

Insurance Coverage

California and Nevada

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UPDATE



MESSAGE FROM THE EDITOR

In the last two quarters, our appellate courts have addressed a wide spectrum of coverage issues. We hope you find our brief summaries of them informative. In this issue, we also include an article pertaining to proofs of loss in first party cases which was prompted by a recent appellate decision that is currently unpublished. As always, we welcome any comments, questions or the opportunity to elaborate on any coverage question you or your group may have.

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Failure to Investigate Whether Additional Policies Provided Coverage Results in Breach of Covenant of Good Faith and Fair Dealing

Safeco Ins. Co. of America v. Parks
(Second District Court of Appeal, January 28, 2009) 170 Cal.App.4th 992, 88 Cal.Rptr.3d 730

The Second District affirmed a trial court's \$3.2 million judgment against Safeco, holding, in part, that it was unreasonable for Safeco not to search for other policies it had issued that might provide coverage for an underage defendant in a personal injury action after concluding that there was no coverage for her as an insured under a policy issued to the boyfriend of the girl's mother. The court pointed out that Safeco knew that the girl did not live with her mother and therefore it was possible that there was insurance at the location she was residing - which in this case was a Safeco policy issued to her grandmother. The court concluded that a jury could find Safeco liable for breach of the implied covenant of good faith and fair dealing due to the unreasonable investigation and thus affirmed the prior denial of Safeco's motion for summary adjudication. ■

Professional Services Exclusion Does Not Apply

*Food Pro International, Inc. v.
Farmers Insurance Exchange*
(Sixth District Court of Appeal, December 30,
2008) 169 Cal.App.4th 976, 89 Cal.Rptr.3d 1

The insured consulting firm, Food Pro, was hired to assist another company in the relocation of the latter's fruit processing operations to a new plant. Food Pro's work involved two design phases and an equipment installation phase. During the final phase, Food Pro's duties were to include acting as the owner's representative vis-à-vis the contractors and suppliers, coordinating contractor activities on the project and making on-site inspections to determine, in general, if the work was proceeding in accordance with the contract documents. A contractor's employee was injured on the project and sued Food Pro. Food Pro's general liability insurer, Farmers, denied coverage, relying on a professional services exclusion. In the coverage action, the trial court held that the professional services exclusion applied because, it concluded, at the time of the accident Food Pro was at the work site only to provide professional services. The Court of Appeal reversed. It found that the particular work Food Pro was doing which allegedly led to the injury did not involve supervisory or engineering services, or any other specialized skill, and therefore the professional services exclusion did not apply. ■

Time on Risk Allocation of Settlements and Defense Costs Affirmed

*Employers Mutual Casualty Company v.
Philadelphia Indemnity Insurance*
(Second District Court of Appeal, November 19,
2008) 169 Cal.App.4th 340, 86 Cal.Rptr.3d 383

The insured, a mobile home park owner, was sued for failing to adequately maintain the mobile home park. During the time that it owned the park, the owner was covered by non-overlapping policies from several insurers. Employers accepted the owner's tender of defense, and Philadelphia denied coverage. Employers eventually settled the lawsuit. The settlement consisted of both damages and payment of plaintiffs' attorneys' fees. Employers subsequently brought a contribution action against Philadelphia. The Court of Appeal upheld the trial court's "time on the risk" method for allocating costs. The relevant time period for plaintiffs' claims was nine years. During this time, the insured was covered by an insurance policy from Philadelphia for two years. Thus, Philadelphia was responsible to pay two-ninths of the defense costs and the settlement. ■

Insurer Not Entitled to Special Jury Instruction on "Genuine Dispute"

McCoy v. Progressive West Ins. Co.
(Second District Court of Appeal, February 4,
2009) 171 Cal.App.4th 785, 90 Cal.Rptr.3d 74

Progressive refused to pay a property claim based on evidence that the insured may have been involved in the theft and destruction of his vehicle. The insured sued, alleging, among other things, bad faith. During trial, Progressive requested special jury instructions addressing the "genuine dispute" rule. The trial court

refused to give them. The jury subsequently awarded punitive damages. The Court of Appeal upheld the trial court's refusal to give the instructions. It stated that the "linchpin of a bad faith claim is that the denial of coverage was unreasonable" and that a "genuine dispute" exists "only where the insurer's position is maintained in good faith and on reasonable grounds." Because the trial court had adequately instructed the jury on the issue of reasonableness pursuant to California Approved Civil Instructions numbers 2331 and 2332, the Court of Appeal concluded, no further instructions were necessary. ■

Court Upholds Limit on Benefits for "Additional Driver"

Mercury Insurance v. David Douglas Pearson
(First District Court of Appeal, December 4, 2008) 169 Cal. App.4th 1064, 87 Cal. Rptr.3d 310

An "additional driver" named on the insured's policy sought coverage for an accident wherein he was struck, while on foot, by an uninsured motorist. He sought reformation of the policy to establish that it would provide the same benefits to which the "named insured" was entitled. The Court of Appeal concluded that the policy was unambiguous that "additional drivers" receive less coverage than "named insureds", and were not covered while outside the vehicle. It also held that there was no basis for reformation based on mistake because the named insured and "additional driver" both signed an endorsement that clearly provided for the limited coverage. The Court also found that the representations allegedly made by the agent/agency were not attributable to the insurer because the agent/agency did not exclusively represent the insurer and their acts were performed for the named insured/additional insured. ■

Third Party Not Entitled to Bring Declaratory Action Against Insurer Unless Actual Controversy Between Them Exists

Otay Land Company v. Royal Indemnity Company
(Fourth District Court of Appeal, November 25, 2008) 169 Cal.App.4th 556, 86 Cal.Rptr.3d 408

A property owner brought a declaratory action against the former owner's insurer to determine whether the insurer was obligated to provide coverage for the former owner with respect to environmental litigation concerning the property. The Court of Appeal upheld the trial court's ruling that the current property owner had no standing. For a third party to have standing, the Court said, the third party must: (1) have privity of contract with the insurer, (2) be a judgment creditor of the insured, or (3) be an assignee of the insured's rights. In this case, the property owner did not satisfy any of these requirements. ■

Voluntary Transfer of Title Does Not Confer Insured Status by "Operation of Law"

Kwok v. Transnation Title Ins. Co.
(Second District Court of Appeal, February 10, 2009) 170 Cal.App.4th 1562, 89 Cal.Rptr.3d 141

The insured, an LLC, transferred real property to a family trust before the LLC's dissolution. The family trust later tendered a claim to the LLC's insurer. The insurer denied the claim on the ground that the family trust was not an insured under the policy. The Second District Court of Appeal held that property transferred from the LLC to the family trust before the LLC's dissolution was a voluntary act, not one arising by operation of law and therefore the family trust did not succeed as an insured "by operation of law" under the terms of the policy. ■

“First Publication” Clause Excludes Coverage for Trade Dress Infringement Claims

United National Insurance Company v. Spectrum Worldwide, Inc.
(Ninth Circuit Court of Appeals, February 2, 2009) 555 F.3d 772

Spectrum was sued for trade dress infringement arising from the marketing of a celebrity diet drink and similarity of the products’ labels. Spectrum had begun using the allegedly infringing label in 1999. In a subsequent coverage action, United National, which had issued Spectrum an excess liability policy in 2001, asserted that the policy’s first publication exclusion applied, and the Ninth Circuit agreed. The Court found the exclusionary language “clear and explicit” and also based its decision on the judicial estoppel doctrine, finding conclusive the date of the first publication based on a position Spectrum had taken in prior litigation. ■

Insurer that Refuses to Provide Defense May Be Bound by Judgment Against Insured Even Though Policy Provides Only Defense Cost Reimbursement

Executive Risk Indemnity, Inc. v. Jones
(First District Court of Appeal, February 20, 2009) 171 Cal.App.4th 319, 89 Cal.Rptr.3d 747

The insured’s insolvency and inability to mount its own defense resulted in a \$22 million judicially confirmed arbitration award against it. ERII had refused to provide a defense because the policy provided only defense cost reimbursement. In a declaratory relief action, the trial court concluded the award and judgment could not be considered a covered “loss,” because ERII had not been a party to the arbitration proceeding or in privity with a

party and thus, based on collateral estoppel, was not bound by the result. The Court of Appeal reversed. First, it said, the policy unambiguously stated that a “Loss” included “damages, judgments, awards, settlements and Defense Expenses which an Insured is legally obligated to pay as a result of a Claim.” Second, “when an insurer: (1) is duly notified of the underlying claim; and (2) is given a full opportunity to protect its interests, the resulting judgment – if obtained without fraud or collusion – is binding against the insurer in any later coverage litigation on the claim involving its insured.” ■

Additional Coverage Beyond Original Policy Limits Required to Comply With Terms of Policy

Patrick A. Major et al., v. Western Home Insurance Company
(Fourth District Court of Appeal, January 6, 2009) 169 Cal.App.4th 1197, 87 Cal.Rptr.3d 556

Homeowners brought a bad faith action against Western Home after a dispute arose regarding the amount of coverage and benefits paid under an extended replacement cost policy with respect to a fire-destroyed home. The policy required the homeowners to permit an inspection of the property to determine policy limits and replacement costs. Western Home conducted an inspection after the policy was issued, but did not increase the policy limits to reflect the findings of the inspection until after a lawsuit was filed. The homeowners subsequently made a claim for supplemental benefits, but Western Home refused to pay the increased policy limits. The Court of Appeal upheld a jury verdict for \$1.3 million, rejecting Western Home’s position that the increase in policy limits was a “gift” or constituted “courtesy benefits.” It concluded that Western Home was contractually bound to pay the homeowners the increased limits under the terms of the policy. ■

No Duty to Defend Where Policy Expressly Excludes Insured's Failure to Pay Money

GGIS Insurance Services, Inc. v.

Superior Court (Capital Indemnity Corp.)

(Second District Court of Appeal, December 11, 2008) 168 Cal.App.4th 1493, 86 Cal.Rptr.3d 515

The insured, GGIS, was a general insurance agency. The Pennsylvania insurance commissioner brought an action against it alleging liability for failure to pay the commissioner premiums collected and uncollected as to which GGIS had agreed to pay to two insurers that were in rehabilitation. GGIS tendered its defense under its Insurance Agents and Brokers Professional liability Policy to Capital Indemnity. In the coverage action, the trial court denied Capital Indemnity's summary adjudication motion on the duty to defend. On appeal, the Second District reversed. It concluded that an exclusion for "any failure to pay" was prominently displayed, unambiguous and applied to preclude the duty to defend. ■

Third Party Administrator May be Liable to Excess Carrier Not in Privity with Administrator

Nat'l Union Fire Ins. Co. of Pittsburgh, PA v.

Cambridge Integrated Svcs. Group, Inc.

(First District Court of Appeal, February 11, 2009) 171 Cal.App.4th 35, 89 Cal.Rptr.3d 473

Cambridge, an administrator of workers' compensation claims for the insured, approved a request for a former employee's surgery, resulting in expenses in excess of \$1.5 million to the insured and its excess carrier, National. National brought suit against Cambridge for negligence, breach of contract, negligent misrepresentation and subrogation. The trial court sustained Cambridge's demurrer to the complaint without leave to

amend. The Court of Appeal reversed on the causes of action for negligence, breach of contract and subrogation. Because Cambridge was required to manage all workers' compensation claims filed against the insured, including those that would involve excess insurance, Cambridge owed National a duty of care and it was foreseeable that any mishandling of claims could affect National. Further, National was a third party beneficiary of the Cambridge contract because one purpose of the contract was to minimize the insured's liability for worker's compensation claims, which would benefit National. Additionally, Cambridge administered all of the insured's worker's compensation claims, including those that exceeded the self-insurance limit. Finally, National was subrogated to the insured's rights against the administrator. ■

Back to Basics: Proof of Loss in Appraisals

California's Sixth District Court of Appeal recently upheld an appraisal award involving extensive fire damage to a mixed commercial/residential building known as the Pajaro Wall Street Inn. (*Pajaro Wall Street Inn v. CIBA Insurance Services*, 2009 WL 297001, February 9, 2009.)

While this case is currently unpublished, the facts highlight the need to require policyholders to submit a proof of loss setting forth the scope of their damages. A December 2004 fire caused significant damage to the upper floors of a four story building. Pajaro retained a public adjuster and in May 2005 obtained a repair estimate of \$8.4 million. Pajaro then dismissed the public adjuster and retained a second one that relied on the first estimate. By September 2006, Pajaro dismissed its second public adjuster and retained a third one that obtained a new repair estimate of \$16.4 million.

According to the insurers, the revised estimate that nearly doubled the original estimate was not disclosed to the insurers prior to its presentation at the appraisal hearing. The new estimate increased the original by 10.8% and added to the scope of repair significantly, including items that related to a planned conversion of the building to increase the number of units. The Court of Appeal ultimately affirmed the award and rejected Pajaro's claims which included, among other things, that the appraisal panel improperly decided coverage issues.

The Court agreed that the appraisal panel had the authority to decide whether or not certain claimed damage had actually been sustained. Such a determination did not involve a determination of causation and was therefore appropriate. The Court also agreed that the panel did not err by valuing certain building components based on the current cost of replacement materials, rather than the cost to replicate the full dimensional lumber used in original construction in 1911. In addition, the Court agreed that the panel did not fail to consider all aspects of claimed damage by using the insurers' proposed statement of loss, even though it contained fewer categories of damage than that proposed by Pajaro. The insurers' statement of loss and that proposed by the insured contained essentially the same categories, although described differently. Finally, the Court concluded that the panel did not err when it established the amount of time necessary to repair the damage, even though that determination could then be used by the insurers in calculating the amount of the business income loss.

The facts of this case demonstrate that, especially in cases where there is a dispute over the scope of damage, insurers should consider requiring the submission of a proof of loss from the policyholder. Under the California Insurance Code a proof of loss is required to be submitted under penalty of perjury by the policyholder within sixty days of the loss. Requiring a proof of loss narrows the scope of the claim so as to avoid the situation in Pajaro - continued and greatly expanded estimates up to and at the time of appraisal.



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