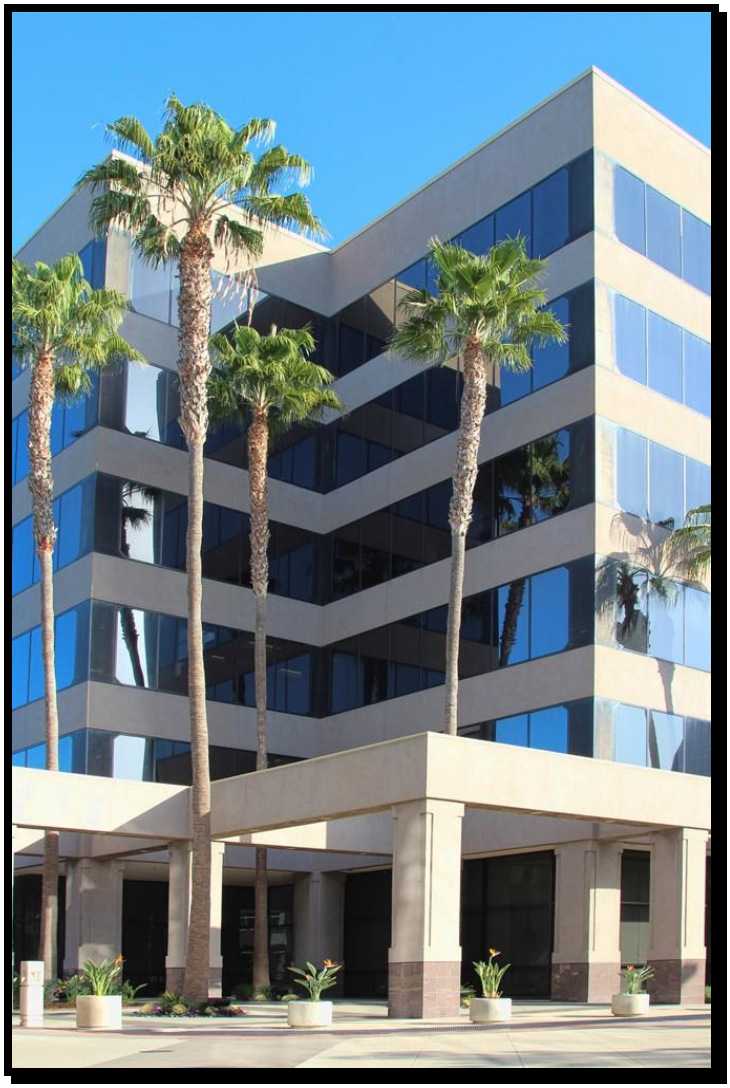
2019 ANNUAL REVIEW OF CALIFORNIA INSURANCE LAW



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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.

SMITH SMITH & FEELEY LLP *is a firm dedicated to the practice of insurance law. Our mission is to provide all clients with prompt, innovative and cost-effective solutions to insurance claims and litigation, while adhering to the highest professional standards.*

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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?

Yahoo! Inc. v. National Union Fire Ins. Co. (Case No. S253593) – Does a commercial general liability insurance policy that provides coverage for "personal injury," defined as "injury arising out of oral or written publication of material that violates a person's right of privacy," and that has been modified by endorsement with regard to advertising injuries, trigger the insurer's duty to defend the insured against a claim that the insured violated the Telephone Consumer Protection Act by sending unsolicited text message advertisements that did not reveal any private information?

THIRD-PARTY INSURANCE

(General Liability)

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.

After Developer Obtains Default Judgment Against Subcontractor, Developer's Excess Liability Insurer Prevails in Judgment Creditor Action Against Subcontractor's General Liability Insurer

After a developer obtained an approximately $1.5 million default judgment against a subcontractor, the developer's excess liability insurer prevailed in a judgment creditor action against the subcontractor's general liability insurer. *(Insurance Co. of the State of Pa. v. American Safety Indem. Co.* (2019) 32 Cal.App.5th 898)

Facts

New Millennium Homes LLC (NMH) was the developer of a housing development. In 2004, NMH hired Camarillo Engineering, Inc. (Camarillo) to perform mass grading, compacting and finish grading at the development. The subcontract gave NMH indemnity rights against Camarillo for claims of property damage "arising out of or resulting from the activities of" Camarillo.

In December 2005, Amir and Brenda Moghadam bought one of the homes from NMH. In early 2009 the Moghadams began to notice cracks in their house, and in May 2009 the Moghadams complained to NMH. A geotechnical engineer concluded that the distress to the Moghadam residence was due in part to differential settlement caused by improper soil compaction.

In September 2011, the Moghadams instituted arbitration proceedings against NMH for defective construction, alleging total damages of "at least $2,347,592." The arbitrator concluded that the Moghadams' house had been damaged due to differential settling resulting from improper soil compaction. The arbitrator awarded the Moghadams $1,176,633 against NMH, and the arbitrator's award was confirmed as a judgment. NMH's excess liability insurer, Insurance Company of the State of Pennsylvania (ISCOP), fully indemnified NMH for that judgment.

While the arbitration was pending, NMH sued Camarillo for contractual indemnity. NMH's complaint against Camarillo included as an exhibit the Moghadams' arbitration claim in which the Moghadams alleged damages of "at least $2,347,592." Camarillo sought defense and indemnity from its commercial general liability insurer, American Safety Indemnity Company (ASIC), which had issued six consecutive policies that were in effect from December 1, 2003 until August 1, 2009. ASIC declined to defend or indemnify Camarillo against NMH's lawsuit. NMH eventually obtained a default judgment against Camarillo consisting of damages of $1,176,633 and attorney fees of $356,340 for a total of $1,532,973.

Pursuant to Insurance Code section 11580, ICSOP (as subrogee of NMH) then brought a judgment creditor action against ASIC (as liability insurer of Camarillo) in an effort to collect the $1,532,973 default judgment that NMH had obtained against Camarillo. The trial judge entered summary judgment in favor of ICSOP, finding that ICSOP was entitled to recover $1,532,973 from ASIC. ASIC appealed.

Holding

The California Court of Appeal affirmed. It ruled that pursuant to Insurance Code section 11580,

ICSOP was entitled to recover the full $1,532,973 from ASIC.

ASIC argued that pursuant to Code of Civil Procedure section 580, the default judgment NMH had obtained against Camarillo in the underlying action was void because NMH's complaint failed to specify the amount of damages sought against Camarillo. The appellate court disagreed, reasoning that the Moghadams' arbitration claim against NMH was attached to and incorporated by reference in NMH's complaint against Camarillo. The Moghadams' arbitration claim specified the damages the Moghadams sought from NMH, for which NMH in turn sought indemnity from Camarillo. Because the Moghadams' arbitration claim sought damages of "at least $2,347,592" against NMH, NMH's complaint put Camarillo on notice of what Camarillo's maximum liability might be, and thus a default judgment of $1,532,973 did not violate Camarillo's due process rights.

ASIC next argued that NMH's default judgment against Camarillo was not based upon "property damage." The appellate court disagreed. In the arbitration proceeding, the Moghadams recovered damages from NMH because of "property damage" (i.e., physical injury to tangible property), and in the indemnity action, NMH passed those same damages along to Camarillo (i.e., the party who had caused the property damage). Thus, NMH's default judgment against Camarillo was based upon "property damage."

ASIC also argued that there was insufficient proof as to when property damage "first occurred" at the Moghadams' property. The appellate court likewise rejected that argument. ASIC's sixth policy covered property damage that "occurs during the policy period" (i.e., August 1, 2008 through August 1, 2009), but excluded any property damage that commenced before the policy's effective date (i.e., August 1, 2008). Here, ICSOP showed that the Moghadams' property damage occurred in May 2009 (i.e., during ASIC's sixth policy period), and ASIC failed to show that the Moghadams' property damage commenced before August 1, 2008 (i.e., before ASIC's sixth policy period).

Last, ASIC argued that its policies all contained self-insured retention (SIR) or deductible clauses making Camarillo's payment of an SIR or a deductible a "condition precedent" to coverage, and that ICSOP had not proven Camarillo ever paid any SIR or deductible amount. The appellate court rejected that argument as well. The court reasoned that the ASIC policies' SIR and deductible clauses stated that Camarillo was required to pay an SIR or a deductible "at our [ASIC's] request," and ASIC failed to show that it ever asked Camarillo to pay any SIR or deductible amount.

Comment

ASIC also raised some other arguments in the appellate court, but the appellate court refused to consider those arguments because ASIC had not properly raised them in the trial court.

At some earlier point, ASIC presumably had been very confident of its coverage position, because ASIC declined to even defend Camarillo in the contractual indemnity lawsuit brought by NMH. That resulted in NMH obtaining the approximately $1.5 million default judgment against Camarillo, which then led to ICSOP (as subrogee of NMH) successfully pursuing the judgment creditor action against ASIC (as liability insurer of Camarillo).

Additional Insured Endorsement's "Care, Custody, or Control" Exclusion Does Not Relieve Insurer of Duty to Defend General Contractor

An additional insured endorsement's "care, custody, or control" exclusion did not relieve an insurer of a duty to defend its additional insured, a general contractor, in a construction defect lawsuit. (*McMillin Homes Construction, Inc. v. National Fire & Marine Ins. Co.* (2019) 35 Cal.App.5th 1042)

Facts

McMillin Homes Construction, Inc. (McMillin) was the general contractor for a housing project in the

San Diego area. McMillin hired Martin Roofing Company, Inc. (Martin) to install roofs at the project. The subcontract required Martin to obtain general liability insurance naming McMillin as an additional insured.

Martin obtained a general liability policy through National Fire & Marine Insurance Company (National Fire). The policy included an endorsement covering McMillin as an additional insured for property damage occurring during the policy period and arising out of Martin's ongoing operations. However, the endorsement also contained an exclusion for property damage to "property in the care, custody, or control of the additional insured…."

Following completion of construction, various homeowners sued McMillin for construction defects at the project. Among other things, the homeowners alleged that roofing defects had caused water intrusion damage to their homes.

McMillin tendered the defense of the construction defect action to National Fire, asserting that McMillin was an additional insured on the National Fire policy. However, National Fire refused to defend McMillin.

McMillin subsequently sued National Fire for breach of contract and bad faith. McMillin essentially alleged that National Fire had erroneously and unreasonably failed to defend McMillan in the underlying construction defect action.

Following a bench trial on the duty to defend the issue, the trial court ruled that National Fire had no duty to defend McMillin in the construction defect action. McMillin appealed.

Holding

The Court of Appeal reversed, and held that National Fire did have a duty to defend McMillin in the construction defect action.

The appellate court reasoned that the additional insured endorsement covered McMillin for property damage occurring during the policy period and arising out of Martin's ongoing operations at the project. Here, the homes in question "could have" sustained property damage during the policy period and while Martin's operations were ongoing. Thus, the homeowners' claims against McMillin in the construction defect action potentially fell within the basic insuring language of the additional insured endorsement.

Further, the additional insured endorsement's "care, custody, or control" exclusion did not eliminate the possibility of coverage. Citing prior cases, the appellate court held that the care, custody, or control exclusion only applies where the insured has "exclusive or complete control" of the property that was damaged; the exclusion does not apply where the insured merely has "shared control" of the property. Here, McMillin was responsible for supervising the whole project and coordinating schedules to ensure that the project was finished on time. However, Martin was responsible for controlling its specific jobsite and supervising the roofing work. Thus, the most that could be said is that McMillin as general contractor and Martin as subcontractor had "shared control" over Martin's roofing work. As such, the care, custody, or control exclusion did not relieve National Fire of a duty to defend McMillin in the underlying action.

The appellate court thus reversed and instructed the trial court to enter a new judgment in favor of McMillin on the issue of whether National Fire had a duty to defend.

Comment

This case is consistent with prior appellate cases holding that a standard "care, custody, or control" exclusion will apply only where the insured seeking coverage has exclusive or complete control – not merely shared control – over the property that is damaged. (See, e.g., *Home Indem. Co. v. Leo L. Davis, Inc.* (1978) 79 Cal.App.3d 863, 872.) Here, the facts indicated only shared control between the

general contractor and its roofing subcontractor. Because the insurer did not prove that coverage for the underlying construction defect litigation was impossible, the insurer had a duty to defend the general contractor.

"Mislabeling" Lawsuit Against Prescription Drug Retailer Does Not Trigger Coverage Under Additional Insured Endorsement in Supplier's General Liability Policy

A customer's "mislabeling" lawsuit against a prescription drug retailer was not potentially covered under an additional insured endorsement issued by the drug supplier's general liability insurer. (*Target Corp. v. Golden State Ins. Co. Ltd.* (2019) 41 Cal.App.5th 13)

Facts

McKesson Corporation distributes bulk prescription drugs to retailers. McKesson does not manufacture drugs.

McKesson entered into a pharmaceutical supply agreement with Target Corporation pursuant to which McKesson agreed to supply bulk drugs to Target. Among other things, the agreement required McKesson to obtain a commercial general liability policy covering product liability claims and naming Target as an additional insured.

Golden State Insurance Company Limited issued a general liability policy listing McKesson as the named insured and Target as an additional insured. The additional insured endorsement provided that coverage applied "only with respect to 'bodily injury' ... arising out of 'your [McKesson's] products' which are distributed or sold in the regular course of the vendor's [Target's] business." The additional insured endorsement excluded coverage for "repackaging" of products or "products which, after distribution or sale by you [McKesson], have been labeled or relabeled."

McKesson sold a bulk quantity of a prescription drug to Target. Target, in turn, repackaged the drug and dispensed a small quantity of it to a customer. When Target dispensed the drug to the customer, Target placed on the bottle a label that (1) instructed the customer to "finish all of this medicine unless otherwise directed by your doctor" and (2) failed to warn the customer that the customer should stop using the medicine if any skin rash appeared. After ingesting the prescription drug pursuant to the instructions on the label, the customer suffered a very serious skin injury.

The customer subsequently sued Target. In the customer's lawsuit, the customer alleged not that Target had dispensed a defectively designed drug, but rather that Target had failed to provide adequate warnings about possible adverse reactions to the drug and information about when to discontinue using the drug.

Target tendered defense of the customer's lawsuit to Golden State, claiming that Target was entitled to coverage as an additional insured on McKesson's general liability policy through Golden State. Golden State initially provided Target with a defense, but later withdrew from Target's defense.

Thereafter, Target sued Golden State, claiming that Golden State had breached a duty to defend Target against the customer's lawsuit. The trial court entered summary judgment in favor of Golden State. Target appealed.

Holding

The Court of Appeal affirmed the summary judgment in favor of Golden State.

The appellate court began by focusing on the additional insured endorsement's basic insuring language, which limited Golden State's duty to defend Target to claims "arising out of" McKesson's products. According to the appellate court, the customer's claim against Target did not "arise out of" a drug supplied by McKesson. Rather, the customer's claim against Target arose out of Target's failure to warn of the risks and

possible side effects of the drug. Thus, according to the appellate court, there was no "minimal causal connection or incidental relationship" between McKesson's product and the customer's injury.

In addition, the appellate court held that the additional insured endorsement excluded coverage for "repackaging" of products or "products which, after distribution or sale by you [McKesson], have been labeled or relabeled." Here, Target had repackaged the drug and labeled it before selling it to the customer. Thus, Target's acts fell squarely within the endorsement's exclusions for repackaging and labeling / relabeling.

Because there was no potential for coverage, Golden State had no duty to defend Target against the customer's lawsuit.

Comment

One can perhaps question the appellate court's conclusion that the customer's claim against Target did not "arise out of" McKesson's product. Admittedly, the customer's claim was based not on some defect in McKesson's product itself, but rather on Target's alleged failure to provide warnings about use of the product. Nevertheless, it would seem that there was a "minimal causal connection" between McKesson's product and the customer's injury because, without McKesson's product, the customer never would have suffered injury.

In any event, the appellate court correctly determined that the customer's claim against Target fell within the additional insured endorsement's exclusion for "repackaging" of products or "products which, after distribution or sale by [McKesson], have been labeled or relabeled." Simply put, the customer's claim was based on Target's alleged mislabeling of a non-defective product supplied by McKesson. The purpose of this type of "vendor's endorsement" is to provide the additional insured with coverage for vicarious liability arising from a defective product distributed by the named insured. The endorsement is not intended to cover the additional insured for direct liability arising from mislabeling a non-defective product distributed by the name insured.

(Employment Practices Liability)

"Wage and Hour" Exclusion Does Not Eliminate Insurer's Duty to Defend Insured Against Employees' Lawsuit Alleging Failure to Reimburse Work-Related Expenses

An employment practice liability policy's "wage and hour" exclusion did not relieve the insurer of a duty to defend its insured against a class action lawsuit alleging, among other things, that the insured failed to reimburse employees for work-related expenses. (*Southern California Pizza Co., LLC v. Certain Underwriters at Lloyd's, London* (2019) 40 Cal.App.5th 140)

Facts

Southern California Pizza Company, LLC ("SCPC") owns and operates over 250 restaurants. Various employees filed a class action lawsuit against SCPC, alleging that SCPC (1) failed to reimburse its delivery drivers for certain mileage expenses, work travel-related costs and cell phone expenses (Lab. Code §§ 2800, 2802), and (2) failed to include certain statutorily-required information on each wage statement (Lab. Code § 226).

SCPC sought defense and indemnity under an employment practice liability insurance policy issued by Certain Underwriters at Lloyd's, London ("Underwriters"). The policy's basic insuring agreement provided in substance that Underwriters would pay loss SCPC was required to pay because of a claim for an employment-related workplace tort not otherwise excluded. The policy contained an endorsement which excluded indemnity coverage for claims based upon "wage and hour" laws, but which provided $250,000 in defense costs for such claims. Underwriters denied indemnity coverage to SCPC for the class action

lawsuit, but provided SCPC with $250,000 in defense costs.

SCPC sued Underwriters for breach of contract and bad faith, alleging that Underwriters' duty to defend SCPC was not limited to the $250,000 sub-limit in the endorsement. The trial court ruled that SCPC had failed to state a claim against Underwriters and thus dismissed SCPC's lawsuit against Underwriters. SCPC appealed.

Holding

The Court of Appeal reversed, holding that Underwriters' duty to defend SCPC was not limited to the $250,000 defense cost sub-limit set forth in the endorsement.

According to the appellate court, the employees' claim that SCPC failed to reimburse business expenses could be deemed a claim for an "employment-related workplace tort" within the meaning of the insuring agreement. The court reasoned that the employees' claim was based on SCPC's alleged violation of Labor Code section 2802, which requires employers to indemnify employees for all necessary work expenses. According to the court, an employer's violation of section 2802 could at least arguably be deemed a "tort."

Further, the employees' claim that SCPC failed to reimburse business expenses did not fall within the scope of the policy's "wage and hour" exclusion. According to the appellate court, the "wage and hour" exclusion only barred coverage for claims based on alleged violation of laws "concerning duration worked and/or remuneration received in exchange for work." Here, the employees' claim was premised not on failure to pay wages for work performed, but rather on failure to reimburse for work-related expenses incurred. Thus, the employees' business expense reimbursement claim against SCPC did not fall within the scope of the "wage and hour" exclusion. Accordingly, Underwriters' duty to defend SCPC was not limited to the $250,000 sub-limit.

Comment

The appellate court held that the employees' other claim (i.e., that SCPC failed to include all required information on wage statements) did fall within the scope of the policy's "wage and hour" exclusion. The court reasoned that the employees' wage statement claim was based on SCPC's alleged violation of Labor Code section 226, which requires employers to provide certain written information to employees each time wages are paid. According to the court, that statute is a "quintessential wage law."

In any event, because the employees' expense reimbursement claim was not subject to the wage and hour exclusion, the $250,000 defense cost sub-limit did not apply.

(Homeowners)

"Business Pursuits / Rental" Exclusion Relieves Insurer of Duty to Defend Insured Against Suit Brought By Tenant

A homeowners policy's "business pursuits / rental" exclusion relieved an insurer of any duty to defend its insured against a personal injury lawsuit brought by a long-term tenant. (*Terrell v. State Farm General Ins. Co.* (2019) 40 Cal.App.5th 597)

Facts

In 2000, Paul Terrell purchased a home in San Francisco. Initially, Terrell himself lived in the home. He obtained a homeowners policy through State Farm General Insurance Company.

In 2003, Terrell moved out of the property and began renting it to tenants. In January 2004, after conferring with his State Farm agent, Terrell cancelled the homeowners policy and replaced it with a rental dwelling policy. However, later, Terrell told State Farm that he was moving back to the property, and thus he asked State Farm to change his coverage. Accordingly, in January 2005, State

Farm cancelled Terrell's rental dwelling policy and replaced it with another homeowners policy. However, Terrell never moved back to the property. Instead, his existing tenants remained at the property until May 2006.

In June 2006, Terrell rented the property to a new tenant, Pamela Fitzgerald. The lease identified Fitzgerald and her minor daughter, Mary Fitzgerald, as the occupants.

Eight years later, Fitzgerald's daughter Mary was injured when the front porch of the property collapsed. The Fitzgeralds thus sued Terrell for premises liability. Terrell, in turn, sought a defense under the homeowners policy issued by State Farm. However, State Farm declined to defend Terrell because the homeowners policy excluded coverage for injuries arising out of an insured's "business pursuits" or "rental" activities.

Terrell sued State Farm for breach of contract and bad faith, alleging that State Farm had incorrectly and unreasonably refused to defend Terrell against the Fitzgeralds' lawsuit. State Farm moved for summary judgment based on the policy's business pursuits / rental exclusion. The trial court granted State Farm's motion. Terrell appealed.

Holding

The Court of Appeal affirmed. The State Farm policy's business pursuits / rental exclusion barred coverage for bodily injury "arising out of business pursuits of any insured or the rental or holding for rental of any part of any premises by any insured." The State Farm policy defined a "business" as "a trade, profession or occupation," and courts generally hold that a "business pursuit" is any regular activity engaged in for profit. Further, while the State Farm policy did not separately define "rental," the appellate court held that a "rental" simply means "something that is let out for rent." Here, Terrell's rental of the property to the Fitzgeralds was both an excluded "business pursuit" and an excluded "rental" of premises.

The appellate court acknowledged that the business pursuits / rental exclusion was subject to an exception for "activities which are ordinarily incident to non-business pursuits." However, according to the court, the "ordinarily incident" exception applies where the insured's alleged acts or omissions did not further the interests of the insured's business and were not directly related to that business. Here, any maintenance activities undertaken by Terrell would have furthered the interests of his rental business or enhanced the value of his rental property. Thus, the "ordinarily incident" exception did not restore coverage.

The appellate court also briefly noted that the business pursuits / rental exclusion contained a separate exception for "the rental or holding for rental of a residence of yours ... on an occasional basis for the exclusive use of a residence." Here, however, Terrell's rental activities could not be deemed "occasional." Rather, Terrell had leased the property to the initial tenants from 2003 to 2006, and then had leased the property to the Fitzgeralds from 2006 through 2014. Those were not "occasional" rentals.

Because the Fitzgeralds' claims against Terrell in the underlying lawsuit were not potentially covered under the State Farm policy, Terrell could not recover against State Farm for either breach of contract or bad faith.

Comment

In this case, the appellate court had little difficulty finding that the claims against the insured fell within the general exclusionary language of the business pursuits / rental exclusion. The court spent most of its time focusing on the exclusion's exception for "activities which are ordinarily incident to non-business pursuits." Note that most homeowners insurers have previously deleted the "ordinarily incident" exception from their policies in order to eliminate disputes about the exception's meaning and application. Here, although the exclusion still contained the exception, the appellate court ultimately held that the exception did not apply.

(Excess / Umbrella)

Higher-Layer Excess Policies Do Not Incorporate Lower-Layer Umbrella Policies' Self-Insured Retentions, and Cover Defense Costs Without Regard to Outcome of Case

An insured's higher-layer excess policies did not incorporate lower-layer umbrella policies' self-insured retentions, and did cover defense costs without regard to the outcome of the case. *(Deere & Company v. Allstate Ins. Co.* (2019) 32 Cal.App.5th 1230)

Facts

Deere & Company is a manufacturer of farm equipment. Numerous parties filed lawsuits against Deere in various jurisdictions for personal injuries arising from alleged exposure to asbestos-containing brakes, clutch assemblies, and gaskets used in Deere machines.

From 1958 through 1986, Deere's insurance coverage consisted of numerous primary, umbrella, and excess policies. The primary policies did not cover products-liability claims, and thus those policies did not cover Deere's alleged liability in the asbestos lawsuits. Rather, coverage for products liability was provided by a series of first-layer umbrella policies that provided coverage to Deere in excess of self-insured retentions (ranging over time from $50,000 to $2.5 million). Deere also had several layers of excess insurance policies, which sat above the first-layer umbrella policy limits.

Deere filed suit for declaratory relief and breach of contract with respect to over 100 umbrella and excess general liability policies issued to Deere from 1958 through 1986. Deere sought a declaration of coverage and compensatory damages for breach of contract, claiming that the policies covered the asbestos personal injury claims.

The coverage dispute proceeded to trial in three phases. In Phase III, that the trial court concluded that (1) the SIRs that Deere agreed to pay in its first-layer umbrella policies also applied to the higher-layer excess policies, and (2) the insurers were not obligated to pay defense costs when tort cases were dismissed without payment to a claimant. Deere appealed.

Holding

The California Court of Appeal reversed.

As to the first issue, the appellate court held that the higher-layer excess policies did not incorporate the lower-layer umbrella policies' self-insured retentions. The court agreed that the higher-layer excess policies were "follow form" policies. Thus, the higher-layer excess policies generally provided the same scope of coverage as the underlying policies, with the exception of the policy limits. After examining the language of the various policies, the appellate court held that once Deere paid the SIR, the first-layer umbrella policies were triggered, and once the first-layer umbrella policies are exhausted, the higher-layer excess policies were triggered. Thus, Deere did not continue to owe SIRs with respect to subsequent claims under the higher-layer excess policies.

As to the second issue, the appellate court held that the higher-layer excess policies obligated the insurers to indemnify Deere for its defense costs without regard to the outcome in the underlying case. Nothing in the language of the higher-layer excess policies required a determination that Deere must pay damages (as opposed to obtaining a dismissal without payment) before the higher-layer excess insurers were obligated to pay the litigation expenses associated with Deere's defense of the underlying asbestos actions. Thus, the higher-layer excess policies obligated the excess insurers to indemnify Deere for its defense costs in the underlying cases, irrespective of how those claims were resolved.

Comment

This case provides a good overview of the differences between primary and secondary policies, as well as the differences between deductibles and SIRs. Based on the specific language of the policies at issue, the appellate court correctly determined that the higher-layer excess policies did not incorporate the lower-layer umbrella policies' self-insured retentions, and did cover defense costs without regard to the outcome of the underlying tort case.

(Subrogation / Contribution)

Insurer of "Suspended" Developer Cannot Pursue Subrogation Action Against Developer's Subcontractors

The insurer of a developer whose corporate powers were "suspended" was barred from pursuing a subrogation action against the developer's subcontractors. (*Travelers Property Casualty Company of America v. Engel Insulation, Inc.* (2018) 29 Cal.App.5th 830)

Facts

Westlake Villas, LLC was the developer of a housing project. Westlake hired various subcontractors, including Engel Insulation, Inc., to assist with the construction. The written subcontracts gave Westlake contractual indemnity rights against the subcontractors.

Following completion of the project, a homeowners' association filed a construction defect action against Westlake. Westlake was an additional insured on general liability policies issued by Travelers Property Casualty Company of America, and Travelers thus defended Westlake in the construction defect action.

Travelers later filed a subrogation action against Engel and other subcontractors to recover attorneys' fees and costs Travelers had incurred in defending Westlake in the construction defect action. All of Travelers' causes of action were based on alleged contractual indemnity rights that its insured, Westlake, had against Engel and the other subcontractors.

During the course of the subrogation lawsuit, Engel discovered that Westlake had failed to pay state taxes and that Westlake's corporate powers were thus "suspended." Engel moved to dismiss Travelers' lawsuit, arguing that because Westlake as a suspended entity could not sue Engel, Travelers as subrogee of Westlake likewise could not sue Engel. The trial court granted Engel's motion and dismissed Travelers' lawsuit. Travelers appealed.

Holding

The California Court of Appeal affirmed the dismissal of Travelers' lawsuit. Pursuant to Revenue and Taxation Code section 23301, Westlake's failure to pay state taxes had resulted in a suspension of Westlake's corporate powers – including its power to prosecute or defend lawsuits. Travelers, as subrogee of Westlake, had no greater rights than Westlake. Thus, because Westlake was barred from suing Engel, Travelers was likewise barred from suing Engel.

Travelers sought to avoid dismissal by relying on Revenue and Taxation Code section 19719. That statute generally authorizes criminal penalties against anyone who attempts to exercise the powers of a suspended corporation, but contains an exception for "any insurer … who provides a defense for a suspended corporation … and, in conjunction with this defense, prosecutes subrogation, contribution, or indemnity rights against persons or entities in the name of the suspended corporation." The appellate court rejected Travelers' argument that section 19719's exception authorized Travelers to proceed with its subrogation action against Engel. According to the appellate court, section 19719's exception merely means that an insurer who defends a suspended insured and/or pursues subrogation claims on behalf of a suspended insured will not face criminal penalties. However, that exception "does not … alter the substantive law regarding subrogation,"

namely, that a subrogated insurer has no greater rights than its insured.

Comment

This case reiterates a basic principle of insurance law, which is that a subrogated insurer "stands in the shoes" of its insured. Because the insured, Westlake, had failed to pay taxes and could not prosecute litigation, its insurer, Travelers, was likewise barred from prosecuting any litigation to enforce Westlake's rights.

Note that if a suspended entity (or someone on its behalf) pays the back taxes and obtains a "certificate of revivor," the entity may be allowed to pursue litigation. However, that did not happen here. Neither Westlake nor Travelers paid the back taxes necessary for a certificate of revivor.

Despite Statute Prohibiting Public Entities from Seeking Indemnity from Employees, Public Entity's Insurer Is Entitled to Recover from Employees' Insurer

Despite California Government Code section 825.4, which generally prohibits public entities from seeking indemnity from employees, a public entity's liability insurer was entitled to recover from its employees' liability insurer. (*Westport Ins. Corp. v. California Cas. Mgmt. Co.* (9th Cir. 2019) 916 F.3d 769)

Facts

During the mid-1990's, a teacher employed by the Moraga School District sexually molested three middle school students. In 2013, the students sued the District and three school administrators. The students alleged that the school administrators negligently failed to prevent the molestations from occurring, and that the District was vicariously liable for such negligence.

At the time of the molestations, the District and the three school administrators were insured under primary and excess policies issued by Westport Insurance Corporation. In addition, the three school administrators were insured under excess policies issued by California Casualty Management Company.

The three students eventually settled their claims against the District and the school administrators for a total of $15.8 million. Westport funded the entirety of the settlements, with California Casualty refusing to contribute anything.

Westport later filed suit against California Casualty in federal court. The federal district court ruled that Westport was entitled to recover $2.6 million plus prejudgment interest of about $755,000 from California Casualty. California Casualty appealed.

Holding

The Ninth Circuit Court of Appeals, applying California law, affirmed the ruling that Westport was entitled to recover from California Casualty.

California Casualty argued that Westport's lawsuit against California Casualty was barred by California Government Code section 825.4, which provides that "if a public entity pays any claim or judgment against itself or against an employee … for an injury arising out of an act or omission of the employee …, he [the employee] is not liable to indemnify the public entity." However, the Ninth Circuit held that section 825.4 did not bar Westport's claim against California Casualty because section 825.4 "is not wholly inconsistent with contribution from an employee's insurer…." In other words, section 825.4 "does not contain a blanket ban on an employee's insurer contributing to the employee's defense and settlement costs."

Next, California Casualty argued that the California Casualty excess policies applied only when all other insurance policies had been exhausted, and the Westport excess policies had not been exhausted. The federal appellate court disagreed. The California Casualty excess policies broadly covered all damages "in excess of the required underlying primary collectible insurance," while the

Westport excess policies only covered damages in excess of "any other collectible insurance available to the insured." Thus, the California Casualty excess policies applied upon exhaustion of the Westport primary policies, not upon exhaustion of all other insurance.

California Casualty also challenged the manner in which the district court had apportioned liability amongst the District and the three school administrators. The district court: (1) divided each molestation victim's settlement equally across the policy periods in which she was molested; (2) then reduced each policy period amount by 25% to reflect the District's liability; (3) then deducted $1 million from each policy period in accordance with the limits of each Westport primary policy; and (4) then assessed liability against California Casualty up to its policy limit of $150,000 for each administrator in each policy period. This methodology resulted in California Casualty owing $2.6 million of the $15.8 million settlement amount paid to the three sexual molestation victims. According to the appellate court, given the underlying facts and the language of the various policies, the district court did not err in apportioning liability in this fashion.

Last, California Casualty argued that prejudgment interest on the principal amount should have been calculated at seven percent rather ten percent. The appellate court rejected that argument as well. Westport's action against California Casualty was based on a contract, and pursuant to California Civil Code section 3289, a party who is entitled to recover under a contract is also entitled to prejudgment interest at ten percent. Thus, the district court had properly awarded Westport prejudgment interest of approximately $755,000.

Comment

In some prior cases, California appellate courts had likewise held that notwithstanding Government Code section 825.4, a public entity could recover under an employee's liability policy. (See, e.g., *Government Employees. Ins. Co. v. Gibraltar Cas. Co.* (1986) 184 Cal.App.3d 163 and *Younker v. County of San Diego* (1991) 233 Cal.App.3d 1324.) However, in those prior cases, the public entity was an "additional insured" on the employee's policy, and thus the appellate courts were largely able to sidestep section 825.4. Here, by contrast, the public entity (the District) was not an additional insured on the employees' (the school administrators') policy through California Casualty. Thus, the Ninth Circuit had to deal head-on with section 825.4. Ultimately, the federal appellate court held that while section 825.4 relieves an employee of any obligation to personally contribute to any settlement or judgment, the statute does not relieve the employee's insurer of any such obligation.

(Miscellaneous)

Trial Court Properly Grants Insurer's Motion to Set Aside Default Judgments Against Insured on Ground of Extrinsic Mistake

A trial court properly granted an insurer's motion to set aside default judgments against its insured based on the equitable ground of extrinsic mistake. (*Mechling v. Asbestos Defendants* (2018) 29 Cal.App.5th 1241)

Facts

From the 1960's through the early 1970's, Associated Insulation of California (Associated) allegedly sold asbestos-containing products. During that time-frame, Associated had liability policies through Fireman's Fund Insurance Company (Fireman's Fund). In 1974, Associated ceased operations, and at some point, its corporate powers were suspended.

Beginning in 2009, plaintiffs William Mechling, James Greely, Omar Barstad, and Alexander Corns (collectively plaintiffs) filed personal injury actions against Associated and other defendants for injuries arising out of plaintiffs' alleged exposure to asbestos. Plaintiffs served the complaints on Associated, but Associated did not respond to the

complaints or notify Fireman's Fund of the lawsuits. At some point, two of the plaintiffs – Mechling and Greeley – sent copies of their complaints to Fireman's Fund and made a "demand for coverage." In March 2012, Fireman's Fund responded that it had searched its records but could not find any evidence that it had ever issued any policies to Associated.

Between 2013 and 2015, the trial court entered default judgments against Associated in all four cases. The default judgments ranged from $350,000 to $1,960,458. Plaintiffs served notice of entry of the default judgments on Associated, but not on Fireman's Fund.

After entry of the default judgments, Fireman's Fund located insurance policies appearing to provide coverage for Associated. In February 2016, Fireman's Fund retained counsel, and in July 2016, Fireman's Fund moved to set aside the default judgments on equitable grounds. The trial court granted Fireman's Fund's motion, and the plaintiffs appealed.

Holding

The California Court of Appeal affirmed. The appellate court noted that a trial court has inherent power to vacate a default judgment on equitable grounds, including the ground of "extrinsic mistake." To qualify for equitable relief based on extrinsic mistake, the defendant must demonstrate: (1) a meritorious defense; (2) a satisfactory excuse for not presenting a defense to the action; and (3) diligence in seeking to set aside the default once the mistake has been discovered. Here the trial court acted within its discretion in concluding that Fireman's Fund had satisfied all three requirements.

Specifically, Fireman's had shown a meritorious defense because it was reasonable to infer that plaintiffs' damages awards would have been lower if had Fireman's Fund had challenged plaintiffs' proof of causation and damages. In addition, Fireman's Fund had shown a satisfactory excuse for not presenting a defense because: (a) even though Fireman's Fund received notice of the Mechling and Greely lawsuits in 2012, at that time Fireman's Fund mistakenly thought that Associated was not an "insured"; and (b) Fireman's Fund never received any notice of the Barstad and Corns lawsuits before entry of the default judgments in those cases. Last, once the mistake was discovered, Fireman's Fund had acted diligently in seeking to set aside the defaults.

Under the circumstances, the trial court could find that there were "exceptional circumstances" warranting equitable relief. Thus, the trial court did not abuse its discretion in granting Fireman's Fund's motion to set aside the default judgments.

Comment

Note that the appellate court's review of the trial court's ruling was governed by the deferential "abuse of discretion" standard. Under that standard, an appellate court will reverse the trial court only if the trial court's decision is "so irrational or arbitrary that no reasonable person could agree with it." Here, the trial court's order was neither irrational nor arbitrary, and was consistent with the general policy that cases should be decided on their merits rather than by default.

In Personal Injury Action Brought Against Deceased Insured's Estate Pursuant to Probate Code, Insurer Is De Facto "Party" That Can Be Liable for Costs

In a plaintiff's personal injury action brought against a deceased insured's estate pursuant to Probate Code sections 550 et seq., the deceased insured's liability insurer was a de facto "party" that could be liable for costs after rejecting the plaintiff's reasonable statutory offer to compromise. (*Meleski v. Estate of Hotlen* (2018) 29 Cal.App.5th 616)

Facts

Amanda Meleski was injured in an automobile accident caused by Albert Hotlen. At the time of

the accident, Hotlen was insured on an Allstate Insurance Company automobile policy with liability limits of $100,000.

After the accident, Hotlen died. Hotlen did not have any assets other than the Allstate policy.

Pursuant to Probate Code sections 550 et seq., Meleski filed a personal injury lawsuit naming "the Estate of Albert Hotlen" as the defendant, without naming Hotlen's personal representative or successor in interest as a defendant. Probate Code sections 550 et seq. allowed Meleski to serve her complaint on Allstate, and to recover damages in the lawsuit only to the extent of Allstate's policy limits. Allstate hired counsel to defend Hotlen's estate against Meleski's lawsuit.

Before trial, pursuant to Code of Civil Procedure section 998, Meleski offered to settle her claims against Hotlen's estate for $99,999 (one dollar less than the policy limits). Allstate, on behalf of the estate, declined to accept the offer. The matter proceeded to trial and the jury awarded Meleski $180,613.

Meleski then asserted that because she obtained a verdict in excess of her pre-trial statutory offer, she was entitled to recover expert witness fees and other litigation costs totaling $66,017. Specifically, Meleski argued that she was entitled to recover those costs not from Hotlen's estate but rather from Allstate, since it was Allstate that had refused to accept Meleski's statutory offer. The trial court disagreed, ruling that pursuant to the Probate Code, Meleski's recovery was limited to Allstate's policy limits of $100,000. Meleski appealed.

Holding

The California Court of Appeal reversed. It held that pursuant to Code of Civil Procedure section 998, Allstate was liable for Meleski's expert witness fees and other litigation costs.

Section 998 provides that before trial, "any party" may serve a written offer to compromise upon "any other party to the action." The statute allows an award of costs against a party who refuses a reasonable offer of compromise. According to the appellate court, the named defendant, Hotlen's estate, was not really a "party" because an estate is not a legal entity and the estate was not at risk for payment of damages. Rather, Allstate alone controlled the litigation and Allstate alone was at risk for payment of damages; thus, for purposes of section 998, Allstate should be considered a "party" who had failed to accept a reasonable settlement offer from Meleski.

The appellate court agreed that when a plaintiff sues an insured's estate pursuant to Probate Code sections 550 et seq., the plaintiff can only recover "damages" up to the amount of the policy limit. Here, however, Meleski's expert witness fees and other litigation costs were not "damages," but rather were "costs." Further, the purpose of the Probate Code sections is to restrict an estate's liability to the available policy limits, not to limit a litigating insurer's liability for failing to accept a reasonable offer of compromise.

Comment

The appellate court concluded that under the circumstances of this case, treating Hotlen's estate as a party was a "legal fiction." According to the court, "in actuality, Allstate is the party litigating the case, inasmuch as it alone is at risk of loss and it alone controls the litigation." The court concluded that requiring Allstate to pay Meleski's expert witness fees and other litigation costs would uphold the purpose of Code of Civil Procedure section 998 (i.e., making a party accountable for its own actions in failing to accept a reasonable settlement offer) without offending the objective of Probate Code sections 550 et seq. (i.e., protecting a deceased insured's estate from obligations in excess of the insurance policy limits).

FIRST-PARTY INSURANCE

(Commercial)

Insured Established That "War" Exclusions Should Be Given "Special" Meaning Based on Industry Usage, Not "Plain and Ordinary" Meaning

Where an insured established that a policy's "war" exclusions had "special" meaning based on usage in the insurance industry, the "special" meaning (not the "plain and ordinary" meaning) applied. (*Universal Cable Productions, LLC v. Atlantic Specialty Insurance Company* (2019 9th Cir.) 929 F.3d 1143)

Facts

Universal Cable Productions, LLC ("Universal") negotiated with Atlantic Specialty Insurance Company ("Atlantic") for the purchase of a television production insurance policy. Universal's broker informed Atlantic that Universal was planning to film a series in Israel, and the broker proposed certain policy language, including some exclusions. The proposed exclusions were based on standard Insurance Service Office, Inc. ("ISO") forms. After Atlantic slightly modified the proposed exclusions, the policy covered certain losses caused by terrorism, but excluded losses caused by (1) "war," (2) "warlike action by a military force" or (3) "insurrection, rebellion, [or] revolution."

Hamas is an organization that operates in Palestine and Gaza. The United States has never recognized Palestine or Gaza as a sovereign territorial nation, nor has the United States ever recognized Hamas as a sovereign or quasi-sovereign (i.e., a de jure or de facto government). In fact, the United States has designated Hamas as a terrorist organization.

While Universal was filming a television series in Israel, three Israelis were kidnapped and killed, and Hamas was suspected of involvement in the deaths. Soon after, a Palestinian teenager was abducted and killed, presumably in retaliation. Hamas then began firing rockets into Israel.

As a result of the rocket fire, Universal temporarily suspended the television production and, eventually, Universal moved the production out of Israel altogether. Universal incurred significant expenses as a result of the suspension and move, and then filed an insurance claim for coverage of those costs. Atlantic denied coverage, stating that although the policy covered certain expenses related to terrorism, Hamas' actions were excluded as (1) "war" or (2) "warlike action by a military force."

Universal sued Atlantic for breach of contract and bad faith. Atlantic moved for summary judgment, arguing that the exclusions for (1) "war" and (2) "warlike action by a military force" eliminated coverage for Universal's claims. Universal moved for partial summary judgment, and argued that these exclusions did not apply because the terms had a specialized meaning in the insurance industry.

Universal provided the district court with unrebutted evidence that, in the insurance context, the term "war" has a special meaning that requires the existence of hostilities between de jure or de facto governments. Universal relied on caselaw, insurance treatises and expert testimony to show the existence of this industry custom. In short, Universal argued that "war" and "warlike action by a military force" required hostilities between de jure or de facto sovereigns, that Hamas was not acting as a sovereign and that, therefore, Hamas' actions were not excluded from coverage.

The district court granted summary judgment to Atlantic and held that, the terms "war" and "warlike action by a military force" – when interpreted in light of their plain and ordinary meanings – eliminated coverage. The district court held that Hamas' actions clearly constituted "war" and "warlike action by a military force" (which were excluded) rather than acts of terrorism (which were covered). Because the district court found the policy excluded coverage, the court also granted

summary judgment to Atlantic on Universal's bad faith claim. In addition, because the district court determined the first two exclusions applied, the district court did not determine the third exclusion applied, i.e., whether Hamas' actions constituted "insurrection, rebellion, [or] revolution." Universal appealed.

Holding

The Ninth Circuit Court of Appeals reversed the order granting summary judgment in favor of Atlantic and held that that the exclusions for "war" and "warlike action by a military force" did not apply. The Court recited the familiar rule that, when an ambiguity exists, the ambiguity generally will be construed against the party – typically, the insurer – who drafted the language. But the Court also noted that, if the *insured* drafted the language, the language could be construed against the insured.

The Court of Appeals noted that Universal was a sophisticated purchaser of insurance with at least some bargaining strength. The Court also noted that, during the course of negotiations for the policy, Universal's broker had *offered* the relevant language of the exclusions, but had not actually *drafted* the language. Instead, the language was standard ISO "form" language that Atlantic itself (and many other carriers) used in other policies. Under these circumstances, the Court of Appeals declined to construe any ambiguity against either Atlantic or Universal.

Pursuant to California Civil Code section 1644, the terms in an insurance policy are "understood in their ordinary and popular sense, rather than according to their strict legal meaning; unless used by the parties in a technical sense, or *unless a special meaning is given to them by usage, in which case the latter must be followed*." The Court of Appeals determined the terms "war" and "warlike action by a military force" have a specialized meaning in the insurance context and the parties had, at the least, constructive notice of the meaning of these terms. Under that specialized meaning, both "war" and "warlike action by a military force" require hostilities between either de jure or de facto sovereigns, and Hamas constitutes neither.

Although the district court erroneously determined the first two exclusions applied, the district court did not determine whether the third exclusion (for "insurrection, rebellion, [or] revolution") applied. Thus, the Court of Appeals remanded the case to the district court for a determination of that issue.

Comment

California Civil Code section 1644 requires courts to apply the specialized meaning of a term – instead of the plain, ordinary meaning – when that specialized meaning has been developed from customary usage in a given industry and when both parties have constructive notice of that usage. Here, the Court of Appeals relied on the fact that Universal's broker had knowledge of the trade meaning of the two exclusions, and that Universal therefore had constructive knowledge of the meaning.

The impact of this case likely will be somewhat confined, because most insureds do not propose policy language to insurers, and most insureds do not have constructive notice of the specialized meaning, if any, of a term in a policy.

(Uninsured Motorist)

Uninsured Motorist Policy Allows Insurer to Reduce Payments to Insured by Amount of Medical Expenses That Are Eligible for Payment Through Workers' Compensation

An uninsured motorist policy allowed an insurer to reduce payments to an insured by the amount of medical expenses that were eligible for payment through workers' compensation, regardless of whether the insured actually sought payment of those expenses through workers' compensation. (*Case v. State Farm Mutual Auto. Ins. Co.* (2018) 30 Cal.App.5th 397)

Facts

In March 2013, Melissa Case was employed by Lawry's Restaurant, Inc., and was insured under a personal automobile policy issued by State Farm Mutual Auto Insurance Company. The State Farm policy had uninsured motorist (UM) bodily injury limits of $100,000 per person. In late March 2013, while returning to Lawry's from an off-site catering location, Case was injured in a car accident involving an uninsured driver. The next day, Case sought benefits through Lawry's workers' compensation policy and Case submitted a claim for benefits under the UM section of her State Farm auto policy.

In July 2014, Case through her counsel sent State Farm a demand for UM benefits totaling approximately $67,000, which included almost $40,000 for alleged past and future medical expenses. In August 2014, Case submitted documentation showing that there was a workers' compensation lien for about $1,900. Between October and November 2014, Case and the workers' compensation insurer submitted more documentation showing that the workers' compensation lien had increased to about $2,200.

In November 2014, Case made a demand for UM arbitration, and her counsel simultaneously submitted a declaration stating that Case did not expect to receive any additional workers' compensation benefits. State Farm responded that State Farm still needed to determine "to what extent workers' compensation benefits continue to be owed" to Case before State Farm could determine whether it might owe any UM benefits to Case.

In May 2015, Case sued State Farm for breach of contract and bad faith. Case essentially alleged that although she had already provided State Farm with information concerning the workers' compensation lien, State Farm had failed to pay her claim for UM benefits.

In September 2015, the workers' compensation insurer finally determined that in fact Case did not have any additional medical expenses that were payable through workers' compensation. Case's counsel promptly informed State Farm that Case had exhausted the possibility of receiving additional payments through workers' compensation. Two months later, in November 2015, State Farm settled Case's UM claim for $35,000.

State Farm then moved for summary judgment, contending that (1) it had paid all policy benefits due and thus it could not be liable for breach of contract, and (2) its refusal to pay Case's UM claim before Case's claim for workers' compensation benefits had been resolved did not constitute bad faith. The trial court granted State Farm's motion. Case appealed.

Holding

The California Court of Appeal affirmed.

With respect to the Case's claim for breach of contract, Case had not shown that State Farm still owed her any benefits under the UM section of the policy. Thus, the trial court properly found that Case had no claim for breach of contract.

With respect to Case's claim for bad faith, consistent with Insurance Code section 11580.2, the State Farm policy's UM section provided that "any amount payable … shall be reduced by any amount paid *or payable* to … the insured … under any *workers' compensation*, disability benefits, or similar law." (Italics added.) This policy provision authorized State Farm to request a determination regarding the extent to which Case's past and future medical expenses were eligible for payment through worker's compensation, regardless of whether Case actually sought payment through workers' compensation. Here, it was not until September 2015 that the workers' compensation insurer finally determined that Case was not entitled to any additional benefits through workers' compensation. A mere two months later, in November 2015, State Farm settled Case's UM claim. Because State Farm resolved Case's UM claim "shortly after" the determination that Case

was not entitled to any further medical expenses through workers' compensation, as a matter of law, State Farm had not unreasonably delayed payment of UM benefits to Case. Thus, Case could not recover from State Farm for "bad faith."

Comment

Under a UM policy's standard loss-payable-reduction provision, the insurer is liable only for any difference between the UM policy limits and the amount of workers' compensation benefits that have been paid or are "payable" to the insured. Notably, this provision allows benefits owed under a UM policy to be reduced by the amount of medical expenses that are eligible for payment through workers' compensation, regardless of whether the insured actually seeks payment of such expenses through workers' compensation. As the amount of the medical expenses that are eligible for payment through the workers' compensation increases, the insurer's obligation to pay UM benefits decreases.

Heir Is Entitled to Uninsured Motorist Benefits Only Under Automobile Policy, Not Umbrella Policy

A legal heir was entitled to recover uninsured motorist benefits only under an automobile policy, not under an umbrella policy. (*Komorsky v. Farmers Insurance Exchange* (2019) 33 Cal.App.5th 960)

Facts

Alan and Linda Liker, husband and wife, were named insureds on an automobile liability insurance policy issued by Farmers Insurance Exchange (Farmers). The Farmers automobile policy provided uninsured motorist coverage of up to $250,000 per person. Mr. Liker was also the named insured on an umbrella insurance policy issued by Truck Insurance Exchange (Truck). The Truck umbrella policy provided uninsured motorist coverage of up to $1,000,000.

Melissa Komorsky was Mrs. Liker's adult daughter from a prior marriage. Ms. Komorsky did not reside with Mr. and Mrs. Liker.

Mrs. Liker was killed in an auto accident caused by an uninsured motorist. Mr. Liker made a claim for uninsured motorist benefits under both the Farmers automobile policy and the Truck umbrella policy. Ms. Komorsky also made a claim for uninsured motorist benefits under both policies.

Ms. Komorsky sued Farmers, Truck and Mr. Liker for a declaration that Ms. Komorsky was entitled to uninsured motorist benefits under both the Farmers automobile policy and the Truck umbrella policy. At least initially, Farmers and Truck asserted that Ms. Komorsky was entitled to benefits under both policies. However, Mr. Liker contended that Ms. Komorsky was only entitled to benefits under the Farmers automobile policy, not under the Truck umbrella policy.

Ultimately, the trial court ruled that Ms. Komorsky was entitled to uninsured motorist benefits only under the Farmers automobile policy, not under the Truck umbrella policy. Ms. Komorsky appealed.

Holding

The California Court of Appeal affirmed.

Insurance Code section 11580.2(a)(1) requires a primary automobile liability insurance policy to include uninsured motorist coverage, unless the insurer and insured agree in writing to waive such coverage. Pursuant to section 11580.2(a)(1), uninsured motorist coverage must provide benefits to the insured "or the insured's heirs" for damages they are entitled to recover from an uninsured motorist. Section 11580.2(a)(1) further states that "a policy shall be excluded from the application of this section if the automobile liability coverage is provided only on an excess or umbrella basis."

Consistent with section 11580.2(a)(1), the Farmers automobile policy defined an "insured" so as to include Mr. and Mrs. Liker and "any person for damages that person is entitled to recover"

because of bodily injury to either Mr. or Mrs. Liker. Here, Ms. Komorsky was an heir of Mrs. Liker, and thus Ms. Komorsky was a person who was "entitled to recover" damages because of the death of Mrs. Liker. As such, Ms. Komorsky was an "insured" under the uninsured motorist provisions of the Farmers automobile policy.

However, by its terms, section 11580.2(a)(1) was not applicable to the Truck umbrella policy. Specifically, the statute did not require that the Truck umbrella policy define an "insured" so as include an heir of Mrs. Liker. With respect to the Truck umbrella policy itself, the policy stated that Truck would pay uninsured motorist benefits to Mr. and Mrs. Liker and "any other insured under this policy." The Truck umbrella policy then defined an "insured" so as to include Mrs. Liker's relatives who were living in her household. Here, at the time of Mrs. Liker's death, Ms. Komorsky was not living in Mrs. Liker's household. Thus, Ms. Komorsky was not an "insured" under the uninsured motorist provisions of the Truck umbrella policy.

Comment

Ms. Komorsky also argued that Truck should be "estopped" from denying coverage to her under the Truck umbrella policy, and that the Truck umbrella policy should be "reformed" to include Ms. Komorsky as an insured under the policy. The appellate court rejected both arguments, reasoning that neither the elements for estoppel nor the elements for reformation were present.

Ultimately, the real "winner" in this case may have been Mr. Liker. The ruling that Ms. Komorsky was not entitled to uninsured motorist benefits under the Truck umbrella policy essentially meant that Mr. Liker was the only one who was entitled to such benefits under that policy.

(Insolvency)

Superior Court Can Decide Factual Issue Necessary to Determine Coverage Under Excess Workers' Compensation Insurance Policy

A superior court could decide a factual issue necessary to determine coverage under an excess workers' compensation insurance policy, even if the superior court's finding might contradict a stipulated fact in an earlier workers' compensation proceeding. (*California Insurance Guarantee Association v. San Diego County School Risk Management Joint Powers Authority* (2019) 41 Cal.App.5th 640)

Facts

The Mountain Empire Unified School District (the District) is a lawfully self-insured employer under the workers' compensation statutes. For workers' compensation liabilities above $100,000, the District procured excess workers' compensation policies, including a Kemper Insurance Company (Kemper) excess policy that was in effect from July 2002 to July 2003 and a Swiss Re Group (Swiss Re) excess policy that was in effect from July 2003 to July 2004.

Colleen Knowles worked as bus driver for the District. Between 1995 and 2002, Knowles suffered various work-related injuries. In May 2003, Knowles submitted a claim for workers' compensation benefits to the District. In the claim form, Knowles listed tendonitis in her right arm and carpal tunnel syndrome in her right wrist from "repeated usage over a long period of time from 1995 to 2003." Doctors who examined Knowles issued reports stating that Knowles was suffering pain from "repetitive overuse." In February 2004, Knowles was placed on a modified work schedule, and in June 2004, Knowles ceased working for the District.

Knowles filed an application for adjudication before the Workers' Compensation Appeals Board (WCAB). Initially, the District asserted that Knowles suffered from a "cumulative injury." However, later, Knowles and the District stipulated that Knowles had suffered a "specific injury" in May 2003 (a date encompassed only by the Kemper excess policy). A workers' compensation judge approved the parties' stipulation and entered an award in favor of Knowles.

Thereafter, the District started paying workers' compensation benefits to Knowles. Once the District had paid $100,000 to Knowles, the District sought reimbursement under the Kemper excess policy. Kemper reimbursed the District $207,908 until 2013, when Kemper was declared insolvent.

At that point, the District submitted a claim to the California Insurance Guarantee Association (CIGA) for the amount the insolvent Kemper owed. However, CIGA denied the District's claim on the ground that it was not a "covered claim" under the CIGA statutes. Specifically, CIGA asserted that Knowles had not actually suffered a "specific" injury only during the Kemper policy period, but rather had suffered a "cumulative" injury during both the Kemper and Swiss Re policy periods. CIGA thus asserted that the District could pursue other available insurance – namely, coverage under the Swiss Re policy.

CIGA filed a declaratory relief action against the District, seeking a determination that the District's reimbursement claim was not a covered claim because Knowles suffered a cumulative injury for which other insurance is available. The District cross-complained against CIGA, seeking reimbursement of funds paid to Knowles after Kemper went insolvent.

The District moved for summary judgment, arguing that the superior court lacked jurisdiction to determine that Knowles suffered a cumulative injury, as this fact had already been settled before the WCAB. The superior court granted the District's motion. CIGA appealed.

Holding

The Court of Appeal reversed. According to the appellate court, the WCAB had jurisdiction to determine the threshold question of whether Knowles was entitled to *compensation* from the District. However, the superior court had jurisdiction to determine the separate question of whether the District was entitled to *indemnity* under the excess policy issued by Kemper and/or the excess policy issued by Swiss Re.

Here, the WCAB had approved a stipulation that Knowles had suffered a specific injury (which if true meant that the District was entitled to indemnity only under the Kemper policy). Nevertheless, under these circumstances, the superior court had jurisdiction to determine that Knowles had actually suffered a cumulative injury (such that the District would potentially be entitled to indemnity under both the Kemper policy and the Swiss Re policy). If both policies were triggered, then the District's claim would not be a "covered claim" under the CIGA statutory scheme, because a "covered claim" does not include a claim that is covered by other insurance.

Comment

Courts have rejected exclusive WCAB jurisdiction in actions that do not implicate the payment of benefits to the injured worker. Here, the District's obligation to pay benefits to Knowles would remain the same even if the superior found that Knowles suffered a cumulative injury rather than a specific injury. CIGA's action only concerned who – as between the District, CIGA, and Swiss Re – would bear the ultimate cost of the District's compensation obligation. Accordingly, CIGA's action did not fall within the WCAB's exclusive jurisdiction.

(Miscellaneous)

Where Lease Requires Landlord to Procure Fire Insurance for Benefit of Tenant, Landlord's Insurer May Not Subrogate Against Tenant

Where a commercial lease required a landlord to procure fire insurance for the benefit of a tenant, the landlord's insurer could not pursue a subrogation action against the tenant for fire damage allegedly caused by the tenant. (*Western Heritage Ins. Co. v. Frances Todd, Inc.* (2019) 33 Cal.App.5th 976)

Facts

The East Shore Commercial Condominiums is a commercial condominium project managed by the East Shore Commercial Condominiums Owners' Association. The project's Covenants, Conditions & Restrictions required the Association to obtain a master fire insurance policy insuring the Association and the owners, and waiving subrogation rights against the Association, owners and occupants. The CC&Rs prohibited anyone else from purchasing fire insurance for the premises.

William R. de Carion owned one of the condominium units and leased it to Frances Todd, Inc. The lease specified that Todd would carry liability insurance with de Carion named as an additional insured, but the lease did not specify which party would carry fire insurance. The lease further specified that at the end of the lease, Todd would return the premises to de Carion in substantially the same condition as at the beginning of the lease, except for reasonable wear and tear and "casualty."

Western Heritage Insurance Company issued a fire insurance policy to the Association. Each condominium owner, including de Carion, was also an insured on the policy, but only for liability coverage, not fire coverage. While the policy was in effect, a fire started in the unit de Carion had leased to Todd. Western Heritage paid for the damage.

Later, Western Heritage filed a subrogation action against Todd, alleging that Todd had negligently started the fire in the unit. Todd moved for summary judgment, arguing that Todd was an implied co-insured under the policy, and that Western Heritage therefore could not bring a subrogation action against Todd. The trial judge granted Todd's motion. Western Heritage appealed.

Holding

The Court of Appeal affirmed. Under California law, the insurer of a landlord may not subrogate against a tenant who negligently causes a fire, if the policy was intended to benefit the tenant. In such cases, even though the tenant is not a named insured on the policy, the tenant is treated as an insured. Because the insurer cannot subrogate against the landlord (a named insured), the insurer cannot subrogate against the tenant (an implied insured).

Here, the Western Heritage policy was maintained for Todd's benefit. In that regard, the CC&Rs required the Association to purchase fire insurance for the Association and owners such as de Carion, and prohibited anyone else from purchasing fire insurance for the premises. Further, the lease itself required Todd to obtain only liability insurance, thus implying that de Carion would carry fire insurance. Also, the lease's yield-up clause provided that at the end of the lease, Todd would return the premises to de Carion in substantially the same condition as at the beginning of the lease, except for reasonable wear and tear and "casualty." These factors all indicated that the Western Heritage policy was purchased and maintained for Todd's benefit. Thus, Western Heritage was barred from pursuing a subrogation action against Todd.

Comment

California courts hold that a tenant is not liable for negligently caused fire damages where the

landlord and tenant intended the landlord's fire policy to be for their mutual benefit. The import of this rule is that in such a case, a landlord's insurer may not seek subrogation against a tenant for a fire the tenant negligently causes, even when the elements necessary for subrogation have otherwise been met.

Insurer Not Liable Where Insured's Contractor Cashes Jointly-Payable Check Pursuant to Authority Granted in Contract

A property insurer was not liable where the insured's contractor cashed a jointly-payable check pursuant to a power of attorney granted in a construction contract. (*Jozefowicz v. Allstate Ins. Co.* (2019) 35 Cal.App.5th 829)

Facts

Stanley Jozefowicz owned a mobile home for which he obtained a homeowners policy through Allstate Insurance Company. In May 2014, the mobile home was damaged in a fire. Jozefowicz submitted a claim to Allstate, and Jozefowicz hired Sunny Hills Restoration to perform repairs to the mobile home. The contract between Jozefowicz and Sunny Hills stated that Jozefowicz was appointing Sunny Hills as his representative to endorse and deposit any insurance checks, and directed Allstate to include Sunny Hills on any checks relating to the work. A copy of the contract was sent to Allstate.

In January 2015, Allstate issued a check for $20,943.97 made payable to both Jozefowicz and Sunny Hills to pay for repairs to Jozefowicz's mobile home. Allstate sent the check directly to Jozefowicz, but he never cashed it. Around the same time, a dispute arose between Jozefowicz and Sunny Hills over the scope and quality of the work. Sometime later, Sunny Hills contacted Allstate and requested that the check be reissued and sent directly to Sunny Hills. In March 2015, Allstate issued a second check in the same amount, made payable to Jozefowicz and Sunny Hills, and sent it directly to Sunny Hills. Sunny Hills endorsed the check and deposited it into its own bank account.

Jozefowicz sued Allstate under California Uniform Commercial Code section 3309, which provides a cause of action for recovery of a lost, stolen or destroyed check. Allstate moved for summary judgment, contending that Jozefowicz was unable to satisfy the elements of a statutory claim under section 3309. The trial court agreed and granted Allstate's motion. Jozefowicz appealed.

Holding

The California Court of Appeal affirmed. California Uniform Commercial Code section 3309 provides that "a person not in possession of an instrument is entitled to enforce the instrument if (1) the person was in possession of the instrument and entitled to enforce it when loss of possession occurred, (2) the loss of possession was not the result of a transfer by the person or a lawful seizure, and (3) the person cannot reasonably obtain possession of the instrument because the instrument was destroyed, its whereabouts cannot be determined, or it is in the wrongful possession of an unknown person or a person that cannot be found or is not amenable to service of process."

Here, Jozefowicz expressly instructed Allstate to include Sunny Hills on all checks and notified Allstate that Sunny Hills was permitted to deposit all checks. Accordingly, the loss of possession was the result of a transfer and/or a lawful seizure, thus negating the second element of section 3309. Accordingly, Jozefowicz could not recover from Allstate.

Jozefowicz argued that his contract with Sunny Hills failed to comply with certain Probate Code provisions governing powers of attorney, and thus Sunny Hills was not actually his representative when it negotiated the check. The appellate court rejected that argument, because the Probate Code provisions do not apply to a power of attorney coupled with an interest, which is what Sunny Hills had obtained here.

Comment

Note that Jozefowicz did not bring an action to enforce the insurance contract. Rather, he brought an action to enforce the check. However, under the facts of this case, he could not satisfy the requirements necessary to enforce the check. As such, he could not recover against Allstate.

BAD FAITH

Evidence Supports Punitive Damage Award Against Insurer for Bad Faith Delay in Paying Underinsured Motorist Benefits

A California appellate court has held that there was sufficient evidence to support a punitive damage award against an insurer for bad faith delay in paying its insured's claim for underinsured motorist benefits. (*Mazik v. GEICO General Ins. Co.* (2019) 35 Cal.App.5th 455)

Facts

In August 2008, Michael Mazik's car was struck head-on by another car which had crossed over the center line of the highway. Both cars were traveling about 50 miles per hour. The driver of the other car was killed in the collision.

As a result of the collision, Mazik suffered abrasions, lacerations, and a badly-fractured left heel bone. Due to the nature of the fracture, doctors could not operate on it. The fractured heel bone left Mazik with severely restricted range of motion, arthritis, a deformity, and chronic pain in his ankle.

The responsible driver's auto insurer, Mercury Insurance Company, paid its $50,000 policy limit in settlement of the responsible driver's liability to Mazik. In December 2009, Mazik submitted a claim to his own insurer, GEICO General Insurance Company, under a policy with uninsured / underinsured motorist limits of $100,000. Mazik requested $50,000 from GEICO, representing the full policy amount offset by the $50,000 payment Mazik had already received.

A GEICO adjuster reviewed the demand and prepared a "Claim Evaluation Summary," but the summary omitted information from the medical records that Mazik had provided. The summary calculated a "negotiation range" for the full value of Mazik's claim (including the $50,000 that Mercury had already paid) at between approximately $47,000 and approximately $52,600. The adjuster obtained approval from GEICO's regional liability administrator, Lon Grothen, to reject Mazik's $50,000 claim. In January 2010, GEICO offered Mazik a settlement of $1,000. In September 2010, GEICO increased its settlement offer to $13,800, and in January 2011, GEICO increased its settlement offer to $18,000.

At GEICO's request, in May 2011, Mazik submitted to an independent medical examination. The doctor who examined Mazik concluded that Mazik was "doing well" and that there was no indication he needed surgery.

In February 2012, GEICO increased its settlement offer to $18,877. Mazik rejected that offer and reasserted his demand for the policy limits. However, GEICO did not make any further settlement offers because, according to GEICO'S regional liability administrator, Grothen, Mazik would not negotiate and GEICO did not want to "bid against itself." Grothen thus instructed the claim adjuster to move the case into arbitration.

In April 2013, Mazik and GEICO arbitrated Mazik's underinsured motorist claim. The arbitrator issued an award in favor of Mazik for the full policy limits. In June 2013, GEICO paid Mazik $50,000 under the policy.

Mazik subsequently sued GEICO for bad faith delay in paying Mazik's claim for underinsured motorist benefits. The jury in the bad faith case awarded Mazik compensatory damages of $313,508 (consisting of $300,000 for emotional distress and $13,508 for attorney's fees and costs to recover policy benefits). The jury also awarded

Mazik punitive damages of $4 million, which the trial judge later reduced to $1 million. GEICO appealed the punitive damages award.

Holding

The Court of Appeal affirmed the award of punitive damages against GEICO.

The appellate court rejected GEICO's claim that there was insufficient evidence that any "officer, director, or managing agent" of GEICO was involved in bad faith. Under Civil Code section 3294, an award of punitive damages against a corporation requires conscious disregard, authorization, ratification or an act of oppression, fraud, or malice "on the part of an officer, director, or managing agent of the corporation." Here, GEICO's regional liability administrator, Grothen, was involved in handling Mazik's claim. Further, Grothen had wide authority over the settlement of claims because he supervised over 100 adjusters in three large California counties, and part of his job was to establish "settlement standards" within his region. Thus, there was sufficient evidence that Grothen was a "managing agent" of GEICO.

The appellate court also rejected GEICO's claim that, even if Grothen was a managing agent, there was insufficient evidence that Grothen personally engaged in "oppression, fraud, or malice" or authorized or ratified such conduct by other employees. According to the court, there was sufficient evidence for the jury to conclude that Grothen personally engaged in oppressive conduct. Specifically, there was evidence that Grothen was aware that the claims adjusters reported only selected information; that Grothen was fully aware of the serious nature of Mazik's injuries; and that Grothen adopted an improper adversarial approach to resolving Mazik's claim. Thus, the record supported the jury's conclusion that GEICO's conduct amounted to oppression or malice warranting punitive damages.

Last, the appellate court rejected GEICO's claim that, even after the trial court reduced the punitive damages award to $1 million, the award was still excessive. In considering whether the amount of punitive damages is constitutionally permissible, courts consider three factors: (1) the degree of reprehensibility of the defendant's misconduct; (2) the disparity between the actual or potential harm suffered by the plaintiff and the punitive damages award; and (3) the difference between the punitive damages awarded by the jury and the civil penalties authorized or imposed in comparable cases. Of these three factors, the most important is the degree of reprehensibility of the defendant's conduct. Here, given GEICO's "significant reprehensible conduct," and given the roughly three-to-one ratio of punitive to compensatory damages, the trial court's decision approving punitive damages of $1 million was within constitutional boundaries.

Comment

Pursuant to California Civil Code section 3294(a), punitive damages may be awarded only on proof by "clear and convincing evidence" that the defendant "has been guilty of oppression, fraud, or malice." Section 3294(b) then describes the proof necessary when the defendant is an employer whose employee allegedly engaged in such conduct. An employer may not be liable for punitive damages based upon the acts of an employee unless the employer (1) "had advance knowledge of the unfitness of the employee and employed him or her with a conscious disregard of the rights or safety of others"; or (2) "authorized or ratified the wrongful conduct for which the damages are awarded"; or (3) "was personally guilty of oppression, fraud, or malice." (Cal. Civ. Code § 3294(b).) Further, with respect to a corporate employer, "the advance knowledge and conscious disregard, authorization, ratification or act of oppression, fraud, or malice must be on the part of an officer, director, or managing agent of the corporation." (*Ibid*.)

Under "Fraudulent Conveyance" Statute, Third-Party Claimant Can Challenge Insured's Release of Bad Faith Claim Against Insurer That Allegedly Breached Duty to Settle

Under California's Uniform Voidable Transactions Act, a third-party claimant could challenge an insured's release of a bad faith claim against an insurer after the insurer allegedly failed to accept a reasonable settlement demand within policy limits. (*Potter v. Alliance United Insurance Co.* (2019) 37 Cal.App.5th 894)

Facts

In October 2007, Christopher Potter (Potter) was severely injured in an auto accident caused by Jesus Remedios Avalos-Tovar (Tovar). At the time of the accident, Tovar was insured under an Alliance United Insurance Company (AUIC) automobile policy with bodily injury liability limits of $15,000 per person. Tovar did not have any other significant assets.

Two months after the accident, Potter wrote to AUIC and offered to settle his claims against Tovar in exchange for the $15,000 policy limit. Although the settlement offer stated that it would expire in 30 days, AUIC did not accept the offer within that time.

Subsequently, Potter filed a personal injury action against Tovar. In July 2009, the personal injury action proceeded to trial and the jury returned a verdict of $908,643 in favor of Potter. Tovar then filed a motion for a new trial, which the trial court granted. Potter appealed the order granting the motion for new trial.

In April 2010, while Potter's appeal was pending, AUIC and Tovar entered into a confidential Settlement Agreement and Release (Release). Pursuant to that Release, AUIC paid Tovar $75,000 to release any bad faith claim Tovar had against AUIC based on AUIC's failure to accept Potter's earlier offer to settle for the $15,000 policy limit.

In November 2011, the Court of Appeal affirmed the order granting a new trial in the personal injury action, and the appellate court remanded the action for retrial. In early April 2012 (some two years after the Release had been signed), Tovar's counsel disclosed the existence of the Release to Potter's counsel.

Approximately a year later, the personal injury action went to trial for the second time. The jury again returned a verdict in Potter's favor, this time awarding him $975,000 in damages. The trial court subsequently awarded Potter costs and prejudgment interest, which brought the judgment in favor of Potter to $1,523,887.

AUIC paid its $15,000 policy limit in partial satisfaction of the judgment Tovar owed to Potter. Potter desired to take an assignment of Tovar's bad faith claim against AUIC in exchange for Potter's agreement not to execute on Tovar's personal assets. However, because Tovar had already signed the Release in favor of AUIC, Tovar could not give any such assignment to Potter.

Potter sued AUIC for statutory fraudulent conveyance based on California Civil Code section 3439, et seq., commonly referred to as the Uniform Voidable Transactions Act (UVTA). Potter essentially alleged that Tovar was insolvent prior to and at the time Tovar and AUIC entered into the Release; that Tovar had a viable claim against AUIC for bad faith failure to settle, which was an asset Tovar could have used to pay down his civil liability to Potter; and that AUIC participated in a fraudulent conveyance of that asset by entering into the Release with Tovar, thus preventing Potter from collecting on the judgment in Potter's favor. The trial court ruled that Potter had failed to state a cause of action against AUIC, and thus dismissed Potter's suit against AUIC. Potter appealed.

Holding

The Court of Appeal reversed, and held that Potter had sufficiently stated a cause of action against AUIC under the UVTA.

The appellate court noted that under the UVTA, a "fraudulent transfer" is a transfer by the debtor of property to a third person undertaken with the intent to prevent a creditor from reaching that property in satisfaction of the creditor's claim. Under the UVTA, a transfer can be invalid either because of actual fraud or constructive fraud. A creditor who is damaged by a fraudulent transfer can either (a) set the transfer aside, or (b) obtain monetary damages from the transferor or the transferee.

Here, Potter had stated a cause of action against AUIC for violation of the UVTA. Specifically, Potter sufficiently alleged actual or constructive fraud by AUIC. Further, Tovar's release of AUIC for bad faith failure to settle was the transfer of an asset under the UVTA because Tovar's bad faith claim against AUIC was an assignable form of personal property when the Release was signed. Also, while Potter did not have a judgment against Tovar when the Release was signed, Potter did have a claim against Tovar at that time. In addition, Potter sufficiently alleged injury because the bad faith claim was an asset of Tovar's that was essentially put out of Potter's reach by the Release. Last, AUIC was a proper defendant because the transfer of the bad faith claim was made for AUIC's benefit.

Under the circumstances, the appellate court remanded the case to the trial court so that Potter could pursue his claim against AUIC under the UVTA.

Comment

Note that this is a "pleading" case, i.e., the appellate court was only examining whether Potter had alleged facts which, if proven, could give Potter a right to recover against AUIC. Whether Potter can actually prove his allegations remains to be seen.

That said, if Potter's allegations are true, the case could present difficulties for AUIC. The essence of Potter's claim is that the Release was fraudulent because the insolvent Tovar transferred his claim for bad faith to AUIC; AUIC intended to prevent Potter from collecting the full amount of any judgment against Tovar; and Tovar did not receive reasonably equivalent value for the claim released. If true, such facts could have rather "bad optics" for AUIC.

"Anti-SLAPP" Statute Does Not Bar Insured's Bad Faith Lawsuit Against Insurer

California Code of Civil Procedure section 425.16, which authorizes the dismissal of a "strategic lawsuit against public participation," did not require dismissal of an insured's bad faith lawsuit arising from an insurer's failure to provide independent counsel. (*Miller Marital Deduction Trust v. Zurich American Ins. Co.* (2019) 41 Cal.App.5th 247)

Facts

Helen Miller and related parties (the Millers) own a piece of real property. The Millers filed a federal court lawsuit against various previous owners / lessees of the property, including the Estate of Jack Miller (Miller's Estate) and Mary DuBois (DuBois), alleging that those parties were responsible for environmental contamination emanating from the property. Miller's Estate was an insured under various policies issued by Zurich American Insurance Company (Zurich). Zurich thus hired panel counsel to defend Miller's Estate against the Millers' lawsuit.

DuBois filed a counterclaim against the Millers, alleging that the Millers themselves had contributed to the contamination. In connection with DuBois' counterclaim, the Millers claimed that they were additional insureds under the policies Miller's Estate had through Zurich. Zurich agreed to defend the Millers against DuBois' counterclaim, subject to a reservation of rights. Zurich appointed panel counsel to defend the Millers, but refused to

pay for independent counsel to represent the Millers.

The Millers then filed a state court action against Zurich, alleging that Zurich had breached the policies and acted in bad faith by refusing to provide the Millers with independent counsel to defend against DuBois' counterclaim. Among other things, the Millers alleged that Zurich: (1) placed limitations on appointed panel counsel's ability to defend the Millers; (2) allowed panel counsel for Miller's Estate (an adverse party) to advise Zurich regarding whether Zurich owed independent counsel to the Millers; (3) allowed panel counsel for Miller's Estate to communicate with and advise the claim representative who was overseeing the Millers' defense; and (4) allowed panel counsel for Miller's Estate to exert influence and control over panel counsel for the Millers. The Millers' lawsuit did not name any attorney as a defendant.

Pursuant to Code of Civil Procedure section 425.16, Zurich filed a special motion to strike the Millers' complaint as a strategic lawsuit against public participation (i.e., an "anti-SLAPP" motion). Zurich argued that the Millers' claims arose from protected speech by attorneys retained by Zurich, and that the Millers could not demonstrate a probability of prevailing. The trial court denied Zurich's motion. Zurich appealed.

Holding

The California Court of Appeal affirmed the denial of Zurich's anti-SLAPP motion. Pursuant to Code of Civil Procedure section 425.16, a cause of action can be stricken if it (1) arises from protected speech and (2) lacks even minimal merit. Here, Zurich could not establish the first prong, i.e., that the allegations against Zurich arose from protected speech. Zurich's alleged liability was based not on the fact of counsels' communications, but rather on Zurich's refusal to provide independent counsel to the Millers. The allegations of counsels' communications were merely evidence providing context for the allegation that Zurich failed to provide independent counsel. Thus, the appellate court rejected Zurich's argument that counsels' communications gave rise to Zurich's alleged liability for bad faith.

Comment

Not all attorney conduct in connection with litigation, or in the course of representing clients, is protected by section 425.16. The involvement of lawyers and legal proceedings does not necessarily shield an insurer from liability for alleged bad faith. Here, the Millers sought relief against Zurich – and not against any counsel – based on the overarching premise that Zurich breached its duty to defend by failing to provide independent counsel to defend the Millers against DuBois' counterclaim. Such alleged conduct did not fall within the scope of the anti-SLAPP statute.

CHOICE OF LAW

California's "Notice-Prejudice" Rule is Fundamental Public Policy for Choice of Law Analysis, and Rule Applies to Consent Provisions in First-Party Policies But Not Third-Party Policies

California's common law "notice-prejudice" rule is a fundamental public policy for purposes of choice of law analysis, and the rule applies to consent provisions in first-party insurance policies but not to consent provisions in third-party policies. (*Pitzer College v. Indian Harbor Ins. Co.* (2019) 33 Cal.App.5th 976)

Facts

Pitzer College (Pitzer) purchased an insurance policy from Indian Harbor Insurance Company (Indian Harbor) to cover Pitzer for legal and remediation expenses resulting from pollution conditions discovered during the policy period of July 23, 2010 to July 23, 2011. The policy contained a "notice" provision requiring Pitzer to provide oral or written notice of any pollution condition to Indian Harbor and, in the event of oral notice, to "furnish … a written report as soon as practicable." The policy also contained a "consent"

provision requiring Pitzer to obtain Indian Harbor's written consent before incurring expenses or commencing remediation due to a pollution condition, except if done on an "emergency basis." Last, the policy contained a "choice of law" provision stating that New York law would govern all matters under the policy.

On January 10, 2011, Pitzer discovered darkened soil at the construction site for a new dormitory on campus. By January 21, 2011, Pitzer determined that there was lead in the soil and that remediation was required. Under pressure to complete the dormitory, Pitzer conferred with environmental consultants and developed a remediation plan. In March 2011, the remediation work was started, and in April 2011, the remediation work was successfully completed at a cost of almost $2 million. Pitzer did not obtain Indian Harbor's consent before commencing remediation or paying remediation costs.

In July 2011, Pitzer notified Indian Harbor of the remediation. Indian Harbor denied coverage based on Pitzer's failure to give notice as soon as practicable and Pitzer's failure to obtain Indian Harbor's consent before commencing remediation.

Pitzer filed a breach of contract action against Indian Harbor in California state court. Indian Harbor removed the case to federal court and moved for summary judgment, claiming that it had no obligation to indemnify Pitzer for the remediation costs because Pitzer had violated the policy's notice and consent provisions. The federal district judge concluded that: (1) New York law applied; (2) under New York law, the policy was subject to a strict "no-prejudice" rule which allowed Indian Harbor to deny coverage merely by showing that Pitzer failed to comply with the policy's notice provision, without having to show that Indian Harbor suffered prejudice; and (3) Pitzer had also failed to comply with the policy's consent provision. The district court thus granted Indian Harbor's motion for summary judgment.

Pitzer 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: (1) whether California's "notice-prejudice" rule is a fundamental public policy for the purpose of choice of law analysis; and (2) if so, whether the notice-prejudice rule applies to the consent provision of the Indian Harbor policy. The California Supreme Court agreed to review those issues.

Holding

The California Supreme Court began by noting that California courts generally enforce a contractual choice of law provision unless the parties' choice of law is contrary to a "fundamental public policy" of California and California has a "materially greater interest" than the chosen state in the determination of the issue. The Supreme Court then emphasized that under California's notice-prejudice rule, an insurer cannot deny coverage based on an insured's failure to comply with a notice provision unless the insurer was "substantially prejudiced" by the late notice. After examining the reasons for the notice-prejudice rule, the Supreme Court concluded that the notice-prejudice rule is indeed a fundamental public policy of California. The Supreme Court left it for the Ninth Circuit to decide whether California has a materially greater interest than New York in determining the coverage issue (such that the insurance policy's choice of law provision would be unenforceable as contrary to California public policy).

The Supreme Court next held that the notice-prejudice rule that applies to *notice provisions* also applies to *consent provisions in first-party policies* but not to *consent provisions in third-party policies*. In so holding, the Supreme Court distinguished between a true first-party case (in which there is no claim of liability against the insured and hence no need for the insurer to have complete control of the claim handling) and a third-party case (in which there is a claim of liability against the insured and hence a need for the insurer to have unimpaired control of the claim handling). Here, Pitzer and Indian Harbor disputed whether the subject policy should be considered a first-party policy (to which the notice-prejudice rule would apply) or a third-

party policy (to which the notice-prejudice rule would not apply). The Supreme Court concluded that the Ninth Circuit would have to decide that issue.

Comment

The genesis of this case was the insurance policy's choice of law provision, which stated that New York law should govern all issues arising under the policy. The Supreme Court's opinion provides a good summary of how California courts should determine whether to enforce a contractual choice of law provision that calls for application of another state's law.

Beyond that, the opinion provides a good overview of California's notice-prejudice rule, which requires an insurer to prove that the insured's late notice of a claim has substantially prejudiced the insurer's ability to investigate and resolve the insured's claim. The upshot of this case is that, under California law, the notice-prejudice rule applies to: (1) notice provisions in general; and (2) consent provisions in first-party policies, but not consent provisions (aka "no voluntary payment" provisions) in third-party policies.

CONTRACTUAL INDEMNITY

California Appellate Court Broadly Construes Subcontractor's "Duty to Defend" Developer Under Indemnity Agreement

A California appellate court has broadly interpreted a subcontractor's "duty to defend" a developer pursuant to the terms of an indemnity clause in the parties' contract. (*Centex Homes v. R-Help Construction Co., Inc.* (2019) 32 Cal.App.5th 1230)

Facts

Centex Homes hired R-Help Construction Company, Inc. to trench, install and inspect all utility boxes and conduits for a residential construction project. The contract required R-Help to indemnify and defend Centex against all claims "to the extent such claims in whole or in part arise out of or relate to" R-Help's work.

Matthias Wagener was injured at the project when he fell into a utility box that allegedly had an improperly-installed lid. Wagener subsequently sued Centex, R-Help and others, alleging that the defendants negligently maintained and inspected the utility box lid so as to create an unstable platform which resulted in Wagener's fall. Centex tendered the complaint to R-Help for defense and indemnity, but R-Help did not respond to the tender. Centex then cross-complained against R-Help, alleging causes of action for breach of contract and declaratory relief. Throughout the litigation, Centex and R-Help disputed whether R-Help had actually worked on the utility box where Wagener was injured.

Eventually Wagener resolved his tort claims against all the defendants. However, Centex continued pursuing its cross-complaint against R-Help.

At trial, a jury concluded that R-Help did not actually work on the utility box where Wagener was injured, and that R-Help thus had no duty to defend Centex against Wagener's tort claim. The trial court thus entered judgment in favor of R-Help. Centex appealed.

Holding

The appellate court reversed.

The appellate court began by holding that whether R-Help had a "duty to defend" Centex under the indemnity agreement presented a question of law for the trial court, not a question of fact for a jury. Thus, the trial court erred in submitting that issue to a jury.

The appellate court further held that pursuant to *Crawford v. Weather Shield Mfg., Inc.* (2008) 44 Cal.App.4th 541, Wagener's mere allegation that his injury arose out of R-Help's work for Centex was sufficient to trigger R-Help's duty to defend

Centex against Wagener's claim. Because Wagener had alleged facts "embraced by the indemnity agreement," R-Help had a duty to defend Centex throughout the underlying tort action unless and until R-Help could conclusively show that Wagener's claim against Centex was not covered by the indemnity agreement.

Here, during the pendency of the underlying tort action, R-Help did not conclusively show that Wagener's claim against Centex was outside the scope of the indemnity agreement. Thus, as matter of law, R-Help had breached a duty to defend Centex against Wagener's claim. The appellate court thus remanded the case to the trial court so that Centex could prove the amount of damages it had sustained as a result of R-Help's breach.

Comment

The appellate court applied "duty to defend" principles from cases involving liability insurance policies to the present case involving a contractual indemnity provision. The court held that R-Help (the indemnitor) had an immediate duty to defend Centex (the indemnitee), despite R-Help's claim that it did not actually have any duty to indemnify Centex. Because Wagener's tort claim against Centex was "embraced by the indemnity agreement," R-Help had a duty to defend unless and until it could conclusively prove that the tort claim was not covered by the indemnity agreement.

This case may significantly benefit parties (e.g., developers, landlords, etc.) who have contractual indemnity rights against other parties (e.g., subcontractors, tenants, etc.). If the indemnity clause is properly worded, the former may be able to completely transfer their costs of defense onto the latter, without regard to the presence of insurance.

ALSO OF INTEREST

Where Insureds Mistakenly Provide Tax Returns to Insurer's Attorney, and Attorney Then Discloses Returns to Insurer and Accountants, Attorney Can Be Held Liable for "Invasion of Privacy," But Not "Elder Abuse"

Where the insureds mistakenly provided their tax returns to the insurer's attorney during investigation of a first-party claim, and the attorney then disclosed the returns to the insurer and its accountants, the attorney could be held liable for "invasion of privacy," but not "elder abuse." (*Strawn v. Morris, Polich & Purdy, LLP* (2019) 30 Cal.App.5th 1087)

Facts

In June 2009, Dennis and Diane Strawn's home and pickup truck were damaged by fire. The Strawns immediately submitted claims to their insurer, State Farm General Insurance Company. State Farm hired Attorney Douglas Wood to assist with investigation of the Strawns' claims.

The District Attorney subsequently prosecuted Mr. Strawn for arson in connection with the fire. However, in February 2013, the D.A. dismissed the charges against Mr. Strawn.

In August 2015, State Farm denied the Strawns' insurance claims on the ground that Mr. Strawn had intentionally set the fire and Mrs. Strawn had fraudulently concealed evidence of her husband's wrongful act.

A year later, in August 2016, the Strawns sued State Farm and its attorney, Wood. With regard to State Farm, the Strawns alleged that State Farm had insisted that the Strawns provide information that was not relevant to the cause of the fire; had encouraged a criminal prosecution of Mr. Strawn for arson; had withheld exculpatory evidence that tended to show that any intentional wrongdoing was done by others; and had failed to pay the

Strawns' lender even though the lender was not subject to any coverage defenses. These allegations formed the basis for causes of action against State Farm for "breach of contract," "breach of the covenant of good faith and fair dealing" and "intentional infliction of emotional distress."

With regard to Wood, the Strawns alleged that Wood repeatedly demanded the Strawns' financial records, including tax returns; that in response, the Strawns agreed to provide financial records used to prepare the tax returns, but not the actual returns (the returns being privileged); that the Strawns' accountant then mistakenly provided the returns to Wood; and that Wood failed to inform the Strawns of the error and instead sent the returns to State Farm and State Farm's forensic accounting firm. The Strawns also alleged that Wood "assisted" State Farm in retaining funds that rightfully belonged to the Strawns. These allegations formed the basis for causes of action against Wood for "invasion of privacy" and "elder abuse."

Wood filed a demurrer, which the trial judge sustained without leave to amend. The Strawns appealed.

Holding

The Court of Appeal reversed in part and affirmed in part.

Specifically, the appellate court reversed the trial court's ruling as to the Strawns' claim against Wood for "invasion of privacy." According to the appellate court, the Strawns had sufficiently alleged facts satisfying the elements of a claim for invasion of privacy, namely: (1) a legally protected privacy interest; (2) a reasonable expectation of privacy in the circumstances; and (3) conduct by defendant constituting a serious invasion of privacy. Moreover, there was a factual issue as to whether the "litigation privilege" relieved Wood of any liability for his pre-litigation conduct in disclosing the Strawns' tax returns to State Farm and its accountants. Thus, at least for pleading purposes, the Strawns had stated a claim against Wood for invasion of privacy.

However, the appellate court affirmed the trial court's ruling as to the Strawns' claim against Wood for "elder abuse." The appellate court noted that an insurer's bad faith denial of a claim can perhaps support a cause of action for financial elder abuse against the insurer. However, liability for financial elder abuse cannot be imposed on an attorney who assists the insurer in investigating the claim. Allowing such a claim against an insurer's attorney would circumvent the well-established rule that an insurer's agents cannot be found liable for bad faith denial of coverage.

Comment

The appellate court held that under the circumstance of this case, the insureds could proceed against the insurer's attorney for invasion of privacy. The appellate court noted that although tax returns are privileged from disclosure, the privilege is not absolute. This is reflected in Insurance Code section 2071(a), which provides that "[t]he insurer shall inform the insured that tax returns are privileged against disclosure under applicable law but may be necessary to process or determine the claim." Thus, the statute allows the insured to decide whether to disclose tax returns during the insurer's processing of a claim. Here, the gist of the Strawns' invasion of privacy claim was that Wood improperly provided the Strawns' tax returns to State Farm and its accountants despite the Strawns' assertion of their privilege not to disclose the returns.