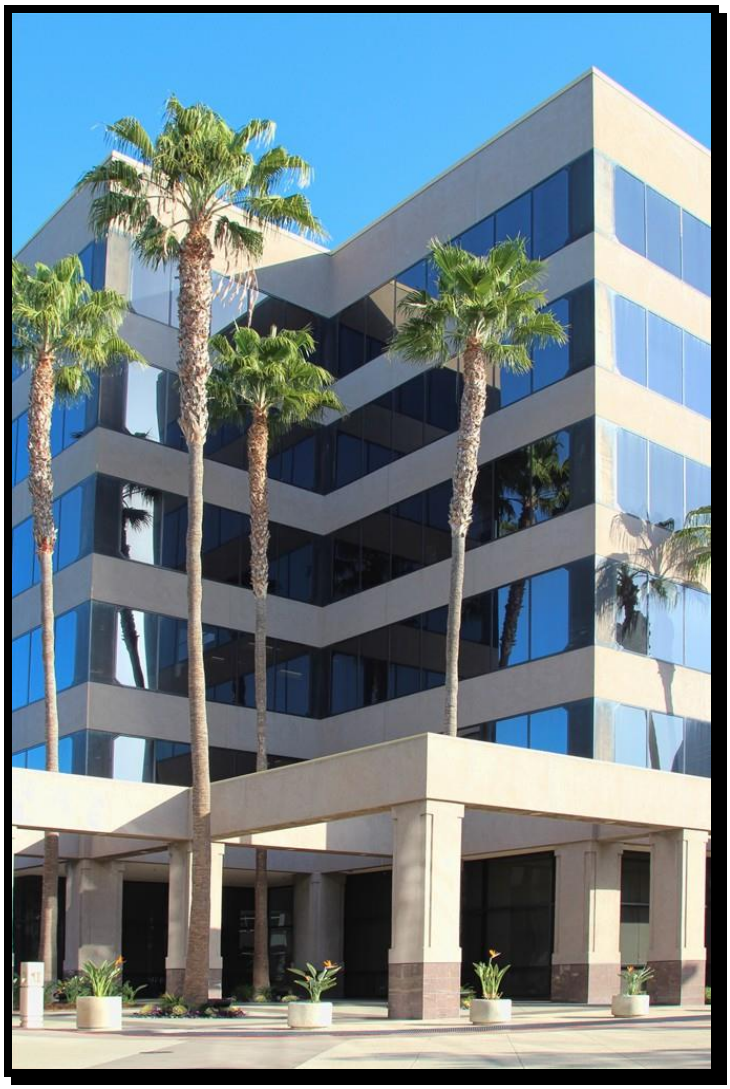
2018 ANNUAL REVIEW OF CALIFORNIA INSURANCE LAW



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To Our Clients and Friends:

Last year was filled with a number of interesting developments in property and liability insurance law. Below are summaries of some major cases decided in the last twelve months that may impact your California claims next year.

Best wishes for the coming year.

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PENDING BEFORE THE CALIFORNIA SUPREME COURT

The following cases are currently under review by the California Supreme Court:

Montrose Chemical Corp. v. Superior Court (Case No. S244737) - When continuous property damage occurs during several periods for which an insured purchased multiple layers of excess insurance, does the rule of "horizontal exhaustion" require the insured to exhaust excess insurance at lower levels for all periods before obtaining coverage from higher level excess insurance in any period?

Pitzer College v. Indian Harbor Ins. Co. (Case No. S239510) – (1) Is California's common law notice-prejudice rule a fundamental public policy for the purpose of choice-of-law analysis? (2) If the notice-prejudice rule is a fundamental public policy for the purpose of choice-of-law analysis, can the notice-prejudice rule apply to the consent provision in this case?

LIABILITY INSURANCE

MISCELLANEOUS

LIABILITY INSURANCE

"Occurrence" Found Where Insured Employer Negligently Hires, Retains or Supervises Employee Who Intentionally Injures Third-Party Claimant

For purposes of a commercial general liability policy, an "occurrence" includes an insured employer's alleged negligence in hiring, retaining or supervising an employee who intentionally injures a third–party claimant. (*Liberty Surplus Insurance Corp. v. Ledesma & Meyer Construction Co., Inc.* (2018) 5 Cal.5th 216)

Facts

A school district hired Ledesma & Meyer Construction Company, Inc. (L&M) to manage a construction project at a middle school. L&M, in turn, hired Darold Hecht as an assistant construction superintendent for the project. While the project was underway, Hecht allegedly sexually abused Jane Doe, who was a 13–year–old student at the school.

Doe later filed a state court lawsuit against various parties, including L&M. As to L&M, Doe alleged that L&M had negligently hired, retained and supervised Hecht, and that such negligence was a proximate cause of Doe's injuries.

L&M tendered the lawsuit to its commercial general liability insurer, Liberty Surplus Insurance Corporation (Liberty). The Liberty CGL policy provided that Liberty would indemnify L&M against damages because of bodily injury caused by an "occurrence," which was defined as "an accident…." The policy further provided that Liberty would defend L&M against any suit seeking such damages. Liberty agreed to defend L&M against Doe's lawsuit under a reservation of rights

Liberty then filed a federal court declaratory relief action, seeking a determination that Liberty had no duty to defend or indemnify L&M against Doe's lawsuit. The federal district judge ruled that L&M's alleged negligence in hiring, retaining and supervising Hecht was not an "occurrence," or "accident," and that Liberty thus had no duty to defend or indemnify L&M against Doe's lawsuit. L&M appealed that ruling to the Ninth Circuit Court of Appeals. During the pendency of the appeal, the Ninth Circuit asked the California Supreme Court to review the "occurrence" issue, and the Supreme Court agreed to address that issue.

Holding

The California Supreme Court concluded that Doe's claims against L&M for negligent hiring, retention and supervision were based on an "occurrence," or "accident," within the meaning of the Liberty policy. The Supreme Court noted that for purposes of liability coverage, an "accident" is generally defined as "an unexpected, unforeseen, or undesigned happening or consequence from either a known or an unknown cause." Further, "the word 'accident' in the coverage clause of a liability policy refers to the, *conduct of the insured* for which liability is sought to be imposed...." Here, the gravamen of the claim against L&M was that L&M had negligently created conditions which allowed Hecht to sexually molest Doe. Although Hecht's own acts of sexual molestation constituted "willful acts" that were not covered, L&M's alleged negligence in hiring, retaining and supervising Hecht "were independently tortious acts" that could be covered. In other words, "Hecht's intentional conduct does not preclude potential coverage for L&M."

The Supreme Court rejected the argument that L&M's alleged negligence was "too attenuated" from Hecht's acts of molestation to be considered a cause of Doe's injuries. Any such argument ignores California case law expressly recognizing that negligent hiring, retention, or supervision of an employee can indeed be a "substantial factor" of a sexual molestation perpetrated by the employee.

The Supreme Court also observed that insurance cases discussing *where* or *when* an "occurrence" takes place are not necessarily relevant in determining *whether* there has been an "occurrence" in the first instance. In determining *whether* there has been an "occurrence" in the first instance, the Supreme Court agreed that "an accident is never present when the insured performs a deliberate act unless some additional, unexpected, independent, and unforeseen happening occurs that produces the damage." Here, while L&M may have "deliberately" hired, retained or supervised Hecht, Hecht's act of molesting Doe was an "additional, unexpected, independent, and unforeseen happening" that produced the damage. In other words, the sexual abuse Doe suffered at the hands of Hecht "may be deemed an unexpected consequence of L&M's independently tortious acts of negligence" in hiring, retaining and supervising Hecht. Thus, with respect to L&M, there was an "occurrence," or "accident," within the meaning of the Liberty policy.

Comment

Whether an insured's liability stems from an "occurrence," or "accident," requires a careful analysis of the causal connection between the insured's alleged conduct and the claimant's injury. In many cases, the insured's alleged conduct may, at some level, have been "deliberate." The real question is whether there was "some additional, unexpected, independent, and unforeseen happening" that produced the damage. Here, after L&M hired Hecht as a construction manager, the "additional, unexpected, independent, and unforeseen happening" was that Hecht sexually molested Doe. Thus, from L&M's perspective, there was an "occurrence," or "accident."

General Liability Insurer Has No Duty to Defend Pharmaceutical Manufacturer Against Governmental Lawsuits Alleging Fraudulent Scheme to Promote Opioid Use

A general liability insurer had no duty to defend its insured, a pharmaceutical company, against governmental lawsuits alleging that the insured engaged in a fraudulent scheme to promote opioid use. (*Travelers Property Casualty Company of America v. Actavis, Inc.* (2017) 16 Cal.App.5th 1026)

Facts

Watson Pharmaceuticals, Inc. and related companies (collectively "Watson") manufacture prescription medicines, including opioid pain killers. In response to the current "opioid epidemic" in the United States, three governmental entities – the County of Santa Clara, California, the County of Orange, California, and the City of Chicago, Illinois – filed lawsuits alleging that Watson had fraudulently promoted opioid painkiller use, which in turn caused the governmental entities to suffer financial losses in responding to the consequences of the opioid epidemic.

Specifically, the governmental entities alleged the following: By the 1990's, Watson had developed the ability to cheaply produce opioid painkillers, but there was only a small market for such painkillers. Watson knew that opioids were an effective treatment for short-term post-surgical pain, trauma-related pain, and end-of-life care, and also knew that opioids were too addictive and too debilitating for long-term use. In order to realize "blockbuster profits," Watson engaged in a sophisticated and deceptive marketing campaign designed to increase sales of its opioid products by promoting them for treating long-term chronic pain – purposes for which Watson knew opioids were not suited. Watson spent millions of dollars developing seemingly scientific materials, studies, and guidelines that misrepresented the risks, benefits, and superiority of opioids to treat chronic pain, and

Watson then distributed those materials, studies, and guidelines to physicians to encourage them to prescribe opioids for chronic pain. Watson knew and intended that its representations "would persuade doctors to prescribe, and patients to use, opioids for chronic pain." Watson's marketing campaign was "wildly successful" and contributed to the current opioid epidemic as well as an ancillary resurgence in heroin use. As a result, the governmental entities have incurred and will continue to incur huge costs in caring for citizens injured by opioid abuse and heroin addiction.

Watson was an insured on consecutive commercial general liability policies issued by St. Paul Fire and Marine Insurance Company and Travelers Property Casualty Company of America (collectively "Travelers"). The policies provided in relevant part that Travelers would indemnify Watson against damages because of "bodily injury" caused by an "occurrence" not otherwise excluded, and that Travelers would defend Watson against any suit seeking such damages. The policies all contained "products-completed operations" exclusions which barred coverage for bodily injury arising out of an insured's products or representations concerning the suitability and safety of such products.

Travelers declined to defend Watson against the governmental entities' lawsuits, and then filed a declaratory relief action seeking confirmation of its position. After a bench trial, the trial court ruled that Travelers had no duty to defend or indemnify Watson against the underlying lawsuits. Watson appealed.

Holding

The California Court of Appeal affirmed.

The appellate court began by holding that the claims the governmental entities were asserting against Watson in the underlying lawsuits were not the result of an "accident." Under California law, an insured's deliberate act is not an "accident" unless some additional, unexpected, independent, and unforeseen happening causes the resulting injury. The allegations that Watson engaged in a sophisticated and highly deceptive marketing campaign aimed at increasing sales of opioids and enhancing corporate profits were allegations of deliberate, intentional acts. It was "not unexpected or unforeseen" that this marketing campaign would lead to increased opioid addiction and to a resurgence in heroin addiction. Because there was no "accident," there was no possibility of coverage and hence no duty to defend.

Further, the claims that the governmental entities were asserting against Watson fell within the scope of the policies' "products-completed operations" exclusions. Those exclusions barred coverage for bodily injury "arising out of ...any goods or products... manufactured, sold, handled, distributed or disposed of by [Watson]" or "warranties or representations made at any time, or that should have been made, with respect to the fitness, quality, durability, performance, handling, maintenance, operation, safety, or use of such goods or products." Both the alleged opioid epidemic and the alleged ancillary resurgence in heroin use arose out of (i.e., flowed from) Watson's act of marketing and selling its products (i.e., opioid painkillers) for purposes for which Watson knew they were not suited (i.e., treatment of long-term, chronic, non-acute pain). Although the governmental entities were not alleging that Watson's opioid painkiller products were "defective," the policies' "products-completed operations" exclusions did not require that the injuries arise out of an insured's "defective" product – only that the injuries arise out of the insured's "product."

Comment

Note the alleged sequence of events here: (1) in order to maximize profits, the insured allegedly engaged in a deceptive marketing campaign to convince doctors that opioid pain killers were safe for treating long-term chronic pain; (2) doctors, in turn, prescribed opioids for treating long-term chronic pain; (3) patients became addicted to opioids; and (4) some patients then turned to

heroin, which produces a "high" similar to opioids but at a lower cost. While there is a direct connection between the insured's allegedly deceptive marketing campaign and the patients' addiction to opioid pain killers, there is a slightly more attenuated connection between the insured's marketing campaign and some patients' eventual addiction to heroin. If there was any room for the appellate court to find a duty to defend here, it would have been with respect to those patients who eventually became addicted to heroin. Nevertheless, the court concluded that there was no "accident," and enforced the exclusion for injuries "arising out of [the insured's] products," both as to injuries stemming from opioid pain killers and injuries stemming from heroin.

Policy Covering "Loss of Use of Tangible Property Not Physically Injured" Covers Insured's Liability for Claimant's Loss of Ability to Use Property as Nightclub

A general liability policy covering "loss of use of property that is not physically injured" covered an insured whose negligence led to the claimant's loss of ability to continue using its property as a nightclub. *(Thee Sombrero, Inc. v. Scottsdale Insurance Company* (2018) 28 Cal.App.5th 729)

Facts

Thee Sombrero, Inc. (Sombrero) owned a piece of commercial property in the City of Colton (City). The City issued a conditional use permit (CUP) authorizing the use of the property as a nightclub. The CUP required the nightclub to have a single entrance door equipped with a metal detector.

Sombrero leased the property to tenants who operated it as a nightclub. Crime Enforcement Services (CES) provided security guard services at the nightclub. At some point CES converted a storage area at the property into a "VIP entrance" that did not have a metal detector.

A nightclub patron armed with a weapon gained entrance to the nightclub through the VIP entrance and shot and killed another patron. Following the shooting, the City revoked the original CUP and replaced it with a modified CUP which provided that the property could be operated only as a banquet hall.

Sombrero sued CES, alleging that CES's negligence caused the shooting, which in turn led to the revocation of the original CUP, which in turn lowered the rental value of the property and caused "lost income." Sombrero obtained a default judgment against CES for $923,078, which represented the difference between the value of the property when used as a nightclub (per the original CUP) and the value of the property when used as a banquet hall (per the modified CUP).

Thereafter, Sombrero brought a "direct action" to collect the judgment from CES's general liability insurer, Scottsdale Insurance Company (Scottsdale). The Scottsdale policy covered damages CES owed because of "property damage," which was defined as "physical injury to tangible property" or "loss of use of tangible property that is not physically injured." The trial court entered summary judgment in favor of Scottsdale, finding that the judgment Sombrero had obtained against CES in the underlying action did not represent damages because of "property damage" as defined in the Scottsdale policy. Sombrero appealed.

Holding

The California Court of Appeal reversed. In the underlying action, Sombrero alleged that CES's negligence caused the revocation of the original CUP, which caused Sombrero to lose the ability to use its property as a nightclub. According to the appellate court, Sombrero's "loss of the ability to use the property as a nightclub is, by definition, a 'loss of use' of 'tangible property.'"

Although revocation of the CUP itself was an injury to intangible property rights, revocation of the CUP

led to an inability to use Sombrero's premises, which was a loss of use of tangible property not physically injured. The appellate court reasoned that a loss of use of tangible property does not require a total loss of all use of the property, but rather only a loss of any significant use of the property. Further, once there is covered property damage, the policy covers any ensuing economic losses as damages "because of" property damage.

In short, Sombrero's loss of the ability to use its property as a nightclub did constitute "property damage" within the meaning of the Scottsdale policy. Thus, the trial court had erred in granting summary judgment in favor of Scottsdale.

Comment

The appellate court cited an earlier case – *Hendrickson v. Zurich American Ins. Co. of Illinois* (1999) 72 Cal.App.4th 1084 – for the proposition that a "loss of use of tangible property not physically injured" does not require a loss of all use of tangible property, but rather only "a loss of a particular use of tangible property…." Thus, the fact that Sombrero could still use the property as a banquet hall was not dispositive. Sombrero could not use the property as a nightclub, and that constituted a loss of use of tangible property not physically injured.

"Faulty Workmanship" Exclusions Do Not Relieve Insurer of Duty to Indemnify Insured for Damage to Insured's Non-Defective Work Occurring Before Completion of Work

A commercial general liability policy's "faulty workmanship" exclusions – exclusions j.(5) and j.(6) – did not relieve the insurer of a duty to indemnify its insured for property damage to the insured's non-defective work occurring before the work was complete. (*Global Modular, Inc. v. Kadena Pacific, Inc.* (2017) 15 Cal. App. 5th 127)

Facts

The United States Department of Veterans Affairs ("VA") hired Kadena Pacific, Inc. ("Kadena") as general contractor for construction of a rehabilitation center that would consist of 53 modular units. Kadena hired Global Modular, Inc. ("Global") to partially build, deliver, and then install the modular units for the project. Because Kadena hired a different subcontractor to install the roofing for the modular units, Global agreed to deliver the modular units covered only by a roof substrate consisting of a 3/4" base sheet of plywood. The Kadena-Global subcontract stated that Global assumed responsibility "for any loss or damage to the [units] ... however caused, until final acceptance thereof by [Kadena]." The subcontract conditioned "final acceptance" upon the VA's approval of the units.

Initially, the subcontract called for Global to deliver and finish the modular units during the summer of 2010. However, due to delays caused at least partially by Global, Global did not deliver the units until October and November 2010 (the beginning of the rainy season). Although Global tried to protect the units from rain by covering them with plastic tarps, the interiors suffered water damage from October 2010 through January 2011. As of mid-February 2011, Global was still in the process of trying to remediate the interior water damage and had not yet completed installing the units. However, by this time, the relationship between Kadena and Global had deteriorated, and Kadena and Global mutually terminated their contract. Kadena then oversaw remediation of the water-damaged interiors and completion of the project.

Global sued Kadena for alleged failure to pay under the subcontract. Kadena cross-complained against Global, alleging that Global had breached the contract by (1) failing to provide services and materials required under the contract in a timely manner, (2) failing to provide modular units which were constructed in a workmanlike manner, and (3) failing to deliver the modular units in a manner which would protect them from rain. The jury agreed with Kadena and found Global contractually

liable for a total of $1,068,542, consisting of $776,478 for repair of the water-damage interiors and $292,064 for delay cause by the repairs.

Global had a commercial general liability policy with North American Capacity Insurance Company (NAC). The NAC policy covered damages Global owed because of "property damage" caused by an "occurrence" and not otherwise excluded. NAC filed a declaratory judgment action seeking a determination regarding its duty to indemnify Global for the underlying judgment in favor of Kadena. The trial court granted summary judgment in favor of Kadena, finding that the judgment Kadena obtained against Global in the underlying action was covered by the NAC policy. NAC appealed.

Holding

The Court of Appeal affirmed the summary judgment in favor of Kadena and against NAC.

The appellate court began by holding that to the extent Kadena's judgment against Global was for the cost of repairing water damage to the interior of the units, the NAC policy provided coverage. Because the interior water damage clearly was "property damage" caused by an "occurrence," the only issue was whether some exclusion applied.

The appellate court rejected NAC's reliance on exclusion j.(5), which bars coverage for property damage to "that particular part of real property on which you or any contractors or subcontractors working directly or indirectly on your behalf *are performing operations*, if the 'property damage' arises out of those operations." Italics added. According to the appellate court, the phrase "are performing operations" indicates that exclusion j.(5) applies "only to damage caused during physical construction activities." Thus, exclusion j.(5) did not apply to the water intrusion damage "because the intrusion occurred during heavy rains when Global was not working on the units."

The appellate court likewise rejected NAC's reliance on exclusion j.(6), which bars coverage for property damage to "*that particular part of any property* that must be restored, repaired or replaced because '*your work' was incorrectly performed on it.*" Italics added. According to the appellate court, exclusion j.(6)'s reference to "that particular part" means that the exclusion applies "to the specific part of the insured's work on which the insured performed faulty workmanship and not, more broadly, to the general area of the construction site affected by the insured's work." Thus, assuming Global's waterproofing efforts constituted "incorrectly performed" work, the "particular part" of the property "on" which Global performed work was the plywood roof substrate, not the interior parts of the units for which Kadena sought repair/replacement costs. The units' interior parts "were not defective and were not the subject of Global's incorrect work, and as a result, their repair and replacement costs do not fall under exclusion j.(6)."

The appellate court also held that to the extent Kadena's judgment against Global was for delay damages caused by the water intrusion, the NAC policy provided coverage. According to the appellate court, "delay damages arising from 'property damage' fall under the insuring clause, which obligates NAC to "pay those sums that the insured becomes legally obligated to pay as damages because of ... 'property damage' to which this insurance applies." Here, the delay damages constituted "a consequential loss (a loss occasioned by the water intrusion) and as such, is part of the damages NAC must pay 'because of' property damage."

Comment

Some prior California appellate decisions contain broad language suggesting that exclusions j.(5) and j.(6) always preclude coverage for damage to an insured's work while construction is ongoing. (See, e.g., *Baroco West, Inc. v. Scottsdale Ins. Co.* (2003) 110 Cal.App.4th 96 and *Clarendon America Ins. Co. v. General Security Indemnity Co. of Arizona* (2011) 193 Cal.App.4th 1311.) However, in

Kadena, the appellate court distinguished those earlier decisions because "none of these decisions interpret the exclusionary language at issue here – 'are performing operations,' 'that particular part,' and 'work ... incorrectly performed'." The Kadena court broke exclusions j.(5) and j.(6) down into constituent parts, and then narrowly construed each part. That is consistent with the general rule that courts resolve all doubts, uncertainties and ambiguities in exclusionary language in favor of the insured and against the insurer.

"Impaired Property" Exclusion Relieves Insurer of Duty to Defend Insured Contractor Against Suit Alleging That Insured's Negligent Work Resulted in Loss of Use of Claimant's Property

A general liability policy's "impaired property" exclusion relieved an insurer of any duty to defend an insured against a suit alleging that the insured had negligently installed electrical equipment which caused a loss of use of the claimant's property. (*All Green Electric, Inc. v. Security National Insurance Co*. (2018) 22 Cal.App.5th 407)

Facts

J. Bruce Jacobs, M.D., hired All Green Electric, Inc. to perform electrical work as part of the construction of Dr. Jacobs' MRI and X-ray facility. All Green's work including running power and outlets to a room in which a mammography machine was to be installed. After the mammography machine was installed, the machine would not function properly due to a magnetic field in the room. As a result, the machine was moved to a second room, but the problem continued. Dr. Jacobs then hired a contractor to install steel shielding in the second room, but the problem persisted. Ultimately, Dr. Jacobs hired an electromagnetic field expert who determined that the magnetic field was caused by a loose bolt in an electrical cabinet installed by All Green. When the bolt was tightened, the magnetic field instantly disappeared.

Dr. Jacobs sued All Green, alleging that All Green had negligently failed to tighten one of the bolts in the electrical cabinet installed by All Green, and that such negligence resulted in the magnetic field that interfered with the operation of the mammography machine. Dr. Jacobs sought damages for unnecessary modifications and repairs, harm to Dr. Jacobs' reputation, loss of business, and loss of profits.

All Green tendered defense of the lawsuit to its insurer, State National Insurance company (SNIC), which had issued commercial general liability policies covering All Green for damages because of property damage caused by an occurrence and not subject to any exclusion. SNIC denied All Green's tender based on the "impaired property" exclusion in All Green's policies. That exclusion barred coverage for property damage "to 'impaired property' or property that has not been physically injured, arising out of: [¶] (1) A defect, deficiency, inadequacy or dangerous condition in 'your product' or 'your work;' or [¶] (2) A delay or failure by you or anyone acting on your behalf to perform a contract or agreement in accordance with its terms." The SNIC policies defined "impaired property" as "tangible property, other than 'your product' or 'your work,' that cannot be used or is less useful because: [¶] a. it incorporates 'your product' or 'your work' that is known or thought to be defective, deficient, inadequate or dangerous; or [¶] b. You have failed to fulfill the terms of a contract or agreement; [¶] if such property can be restored to use by the repair, replacement, adjustment or removal of 'your product' or 'your work' or your fulfilling the terms of the contract or agreement."

All Green sued SNIC for breach of contract and bad faith based on SNIC's alleged wrongful failure to defend All Green against Dr. Jacobs' lawsuit. SNIC moved for summary judgment, arguing that the policies' "impaired property" exclusion eliminated any potential for coverage. The trial court granted SNIC's motion. All Green appealed.

Holding

The California Court of Appeal affirmed the summary judgment in favor of SNIC.

The appellate court held that Dr. Jacobs' claims against All Green in the underlying lawsuit fell within the SNIC policies' "impaired property" exclusion. In the underlying lawsuit, Dr. Jacobs had alleged that All Green's failure to tighten a bolt had resulted in loss of use of the mammogram machine. That was property damage (loss of use) to impaired property (the mammogram machine) that could not be used because of an alleged deficiency in All Green's work (the loose bolt), and the impaired property could be restored by adjusting All Green's work (tightening the bolt). Thus, the "impaired property" exclusion applied.

The appellate court acknowledged that the impaired property exclusion contained an exception stating that "[t]his exclusion does not apply to the loss of use of other property arising out of the sudden and accidental physical injury to 'your product' or 'your work' after it has been put to its intended use." However, there were no allegations or extrinsic facts suggesting that All Green or anyone else had somehow suddenly and accidently caused physical injury to the electrical cabinet after All Green's work was complete. Thus, the exclusion's exception was inapplicable.

Comment

The insured, All Green, insisted that it had properly tightened the bolt and that it therefore had no liability to Dr. Jacobs in the underlying action. However, the appellate court held that All Green's mere denial of liability in the underlying action did not create a "potential" for coverage. The court reasoned that if All Green was *not* negligent, then All Green had no liability at all, and SNIC would thus have no duty to indemnify under the policy. Conversely, if All Green *was* negligent, then All Green's liability would be excluded from coverage by the "impaired property" exclusion, and SNIC would likewise have no duty to indemnify under the policy. Because in either scenario there was no "potential" for indemnity, there was no duty to defend.

"Ongoing Operations" Additional Insured Endorsement Requires Insurer to Defend Developer in Construction Defect Action, Despite Fact That Homeowners Did Not Purchase Homes from Developer Until After Completion of Operations by Subcontractor

An "ongoing operations" additional insured endorsement required an insurer to defend a developer in a construction defect action, despite the fact that the homeowner plaintiffs did not purchase the homes from the developer until after the completion of operations by the named insured subcontractor. (*McMillin Management Services, L.P. v. Financial Pacific Ins. Co.* (2017) 17 Cal.App.5th 187)

Facts

McMillin Management Services, L.P. (McMillin) was the developer of a residential project in Brawley, California. McMillin hired various subcontractors to help construct the project, including Martinez Construction Concrete Contractor, Inc. (Martinez), which performed concrete flatwork on the project, and Rozema Corporation (Rozema), which performed lath and stucco work on the project. During the time Martinez and Rozema worked on the project, Martinez and Rozema were named insureds on general liability policies issued by Lexington Insurance Company (Lexington). The Lexington policies included endorsements listing McMillin as an additional insured, "but only with respect to liability arising out of your [i.e., Martinez's or Rozema's] ongoing operations performed for [McMillin]."

After Martinez and Rozema finished their work at the project, McMillin sold the homes to various individuals. Several years later, various homeowners within the project filed a construction defect action against McMillin. McMillin tendered

defense of the action to Lexington, but Lexington refused to defend McMillin.

McMillin sued Lexington for breach of contract and bad faith arising from Lexington's refusal to defend McMillin in the construction defect litigation. Lexington moved for summary judgment, essentially arguing that because the homeowners had purchased their homes from McMillin *after* Martinez and Rozema finished working at the project, McMillin did not face any potential liability "arising out of your [i.e., Martinez's or Rozema's] ongoing operations performed for [McMillin]." The trial court granted Lexington's motion for summary judgment. McMillin appealed.

Holding

The Court of Appeal reversed. The appellate court focused on the language of the additional insured endorsements, which covered McMillin for liability "*arising out of* your [i.e., Martinez's or Rozema's] *ongoing operations* performed for [McMillin]." According to the court, the mere fact that there were no homeowners at the time of Martinez's and Rozema's ongoing operations did *not* preclude the possibility that McMillin might have liability "*arising out of"* Martinez's or Rozema's "ongoing operations." If property damage occurred *before* Martinez and Rozema finished working at the jobsite, then McMillin would be entitled to coverage pursuant to the ongoing operations additional insured endorsement. Lexington had not established as a matter of law that all of the property damage in the underlying action necessarily occurred after the completion of Martinez's and Rozema's ongoing operations. As such, Lexington was not entitled to summary judgment.

Comment

The ongoing operations additional insured endorsement in this case also contained an exclusion for bodily injury or property damage "occurring after (1) All work ... to be performed at the site of the covered operations has been completed; or (2) That portion of 'your work' out of which the injury or damage arises has been put to its intended use...." However, Lexington did not rely on the exclusion in its motion for summary judgment. Instead, Lexington relied solely on the scope of the additional insured endorsement's "insuring language," which covered an additional insured for liability "arising out of [the named insured's] ongoing operations performed for [the additional insured]." As is evident, the appellate court was not persuaded by Lexington's interpretation of the insuring language in the endorsement.

Liability Policy Covering "Personal Injury" Offense of "Invasion of Right of Private Occupancy" Covers Non-Physical Invasions of Rights in Real Property

A liability policy covering the "personal injury" offense of "invasion of the right of private occupancy" required the insurer to defend an insured against a suit alleging a non-physical invasion of the claimant's rights in real property. (*Albert v. Truck Ins. Exch.* (2018) 23 Cal.App.5th 367)

Facts

A 400-foot long, 26-foot wide private road straddled the boundary between Shelly Albert's property and another neighbor's property, so that Albert and the other neighbor each owned half (i.e., 13 feet) of the road measured from the center of the road. The private road, in turn, allegedly provided a third neighbor, Henri Baccouche, with the only access to Baccouche's property. Baccouche claimed that he had an easement over the private road so that he could get to and from his property.

Albert built a fence on her own property that prevented Baccouche from using the half of the private road located on Albert's property. In other words, after Albert built the fence, Baccouche could only access his property using a 13-foot wide road rather than a 26-foot wide road.

As a result, Baccouche sued Albert for private nuisance, alleging that Albert had "erected a permanent chain-link fence on certain portions of [Albert's] property that were subject to a reciprocal easement as a private roadway for ingress and egress." Baccouche further alleged that the fence "constitutes a nuisance within the meaning of Civil Code Section 3479 in that it ... interferes with the comfortable enjoyment by [Baccouche] of his property, including access thereto."

Albert sought a defense from her personal umbrella insurer, Truck Insurance Exchange (Truck). The Truck umbrella policy provided that Truck would indemnify Albert against damages because of specified "personal injury" offenses, including "wrongful eviction, wrongful entry or invasion of the right of private occupancy." The policy further provided that Truck would defend Albert against any claim or suit seeking damages "covered by this insurance but not covered by other insurance." Truck refused to defend Albert against Baccouche's lawsuit.

Albert then sued Truck for breach of contract and bad faith, alleging that Baccouche's underlying lawsuit against Albert was potentially covered under the "personal injury" provisions of the Truck policy, and that Albert was thus entitled to a defense from Truck. The trial court disagreed. The trial court thus granted Truck's motion for summary judgment on all issues and denied Albert's cross-motion for summary adjudication on the duty to defend issue. Albert appealed.

Holding

The Court of Appeal reversed, and held that Truck did have a duty to defend Albert against Baccouche's lawsuit.

The appellate court agreed that Baccouche was not seeking any damages from Albert because of the personal injury offense of "wrongful entry." According to the appellate court, a "wrongful entry" requires that the insured enter onto *another's* real property. Here, Albert built a fence on *her own* property. Although Albert's act of building a fence on her own property might have wrongfully interfered with Baccouche's easement rights, Albert could not have "wrongfully entered" onto Albert's own property.

However, the appellate court held that Baccouche was seeking damages from Albert because of the personal injury offense of "invasion of the right of private occupancy." After an exhaustive review of case law, the appellate court held that the term "invasion of the right of private occupancy" is susceptible to more than one reasonable interpretation and hence is "ambiguous." According to the appellate court, an invasion of the right of private occupancy *"does not have to be a physical invasion of the land; a non-physical invasion of real property rights can interfere with the use and enjoyment of real property."* Here, Baccouche alleged that Albert blocked half of the only road providing access to Baccouche's property, which in turn "interfered with [Baccouche's] comfortable enjoyment … of his property, including access thereto." Thus, Albert's alleged conduct "invaded Baccouche's right of private occupancy by interfering with his right to use and enjoy his property."

Because Baccouche sought damages against Albert that were potentially covered by Truck's personal umbrella policy, Albert was entitled to a defense from Truck.

Comment

This is the second time the "neighbor dispute" between Baccouche and Albert has resulted in a published case regarding insurance coverage issues. In the first case, *Albert v. Mid-Century Ins. Co.* (2015) 236 Cal.App.4th 1281, the appellate court held that a homeowners insurer had no duty to defend Albert against allegations that she trimmed trees located on or near the property line between Albert and Baccouche. In that case, the homeowners policy limited coverage to "property damage" caused by an "accident," and Albert's alleged conduct in trimming Baccouche's trees was not an "accident."

By contrast, the current case involved a personal umbrella policy that provided separate coverage for "personal injury," without any requirement of an "accident." The appellate court gave an expansive interpretation of the personal injury offense of "invasion of the right of private occupancy," essentially holding that the term can encompass any act by an insured that interferes with the claimant's ability to access, use, develop or enjoy real property. The appellate court disagreed with an earlier case, *Sterling Builders, Inc. v. United Nat. Ins. Co.* (2000) 79 Cal.App.4th 105, in which the appellate court held that an "invasion of the right of private occupancy" must involve a "physical occupation of or trespass on" real property.

Professional Liability Insurer Has No Duty to Defend Insured Against Claim That Insured Knew About, or Reasonably Could Have Foreseen, Before Inception of Policy

A professional liability insurer had no duty to defend its insured against a claim that the insured knew about, or reasonably could have foreseen, before the effective date of the policy. *(Admiral Insurance Company v. Superior Court* (2017) 18 Cal.App.5th 383)

Facts

A Perfect Match, Inc. (Perfect Match) is a company that matches egg donors and gestational surrogates with infertile families. Perfect Match not a licensed health care provider and does not employ doctors, nurses, or other health care professionals.

In 2011, Monica Ghersi and Carlos Arango utilized the services of Perfect Match to locate an egg donor and a gestational surrogate. The surrogate later gave birth to a baby girl who developed a rare cancer.

Following an investigation, Ghersi and Arango retained an attorney. In June 2012, the attorney sent Perfect Match three letters, one on behalf of each parent and one on behalf of their infant daughter. Each letter referred to Code of Civil Procedure section 364 and announced an intent to file a complaint against Perfect Match for "negligent and unprofessional ... conduct … while in the performance of professional duties…." Upon receiving the letters, Perfect Match consulted with its insurance broker. Because Perfect Match interpreted the letters as something less than an actual "claim" and because Perfect Match was concerned about a possible increase in premiums, Perfect Match decided not to notify its current insurer.

In October 2012, Perfect Match applied to Admiral Insurance Company (Admiral) for a new liability policy. Among other things, the application inquired whether Perfect Match was "aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit?" Perfect Match responded "No."

Admiral subsequently issued a professional liability policy to Perfect Match covering claims made during the period of December 5, 2012, through December 5, 2013. The policy's insuring agreement stated that Admiral would pay amounts that Perfect Match was "legally obligated to pay as damages caused by a professional incident ... for which a claim is first made against the insured during the policy period." However, the insuring agreement further provided that Admiral was obligated to pay only if *"prior to the inception date of the policy, no insured knew, nor could have reasonably foreseen, that the professional incident might result in a claim."* The policy defined a "professional incident" as "a negligent act, error or omission in the rendering of or failure to render professional services by the insured."

Ghersi and Arango filed suit against Perfect Match in the latter part of 2012, and had the complaint served on Perfect Match in March 2013. Perfect Match tendered the lawsuit to Admiral for defense, but Admiral refused to provide Perfect Match with a defense.

Perfect Match later sued Admiral for breach of contract and bad faith arising from Admiral's alleged wrongful refusal to defend Perfect Match against Ghersi's and Arango's lawsuit. Admiral moved for summary judgment, arguing that there was no possibility of coverage under the policy because prior to the inception of the policy Perfect Match knew or reasonably could have foreseen that the professional services it provided to Ghersi and Arango might result in a claim. The trial court denied Admiral's motion. Admiral sought appellate review.

Holding

The California Court of Appeal held that the trial court erred in denying Admiral's motion for summary judgment against Perfect Match. According to the appellate court, the policy's "prior notice" provision is an "integral part of the insuring agreement itself" and specifies that "there is no coverage if the insured knew or reasonably could have foreseen that the professional incident might result in a claim." Here, Perfect Match had been aware of Ghersi's and Arango's intention to sue Perfect Match since June 2012, some six months prior to inception of the Admiral policy in December 2012. Thus the "undisputed facts demonstrate that Perfect Match had notice prior to the inception of the policy that Ghersi and Arango intended to file a lawsuit" against Perfect Match. As such, the Admiral policy did not potentially cover any liability Perfect Match might have to Ghersi and Arango in the underlying action. Because there was no potential for coverage, Admiral had no duty to defend.

Comment

Admiral also moved for summary judgment on the separate ground that Perfect Match had made a material misrepresentation in the application for the Admiral policy. However, the appellate court held that "the application form and the responses to the questions on it are largely a red herring because the policy (i.e., the parties' agreement) itself explains there is no coverage for a claim arising from a professional incident if, prior to the inception of the policy, the insured knew or could have reasonably foreseen that the professional incident might result in a claim." Because there was no coverage under the policy as written, there was no need to consider whether the insured had made a material misrepresentation in the application.

"Each Person" Limit Applies to All Damages, Including Loss of Consortium Damages, Arising from Bodily Injury to One Person

An automobile liability policy's "each person" limit applied to all damages, including loss of consortium damages, arising from bodily injury to one person. (*Jones v. IDS Property Casualty Insurance Co.* (2018) 27 Cal.App.5th 625)

Facts

Mark Jones was seriously injured in an automobile accident caused by Richard Buhler. Mr. Jones and his wife Melanie Jones later sued Mr. Buhler, with Mr. Jones seeking damages for bodily injury and Mrs. Jones seeking damages for loss of consortium.

At the time of the accident, Mr. Buhler was the named insured on an IDS Property Casualty Insurance Company (IDS) auto policy with bodily injury limits of $250,000 each person / $500,000 each occurrence. The policy's limit of liability provision stated as follows: "[¶] 1. *The bodily injury liability limits for each person is the maximum we will pay as damages for bodily injury, including damages for care and loss of services, to one person per occurrence*. [¶] 2. Subject to the bodily injury liability for each person, the bodily injury liability limit for each occurrence is the maximum we will pay as damages for bodily injury, including damages for care and loss of services, to two or more persons in one occurrence." (Italics added.)

Mr. and Mrs. Jones obtained a judgment of $1,500,000 in their personal injury action against Mr. Buhler, with Mr. Jones receiving an award of $1,350,000 for his bodily injury and Mrs. Jones

receiving an award of $150,000 for her loss of consortium. IDS paid the policy's $250,000 each person limit in partial satisfaction of Mr. Buhler's liability to Mr. and Mrs. Jones.

Mr. and Mrs. Jones then filed a declaratory relief action against IDS, seeking a ruling that the IDS policy provided $250,000 in limits for Mr. Jones' claim as well as $250,000 in limits for Mrs. Jones' claim, so that the total amount available was the $500,000 each occurrence limit. The trial court ruled in favor of IDS, holding that Mr. Jones' bodily injury claim and Mrs. Jones' loss of consortium claim were both subject to the policy's $250,000 each person limit rather than the $500,000 each occurrence limit. Mr. and Mrs. Jones appealed.

Holding

The California Court of Appeal affirmed the declaratory judgment in favor of IDS. The IDS policy provided that the $250,000 each person limit "is the maximum we will pay as damages for bodily injury, including damages for care and loss of services, to one person per occurrence." After a comprehensive review of California case law involving similar policy language, the appellate court concluded that the IDS policy sufficiently apprised the insured, Mr. Buhler, that the lower $250,000 each person limit applied to all damages, including loss of consortium damages, arising from bodily injury to any one person. Thus, the $250,000 each person limit applied to both Mr. Jones' claim for bodily injury and Mrs. Jones' claim for loss of consortium. Accordingly, IDS had already paid everything it owed under the policy.

Comment

An insurer may limit its liability in accidents were loss of consortium damages are claimed by expressly providing that such damages are subject to the "each person" limitation. (*Abellon v. Hartford Ins. Co.* (1985) 167 Cal.App.3d 21, 33.) Here, the policy language in the IDS policy was slightly different from the policy language in some earlier cases in which courts had held that the "each person" limit applied to all damages, including loss of consortium damages, arising from bodily injury to one person. (See, e.g., *United Services Automobile Assn. v. Warner* (1976) 64 Cal.App.3d 957 and *Mercury Ins. Co. v. Ayala* (2004) 116 Cal.App.4th 1198.) Nevertheless, the appellate court held that IDS's policy language was "sufficient" to result in an aggregation of any damages suffered by the spouse claiming loss of consortium with the damages suffered by the spouse claiming the actual bodily injury. A reasonable insured reading the policy would understand this.

Insurer's Defense of Additional Insured Under Reservation of Rights Does Not Create Conflict of Interest Requiring Independent Counsel

An insurer's agreement to defend an additional insured developer under a reservation of rights did not trigger a conflict of interest sufficient to give the developer the right to have independent counsel. (*Centex Homes v. St. Paul Fire and Marine Insurance Co.* (2018) 19 Cal.App.5th 789)

Facts

Centex Homes (Centex) was the developer of two residential housing projects. Centex did not directly perform any of the construction on the homes. Rather, Centex hired various subcontractors, including Ad Land Venture LP (Ad Land), to perform the construction.

After the projects were completed, some of those who purchased homes sued Centex for construction defects. Centex in turn sought coverage as an additional insured on a general liability policy which Ad Land had obtained through St. Paul Fire & Marine Insurance Company (St. Paul). In response to Centex's tender, St. Paul appointed Attorney David Lee to defend Centex under a reservation of rights. Among other things, St. Paul reserved its right to deny coverage to Centex for (1) property damage to Ad Land's own work and (2) property damage arising from work of other subcontractors not insured by St. Paul. St.

Paul did not place any limits on appointed defense counsel Lee's representation of Centex.

Centex filed a cross-complaint against all the subcontractors and St. Paul. With respect to St. Paul, Centex sought a declaration that Centex was entitled to independent counsel under Civil Code section 2860 because St. Paul's reservation of rights created significant conflicts of interest. Appointed defense counsel, Lee, did not have any involvement in either the prosecution or defense of Centex's cross-complaint.

St. Paul moved for summary adjudication on Centex's claim for declaratory relief. The trial court granted St. Paul's motion, holding that St. Paul was not obligated to provide independent counsel to Centex. Centex appealed.

Holding

The Court of Appeal affirmed.

The appellate court rejected Centex's argument that any "possible" or "potential" conflict was legally sufficient to require St. Paul to provide Centex with independent counsel. California Civil Code section 2860 requires independent counsel only when conflicts are "actual," not merely "possible." Further, while California Rule of Professional Conduct 3–310(C)(1) limits an attorney's ability to represent "more than one client in a matter in which the interests of the clients *potentially* conflict," the appellate court declined to apply that rule to the insured-insurer relationship in which the insured is the true "client" and the insurer is merely the "indemnity provider."

The appellate court also rejected Centex's argument that appointed defense counsel, Lee, could "influence the outcome of the coverage dispute" between Centex and St. Paul, and that Centex was thus entitled to independent counsel. Here, Centex had failed to show how Lee could have controlled the outcome of any coverage issue to the detriment of Centex and to the benefit of St. Paul. The appellate court emphasized that Centex was strictly liable for any construction defects, and thus the issue of causation would not necessarily have been litigated in the construction defect litigation. Further, St. Paul had not placed any restrictions on Lee's representation of Centex.

Last, the appellate court rejected Centex's argument that St. Paul "controlled both sides of the litigation" and that independent counsel was thus required. Although St. Paul did appoint counsel for Centex with respect to the main action, St. Paul did not appoint counsel for Centex with respect to the cross–complaint. Thus, St. Paul did not control both sides of the litigation.

Comment

The litigants in this case – Centex and St. Paul – have a history of insurance coverage disputes. In a prior reported case, *Centex Homes v. St. Paul Fire & Marine Ins. Co.* (2015) 237 Cal.App.4th 23, another California appellate court held that Centex had failed to state a cause of action for declaratory relief against St. Paul arising from St. Paul's refusal to provide independent counsel to Centex in construction defect litigation. The appellate court in that case held that Centex's allegations amounted to mere speculation about how appointed defense counsel might control the outcome of coverage issues, "without describing how this is occurring in the underlying construction defect litigation. Centex is alleging conclusions without substance, not facts." (*Id*. at 31–32.) Likewise, in the present case, the appellate court held that Centex had not produced any evidence as to how appointed defense counsel could or would control the outcome of any coverage issues. As such, Centex had not made any showing that it was entitled to independent counsel.

PROPERTY INSURANCE

Valuable Possessions Policy Does Not Cover Insured's Financial Loss Resulting from Purchase of Counterfeit Wine

A valuable possessions policy did not cover an insured's financial loss resulting from the purchase of counterfeit wine, there being no loss to covered property. *(Doyle v. Fireman's Fund Ins. Co.* (2018) 21 Cal.App.5th 33)

Facts

David Doyle is a collector of rare, vintage wine. Doyle insured his "world class" wine collection against loss or damage by purchasing a "Valuable Possessions" policy from Fireman's Fund Insurance Company (Fireman's Fund), with a blanket policy limit of $19 million. The policy's "Perils Insured Against" provision stated that Fireman's Fund was insuring against "direct and accidental loss ... to covered property."

During the years the Fireman's Fund policy was in force, Doyle paid close to $18 million for purportedly rare, vintage wine from Rudy Kurniawan. However, law enforcement authorities later discovered that for many years Kurniawan had been filling empty wine bottles with his own wine blend and had been affixing counterfeit labels to the bottles. Kurniawan was convicted of fraud and was sentenced to a 10-year prison term.

Doyle made a claim to Fireman's Fund for the losses Doyle had sustained due to Kurniawan's fraud. Fireman's Fund denied Doyle's claim, asserting that there was no covered loss under the policy.

Doyle subsequently sued Fireman's Fund for breach of contract and related causes of action. However, the trial court dismissed Doyle's complaint on the ground that it failed to state a viable claim against Fireman's Fund. Doyle appealed.

Holding

The Court of Appeal affirmed, reasoning that Doyle had not sustained any direct and accidental loss to covered property. The appellate court emphasized that nothing happened *to* the wine Doyle had purchased and insured. Rather, the wine was counterfeit (and essentially worthless) when purchased, and it remained counterfeit (and essentially worthless) throughout the entire coverage period of the policy. Although Doyle suffered a financial injury, the financial injury did not result from any loss to property that was covered by the policy. Thus, the Fireman's Fund policy did not apply.

Comment

The policy in this case insured against "direct and accidental loss to covered property" as opposed to "direct and accidental physical loss to covered property." However, the court held that while the policy did not use the word "physical," the policy still required some loss to (i.e., some change in condition of) the property itself. Because that requirement was not met, the claim did not fall within the basic insuring agreement, and hence there was no need to consider exclusions.

Party-Appointed Appraiser is "Arbitrator" and, Subject to Narrow Exceptions, is Barred from Giving Evidence About Appraisal Proceeding

A party-appointed appraiser is an "arbitrator" and is barred from giving evidence about the appraisal proceeding, except for evidence that the award was procured by "corruption, fraud, or other undue means" or that the members of the panel "exceeded their powers." (*Khorsand v. Liberty Mutual Fire Ins. Co.* (2018) 20 Cal.App.5th 1028)

Facts

Liberty Mutual Fire Insurance Company issued a homeowner insurance policy to Arash Khorsand and Mahshid Fahandeza. Khorsand and Fahandeza submitted a claim for damage allegedly caused by a plumbing leak, but the parties had very different evaluations of the extent of covered damage and cost of repair. Specifically, Liberty Mutual determined the cost of repair was about $34,000, while Khorsand and Fahandeza determined the cost of repair was about $482,000.

Khorsand and Fahandeza then submitted a second claim for damage allegedly caused by rain, but the parties again had very different evaluations of the extent of covered damage and cost of repair. Specifically, Liberty Mutual determined the cost of repair was about $66,000, while Khorsand and Fahandeza determined the cost of repair was about $288,000.

Because of the dispute, Khorsand and Fahandeza demanded appraisal of the damage, and ultimately obtained a court order compelling Liberty Mutual to participate in the appraisal as to both claims. In ordering the appraisal, the court directed the appraisal panel to value separately items of loss about which Liberty Mutual disputed coverage.

Each side selected an appraiser, and the two appraisers appointed an umpire. Ultimately, the umpire and Liberty Mutual's selected appraiser signed the award, but Khorsand's and Fahandeza's selected appraiser did not. The award stated that the total amount of the two losses was $132,293.04 – which was only a fraction of what Khorsand and Fahandeza had sought. And, importantly, the $132,293.04 award included $96,530.37 for items about which Liberty Mutual disputed coverage.

Liberty Mutual filed a petition to confirm the award, but Khorsand and Fahandeza opposed that petition and filed their own petition to correct or vacate the award. In support of their petition to correct or vacate the award, the appraiser selected by Khorsand and Fahandeza submitted a declaration in which he provided an account of the appraisal proceedings, including his summary of the evidence presented and the appraisal panel's deliberations. His declaration also forth his reasons for declining to sign the award.

Liberty Mutual objected to the entire declaration as inadmissible. Specifically, Liberty Mutual asserted that, subject to some exceptions, Evidence Code section 703.5 bars an "arbitrator" from testifying about any statement, conduct, decision, or ruling, occurring at or in conjunction with an arbitration. The trial judge overruled Liberty Mutual's objection, and held that Khorsand's and Fahandeza's appraiser was not an "arbitrator." But even after considering Khorsand's and Fahandeza's appraiser's declaration, the trial judge granted Liberty Mutual's petition to confirm the award. Khorsand and Fahandeza then appealed.

Holding

The Court of Appeal rejected the trial judge's ruling that Khorsand's and Fahandeza's appraiser was not an "arbitrator." The Court of Appeal held that each member of the appraisal panel was an "arbitrator," and that Evidence Code section 703.5 severely limited the extent to which an appraiser could give evidence about any statement, conduct, decision, or ruling occurring at or in conjunction with the appraisal proceeding. However, the Court of Appeal held that an appraiser *could* give evidence that the award was procured by "corruption, fraud, or other undue means" or that the members of the panel "exceeded their powers."

Thus, the Court of Appeal held the trial judge should not have admitted the *entire* declaration into evidence but, instead, should have admitted only that *part* of declaration that was intended to show the award was procured by "corruption, fraud, or other undue means" or that the members of the panel "exceeded their powers." Although the Court of Appeal held the trial judge should not have admitted the entire declaration into evidence, the Court of Appeal ultimately affirmed the trial judge's ruling confirming the appraisal award. In other words, the Court of Appeal ruled the trial judge

improperly admitted the appraiser's entire declaration, but still reached the correct conclusion.

Comment

This case reinforces the concept that appraisers are arbitrators, albeit arbitrators with limited authority. Unlike other arbitrators, who typically decide all issues of law and fact, appraisers decide only a limited issue of fact, i.e., the amount of loss. Appraisers clearly have no authority to determine coverage issues, such as causation or policy interpretation.

This case also reinforces the concept that, if two of the three members of an appraisal panel sign an award, the award can be vacated or corrected only for extremely limited reasons. And, as illustrated in this case, a member of the appraisal panel is barred from giving evidence about any statement, conduct, decision, or ruling occurring at or in conjunction with the appraisal proceeding. Instead, a member of the appraisal panel is limited to giving evidence the award was procured by "corruption, fraud, or other undue means" or that the members of the panel "exceeded their powers."

BAD FAITH

Trial Judge's Errors During Trial Mandate Reversal of Bad Faith and Punitive Damage Award Against General Liability Insurers

A trial judge's prejudicial errors during trial mandated reversal of an $8.2 million bad faith award and a $46 million punitive damage award against liability insurers who allegedly mishandled the defense of an insured in underlying litigation. *(Victaulic Co. v. American Home Assurance Co.* (2018) 20 Cal.App.5th 948)

Facts

Victaulic Company (Victaulic) is a Pennsylvania corporation that produces mechanical pipe joining systems. Victaulic purchased commercial general liability, umbrella and excess policies through American Home Assurance Company, Insurance Company of the State of Pennsylvania, and National Union Fire Insurance Company of Pittsburgh, PA (collectively AIG).

Plaintiffs filed nine different lawsuits against Victaulic in several different jurisdictions, seeking damages from Victaulic because of property damage caused by alleged defects in Victaulic's products. Victaulic tendered the lawsuits to AIG. AIG's director of complex claims, Nancy Finberg, concluded that there was a "potential" for coverage. AIG thus agreed to defend Victaulic in the lawsuits subject to a reservation of rights, and subject to the self-insured retention provisions of the policies.

AIG later filed a declaratory relief action against Victaulic in Pennsylvania (Victaulic's home state), seeking a declaration that AIG did not have any duty to defend or indemnify Victaulic in the underlying lawsuits. Ultimately, the Pennsylvania court dismissed that case on the ground that the third-party claimants were indispensable parties and were not amenable to jurisdiction in Pennsylvania.

Meanwhile, Victaulic sued AIG in California for breach of contract and bad faith, alleging that AIG had failed to pay amounts due under the policies and that AIG had thus failed to meaningfully defend and indemnify Victaulic in the underlying lawsuits. AIG cross-complained, seeking a declaration that AIG did not have any duty to defend or indemnify Victaulic in the underlying lawsuits. During the California coverage litigation, Ms. Finberg verified AIG's responses to request for admissions (RFAs) in which AIG denied that it had any duty to defend Victaulic in the underlying lawsuits. Eventually, the trial judge summarily adjudicated that AIG did have a duty to defend Victaulic in three of the underlying lawsuits.

The trial judge then bifurcated the coverage case, with Phase 1 consisting of a bench trial on the issues of whether AIG had a duty to defend and indemnify Victaulic in the underlying lawsuits. The trial judge ultimately ruled that AIG did have a duty to defend and indemnify Victaulic in the underlying lawsuits.

Phase 2 consisted of a three-and-a half week jury trial on the issue of breach of contract and bad faith. The bulk of Phase 2 was devoted to Victaulic's claim that AIG acted unreasonably by filing the declaratory relief actions against Victaulic. During Phase 2, the trial judge allowed Victaulic's counsel to interrogate AIG's claim director, Ms. Finberg, about AIG's responses to RFAs in which AIG denied that it had any duty to defend Victaulic. During Victaulic's interrogation of Ms. Finberg regarding the RFA responses, the trial judge himself twice aggressively interrogated Ms. Finberg, and ultimately the judge abruptly halted the questioning for an in-chambers conference in which the judge concluded that Ms. Finberg had "made an admission that she perjured herself" in connection with the RFAs. When Ms. Finberg resumed the stand the next day, represented by personal counsel, the trial judge ruled that Ms. Finberg could, on a blanket basis, claim the Fifth Amendment privilege against self-incrimination and would do so in front of the jury. AIG moved for a mistrial, which the trial judge denied. During closing arguments in Phase 2, Victaulic's counsel focused on "Ms. Finberg," "RFAs," "lies," and "penalty of perjury." After brief deliberations, the jury awarded Victaulic breach of contract damages of over $1 million and *Brandt* bad faith attorney fee damages of over $8.2 million. The jury also found that AIG acted with fraud, oppression, or malice committed by a managing agent.

Phase 3 was the punitive damages trial. It consisted of one hour of argument by counsel for each side. Following brief deliberation, the jury awarded $46 million in punitive damages against AIG.

The trial judge denied AIG's motion for new trial, and AIG appealed the judgment.

Holding

The California Court of Appeal found that the trial judge had committed multiple prejudicial errors during trial, and thus reversed the judgment.

Specifically, the trial judge erred in allowing Victaulic's counsel to question Ms. Finberg about AIG's denials of the RFAs on the "duty to defend" issue. The appellate court reasoned that if a party improperly denies RFAs, that party can be held liable for the cost the propounding party incurs in proving the denied matter. However, the California discovery statutes do not authorize a party's denial of RFAs to be used as evidence at trial.

Further, the trial judge improperly assumed the role of advocate and impugned Ms. Finberg's integrity before the jury. While a trial judge has the power to examine a witness, the trial judge "cannot become an advocate for either party or cast aspersions upon a witness." Here, the trial judge had openly attacked Ms. Finberg on the witness stand and had acted as an advocate for Victaulic.

Last, the trial judge erred in handling Ms. Finberg's invocation of the privilege against self-incrimination. Specifically, the trial judge erred in: (1) allowing Ms. Finberg to invoke the privilege after she had already testified under Victaulic's questioning for nearly two days; (2) allowing Ms. Finberg to unilaterally invoke the privilege on a blanket basis; (3) failing to either strike Ms. Finberg's testimony or declare a mistrial; and (4) requiring Ms. Finberg to invoke the privilege in front of the jury.

The appellate court concluded that the trial judge's multiple errors in handling Ms. Finberg's testimony, coupled with Victaulic's exploitation of those errors in closing argument, "surely" influenced the jury's bad faith verdict. The appellate court thus reversed the judgment that had been entered in favor of Victaulic and against AIG.

Comment

The appellate court agreed with AIG that there were serious errors during the trial, beginning with the trial judge's allowance of the use of the RFA responses, compounded by the judge's intensive questioning of Ms. Finberg, and compounded further by the judge's handling of Ms. Finberg's invocation of the Fifth Amendment privilege. According to the appellate court, the "cumulative effect" of the errors left no doubt that AIG was prejudiced at trial. As such, reversal was warranted.

REGULATION

Fair Claims Settlement Practices Regulations Do Not Conflict with Unfair Insurance Practices Act

A California appellate court has concluded that core provisions of the Fair Claims Settlement Practices Regulations do not conflict with the Unfair Insurance Practices Act. *(PacifiCare Life and Health Insurance Company v. Jones* (2018) 27 Cal.App.5th 391)

Facts

In 2008, the California Insurance Commissioner ("Commissioner") filed an administrative action against PacifiCare Life and Health Insurance Company ("PacifiCare"). The Commissioner alleged that PacifiCare had repeatedly violated the Fair Claims Settlement Practices Regulations (10 Cal. Code Regs. § 2695.1, et seq.), which were promulgated pursuant to the Unfair Insurance Practices Act ("UIPA") (Cal Ins. Code § 790, et seq.). Following an evidentiary hearing, the Commissioner found that PacifiCare had engaged in over 900,000 acts and practices in violation of the regulations. As a result, the Commissioner ordered PacifiCare to pay penalties of over $173 million.

PacifiCare subsequently filed a complaint for declaratory and injunctive relief challenging the Commissioner's order. Among other things, PacifiCare challenged the validity of three regulations previously promulgated by the Commissioner.

First, PacifiCare challenged a regulation which describes the UIPA as "enumerating sixteen claims settlement practices that, when either knowingly committed on a single occasion, or performed with such frequency as to indicate a general business practice, are considered to be unfair claims settlement practices...." PacifiCare argued that the regulation's language is inconsistent with the UIPA because the UIPA governs only an insurer's pattern of knowing violations, not an insurer's commission of any single violation.

Second, PacifiCare challenged a regulation which defines "knowingly committed" as "performed with actual, implied or constructive knowledge, including but not limited to, that which is implied by operation of law." PacifiCare argued that this definition is invalid because under the UIPA, "knowingly" means deliberately, which is inconsistent with implied or constructive knowledge.

Third, PacifiCare challenged a regulation which defines "willful" as "simply a purpose or willingness to commit the act, or make the omission.... It does not require any intent to violate law, or to injure another, or to acquire any advantage." PacifiCare argued that this regulation impermissibly blurs the distinction between willful and non-willful violations, and is inconsistent with statutory definitions of willful.

PacifiCare moved for judgment on the pleadings on its claim for declaratory relief, seeking a determination that each of the challenged regulations was inconsistent with the UIPA and, therefore, facially invalid. The trial court granted PacifiCare's motion with respect to all three regulations, declaring that all three regulations impermissibly conflict and are inconsistent with the statutory language. Thereafter, the trial court

enjoined the Commissioner from continuing to enforce those three regulations. The Commissioner appealed.

Holding

The California Court of Appeal reversed the injunction in its entirety.

After an extensive review of the history and purpose of the UIPA, the appellate court concluded the trial court had erred in finding that the statutory scheme applies only when an insurer engages in conduct with such frequency as to indicate a general business practice. Rather, as the California Supreme Court held in *Royal Globe Ins. Co. v. Superior Court* (1979) 23 Cal.3d 880, and as the language of the UIPA itself indicates, the UIPA can be violated by an insurer's single knowing act. Thus, the Commissioner could promulgate a regulation defining an unfair claims settlement practice so as to include either an insurer's single knowing violation or an insurer's general business practice.

Next, the appellate court concluded that the trial court had erred in declaring invalid the regulation defining "knowingly committed." The appellate court reasoned that the Commissioner has broad authority to promulgate regulations relating to the UIPA, including regulations defining the terms used in the statutory scheme. Here, the regulation defining "knowingly committed" was not inconsistent with the statutes to which the regulation related. The regulation defines the knowledge of a corporation rather than an individual, and the definition is consistent with traditional principles establishing corporate knowledge.

Last, the appellate court concluded that the trial court had erred in declaring invalid the regulation defining "willful." According to the appellate court, that regulation does not impermissibly blur the distinction between willful and non-willful violations. Committing a wrong in a willful manner simply requires knowledge that the specific conduct violated a regulation, and an intention to nonetheless engage in such conduct.

Comment

The UIPA expressly authorizes the Commissioner to adopt regulations necessary to implement the UIPA. In this case, the appellate court held that all of the challenged regulations were indeed consistent with the UIPA. The appellate court thus reversed the trial court's order prohibiting enforcement of those regulations.

Given the amount at stake (over $173 million in penalties, along with interest), one can assume that PacifiCare will seek review by the California Supreme Court.

MISCELLANEOUS

Insured's "Unclean Hands" Prevents Insured from Continuing to Pursue Lawsuit Against Insurer

An insured's "unclean hands" in denying the authenticity of a certificate of cancellation filed with the California Secretary of State prevented the insured from continuing to pursue a lawsuit against its insurer. *(DD Hair Lounge, LLC v. State Farm General Insurance Co.* (2018) 20 Cal.App.5th 1238)

Facts

In August 2013, Uche Umeagukwu formed a limited liability company called DD Hair Lounge, LLC. Shortly after DD Hair was formed, DD Hair allegedly suffered a burglary loss. DD Hair submitted a claim to its insurer, State Farm General Insurance Company, but State Farm denied the claim.

In January 2014, DD Hair sued State Farm based on State Farm's refusal to pay the burglary claim. In November 2014, DD Hair, acting through Ms. Umeagukwu, filed a certificate of cancellation with

the California Secretary of State. At the time DD Hair filed the certificate of cancellation (i.e., November 2014), California Corporations Code section 17707.06 provided that upon filing a certificate of cancellation, an LLC's *"powers, rights, and privileges shall cease."* The certificate of cancellation itself contained a similar statement (i.e., that upon filing the certificate of cancellation, DD Hair's "powers, rights and privileges will cease…"). DD Hair did not inform either State Farm or the court that DD Hair had filed the certificate of cancellation.

In September 2015, State Farm discovered that DD Hair had filed the certificate of cancellation. State Farm thus filed a motion for judgment on the pleadings, arguing that once DD Hair cancelled its LLC status in November 2014, Corporations Code section 17707.06 deprived DD Hair of the power to pursue its case against State Farm. DD Hair opposed the motion, arguing that Ms. Umeagukwu's signature on the certificate of cancellation was "forged." Because of the dispute concerning the authenticity of Ms. Umeagukwu's signature on the certificate of cancellation, the trial court denied State Farm's motion for judgment on the pleadings. The trial court then scheduled an evidentiary hearing for mid-January 2016 to resolve the issue regarding authenticity of the certificate of cancellation.

Effective January 1, 2016, Corporations Code section 17707.06 was amended to provide that when an LLC files a certificate of cancellation, the LLC still retains its powers of *"prosecuting and defending actions by or against it in order to collect and discharge obligations."* In mid-January 2016, the trial court held the evidentiary hearing to determine whether the November 2014 certificate of cancellation was authentic. After the hearing, the court ruled that Ms. Umeagukwu's signature was genuine, that the certificate of cancellation was validly filed, and that as a result DD Hair could not maintain the lawsuit against State Farm. The trial court thus dismissed DD Hair's lawsuit against State Farm.

DD Hair appealed, arguing that although DD Hair had filed the certificate of cancellation in November 2014, the January 2016 amendment to section 17707.06 was retroactive and gave DD Hair authority to continue pursuing its case against State Farm.

Holding

The Court of Appeal affirmed the dismissal of DD Hair's lawsuit against State Farm.

The appellate court agreed with DD Hair that the January 1, 2016 amendment of section 17707.06 was intended to be retroactive. Thus, under normal circumstances, the amended statute would apply to the November 2014 notice of cancellation and would give DD Hair authority to continue prosecuting its case against State Farm.

Nevertheless, relying on the doctrine of "unclean hands," the appellate court declined to apply amended section 17707.06 to reinvigorate DD Hair's right to pursue a lawsuit against State Farm. The appellate court emphasized that DD Hair's principal, Ms. Umeagukwu, had concealed the November 2014 certificate of cancellation for almost a year before State Farm discovered it in September 2015. Thereafter, Ms. Umeagukwu claimed that the certificate was forged, forcing the trial court to hold an evidentiary hearing which prolonged the proceedings into 2016, after the amendment to section 17707.06 became effective. Had Ms. Umeagukwu been forthright, DD Hair's case would have been swiftly dismissed and judgment entered based on the version of section 17707.06 then in effect. Thus, Ms. Umeagukwu's "delays and denials positioned DD Hair to raise the argument that the newly revised section 17707.06 preserved its rights." As such, the doctrine of unclean hands prevented DD Hair from relying on the amended version of section 17707.06, and the trial court had correctly dismissed DD Hair's lawsuit.

Comment

The doctrine of "unclean hands," which applies to both law and equity, requires that "a plaintiff act fairly in the matter for which he seeks a remedy. He must come into court with clean hands, and keep them clean, or he will be denied relief, regardless of the merits of his claim." (*Kendall-Jackson Winery, Ltd. v. Superior Court* (1999) 76 Cal.App.4th 970, 978.) The primary requirement for application of the unclean hands doctrine is that the misconduct must relate directly to the cause at issue.

Here, by "concealing the certificate of cancellation for nearly a year" and then "engaging in the time-consuming charade of disingenuously challenging that certificate's authenticity," DD Hair had effectively stalled the case to a point where DD Hair could arguably have obtained relief under the amended version of section 17707.06. Had DD Hair acted with "clean hands," its claim would have properly been extinguished long before the effective date of the amendment to section 17707.06.

Lawsuit Filed by Group of Insurers, As Subrogees of More Than 100 Insureds, Does Not Qualify as "Mass Action" Under Class Action Fairness Act

A lawsuit filed by 26 insurers, as subrogees of their 145 insureds, did not qualify as a "mass action" within the meaning of the Class Action Fairness Act of 2005 because the lawsuit did not satisfy the statute's numerosity requirement, which requires 100 or more named plaintiffs. *(Liberty Mutual Fire Insurance Company v. EZ–FLO International, Inc.* (9th Cir. 2017) 877 F.3d 1081)

Facts

EZ–FLO International, Inc. ("EZ–FLO") manufactures supply lines that connect water pipes to plumbing fixtures. An alleged manufacturing defect in the supply lines caused leaks which resulted in water damage to many homes. A group of 26 insurers made payments to 145 insured homeowners for water damage allegedly caused by the defective supply lines.

The 26 insurers, as subrogees of their 145 insureds, filed a lawsuit against EZ–FLO in state court alleging that EZ–FLO's defective supply lines allowed water to leak out of the supply lines. The insurers sought to recover over $5 million in payments they had made to their 145 insureds.

EZ–FLO removed the lawsuit to federal court under the Class Action Fairness Act of 2005 ("CAFA"), which allows a defendant to remove a "mass action" comprised of "100 or more persons" to federal court if the amount in controversy exceeds $5 million. The insurers moved to remand the case back to state court due to lack of jurisdiction under CAFA. The district court granted the motion. EZ–FLO appealed.

Holding

The Ninth Circuit Court of Appeals affirmed the judgment of the district court. The Ninth Circuit agreed that in light of the United States Supreme Court's ruling in *Mississippi ex rel. Hood v. AU Optronics Corp.* (2014) 571 U.S. 161, the district court lacked jurisdiction under CAFA. In *Hood*, the U.S. Supreme Court held that a "mass action" under CAFA requires monetary claims brought by "100 or more persons," and that the word "persons" is synonymous with named plaintiffs. Here, the only named plaintiffs were the 26 insurance companies.

EZ–FLO argued that the 145 insureds should be considered plaintiffs for analyzing the numerosity requirement under CAFA because, in subrogation cases, the insurers "stand in the shoes" of the insureds. The Ninth Circuit rejected that argument and held that in light of *Hood*, CAFA's numerosity requirement was not satisfied because the insureds themselves were not named plaintiffs.

Comment

In order for a lawsuit to be removed to federal court under CAFA, there must be 100 or more named plaintiffs. Consequently, CAFA's numerosity requirement greatly restricts a defendant's ability to remove to federal court an action filed by insurers as subrogees of their insureds. Indeed, such an action apparently could proceed only if it involved at least 100 insurers as subrogees of their insureds.