisal services" and "essentially to determine replacement cost and to be their advocate in the appraisal process."

Appellants' attorneys selected an umpire that "demonstrated a fundamental misunderstanding" of replacement costs. Appellants contended that no one could adequately define the correct standard for replacement costs during the appraisal process, so they were not awarded proper replacement costs and suffered damages of \$1.8 million. Appellants sued Carneghi and Dailey for negligence in connection with the flawed appraisal process. Carneghi and Dailey demurred. The trial court sustained their demurrers. Appellants appealed.

Holding:

The Court of Appeal first considered Appellants' challenge to Carneghi's demurrer, on the grounds the appraisal process set forth in section 2071 is not an "arbitration." The Court of Appeal noted Appellants failed to raise this argument before the trial court and it was arguably waived. Nevertheless, it rejected Appellants' argument. It is well-established in California that "[a]n agreement to conduct an appraisal contained in a policy of insurance constitutes an 'agreement' within the meaning of [Code of Civil Procedure] section 1280, subdivision (a), and therefore is considered to be an arbitration agreement subject to the statutory contractual arbitration law."

Appellants then challenged appraiser Carneghi's arbitral immunity, noting no case had specifically extended arbitral immunity to appraisers. Appellants contended an appraiser's duties are analogous to lawyers as opposed to arbitrators, and even if Carneghi was considered an arbitrator, he should not be entitled to immunity because he was a party arbitrator, not a "true neutral arbitrator."

In rejecting Appellants' arguments, the Court of Appeal stated "[i]t has long been recognized that, in private arbitration proceedings, an arbitrator enjoys the benefit of an arbitral privilege because the role that he or she exercises is analogous to that of a judge." Although no decision has expressly stated that appraisers are entitled to arbitral immunity, several decisions opined on the similarities between both arbitrations and appraisals and arbitrators and appraisers. The Court of Appeal also held an appraiser under section 2071 must be

"disinterested" and, therefore, should not be subject to tort liability in that role even if the appraiser was party appointed.

In evaluating Dailey's demurrer, the Court of Appeal noted the litigation privilege applies to "any communication (1) made in judicial or quasi-judicial proceedings; (2) by litigants or other participants authorized by law; (3) to achieve the objects of the litigation; and (4) that have some connection or logical relation to the action." The litigation privilege protects statements made in private, contractual arbitration. It has also been used to protect opposing party expert witnesses and experts jointly retained.

Appellants contended the litigation privilege only protects experts of a party opponent, not a party's own experts. The Court of Appeal agreed, noting several California decisions that did not limit application of the litigation privilege to cases where the expert did not testify, and a majority of the out-of-state courts holding the same.

The Court of Appeal also analyzed the policy considerations behind the litigation privilege and found as a whole they did not favor applying the litigation privilege to Dailey. The Court noted the litigation privilege promotes truthful testimony. An expert retained by a party is not an unbiased witness and the threat of liability for negligence "may actually encourage more careful and reliable evaluation of the case by the expert."

The Court of Appeal found no reason why the attorney hiring a negligent expert should be potentially liable for malpractice while the most culpable party, the negligent expert, should "totally escape accountability." The Court of Appeal reversed the trial court's decision sustaining Dailey's demurrer, concluding the litigation privilege does not apply to prevent a party from suing her or his own expert witness, even if that suit is based on the expert's testimony.

ATTORNEYS-IN-FACT

Fogel v. Farmers Group, Inc. (Mar. 18, 2008) 160 Cal.App.4th 1403

Claims Against Attorneys-in-Fact are Not Precluded By Insurance Code §1860.1

Facts:

A reciprocal insurance exchange (also called an interinsurance exchange) "is an unincorporated business organization of a special character in which the participants, called subscribers ... are both insurers and insured; for their mutual

protection, they exchange insurance contracts through the medium of an attorney-in-fact.’ ” (Cal. Ins. Code §§ 1300, 1301, 1305.) The interinsurance exchange is managed by the attorney-in-fact, which may be a corporation, and which is appointed by the subscribers through powers-of-attorney. For its services, the attorney-in-fact typically receives a percentage of the premiums the subscribers pay to the interinsurance exchange

In November 1988, California voters approved an initiative that was designated Proposition 103. Among other things, Proposition 103 enacted a statutory scheme governing the rate approval process for insurers, which provides for hearings before an administrative law judge in certain circumstances and allows for consumer participation. The key provision is found in subdivision (a) of Insurance Code section 1861.05. That provision states that rates cannot be approved or remain in effect if they are “excessive, inadequate, unfairly discriminatory or otherwise in violation of” chapter 9 of division 1, part 2 of the Insurance Code, governing rates and rating organizations (hereafter “Chapter 9”). Under the “prior approval” system now in operation, the insurer is free to choose any rate that is neither “excessive” nor “inadequate” and submit an application for approval. Based upon the information provided by the insurer, the Insurance Commissioner determines the maximum and minimum permitted earned premium, and must approve the rate if it falls between them.

Even though Proposition 103 repealed several sections of Chapter 9 that were inconsistent with the new statutory scheme, it left intact a provision of the former law-Insurance Code section 1860.1. Section 1860.1 provides: “No act done, action taken or agreement made pursuant to the authority conferred by this chapter shall constitute a violation of or grounds for prosecution or civil proceedings under any other law of this State heretofore or hereafter enacted which does not specifically refer to insurance.” This statute was enacted as part of the McBride-Grunsky Insurance Regulatory Act of 1947, to exempt insurers from federal regulatory legislation, including antitrust laws, and to authorize cooperation between insurers in rate making and other related matters.

Plaintiff Benjamin Fogel (“Fogel”) held automobile, homeowners and umbrella insurance policies issued through Farmers Insurance Exchange, Fire Insurance Exchange, and Truck Insurance Exchange (collectively the “Exchanges”). The Exchanges are reciprocal insurance exchanges. In August 2003, Fogel, on behalf of all policyholders of the Exchanges, filed a class action lawsuit against Farmers Group, Inc. (“FGI”) and the attorneys-in-fact for the Exchanges. Fogel’s first amended complaint alleged that although the attorneys-in-fact had a form subscription agreement containing a power of attorney, they did not actually require policyholders to sign the agreement. The amended complaint also alleged that the attorneys-in-fact had earned excessive attorney-in-fact fees

("AIF Fees"). The amended complaint asserted two causes of action on behalf of all policyholders in the Exchanges. First, it alleged that each of the attorneys-in-fact breached its fiduciary duty owed to the policyholders by collecting excessive AIF Fees. Second, it alleged that the attorneys-in-fact's practices of collecting AIF Fees without a signed power of attorney and collecting excessive fees were unlawful and/or unfair within the meaning of Business and Professions Code section 17200 et seq.

The trial court granted defendants' motion for summary judgment, holding that the lawsuit was precluded under *Walker v. Allstate Indemnity Co.* (2000) 77 Cal.App.4th 750 ("Walker"). In *Walker*, plaintiffs filed a lawsuit against more than 70 insurers and the Insurance Commissioner, "seeking damages or disgorgement of allegedly excessive premiums that the insurers [had been] authorized to collect." Plaintiffs alleged the Commissioner failed to make the generic determinations and adopt the factors needed to apply the ratemaking formulas to determine whether rates were within the range allowed by section 1861.05. The *Walker* Court held that section 1860.1 barred plaintiffs' claims, stating: "If section 1860.1 has any meaning whatsoever ..., the section must bar claims based upon an insurer's charging a rate that has been approved by the commissioner." Thus, the court concluded that plaintiffs' civil action challenging the approved rates was barred by section 1860.1. In addition, the trial court held that Fogel had authorized the defendants to collect the AIF Fees because the subscription agreements were incorporated into Fogel's policies and Fogel waived or was estopped from complaining he did not authorize the collection of the AIF Fees.

Holding:

On appeal, the Court held that *Walker* did not directly address the issues at bar. Moreover, the Court held that Fogel's claims did not come within the plain language of section 1860.1. Fogel alleged that defendants breached their fiduciary duty as attorneys-in-fact and committed unfair business practices by collecting excessive AIF Fees and/or collecting AIF Fees without a signed subscription agreement. Section 1860.1 states that only those civil proceedings based upon an "act done, action taken or agreement made pursuant to the authority conferred by [Chapter 9]" are precluded. Thus, Fogel's claims would be precluded only if defendants' collection of AIF Fees is an act done or action taken under the authority conferred by Chapter 9. However, while an insurer's rates are examined by Chapter 9, nothing in that Chapter regulates an attorney-in-fact's expected profit or rate of return. Thus, section 1860.1 did not preclude Fogel's claim.

In addition, defendants argued that Fogel's lawsuit was barred by the federal filed rate doctrine. The filed rate doctrine derives from the tariff-filing requirements of the Federal Communications Act of 1934. Under this doctrine,

once a carrier's tariff is approved by the FCC it is considered to be the law and no action may be brought against the carrier which would invalidate the tariff. Defendants argued that California's "prior approval" system was analogous to the federal filed rate doctrine and any actions seeking to invalidate premiums and/or AIF Fees should be barred. The Court disagreed, holding that federal filed rate doctrine was inapplicable because under the federal system the carrier must charge the tariff and cannot offer rebates to its customer. In contrast, under California law, insurers are allowed to rebate excess premiums to the customer.

Fogel also argued that: (1) a subscription agreement was not incorporated by reference into his policies; and (2) waiver and estoppel did not apply. The Court of Appeal reviewed the language of his policies and held that although the policies state that the attorney-in-fact was authorized to execute the policies it did not specifically refer to the subscription agreement. Therefore, the subscription agreement was not incorporated by reference into the policies. The Court of Appeal also stated that waiver and estoppel may apply. However, those doctrines would only require Fogel to pay the reasonable value of the services provided by the attorney-in-fact. Since Fogel was seeking to recover excessive AIF Fees these doctrines would not apply.

Finally, Fogel filed his own motion for summary adjudication with the trial court seeking an order that the exhaustion of administrative remedies rule did not bar his claim. The trial court did not address this issue, having granted summary judgment to the defendants. On appeal, Fogel asked the Court of Appeal to rule that the trial court should have granted his motion for summary adjudication on this issue. The Court of Appeal agreed. The Court of Appeal again noted that the collection of AIF Fees was not regulated by Chapter 9. Therefore, Fogel was not required to submit to an administrative proceeding under Chapter 9. Thus, the Court of Appeal reversed the trial court's grant of summary judgment and remanded the case to the trial court with an order to grant Fogel's motion to summarily adjudicate the issue of exhaustion of administrative remedies.

BAD FAITH

Brehm v. 21st Century Ins. Co. (Sept. 16, 2008) 166 Cal.App.4th 1225

"Genuine Dispute" Rule Does Not Bar Complaint for Bad Faith Where Insurer Allegedly Conducts Biased, Incomplete Investigation

Facts

Stuart Brehm filed a bad faith suit against 21st Century Insurance Company arising out of 21st Century's handling of a claim for underinsured motorist (UIM)

benefits. Brehm's parents were named insureds (and Brehm qualified as an insured) on a policy issued by 21st Century. The 21st Century policy provided underinsured motorist (UIM) benefits of \$100,000 per person.

Brehm alleged that he, his father and his mother all were injured in a traffic accident caused by a third party, who had liability insurance with a limit of \$30,000 per accident. The third party's insurance carrier exhausted its limit by paying \$10,000 to Brehm, \$10,000 to Brehm's father and \$10,000 to Brehm's mother.

In addition, Brehm alleged he made a UIM claim against 21st Century, and submitted medical reports, bills and diagnostic test results that showed he had suffered "a severe shoulder injury that would require costly surgery and related costs and expenses." Brehm further alleged that he initially demanded \$85,000 under the UIM coverage and that, in response, 21st Century arranged for a biased doctor, who was a professional expert witness, to examine Brehm.

According to Brehm, 21st Century's expert concluded that Brehm had only suffered "soft tissue" injuries and that surgery was not necessary. Based on this examination, 21st Century offered to pay Brehm only \$5,000 under the UIM coverage. Brehm also alleged that he then submitted to "a truly independent medical examination" by another doctor. That doctor concluded that Brehm had indeed suffered a shoulder injury and that it was "more likely than not" that Brehm would require surgery.

Based on this report, Brehm demanded that 21st Century pay \$90,000 (i.e., the \$100,000 UIM limit less the \$10,000 the third party's insurer had paid). However, Brehm alleged, 21st Century again offered only \$5,000. Brehm ultimately obtained an arbitration award of \$90,000, which 21st Century paid.

The trial court ruled that, at most, the allegations in Brehm's complaint showed the parties' experts had differing views regarding the extent of Brehm's injuries, and that there was a "genuine dispute" about the issue. Thus, the trial court sustained 21st Century's demurrer to Brehm's complaint and entered judgment in favor of 21st Century. Brehm appealed.

Holding:

The Court of Appeal reversed, holding that Brehm's allegations, although not yet proven, were sufficient to at least state a cause of action for bad faith. Among other things, the Court reiterated that "[t]he genuine dispute rule does not relieve an insurer from its obligation to thoroughly and fairly investigate, process and evaluate the insured's claim," and that "an expert's testimony will not

automatically insulate an insurer from a bad faith claim based on a biased investigation.”

In essence, the Court held that, if Brehm could actually prove that 21st Century had knowingly selected a biased expert for the specific purpose of minimizing the amount Brehm could collect, then the “genuine dispute” rule would not apply.

CONTRACT INTERPRETATION

Employers Reinsurance Co. v. Superior Court (Apr. 3, 2008) 161 Cal.App.4th 906

Course of Performance Evidence is Admissible to Interpret an Insurance Contract When the Performance is Pursuant to the Contract and Not a Subsequent Settlement or Claims Handling Agreement

Facts:

Thorpe Insulation Company ("Thorpe") was a distributor and installer of asbestos insulation products. Thorpe was sued in thousands of personal injury lawsuits and, over time, tendered the lawsuits to its primary and excess insurers. Thorpe's policies covered both products/completed operations claims ("products claims") and non-products claims ("operations claims"). The policies' aggregate limits applied to products claims, but not to operations claims.

In 1978, Thorpe began tendering lawsuits to its primary insurers. In 1984, Thorpe and ten of its primary insurers entered into a Claim Handling and Settlement Agreement (the "1984 Agreement"). The stated purpose of the 1984 Agreement was to "clarify among" the parties to the agreement "the apportionment of defense and indemnification of Thorpe[.]" The 1984 Agreement provided, among other things, that it should not be construed "as a policy interpretation, and shall not be used in any Court ... to interpret the obligations under general liability or other policies" and was "without prejudice to later assertion by any such parties of claims against each other ... pursuant to the several reservations of rights ... contained in this Agreement."

Thorpe's primary insurers charged all settlement payments against their aggregate limits treating the claims as products claims. As the primary policies exhausted, Thorpe began tendering claims to its first level excess insurers. In 1998, seven of Thorpe's first level excess insurers entered into an Interim Excess Insurance Claims Handling Agreement (the "1998 Agreement"). The stated purpose and terms of the 1998 Agreement were similar to those of the 1984

Agreement. The 1998 Agreement also considered an excess insurer's policy to be implicated when the underlying primary policy is "contend[ed to] have been exhausted." Thorpe was not a party to the 1998 Agreement, but received a copy and advised its first level excess layer insurers that it reserved all rights under their policies.

Thorpe's first level (and upper level) excess insurers charged payments under their policies against aggregate limits again treating all claims as products claims. When Thorpe had nearly exhausted all of its \$180 million in aggregate limits, it sued its insurers seeking a declaration they still owed defense and indemnity in connection with claims it contended were operations claims not subject to aggregate limits.

The insurers contended that, by accepting payment of their aggregate limits on a layer-by-layer basis over several decades, Thorpe understood that all of the underlying claims were products claims under the terms of the policies. Thorpe filed a motion in limine to exclude evidence of the parties' post-policy course of performance. The trial court granted the motion on two grounds: (1) course of performance evidence is only relevant if it predates a controversy and the 1984 Agreement indicated the existence of a controversy, and (2) such evidence is relevant only if it sheds light on the intent of the parties at the time of contracting and the individuals who negotiated the subject policies were not the same as those who performed under them.

The insurers filed a petition for writ of mandate. The court of appeal issued an order to show cause to consider whether the trial court erred in concluding the policies' claims handling history was irrelevant to the issue of policy interpretation.

Holding:

Preliminarily, the appellate court concluded that course of performance evidence is generally admissible to interpret insurance policies, even standard form insurance policies. The court also concluded the admissibility of course of performance evidence does not require the individual performing under the contract being the individual who had negotiated the contract.

However, the appellate court held course of performance evidence is only relevant to the issue of contract interpretation when the performance is attributable to the parties' understanding of the contract. The court determined that in the case before it, the 1984 and 1998 Agreements, not the policies, governed the bulk of the parties' performance. Among other things, the court found particularly relevant the fact that Thorpe obtained excess coverage proceeds because the insurers to the 1998 Agreement had agreed among themselves to make those payments while

reserving rights to subsequently contend the payments were not, in fact, due under their policies.

The court concluded the trial court did not err in excluding evidence of performance following the 1984 Agreement. But the court left open the possibility that pre-1984 course of performance evidence and course of performance evidence as to excess insurers not parties to the 1998 Agreement could still be admissible.

CONTRIBUTION

Employers Mutual Cas. Co. v. Philadelphia Indemnity Ins. Co.
(Nov. 19, 2008) 169 Cal.App.4th 340

Insurer Obligated to Pay Contribution Towards Settlement of Attorney Fees Claim Even Though No Costs Had Been Taxed by a Court

Facts:

Philadelphia, Employers, and Evanston Insurance Company (Evanston) each issued liability policies to an owner of a mobile home park. A number of park residents sued the insured under the Mobilehome Residency Law (California Civil Code § 798 et seq.), alleging he failed to maintain the park's sewer system and other systems and structures. The insured tendered his defense to Employers, Evanston, and Philadelphia. Employers and Evanston agreed to defend while Philadelphia denied coverage.

Employers and Evanston appointed different law firms to represent the insured. In addition, the insurers paid for the insured's independent counsel under Civil Code section 2860.

The underlying action settled for \$3 million. Employers and Evanston each paid \$1.5 million, allocating \$1.2 million to damages and \$1.8 million to plaintiffs' attorney fees and costs under the Mobilehome Residency Law, which entitles a prevailing party to recover reasonable attorney fees and costs. Employers and Evanston paid post-tender attorney fees and costs to the defense firms for a total of \$740,759.16. Evanston assigned its contribution rights to Employers, and Employers sued Philadelphia for equitable contribution.

The trial court concluded Philadelphia owed a duty to defend the underlying action and applied a "time on the risk" allocation to determine each insurer's equitable share. The court further concluded Philadelphia was required to contribute to the \$1.8 million paid to settle plaintiffs' attorney fees claim. It held

this portion of the settlement was covered under Philadelphia's supplementary payments provision. This provision obligated Philadelphia to pay "[a]ll costs taxed against the insured in the 'suit.'"

The trial court rejected Philadelphia's contention its supplementary payments coverage applied only after an order of taxation was entered. The court concluded the word "taxed" did not literally require an order of taxation and was broad enough to include a settlement. Philadelphia's policy did not define "taxed" and, interpreting any ambiguity against the insurer, the trial court concluded this phrase did not require a court order.

Philadelphia appealed. It argued the trial court erred in concluding the attorney fees settlement was covered under the supplementary payments coverage when no order of taxation had been entered. Philadelphia further argued this portion of the settlement was uncovered because the underlying plaintiffs were not entitled to statutory attorney fees. Even if this portion of the settlement was covered, Philadelphia argued its portion should be reduced because only a portion of the underlying plaintiffs were conceivably injured during its policy periods. Employers cross-appealed the trial court's denial of its claim for prejudgment interest.

Holding:

The Court of Appeal affirmed. It concluded the Mobilehome Residency Law provided a statutory basis for the underlying plaintiffs' attorney fees claim. It also rejected Philadelphia's contention that an order of taxation was required to trigger the supplementary payments coverage. The term "taxed" was not defined in Philadelphia's policy and, turning to the dictionary, the Court observed taxed could "narrowly refer to the judicial assessment of costs or broadly to any levy of an assessment." The Court chose the latter, broader interpretation. It concluded this construction was also sensible as a matter of policy and equity because it allowed an insured (or co-insurer) to settle a claim instead of litigating it to judgment and risking a greater liability.

In its reply brief, Philadelphia raised two new arguments: (1) Employers should be estopped from claiming the settlement fell within Philadelphia's supplementary payments coverage because there was no evidence Employers had paid any portion of the settlement under its own supplementary payments coverage; and (2) relying on *Combs v. State Farm Fire & Cas. Co.* (2006) 143 Cal.App.4th 1338, the attorney fees portion of the settlement is uncovered because the obligation to pay costs "taxed" against the insured arises only after liability is established.

The Court rejected each argument as untimely because it had been raised for the first time in Philadelphia's reply brief. Additionally, the Court held the arguments lacked merit. The estoppel argument failed because Philadelphia provided no evidence of detrimental reliance. The Combs-based argument failed because the settlement of the underlying action was sufficient to prove the insured's liability for insurance purposes. Additionally, the Combs court never analyzed whether attorney fees in a settlement agreement constitute taxed costs.

The Court also rejected Philadelphia's request to prorate the settlement. It concluded there was no basis in the appellate record to reduce Philadelphia's share of the statutory attorney fees.

The Court denied Employers' cross-appeal. The Court found it was impossible to determine from the appellate record whether the trial court had allocated attorney fees pursuant to stipulated facts or from a judicial determination based on conflicting evidence. Thus Employers had failed to prove entitlement to prejudgment interest.

DIRECTORS AND OFFICERS INSURANCE

Westrec Marina Management, Inc. v. Arrowood Indemnity Co. (June 16, 2008) 163 Cal.App.4th 1387

Letter From Claimant's Attorney to Insured is "Claim" under "Claims Made and Reported" Policy

Facts:

Arrowood Indemnity Company issued two consecutive directors and officers liability insurance policies to Westrec Marina Management, Inc. The first policy was effective from July 1, 2002 to July 1, 2003, and the second policy was effective from July 1, 2003 to July 1, 2004. Each policy provided coverage for losses incurred in connection with claims "first made" against the insured during the policy period and reported to the insurer within 30 days after the expiration of the policy.

Bette Clark was a former employee of Westrec. In June 2003 (during the first policy period), Clark's attorney faxed a letter to Westrec stating that Clark had been subjected to sex discrimination at Westrec, had been wrongfully terminated from Westrec, and had received a "right to sue" notice from the Department of Fair Employment and Housing allowing her to sue Westrec.

The letter from Clark's attorney stated that Westrec might prefer "to resolve or mediate this matter" rather than become involved in expensive litigation, and asked Westrec to contact Clark's attorney to discuss the matter. Westrec did not notify Arrowood of this letter within 30 days after the expiration of the first policy.

In December 2003 (during the second policy period), Clark sued Westrec for employment discrimination and wrongful termination. Westrec promptly tendered the lawsuit to Arrowood for defense. However, Arrowood rejected Westrec's tender on the ground that the letter from Clark's attorney to Westrec in June 2003 constituted a "claim" made against Westrec during the first policy period, and Westrec had failed to provide notice of that claim to Arrowood within 30 days after the expiration of the first policy.

Westrec then filed a breach of contract/bad faith lawsuit against Arrowood alleging that Arrowood had wrongfully refused to defend Westrec in the underlying lawsuit brought by Clark. The trial court ruled in favor of Arrowood, and Westrec appealed.

Holding:

The Court of Appeal affirmed the judgment in favor of Arrowood. According to the appellate court, the letter that Clark's attorney sent to Westrec in June 2003 constituted a "claim" that was made against Westrec during the first policy period. Both Arrowood policies defined a "claim" so as to include "a written demand for civil damages or other relief," and the June 2003 letter from Clark's attorney to Westrec was "a settlement demand seeking monetary compensation" from Westrec.

The appellate court stated that "although the [June 2003] letter did not expressly demand payment or refer to any specific amount, its meaning was clear that, absent some form of negotiated compensation, Clark would commence a lawsuit against Westrec." In short, the letter Clark's attorney sent to Westrec in June 2003 constituted a "claim" that was made against Westrec during the first policy period, and Westrec failed to provide notice of that "claim" to Arrowood within 30 days after the expiration of the first policy.

Moreover, the court concluded that the letter Clark's attorney sent to Westrec in June 2003 (during the first policy period) was the "same claim" as the lawsuit Clark filed against Westrec in December 2003 (during the second policy period). In that regard, both Arrowood policies stated that "all claims based on, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving the same or related facts, circumstances, situations, transactions or events, shall be deemed to be a single claim."

According to the court, the December 2003 lawsuit and the June 2003 letter “constituted a single claim that was first made at the time of the [June 2003] letter.” Because Westrec failed to provide Arrowood with notice of that claim within 30 days after expiration of the first policy, Arrowood had no duty to defend or indemnify Arrowood.

DISABILITY

Hecht v. The Paul Revere Life Ins. Co. (Oct. 14, 2008) 168 Cal.App.4th 30

Insured Was Not “Totally Disabled” by Chronic Pain and Physical Limitations When Still Able to Perform Important Duties of His Occupation

Facts:

Michael Hecht (“Hecht”) is the owner and president of a multi-unit retail clothing business. For about 20 years, Hecht was a “hands on” owner who frequently did physical labor. The Paul Revere Life Insurance Company (“Paul Revere”) issued a disability policy to Hecht in 1990 with Hecht listing his duties as “buyer/manager/office operations” on the policy application. Under the policy’s “total disability” provision, Hecht would be eligible for benefits if he were “unable to perform the important duties of [his] Occupation.”

Hecht suffered neck and back pain after an October 2000 automobile accident. He was diagnosed with a lumbar injury that included bulging discs, spinal stenosis, and muscle spasms. Hecht’s ability to walk, sit, bend, and lift objects was impeded by his injury and his physician declared he was “partially disabled” when Hecht made his claim for disability benefits under the Paul Revere policy.

Despite his pain and physical limitations, Hecht continued to work full time as owner/president of his business and his income did not suffer as a result of the accident. A key employee testified in deposition that Hecht continued to perform all of the duties he was performing before the accident, but with physical limitations and “less gusto” than before the accident. Hecht could no longer lift certain items of clothing, help to load and unload merchandise, climb ladders, and sit or stand for lengthy periods of time.

Relying on *Erreca v. West. States Life Ins. Co.* (1942) 19 Cal.2d 388, the trial court granted Paul Revere’s motion for summary judgment. *Erreca* held that “total disability” means a disability that “renders the insured unable to perform the

substantial and material acts necessary to the prosecution of business or occupation in the usual or customary way” and that an insured is not totally disabled “if he is physically and mentally capable of performing a substantial portion of the work connected with his employment.”

Both parties agreed on appeal that Erreca controlled, but disputed which portion of the Erreca rule was determinative. Hecht argued the court should focus on whether he is “unable to prosecute [his] business or occupation in the usual or customary way.” Paul Revere argued the focus should be on whether Hecht was able to perform a “substantial portion” of the work he listed in the policy application.

Holding:

The Court of Appeal found that whether Hecht could perform some of his job functions exactly as he did before the accident was a contested issue of fact. However, the court concluded Hecht’s position misconstrued the phrase “usual or customary.” Whether Hecht could perform every one of his job functions in the same way he had performed them before the accident, or performed them differently than others in the same position at other businesses, was not material.

The issue was whether Hecht’s job required him to perform the physical labor he could no longer perform. By continuing to work every day and performing the acts necessary to the conduct of his business, Hecht had shown he is still “physically and mentally capable of performing a substantial portion of the work connected with his employment.”

As a result, the court concluded the duties Hecht could no longer perform could not be considered “the important duties of [his] Occupation” as “buyer/manager/office operations.” Accordingly, the court held there were no material issues of fact and Hecht was not totally disabled and therefore affirmed the trial court’s grant of summary judgment.

DISCOVERY

Puerto v. Superior Court (Jan. 15, 2008) 158 Cal.App.4th 1242

A Protective Order Requiring That Identified Witnesses Opt-In to the Disclosure of Their Identifying Information Was Improper

Facts:

Jason Puerto and others filed suit against their former employer, Wild Oats Markets, Inc., alleging that they had been misclassified as exempt employees and

deprived of overtime pay wage. In response to a form interrogatory, Wild Oats provided the names of between 2,600 and 3,000 employees who might have relevant information. It refused to provide their telephone numbers or addresses.

In response to the plaintiffs' motion to compel, the trial court adopted a procedure to protect the privacy of those individuals Wild Oats identified. It required a notice be sent to those individuals, seeking permission for a third party administrator to disclose their addresses and phone numbers. The plaintiffs felt this procedure unduly hampered their discovery and sought a petition for a writ of mandate.

Holding:

The Court of Appeal concluded that the opt-in privacy notice unduly hampered the plaintiffs in conducting discovery to which they were entitled. It held that the order erected obstacles that not only exceeded the protections necessary to adequately guard the privacy rights of the employees involved but also exceed the discovery protections given by law to far more sensitive personal information.

The court rejected Wild Oats' argument that the employees it identified in response to the interrogatories were not necessarily percipient witnesses and that not all of their contact information should be subject to disclosure. The court explained that if Wild Oats had provided a list that was overly broad, it had provided an evasive response and would be subject to sanctions for discovery abuse.

The court reminded: "The disclosure of the names and addresses of potential witnesses is a routine and essential part of pretrial discovery." It then evaluated the plaintiffs' need for discovery and the potential witnesses' expectations of privacy. Among other things it pointed out that:

Generally, witnesses are not permitted to decline to participate in civil discovery, even when the information sought from them is personal or private. Compliance with subpoenas is not optional; if a witness receiving a subpoena wishes to resist it, the witness cannot merely opt out, but must make a motion to quash or modify that subpoena. (§ 1987.1.) Simple disobedience may be punished as contempt. (§ 1991.) When a subpoena is served seeking the personal records of a nonparty consumer under section 1985.3, the party seeking discovery is not required to obtain the consumer's affirmative consent to the release of those records. If the nonparty consumer wishes to object to the release of the records, he or she must "serve on the subpoenaing party, the witness, and the deposition officer, a written objection that cites the specific grounds on which production of the personal records should be prohibited."

It then explained: “The trial court articulated no justification for placing in the hands of witnesses absolute and unreviewable veto power over the petitioners’ access to contact information to permit them to pursue legitimate discovery into their civil claims, and upon performing the appropriate privacy analysis we perceive no basis for affording these witnesses’ addresses and telephone numbers protections in excess of those afforded to vastly more private consumer and employment records.”

The court did recognize that trial courts are not without power to protect non-litigants’ personal information, but concluded the particular order was not a reasonable one.

Liberty Mutual Fire Ins. Co. v. LcL Administrators, Inc. (June 10, 2008)
163 Cal.App.4th 1093

Trial Court Acted Within Its Discretion in Issuing Terminating Sanctions After Repeated Instances of Discovery Misconduct

Facts:

Liberty Mutual Fire Insurance Company (“Liberty”) sued LcL Administrators, Inc. (“LcL”) to recover premiums owed on workers’ compensation insurance policies issued to LcL. LcL denied the allegations and cross complained for breach of contract and bad faith. LcL claimed Liberty did not properly handle the claims.

Liberty served interrogatories seeking all facts, documents, and witnesses supporting LcL’s denials. LcL’s responses provided no substantive information. After Liberty’s “meet and confer” letter was ignored, it successfully moved to compel further responses. LcL’s supplemental responses again failed to correct the inadequacies, so Liberty moved for issue and monetary sanctions.

The trial court denied issue sanctions but again ordered LcL to provide substantive responses. LcL’s supplemental responses asserted “the contracts of insurance were improperly implemented and interpreted.” LcL claimed that providing more information would have required compiling information from documents in Liberty’s possession.

In response, Liberty threatened a motion to strike LcL’s answer unless LcL served substantive responses. Although further responses were promised, they were never served. Liberty moved for terminating sanctions. The trial court

granted the motion and ordered LcL's answer stricken. Liberty then obtained a default judgment for \$512,518 in unpaid premiums, plus interest and costs.

Liberty also served interrogatories seeking to obtain the facts and documents supporting the allegations in LcL's cross complaint. LcL failed to respond and Liberty moved to compel. LcL asserted Liberty had not allowed inspection of documents necessary for LcL to respond. The trial court rejected this contention and granted Liberty's motion. LcL still failed to comply, so Liberty filed a second motion to compel. LcL filed a statement of non-opposition, and the trial court granted the second motion and again ordered LcL to serve responses.

LcL's "supplemental" responses stated Liberty had restricted LcL's access to documents (even though LcL had failed to propound its own discovery), which purportedly made it impossible for LcL to provide substantive responses. Liberty then successfully moved to strike LcL's cross complaint based on LcL's "flagrant abuse of the discovery process."

The trial court granted this motion, which it heard concurrently with Liberty's motion to strike LcL's answer. It found LcL's responses were "devoid of any substantive information, ... evasive and incomplete." The court also concluded LcL had failed to meet and confer and that its conduct constituted a flagrant abuse of the discovery process, warranting terminating sanctions. LcL appealed.

Holding:

The Court of Appeal reviewed the discovery statutes and concluded trial courts are authorized to strike pleadings for discovery abuses, and that these orders are reviewed on appeal on an abuse of discretion standard. There are only two absolute prerequisites before such sanctions can be issued – there must be a failure to comply with a prior discovery order, and the failure must be willful.

LcL argued the trial court erred in ruling LcL acted willfully, because this ruling was predicated on a finding LcL had acted evasively. LcL contended this finding was unsupported because LcL had given Liberty all the evidence LcL possessed in support of its affirmative answers and cross-claims.

The Court of Appeal disagreed. It concluded LcL's discovery responses, which listed sixty-five Liberty employees (none of whom were associated with LcL) and Liberty's entire compendium of workers compensation files, as "worthless." Moreover, LcL's discovery responses were "evasive" because they stated LcL's responses would be "developed" by "future discovery" even though the lawsuit had been pending for sixteen months and LcL had not propounded any discovery. Additionally LcL had actually reviewed Liberty's files and its

statement that it needed Liberty's documents to respond to discovery was "downright deceptive." The Court concluded LcL's "game playing" was "willful."

The Court of Appeal also rejected LcL's argument that "evasiveness" can only occur if evidence is concealed. Instead, evasiveness can be shown through stonewalling. The Court also rejected LcL contention that terminating sanctions were inappropriate because Liberty's "ability to go to trial" had not been prejudiced. Not only did this contention lack any supporting authority but, more importantly, Liberty had been prejudiced because "[a] party cannot intelligently defend itself ... when the other side's discovery responses consist of legal double-talk and provide no useful information."

LcL also asserted terminating sanctions did not "further the objects of discovery" and were punitive. The Court disagreed, concluding terminating sanctions were imposed after "prior efforts yielded no results." LcL was not allowed to "continue its stalling tactics indefinitely."

The Court lastly rejected LcL's contention that, in imposing terminating sanctions, the trial court improperly considered LcL's past misconduct instead of its "current transgressions." A party's "history as a repeat offender is not only relevant, but also significant, in deciding whether to impose terminating sanctions."

DUTY TO DEFEND

American Casualty Co. of Reading, PA v. Miller (Jan. 29, 2008) **159 Cal.App.4th 501**

"Pollution" Exclusion Bars Coverage for Liability Arising from Insured's Release of Solvent into Public Sewer System

Facts:

Michael Miller operated a furniture stripping business in the City of Santa Monica, California. As part of his business, Miller generated wastewater containing solvents. The City issued Miller a "wastewater permit" which allowed him to discharge wastewater from his premises into the City's sewer, but which prohibited him from discharging any solvents into the sewer.

On at least one occasion, Miller allegedly allowed wastewater containing a solvent, methylene chloride, to flow into an onsite waste dump which emptied into a City sewer. The wastewater allegedly caused serious injuries to Vicente

Valenzuela, a workman who was performing some repairs in the sewer. As a result of the incident, Miller was charged with, and pled guilty to, negligent discharge of pollutants into a public sewer system.

Valenzuela filed a personal injury action against Miller, alleging that Miller had negligently discharged methylene chloride into the sewer causing injuries to Valenzuela. Miller tendered Valenzuela's personal injury action to Miller's general liability insurer, American Casualty Company of Reading, PA. However, citing the policy's "pollution" exclusion, American Casualty declined to defend Miller against Valenzuela's lawsuit.

Thereafter Valenzuela settled his personal injury action against Miller. As part of the settlement, Miller assigned his rights against American Casualty to Valenzuela. Valenzuela then demanded that American Casualty pay its policy limit of \$1 million.

American Casualty filed a declaratory relief action against the insured, Miller, and the third party-claimant, Valenzuela, alleging that the policy's pollution exclusion applied and that American Casualty thus had no duty to defend or indemnify Miller against Valenzuela's lawsuit. The trial court agreed that the pollution exclusion barred any potential for coverage in the underlying lawsuit, and thus entered summary judgment in favor of American Casualty. Miller and Valenzuela appealed.

Holding

The Court of Appeal affirmed. The American Casualty policy's "pollution" exclusion barred coverage for bodily injury or property damage "arising out of the actual, alleged, or threatened discharge, dispersal, seepage, migration, release or escape of 'pollutants' ... at or from any premises ... which is ... owned or occupied by ... any insured." The policy defined "pollutants" as "any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals, and waste. Waste includes materials to be recycled, reconditioned or reclaimed."

Here, Valenzuela's personal injury action against Miller was based on Miller's alleged negligence in allowing the release or discharge of a "pollutant" (i.e., wastewater containing methylene chloride) into a public sewer system. As such, Valenzuela's claim against Miller fell within the scope of the American Casualty policy's "pollution" exclusion, and American Casualty thus had no duty to defend or indemnify Miller against Valenzuela's claims.

Lyons v. Fire Insurance Exchange (Mar. 7, 2008) 161 Cal.App.4th 880

Where Policy Covers “Personal Injury” Caused by “Accident,” Insurer Has No Duty to Defend Insured Against Suit Alleging “Intentional” False Imprisonment

Facts:

Plaintiff Stephen Lyons, a sports newscaster and former professional baseball player, met Stacey Roy while they were each vacationing with their families in Hawaii. After an afternoon of poolside conversation, Lyons accompanied Roy up the elevator to the floor where Roy’s hotel room was. The two then exited the elevator. According to Roy, Lyons then took Roy’s wrist, led her to a hallway alcove, partially removed her clothes and tried to force her to perform a sexual act.

Lyons had a somewhat different version of the incident. He admitted that he took Roy’s wrist, led her to the alcove and asked her to expose her breasts. However, he claimed that when Roy declined, he took her to the door of her hotel room and then he returned to the pool.

Roy subsequently filed a civil suit against Lyons, alleging assault, battery and false imprisonment. Lyons tendered the defense of the action to his homeowners insurer, Fire Insurance Exchange (FIE), under a policy covering “bodily injury,” “property damage” or “personal injury” resulting from an “occurrence.” The policy defined “personal injury” so as to include “false arrest, imprisonment... and detention,” and defined an “occurrence” as an “accident.” FIE denied Lyons’ tender on the ground that none of Roy’s claims against Lyons arose from an “occurrence,” or “accident,” as required by the FIE policy.

Lyons then sued FIE for breach of contract and bad faith, alleging that FIE had wrongfully failed to defend Lyons against Roy’s lawsuit. However, the trial court found that Roy’s suit against Lyons was not potentially covered under the FIE policy and thus entered summary judgment in favor of FIE.

Holding:

The Court of Appeal affirmed the trial court’s grant of summary judgment in favor of FIE. First, the Court rejected Lyons’ argument that the requirement of an “accident” did not apply to “personal injury” offenses such as “false imprisonment.” Rather, the Court held that the “accident” requirement applied to all coverages under the policy – bodily injury, property damage and personal injury.

Second, the Court held that under the undisputed facts (i.e., that Lyons took Roy’s wrist in the context of his sexual advances, and that his conduct restrained her), there was no way that the alleged false imprisonment arose from an

“accident.” To the contrary, all of Lyons’ conduct was intentional and deliberate. Although Lyons may have believed that Roy would consent to his sexual advances, that did not turn Lyons’ intentional conduct into an “accident” because, under California law, the term “accident” refers to the nature of the insured’s conduct, not his state of mind. Therefore, mistaken consent does not, as a matter of law, create an accident for coverage purposes.

The Court pointed out that there may be situations where a false imprisonment can occur by “accident” (e.g., where a shopkeeper at closing time intentionally locks his storage vault but forgets that he had sent an employee inside to take inventory). Here, however, Lyons’ deliberate conduct (taking Roy by the wrist in the context of a sexual advance) could not be characterized as an “accident.”

Since there was no potential for coverage under the policy, FIE did not have a duty to defend Lyons against Roy’s lawsuit, and summary judgment in favor of the FIE was proper.

Great Western Drywall, Inc. v. Interstate Fire & Casualty Company
(Mar. 12, 2008) 161 Cal.App.4th 1033

“Cross-Suits” Exclusion Relieves Insurer of Duty to Defend Named Insured
Against Suit Brought by Additional Insured

Facts:

Roel Construction Co., Inc. (Roel) was the general contractor on a condominium project in San Diego. Roel entered into a subcontract with Great Western Drywall, Inc. (Great Western) whereby Great Western agreed to install drywall and perform other work on the project. The subcontract gave Roel certain express indemnity rights against Great Western, and also apparently required that Roel be listed as an additional insured on Great Western’s general liability policy.

Great Western sued Roel over a payment dispute. Roel cross-complained against Great Western for breach of contract, negligence, “money due for work and materials,” account stated, and money had and received. In its cross-complaint Roel alleged that: (a) Roel overpaid Great Western under the subcontract; (b) Roel was required to hire other subcontractors to finish and correct Great Western’s work after Great Western abandoned the project; and (c) in the course of its work, Great Western negligently caused property damage to other work (specifically window glass and tubs).

Interstate Fire & Casualty Company (Interstate) had issued a general liability policy identifying Great Western as named insured and Roel as additional insured. The Interstate policy included a “cross-suits” exclusion which stated that there was no coverage for “any claim or suit for injury or damage by one Insured against another Insured. This exclusion does not apply to ...actions to apportion liability between Insureds where any Insured has been sued for a covered loss.” Great Western tendered defense of Roel’s cross-complaint to Interstate. Although eventually Interstate agreed to defend Great Western against Roel’s cross-complaint, Interstate never did actually fund Great Western’s defense.

The Great Western/Roel litigation went to trial. The trial court awarded Great Western approximately \$332,000 on its complaint against Roel, and awarded Roel approximately \$321,000 on its cross-complaint against Great Western, for a net recovery to Great Western of approximately \$11,000.

Great Western then filed a bad faith action against Interstate for failing to defend and indemnify Great Western against Roel’s cross-complaint in the underlying litigation. The trial court ruled that the Interstate policy’s “cross-suits” exclusion applied, and that Interstate thus had no duty to defend or indemnify Great Western against Roel’s claims. Great Western appealed.

Holding:

The Court of Appeal affirmed, holding that the Interstate policy’s “cross-suits” exclusion relieved Interstate of any duty to defend or indemnify Great Western against Roel’s cross-complaint in the underlying litigation.

The appellate court began by noting that the first portion of the exclusion barred coverage for “any claim or suit for injury or damage by one Insured against another Insured.” This language precluded coverage for the cross-complaint which Roel as “additional insured” had filed against Great Western as “named insured.”

The appellate court acknowledged that the exclusion had an exception for “actions to apportion liability between Insureds where any Insured has been sued for a covered loss.” However, according to the court, this exception was only intended to apply where a third party filed a lawsuit for covered damages against one insured, who then filed a cross-complaint for indemnity against another insured. Here, no third party ever filed a suit for damages against Roel. Thus, Roel’s cross-complaint against Great Western could not be characterized as an action “to apportion liability between Insureds where any Insured has been sued for a covered loss.”

Because the basic exclusionary language applied, and the exception did not,

Interstate had no duty to defend or indemnify Great Western against Roel's cross-complaint in the underlying litigation.

Manzarek v. St. Paul Fire & Marine Ins. Co. (Mar. 25, 2008, 9th Cir.) 519 F.3d 1025

Ninth Circuit Finds a Duty to Defend Lawsuits Filed Against a Rock Band Musician and Related Corporation

Facts:

St. Paul Fire & Marine Insurance Company issued commercial general liability policies to Raymond Manzarek (a founding member of the rock group The Doors) and Doors Touring, Inc. (DTI). The policies each contained a Field of Entertainment Limitation Endorsement (FELE), which excluded coverage for "advertising injury" that "results from the content of, or the advertising or publicizing for, any Properties or Programs which are within your Field of Entertainment." The policies defined "Field of Entertainment Business" to include "[t]he creation, production, publication, distribution, exploitation, exhibition, advertising and publicizing of product or material in any and all media such as motion pictures..., television programs, commercials or industrial or educational or training films, phonograph records, audio or video tapes, CDs or CD ROMs, computer online services or internet or Web site pages, cassettes or discs, electrical transcriptions, music in sheet or other form, live performance, books or other publications."

Manzarek and DTI sued St. Paul for breach of contract and bad faith after St. Paul refused to defend them against two underlying actions filed by former band members and their heirs. The underlying actions alleged that Manzarek and DTI (1) infringed The Doors name, logo and tours and (2) improperly used The Doors logo on their website to market products and merchandise. In one of the underlying actions, a former band member also alleged that he suffered damage to his reputation.

The federal trial court granted St. Paul's motion to dismiss based on the policies' FELE. The trial court held that the FELE was conspicuous, plain and clear and that it eliminated St. Paul's duty to defend the underlying actions.

Manzarek and DTI appealed, arguing that the FELE did not relieve St. Paul of the duty to defend Manzarek and DTI in the underlying actions. Manzarek and DTI also complained that St. Paul had not issued or delivered any policy before Manzarek and DTI tendered the underlying actions to St. Paul.

Holding:

The Ninth Circuit Court of Appeal, applying California law, reversed the trial court's ruling in favor of St. Paul, and held that St. Paul did have a duty to defend Manzarek and DTI under the policies' "advertising injury" coverage and "bodily injury" coverage.

With respect to "advertising injury" coverage, the Ninth Circuit noted that the underlying actions were silent as to what product the insureds advertised on their website. Further, according to the appellate court, the FELE might not apply to advertisements for products such as t-shirts, salad dressing or guitars outside the insureds' field of entertainment business. Because the FELE did not necessarily apply in all scenarios, St Paul had a duty to defend Manzarek and DTI under the "advertising injury" coverage. The appellate court also expressed concern about enforcing a limitation of coverage if the policies were not delivered prior to the insureds' tender of the underlying actions.

With respect to "bodily injury" coverage, the appellate court further held that the former band member's alleged damage to reputation potentially triggered the "bodily injury" coverage, since St. Paul's definition of "bodily injury" included mental anguish and emotional distress. Thus, for this independent reason, St. Paul had a duty to defend Manzarek and DTI in the underlying actions.

Monticello Ins. Co. v. Essex Ins. Co. (Apr. 28, 2008)
162 Cal.App.4th 1376

Absent "Potential" for Coverage, General Contractor Not Entitled to Defense as "Additional Insured" Under Subcontractor's Policy

Facts:

Martina and Georgean Goldman hired Blumenfeld Construction Company to act as general contractor for the construction of the Goldmans' residence. Blumenfeld in turn hired Dana Drywall to act as drywall subcontractor for the project.

Following completion of construction, the Goldmans filed a construction defect action against the general contractor, Blumenfeld. In their complaint, the Goldmans alleged that their house suffered from various defects, including "excessive cracking in the interior and exterior of the property," "premature failure of painted surfaces" and "water damage to structure." Blumenfeld tendered defense of the construction defect action to its own insurer, Monticello Insurance Company, and Monticello agreed to defend Blumenfeld in the action.

Blumenfeld filed a cross-complaint for indemnity against various subcontractors, including Dana Drywall. Dana Drywall tendered defense of the cross-complaint to its insurer, Essex Insurance Company, and Essex agreed to defend Dana Drywall against the cross-complaint.

Later, Blumenfeld tendered defense of the action to Dana Drywall's insurer, Essex, on the ground that Blumenfeld was an "additional insured" on Dana Drywall's policy through Essex. The Essex policy did contain an endorsement stating that Blumenfeld is "an additional insured under this policy, but only as respects negligent acts or omissions of [Dana Drywall] and only for occurrences, claims or coverages not otherwise excluded in the policy. It is further understood that where no coverage shall apply herein for [Dana Drywall], no coverage nor defense shall be afforded to [Blumenfeld]." Essex rejected Blumenfeld's tender.

The construction defect action settled. Thereafter, Blumenfeld's insurer, Monticello, filed a contribution action against Essex. Monticello essentially alleged that Monticello and Essex both had a duty to defend Blumenfeld in the underlying construction defect action, and that Monticello had to share in Blumenfeld's defense costs.

The trial court ruled that Monticello failed to prove it was entitled to contribution from Essex, and thus entered judgment in favor of Essex. Monticello appealed.

Holding:

The Court of Appeal affirmed, holding that Monticello had failed to show that the Goldmans' claims against Blumenfeld in the underlying construction defect action were potentially covered under Dana Drywall's policy through Essex. The court reasoned that while the complaint in the underlying action did contain allegations of "excessive cracking," "premature failure of painted surfaces" and "water damage to structure," there were no allegations that those damages were in any way related to the work of Dana Drywall.

According to the appellate court, Essex was "not required to speculate" that these damages might be attributable to the work of Dana Drywall. The court also held that Monticello could not rely on the Goldmans' "defect list" from the underlying construction defect action to establish that Essex had a duty to defend Blumenfeld in the underlying action.

The court noted that while Monticello had introduced the defect list into evidence in the contribution action, Monticello failed to prove that the defect list was ever provided to Essex during the pendency of the underlying construction

defect action. Because there was no proof that Essex ever had the defect list while the underlying action was pending, Monticello could not rely on the defect list to prove that Essex had a duty to defend Blumenfeld. Nor was it sufficient that Blumenfeld's cross-complaint against Dana Drywall contained allegations that Dana Drywall was negligent.

According to the court, Blumenfeld's cross-complaint for indemnity "does nothing to alter the fact that the Goldmans, the plaintiffs in the main action, the action for which a defense is sought, did not allege covered damages against Dana Drywall."

State Farm Fire and Casualty Co. v Superior Court (June 26, 2008)
164 Cal.App.4th 317

Homeowners Insurer Must Defend Insured Whose Deliberate Act Allegedly Caused Claimant to Suffer Unintended Injury

Facts:

Joshua Wright and Jeffrey Lint attended a party. During the evening, the two began to argue. Wright went outside and Lint followed him. Lint then grabbed Wright, picked him up and threw him into the shallow end of a swimming pool. Wright landed on the pool's concrete step and suffered injuries. As a result of the swimming pool incident, Lint was charged with misdemeanor battery, to which Lint pled nolo contendere.

Wright presented a claim to Lint's homeowners insurer, State Farm Fire and Casualty Company. In the course of investigating the matter, State Farm obtained a recorded statement from Lint in which Lint stated that "if I wanted to hurt [Wright] ... I would have just hit him, but I didn't want to hurt him." State Farm declined to defend or indemnify Lint against Wright's claim, asserting that Lint's alleged liability (1) did not result from an "occurrence" as required by the policy's insuring clause, and (2) fell within the policy's exclusion for "expected or intended" injuries or "willful and malicious" acts.

Wright filed a personal injury action against Lint, alleging various theories including negligence. During Lint's deposition, Lint testified that when he followed Wright outside, he did not intend to hurt Wright and simply wanted to talk to Wright. Lint further testified that he threw Wright in the pool "[j]ust to get him wet," as "horseplay" and as "something to laugh about." Lint retendered his defense to State Farm, but State Farm again refused to defend Lint.

Lint stipulated to a judgment in favor of Wright for \$60,000 and assigned his rights against State Farm to Wright. Wright then amended his complaint to include causes of action against State Farm for declaratory relief and breach of contract.

The trial court found that when Lint threw Wright into the pool, Lint only intended to get Wright wet and did not intend to injure Wright in any way. The trial court concluded that Wright's injury arose from an "occurrence" and was not excluded from coverage, and that State Farm thus had a duty to defend Lint against Wright's claim. State Farm sought appellate review.

Holding:

The Court of Appeal upheld the trial court's ruling that State Farm was obligated to defend Lint against Wright's personal injury claim.

The appellate court first addressed whether Wright's claim against Lint arose from an "occurrence," or "accident." The court noted that although Lint deliberately picked Wright up and threw him in the pool, Lint only intended to "get [Wright] wet" and did not intend for Wright to land on the pool step. The court recited the rule that "an 'accident' exists when any aspect in the causal series of events leading to the injury or damage was unintended by the insured and a matter of fortuity." The court then concluded that "Lint miscalculated one aspect in the causal series of events leading to Wright's injury, namely, the force necessary to throw Wright far enough out into the pool so that he would land in the water." Because Lint did not expect or intend that Wright would land on the pool steps where Wright could get injured, Wright's injury arose from an "occurrence," or "accident."

The court next addressed State Farm's policy exclusion for "bodily injury ... (1) which is either expected or intended by the insured; or (2) which is the result of willful and malicious acts of the insured." According to the court, Wright's injury was not "expected or intended" by Lint and was not the result of a "willful and malicious act" by Lint. Thus, this exclusion did not relieve State Farm of the duty to defend Lint against Wright's claim.

Because Wright's claim against Lint was potentially covered under the State Farm policy, State Farm was obligated to defend Lint against Wright's claim.

Sony Computer Entertainment America, Inc. v. American Home Assurance Co. (July 15, 2008, 9th Cir.) 532 F.3d 1007

Insurers Have No Duty to Defend Insured in Class Actions Alleging Product Defects in Video Game System

Facts:

Sony Computer Entertainment America, Inc. (Sony) marketed and distributed the “PlayStation 2,” a home entertainment system that supposedly was capable of playing audio and video CDs and DVDs as well as video games.

PlayStation users filed two class action lawsuits against Sony in California state court. In those lawsuits the plaintiffs alleged that the PlayStation 2 systems suffered from an “inherent” or “fundamental” design defect that rendered them unable to play DVDs and certain game discs. The plaintiffs’ complaints included causes of action for breach of express and implied warranties, negligent misrepresentation, false advertising and unfair business practices. The plaintiffs’ negligent misrepresentation and false advertising claims were based on statements Sony made in press releases, product packaging and advertising that the PlayStation 2 would function as a DVD player as well as a game player.

Sony was the named insured on both a media liability policy issued by American International Specialty Lines Insurance Company (AISLIC) and a commercial general liability policy issued by American Home Assurance Company (American Home). Sony tendered the class action lawsuits to AISLIC and American Home, but both insurers rejected Sony’s tenders. Sony then filed a breach of contract / bad faith lawsuit against AISLIC and American Home in federal court, alleging that AISLIC and American Home had wrongfully failed to defend Sony in the underlying class action lawsuits.

The district court granted summary judgments in favor of both AISLIC and American Home, and Sony appealed.

Holding:

The Ninth Circuit Court of Appeal, applying California law, affirmed the judgments in favor of AISLIC and American Home. With respect to the AISLIC media liability policy, that policy provided that AISLIC would indemnify Sony and provide defense costs for lawsuits seeking damages because of specified “wrongful acts,” including “negligent publication.” The appellate court rejected Sony’s argument that the term “negligent publication” should be broadly interpreted to include any “communication of information to the public ... exhibiting a lack of due care,” and that it should thus extend to the claims of

negligent misrepresentation and false advertising made in the underlying class action lawsuits.

Rather, the appellate court held that when read in the context of the policy as whole, the term “negligent publication” referred to “a very narrow tort in which the publication of material encourages or instructs readers to engage in harmful conduct.” Since the plaintiffs in the underlying class action lawsuits did not allege that Sony had led readers to engage in harmful conduct, the coverage for “negligent publication” was inapplicable. Thus, AISLIC had no duty to defend or indemnify Sony.

With respect to the American Home general liability policy, that policy provided that American Home would indemnify and defend Sony against lawsuits seeking damages because of “property damage,” which was defined so as to include (1) “physical injury to tangible property” and (2) “loss of use of tangible property that is not physically injured.”

As to the issue of “physical injury to tangible property,” the underlying class representative plaintiffs did not allege that Sony’s PlayStation 2 systems had scratched or damaged discs which were inserted into the systems, and in fact the class representative plaintiffs specifically denied that any such damage had occurred. Nor was it sufficient that other members of the putative class may have claimed scratches or other damage to discs, since any such claims were never incorporated into the underlying class action lawsuit.

As to the issue of “loss of use of tangible property that is not physically injured,” the class representative plaintiffs did not allege that defects in the PlayStation 2 had caused them to suffer a “loss of use” of game discs or DVDs. Moreover, even if class representative plaintiffs had made that claim, any such claim would fall within the scope of the policy’s “impaired property” exclusion, which barred coverage for “loss of use” property damage arising out of a “defect, deficiency, inadequacy or dangerous condition in [Sony’s] product.”

The appellate court concluded that under the circumstances, American Home had no duty to defend Sony in the underlying class action lawsuits.

Crawford v. Weather Shield Mfg., Inc. (July 21, 2008) 44 Cal. 4th 541

Indemnity Clause in Construction Contract Can Impose Duty to “Defend” Even in Absence of Duty to “Indemnify”

Facts:

A developer entered into a subcontract with a window manufacturer pursuant to which the window manufacturer supplied windows for one of the developer’s residential housing projects. The written subcontract contained a clause stating that the window manufacturer would (1) “indemnify ... [the developer] against all claims ... growing out of execution of the work, and (2) “defend any suit or action brought against [the developer] founded upon the claim of such damage.”

After the project was completed, numerous homeowners filed construction defect actions against the developer, the window manufacturer and other parties. Among other things, the homeowners alleged that the window manufacturer had improperly designed and manufactured the windows, causing them to leak and fog.

The developer tendered its defense to the window manufacturer, but the window manufacturer refused to defend. The developer then filed a cross-complaint for contractual indemnity against the window manufacturer, seeking to recover the costs of any settlement or judgment in favor of the homeowners, plus the costs of defending against the homeowners’ claims.

The homeowners settled their claims against the developer. The homeowners then proceeded to trial against the window manufacturer, but the jury found that the window manufacturer was not negligent. In a subsequent bench trial on the developer’s cross-complaint for indemnity against the window manufacturer, the trial court ruled that even though the window manufacturer had been found not negligent and thus had no duty to “indemnify” the developer for its settlement with the homeowners, the window manufacturer had a separate duty to “defend” the developer and thus had to pay the developer’s defense costs related to claims involving the windows.

Holding:

The California Supreme Court affirmed the trial court’s ruling requiring the window manufacturer to pay the developer’s defense costs related to window claims. The Supreme Court acknowledged that contractual indemnity clauses should be narrowly construed against the party seeking indemnification. However, the Supreme Court concluded that even construing the subject indemnity clause

narrowly, the clause expressly and unambiguously required the window manufacturer to “defend” the developer against suits alleging window problems.

Thus, the window manufacturer had an obligation to “defend” the developer against the window claims, even though the window manufacturer was ultimately found not negligent and thus had no duty to “indemnify” the developer for amounts paid in settlement of the window claims. In the course of its opinion, the Supreme Court specifically overruled a prior Court of Appeal decision, *Regan Roofing Co. v. Superior Court* (1994) 24 Cal.App.4th 425, which had reached a contrary result.

EMPLOYER LIABILITY INSURANCE

***Power Fabricating, Inc. v. State Compensation Ins. Fund* (Sept. 30, 2008)**
167 Cal.App.4th 1446

Employer Liability Insurance Coverage Does Not Apply Unless Worker Was Injured in Course and Scope of Employment with Insured and Either Insured May Be Sued in Non-Employer Capacity or Workers’ Compensation Law Does Not Apply to Claim

Facts:

Jonathon Kryzak, an apprentice electrician, was fatally electrocuted in the course of his employment. State Compensation Fund (“State Fund”) issued a policy of insurance to Power Fabricating Inc. (“Power”) that afforded coverage for workers’ compensation claims and ELI coverage. State Fund paid workers’ compensation benefits to Kryzak’s widow.

Kryzak’s widow also brought a civil action against Power and a related entity, Power Temporary Systems, Inc. (“PTSI”). Power tendered the civil action to State Fund which denied the tender. Power then sued State Fund for breach of contract for refusing to defend and indemnify it in the Kryzak action. The trial court granted summary judgment in favor of State Fund and Power appealed.

Power argued summary judgment was inappropriate because there was a disputed issue of fact as to whether Power, PTSI, or a joint venture of the two entities, was Kryzak’s employer at the time of the accident. Power contended ELI coverage would apply if Kryzak was an employee of the joint venture and was injured by Power’s negligent acts or if Kryzak was Power’s employee but was injured by acts of the joint venture for which Power was derivatively liable.

Holding:

The Court of Appeal rejected both assertions. The ELI coverage only applied to injury arising out of or in the course of employment by the insured. To the extent the joint venture, as an entity distinct from either Power or PTSI, employed Kryzak, the ELI coverage would not apply in the first instance. Relying on *Producers Dairy Delivery Co. v. Sentry Ins. Co.* (1986) 41 Cal.3d 903, the court held Power could not invoke coverage under the policy, which required employment by an insured, but then avoid the application of the worker's compensation exclusion on the theory a non-insured entity was actually Kryzak's employer.

The court also rejected Power's second argument, holding the workers' compensation exclusion would apply to Power's derivative liability for the joint venture. The ELI coverage excluded liability for claims arising under the workers' compensation law. Kryzak's widow's claim did not invoke any exceptions to application of the workers' compensation law. In addition, the complaint alleged only Power, not PTSI, was negligent, eliminating any risk of derivative liability. Even if such risk existed, Power's derivative liability would not fall within an exception to the workers' compensation law because it would not qualify as one of the non-employment capacities excepted from the law.

Holding that ELI coverage was dependent on both the party seeking coverage qualifying as an insured and the claim being outside the scope of the workers' compensation law, and thereby the workers' compensation exclusion, the court concluded summary judgment was properly awarded to State Fund and affirmed the trial court's decision.

EXCESS INSURERS

***Qualcomm v. Certain Underwriters at Lloyd's, London* (Mar. 25, 2008)**
161 Cal.App.4th 184

Excess Insurer Has No Duty to Pay Where Insured Settles With Primary Insurer For Less Than Primary Policy's Limits

Facts:

National Union Fire Insurance Company of Pittsburgh (National Union) issued Qualcomm, Inc. (Qualcomm) a primary directors and officers (D&O) liability policy, which insured Qualcomm and its directors and officers for "loss," including settlements and defense costs arising from civil lawsuits. National Union's primary policy had a \$20 million limit of liability.

Certain Underwriters at Lloyd’s, London (Underwriters) issued Qualcomm a first level excess D&O liability policy, which provided another \$20 million in coverage in excess of National Union’s \$20 million primary policy limit. The Underwriters excess policy contained an “exhaustion” clause which stated that “Underwriters shall be liable only after the insurers under each of the Underlying Policies [i.e., the National Union primary policy] have paid or have been held liable to pay the full amount of the Underlying Limit of Liability.”

Various Qualcomm employees filed a class action lawsuit against Qualcomm asserting a right to unvested company stock options. Other employees filed similar lawsuits, asserting a right to accelerated vesting of stock options.

Qualcomm tendered the defense of these underlying actions to National Union and Underwriters. Qualcomm settled a coverage dispute with National Union in exchange for National Union’s payment of \$16 million under the National Union \$20 million primary policy. Qualcomm then paid the \$4 million “gap” between National Union’s settlement amount and National Union’s primary policy limit. Thereafter, Qualcomm sought coverage from the excess insurer, Underwriters, for an additional \$9 million in settlement payments and defense expenses that Qualcomm incurred in the underlying actions. Underwriters asserted that it had no obligation to pay, as the underlying National Union primary policy had not exhausted.

Qualcomm sued Underwriters for breach of contract and declaratory relief, contending that Underwriters’ excess policy obligated it to reimburse Qualcomm for the \$9 million Qualcomm had incurred in defending and settling the underlying actions. Qualcomm asserted that National Union and Qualcomm had collectively paid at least \$20 million for the defense and indemnity of the underlying actions. Underwriters countered that the “exhaustion” clause in its excess policy required National Union to pay or become obligated to pay its entire \$20 million policy limit. The trial court ruled in Underwriters’ favor and Qualcomm appealed.

Holding:

The Court of Appeal affirmed the trial court’s ruling, concluding that the “exhaustion” clause in Underwriters’ excess policy unambiguously required National Union to pay or be legally obligated to pay no less than its \$20 million primary policy limit before Underwriters became obligated to pay under its excess policy. In holding that the Underwriters’ excess policy was not triggered, the appellate court rejected Qualcomm’s public policy arguments regarding the encouragement of settlements between insureds and primary insurers. Instead, the appellate court focused on the “literal language” of the excess policy, which

required that the primary insurer pay the “full amount” of its limits before the excess policy would apply.

“GARAGE OPERATIONS” LIABILITY INSURANCE

Spangle v. Farmers Ins. Exch. (Aug. 29, 2008) 166 Cal.App.4th 560

Triable Issues of Fact Concerning “Ownership” of Vehicle Precluded a Finding That Person Was “Insured” as a Permissive User under “Garage Operations” Liability Policy

Facts:

Sixteen year old Kevin McCarty’s (“McCarty’s”) father purchased for him a used SUV from Triple Crown Auto Sales, Inc. (“Triple Crown”). Although the SUV was for McCarty, Triple Crown required McCarty’s father to sign the purchase agreement because of its policy of not entering into such agreements with minors. However, even though a minor, McCarty signed DMV paperwork as the purchaser of the SUV and executed a DMV power of attorney authorizing Triple Crown to forward necessary documentation to the DMV to transfer title of the SUV.

At the time of this transaction, Triple Crown was insured under a commercial automobile and garage operations policy issued by Mid-Century.

Approximately one week following the purchase of the SUV, McCarty collided with, and seriously injured, Spangle, while driving the SUV. Spangle obtained judgment against McCarty in an amount that exceeded the limits of McCarty’s insurance. Spangle also made a policy limits settlement demand on Mid-Century. Mid-Century rejected the demand on several grounds, including that McCarty was excluded from coverage as “customers” of Triple Crown, and that the accident did not result from Triple Crown’s “garage operations.”

Spangle then sued Mid-Century, alleging claims for bad faith and breach of contract, and a claim as a judgment creditor seeking recovery against the debtor’s insured under Insurance Code section 11580(b)(2). Spangle claimed that McCarty was “insured” as a permissive user under the policy, as legal title never passed from Triple Crown to McCarty and Triple Crown was the “owner” of the SUV at the time of the accident. Spangle and Mid-Century filed cross-motions for summary judgment.

The trial court granted Mid-Century's motion for summary judgment on the grounds that the accident was not covered because it did not "result from" Triple Crown's "garage operations." However, the trial court declined to grant summary judgment on the issue of whether McCarty was excluded from coverage as a "customer" and on the issue of whether Triple Crown was an "owner" of the SUV.

On appeal, Mid-Century argued that the policy only covered liability "resulting" from "garage operations" which should be interpreted as "ownership, maintenance [or] use of locations for garage business" or "the roads or other access that adjoin these locations." Since McCarty's accident occurred 50 miles from Triple Crown's lot while McCarty was driving the SUV for his private purposes, it did not result from "garage operations" and was not covered .

Holding:

The Court of Appeal rejected Mid-Century's interpretation, and stated the policy defined "garage operations," in part, to include "the ownership, maintenance or use of covered autos." The Court further reasoned that there was no requirement that "use" of the "covered auto" have any relation to Triple Crown's business of selling or repairing motor vehicles.

As a result, the Court held that the accident resulted from McCarty's use of the SUV and, therefore, Spangle's injuries fell within the policy's insuring provision, regardless of whether the accident occurred 50 miles or 5 blocks from Triple Crown's lot. The Court also reasoned that Triple Crown had a reasonable expectation of coverage based on the language of the policy itself, and noted that its interpretation of the "garage operations" provision was consistent with interpretations provided by commentators and courts in non-California cases.

The Court also rejected Mid-Century's argument that McCarty was excluded from the definition of "insured" because he was a "customer" of Triple Crown. Since neither the policy nor California insurance authorities addressed the definition of the term "customer," the Court looked to the ordinary and popular meaning of the term "customer" as being a purchaser or buyer of goods and services. Since McCarty's father purchased the SUV, and McCarty was not a party to the purchase-sale transaction, the Court held that McCarty was not Triple Crown's customer.

The Court found it irrelevant that McCarty's father planned to give him the SUV, stating not every gift recipient constitutes a "customer" of the retailer from whom the gift was purchased. The Court also found it irrelevant that McCarty signed DMV paperwork stating he was the "purchaser," as this paperwork dealt with formalities of the registration process and did not alter the nature of the transaction.

The Court further stated that even if McCarty was a potential customer prior to the sale, because of test driving the vehicle or otherwise, the potential went unrealized once the actual sale was made to McCarty's father. As a result, McCarty was neither a "customer" nor a potential "customer" when the accident occurred. Finally, the Court noted that because "customer" was ambiguous, it must construe the exclusion narrowly in favor of coverage.

Accordingly, the Court held that it could not be established as a matter of law that McCarty was a "customer" of Triple Crown at the time of the accident, thereby precluding entry of summary judgment.

The Court also rejected Spangle's request that the Court direct the trial court to grant her motion for summary adjudication on the coverage issue. The Court noted that its analysis of the "garage operations" provision assumed McCarty was an "insured" as a permissive user under the policy. The policy would only cover McCarty as a permissive user if Triple Crown was an "owner" of the SUV at the time of the accident. As Spangle failed to cite any admissible evidence to support this fact, the Court found that triable issues of fact existed as to whether Triple Crown was an "owner" of the SUV at the time of the accident.

INTERVENTION

Royal Indemnity Co. v. United Enterprises, Inc. (Apr. 23, 2008)
162 Cal.App.4th 194

Third Party Claimant Not Entitled to Intervene in Insurer's Declaratory Relief Action Against Insured

Facts:

United Enterprises, Inc. (United) owned real property on which it operated a trap and shooting range. Flat Rock Land Company (Flat Rock) eventually acquired the property.

After Flat Rock acquired the property, Flat Rock apparently discovered that the property had become contaminated during the time that United owned the property. Flat Rock thus sued United, seek recovery of environmental cleanup costs incurred in connection with the property.

United tendered defense of the action to various liability insurers, including Royal Indemnity Company (Royal). Royal agreed to defend United under

reservation of rights. Royal then filed a declaratory relief action against United, seeking a ruling that Royal did not have any duty to defend or indemnify United in the underlying action brought by Flat Rock. Royal did not name the third-party claimant, Flat Rock, as a defendant in the declaratory relief action.

Flat Rock filed a motion to intervene in Royal's declaratory relief action against United, claiming that Flat Rock had a "direct and immediate interest" in the outcome of the declaratory relief action and that Flat Rock should thus be allowed to participate in the declaratory relief action. The trial court denied Flat Rock's motion and Flat Rock appealed.

Holding:

The Court of Appeal affirmed the trial court's order denying Flat Rock's request to intervene in Royal's declaratory relief action against United. According to the appellate court, Flat Rock "cannot show an adequately direct interest to obtain intervention in this insurance coverage action." The appellate court emphasized that Flat Rock was not an insured under United's policy through Royal, and thus Flat Rock had no direct rights under the policy. Moreover, as a mere potential (as opposed to actual) judgment creditor of United, Flat Rock did not yet have standing to bring a judgment creditor action against Royal under Insurance Code section 11580.9(b)(2). Nor was Flat Rock an assignee of any of United's rights under the Royal policy. Since Flat Rock "does not yet have a protectable interest in the insurance proceeds," the trial court did not abuse its discretion in denying Flat Rock's request to intervene in the declaratory relief action.

MEDIATION

***Campagnone v. Enjoyable Pools & Spas Service & Repairs, Inc.*
(May 30, 2008) 163 Cal.App.4th 566**

Insurers With Potential Insurance Coverage Can Be Sanctioned for Failing to Attend Court-Ordered Mediation

Facts:

Sta-Rite Industries and Enjoyable Pools & Spas Service & Repairs, Inc., appealed from a \$2,424,000 judgment entered after a jury trial in a personal injury case. Sta-Rite filed a Certificate of Interested Entities or Persons with the Court of Appeal, listing National Union Fire Insurance Company, which issued an excess policy to Sta-Rite for amounts over \$3,000,000, as an interested entity.

The Court of Appeal ordered the parties to participate in the Court's mediation program. Sta-Rite and its attorneys attended, but National Union did not send a representative. Plaintiffs sought sanctions against Sta-Rite, its counsel, and National Union because National Union did not participate in the mediation and Sta-Rite and its counsel allegedly did not participate in the mediation in good faith.

Holding:

In considering the request for sanctions, the Court reviewed the success of its mediation program. The court noted the success of mediation of cases for which insurance coverage is potentially applicable depends on the attendance of carrier representatives with full authority.

Consequently, the Third Appellate District's local rules include Local Rule 1(d)(9) which provides that all parties and their counsel of record must attend all mediation sessions in person and with full settlement authority. Additionally, if a party has "potential insurance coverage applicable to any of the issues in dispute, a representative of each insurance carrier whose policy may apply also must attend all mediation sessions in person, with full settlement authority..."

The Court stated it was putting all parties on notice that an "unreasonable violation" of Rule 1(d)(9) will result in monetary sanctions. The Court reasoned it has authority to impose such sanctions under the Appellate Rules of the California Rules of Court, Rule 8.276(a) and Local Rule 1(g).

The Court also concluded it can impose such sanctions against insurers because they are considered parties to a mediation. The court cited *Doctors' Co. Ins. Services v. Superior Court*, 225 Cal.App.3d 1284, 1295 (1990), and *American Mutual. Liability Ins. Co. v. Superior Court*, 38 Cal.App.3d 579, 591-92 (1974), in support of this conclusion. *Doctors* held the litigation privilege applied to insurers because insurers are authorized "participants" in litigation because they have a vital stake in the progress and outcome of litigation. *Doctors*, supra, 225 Cal.App.3d at 1295. *American Mutual* held an insured which sues defense counsel retained by an insurer could not waive the attorney-client privilege held by the defending insurer that flows from the common interest it and the insured have in communicating with counsel retained to defend the insured. *American Mutual*, supra, 38 Cal.App.3d at 591-92.

The Court held that even though National Union was an excess carrier, it was within the scope of Rule 1(d)(9) because its policy attached in excess of \$3 million and the amount in controversy in the case was the judgment (over \$2.4 million) plus interest at the rate of 10 percent. The Court declined to order

sanctions against National Union because it had not been notified of the mediation.

The Court also declined to sanction Sta-Rite for its failure to notify National Union because the Court's local rule did not clearly assign a duty to a party or its counsel to notify the carrier. However, the Court stated this duty was now clear through the publication of its opinion. Thus, in the future, a party will be subject to sanctions if it fails to notify an insurer with potential coverage of its obligation under Rule 1(d)(9) to send a fully authorized representative to a court-ordered mediation.

The Court also declined to order sanctions against Sta-Rite and its counsel for their alleged failure to participate in mediation in good faith. The Court reasoned the basis for the claim could not be advanced without revealing communications that were confidential pursuant to the Court's local rules and Evidence Code section 1119(c). The Court distinguished conduct, including the failure to attend a mediation, which can be disclosed by a party, from communications, which must be kept confidential.

Simmons v. Ghaderi (July 21, 2008) 44 Cal.4th 570

Evidence of Mediation Conduct Was Not Admissible to Establish a Settlement When the Defendant Sought to Back Out of a Settlement Made at the Mediation

Facts:

The parties to a medical malpractice case attended a mediation. Defendant Lida Ghaderi, M.D. provided her medical malpractice insurer, Cooperative American Physicians/Mutual Protection Trust ("CAPMPT") with her written consent to settle the case for the amount of \$125,000. The plaintiffs unconditionally accepted a \$125,000 settlement offer. While the mediator was reducing the settlement agreement to writing, the CAP-MPT claims specialist told Dr. Ghaderi a settlement had been reached. Dr. Ghaderi promptly revoked her consent to settle, and left the mediation.

Plaintiffs ultimately amended their medical malpractice complaint to include a cause of action for breach of the oral settlement contract. After a bifurcated trial on that cause of action, the trial court entered judgment in favor of plaintiffs in the amount of \$125,000. Dr. Ghaderi appealed, arguing that the Evidence Code provisions governing mediation confidentiality prevented plaintiffs from introducing any evidence of the oral settlement agreement.

The court of appeal concluded that Dr. Ghaderi was estopped from relying on mediation confidentiality and therefore affirmed.

Holding:

The California Supreme Court reversed. It held that the statutory scheme for mediations limited the instances in which conduct undertaken in connection with the mediation could be used and that the scheme did not include establishing a settlement under the circumstances. The Court recognized that the statutory scheme could give a wrongdoer, such as a litigant who wanted to back out of a settlement, an unfair advantage, but nonetheless held that the courts were not empowered to create exceptions.

PROPERTY INSURANCE

De Bruyn v. Superior Court (Jan. 14, 2008) 158 Cal.App.4th 1213

“Absolute” Mold Exclusion is Valid, Even Though Covered Water Damage is Predominant Cause of Mold

Facts:

Rudolf De Bruyn purchased a homeowner’s insurance policy from Farmers Insurance Exchange. The policy was written on an “allrisk” basis for the dwelling and on a “specified-peril” basis for personal property. Among other things, the policy covered losses to the dwelling and personal property caused by a “sudden and accidental discharge” of water from a plumbing system or household appliance. The policy also included a so-called “absolute” exclusion for mold. The exclusion provided that the policy did not “under any circumstances” cover mold, even if resulting from a covered cause of loss (such as the “sudden and accidental” discharge of water from a plumbing system). Other language in the policy provided that “[w]henver ... mold ... occurs, the ... mold ... and any resulting loss is always excluded under this policy, however caused.”

De Bruyn and his family returned from a sixday vacation to find that a toilet had overflowed and damaged their home. A few days later, De Bruyn discovered that the dishwasher also had leaked. Both water leaks caused mold. De Bruyn made claims to Farmers, and Farmers paid De Bruyn for the water damage but denied payment for damage related to mold.

De Bruyn sued Farmers based upon Farmers’ denial of coverage for mold-related damage resulting from the toilet overflow and dishwasher leak. Among other things, De Bruyn alleged the “absolute” mold exclusion was invalid pursuant

to California’s predominant cause doctrine. Farmers demurred to portions of De Bruyn’s complaint, asserting that the “absolute” mold exclusion was valid and eliminated any obligation to pay for mold damage, even when mold was caused by a covered peril. The trial court sustained Farmers’ demurrer, and De Bruyn sought relief in the Court of Appeal.

Holding:

The Court of Appeal affirmed, holding that the “absolute” mold exclusion was valid. The Court acknowledged that the loss involved two distinct perils— sudden discharge of water and mold—because each can occur without the other. However, the Court reiterated that the purpose of predominant cause doctrine is to bring about “a fair result within the reasonable expectations of both the insured and the insurer,” as set forth by the California Supreme Court in *Garvey v. State Farm Fire & Casualty Co.* (1989) 48 Cal.3d 395.

The Court also reiterated that an insurer may limit coverage to some, but not all, manifestations of a given peril, as long as “[a] reasonable insured would readily understand from the policy language which perils are covered and which are not.” (*Julian v. Hartford Underwriters Ins. Co.* (2005) 35 Cal.4th 747.) According to the Court of Appeal, the primary issue is whether the policy “plainly and precisely communicate[s] an excluded risk” to a reasonable insured— and Farmers’ policy satisfied that requirement.

Everett v. State Farm General Ins. Co. (Apr. 29, 2008)
162 Cal.App.4th 649

Homeowner’s Policy Clearly Stated Replacement of Homeowner’s Property Limited to Policy Limit Stated in Declarations

Facts:

Agnes Everett (“Everett”) purchased a home in October, 1991 for \$99,000. At the same time, she purchased a homeowner’s policy from State Farm (“the Policy”). The Policy included an endorsement for guaranteed replacement cost coverage which provided that State Farm would pay the full amount needed to repair the damaged or destroyed dwelling with like or equivalent construction, without regard to policy limits.

In August 1997, State Farm eliminated the guaranteed replacement cost coverage in its homeowner policies and sent each policyholder a notice of the change in coverage. The notice complied with applicable law and informed the insureds that if they chose to renew their homeowners policies with State Farm, guaranteed replacement coverage would no longer be available. The insureds were

informed that their policy now has a stated limit of liability that reflects the maximum that will be paid in case of loss.

On September 29, 1997, Everett renewed her homeowners policy with the new terms providing for a stated policy limit. Each year from 2000 to 2003, State Farm sent a renewal certificate to Everett which provided Everett with a reminder that it was her responsibility to insure her home with adequate coverage. State Farm provided Everett with a replacement cost estimate, but State Farm's renewal certificate advised her State Farm does not guarantee this figure will represent the actual cost to replace her home and it is her responsibility to select the appropriate amount of coverage. In addition, every two years State Farm mailed to its California insureds a "California Residential Property Insurance Disclosure" that explained the terms "replacement cost" and "extended replacement cost," in compliance with Insurance Code section 10102.

On October 25, 2003, Everett's home was destroyed by fire. State Farm adjusted Everett's claim and paid her \$138,654.48 for her structural loss and \$76,620 for her personal property.

Dissatisfied with this payout, Everett sued State Farm on March 25, 2005, asserting claims for breach of contract, breach of implied covenant of good faith and fair dealing, negligence, reformation, and fraud. Her breach of contract claims were based on two theories. First, she alleged the policy in effect at the time of her loss provided guaranteed replacement cost coverage, such that she was entitled to full payment to replace her property without regard to policy limits. Alternatively, she alleged State Farm failed to provide sufficient notice of the changes in her policy and, therefore, the guaranteed replacement cost coverage should remain in place.

State Farm filed a motion for summary adjudication, arguing the policy in place at the time of Everett's loss did not include guaranteed replacement cost coverage and that she received sufficient notice of the change in coverage with her 1997 renewal. The trial court granted the motion.

Holding:

The Court of Appeal affirmed and held the coverage afforded under the policy clearly and unequivocally limits payment to the amount stated in the declarations page. The policy provided the following:

We will pay up to the applicable limit of liability shown in the Declarations, the reasonable and necessary cost to repair or replace with similar construction and for the same use on the premises shown in the Declarations . . .

The court held Everett's policy did not include language guaranteeing replacement cost coverage. It rejected Everett's contention the policy was unclear for stating in the declarations both a dollar amount of coverage and a statement that the policy included replacement cost for "similar construction."

The court rejected Everett's contention that State Farm used the word "replace" to deceive its customers into thinking they would receive the full cost to rebuild their homes. The court noted that even if the word "replace" is interpreted as restoring the property to its similar state prior to the fire, the "Coverage A Loss Settlement Endorsement" clearly limits payment to the amount stated in the declarations page. The court concluded the policy was not ambiguous.

The court also disagreed with Everett's contention State Farm was liable under the California Residential Property Insurance disclosure statement (Ins. Code Sections 10101 & 10102) for failing to maintain policy limits equal to replacement costs. The court held Insurance Code sections 10101 and 10102 do not require State Farm to set policy limits that equal the cost to replace the property. Instead, it is up to the insured to determine whether he or she has sufficient coverage for his or her needs. In addition, State Farm's renewal certificates contained reminders that the State Farm replacement cost figure was only an estimate.

The court also concluded State Farm complied with Insurance Code section 678(a)(1)(A), which governs the method an insurer must use to provide notice to an insured of a reduction in coverage.

Lastly, the court rejected Everett's negligent misrepresentation claims against the State Farm agents who sold and serviced Everett's policy. The court noted the policy included an integration clause stating the policy "contains all of the agreements between you and us and any of our agents." The policy further stated that its terms could not be modified by any oral agreement. Accordingly, the court concluded no oral representation could have been effective to change the terms of the fully integrated policy.

Devonwood Condominium Owners Association v. Farmers Insurance Exchange (May 20, 2008) 162 Cal.App.4th 1498

Because Appraisal Panel Only Decided "Amount" of Loss, Court Could Confirm Amount of Award, but Could Not Enter Money Judgment

Facts:

After a fire damaged a unit located within the Devonwood condominium project, the Devonwood Condominium Owners Association (Devonwood)

submitted a claim to its insurer, Farmers Insurance Exchange (Farmers). When the parties could not agree on the amount of the loss, Devonwood demanded appraisal. Each party selected an appraiser, and the two appraisers selected an umpire.

This appraisal panel issued a unanimous written appraisal award, which set forth two categories of replacement cost values. The first category, the “replacement cost value of fire-related structure damage, exclusive of floor coverings, ceiling coverings (including paint), and wall coverings (including paint) in the residential unit,” totaled \$122,460.65. The second category, the “replacement cost value of interior painting of walls and ceilings due to fire-related structure damage,” totaled \$7,479.22. The written award provided in relevant part: “Attached to this award is a breakdown which sets forth those items included herein. This breakdown sets forth the above award in detail and is made without consideration of ... or any coverage or other provision of the above policy which might affect the amount of the insurer’s liability thereunder....”

Devonwood subsequently filed a petition in superior court to confirm the appraisal award. Farmers opposed the petition, arguing that it was not obligated under the policy to pay for painting interior areas. However, the superior court confirmed the appraisal award, and entered a money judgment against Farmers in the sum of \$129,939.87. Farmers appealed.

Holding:

The Court of Appeal vacated the judgment, and remanded the case to the superior court with instructions to enter a new judgment that conformed to the appraisal award. The Court of Appeal reasoned that the appraisers stated on the face of the award that the award was made “without consideration of ... any coverage or other provision of the above policy which might affect the amount of the insurer’s liability thereunder....”

In short, the Court of Appeal found that the appraisal panel merely determined the amount of the loss, and did not decide whether Farmers actually owed any amount under the policy. Thus, Court of Appeal held that the superior court’s statutory authority was limited to the issuance of a judgment which brought finality to the dollar amount of the replacement cost values—and nothing more.

Roberts v. Assurance Company of America (May 30, 2008)
163 Cal.App.4th 1398

Engineer's Design Errors Are Not "Defective Methods in Construction" and Do Not Trigger Collapse Coverage

Facts:

Jim Roberts purchased an undeveloped lot located on a steep slope with the intention of building a home on it. Roberts also obtained a builder's risk policy from Assurance Company of America.

Assurance issued two consecutive annual builder's risk policies and, later, an unsold dwelling policy. The builder's risk policies provided first-party property coverage during the course of construction and obligated Assurance to pay "for direct physical loss to Covered Property from any Covered Loss described in this Coverage Form." The unsold dwelling policy provided first party property coverage for the property until it was sold or occupied and obligated Assurance to pay for "direct physical loss to Covered Property from a Covered Cause of Loss described in this Coverage Form."

While construction was under way, Roberts noticed cracks in the foundation and a retaining wall next to the house, which worsened over the next few months. After a period of heavy rains, a landslide occurred, causing severe damage to the dwelling.

Assurance retained an engineer to investigate the causes of the landslide. The engineer concluded the damage was caused by an ancient landslide under the property, and that the ancient landslide was activated by the placement of fill soils on Roberts' property and a neighboring lot during grading. The engineer also concluded that heavy rains accelerated the rate of slope subsidence that had already begun and constituted a second cause of the landslide.

Assurance's policies contained exclusions for earth movement, weather conditions that contribute to a loss caused by earth movement, acts or decisions of any governmental, regulatory or controlling body, and loss caused by faulty, inadequate or defective planning, development, surveying, siting, design, construction or grading. The policies also provided coverage for "collapse" if caused by various named perils, one of which was "[u]se of defective materials or methods in construction, remodeling or renovation if the collapse occurs during the course of construction, remodeling or renovation."

Ultimately, Assurance denied Roberts' first party claim. Thereafter, Roberts filed suit against Assurance for breach of contract, breach of the implied covenant

of good faith and fair dealing, and declaratory relief. The trial court granted summary adjudication in favor of Assurance, and Roberts appealed.

On appeal, Roberts argued that the predominant cause of the loss was a developer's concealment of the existence of the underlying ancient landslide. Alternatively, Roberts argued that his own geotechnical expert's failure to adequately survey, design or site the project—and the resulting overloading of the slope—was a “defective” method in construction and that the “collapse” coverage therefore applied.

Holding

The Court of Appeal held that the developer's alleged concealment of the ancient landslide was not a conceptually distinct peril apart from the ancient landslide itself. According to the Court, the reason for the earth movement, whether due to the alleged concealment of the ancient landslide or due to the placement of fill, was immaterial. In addition, according to the Court, “[c]oncealment by the developer was not a separate cause for the loss, but merely a separate explanation for the single cause of the loss, i.e., earth movement.” The Court also noted that even if the predominant cause doctrine did apply, Roberts admitted that his own geotechnical engineer knew of the ancient landslide but failed to report its presence when performing engineering services for the lot.

Finally, the Court of Appeal held that Roberts' geotechnical expert's failure to adequately survey, design or site the project was a “design error,” not a “defective method in construction,” and that the collapse coverage provision therefore did not apply.

City of Hollister v. Monterey Ins. Co. (July 29, 2008) 165 Cal.App.4th 455

Insurer is Properly Estopped from Relying Upon Failed Condition Precedent to Insurance Coverage Where Insurer's Own Conduct Caused the Failure

Facts:

The City of Hollister (“City”) owned a structure at the Hollister Municipal Airport, called Building 25, since 1947. Building 25 served various functions over the years including an auditorium, a gymnasium, a post office, etc.

The City insured Building 25 against fire loss under a commercial lines policy issued by Monterey Insurance Company (“MIC”). The policy included a “Functional Building Valuation” endorsement that obligated MIC to repair or replace the building if, within 180 days after the loss, the City “contract[ed] for repair or replacement of the loss or damage to restore the building . . . for the same

occupancy and use . . .” Otherwise, the City was only entitled to Building 25’s “market value.”

Building 25 was accidentally destroyed by fire on November 23, 2002. Approximately a year prior to the fire, MIC inspected Building 25 and recommended that it be repainted. In response, the City told MIC that the City was considering whether to demolish Building 25. Although Building 25 was neither demolished nor repainted, MIC renewed the City’s policy anyway.

After the fire, MIC retained an independent adjuster that concluded that Building 25 was a “total loss.” MIC re-assigned the claim to a general adjuster, Jack Boczar, who personally inspected Building 25. While at Building 25, Boczar was purportedly told by unnamed persons at the building that the City had planned on demolishing the building prior the fire.

In its initial letter to the City after the fire, more than a month after the claim was presented, MIC told the City that its investigation was continuing. MIC requested documents pertaining to any intended demolition of Building 25. After MIC sent its letter, Boczar orally told City officials that, because he believed that the City intended to demolish Building 25 before the fire, he would fight (or “resist”) a claim for functional replacement coverage. City officials denied having decided to demolish Building 25 and expressed a desire to move forward with replacement of the structure. City officials also noted that it only had 120 days left to enter into a contract to replace the building but Boczar refused to extend the 180 day limit.

Thereafter, the City’s attorney and insurance broker sent numerous letters to MIC regarding the status of MIC’s investigation and seeking MIC’s determination regarding coverage for a replacement building and, if such coverage would be provided, in what amount. The City also complained in its letters about the pace of MIC’s investigation and reported that it was unable to enter into a contract to replace Building 25 until MIC reached a coverage determination.

MIC either failed to respond to the City’s letters entirely or delayed for weeks or months before responding. When it did respond, MIC never articulated a clear position with regard to replacement coverage and refused to discuss valuation methods in the event that it determined that replacement coverage did exist. Although MIC agreed to extend the 180 day period to contract for a replacement building by 60 days, the City indicated that because of the lengthy delay that had already occurred, it was impossible to meet the extended deadline.

The City filed a declaratory relief suit asking for a determination of its rights under the policy and seeking a declaration of its right to “complete the

public bidding process and execute a construction contract to build a functional replacement.” The trial court found that MIC’s conduct, i.e., Boczar’s statement that MIC would “fight” replacement coverage, the failure to reach a timely coverage determination, the failure to respond to three letters from the City at all, the long delays in communicating with the City, and the ambiguous responses MIC provided to the City’s inquiries, prevented the City from contracting to replace Building 25 because the City was unable to “front” the costs. Judgment was entered in favor of the City estopping MIC from enforcing the 180 day provision.

On appeal, MIC contended that the trial court lacked substantial evidence of the facts necessary to support equitable estoppel. The Court of Appeal observed that the elements of equitable estoppel are often poorly-described in the case law using terms that require fraudulent conduct. Equitable estoppel may be imposed if the party to be estopped has engaged in “blameworthy or inequitable conduct,” causing another disadvantage, and warranting a conclusion that the first party should not be permitted to exploit the disadvantage. With regard to the general contracting principles, estoppel is appropriate where one contracting party fails to reasonably cooperate with another contracting party with regard to the performance of a condition.

Holding:

In the insurance setting, an insurance carrier that violates California’s insurance claims practices regulations, including those regulations that require an insurer to cooperate with and assist the insured in determining the extent of the insurer liability and to communicate regularly with the insured, may be estopped to argue forfeiture of benefits by policyholders. Furthermore, without reference to regulations, an insurer remains obligated to “bring to the insured’s attention relevant information so as to enable the insured to take action to secure rights afforded by the policy.”

MIC’s argument that the City’s alleged intention to demolish Building 25 justified its threat to fight replacement coverage lacked a basis in law as shown by MIC’s eventual abandonment of the argument prior to trial. MIC’s suggestion that replacement coverage might be denied and refusal to abandon or clarify that position, although coverage was never actually denied, was significant in precluding the City from contracting to replace the building. The City could not be expected to enter into a contract to replace Building 25 without understanding whether MIC intended to cover its cost.

The Court of Appeal held that the trial court properly found that MIC intentionally interfered with the City’s performance of the 180-day contracting

condition by obstructing, delaying, and interfering with the City's attempt to determine its rights under the policy.

PROPOSITION 51

Bayer-Bel v. Litovsky (Jan. 25, 2008) 159 Cal.App.4th 396

A Negligent Driver and Negligently Entrusting Owner Are Not Jointly and Severally Liable

Facts:

Sixteen-year old Anna Litovsky and her friend Liana cut class, met up with Anthony Mosley and Eugene Green and went to a party in Mosley's SUV. When Litovsky realized people were drinking and using drugs, she asked Mosley to take her back to school. He and Green both refused because they had been drinking. The four agreed that Liana (who had a learner's permit) would drive and Green would accompany the girls. Mosley stayed at the party.

Liana drove to the school and got out of the car. Green asked Litovsky (who did not have a driver's license or a learner's permit) to drive him back to the party. She complied. On the way, Litovsky (driving on the wrong side of the street) crashed head-on into a car driven by Paulette Bayer-Bel.

Bayer-Bel sued Litovsky, Mosley, and Green, alleging causes of action for negligence (against Litovsky as the driver, and Mosley as the owner) and negligent entrustment (against Mosley and Green).

At trial, the jury awarded both economic and noneconomic damages. It allocated 60 percent fault to Bayer-Bel because she was not wearing her seatbelt. Of the remaining 40 percent, the jury allocated 40 percent to Litovsky, 20 percent to Mosley, and 40 percent to Green.

The trial court refused to apply Proposition 51 (Cal.Civ. Code § 1431.2(a)), finding that all three defendants' liability was based on something akin to respondeat superior or vicarious liability, not comparative fault — and entered a judgment making Litovsky, Mosley and Green all jointly and severally liable for the entire amount of the judgment. Litovsky appealed.

Holding:

The Court of Appeal reversed and remanded as to Litovsky. It found that while she could be jointly and severally liable for economic damages, she could

not be jointly and severally liable for noneconomic damages. Proposition 51 did away with joint and several liability for noneconomic damages. However, when a defendant's liability is secondary, as is the case when an employer is sued for the negligence of an employee or the owner of a car because of the driver's negligence, Proposition 51 does not apply.

Since Mosley was liable not only as the owner of the car, but also for negligently entrusting it to Green, Liana and Litovsky, his liability was not just secondary. Thus, the exception to Proposition 51 did not apply and Litovsky's negligence should not have been jointly and severally liable with Mosley.

PROPOSITION 213

***Ieremia v. Hilmar Unified School District (Aug. 26, 2008)* 166 Cal.App.4th 324**

Proposition 213 Does Not Automatically Prevent an Uninsured Vehicle Owner's Spouse From Recovering Noneconomic Damages

Facts:

Roy and Puaolele Ieremia were husband and wife. They were in a serious accident while driving a Dodge Durango that Roy had bought without Puaolele's knowledge. Roy bought the Durango from his boss, Jesse Mauga. Over the course of several months Roy made installment payments to Mauga out of his earnings. When Roy started making payments, Mauga gave him the keys to and full possession of the Durango.

Roy was the exclusive driver of the Durango, which he drove to and from work from his sister's home. Mauga submitted a notice of transfer and release of liability to the Department of Motor Vehicles reflecting the sale of the Durango to Roy. Roy made the final payment for the purchase of the Durango. After Roy made the final payment, he asked Mauga for the pink slip on the Durango. Mauga intended to give Roy the pink slip, but had not gotten around to it before Roy and Puaolele were involved in a collision. Thus at the time of the accident, neither Roy nor Puaolele was on the title to the Durango.

Puaolele did not know Roy had purchased the Durango using their community funds. She did not know he was using it to get to and from work from his sister's home. She never had possession of the keys to the car. She never drove the car. Roy brought the Durango home for the first time a day or two before the collision.

It was Puaolele's understanding from Roy that his boss had lent him the car so that they could make a trip to a casino, which was apparently where they were headed when the accident occurred. The first time Puaolele had ever been in the Durango was the day she and Roy headed to the casino. On that fateful day, Roy and Puaolele were injured in a serious collision. Neither Roy nor Puaolele had automobile liability insurance and the Durango was not covered by a liability policy of any sort.

Roy and Puaolele sued for personal injuries they sustained in the collision. The jury awarded Puaolele \$128,145 in economic damages and \$1.9 million in noneconomic damages.

The defendants appealed. They asserted the trial court erred in allowing Puaolele to obtain an award of noneconomic damages at trial. The defendants argued that Civil Code, section 3333.4(a)(2), which was enacted by virtue of Proposition 213, precluded Puaolele's recovery of noneconomic damages because she was an owner of the uninsured vehicle in which she was a passenger at the time of the accident.

Holding:

The Court of Appeal affirmed. The court reasoned that Proposition 213 was enacted as a means of pressuring automobile owners and drivers to maintain liability insurance. The pressure came from the fact that it precluded an uninsured owner or driver from recovering noneconomic damages from a negligent owner or driver of another vehicle.

While Proposition 213 precluded an uninsured owner or driver from recovering noneconomic damages, it did not define what it meant to be an "owner." That determination had to be made on a case-by-case basis.

The court stated:

Considering the electorate's intended purposes, it would be anomalous to adopt a construction of the word "owner" in section 3333.4(a)(2) that would deprive a person of the right to noneconomic damages without regard to their individual culpability for the vehicle's uninsured status. We simply do not believe the voters intended Proposition 213 to be construed to apply to a spouse whose only incident of ownership in a vehicle is a community property interest of which he or she is completely unaware.

Since Puaolele was not even aware she had an ownership interest in the Durango and thus could not have been culpable for it being uninsured and since she was only a passenger in it, the court held that she was not precluded from recovering noneconomic damages.

PUNITIVE DAMAGES

Sumpter v. Matteson (Jan. 10, 2008) 158 Cal.App.4th 928

A Jury Is Never Required to Award Punitive Damages

Facts:

Tasha Sumpter was injured in an automobile accident caused by Richard Matteson. The accident occurred when Matteson ran a red light at an intersection. Matteson ran the red light because he was under the influence of methamphetamines and believed the light would turn green before he arrived at the intersection.

At the time of the accident, Sumpter told the police she had not been injured. She did not seek treatment until eleven days after the accident and began a course of treatment a week after that. Ten months before the accident, Sumpter was injured in a slip-and-fall accident. Three months after Sumpter completed treatment with respect to the accident with Matteson, she fell in her yard when her knee locked.

In Sumpter's lawsuit against Matteson, the jury awarded her \$13,317.91 for past economic loss, including lost earnings and past medical expenses and \$20,000 for past noneconomic loss. It gave her nothing for future economic loss and nothing for future noneconomic loss. The jury determined that Matteson did not "engage in the conduct with malice or oppression" and did not award punitive damages.

Sumpter moved for a new trial or an order increasing the damage award. She took the position that the damage award of \$13,317.91 was inadequate as a matter of law in light of her medical bills which totaled \$131,282.42. She also took the position that in finding Matteson acted without malice, the jury returned a verdict which was contrary to the evidence.

The trial court denied Sumpter's motion and Sumpter appealed.

Holding:

The Court of Appeal affirmed. The court ruled that substantial evidence supported the jury's award of \$13,317 in economic damages, rather than Sumpter's claimed medical bills of \$131,282. This evidence included the prior injury and the subsequent injury and expert testimony about both. This evidence was adequate to allow the jury to conclude that only a small portion of Sumpter's medical bills were causally related to the accident with Matteson.

The court rejected Sumpter's argument that she was entitled to an award of punitive damages. Punitive damages are allowed when a defendant acts maliciously, fraudulently or oppressively or with a conscious disregard of the rights or safety of others. However, no matter how clear the evidence is that a defendant acts like this, a plaintiff is never entitled to punitive damages.

The court recognized that Matteson's conduct reflected a conscious disregard for the rights and safety of others and would have supported the imposition of punitive damages in this case. However, it stated: "[T]he issue before us is not whether the evidence would have supported an award of punitive damages by the jury, but rather, whether the jury's finding that Matteson acted without malice requires reversal and a new trial on the amount of punitive damages."

Since a jury is never required to award punitive damages, the court refused to overrule the jury's decision not to award them.

Holdgrafer v. Unocal Corp. (Mar. 4, 2008) 160 Cal.App.4th 907**No Use of Unrelated "Bad Acts" To Show Malice, Fraud, or Oppression****Facts:**

The Holdgraferes owned land on which they had constructed commercial buildings, which they rented out. The land under the buildings had become contaminated by leakage from pipelines owned and operated by Unocal.

Unocal was aware of and admitted to the contamination and over a period of years worked with the Holdgraferes and other adjacent property owners on resolving the contamination problem. Unocal acknowledged responsibility and agreed that it would comply with any governmental remediation requirements. Among other things, Unocal assisted in the refinancing of the various properties so that stigma associated with the contamination problems would not adversely impact the various property owners.

Eventually, negotiations between the Holdgrafers and Unocal broke down and the Holdgrafers sued. At trial, the trial court allowed the Holdgrafers, over Unocal's objections, to introduce evidence of pipeline leaks and soil contamination at other facilities in California. That evidence showed instances in which Unocal hid the fact of the leaks and denied responsibility. The Holdgrafers offered to prove Unocal had acted maliciously as to them and was therefore worthy of being held liable for punitive damages.

The jury rendered an award of compensatory and punitive damages against Unocal. Unocal appealed.

Holding:

The Court of Appeal affirmed the compensatory damage award and reversed and remanded as to punitive damages. It held that the evidence of other leaks and contamination should not have been admitted and that by allowing such evidence, the trial court had prejudiced Unocal.

In the case of *State Farm Mutual Automobile Ins. Co. v. Campbell*, 538 U.S. 408 (2003), the United States Supreme Court held that due process requirements of the United States Constitution prohibited the introduction of evidence of dissimilar conduct as a basis for awarding punitive damages. There, the Supreme Court explained:

A defendant's dissimilar acts, independent from the acts upon which liability was premised, may not serve as the basis for punitive damages. A defendant should be punished for the conduct that harmed the plaintiff, not for being an unsavory individual or business. Due process does not permit courts, in the calculation of punitive damages, to adjudicate the merits of other parties' hypothetical claims against a defendant under the guise of the reprehensibility analysis... Punishment on these bases creates the possibility of multiple punitive damages awards for the same conduct...

It also held that evidence of such conduct is admissible only if the court "ensure[s] the conduct in question replicates the prior transgressions." And, "although evidence of other acts need not be identical to have relevance in the calculation of punitive damages," the court must exclude evidence regarding conduct "that had nothing to do" with the plaintiff's claim. The appellate court stated that while the *State Farm* case dealt with the amount of punitive damages, there was no reason why the same considerations should not apply to liability for punitive damages.

Thus, it considered whether the evidence of other leaks was similar to or dissimilar from the evidence relative to the contamination on the Holdgrafers' property. It stated of the disputed evidence:

This conduct is radically different from the conduct at issue in this case. Unocal reported the Tank Farm Road spill to the state and all of the affected property owners. The contamination was contained and was thereafter continuously monitored by public and private entities, including Plaintiffs, to whom Unocal made full and continuing disclosure. The harm involved the subterranean infiltration of oil onto Plaintiffs' property, for which they rightfully sought compensation to protect their investment. Settlement negotiations continued for over a decade.

During this period Unocal not only sought to prevent a recurrence, but guaranteed loans, and otherwise assisted in protecting Plaintiffs from a negative financial impact on their investment. When Plaintiffs determined they were not receiving appropriate satisfaction for their loss, they sued.

On this basis, the trial court held that Unocal had been prejudiced and was entitled to have the question of punitive damages retried. It rejected Unocal's argument that without the disputed evidence there was no basis for a punitive damage award and that there should be no remand.

RESCISSION

***Ticconi v. Blue Shield of California Life & Health Ins. Co. (Feb. 27, 2008)* 160 Cal.App.4th 528**

It Is Improper to Weigh Legal and Factual Issues of Fraud and Unclean Hands in Determining Class Certification, When Such Defenses are Unavailable to Defendant

Facts:

Plaintiff Augusto Ticconi ("Ticconi") alleged that he applied for a policy of short term health and accidental death insurance from Blue Shield of California Life and Health Insurance Company ("Blue Shield") and truthfully answered all health questions on the policy application. Thereafter, Blue Shield issued an insurance policy to Ticconi effective January 1, 2004 with a one year duration (the "Policy"). Ticconi's application was neither attached to the Policy nor endorsed onto it when the Policy was issued.

Ticconi alleged he required "significant health care services" during the policy period that totaled over \$100,000. After Ticconi submitted his bills for payment, Blue Shield rescinded the Policy stating that Ticconi has made material

misrepresentations in the application and that a reasonable investigation would have shown this.

Ticconi filed a complaint, alleging that Blue Shield issued the policy without attaching a copy of his application to, or endorsing a copy upon, the Policy in violation of Insurance Code section 10113 which forbids incorporation of an application by reference. Ticconi further alleged that Blue Shield's rescission of the Policy was an unfair and unlawful business practice in violation of the UCL and that Blue Shield had rescinded numerous policies that did not have the application attached to or endorsed on the Policies in violation of Insurance Code section 10113 and 10381.5 in the past four years.

Ticconi moved for class certification of a class defined as "[a]ll California residents who were issued a policy of health insurance by Blue Shield Life . . . and who thereafter had the policy rescinded by Blue Shield Life since March 28, 2001, based upon alleged misrepresentations contained in the policy application." Blue Shield opposed the motion. The trial court denied Ticconi's motion for class certification because Blue Shield's defenses of fraud and unclean hands raised individual factual issues such that adjudication on a class wide basis would not be beneficial. Plaintiff timely appealed.

Holding:

In reversing the trial court's decision, the Court of Appeal first stated that unfair competition under the UCL is broadly defined to include "any unlawful, unfair or fraudulent business act or practice and unfair, deceptive, untrue or misleading advertising and any act prohibited [by section 17500, the false advertising law]." The Court of Appeal then stated that the unlawful conduct alleged by Ticconi was "postclaims underwriting by rescinding disability insurance policies based on alleged misrepresentations in the application, which applications were incorporated by reference but neither endorsed on nor attached to the insureds' applications in violation of Insurance Code sections 10113 and 10381.5."

The Court of Appeal stated that the practice of postclaims underwriting is "categorically prohibited" by Insurance Code section 10384. The Court also stated that the consequence for failing to comply with Insurance Code section 10113 is that the insured is not bound by statements made in that application and the insurer may not invoke the defense of misrepresentation in or omission for the unattached and unendorsed application.

The Court of Appeal held that conduct in contravention of Insurance Code sections 10113, 10381.5 and 10384, including the failure to attach applications to or endorse them on the policies when issued and later engaging in postclaims

underwriting by holding the insured to statements in those unattached and unendorsed applications as grounds for voiding policies, clearly constitutes a predicate unlawful practice sufficient to raise a UCL cause of action.

The Court of Appeal also rejected Blue Shields' reliance upon *Samura v. Kaiser Foundation Health Plan, Inc.* (1993) 17 Cal.App.4th 1284, for asserting that Insurance Code sections 10113 and 10381.5 are regulatory in nature and do not provide a basis for a UCL action because they do not proscribe any conduct. The Court of Appeal stated that *Samura* involved provisions of the Knox-Keene Act (Health & Saf. Code, §§ 1242,1363,1367) that did not define an unlawful act and entrusted regulatory power exclusively to the Department of Corporations. By comparison, the Court of Appeal noted that Insurance Code section 10384 explicitly makes postclaims underwriting unlawful and provides a basis for injunctive relief.

The Court of Appeal further stated that under Code of Civil Procedure section 382, the party seeking class certification has the burden of establishing the existence of both an ascertainable class and a well-defined community of interest among class members. The Court of Appeal held that if Ticconi's allegations are true, Blue Shield's conduct would constitute a blatant violation of the Insurance Code and an unfair business practice that can be enjoined under the UCL. The Court of Appeal further stated that Ticconi's defined class raised factual and legal issues that would go to Blue Shield's liability and would be universal to all class members. Accordingly, the Court of Appeal held that common issues of law and fact would predominate.

The Court of Appeal stated that the trial court's sole rationale for denying class certification was based upon the flawed assumption that the legal and factual issues concerning Blue Shield's defenses of fraud and unclean hands outweighed the common issues of law and fact related to Blue Shield's liability. Specifically, the Court of Appeal stated that the equitable defense of unclean hands was not available in a UCL action that is based on the violation of a statute, because allowing such a defense would "sanction the defendant for engaging in an act declared by statute to be void or against public policy." The Court of Appeal also relied upon the California Supreme Court's ruling in *Cortez v. Purolator Air Filtration Products Co.* (2000) 23 Cal. 4th 163, 179, for the principle that equitable defenses may not be used to defeat a cause of action under the UCL.

The Court of Appeal also stated that fraud was not available to Blue Shield as a defense to the UCL cause of action because Blue Shield had failed to attach the insureds' application to, or endorse them on, the policies. As a result, the insureds were not bound by any statements made in those applications pursuant to Insurance Code section 10381.5. Additionally, the Court of Appeal stated that

allowing such a defense would violate the anti-waiver provision of Insurance Code section 10113, which provides that "[a]ny waiver of the provisions of this section shall be void." Finally, the Court of Appeal noted that Blue Shield was specifically precluded from relying upon the application as a defense by the California Supreme Court decision in *Telford v. New York Life Ins. Co.* (1937) 9 Cal.2d 103, 106 (holding that the insured was not bound by certain statement contained in the portion of the application that had not been attached to the policy and that such statements could not afford a basis for a defense by the defendant).

The Court of Appeal noted that the trial court could consider the insureds' non-disclosures or misrepresentations in fashioning equitable remedies authorized by the UCL, but stated that such individualized considerations at the remedy state did not preclude class treatment of liability. Accordingly, the Court of Appeal held that since Blue Shield was precluded from raising the defenses of fraud and unclean hands, it was error for the trial court to weigh the legal and factual issues associated with such defenses in denying Ticconi's motion for class certification.

***New Hampshire Ins. Co. v. C'Est Moi, Inc.* (Mar. 20, 2008, 9th Cir.)**
519 F.3d 937

Insured's "Unintentional" But "Material" Misrepresentations in Application Give Marine Insurer Right to Rescind

Facts:

In 1986, Lawrence O'Rourke (O'Rourke) purchased all the stock of C'Est Moi, Inc. (C'Est Moi). As part of the purchase, O'Rourke paid \$300,000 for a yacht owned by C'Est Moi. O'Rourke subsequently insured the yacht through Washington International Insurance Company (Washington International).

In 1992, a fire destroyed the yacht and Washington International paid O'Rourke \$450,000 for the loss. O'Rourke reacquired the yacht from Washington International at salvage, paid off a loan and began restoring it. Washington International stopped insuring the yacht after the fire, and it remained uninsured until 2001 (a period of nine years).

In 2001 C'Est Moi applied for a yacht policy through New Hampshire Insurance Company (NHIC). In the application, C'Est Moi listed the purchase price as "\$450,000" even though O'Rourke had only paid \$300,000 for the yacht in 1986. C'Est Moi also listed the "present marine insurer" as "Wash Int.," even though the yacht was not insured when the application was filled out in 2001.

After reviewing the application, NHIC issued a policy to C'Est Moi covering the yacht. In 2004, the yacht sank in calm waters while docked at Newport Beach, California. O'Rourke, on behalf of C'Est Moi, filed an insurance claim. NHIC investigated and determined that the likely cause was a malfunctioning bilge pump. NHIC then sued C'Est Moi in federal district court to rescind the insurance policy.

The district court granted summary judgment in favor of NHIC, holding that the doctrine of *uberrimae fidei* applied and that C'Est Moi misrepresented material facts on its insurance application. C'Est Moi appealed.

Holding:

The Ninth Circuit Court of Appeals affirmed the judgment in favor of NHIC. The appellate court first noted that under the federal maritime doctrine of *uberrimae fidei*, an applicant for marine insurance owes the insurer a “duty of utmost good faith,” and is “bound to reveal every fact within his knowledge that is material to the risk.” Under this doctrine, if an insured misrepresents a material fact in the application, the insurer may rescind the policy, even if the misrepresentation was “unintentional.”

The court acknowledged that the NHIC policy contained a provision stating that the policy would be void if the insured “intentionally” concealed or misrepresented any material fact or circumstance relating to the insurance application. However, according to the court, this provision was not sufficient to modify or eliminate the insured’s *uberrimae fidei* obligation. Thus, NHIC was entitled to rescind even if C'Est Moi’s misrepresentations were merely “unintentional.”

The court next held that C'Est Moi’s misrepresentations in the application were “material.” The court reiterated the rule that if insurer demands answers to specific questions in an application for insurance, that fact is in itself usually sufficient to establish “materiality” as a matter of law.” Here, NHIC’s insurance application asked for the yacht’s purchase price and present insurer, and C'Est Moi misrepresented both facts. Both facts were facts which NHIC would naturally want to know in determining whether to issue a policy to C'Est Moi and, if so, on what terms. Thus, as a matter of law, C'Est Moi’s misrepresentations were “material” and NHIC was entitled to rescind.

Grenall v. United of Omaha Life Ins. Co. (July 25, 2008)
165 Cal.App.4th 188

Annuitant's Mistake About Her Health at Time She Purchased the Annuity Does Not Entitle the Estate to Rescind the Contract

Facts:

Jean Simes submitted an annuity application to United of Omaha Life Insurance Company on October 2, 2001, with a single premium of \$321,131. United issued Simes the annuity, effective the date of the signed application, and Simes received a copy of the contract six weeks later. It provided for \$3,000 monthly payments to Simes for "life only" -- specifically, a "life contingent payable . . . as long as the annuitant lives." The annuity also allowed Simes to return it within 30 days to cancel it and obtain a refund.

After receiving three benefit payments, Simes was diagnosed with ovarian cancer on January 25, 2002 and died on January 30, 2002. United stopped paying monthly benefits when it learned of Simes' death, and the administrators of Simes' estate ("the Estate") filed suit against United. The Estate alleged a claim for breach of contract, contending United refused to make payments under the terms of the annuity "until the sum of the benefit payment equals the single premium." The Estate also sought declaratory relief to resolve the parties' respective rights under the contract.

United moved for summary judgment, contending the contract provided for a life annuity and did not require a refund of premium to the Estate. In its opposition the Estate argued the annuity was a contract of adhesion and alleged unconscionability issues.

The trial court granted United summary judgment on the breach of contract claim, finding United had not breached the agreed-upon payment provisions and the annuity required benefit payments to be made only during Simes' lifetime. The trial court denied the motion as to the declaratory relief cause of action, finding factual issues existed.

After additional discovery United renewed its motion, arguing the Estate could not prevail on the factual issues identified in the trial court's previous order. In its opposition, the Estate asserted a claim for rescission based on mistake of fact. It produced evidence that Simes did not know she had a fatal illness at the time she purchased the annuity or during the statutory rescission period. The Estate also argued the contract was unconscionable.

The trial court entered summary judgment in United's favor. It found Simes' "undetected cancer did not constitute a mistake of fact rendering enforcement [of the annuity contract] unconscionable." The trial court noted purchasers of annuities assume the risk of dying before recouping their investments, and it was thus reasonably foreseeable that Simes might die before her benefit payments matched her premium. It was therefore reasonable to allocate to Simes the risk of a mistake regarding her life expectancy.

On appeal, the Estate argued the facts showed: (1) Simes did not know at the time of her application and during the statutory rescission period that she had terminal ovarian cancer that would result in her death four months later; (2) Simes' illness affected her ability to make decisions; and (3) Simes did not receive a copy of the annuity policy until mid-November of 2001.

Holding:

The Court of Appeal noted the "sole issue argued by the Estate on appeal was whether the facts provided a legal basis for rescission of the annuity contract based upon mistake of fact." The Court held it did not, as a matter of law. It noted "the alleged mistake may be characterized as Simes' erroneous belief at the time of the contract that she was in good health and had a reasonable life expectancy."

Since the Estate asserted a unilateral mistake and provided no evidence United had reason to know of or caused the mistake, the Estate would need to prove: (1) Simes was mistaken regarding a basic assumption upon which she made the contract; (2) the mistake materially affected the agreed exchange of performances in a way that was adverse to Simes; (3) Simes did not bear the risk of the mistake; and (4) the effect of the mistake was such that enforcement of the contract would be unconscionable.

The Court held the Estate could not establish the third element because Simes bore the risk of a mistake regarding her current health or life expectancy. The annuity did not expressly assign this risk to Simes, but the Court held parties who contract for "life contingent" benefits necessarily do so based on limited knowledge about the length of their lives or the state of their health. Allocating the risk to Simes was reasonable because such risks are an inherent part of life annuity contracts, which are essentially a "longevity waiver measured by average life expectancy."

The Court concluded this was consistent with past California cases and the law in other jurisdictions. It also rejected the Estate's effort to distinguish these other cases on the grounds that Simes' mistake was not about an unknown risk of future death, but about an existing fact – that she was suffering from a fatal illness. Although no California cases directly considered rescission based on this type of mistake, other jurisdictions had refused to rescind in this context.

The Court agreed allocation of risk to the annuitant in these circumstances “is not only reasonable but a practical necessity.” Otherwise, it would be difficult to see how any company could carry on an annuity business “if the estate of an annuitant could rescind whenever it turned out the condition of his health did not ‘warrant a reasonable expectation of life.’” The Court therefore affirmed the trial court’s ruling.

SETTLEMENT

Myerchin v. Family Benefits, Inc. (Apr. 22, 2008) 162 Cal.App.4th 1526

Plaintiff Could Not Disavow a Settlement After Accepting Payment

Facts:

Joseph Myerchin sued Family Benefits, Inc. for breach of contract. Shortly after filing his complaint, Myerchin entered into a written settlement agreement with Family Benefits. However, after accepting and spending the money paid to him pursuant to the settlement, Myerchin refused to dismiss the complaint.

Family Benefits moved for summary judgment based on the settlement agreement. Myerchin opposed the motion, arguing the settlement agreement was unenforceable, because Family Benefits’ attorney had continued to negotiate it with him directly, even after becoming aware he had retained counsel.

The trial court rejected Myerchin’s assertion the evidence of direct negotiation, even if true, rendered the agreement unenforceable, and granted summary judgment.

Holding:

The Court of Appeal affirmed. A key fact in the court’s analysis was that even though Myerchin sought to disavow the settlement, he did not return the settlement proceeds. The court noted that Civil Code section 1691 provides that a party wishing to rescind a contract must “promptly upon discovering the facts which entitle him to rescind,” do two things to effect that rescission: “give notice of rescission to the party as to whom he rescinds; and restore to the other party everything of value which he has received from him under the contract or offer to restore the same upon condition that the other party do likewise, unless the latter is unable or positively refuses to do so.” Since Myerchin did neither, he was not entitled to rescind the settlement agreement.

The court rejected Myerchin's argument that he did not need to return the settlement proceeds as they could be used as an offset against his expected judgment against Family Benefits. It reasoned that Family Benefits paid the settlement to buy its peace and to avoid the cost of litigation and would not be getting the benefit of the bargain.

The court also rejected Myerchin's argument that the agreement was void as Family Benefits' attorney continued to negotiate with him even after he engaged counsel of his own. The court noted that the rule prohibiting an attorney to communicate with a represented opponent was designed to prevent interference in with the attorney-client relationship. However, here, the direct dealings predated Myerchin's engagement of counsel. Further, there was no evidence of undue influence. The public policy favoring settlements was a significant consideration in balancing the equities.

Greentree Financial Group, Inc. v. Execute Sports, Inc. (May 6, 2008)
163 Cal.App.4th 495

A Settlement Which Included a Penalty for the Defendant's Failure to Abide by Its Terms Was Unenforceable

Facts:

Greentree Financial Group sued Execute Sports, Inc. for breach of contract. It sought \$45,000 for financial advisory services it provided to Execute Sports.

Before trial, the parties agreed to settle the case for less than half the amount sought by the complaint. The settlement provided that Execute Sports would make installment payments. It also provided that if Execute Sports failed to make a payment, Greentree Financial Group could file a stipulation for entry of judgment, with the amount of the judgment being the entire amount sought in the complaint, as well as prejudgment interest, attorney fees, and costs.

Execute Sports failed to make the first payment, and the trial court entered judgment pursuant to the terms of the parties' stipulation for entry of judgment.

Holding:

The Court of Appeal reversed and remanded. It held that the judgment constitutes an unenforceable penalty because it bears no reasonable relationship to the range of actual damages the parties could have anticipated would flow from a breach of their settlement agreement. And, it directed the trial court to enter judgment in the amount specified in the settlement agreement, plus postjudgment interest and costs.

Chen v. Interinsurance Exch. of the Automobile Club (June 19, 2008)
164 Cal.App.4th 117

Offer to Settle in Exchange for Release of “All Claims” is Not a Valid Settlement Offer under California Code of Civil Procedure Section 998 if Plaintiff Has Pending, Non-Litigated Claim

Facts:

Po-Jen Chen and Fang-Mei Lin (“appellants”) owned two homes insured by the Interinsurance Exchange of the Automobile Club (“Interinsurance”). Both homes were damaged in separate incidents. Appellants filed claims with Interinsurance and subsequently filed a lawsuit (the “Action”) in which they alleged Interinsurance mishandled the claims by, among other things, authorizing inadequate repair work, failing to pay certain benefits, and refusing to properly remediate mold contamination.

While the Action was pending one of the homes sustained water damage in the kitchen and appellants filed a new claim with Interinsurance. This new claim was not included in the Action.

Prior to trial, Interinsurance made a statutory settlement offer under Section 998 for \$251,000. It conditioned the offer “upon [appellants] executing a dismissal with prejudice of the action as well as a general release of all claims in lieu of an entry of judgment against defendants.” Appellants rejected the offer and the case proceeded to trial.

By special verdict, the jury found Interinsurance had fully paid appellants’ covered losses for the two claims. However, the jury also found Interinsurance acted unreasonably in handling the claims and awarded appellants a total of \$150,000 for economic as well as non-economic damages.

Because this judgment fell below Interinsurance’s \$251,000 settlement offer, the insurer applied under the cost-shifting provisions of Section 998 for an order requiring appellants to pay Interinsurance’s post-offer costs. The trial court granted the motion. It rejected appellants’ argument that Interinsurance’s settlement offer was invalid under Section 998 because the offer required appellants to release “all claims,” which could be interpreted to include the appellants’ kitchen damage claim that was not included in the Action.

Holding:

The Court of Appeal allowed the appeal and reversed the trial court's ruling. It noted an offer must have several features to be valid under Section 998. Among other things, the offer must not dispose of any claims beyond the claims at issue in the pending lawsuit. This limitation exists because the jury's award must encompass the same claims as those of the settlement offer in order to determine whether the award is more or less favorable than the settlement.

The Court of Appeal agreed the phrase "all claims" in Interinsurance's offer was ambiguous. It was unclear if this included the appellants' pending kitchen flood claim. Although under Civil Code Section 1542, a general release does not affect unknown claims, the kitchen flooding claim was known to all parties at the time of Interinsurance's settlement offer. If appellants accepted the settlement offer and released "all claims," they could therefore have been barred from filing an action on the remaining kitchen flood claim.

Interinsurance's settlement offer was therefore ambiguous and could not provide a basis for a Section 998 costs award. Consequently the Court of Appeal reversed the trial court's award of costs and directed the trial court to recalculate appellants' costs award as the prevailing party, without regard to Section 998.

STANDING

Otay Land Company v. Royal Indemnity Company (Nov. 25, 2008)
169 Cal.App.4th 556

Property Buyer Lacked Standing to Sue Seller's Insurer to Determine Availability of Insurance Coverage for Environmental Cleanup Costs

Facts:

Flat Rock purchased property from United which was environmentally contaminated. Prior to selling the property, United had purchased the Policy from Royal. After the purchase, Flat Rock sued United, and others, in both state and federal court to recover environmental response/clean up costs, damages and other relief. Flat Rock appealed an unfavorable summary judgment ruling in the federal action and the state action was stayed pending the outcome of the federal appeal.

In a separate coverage action, Royal filed a declaratory relief action against United. It requested a declaration that it had no coverage obligations under the Policy. Flat Rock sought leave to intervene on the grounds it was a "potential

claimant” under the Policy and United was not providing a vigorous defense to Royal’s claims.

The trial court denied Flat Rock leave to intervene, and the Appellate Court affirmed, on the grounds that Flat Rock did not meet the applicable statutory criteria for intervention and its reliance on *Thompson v. Mercury Casualty Co.* (2000) 84 Cal.App.4th 90 (“Thompson”), and *Haynes v. Farmers Ins. Exchange* (2004) 32 Cal.4th 1198 (“Haynes”) was inapposite.

Flat Rock then filed a declaratory relief action against Royal. Flat Rock argued it had a legitimate interest in raising coverage arguments related to the Policy that could potentially impact its ability to recover damages and environmental response costs from United. The trial court sustained Royal’s demurrer without leave to amend and dismissed the complaint on the grounds that no actual controversy existed and that Flat Rock lacked standing to sue Royal.

In determining whether Flat Rock had standing, the trial court noted the “no direct action” rule generally prohibits injured third parties, not in contractual privity with the tortfeasor’s insurer, from suing the tortfeasor’s insurer for failing to defend or indemnify the tortfeasor against a claim. The trial court also noted there are three well established exceptions to the “no direct action” rule: (1) the third party plaintiff has a judgment against the insured; (2) the insurer has sued the third party in its own declaratory relief action; or (3) the insured has assigned its rights under the policy to the third party. The trial court held none of these exceptions applied. Flat Rock appealed.

On appeal, Flat Rock admitted it did not have standing under the usual grounds because it lacked contractual privity with Royal and did not qualify under the three exceptions to the “no direct action” rule. Nevertheless, Flat Rock argued it had standing to bring the declaratory relief action under an additional exception to the “no direct action” rule allegedly supported by the *Thompson* and *Haynes* decisions.

Holding:

The Court again rejected Flat Rock’s attempts to rely on *Thompson* and *Haynes*. It found those cases involved unique declaratory relief actions arising out of personal injury claims, where injured third parties sought policy interpretations regarding permissive user coverage, and the insureds lacked any incentive to protect these third parties’ rights as additional insureds or beneficiaries. The Court also noted the insurers in *Thompson* and *Haynes* did not object to the third parties’ involvement, and all parties to these lawsuits impliedly conceded there was a need for a substantive interpretation of the policy language.

The Court distinguished Flat Rock's claim against Royal from the claims at issue in Thompson and Haynes, stating Flat Rock was at best a potential judgment creditor of United, and a potential beneficiary of the Policy issued by Royal. Although Royal had the right to add Flat Rock to the insurer's declaratory relief action, that did not mean Flat Rock had equivalent rights. Flat Rock was not in privity of contract with Royal nor a potential additional insured, and its interests at this stage were purely hypothetical. Accordingly, the Court rejected Flat Rock's claim that it fell within an additional exception to the "no direct action" rule.

Flat Rock also contended it could bring the declaratory relief action because of the "expansive" nature of declaratory relief, regardless of the fact that it lacked standing. The Court rejected this contention and declined to allow Flat Rock to maintain a declaratory relief claim without establishing standing. The Court stated that it remained unknown whether Royal would be required to provide coverage to United and whether Flat Rock would ultimately obtain judgment against United. Therefore, the Court declined to issue an advisory order about whether there should be potential insurance coverage for United's potential tort liability.

STAY OF ACTION

GGIS Ins. Services, Inc. v. Superior Court (Dec. 11, 2008) **168 Cal.App.4th 1493**

Coverage Action Should Not Be Stayed if Coverage Question Involves Matter of Law and Does Not Prejudice Insured in the Underlying Action

Facts:

GGIS Insurance Services, Inc. ("GGIS") was a general insurance agent. Capitol Indemnity Corporation ("Capital") issued an Insurance Agents and Brokers Professional Liability Policy to GGIS. The policy excluded "any Claim, Loss, or Defense Expenses" for certain matters, including "any actual or alleged comingling of, or inability or failure to pay, collect, safeguard or return any money or failure to perform any actuarial service." (Exclusion G).

The Pennsylvania Insurance Commissioner filed a complaint against GGIS and its CEO, Richard Acunto. The Commissioner sought damages arising from GGIS's actions under a Management Agreement with two insolvent California automobile insurers. Under the Management Agreement, GGIS marketed, underwrote, and serviced auto policies on behalf of the two insurers while they were solvent, and collected commission from the premiums. The Management

Agreement provided that GGIS would collect premiums paid by policyholders, retain a portion as commission for services rendered, and remit the remainder to the appropriate insurers.

The Commissioner alleged GGIS failed to remit premiums it collected from insureds and uncollected premiums due to the insurers under the terms of the Management Agreement. GGIS and Acunto (“Petitioners”) tendered the Commissioner’s action to Capital.

Capital accepted the tender, but terminated its payment of defense costs after paying \$25,000. Petitioners filed a breach of contract and bad faith action against Capital and Darwin, Capital’s claims manager. Capital and Darwin moved for summary judgment, arguing the only potential coverage under Capital’s policy had been exhausted through payment of the applicable \$25,000 limit. They also argued the policy exclusions precluded any potential for further coverage. Darwin also argued it was not a party to the insurance policy and thus could not be held liable under any of the counts alleged in the complaint.

Petitioners argued in opposition and in their own cross-motion for summary adjudication that there was a potential for coverage and the exclusions were inapplicable. Petitioners also filed an ex parte application to continue the trial date or stay the action. They argued a continuance or stay was necessary to avoid prejudicing them in the Commissioner’s action, because of alleged overlap among factual issues in the two actions.

The trial court denied Petitioner’s application for a stay, denied their motion for summary adjudication, and denied Capital’s motion for summary judgment. The court concluded triable issues of fact existed concerning the coverage issues and application of Exclusion G which precluded summary judgment for either the Petitioners or Capital. However, the court concluded Darwin was not a party to the insurance contract and thus granted Darwin’s motion for summary judgment.

Petitioners petitioned the Court of Appeal for a writ of mandate, challenging the denial of their stay request.

Holding:

The Court of Appeal stayed all proceedings pending further consideration of the writ. Petitioners also filed a second petition for a writ of mandate, challenging the denial of their motion for summary adjudication. The Court of Appeal consolidated the two writ proceedings and issued a single opinion.

The Court noted coverage actions should be stayed if they might result in a factual determination prejudicial to insureds in underlying third party actions. (Montrose Chemical Corp. v. Sup. Ct. (1993) 6 Cal.4th 287, 301-302.) Since there was a risk of prejudice in any litigation between an insurer and its insured, stays were not limited to declaratory relief actions commenced by insurers.

However, if the trial court can resolve coverage questions as a matter of law, without making any factual determinations that could prejudice the insured in the underlying action, a stay was unwarranted. Adopting this approach, the Court held Exclusion G applied fully and precluded any coverage potential for the Commissioner's claims against Petitioners. The Court concluded no factual determinations were necessary because the Commissioner was essentially suing Petitioners for their failure to pay money due to the insolvent insurers. Exclusion G clearly applied to preclude coverage for such a claim.

Thus, the Court of Appeal concluded the trial court correctly denied petitioners' stay application and motion for summary adjudication. However, upon remand, Capitol could renew its motion for summary judgment which, based on the Court's holdings, should be granted.

SUBROGATION

Fireman's Fund Ins. Co. v. Sizzler USA Real Property, Inc.
(Dec. 18, 2008) 169 Cal.App.4th 415

Lease Term Waiving Subrogation Rights Barred Insurer's Recovery From Tenant

Facts:

Santa Monica Collection LLP ("SMC") leased space in a shopping center to Sizzler USA Real Property, Inc. ("Sizzler"). Sizzler was authorized under its lease to sublet the premises, provided it remained liable for the tenant's obligations. Further, Sizzler was required to obtain liability insurance with at least \$1,000,000 in coverage, and naming SMC as an additional insured. Sizzler also agreed to indemnify SMC from any liability for incidents occurring on the premises.

The leases also contained a release and waiver of subrogation rights against either party for any claims or damages arising from incidents covered by either party's insurance. The waiver applied to SMC and Sizzler, their authorized representatives, and their insurance companies.

Sizzler sublet the premises to Sky Sushi, a night club. A customer was later attacked and stabbed at the club. The victim sued SMC, among others, for his injuries. SMC sought indemnification and defense from Sizzler. Sizzler directed SMC to Sizzler's insurer, Federal Insurance Company. Sizzler's policy with Federal, however, only provided \$750,000 coverage after a self-insured retention of \$250,000, and did not name SMC as an additional insured.

SMC then tendered the underlying case to its insurer, Fireman's Fund Insurance Company. Fireman's Fund tendered the case to Federal. Federal initially declined but subsequently agreed to defend under a reservation of rights when SMC's defense and settlement costs exceeded the \$250,000 retention. Federal later asserted that SMC's defense costs did not count toward the retention.

Fireman's Fund ultimately defended SMC, incurring \$84,101 in defense costs and \$300,000 to settle the case. Fireman's Fund sued Sizzler to recover these defense and indemnity expenditures.

Sizzler argued a subrogation waiver barred Fireman's Fund's claim. Fireman's Fund contended the waiver provision did not apply because Sizzler had breached multiple provisions of the lease. Sizzler failed to acquire liability insurance fully covering SMC for the amount listed in the lease, which Fireman's Fund argued constituted nonperformance of a condition precedent to, and a failure of consideration for, the subrogation waiver.

Second, through Sky Sushi's conduct, Sizzler had violated other lease obligations by maintaining a nuisance on the premises and holding a faulty permit. After a bench trial, the court concluded the subrogation waiver barred Fireman's Fund's claims. Fireman's Fund appealed.

Holding:

The Court of Appeal affirmed. It rejected the contention that Sizzler's failure to procure sufficient liability insurance precluded enforcement of the subrogation waiver. The Court found the subrogation waiver was not premised on Sizzler's procurement of full insurance, but instead, the waiver applied to all claims covered by the insurance of either party, be it tenant or landlord.

The Court also rejected Fireman's Fund's contention that procuring full insurance was a condition precedent to the subrogation waiver provision. A contract provision is deemed a condition precedent only where the contract language plainly requires it. Here, there was no language indicating Sizzler's insurance obligation was a condition precedent to the subrogation waiver.

Similarly, Sizzler's failure to obtain a policy for the full amount required by the lease did not constitute a failure of consideration. The Court concluded Sizzler's breach of its insurance obligation was merely a partial breach, not failure of consideration for the entire lease.

Lastly, the Court held enforcing the subrogation waiver despite Sizzler's breaches would not defeat the parties' intentions. The provision requiring Sizzler to obtain permits applied only to Sizzler, not to subsequent subtenants. Also, the context of the nuisance provision, found under "Repairs and Maintenance," suggested the term concerned the physical condition of the premises rather than activities or operations by subtenants.

Even if the underlying claim against SMC arose from Sizzler's breach of the nuisance provision, the Court found enforcing the subrogation waiver would not be inconsistent with the parties' indemnity provision. The waiver provision applied to insured liabilities, such as the underlying claim, whereas the indemnity provision applied to uninsured liabilities. Thus, the clauses served different purposes, and their coexistence in the same contract was not inconsistent.

UNINSURED/UNDERINSURED MOTORIST INSURANCE

Wedemeyer v. Safeco Ins. Co. of America (Mar. 13, 2008)
160 Cal.App.4th 1297

Insured Only Required to Exhaust Tortfeasor's Motor Vehicle or Automobile Bodily Injury Liability Coverage Before Seeking Underinsured Motorist Coverage

Facts:

Lowell Wedemeyer (Wedemeyer) had an auto policy through Safeco Insurance Company of America (Safeco) with uninsured and underinsured motorist coverage limits of \$500,000 per person.

Wedemeyer was seriously injured when his car was struck from behind by a car driven by Bradley Groscost (Groscost). Groscost had an auto policy through Coast National Insurance Company (Coast National) with bodily injury liability limits of \$15,000 per person. Wedemeyer filed a personal injury lawsuit against Groscost. Coast National offered its \$15,000 limit on behalf of Groscost in exchange for a release of Wedemeyer's claims. Wedemeyer notified Safeco of the lawsuit and of Coast National's offer of Groscost's \$15,000 policy limits.

In the course of discovery in the personal injury lawsuit, Wedemeyer learned that Groscoast was employed by Skyline Management Group (Skyline). Skyline had a general liability policy through Hartford Insurance Company (Hartford) which included hired auto and non-owned auto liability coverage of \$1 million. However, Hartford refused to admit coverage under its policy for the accident involving Groscoast and Wedemeyer.

At that point, Wedemeyer demanded that Safeco pay him \$485,000 (i.e., Safeco's UIM limit of \$500,000, minus Coast National's liability limit of \$15,000). Safeco refused, insisting that Wedemeyer exhaust the \$1 million limit of Skyline's general liability policy through Hartford.

Wedemeyer pursued his litigation against Groscoast. Eventually, Wedemeyer entered into a settlement with Groscoast, Coast National, Skyline and Hartford. Pursuant to the settlement, Wedemeyer received a total of \$515,000 (consisting of Coast National's \$15,000 policy limit, plus \$500,000 under the Hartford policy).

Wedemeyer then filed a breach of contract / bad faith against Safeco based on Safeco's failure to pay its UIM coverage. However, the trial court dismissed Wedemeyer's claims, ruling that Wedemeyer was required to exhaust the liability limits of the Coast National auto policy and the Hartford general liability before seeking benefits under Safeco's UIM coverage.

According to the trial court, since Wedemeyer had already recovered from Coast National and Hartford an amount in excess of Safeco's UIM limits, Safeco was not liable for UIM coverage. Wedemeyer appealed.

Holding:

The California Court of Appeal reversed. California Insurance Code section 11580.2(p)(3) provides that underinsured motorist coverage "does not apply to any bodily injury until the limits of bodily injury liability policies applicable to all insured motor vehicles causing the bodily injury have been exhausted by payment of judgments or settlements."

The appellate court ruled that, read in context, the phrase "bodily injury liability policies" means a motor vehicle or automobile liability policy (such as the Coast National policy), and does not refer to a general liability policy with hired auto and non-owned auto liability coverage (such as the Hartford policy). Thus, according to the appellate court, after Coast National tendered the limits of its auto policy to Wedemeyer, Safeco should have paid the balance of its UIM limits to Wedemeyer. Because Safeco failed to do so, Wedemeyer stated a claim against Safeco for breach of contract.

The appellate court observed that if Safeco had paid its UIM limits to Wedemeyer and Wedemeyer had later recovered more money under the Hartford general liability policy, then, pursuant to the reimbursement / credit provisions of Insurance Code section 11580.2(p)(5), Wedemeyer would have been obligated to reimburse Safeco for any payments received under the Hartford policy. However, the possibility that Safeco might later be entitled to reimbursement of monies paid under the Hartford general liability did not relieve Safeco of the duty to tender its UIM limits once Coast National exhausted its auto liability limits.

Bouton v. USAA Cas. Ins. Co. / O'Hanesian v. State Farm Mutual Automobile Ins. Co. (June 9, 2008) 43 Cal.4th 1190

California Supreme Court Clarifies Scope of Arbitrator's Jurisdiction in UM/UIM Cases

Bouton v. USAA Cas. Ins. Co.

Facts:

Lloyd Bouton was injured in an automobile accident allegedly caused by Kevin Daniels, and settled his claim against Daniels for Daniels' automobile insurance policy limit of \$15,000. Bouton then demanded UIM arbitration with Bouton's sister's insurer, USAA Casualty Insurance Company, seeking damages exceeding the \$15,000 policy limit payment he received from Daniels' insurer.

USAA denied coverage, claiming that Bouton was not a resident of his sister's household, and was therefore not an "insured" under her policy. Bouton filed a motion to compel arbitration. The trial court denied the motion to compel, finding that under section 11580.2(f) and USAA's policy, the parties were only bound to arbitrate the issues of liability and damages, not coverage.

Holding:

The Supreme Court agreed that a court, not an arbitrator, must determine whether Bouton is an "insured" under his sister's policy. The Supreme Court held that whether Bouton is an insured under the insurance policy is not a question regarding the underinsured tortfeasor's liability to the insured or the amount of damages. Rather, it is a question of coverage that must be decided by a court, not an arbitrator.

O'Hanesian v. State Farm Mutual Automobile Ins. Co.

Facts:

Charles O'Hanesian was injured when his car was rear-ended by Curtis Thurlow's car. O'Hanesian sued Thurlow, who failed to appear after being properly served. O'Hanesian submitted evidence regarding the extent of his injuries at a bench trial, and the court awarded him over \$2.7 million in compensatory damages and \$1 million in punitive damages.

O'Hanesian made a demand on Thurlow's liability insurer and received the policy limit of \$100,000. O'Hanesian then made a demand for \$900,000 under the UIM provisions of his own policies through State Farm Mutual Automobile Insurance Company. When State Farm asserted that it was not bound by O'Hanesian's default judgment against Thurlow, O'Hanesian sued State Farm for breach of contract and bad faith.

The trial court ruled that O'Hanesian's lawsuit against State Farm was premature, because no arbitration had occurred as required by the State Farm policies.

Holding:

The Supreme Court upheld the trial court's decision, concluding that it was for an arbitrator, not a court, to decide whether O'Hanesian's default judgment against Thurlow was enforceable against State Farm. The Supreme Court reasoned that the default judgment pertained directly to the underinsured tortfeasor's liability to O'Hanesian and the amount of damages owed, and that those were both issues subject to arbitration under section 11580.2(f) and the State Farm policies.

Explorer Ins. Co. v. Gonzalez (July 16, 2008) 164 Cal.App.4th 1258

Underinsured Motorist Coverage Not Triggered Where Injured Party's Bodily Injury Limit is Equal to Tortfeasor's "Combined Single Limit" for Bodily Injury and Property Damage

Facts:

Dwaine Gonzalez was injured in an automobile collision caused by Benjamin Fernandez. At the time of the accident Fernandez was insured by a Fireman's Fund Insurance Company auto policy with "combined single limits" in the amount of \$100,000 for all bodily injury and property damage caused by any single accident. Gonzalez was insured by an Explorer Insurance Company policy

that included uninsured and underinsured motorist benefits of \$100,000 for all damages from bodily injury sustained by one person in one accident.

Fireman's Fund paid Gonzalez \$78,415.89 for bodily injury and \$21,584.11 for property damage arising from the collision, thus exhausting the limits of the \$100,000 Fireman's Fund policy. Gonzalez then made a claim against the underinsured motorist bodily injury provision of his Explorer policy for \$21,584.11 (i.e., the difference between the \$78,415.89 he received from Fireman's Fund for bodily injury and the \$100,000 limit of his Explorer underinsured motorist coverage).

Explorer denied Gonzalez's claim, asserting that the \$100,000 combined single limit for liability in Fernandez' policy through Fireman's Fund afforded bodily injury limits of liability of up to \$100,000, and therefore, was not "less than" the underinsured motor vehicle bodily injury liability limits of Gonzalez's policy through Explorer.

Explorer later filed a declaratory judgment action against Gonzalez to confirm its position. The trial court ruled in favor of Explorer and Gonzalez appealed.

Holding:

The Court of Appeal affirmed the judgment in favor of Explorer. The appellate court reasoned that under Insurance Code section 11580.2(p)(2), an "underinsured motor vehicle" means "a motor vehicle that is an insured motor vehicle but insured for an amount that is less than the uninsured motorist limits carried on the motor vehicle of the injured person."

Here, the Fireman's Fund policy carried by Fernandez provided "combined" coverage of up to \$100,000 for all bodily injury and property damage caused by any single accident. The Explorer policy carried by Gonzalez provided coverage up to \$100,000 for all damages from bodily injury sustained by any one person in a single accident. Because the amount of the potential coverage was equal, Fernandez' vehicle was not "underinsured" within the meaning of Gonzalez's policy through Explorer.

Mercury Ins. Co. v. Pearson (Dec. 4, 2008) 169 Cal.App.4th 1064

Auto Policy Unambiguously Excludes Uninsured Motorist Coverage for Additional Insured

Facts:

David Pearson (“Pearson”) and his fiancée, Susan Hyung (“Hyung”), were struck by an uninsured motorist when Pearson and Hyung were crossing a street as pedestrians. Hyung died as a result of the accident and Pearson sustained serious bodily injury.

Prior to the accident, Pearson and Hyung obtained an automobile insurance policy through Mercury Insurance Company (“Mercury”). Hyung was designated as the “named insured” in the policy. The policy’s declarations page listed Pearson and Hyung as “drivers,” and a “Designated Persons Endorsement” to the policy specified that Pearson was an additional person insured under the bodily injury coverage of the policy.

The policy provided coverage for injuries arising from accidents with uninsured motorists to all insureds. For purposes of the uninsured motorist provision, the term insured was defined as “(1) the named insured and the spouse of the named insured and, while residents of the same household, relatives of either while occupants of a motor vehicle or otherwise; and (2) any other person while in or upon or entering into or alighting from an insured motor vehicle.”

The policy further provided “the uninsured motorist coverage does not provide coverage for bodily injury sustained by a resident of the same household as the Named Insured, who is not a relative, unless such person(s) is occupying a motor vehicle listed in the policy declarations. It is agreed the designated person(s) is a resident of the same household as the Named Insured, is not a relative, and is only provided coverage when operating or occupying a motor vehicle listed in the policy declarations.”

In capital letters, the policy also set forth this “important notice:” “DO NOT SIGN THIS AGREEMENT UNTIL YOU READ AND UNDERSTAND IT.” The insurance policy was signed by Hyung as the named insured and Pearson as a “resident driver.”

Following the accident, Mercury denied Pearson’s tender, concluding he was a pedestrian at the time of the accident and not Hyung’s spouse or relative living in the same household. Mercury then filed a declaratory relief action to obtain a determination Pearson was not entitled to coverage under the policy.

Pearson cross-complained against Mercury and the insurance agents who issued the policy. He alleged causes of action for declaratory relief and reformation, breach of insurance contract, breach of the implied covenant of good faith and fair dealing, professional negligence, and breach of contract.

Mercury demurred to Pearson's cross-complaint, arguing as a matter of law that the policy did not provide coverage for Pearson as an additional driver and Pearson's claims for professional negligence and breach of contract failed to state a claim against Mercury.

The trial court sustained Mercury's demurrer without leave to amend. It then granted Mercury's motion for judgment on the pleadings as to its original complaint against Pearson.

Holding:

The Court of Appeal affirmed the trial court ruling. The Court concluded the plain language of the policy clearly distinguished the benefits under the uninsured motorist provision between named insured and additional drivers on the policy. Specifically, the policy covered the named insured for accidents from uninsured motorists even where the named insured was a pedestrian at the time of the incident. No such coverage was provided to additional insureds.

Pearson contended the policy was ambiguous because it did not provide coextensive uninsured motorist coverage for additional drivers. The Court disagreed, finding no ambiguity in the policy language. Moreover, Pearson's signature under the "important notice" provision demonstrated his acceptance and understanding of the policy language.

Pearson next contended the allegations in his cross-complaint were sufficient to maintain causes of action for vicarious liability and reformation. He contended the trial court erred in denying him leave to amend to include these claims. In particular, Pearson argued he had asked the agents to procure coverage coextensive to that provided to Hyung and the agents negligently failed to do so. Pearson contended these agents acted as "dual agents" and, thus, Mercury was vicariously liable for their alleged negligence.

The Court rejected this contention, finding Pearson made no contention the agents exclusively represented Mercury. The Court further noted insurance agents that are agents for several companies and either selects the company with which to place the insurance or picks an insurer at the insured's direction, the insurance agent is the agent of the insured, not the insurer. Even if the agents were dual agents, any alleged negligence on their part in procuring the insurance Pearson requested was committed, as a matter of law, in their capacities as Pearson's agent.

The Court further noted the policy expressly stated that any oral statements by the agents do not change the terms of the policy and that the policy embodied all agreements between Pearson and Mercury. Additionally, the “Designated Persons Endorsement” “went to great lengths to ensure that Pearson understood his coverage was no coextensive with Hyung’s.” Thus, Mercury could not as a matter of law have authorized or ratified any alleged misrepresentations by the agents.

Pearson’s request to amend to assert a claim for reformation was also denied. The Court reasoned Pearson could not allege facts showing he and Mercury agreed to policy terms and that he signed the agreement under the mistaken belief that it provided such coverage. The Designated Persons Endorsement negated any such claim, because Pearson “violated a legal duty by ignoring a prominently displayed legal warning and signing the agreement when he had not in fact read or understood it.”

Burks v. Kaiser Foundation Health Plan (Mar. 5, 2008)
160 Cal.App.4th 1021

Health Care Service Plan’s Disclosure of Arbitration Agreement in Small, Unhighlighted Typeface on Enrollment Form Does Not Meet Statutory Requirements

Facts:

Plaintiff Bernard Burks (“Burks”) sued Kaiser Foundation Health Plan, Inc. and others (“Kaiser”), contending he received “egregious treatment” while under Kaiser’s care. Kaiser petitioned to compel arbitration pursuant to an arbitration clause contained in the membership agreement between Burks and Kaiser. Burks opposed the petition for arbitration on the ground that the arbitration clause was unenforceable because it was not “prominently displayed” as required by section 1363.1.

The trial court agreed with Burks and denied Kaiser’s petition to compel arbitration, finding that the arbitration clause was not prominently displayed because it was printed in the same or smaller typeface than the typeface of the remainder of the form, and was neither highlighted, bolded or italicized, nor did it have a separate heading.

Holding:

The Appellate Court affirmed, concluding that the arbitration clause was not “prominently displayed” because there was nothing that made the disclosure stand out from the remainder of the form, such that it could be reasonably expected to command the notice of the person filing out the form, and rejecting Kaiser’s argument that it had substantially complied with section 1363.1.

Section 1363.1 provides that if a health care service plan requires binding arbitration to settle disputes with its members, the plan must disclose that arbitration requirement in “a separate article in the agreement issued to the employer group or individual subscriber.” In addition, the disclosure must be “prominently displayed on the enrollment form signed by each subscriber or enrollee.” A violation of section 1363.1 renders a contractually binding arbitration provision in a health service plan enrollment form unenforceable.

Kaiser argued that its arbitration clause complied with section 1363.1(b)’s requirement of prominence because of its placement immediately above Burks’s signature line. Kaiser argued further that the arbitration clause was prominently displayed because the arbitration clause and the signature line were set apart from the rest of the enrollment form.

In rejecting Kaiser’s arguments the Court relied on the maxim of statutory construction that “Courts should give meaning to every word of a statute if possible, and should avoid a construction making any word surplusage.” The Court noted that section 1363.1(d) already requires disclosure of arbitration to be “displayed.... immediately before the signature line provided for the individual enrolling in the health care service plan” and that section 1363.1(b) separately requires that the arbitration clause be displayed prominently. Accordingly, the Court reasoned that if the placement of the arbitration clause immediately before the signature line were sufficient to constitute “prominence” as required by Section 1363.1(b), there would be no reason for the Legislature to have included the signature line requirement in Section 1363.1(d).

The Court further reasoned that the legislative history of the rule further supports the conclusion that by requiring prominence in addition to placement above the signature line, the Legislature intended to require something more than placement to make the Arbitration Clause prominent. To demonstrate compliance with both statutory requirements, the health plan must be able to point to something other than the placement of an arbitration disclosure to show prominence.

Although the Court accepted the fact that the arbitration clause and the signature line were set apart from the rest of the form and therefore did not

compete with non-arbitration language, the Court held that the arbitration clause nevertheless failed to command attention by standing out from its surroundings. As a result, it was not prominently displayed, because it could not reasonably be expected to command the attention of the person filling out the form.

The Court also rejected Kaiser's argument that even if the arbitration clause did not fully satisfy the current judicial construction of Section 1363.1, it still substantially complied with the statute. The Court relied on the long-established rule that "substantial compliance ... means actual compliance in respect to the substance essential to every reasonable objective of the statute, as distinguished from mere technical imperfections of form," citing to *Camp v. Board of Supervisors* (1981) 123 Cal.App.3d 334, 348. The Court held that a health plan's failure to prominently display the arbitration disclosure on its enrollment form can never be deemed a mere technical imperfection of form, because the requirement of prominence is essential to achieving the legislative purpose of Section 1363.1. Because Kaiser's enrollment form did not prominently display the Arbitration Clause, it was in direct contravention of Section 1363.1(b) and did not substantially comply with the statute.

Long v. Century Indemnity Co. (June 17, 2008) 163 Cal.App.4th 1460

If Insurer's Reservation of Rights Triggers Insured's Right to "Independent Counsel," Any Dispute Regarding Independent Counsel's Fees Must Be Arbitrated, Even If Insurer Does Not Retain "Panel Counsel"

Facts:

In 1996 the California Department of Toxic Substance Control (DTSC) filed an environmental cleanup action against G. Harris International (Harris). Harris' personal attorney, Jay B. Long (Long), tendered Harris' defense to Harris' general liability insurer, Insurance Company of North America (INA). INA agreed to defend Harris under a "reservation of rights" (the exact nature of which was not disclosed in the case).

INA asked Long to represent Harris in the cleanup action brought by the DTSC. However, INA was unwilling to pay Long the hourly rate he requested, contending that Long was subject to the "rate cap" established by California Civil Code section 2860(b). When Long and INA were unable to resolve their dispute regarding hourly rates, they agreed that INA would pay Long at the capped hourly rate that INA contended was applicable, with Long reserving his right to seek payment of his normal hourly rate at some later date.

By July 2002 the DTSC had settled its claims as against Harris. In July 2005 Long demanded that INA pay Long the additional attorney fees Long claimed were due for his representation of Harris (i.e., the difference between what INA had paid Long pursuant to section 2860(b) and Long's normal hourly rate). Without conceding that the "mandatory arbitration" provision of section 2860(c) applied, Long also demanded that INA submit the dispute concerning hourly rates to arbitration. INA refused Long's demand for payment and declined to submit the matter to arbitration, asserting that Long's claim for additional attorney fees was barred by the statute of limitations.

Harris then assigned rights to Long, and Long filed a bad faith action against INA. Long essentially sought to recover from INA the difference between what he was paid by INA and what he would have been paid at his normal hourly rate. Notably, however, Long did not allege facts showing that INA's reservation of rights did not create a conflict of interest that triggered a right to independent counsel.

The trial court dismissed Long's claim against INA on the ground that Long's claim against INA involved a fee dispute regarding the rates to be paid to independent counsel, and that the claim and was therefore subject to mandatory arbitration under Civil Code section 2860(c). Long appealed.

Holding:

The Court of Appeal affirmed, holding that Long's fee dispute with INA was subject to arbitration under Civil Code section 2860(c). The appellate court began by rejecting Long's argument that because INA had never retained "panel counsel" to represent Harris in the underlying environmental cleanup lawsuit, INA could not compel arbitration of the fee dispute. According to the appellate court, there is nothing in Civil Code section 2860 that requires the insurer to retain "panel counsel" before section 2860 can apply. Rather, if the insured has a right to be represented by independent counsel, then section 2860 applies whether or not the insurer retains panel counsel to join with independent counsel in defending the insured.

The appellate court then observed that Long had not alleged that INA's reservation of rights did not trigger a right to independent counsel. Since Long had not alleged that INA's reservation did not trigger a right to independent counsel, the appellate court essentially presumed that INA's reservation of rights did trigger a right to independent counsel and that section 2860 therefore did apply. Since section 2860 applied, any fee dispute between Long and INA was subject to mandatory arbitration.

Briggs v. Resolution Remedies (Nov. 21, 2008) 168 Cal.App.4th 1395

A Trial Court Has No Jurisdiction to Review an Arbitrator's Interlocutory Order in a Matter Assigned to Arbitration under Insurance Code §11580.2

Facts:

In August 2005, Louise Briggs was injured in an automobile accident caused by an uninsured motorist. Although Ms. Briggs was injured while acting in the scope of her employment, she declined to file a workers' compensation claim. Ms. Briggs had an uninsured motorist policy issued by GEICO General Insurance Company. GEICO, however, refused to pay any benefits before there was a determination of Ms. Briggs' entitlement to workers' compensation benefits.

On June 23, 2007, Ms. Briggs and her husband, Scott Briggs, demanded arbitration with GEICO. The dispute was submitted to Resolution Remedies. GEICO filed a motion to stay the arbitration, arguing it was entitled to a stay until after Ms. Briggs pursued workers' compensation benefits pursuant to Insurance Code section 11580.2. The arbitrator, retired Judge Breiner, granted the motion, ruling that in light of the policy language and Insurance Code section 11580.2, GEICO was entitled to a stay until Ms. Briggs filed a workers' compensation claim.

On January 30, 2008, the Briggs filed a petition for writ of mandate pursuant to Code of Civil Procedure section 1085, naming Judge Breiner and Resolution Remedies as respondents and GEICO as an interested party. The Briggs' sought a writ of mandate commanding Judge Breiner and Resolution Remedies to vacate the order granting GEICO's petition to stay and a declaration that the GEICO policy did not impose on them a duty to open a workers' compensation claim to obtain the uninsured motorist benefits. GEICO filed an opposition and demurred on the ground there was no statutory authority for using mandamus power to direct a private arbitrator to set aside an order.

The trial court denied the Briggs' writ of mandate, concluding the arbitration was properly stayed under Insurance Code section 11580.2 and the policy. The court, however, denied GEICO's demurrer. The Briggs' appealed.

Holding:

Because the Court of Appeal agreed with GEICO that the trial court lacked jurisdiction to consider the Briggs' writ petition, it affirmed the trial court's dismissal of the petition on that basis.

As a preliminary matter, the Court of Appeal held it was proper to consider GEICO's jurisdiction argument despite GEICO's failure to appeal on the issue because jurisdictional issues are never waived and can be made at any time.

The Court then examined statutory and case law concerning uninsured motorist coverage and arbitration. The Court stated arbitration pursuant to Insurance Code section 11580.2 is a form of contractual arbitration governed by the California Arbitration Act (CAA). Further, all disputes arising under uninsured motorist coverage should be subject to a decision by the arbitrator. Once a dispute is submitted to arbitration, the CAA contemplates very limited judicial involvement, if any. The arbitrator resolves all questions needed to determine the controversy; decides questions of procedure and discovery; and grants relief for delay in bringing an arbitration to resolution.

The Court noted judicial intervention is incompatible with the policies behind arbitration because it could preclude parties from resolving their dispute before a tribunal of their choosing, and create delays the arbitration system was designed to avoid. The Court stated this was particularly applicable in the matter before it because the trial court had no jurisdiction over the arbitration proceedings before appellants sought a writ of mandate, since the arbitration began without the need to seek a court order compelling arbitration.

Acknowledging the limited role of the judicial system in arbitration proceedings, the Court of Appeal stated that a trial court has limited grounds upon which to vacate an arbitrator's final award and may not even set aside a final award based upon mistakes of law. Further, the Court concluded a trial court has no statutory authority to perform a de novo review of an arbitrator's interlocutory order, which was what happened in this case.

Thus, although the trial court correctly declined to intervene in the arbitration, it did so for the wrong reasons. Accordingly, the Court of Appeal affirmed the judgment of the trial court.

Compulink Management Center v. St. Paul Fire and Marine Ins. Co.
(Dec. 17, 2008) 169 Cal.App.4th 289

**Independent Counsel Fee Disputes Must Be Arbitrated Even When Brought in
Conjunction with Non-Arbitrable Issues**

Facts:

Compulink Management Center, Inc. ("Compulink"), was insured under a general liability policy issued by St. Paul Fire and Marine Insurance Company

("St. Paul"). The policy required St. Paul to defend and indemnify Compulink in certain claims and suits. The policy also included a provision, titled "Expenses Incurred By Protected Persons," which stated that St. Paul will "pay all reasonable expenses that any protected person incurs at [St. Paul's] request while helping [St. Paul] investigate or settle, or defend a protected person against, a claim or suit."

Compulink tendered the defense of certain cross-complaints to St. Paul. St. Paul agreed to defend subject to a reservation of rights and allowed Compulink to select independent counsel because of the potential conflict of interest involved in the defense.

The underlying case settled. Compulink then sued St. Paul for breach of contract, breach of the implied covenant of good faith and fair dealing, and declaratory relief. Compulink alleged St. Paul failed to accept defense of the action, underpaid and delayed payment of legal fees and costs, renege on agreements regarding allocation of defense costs and a reasonably hourly fee rate, impeded settlement efforts, and refused to contribute an adequate amount to the settlement. Compulink sought over \$1,000,000 in damages and a declaration St. Paul was required to pay Compulink's outstanding legal fees from the underlying suit.

St. Paul petitioned the court to compel arbitration of the fee dispute pursuant to California Code of Civil Procedure section 2860, subdivision (c). This statute requires disputes over independent counsel fees to be determined through arbitration.

St. Paul argued Compulink's allegations focused on its claim to additional attorney's fees and, thus, the action was subject to mandatory arbitration. Compulink argued arbitration was not mandatory because the complaint went "far beyond the mere failure to pay attorney's fees" and alleged wrongful conduct by St. Paul. Compulink also argued the "Expenses Incurred By Protected Persons" provision exempted the dispute from mandatory arbitration because it required St. Paul to pay all "reasonable" fees.

The trial court agreed with Compulink and denied the petition to compel arbitration. The trial court cited *Fireman's Fund Ins. Companies v. Younesi* (1996) 48 Cal.App.4th 451 in holding Section 2860 is limited to disputes which only deal with the amount of legal fees or hourly billing rates of independent counsel. St. Paul petitioned the Court of Appeal for review.

Holding:

The Court of Appeal found the language of Section 2860 unambiguous and created no exception from arbitration for independent counsel fee disputes brought

with bad faith claims. It requires arbitration of any and all independent counsel fee disputes unless the parties' insurance policy provides for an alternative dispute resolution procedure.

Compulink argued its claims were not subject to mandatory arbitration based on *Younesi*, supra, 48 Cal.App.4th 451 and *Caiafa Prof. Law Corp. v. State Farm Fire & Cas. Co.* (1993) 15 Cal.App.4th 800. The Court declined to follow *Younesi* to the extent it read *Caiafa* to find a trial court is the proper forum for determining independent counsel fee disputes in an action also asserting fraud claims. The Court emphasized that its decision in *Caiafa* was based on the distinction between *Cumis* fee disputes in state court and those in federal court, where Section 2860's arbitration requirement is not binding. "Caiafa made no exception for *Cumis* fee disputes that were intertwined with other non-arbitrable issues."

The Court also did not agree with Compulink's argument regarding the "Expenses Incurred By Protected Persons" provision. It held that this provision, which required St Paul to pay all "reasonable expenses," was not the same as a duty to pay all reasonable "attorney's fees."

The Court of Appeal thus reversed and remanded the trial court's decision with instructions for the trial court to order arbitration of issues concerning the amount of independent counsel fees allegedly owed by St. Paul.

UNLICENSED INSURERS

Medina v. Safe-Guard Products, International, Inc. (June 19, 2008)
164 Cal.App.4th 105

Plaintiff Must Show Injury Beyond Premiums Paid to Obtain Unfair Competition Law (UCL) Relief Based on an Enforceable, Albeit Illegal, Policy Issued by an Unlicensed Insurer

Facts:

Medina purchased a vehicle service contract from Safe-Guard Products, International, Inc. ("Safe-Guard"). Vehicle contracts are insurance contracts governed by the Insurance Code (Ins. Code § 12800 et seq.), which requires their providers to be licensed in California.

At the time of the purchase of this contract, Safe-Guard was not licensed in California. Medina brought suit against Safe-Guard seeking restitution of the money he paid for the contract on the grounds that it was a void, illegal contract.

Holding:

The court began by addressing the issue of whether an illegal insurance contract, illegal because it was issued by an unlicensed insurer, can still be an enforceable contract. The court looked to both the text of the licensing statute and public policy to reach its conclusion.

Insurance Code section 700 requires every person transacting any class of insurance business in California to have a license from the state Insurance Commissioner and provides for the penalties that may result from a violation of this requirement. The court noted that, as a general rule, it will not impose penalties in addition to those that are provided for expressly or by necessary implication in a statute. The court therefore declined to impute the automatic voiding of the contract as a penalty.

The court then looked to public policy to determine whether an illegal contract in this context should be enforceable. The court opined that the doctrine of “*pari delicto*,” where the party seeking the enforcement of the contract is “less morally blameworthy” than the party against whom the contract is being asserted, applied in this context as an exception to unenforceability. Further, the licensing law is designed to protect consumers. Not enforcing the contract would be punishing the consumer and rewarding the violation of the law.

The court concluded that despite its illegality, an insurance contract issued by an unlicensed insurer is enforceable. The twist to this case, however, was that Medina was not seeking to enforce the vehicle service contract he purchased from Safe-Guard. On the contrary, Medina’s action depended upon the contract being void and unenforceable so that he could seek restitution of the money he paid to purchase it.

The court thus turned to Medina’s claim of unfair competition. Under the UCL, as set forth in Business and Professions Code section 17204, a plaintiff must have suffered “injury in fact and has lost money or property as a result” of the unfair competition.

Medina asserted that the payment for the contract was, by itself, sufficient to show “injury in fact.” The court disagreed. Citing *Hall v. Time* (2008) 158 Cal.App.4th 847, the court opined that Medina had not suffered “injury in fact” because he did not allege that he did not want the service contract, that he was given unsatisfactory service, or that he paid more for coverage than what it was

worth. There is no allegation that Medina relied on Safe-Guard's having a license or that Safe-Guard's not having a license caused him to pay for the service contract. Accordingly the court affirmed the trial court's decision.

In footnote 7, the court hinted that Medina might have a claim for rescission if he had alleged that his contract was voidable, rather than void. The court acknowledged that it would then have to address several other issues that would arise from such a claim, but declined to do so because Medina did not make or propose such an allegation.