

# 2007 ANNUAL REVIEW OF CALIFORNIA INSURANCE LAW



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*INSURANCE LAWYERS*

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## 2007 ANNUAL REVIEW OF CALIFORNIA INSURANCE LAW

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 the major cases and statutory changes from December 2006 through November 2007 that will impact your California claims next year.

Best wishes for the coming year.

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**Ameron Intern. Corp. v. Ins. Co. of State of Pennsylvania**, 60 Cal.Rptr.3d 55 (2007) (Whether insurer has a duty to defend and indemnify insured in administrative proceeding depends on policy language)

**Bouton v. USAA Cas. Ins. Co.**, 52 Cal.Rptr.3d 551 (2006) (Whether person qualified as "insured" for UM/UIM claim must be decided by arbitrator)

**Delgado v. Interinsurance Exch. of Auto. Club of Southern California**, 59 Cal.Rptr.3d 799 (2007) (Insurer must defend insured in assault and battery case where there is a possibility that the insured acted in "self-defense")

**O'Hanesian v. State Farm Mut. Auto. Ins. Co.**, 52 Cal.Rptr.3d 463 (2006) (Arbitration must be completed before insured may pursue lawsuit for UM/UIM benefits)

**State of California v. Underwriters at Lloyd's London**, 53 Cal.Rptr.3d 84 (2006) (Insurer obligated to indemnify for pollution remediation where covered and non-covered event are concurrent causes of indivisible damage)

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### PROPERTY INSURANCE

#### *Where Two Insureds Have Separate Policies Covering Same Property, Each Insurer Must Pay Only Part of Loss*

The California Court of Appeal has held that, where two separate insureds have two separate policies covering the same property, each insurer must pay for only a part of a loss to the property. (*Burns v. California Fair Plan Ass'n*, 152 Cal.App.4th 646 (2007))

#### **Facts**

Ann Burns (Burns) held a life estate in a residence. The Kent Burns Trust (the Trust) held the remainder interest in the property. Burns insured her life estate interest in the property through California Fair Plan (Fair Plan). The Trust separately insured its remainder interest through Clarendon National Insurance Company (Clarendon).

Fair Plan's policy provided coverage on an actual cash value basis, and had a limit of \$477,000. Clarendon's policy provided coverage on a replacement cost basis, and had a limit of \$330,000. Thus, the combined limit of both policies was \$807,000.

After a fire destroyed the residence, Burns submitted a claim to Fair Plan and the Trust submitted a claim to Clarendon. The actual cash value of the damaged property was \$474,000, and the replacement cost was \$486,080. Both Fair Plan's policy and Clarendon's included "other insurance" provisions. Fair Plan's policy had an "excess" clause and Clarendon's policy had a "pro rata" clause.

The insurers asserted that Burns and the Trust were not both entitled to the full insured value of the property. Instead, the insurers asserted that Burns and the Trust should recover on a pro rata basis. As such, Fair Plan divided its policy limit of \$477,000 by \$807,000, and calculated its pro rata liability at \$279,410 (i.e., 59 percent of the actual cash value of \$474,000, less a deductible of \$250). Similarly, Clarendon divided its policy limit of \$330,000 by \$807,000, and calculated its pro rata liability at \$198,792 (i.e., 41 percent of the replacement cost of \$486,080, less a deductible of \$500). Thus, Fair Plan paid \$279,410 to Burns, and Clarendon paid \$198,792 to the Trust.

Burns and the Trust filed an action alleging causes of action for breach of contract and bad faith. They each

sought full recovery on their respective insurance policies, rather than the pro rata payment the insurers made. The trial court granted summary judgments in favor of the insurers, and Burn and the Trust appealed.

#### **Holding**

The Court of Appeal noted that both Burns and the Trust had separate insurable interests in the property, but noted that neither Burns' interest nor the Trust's interest was equal to the whole value of the property. Instead, the value of Burns's life estate by definition was of limited duration, and the value of the Trust's remainder interest was dependent on how long Burns survived.

Insurance Code section 590 provides as follows: "Double insurance exists where the same person is insured by several insurers separately in respect to the same subject and interest." Insurance Code section 591 provides as follows: "In case of double insurance, the several insurers are liable to pay losses thereon as follows: (a) In fire insurance, each insurer shall contribute ratably, without regard to the dates of the several policies." The Court of Appeal noted that this case did *not* involve "double insurance," because Fair Plan and Clarendon did not both insure "the same person."

Insurance Code 2071 provide as follows: "This company shall not be liable for a greater proportion of any loss than the amount hereby insured shall bear to the whole insurance covering the property against the peril involved, whether collectible or not." According to the Court of Appeal, this provision evidences a legislative intent to allow pro rata payment of claims even where there is no "double insurance" and even where there are different insureds.

Together, the insurers paid \$478,202. This amount was more than the estimated actual cash value of the destroyed property of \$474,000. Thus, the Court of Appeal ruled that the insurers had fully paid their obligations under the policies, and that summary judgment in favor of the insurers was proper.

#### **Comment**

This case illustrates that property insurance is not intended to provide for recovery in excess of the value of the property destroyed where there is only one loss. It also illustrates that, where different persons or entities have separate interests in the same property, the value of each interest must be determined separately. Here, allowing each insurer to pay its own

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insured for only a portion of the total loss prevented either insured from gaining a windfall.

### ***Coverage for Property for Which Insured is "Legally Liable" Applies to Bailed Property, and Is Not Liability Insurance***

The California Court of Appeal has held that employee dishonesty coverage for property for which an insured is "legally liable" applies when property has been bailed or entrusted to the insured, and is not third-party liability insurance. (*Simon Marketing v. Gulf Ins. Co.*, 149 Cal.App.4th 616 (2007))

#### **Facts**

Simon Marketing, Inc. performed promotional and marketing services for McDonald's Corporation. As part of these services, Simon designed promotional games for McDonald's and its franchisees.

Jerome Jacobson, Simon's director of security, was responsible for "seeding" high-value winning game tickets across the nation in McDonald's giveaway contests. Unbeknownst to Simon, Jacobson organized a network of accomplices and co-conspirators to funnel high-value winning game tickets to specific individuals. According to Simon, Jacobson stole game pieces with a total redemption value of approximately \$21 million, and received kickbacks from the putative "winners." When the "winners" presented the game pieces, McDonald's (not Simon) issued payments. Jacobson ultimately was arrested, pled guilty and was sentenced to prison.

Federal Insurance Company and Gulf Insurance Company issued policies providing coverage for "direct" losses to property caused by theft or forgery committed by Simon's employees. Federal's policy included coverage for theft of property for which Simon was "legally liable."

After Jacobson's dishonesty was discovered, McDonald's terminated its contracts with Simon. In addition, Simon became embroiled in various pieces of litigation with McDonald's, consumers, and other third parties. McDonald's ultimately held new giveaway contests, which McDonald's and its insurers funded.

Simon sued its insurers, Federal and Gulf, essentially alleging that Simon had gone out of business as a result of Jacobson's fraud. Among other things, Simon alleged (1) the complete loss of its business; (2) out-of-pocket expenses incurred in winding down its business affairs; (3) payments to settle lawsuits; and

(4) defense costs incurred in some of the lawsuits. The trial court granted summary judgment in favor of Federal and Gulf, and Simon appealed.

#### **Holding**

The Court of Appeal affirmed, rejecting Simon's contention that coverage existed because Simon was "legally liable" for the theft of the game pieces. The Court noted that coverage in an employee dishonesty policy for theft of property for which an insured is "legally liable" does not transform the policy into a liability policy. Instead, coverage for theft of property for which an insured is "legally liable" is intended to apply to property for which the insured is a bailee or trustee. In any event, noted the Court, McDonald's (not Simon) had paid for the stolen prizes by funding new giveaway contests.

The Court also noted that the litigation costs associated with the various lawsuits were not "direct" losses, but rather related to Simon's liability for third party losses caused by the tortious acts of Jacobson. In addition, the Court held that the failure of Simon's business because McDonald's and others cancelled its contracts with Simon did not constitute physical loss or damage to insured property. Similarly, the Court held that payments to settle litigation, costs of defense and costs of winding up its business did not constitute physical damage to property.

#### **Comment**

The reasoning of this case is somewhat obscure, largely because the two policies contained insuring agreements and exclusions with somewhat differing language. Ultimately, the Court relied on the fact that both policies essentially were property insurance policies and that it was McDonald's (not Simon) that paid to fund the new contests.

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### GENERAL LIABILITY INSURANCE

#### *In Rental Car Transaction, Excess Insurer Has Limited Duty to Investigate Insurability and Can Rely on Misrepresentations to Avoid Coverage*

The California Supreme Court has held that in the context of a rental car transaction, an excess auto liability insurer satisfies its duty to investigate the insurability of an insured by inspecting the insured's facially valid driver's license and verifying the insured's signature. Therefore, if the insured misrepresents that he has a valid license, the excess insurer can rely on that misrepresentation as a basis for avoiding liability to third parties injured by the insured. (*Philadelphia Indem. Ins. Co. v. Montes-Harris*, 40 Cal.4th 151 (2006))

#### Facts

Alric Burke (Burke) lived in Arizona. In approximately April 2001, Arizona authorities suspended his driver's license and driving privileges.

Two months later, in June 2001, Burke rented a car in California from Budget Rent-A-Car (Budget). Burke showed Budget's rental agent what appeared to be a valid Arizona driver's license. Budget's rental agent photocopied Burke's license and had Burke sign the rental agreement.

At the time of the rental transaction, Budget was the named insured on a master excess liability policy issued by Philadelphia Indemnity Insurance Company (Philadelphia). The Philadelphia excess policy provided limits of \$1 million in excess of the minimum statutory limits of \$15,000 per person and \$30,000 per occurrence for bodily injury. However, the policy *excluded* coverage for injuries arising out of the use of a rental car "obtained through fraud or misrepresentation." Budget had authority to enroll its customers as additional insureds under the policy if the customers so opted, without submitting a written application to Philadelphia.

After inspecting Burke's license and verifying his signature as required by statute, Budget's rental agent concluded that Burke was qualified to rent a car. Thus, Budget's rental agent, acting as Philadelphia's agent for the limited purpose of offering and selling excess liability insurance, offered Burke the option of buying such insurance. Burke accepted the offer and purchased the excess insurance.

A few days after renting the car, Burke was involved in a car accident in California that injured numerous

people (the claimants). The claimants filed a state court action against Budget and Burke to recover damages arising from the accident.

Philadelphia filed a federal court action seeking a judgment that it had no liability for any damages in the underlying personal injury action. The district court ruled that (1) Burke made "at least a negligent misrepresentation" to Budget that he had a valid driver's license, and (2) Philadelphia's excess policy excluded coverage for rentals obtained through misrepresentation. The district court thus ruled that Philadelphia had no liability for damages arising from the accident.

The claimants appealed to the Ninth Circuit Court of Appeals. The claimants argued that under *Barrera v. State Farm Mutual Automobile Ins. Co.* (1969) 71 Cal.2d 659, an auto liability insurer has a duty to conduct a reasonable investigation of the insurability of the insured within a reasonable time of issuance of the policy. The claimants argued that if the insurer breaches its duty under *Barrera* to investigate insurability, the insurer cannot rely on the insured's misrepresentations in procuring the policy as a basis for avoiding liability to third parties who are injured by the insured.

While the appeal was pending before the Ninth Circuit, the Ninth Circuit requested that the California Supreme Court address whether an auto insurer's duty to investigate insurability applies to an excess insurer in the context of a rental car transaction. The Supreme Court agreed to address that question.

#### Holding

The Supreme Court concluded that where the sale of excess liability insurance in a rental car transaction occurs after the customer presents a facially valid driver's license and after the license inspection and signature verification requirements of Vehicle Code section 14608 have been met, the excess insurer has no obligation under *Barrera* to conduct a further inquiry regarding the customer's driver's license. The Supreme Court held that in such a situation, if the insurer acts promptly upon discovering that the customer's driver's license was in fact suspended, then the excess insurer does not forfeit any right to rely on the customer's presentation of the invalid license as a basis for avoiding liability to third persons under the excess policy.

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### Comment

The Supreme Court avoided deciding whether the *Barrera* duty to investigate insurability generally applies, or does not apply, to all excess automobile liability insurers. Rather, the court assumed for purposes of discussion that the *Barrera* duty applies to excess insurers, but then concluded that Philadelphia had not breached that duty. Although the question of whether an insurer has conducted a timely and reasonable investigation of insurability is generally a question of fact, the court concluded that here it was a question of law.

### *Insurer Has No Duty to Defend Suit Alleging Insured Sent Unsolicited Fax Advertisements*

The California Court of Appeal has held that a liability insurer had no duty to defend an insured in an action alleging that the insured sent unsolicited advertisements to fax machines in violation of federal statutory law and common law privacy rights. (**ACS Systems, Inc. v. St. Paul Fire and Marine Ins. Co.**, 147 Cal.App.4th 137 (2007))

### Facts

Various plaintiffs filed a class action lawsuit against ACS Systems, Inc., alleging that ACS had sent thousands of unsolicited advertisements to fax machines. The plaintiffs sought damages from ACS for, among other things, violation of the federal Telephone Consumer Protection Act and invasion of privacy.

ACS tendered defense of the lawsuit to its liability insurer, St. Paul Fire and Marine Company, under a policy covering liability for (1) "advertising injury" and (2) "property damage" caused by "accident." St. Paul rejected ACS' tender.

ACS subsequently sued St. Paul, alleging that St. Paul had breached the insurance policy by failing to defend ACS in the underlying class action lawsuit. However, the trial court ruled that the underlying claims against ACS were not potentially covered under the St. Paul policy, and that St. Paul thus had no duty to defend ACS in the underlying lawsuit. ACS appealed.

### Holding

The Court of Appeal affirmed, finding that the underlying plaintiffs' "junk fax" lawsuit against ACS was not potentially covered under either the "advertising injury" or "property damage" provisions of the St. Paul policy.

With respect to "advertising injury," the court acknowledged that the plaintiffs in the underlying suit had sought damages from ACS for "invasion of privacy," and that the St. Paul policy defined "advertising injury" to include "making known to any person or organization written or spoken material that violates an individual's *right of privacy*." However, the court concluded that the suit against ACS was based on invasion of the privacy right of *seclusion* (i.e., the right to be free at a particular location or time from disturbance by others), and that St. Paul's policy—read in context—only covered ACS for invasion of the privacy right of *secrecy* (i.e., the right to be free from disclosure of personal information to others). Because the underlying plaintiffs' lawsuit suit against ACS was based on alleged violation of *seclusion* privacy, and the St. Paul policy only covered ACS for violation of *secrecy* privacy, the "advertising injury" coverage did not apply.

Turning next to the "property damage" provisions, the court noted that even if ACS' alleged act of sending unsolicited faxes caused the recipients to suffer "property damage," the St. Paul policy only covered property damage caused by "accident." Further, the St. Paul policy specifically excluded coverage for property damage which is "expected or intended" by an insured. According to the court, ACS' alleged act of sending unsolicited faxes was not an "accident," and any property damage suffered by the recipients was "expected or intended" by ACS. Therefore, St. Paul had no duty to defend ACS under the "property damage" provisions.

### Comment

This case represents the first time a California court has considered whether an insurer has a duty to defend an insured who is sued for sending unsolicited "junk faxes." The court examined numerous cases from other jurisdictions—some finding a duty to defend and some finding no duty to defend—before concluding that the particular wording of St. Paul's policy did not impose a duty to defend.

### *"Occurrence" in CGL Policies Means Injurious Exposure to Asbestos, Not the Manufacture and Distribution of Asbestos Products*

In a case of first impression, the California Court of Appeal has ruled that, in the context of multiple claims for bodily injury arising from asbestos exposure, the term "occurrence" in a commercial general liability policy referred to "injurious exposure to asbestos," not the manufacture and distribution of asbestos-containing products. **London Market Insurers v.**

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**Superior Court (Truck Ins. Exch.),** 146 Cal.App.4th 648 (2007)

### Facts

Truck Insurance Exchange (Truck) issued commercial general liability policies to Kaiser, a manufacturer of asbestos products. The policies provided primary liability coverage for Kaiser over 19 policy periods, from 1964 to 1983. The Truck primary liability policies that were effective from January 1971 to April 1980 had a policy limit of \$500,000 for “each occurrence” with no aggregate limit. Those policies defined “occurrence” as “an event or series of events or continuous or repeated exposure to conditions which results in legal liability, regardless of the number of persons, vehicles or objects affected by such act or acts or omission.”

By 2004, more than 24,000 claimants had filed products liability suits against Kaiser. These claimants alleged they had suffered bodily injury, including asbestosis and various cancers, as a result of their exposure to Kaiser’s asbestos products. By October 2004, Truck’s indemnity payments to the claimants had exceeded \$50 million. As a result, Truck filed a declaratory relief action, asserting that all asbestos-related claims in any given year arose out of a single “occurrence” because all had the same underlying cause: “the design, manufacture and distribution by Kaiser and its subsidiaries of asbestos-bearing products.”

London Market Insurers, Kaiser’s excess insurers, asserted that each asbestos claim constituted a separate “occurrence” because the claimants’ asbestos injuries took place at different times, different places and under different circumstances. Therefore, the excess insurers argued, there were multiple occurrences, each of which was subject to a separate “occurrence” limit. The trial court held that, under California law, “occurrence” meant the underlying cause of injury—the act or acts, of the insured that gave rise to the asbestos bodily injury claims. It further held that Kaiser’s manufacture and decision to place asbestos into products constituted a single “occurrence” and, therefore, Truck’s primary policies had been exhausted.

### Holding

The Court of Appeal vacated the trial court’s ruling, finding that Kaiser’s manufacture and distribution of asbestos products over 30 years did not fall within the definition of “occurrence.” First, Kaiser’s manufacture and distribution of asbestos products were not an

“event” (which the court interpreted to mean a “discrete happening that occurred at a specific point in time”). Instead Kaiser’s manufacture and distribution was a course of conduct.

Second, Kaiser’s manufacture and distribution of asbestos products were not “conditions” to which the claimants were exposed. Instead, the asbestos fibers from Kaiser’s products were in fact the “conditions” to which the claimants were exposed.

Third, the court found that the “products hazard” provisions and other provisions in Truck’s policy supported its conclusion that an “occurrence” in Truck’s policies was the injury-producing event, not routine manufacture or distribution.

Finally, the court rejected the Truck’s assertion that California law defined “occurrence” as the underlying or remote cause of an alleged injury and not the immediate cause.

Notwithstanding these rulings, however, the court expressly held that the number of occurrences did not necessarily equal the number of asbestos claimants, and remanded to the trial court the issue of whether certain asbestos injury claims could be aggregated.

### Comment

This case calls into question the reasoning of various other cases, such as *Chemstar v. Liberty Mut. Ins. Co.* 41 F.3d 429 (9th Cir. 1994) and *Mead Reinsurance v. Granite State Ins. Co.* 873 F.2d 1185 (9th Cir. 1989) which found one underlying cause responsible for causing multiple injuries and, therefore, one “occurrence” for purposes of determining policy limits. Liability insurers, whose policies do not contain aggregate limits, will likely find it more difficult to assert that multiple claims arose from one underlying cause or “occurrence” for purposes of determining policy limits, unless that underlying cause is the immediate cause of the claimants’ injuries.

### ***Insurer Has No Duty to Defend or Indemnify Landlord Against Breach of Lease Claim Brought by Tenant***

The California Court of Appeal has held that a liability insurer had no duty to defend or indemnify its insured, a landlord, against claims that the landlord failed to maintain and repair premises leased to a tenant. (***Golden Eagle Ins. Co. v. Cen-Fed, Ltd.***, 148 Cal.App.4th 976 (2007))

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### Facts

Cen-Fed, Ltd. leased part of an office building to Washington Mutual Bank for use as a bank branch. The lease contained an attorney's fees clause which provided that in case of litigation, the prevailing party would be entitled to recover reasonable attorney's fees from the losing party.

Washington Mutual later sued Cen-Fed for breach of lease, alleging that Cen-Fed had failed to maintain and repair the leased premises in accordance with the terms of the lease, and that as a result Washington Mutual was unable to use a portion of the leased premises. Washington Mutual also alleged that Cen-Fed did not properly maintain the building's air conditioning, elevators, restrooms, common areas, paint, etc.

Cen-Fed tendered defense of the action to its general liability insurer, Golden Eagle Insurance Company. Golden Eagle agreed to defend Cen-Fed under a complete reservation of rights.

Ultimately, Washington Mutual obtained a judgment against Cen-Fed for approximately \$505,000, representing the diminution in value of Washington Mutual's leasehold interest. In addition, Washington Mutual as prevailing party was awarded costs of suit (including contractual attorney's fees) against Cen-Fed.

Golden Eagle filed a declaratory relief action against Cen-Fed to determine the scope of Golden Eagle's coverage obligations to Cen-Fed. The trial court ruled that Golden Eagle had no duty to indemnify Cen-Fed for the \$505,000 judgment in favor Washington Mutual. However, the trial court also ruled that although Golden Eagle never had a duty to defend Cen-Fed against Washington Mutual's claims, Golden Eagle had in fact defended Cen-Fed, and therefore Golden Eagle was obligated under the policy's "supplementary payments" provision to indemnify Cen-Fed for all costs (including attorney's fees) which had been awarded to Washington Mutual. Cen-Fed appealed and Golden Eagle cross-appealed.

### Holding

The Court of Appeal resolved all issues in favor of Golden Eagle.

First, the court ruled that Golden Eagle's coverage for "bodily injury and property damage liability" did not potentially cover Cen-Fed's liability to Washington Mutual in the underlying action. According to the court,

Washington Mutual only alleged injury to the value of its leasehold interest (an *intangible property right*), and did not allege "property damage" (which the policy defined as "physical injury to ... or loss of use of ... *tangible property*"). Further, the coverage for bodily injury and property damage liability required an "occurrence," or "accident," and Cen-Fed's alleged failure to discharge its contractual maintenance obligations to Washington Mutual could not be characterized as an "accident."

Next, the court found that Golden Eagle's coverage for "personal injury liability" did not potentially cover Cen-Fed's liability to Washington Mutual in the underlying action. Although the Golden Eagle policy did define personal injury so as to include "wrongful eviction from ... a room, dwelling or premises that a *person* occupies..." the claimant, Washington Mutual, was a *corporate organization, not a person*. Thus, the policy's personal injury coverage did not apply.

Last, the court held that the Golden Eagle policy's "supplementary payments" clause did not cover Cen-Fed's obligation to pay attorney's fees to Washington Mutual in the underlying action. It was true that the supplementary payments clause provided that Golden Eagle would pay all costs (including contractual attorney's fees) assessed against the insured in "any suit ... we *defend*." However, while Golden Eagle had in fact defended Cen-Fed in the underlying action, Golden Eagle never had a *legal duty to defend* Cen-Fed in that action. According to the court, a supplementary payments clause must be read "as applying *only* to those cases where the insurer actually owed a duty to defend."

### Comment

The most significant thing about this case may be court's ruling regarding the supplementary payments provision. This case makes it clear that, if the insurer never had a duty to defend the insured in the first place, the supplementary payments provision is not triggered. On the other hand, if the insurer does have a duty to defend the insured, the insurer may have an obligation to under the supplementary payments provision to pay any costs—including contractual or attorney's fees—which are later assessed against the insured.

***Although Landslide Results in Damage During Successive Policy Periods, There Is Only One "Occurrence" For Purposes of Limits***

The California Court of Appeal has held that although a landslide resulted in damage during successive

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primary policy periods, there was only one “occurrence” and hence only one primary policy limit applied. (*Safeco Ins. Co. v. Fireman’s Fund Ins. Co.*, 148 Cal.app.4th 620 (2007))

### Facts

Harold Lancer and several others owned homes on top of a hill. Lawrence and Linda Rauch and others owned homes at the bottom of the hill. In February 1998, a portion of the uphill properties failed, causing a massive amount of dirt and debris to be deposited onto the downhill properties.

Following the landslide, the slope went unrepaired for over three years, and during that entire time the Rauches were unable to use their backyard. Eventually the Rauches and other downhill neighbors sued Lancer and other uphill owners for nuisance, trespass and negligence. Various parties cross-complained against each other.

At the time of the landslide, Lancer had a homeowners policy through Fireman’s Fund Insurance Company. The Fireman’s Fund homeowners policy covered both “property damage” (defined as physical injury to or loss of use of tangible property) and “personal injury” (defined so as to include wrongful entry and eviction) caused by an “occurrence,” with limits of \$500,000 for all damages resulting from any one occurrence. Following the landslide, Fireman’s Fund renewed the policy for three consecutive years.

At the time of the landslide, Lancer also had a personal umbrella policy through Safeco Insurance Company of America. The Safeco umbrella policy also covered “property damage” and “personal injury” caused by an “occurrence,” with limits of \$5 million per occurrence.

Fireman’s Fund defended Lancer against the lawsuits brought by the Rauches and the other downhill neighbors. Ultimately Fireman’s Fund paid \$500,000 and Safeco paid \$450,000 to settle Lancer’s liability to everyone *except* the Rauches. At that point, Fireman’s Fund contended that it had exhausted its policy limit of \$500,000, but agreed to continue to defending Lancer against the Rauches’ claims under a reservation to seek reimbursement of post-exhaustion defense costs from Safeco. The Rauches then proceeded to trial against Lancer and obtained a judgment of over \$2 million against him.

Safeco filed a declaratory relief action against Fireman’s Fund, asserting that Fireman’s Fund provided \$500,000 for property damage *and* an

additional \$500,000 for personal injury during *each* of Fireman’s Fund’s four policy periods (for a total of \$4 million); that both property damage and personal injury occurred during all four policy periods; and that Fireman’s Fund was therefore responsible for all costs of defending and indemnifying Lancer. Fireman’s Fund cross-complained against Safeco, asserting that the landslide had only caused one “occurrence” under the first of Fireman’s Fund’s four policies; that Fireman’s Fund had already exhausted its applicable policy limit of \$500,000; and that Safeco was thus obligated to reimburse Fireman’s Fund for all defense costs Fireman’s Fund had paid after exhausting its policy limits.

The trial court ruled in favor of Fireman’s Fund, finding that there was a single occurrence during a single policy period and that Fireman’s Fund’s policy limit was thus \$500,000. The trial court thus ruled that Safeco was obligated to indemnify Lancer for any liability above \$500,000, and that Safeco was obligated to reimburse Fireman’s Fund for all defense costs Fireman’s Fund had paid after exhausting its policy limits. Safeco appealed.

### Holding

The Court of Appeal affirmed. The court held that even assuming the Rauches had suffered both property damage and personal injury, both types of harm resulted from a *single cause* (i.e., the landslide). According to the court, for purposes of determining *policy limits*, all damages flowing from a single cause are deemed to be the result of a single “occurrence.” It was irrelevant “that the resulting damage may have continued into subsequent policy periods.” Here, there was only a single occurrence during Fireman’s Fund’s first policy period, so that Fireman’s Fund’s exposure was limited to \$500,000.

### Comment

The appellate court acknowledged that there might be situations where, even though there is only one “occurrence” (i.e., cause of damage), the insured would be entitled to the policy limits under successive policies. One such situation would be where the insured is liable for “continuous or progressively deteriorating” bodily injury or property damage occurring over successive policy periods.

Here, apparently, the appellate court did not feel that Lancer’s liability arose from “continuous or progressively deteriorating” property damage. Rather, this simply was a situation where the property damage occurred in Fireman’s Fund’s first policy period, and

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the effects were felt in subsequent policy periods. According to the court, “the mere continuation of damage during successive policy periods, by itself, does not create a series of indefinitely ongoing occurrences.”

### ***Subcontractors’ Insurers Who Defend Developer as “Additional Insured” Can Recover Portion of Defense Costs from Developer’s Excess Insurer***

The California Court of Appeal has held that subcontractors’ insurers who defended a developer as an “additional insured” were entitled to recover a portion of the developer’s defense costs from the developer’s own excess insurer. (*Transcontinental Ins. Co. v. Ins. Co. of the State of Pennsylvania*, 148 Cal.App.4th 1296 (2007))

#### **Facts**

Barratt American, Inc. acted as developer of a housing project. Barratt hired numerous subcontractors to work on the project, and several of the subcontractors’ insurers named Barratt as an additional insured for claims “arising out of” the subcontractors’ work.

After the project was completed, the homeowners association sued Barratt for alleged construction defects, false advertising and breach of fiduciary duty. Barratt initially obtained a defense from its own primary carrier, United National Insurance Company, but United National soon exhausted its policy (apparently on other claims).

Barratt next tendered the defense to its own excess insurer, Insurance Company of the State of Pennsylvania (ISOP), and to various insurers who had named Barratt as additional insured, including Transcontinental Insurance Company and related insurers (collectively Transcontinental). ISOP initially paid \$600,000 in defense costs on behalf of Barratt, but then asserted that it had no duty to defend Barratt and demanded reimbursement from Transcontinental. Transcontinental reimbursed ISOP for the defense costs ISOP had already paid on behalf of Barratt, and then proceeded to pay an additional \$1.2 million in defense costs on behalf of Barratt. Transcontinental made all payments under a reservation of rights to seek reimbursement from ISOP.

Transcontinental later brought an equitable subrogation/contribution action against ISOP, claiming that ISOP had a duty to pay a share of Barratt’s defense costs. The trial court ruled in favor of Transcontinental, finding that ISOP was obligated to

pay a portion of Barratt’s defense costs. ISOP appealed.

#### **Holding**

The Court of Appeal affirmed. The court acknowledged that under *Presley Homes, Inc. v. American States Ins. Co.* (2001) 90 Cal.App.4th 571, Transcontinental had a prophylactic duty to *defend* its additional insured, Barratt, against *all* claims asserted in the underlying action. However, under *Buss v. Superior Court* (1997) 16 Cal.4th 3, Transcontinental was also entitled to *reimbursement* from Barratt of defense costs for claims that did *not* potentially arise out of work performed by the subcontractors insured by Transcontinental. Moreover, according to the court, the claims against Barratt that were *not* potentially covered by Transcontinental’s policies *were* potentially covered by ISOP’s excess policy.

The court thus concluded that since Transcontinental had paid defense costs on behalf of Barratt for claims which were *not* potentially covered under the Transcontinental policies but which *were* potentially covered under the ISOP excess policy, Transcontinental was “equitably subrogated” to Barratt’s rights to recover those defense costs from ISOP. Transcontinental could thus recover a share of Barratt’s defense costs from ISOP.

#### **Comment**

This case illustrates that an insurer who has a duty to defend an insured in a “mixed” action must provide the insured with a full and complete defense against all claims asserted in the action. However, the insurer who discharges its duty to defend can then seek reimbursement of defense costs for the “uncovered” claims, either from the insured (directly) or another insurer (via subrogation).

### ***In Continuous Injury Case, Insured Cannot Trigger Defense Under Early Excess Policy When Insured Has Later Primary Policy With SIR***

The California Court of Appeal has held that in a continuous injury case, an insured could not trigger a defense under an early excess policy as long as the insured had a later primary policy that applied to the loss—even though that primary policy was subject to a self-insured retention. (*Padilla Construction Co., Inc. v. Transportation Ins. Co.*, 150 Cal.App.4th 984 (2007))

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### Facts

Padilla Construction Co., Inc. was a plastering subcontractor for a residential housing project. In 2002, various homeowners filed a construction defect lawsuit against the project's developer alleging, among other things, continuous mold and decay damage caused by foundation vents which were blocked with stucco. The developer filed a cross-complaint against Padilla, the subcontractor allegedly responsible for the work.

During the initial years in which mold and decay damage allegedly occurred, Padilla had a primary liability policy through Transcontinental Insurance Company and an excess liability policy through Transportation Insurance Company. During the later years in which damage allegedly occurred, Padilla had a primary liability policy through Steadfast Insurance Company, but that policy was subject to a \$25,000 self-insured retention.

Padilla's early primary insurer (Transcontinental) defended Padilla for a short period of time but exhausted its policy on other claims. Padilla then asserted that it was entitled to a defense from its early excess insurer (Transportation) and that it did not want its subsequent primary insurer (Steadfast) to participate in the defense—apparently because the Steadfast primary policy was subject to a \$25,000 SIR. Transportation as excess insurer declined to defend Padilla on the ground that Padilla still had primary coverage available through Steadfast. Padilla later sued Transportation asserting that Transportation as excess insurer had been obligated to “drop down” and defend Padilla. The trial court ruled in favor of Transportation, holding that Transportation as excess insurer had no duty to defend Padilla because Padilla had other available primary insurance in the form of the primary policy issued by Steadfast.

### Holding

The Court of Appeal affirmed.

The appellate court acknowledged that Padilla's alleged liability in the underlying construction defect action was based on continuous property damage—some of which occurred during earlier years when the Transportation excess policy was in force, and some of which occurred during later years when the Steadfast primary policy was in force. However, Steadfast as primary insurer had a prophylactic duty to defend Padilla in the underlying action against *all* claims, whether covered or uncovered. And, under the terms of Transportation's excess policy,

Transportation had no duty to defend if there was any other available primary coverage, such as the primary policy issued by Steadfast.

Further, according to the appellate court, it made no difference that the Steadfast primary policy was subject to a \$25,000 SIR. Although technically the \$25,000 SIR was not “other insurance” within the meaning of the Transportation excess policy, the appellate court refused to treat the SIR as a period of “non-insurance” sufficient to trigger a defense obligation under the Transportation excess policy. Rather, at least for purposes of defense, Padilla would have to satisfy the \$25,000 SIR *and* Steadfast would have to exhaust its primary policy *before* a defense could be triggered under the Transportation excess policy.

### Comment

The appellate court in this case applied California's “horizontal exhaustion” rule, which requires all primary insurance to be exhausted before an excess insurer must “drop down” to defend an insured. This case indicates that the horizontal exhaustion rule applies even when the underlying primary insurance is subject to an SIR which must be satisfied by the insured.

### *In Continuous Injury Case, Presence of Other Available Insurance Relieves CIGA of Duty to Contribute*

The California Court of Appeal has held that in a “continuous and progressive injury” case, the presence of other available insurance relieved the California Insurance Guarantee Association of any duty to contribute toward a judgment against the insured. (*Stonelight Tile, Inc. v. California Ins. Guar. Ass'n*, 150 Cal.App.4th 19 (2007))

### Facts

Stonelight Tile, Inc. operated a tile manufacturing business. Beginning in 1988, Diversified Recycling Services, Inc. operated a recycling business at an adjacent property. Over the next six years, Diversified's recycling generated significant amounts of dust, which interfered with Stonelight's business operations and caused health problems to Stonelight's personnel.

In July 1994, Stonelight and its president David Anson filed suit against Diversified for nuisance, negligence, battery, trespass to land, and intentional and negligent infliction of emotional distress. Prior to trial, the trial court issued a ruling that restricted Stonelight and

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Anson to proof of events within the applicable statutes of limitations. As a result, Stonelight and Anson were not allowed to offer evidence of (1) nuisance or trespass claims or damages arising before July 1991 or (2) personal injury tort claims or damages arising before July 1993. Following trial, the jury returned a general verdict totaling approximately \$1.2 million in favor of Stonelight and Anson and against Diversified. The judgment was affirmed on appeal.

During the period of time for which damages were awarded (i.e., July 1991 through July 1994), Diversified had general liability coverage through four insurers: Superior National Insurance Company, Transamerica Insurance Company, CIGNA Property and Casualty Company and Continental Insurance Company. The first insurer (Superior National) became insolvent and its claims were taken over by the California Insurance Guarantee Association (CIGA). The remaining three insurers (Transamerica, CIGNA and Continental) all remained solvent.

After the underlying action was concluded, Stonelight and Anson brought a "direct action" action against Diversified's three solvent insurers and CIGA in an effort to collect the underlying judgment. Stonelight and Anson later settled with the three solvent insurers for amounts which neither exhausted the solvent insurers' policies nor completely satisfied the underlying judgment. CIGA then moved for summary judgment asserting that since the three solvent insurers had each been obligated to pay the full amount of the underlying judgment, there was "other insurance" available to satisfy the judgment and, hence, no "covered claim" that CIGA could pay. The trial agreed and granted summary judgment in favor of CIGA.

### Holding

The Court of Appeal affirmed. It reasoned that under California's "continuous injury" trigger of coverage, each insurer that covers a continuing or progressive loss claim has an independent obligation to respond to the loss in full. Thus, each of the three solvent insurers had been obligated to cover the full amount of the underlying judgment. Accordingly, because there was "other insurance" available to satisfy the underlying judgment, the underlying judgment did not qualify as a "covered claim" (see Ins. Code § 1063.1(c)(9), and CIGA was thus prohibited from paying it. Under such circumstances, Stonelight and Anson could not recover the unsatisfied portion of the underlying judgment from CIGA.

### Comment

It appears that Stonelight and Anson as judgment creditors may have settled "too cheaply" when they accepted amounts which were less than the solvent insurers' policy limits and which did not cover the full amount of the underlying judgment. Since the three solvent insurers had in fact been obligated to pay the full amount of the underlying judgment, Stonelight and Anson could not rely on CIGA to make up the difference.

### *Insurer Has No Duty to Defend Wife Against Claims Arising From Husband's Molestation of Granddaughters*

The United States District Court for the Southern District of California has concluded that an insurer did not have any duty to defend a woman against claims arising from her husband's alleged sexual molestation of their granddaughters. (*Miller v. Allstate Ins. Co.*, 489 F.Supp.2d 1133 (2007))

### Facts

David Combs repeatedly molested his young granddaughters, Alison and Cecilia, over the course of their childhood. Mr. Combs' wife, Myriam Combs, allegedly stood by while the molestations occurred, either unaware of the conduct or unwilling to stop it.

Alison and Cecilia repressed memories of the molestation until adulthood. At that point, they filed suit against their grandfather, Mr. Combs, for sexual assault, battery and intentional infliction of emotional distress, and their grandmother, Mrs. Combs, for negligence.

During the years of abuse, Mr. and Mrs. Combs were named insureds on four policies issued by Allstate Insurance Company: a homeowner's policy, a landlord's policy, a personal umbrella policy and an automobile policy. Mrs. Combs tendered defense of the molestation lawsuit to Allstate, but Allstate declined to defend her in the suit. Thereafter, Mrs. Combs entered into a settlement with Alison and Cecilia pursuant to which Mrs. Combs assigned all of her rights against Allstate to Alison and Cecilia.

Alison and Cecilia, armed with the assignment, then filed suit against Allstate for failing to defend their grandmother, Mrs. Combs, in the underlying action. Allstate moved to dismiss, asserting that the granddaughters' claims against Mrs. Combs in the underlying action were not potentially covered under any of the Allstate policies.

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### Holding

The United States District Court in San Diego held that Alison's and Cecilia's claims against their grandmother, Mrs. Combs, were not potentially covered under the Allstate policies and, thus, Allstate had no duty to defend Mrs. Combs in the underlying action.

The court reasoned that the Allstate homeowner's, landlord's and umbrella policies all barred coverage for bodily injury or personal injury arising out of intentional or criminal acts of an insured person. Since Mrs. Combs' alleged liability in the underlying action arose from the intentional acts (i.e., sexual molestation) by another insured person (i.e., Mr. Combs), Mrs. Combs' alleged liability was barred from coverage under the Allstate homeowner's, landlord's and umbrella policies. Thus, Allstate had no duty to defend Mrs. Combs under those three policies.

As for the Allstate auto policy, it only covered Mrs. Combs for liability "arising out of the ownership, maintenance or use" of an insured vehicle. Although it was alleged in the underlying action that Mrs. Combs had negligently entrusted the family car vehicle to Mr. Combs who then used the car as a place to molest his granddaughters, Mrs. Combs' alleged liability could not be said to have "arisen out of" Mr. Combs' use of the car. Rather, according to the court, Mr. Combs' use of the car was a "circumstance accompanying" the sexual molestations, not a "predominant cause of or substantial factor in" causing the granddaughters' injuries.

Because there was no potential for coverage under the policies, the policies did not require Allstate to defend Mrs. Combs in the underlying action brought by her granddaughters.

### Comment

This case is generally consistent with other California cases involving similar policy language. Assuming the policy contains appropriate wording, an insurer will usually have no duty to defend an insured against claims that he or she negligently facilitated another insured's intentional act of sexual molestation.

### ***"Development/Construction" Exclusion Applies Only If Insured - Not Another Party - Engages in Excluded Activity***

The California Court of Appeal has concluded that a liability policy's "development/construction" exclusion applied only if the insured—and not some third party—

engaged in the excluded activity. (**Marquez Knolls Property Owners Ass'n, Inc. v. Executive Risk Indem., Inc.**, 153 Cal.App.4th 228 (2007))

### Facts

Marquez Knolls Property Owners Association, Inc. (Association) is a non-profit corporation whose members own or reside in homes in the Marquez Knolls area of Pacific Palisades, California. One of the Association's main activities is to mediate disputes between its members over the covenants, conditions and restrictions (CC&Rs) to which their properties were subject.

Association members Nicholas and Yasuko Valery remodeled their property. Later, a neighboring homeowner, Joan Robertson, complained that the Valerys' construction obstructed views from Robertson's property, in violation of the CC&Rs.

In response to Robertson's complaint, the Valerys contacted the Association for assistance in resolving the dispute. The Association allegedly told the Valerys that it would provide informal, non-partisan assistance in an effort to help the neighbors settle their differences. In fact, however, the Association allegedly took Robertson's side in the dispute; issued a formal determination stating that the Valerys' replacement structure violated the CC&Rs; and assisted Robertson in prosecuting a lawsuit against the Valerys.

The Valerys subsequently sued the Association for fraud, breach of fiduciary duty and breach of duty to act in good faith. The Association tendered defense of the lawsuit to Executive Risk Indemnity, Inc. (Executive Risk) under a policy which covered the Association for "wrongful acts," defined as "any actual or alleged error, omission, misstatement, misleading statement or breach of duty." However, the policy also contained a "development/construction exclusion" which barred coverage for any wrongful act "based on, arising out of ... or any way involving ... the design, construction, renovation or rehabilitation of any ... structure or other improvement on any real property." Executive Risk, relying on the development/construction exclusion, declined to defend the Association against the Valerys' lawsuit.

The Association then brought a bad faith action against Executive Risk, claiming that Executive Risk had wrongfully failed to defend the Association in the underlying lawsuit filed by the Valerys. The trial court found that the policy's "development/construction exclusion" barred coverage for any potential liability the Association might have in the underlying lawsuit

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filed by the Valerys, and thus ruled that Executive Risk had no duty to defend the Association in the Valerys' lawsuit. The Association appealed.

### Holding

The Court of Appeal reversed, holding that the "development/construction exclusion" did not bar coverage for the Association's alleged liability to the Valerys in the underlying lawsuit. According to the court, when read in context, the development/construction exclusion only barred coverage for liability arising from the insured's "design, construction, renovation or rehabilitation" of a structure, not someone else's "design, construction, renovation or rehabilitation" of a structure. Here, the Valerys' claims against the Association arose not from the Association's construction activities, but rather from the Valerys' construction activities. Thus, the exclusion did not relieve Executive Risk of the duty to defend the Association against the Valerys' lawsuit.

### Comment

Note that the exclusion contained seemingly broad language, i.e., it barred coverage for any wrongful act "based on, arising out of ... or any way involving ... the design, construction, renovation or rehabilitation of any ... structure." However, despite the seemingly broad wording of the exclusion, the court narrowly construed the exclusion to apply only to wrongful acts arising from the insured's construction activities. According to the court, if the exclusion applied to wrongful acts arising from a third party's construction activities, the exclusion would render the policy largely illusory, since the insured's (i.e., the Association's) primary function was to mediate disputes arising from construction activities of third parties (i.e., the Association's members).

### *Policy Issued in Texas But to Be Performed in California Must Be Interpreted Under California Law; Duty to Defend Found*

The California Court of Appeal has held that (1) a general liability policy which was issued to an insured in Texas but which was to be performed in California should be interpreted under the laws of California, and (2) interpreting the policy under California law, the insured was entitled to a defense from the insurer. (*Frontier Oil Corp. v. RLI Ins. Co.*, 63 Cal.Rptr.3d 816 (2007))

### Facts

The predecessor of Frontier Oil Corporation (Frontier) was an oil and gas company based in Texas with some operations in California. Frontier purchased a general liability policy from a Texas insurer, which was later acquired by RLI Insurance Company (RLI).

The policy's main coverage form provided that RLI would indemnify and defend Frontier against suits alleging bodily injury or property damage, but contained an "absolute" pollution exclusion. However, the policy also contained a "pollution liability endorsement" which *deleted* the absolute pollution exclusion and added *indemnity* coverage for damages arising from "sudden and accidental" releases of pollutants, without mentioning whether there was a duty to *defend* suits seeking such damages. The policy included a "Texas Changes" endorsement which made the policy conform to Texas law regarding notice of claims, policy cancellation and policy renewal. The policy also included some endorsements listing various California public entities as "additional insureds" with respect to

Frontier's oil operations in Beverly Hills, California. Between 2003 and 2005, various plaintiffs sued Frontier in California. The plaintiffs alleged that Frontier's oil operations in Beverly Hills had caused "releases, discharges, fugitive emissions, leaks and spills" of toxic chemicals into the environment and that this had resulted in personal injuries and deaths. Frontier tendered these lawsuits to RLI, but RLI declined to defend Frontier.

Frontier then filed a declaratory relief/bad faith action against RLI in California state court. The trial court ruled that Texas law governed the dispute and that, under Texas law, the pollution liability endorsement provided for *indemnity* against sudden and accidental releases of pollutants but did not provide for a *defense* against suits seeking such damages. The trial court thus ruled that RLI had no duty to defend Frontier in the underlying lawsuits. Frontier appealed.

### Holding

The Court of Appeal reversed, holding that RLI was obligated to defend Frontier in the underlying lawsuits.

The Court reasoned that under California Civil Code section 1646, a contract is to be interpreted according to the law of the place it is to be *performed* if the contract "indicate[s] a place of performance," and according to the law of the place it was *made* if the contract "does not indicate a place of

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performance.” The Court then concluded that for purposes of section 1646, a contract “indicate[s] a place of performance” if the contract expressly specifies a place of performance *or if the intended place of performance can be gleaned from the nature of the contract and its surrounding circumstances*. The Court concluded that since California was the location of the risk insured under the policy, California was the state where the parties intended that RLI would be obligated to perform its defense obligations under the policy. Thus, California law—not Texas law—governed interpretation of the policy.

The Court, interpreting the policy under California law, then held that the RLI policy included a duty to *defend* Frontier against suits seeking damages arising from “sudden and accidental” releases of pollutants. The Court reasoned that the policy’s pollution liability endorsement did not clearly and unmistakably exclude pollution claims from the duty to defend stated in the main coverage form, and therefore the pollution liability endorsement did not exclude pollution claims from the contractual duty to defend. Since the plaintiffs in the underlying actions were seeking damages from Frontier as a result “sudden and accidental” releases of pollutants covered by the policy’s pollution liability endorsement, RLI had a duty to defend.

### Comment

This case presented a “choice-of-law” problem, which can arise when a legal dispute has connections with more than one state. In this case, the Court emphasized that California was the location of the risk insured under the policy, and thus California was where the parties understood the insurer would have to perform its defense obligation. The Court held that under these circumstances the policy impliedly “indicate[d] a place of performance,” and therefore pursuant to California Civil Code section 1646 California law should govern issues of policy interpretation.

### ***Auto Exclusions in CGL Policy Covering Special Event Do Not Eliminate Insurer’s Duty to Defend***

The California Court of Appeal has held that an insurer that issued a CGL policy had a duty to defend its insured, a city, against a suit arising out of an auto accident allegedly caused by a dangerous condition resulting from a city-sponsored special event, notwithstanding various auto exclusions in the policy. (***Essex Ins. Co. v. City of Bakersfield***, 154 Cal.App.4th 885 (2007))

### Facts

Essex issued a general liability policy to the City of Bakersfield to cover a special event sponsored by the City. The policy contained an “Auto Exclusion” which provided “This insurance does not apply to ‘bodily injury’ ... arising out of, caused by or contributed to by the ownership, non-ownership, maintenance, use or entrustment to others of any ‘auto’.” The policy also contained a separate exclusion which provided that “The coverage under this policy does not apply to ‘bodily injury’ ... arising out of: ... automobiles ...”

The City held its special event on private property adjacent to a state highway. The operator of a van driving on the highway applied his brakes near a road that served as an exit from the event. The driver of a tractor-trailer that was following behind the van applied his brakes, causing the tractor-trailer to shift into the opposite lane of traffic and collide with an oncoming vehicle. Navarro was injured in the accident.

Navarro sued the driver of the tractor-trailer and the driver’s employer. Navarro also sued the City, alleging that the City’s location of the special event and lack of traffic control created a dangerous condition that contributed to causing the accident. Essex refused to defend the City against Navarro’s lawsuit, and then filed a lawsuit seeking a declaration that Essex had no duty to defend or indemnify the City. Essex argued that the auto exclusions in its policy eliminated coverage for any suit alleging bodily injury involving automobiles.

The trial court agreed with Essex that the auto exclusions applied and ruled that Essex had no duty to defend or indemnify the City.

### Holding

The Court of Appeal reversed and held that Essex had a duty to defend the City. The Court held that Navarro’s lawsuit fell within the scope of coverage under the Essex policy based on allegations that the City created a dangerous condition on public property that caused bodily injury to Navarro. The Court then held that the auto exclusions were not plain enough or clear enough to defeat the City’s reasonable expectations of a defense against Navarro’s lawsuit.

### Comment

According to the Court, the case law addressing auto exclusions involve situations where the automobile involved was owned, maintained, or used by an insured or an insured’s agent or employee. Here, the

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Court partly relied on the fact that the City did not own, operate, maintain, use, entrust to others any of the automobiles involved in the accident. In addition, the Court relied on the fact that the accident did not occur on the premises of the special event the City had sponsored, and on the fact there was no evidence that the drivers or automobiles involved were entering or leaving the insured premises.

### *Insurer Must Defend Insured in Assault and Battery Case Where Insured's Agent Might Have Acted in "Self-Defense"*

The California Court of Appeal has held that a liability insurer had a duty to defend its insured in an assault and battery case where there was evidence that the insured's agent might have acted in "self-defense." (*Jafari v. EMC Ins. Cos.*, 155 Cal.App.4th 885 (2007))

#### **Facts**

Davar Jafari owned a tire and brake shop. Jafari employed Mark Mitchell as manager of the shop. Farhad Nazemzadeh, a customer, came to the shop to pick up his car. When Mitchell, the shop manager, told Nazemzadeh that his car was not ready for pickup, Nazemzadeh allegedly became verbally abusive and threatened to kill Mitchell. Mitchell responded by punching Nazemzadeh in the face. When the police investigated the incident, Mitchell stated that he was "defending himself" against Nazemzadeh.

Nazemzadeh later sued Jafari (the shop owner) and Mitchell (the shop's manager). Nazemzadeh's complaint contained causes of action for assault, battery, negligence, intentional and negligent infliction of emotional distress, premises liability and negligent hiring.

Jafari tendered defense of the lawsuit to Jafari's business liability insurer, EMC Insurance Companies (EMC). However, EMC refused to defend Jafari on the ground that Jafari's alleged liability did not arise from an "accident" as required by the insuring clause of the policy.

Jafari subsequently filed a suit for breach of contract and bad faith against EMC, alleging that EMC had wrongfully failed to defend and indemnify Jafari in the underlying lawsuit. The trial court ruled in favor of EMC, holding that Jafari's alleged liability in the underlying lawsuit did not arise from an "accident" and that EMC thus had no duty to defend Jafari in the lawsuit. Jafari appealed.

#### **Holding**

The Court of Appeal reversed and held that EMC did have a duty to defend Jafari in the underlying lawsuit. The appellate court reasoned that under existing case law, an "accident" can be found "when any aspect in the causal series of events leading to the injury or damage was unintended by the insured and a matter of fortuity." Citing that rule, the appellate court held that "acts in self-defense can be an 'accident' where the third party's actions provoking the self-defense response were the *unforeseen and unexpected element in the causal chain of events* making the insured's acts in self-defense *unplanned and involuntary*." Because there was evidence that Jafari's employee, Mitchell, had acted in self-defense, EMC had a duty to defend Jafari in the underlying lawsuit.

The appellate court also noted that while the EMC policy had an exclusion for bodily injury which was "expected or intended" by the insured, that exclusion contained an *exception* for bodily injury "*resulting from the use of reasonable force to protect persons or property*." According to the appellate court, the exclusion's exception bolstered the conclusion that the term "accident" in the insuring clause should be interpreted to cover "deliberate acts of self-defense in response to unexpected, unforeseen and unintended events by the third party...."

#### **Comment**

The Court of Appeal's decision in *Jafari v. EMC* is similar to the Court of Appeal's recent decision in *Delgado v. Interinsurance Exchange*. In both cases, the Court of Appeal held that an insured's alleged act of self-defense can qualify as an "accident" within the meaning of the insuring clause in a liability policy. Notably, the California Supreme Court granted the insurer's petition for review in *Delgado*, and the insurer in *Jafari* likewise has recently sought review by the Supreme Court.

Until the Supreme Court resolves this issue, insurers should proceed with caution in this area. Specifically, when faced with an alleged assault and battery incident in which the insured claims to have acted in "self-defense," an insurer should broadly interpret the "accident" requirement.

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### *Insurer Who Covers Property Manager as Additional Insured is Entitled to Contribution from Insurer Who Covers Property Manager as Named Insured*

The California Court of Appeal has ruled that a liability insurer whose policy covered a property manager as an additional insured was entitled to equitable contribution from another insurer whose policy covered the property manager as a named insured. (*Edmondson Property Management v. Kwock*, 156 Cal.App.4th 197 (2007))

#### **Facts**

Lin Kwock owned an apartment complex and employed Edmondson Property Management to manage the complex. The management contract between Kwock and Edmondson required Kwock to indemnify Edmondson against claims connected with Edmondson's management of the property, and further required Kwock to obtain liability insurance listing Edmondson as an additional insured.

A seven-year-old girl who resided at the apartment complex was injured when she fell off the roof of a storage shed at the complex. The girl subsequently filed a personal injury action against Kwock as property owner and Edmondson as property manager. There was evidence that prior to the girl's fall, Edmondson knew the girl was playing on the roof and did nothing to stop her.

California Capital Insurance Company had issued a primary general liability policy listing Kwock as the named insured and Edmondson as an additional insured. Farmers Insurance Group had issued a primary general liability policy listing Edmondson as named insured, but containing an "excess" other insurance clause. California Capital defended both Kwock and Edmondson in the personal injury action. California Capital ultimately paid \$550,000 in settlement on behalf of Kwock and Edmondson, with \$50,000 apportioned to Kwock and \$500,000 allocated to Edmondson. Farmers refused to contribute to the settlement, claiming that: (1) Farmers' coverage for Edmondson was "excess" to California Capital's coverage for Edmondson; and (2) in any event, Farmers' named insured, Edmondson, was entitled to express indemnification from California Capital's named insured, Kwock.

California Capital subsequently filed an action against Farmers in order to recover all or a portion of the \$500,000 California Capital had paid on behalf of Edmondson to settle the underlying personal injury

action. The trial court ruled that: (1) the Farmers policy covering Edmondson was not "excess" to the California Capital policy covering Edmondson; (2) Farmers' named insured, Edmondson, was not entitled to express indemnity from California Capital's named insured, Kwock; and (3) Edmondson's \$500,000 share of the underlying settlement should be shared equally by Farmers and California Capital. The trial court thus ruled that California Capital was entitled to recover from Farmers half of the amount for which Edmondson was liable. Farmers appealed.

#### **Holding**

The Court of Appeal affirmed, holding that California Capital was entitled to contribution from Farmers.

The appellate court rejected Farmers' argument that Farmers' coverage for Edmondson was "excess" to California Capital's coverage for Edmondson. The court emphasized that both the Farmers policy and the California Capital policy were written to provide "primary" coverage to Edmondson. Further, while the Farmers policy did contain an "excess" other insurance clause, the "modern trend" is to ignore an "excess" other insurance clause which is inserted into an otherwise primary policy. Thus, Farmers' "excess" other insurance clause did not bar California Capital's contribution claim against Farmers.

The appellate court also rejected Farmers' argument that Farmers' named insured, Edmondson, was entitled to express indemnity from California Capital's named insured, Kwock. According to the court, the indemnity provision in the property management agreement between Kwock and Edmondson was a "Type II" or "general" indemnity provision which only covered Edmondson for "passive" negligence. Further, because Edmondson knew that the child played on the roof of the shed unsupervised and did not act to stop the child, Edmondson's alleged negligence was not merely "passive" but, rather, was "active." Since Edmondson was "actively" negligent, Edmondson was not entitled to contractual indemnification from Kwock.

The appellate court held that under these circumstances, California Capital was entitled to equitable contribution from Farmers for Edmondson's share of the underlying settlement. Further, according to the appellate court, the trial court properly allocated half of that settlement to California Capital and half to Farmers.

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### Comment

The result in this case apparently would have been different if the management agreement between Kwock and Edmondson had given Edmondson "Type I" or "specific" indemnity rights against Kwock. In that scenario, Edmondson would have been entitled to indemnity from Kwock even for Edmondson's own "active" negligence. If in fact Edmondson had been entitled to indemnification from Kwock, then the entire loss would have been the responsibility of Kwock's insurer, California Capital.

### *Sums Paid In Settlement of Pollution Claims Are Not "Damages" Under Excess Policies*

The California Court of Appeal has held that sums an insured agreed to pay in settlement of pollution claims are not "damages" within the meaning of the insured's excess liability policies. (***Aerojet-General Corp. v. Commercial Union Ins. Co.***, 155 Cal.App.4th 132 (2007))

### Facts

In 2000 and 2001, various California water agencies filed lawsuits against Aerojet-General Corporation alleging that Aerojet was responsible for the costs of remediating groundwater contamination in the San Gabriel Valley. Aerojet put its excess insurers on notice of the suits but no excess insurer accepted Aerojet's request for defense and indemnity.

In 2002, the lawsuits were settled and dismissed. The settlement agreement obligated Aerojet to pay approximately \$175 million, which exceeded the total amount of Aerojet's primary and excess insurance coverage for the period of 1958-1970. Aerojet demanded payment pursuant to its policies, but the excess insurers all denied coverage.

Aerojet then sued its excess insurers to obtain indemnification for the remediation costs Aerojet incurred pursuant to the settlement agreement with the water agencies. The court ruled in favor of the excess insurers and Aerojet appealed.

### Holding

The Court of Appeal affirmed. The court reasoned that the excess insurers' policies only covered "damages" that Aerojet became obligated to pay. Under *Certain Underwriters at Lloyd's of London v. Superior Court* (2001) 24 Cal.4th 945 (*Powerine I*), the term "damages" is limited to "money ordered by a court." Here, no court ever ordered Aerojet to pay money to

the water agencies. Rather, Aerojet and the water agencies negotiated a settlement. Because the costs Aerojet incurred in implementing its settlement with the water agencies did not constitute "damages" (i.e., money ordered by a court), those costs were not covered by the excess insurers' policies.

Moreover, the excess policies contained "attachment of liability" clauses which provided that the excess policies would attach only when the primary insurers admitted liability or a final judgment was entered against the insured. Neither of those events ever occurred.

Last, the excess insurers were not equitably estopped from relying on the terms of their policies. The excess insurers never led Aerojet to believe that it could settle with the water agencies and expect coverage from the excess insurers. To the contrary, the excess insurers all reserved their rights to contest coverage. Thus, there were no grounds for an estoppel.

### Comment

This is the latest California case to address the circumstances in which a liability insurer might - or might not - have a duty to indemnify an insured for the costs of remediating environmental pollution claims. The excess policies in this case were very old and thus presumably did not contain "pollution" exclusions. As a result, the excess insurers were left to argue that coverage was barred by other provisions in the policies (e.g., the "damages" clause and the "attachment of liability" clause).

### *Pollution Exclusion Bars Coverage for Insured's Liability for Odors and Dust Emanating from Compost Facility*

The California Court of Appeal has held that a pollution exclusion relieved an insurer of any duty to defend or indemnify an insured against claims for injuries caused by offensive odors and excessive dust emanating from the insured's compost facility. (***Cold Creek Compost, Inc. v. State Farm Fire and Cas. Co.*** 156 Cal.App.4th 1469 (2007))

### Facts

Cold Creek Compost, Inc. (Cold Creek) operated a facility that composted organic materials including animal waste, grape pomace and yard trimmings. Plaintiffs, a group of individuals living within two miles of Cold Creek's facility, filed an action for nuisance against Cold Creek, seeking both damages and injunctive relief. Plaintiffs alleged that Cold Creek had

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imported and stored on its property huge quantities of animal waste, grape pomace and yard trimmings, and that the composting materials caused noxious odors and excessive dust which injured the plaintiffs.

Cold Creek tendered defense of the action to its business liability insurer, State Farm Fire and Casualty Company (State Farm). The State Farm policies covered an insured's liability for "bodily injury," "property damage" and "personal injury," but excluded coverage for liability "arising out of the actual, alleged or threatened discharge, seepage, migration, dispersal, spill, release or escape of 'pollutants'." The policies defined "pollutants" as "any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste. Waste included material to be recycled, reconditioned or reclaimed." In response to the tender, State Farm agreed to defend Cold Creek under a reservation of rights.

The plaintiffs proceeded to trial against Cold Creek. Following trial, the jury awarded five of the plaintiffs a total of \$125,000 for injuries caused by the odors and dust. At that point, State Farm concluded that plaintiffs' claims against Cold Creek were barred from coverage by the policies' "pollution" exclusions. State Farm thus withdrew from Cold Creek's further defense and refused to indemnify Cold Creek for the damages awarded to the plaintiffs.

Cold Creek later filed an action against State Farm for breach of contract and bad faith, alleging that State Farm had wrongfully failed to defend and indemnify Cold Creek in the underlying action brought by the plaintiffs. The trial court ruled in favor of State Farm, finding that policies' pollution exclusions barred coverage for any liability Cold Creek might have to plaintiffs in the underlying action. Cold Creek appealed.

### Holding

The Court of Appeal affirmed. According to the appellate court, to the extent the plaintiffs suffered bodily injury arising from noxious odors and excessive dust emanating from Cold Creek's compost facility, the odors and dust would be considered "pollutants" within the meaning of the pollution exclusions in the State Farm policies. Because the pollution exclusions clearly and unambiguously barred coverage for any liability Cold Creek might have had to the plaintiffs in the underlying action, State Farm had no duty to defend or indemnify Cold Creek in that action. Thus, State Farm could not be liable to Cold Creek for either breach of contract or bad faith.

### Comment

In California, a pollution exclusion only bars coverage for injuries arising from "traditional environmental pollution" into the air, water and soil, and does not bar coverage for injuries arising from the "negligent use or handling of toxic substances that occur in the normal course of business." (See *MacKinnon v. Truck Ins. Exchange* (2003) 31 Cal.4th 635.) In this case, the appellate court concluded that the insured's alleged widespread dissemination of offensive odors and excessive dust from its compost facility was "traditional environmental pollution" under *MacKinnon*, and thus excluded from coverage by the pollution exclusion in the policies.

## DIRECTORS AND OFFICERS INSURANCE

### *D&O Policy Does Not Cover Insured's Breach of Contract*

The California Court of Appeal has held that an insurer that issued a Directors and Officers liability policy had no duty to pay for a loss arising out of an insured's failure to make payment under a contract. (***August Entertainment, Inc. v. Philadelphia Indem. Ins. Co.***, 146 Cal.App.4th 565 (2007))

### Facts

Philadelphia Indemnity Insurance Company issued a Directors and Officers (D&O) policy to InternetStudios.com, Inc. The policy provided that Philadelphia Indemnity would pay for "loss" caused by a "wrongful act" of an insured, based on a claim made within the policy period. The D&O policy defined "wrongful act" as any "actual or alleged error, misstatement, misleading statement, act, omission, neglect or breach of duty committed by an Insured, individually or otherwise, in his or her capacity as a director or officer."

During the policy period, August Entertainment, Inc. filed a suit alleging that InternetStudios and MacLean (one of InternetStudios' officers) had contracted to purchase film rights from August for \$2 million, but then failed to make payment. After Philadelphia Indemnity denied coverage for the suit, InternetStudios and MacLean assigned to August all rights under the policy and entered into a stipulated judgment. August then sued Philadelphia Indemnity for breach of contract and bad faith.

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In its complaint, August alleged that the stipulated judgment was covered because the loss resulted from a “wrongful act” by MacLean, who mistakenly signed the contract without stating he was an agent for InternetStudios. The trial court disagreed and dismissed the case on demurrer, ruling that the complaint improperly attempted to force an insurer to pay for a corporate breach of contract.

### Holding

The Court of Appeal affirmed the trial court ruling in favor of the insurer. Despite MacLean’s alleged mistake in failing to disclose his status as agent of InternetStudios, there was no question the corporation *voluntarily* accepted the \$2 million contract debt. The insureds’ failure to pay the contract price was not a loss caused by a “wrongful act,” since the policy definition of that term did not include “breach of contract.”

While the D&O policy also contained a breach of contract exclusion, the court held that the presence of that exclusion did not serve to broaden the scope of liability coverage provided under the policy. The Court also cited public policy reasons for its ruling, noting that allowing liability coverage in this instance would encourage corporations to breach their contractual obligations.

### Comment

This case confirms that liability insurers are not guarantors for the contractual obligations of their insureds. However, that the labels attached to a plaintiff’s causes of action are not dispositive. Depending on the facts in some cases an insurer may have a duty to defend and indemnify a cause of action entitled “breach of contract.” (*Vandenberg v. Superior Court* 21 Cal.4th 815 (1999)). Hence, to determine its coverage obligation, a carrier must carefully evaluate the facts relating to a liability claim together with the provisions of its policy.

## BAD FAITH

### *“Genuine Dispute” Defense Continues to Gain Momentum in First-Party Bad Faith Cases*

The “genuine dispute” defense continues to gain momentum in first-party bad faith cases. A recent case, *Laura Rappaport-Scott v. Interinsurance Exch. of the Automobile Club*, 146 Cal.App.4th 831

(2007), illustrates the practical application of the defense.

Laura Rappaport-Scott sustained injuries in a rear-end automobile accident caused by a third-party. The third party’s liability insurer paid its coverage limit of \$25,000.

Rappaport-Scott then made a claim to her own insurer, Interinsurance Exchange of the Automobile Club, which had issued a policy with medical payments coverage limits of \$5,000 and UM/UIM coverage limits of \$100,000.

Rappaport-Scott contended she had sustained damages in excess of \$346,000 (which included about \$46,000 for past and future medical expenses, \$150,000 for lost income and \$150,000 for pain and suffering). She made a settlement demand on Interinsurance Exchange in the amount of \$75,000 (which was the difference between the third party’s liability limit of \$25,000 and Interinsurance Exchange’s UM/UIM limit of \$100,000).

Interinsurance Exchange paid its \$5,000 medical payments coverage limits. However, Interinsurance Exchange otherwise disputed the extent of Rappaport-Scott’s damages and offered her \$7,000 against the policy’s UM/UIM coverage limits.

Ultimately, Rappaport-Scott demanded UM/UIM arbitration. The arbitrator found that Rappaport-Scott had sustained damages totaling \$63,000. This amount was then reduced by \$30,000 (i.e., \$25,000 for the amount the third party’s insurer paid and \$5,000 for the amount Interinsurance Exchange paid under its medical payment coverage). Thus, the net arbitration award to Rappaport-Scott was \$33,000.

After Interinsurance Exchange paid the \$33,000 due under the arbitration award, Rappaport-Scott sued for bad faith, alleging that Interinsurance Exchange had refused to negotiate with her in good faith and had caused an unreasonable delay in concluding her UM/UIM claim. She also alleged that the difference between the amount offered by Interinsurance Exchange (\$7,000) and the net arbitration award (\$33,000) was evidence that Interinsurance Exchange had acted in bad faith. On these facts, the trial court ruled Rappaport-Scott could not state a cause of action for bad faith.

The Court of Appeal affirmed. The Court determined that, despite the disparity between the \$7,000 Interinsurance Exchange offered and the \$33,000 ultimately paid on the policy, the “vast difference” between the \$346,000 in damages Rappaport-Scott

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claimed and the \$63,000 in damages determined by the arbitrator demonstrated, as a matter of law, that a “genuine dispute” existed as to the amount payable on the claim. Thus, the Court determined that Rappaport-Scott could not maintain a cause of action for breach of the implied covenant based on an unreasonable delay in the payment of policy benefits.

### *Inadequate Investigation of Fungus/Collapse Claim Exposes Insurer to Bad Faith Liability*

The California Court of Appeal has held that an insurer’s alleged inadequate investigation of a first-party fungus/collapse claim exposed the insurer to possible bad faith liability, and that the evidence of bad faith was sufficient to create a triable issue of fact. (*Jordan v. Allstate Ins. Co.*, 148 Cal.App.4th 1062 (2007))

#### **Facts**

Mary Ann Jordan purchased a homeowner’s policy from Allstate Insurance Company. The policy provided “all-risk” coverage subject to certain exclusions. Among other things, the policy excluded coverage for loss caused by or consisting of (1) “wet or dry rot” or (2) “collapse.” However, the “collapse” exclusion was subject to an exception that provided coverage for “the entire collapse of a covered building structure” and “the entire collapse of a part of a covered building structure,” if caused by various perils, including “hidden decay of the building structure.”

Jordan discovered that a window had fallen out of the wall of her living room and that the floorboards in the corner of the living room were “giving way.” She hired an expert, who concluded that the damage was caused by a fungus known as *poria incrassata*. Jordan submitted a claim, which Allstate denied based on the exclusion for “wet or dry rot.” Jordan then sued Allstate for breach of contract and bad faith, but the trial court entered summary judgment in favor of Allstate.

On Jordan’s first appeal, the Court of Appeal concluded that, although Allstate’s interpretation of the policy was reasonable, the “wet or dry rot” exclusion and the additional coverage for “collapse” caused by “hidden decay” were contradictory and confusing, thus creating an ambiguity. Thus, the Court of Appeal concluded that Jordan could demonstrate the existence of coverage for her loss if she could establish the occurrence of an “entire” (meaning “actual,” not “imminent”) collapse.

Upon return of the case to the trial court, Allstate moved for summary adjudication of Jordan’s cause of

action for bad faith, arguing that since the Court of Appeal already had concluded that Allstate’s interpretation of its policy was *reasonable* (even though erroneous), Allstate had not acted in bad faith as a matter of law. The trial court was persuaded by that argument and granted Allstate’s motion.

#### **Holding**

On Jordan’s second appeal, the Court of Appeal held that although Allstate’s *interpretation* of the policy was reasonable as a matter of law, there were numerous questions of fact regarding whether Allstate’s *investigation* of Jordan’s claim was adequate. For example, Jordan submitted evidence of the following: (1) Allstate made no attempt to interview Jordan or her expert; (2) Allstate did not hire a structural engineer until long after Jordan filed suit, even though some of Allstate’s own experts previously had recommended that Allstate hire an engineer; (3) Allstate allowed its claim adjusters to determine if a collapse had occurred, despite the fact that the adjusters had no credentials or background in structural engineering; (4) Allstate’s adjusters recognized that the collapse coverage applied where there was “hidden decay,” but never made any attempt to inspect the inner walls or sub flooring of Jordan’s house.

#### **Comment**

This case reinforces the principle that, in order to rely upon the “genuine dispute” doctrine to defeat a claim for bad faith, the insurer first must establish that it conducted a reasonable investigation of the claim. In addition, this case reinforces the principle that even after an insured files suit, the insurer has a continuing obligation of good faith, which includes a continuing duty to investigate the insured’s claim.

### *Insured Can Recover Attorney Fees Incurred Because of Insurer’s Unsuccessful Appeal*

In *Brandt v. Superior Court* (1985) 37 Cal.3d 813, the California Supreme Court held that when an insured establishes an insurer acted in bad faith, the insured may recover attorney fees incurred to recover the contractual benefits the insurer wrongfully withheld. These fees typically are known as “*Brandt* fees.” Significantly, *Brandt* fees may *only* be awarded for attorney fees incurred to recover *contractual* benefits the insurer has wrongfully withheld, and may *not* be awarded for attorney fees incurred to recover *extra-contractual* damages (such as consequential economic loss, emotional distress and punitive damages).

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In a very recent case, *Baron v. Fire Ins. Exch.*, 154 Cal.App.4th 1184 (2007), Baron obtained a judgment against Fire Insurance Exchange following a jury trial. The award included \$93,000 for breach of contract, \$3,000 for fraud, \$1,500,000 for punitive damages and \$480,000 for *Brandt* fees. Fire Insurance Exchange appealed, but the Court of Appeal affirmed the entire judgment. The Court of Appeal also held that, pursuant to *Brandt*, Baron was entitled to recover certain attorney fees he incurred in defending against Fire Insurance Exchange's unsuccessful appeal.

The Court of Appeal held that attorney fees an insured incurs to defend a judgment against the insurer's appeal are a "logical extension" of the *Brandt* fees incurred in pursuing the recovery in the trial court. More specifically, the Court held as follows: "The collection of the benefits due is not complete when the insurer resists the judgment by challenging the judgment on appeal. Thus, to the extent that appellate attorney fees reflect the continuation of services performed to obtain the rejected payment of policy benefits, they should be recoverable under the rationale of *Brandt*."

## RESCISSION

### *Rescission Is Proper Where Applications Mischaracterize Nature of Claims Against Insured*

A recent ruling (*U.S. Specialty Ins. Co. v. Bridge Capital Corp.*, 482 F.Supp.2d 1164 (2007)) illustrates that even where an insured discloses prior claims when applying for coverage, the insurer may rescind the policy if the insured mischaracterizes the nature of the prior claims.

Bridge Capital Corporation applied to U.S. Specialty Insurance Company for a directors and officers policy. The application requested disclosure of any claims made against Bridge Capital or any of its officers and directors in the past five years. Bridge disclosed one gender discrimination suit in response to the question, and stated that Bridge's attorney believed the claim was "frivolous." The next year, when Bridge applied for a renewal of the policy, Bridge identified the same suit listed on the initial application, plus another suit for gender discrimination claim as well as a suit for unpaid commissions.

After issuing the renewal policy, and while defending Bridge in suit brought by a third party, U.S. Specialty learned for the first time that the three suits Bridge had disclosed on the applications also included allegations

of wrongful termination, sexual harassment and retaliation. In addition, after issuing the renewal policy, U.S. Specialty learned of a fourth claim for harassment that Bridge had settled without litigation.

Upon learning of this information, U.S. Specialty asserted it was rescinding both policies. U.S. Specialty then filed an action for declaratory relief, seeking a determination that the rescission was proper, the policies were void and that U.S. Specialty had no obligation to defend Bridge against the third party's suit.

The federal district court granted summary judgment in favor of U.S. Specialty. The evidence established that Bridge's chief executive had personal knowledge of each prior claim, and that he had signed the two insurance applications. The evidence also established that U.S. Specialty relied on Bridge's misrepresentations and omissions when U.S. Specialty issued the policies, and that U.S. Specialty would not have issued the policies if Bridge had disclosed the prior allegations of sexual harassment. Under the circumstances, U.S. Specialty's rescission was proper, the policies were void from inception and the rescission applied to Bridge and all of its officers and directors.

### *Misrepresentations on Application Allow Liability Insurer to Rescind Policy and Obtain Reimbursement of Defense/Settlement Costs*

The California Court of Appeal has held that an insured's misrepresentations on an application for insurance allowed a liability insurer to rescind the policy and obtain reimbursement of defense/settlement costs the insurer had paid on behalf of the insured prior to the rescission. (*LA Sound USA, Inc. v. St. Paul Fire & Marine Ins. Co.*, 156 Cal.App.4th 1259 (2007))

## Facts

LA Sound USA, Inc. (LA Sound) and its directors, Anle Hsu and David Ji, entered into a written joint venture agreement with Hollywood Sound, Inc. (Hollywood Sound) to produce, market and sell audio equipment. The joint venturers used another entity, LSY Trading Development, Inc. (LSY), to begin consolidating their businesses.

Several months after the joint venture was formed, an LA Sound employee contacted an insurance broker about renewing an expiring policy issued by St. Paul Fire & Marine Insurance Company (St. Paul). Based on information supplied by LA Sound, the broker

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completed the application and submitted it to St. Paul. The application asked “Has applicant been active in or is currently active in joint ventures?” and “Is there a labor interchange with any other business or subsidiaries?” Both questions were answered “No.” Based on the information in the application, St. Paul issued a \$1 million general liability policy covering LA Sound as named insured and its directors and officers as additional insureds.

Sometime later, disputes arose amongst the joint venturers. As a result, Hollywood Sound sued LA Sound, Hsu, Ji and LSY for trademark infringement. LA Sound, Hsu, Ji and LSY tendered defense of the trademark infringement action to St. Paul. St. Paul agreed to provide a defense under reservation of rights to LA Sound, Hsu and Ji, but denied coverage as to LSY. Thereafter, St. Paul paid a portion of the defense costs incurred by LA Sound, Hsu and Ji.

Eventually, the trademark infringement action was partially settled. Pursuant to the partial settlement, St. Paul paid \$1 million on behalf of LA Sound, Hsu and Ji to Hollywood Sound, and Hollywood Sound dismissed its claims against LA Sound and its claims against Hsu and Ji in their capacities as officers and directors of LA Sound. However, Hollywood Sound did not dismiss its claims against Hsu and Ji in their individual capacities, and did not dismiss its claims against LSY. After further litigation, Hsu, Ji and LSY paid an additional \$2.85 million to Hollywood Sound to settle Hollywood Sound’s remaining claims.

Following conclusion of the underlying trademark infringement action, LA Sound, Hsu, Ji and LSY filed a bad faith action against St. Paul, seeking to recover defense costs St. Paul had not paid in the underlying action as well as the \$2.85 million which Hsu, Ji and LSY had paid to settle the remaining claims of Hollywood Sound. St. Paul cross-complained, alleging that LA Sound had made misrepresentations on the application, and that as a result St. Paul was entitled to rescind the policy and obtain reimbursement of the defense and settlement costs it had paid on behalf of LA Sound, Hsu and Ji.

The trial court ruled that LA Sound had made material misrepresentations on the application justifying rescission of the policy, and that St. Paul was thus entitled to recover all of the defense and settlement costs it had paid on behalf of LA Sound, Hsu and Ji in the underlying action. The trial court further held that LA Sound, Hsu and Ji were jointly and severally liable for the entire amount of reimbursement. LA Sound, Hsu, Ji and LSY appealed.

### **Holding**

The Court of Appeal affirmed the finding that LA Sound had made material misrepresentations on the application, and that St. Paul was thus entitled to rescind the policy. The appellate court emphasized that the application specifically asked whether LA Sound was involved in joint ventures, that LA Sound had misrepresented its involvement in a joint venture, and that LA Sound had then demanded that St. Paul defend LA Sound against trademark claims related to the joint venture. LA Sound’s misrepresentations, whether intentional or unintentional, were sufficient to give St. Paul a right to rescind. Further, because St. Paul had a right to rescind the policy, St. Paul was entitled to reimbursement of all defense and settlement costs it had paid on behalf of LA Sound, Hsu and Ji.

However, the Court of Appeal reversed the finding that LA Sound, Hsu and Ji were jointly and severally liable for the entire amount of reimbursement. According to the appellate court, although St. Paul was entitled to recover the policy benefits it conferred on LA Sound, Hsu and Ji, St. Paul still had to establish the amount of benefits conferred separately on each insured. In other words, St. Paul bore the burden of allocating its defense and indemnity costs separately amongst LA Sound, Hsu and Ji. The appellate court thus remanded the case to the trial court to make findings as to the amount owed by LA Sound, Hsu and Ji as restitution of the benefits received by each under the rescinded policy.

### **Comment**

An insured’s material misrepresentations on an application—whether intentional or unintentional—will give the insurer the right to rescind the policy and to obtain reimbursement of all policy benefits the insurer paid on behalf of the insured prior to the rescission. However, as this case makes clear, where the insurer has paid policy benefits on behalf of more than one insured, the insurer must prove what portion of the benefits are allocable to each insured, and the insurer can only recover from each insured the benefits allocable to that particular insured.

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### AUTOMOBILE AND UM / UIM INSURANCE

#### *Two Insurers Must Share UM/UIM Loss on Pro Rata Basis*

The Appellate Division has held that where two insurers provide UM/UIM coverage arising out of a loss, the insurers are obligated to share the loss on a pro rata basis, even though one policy specifically describes the vehicle in which the insured was riding. (*State Farm Mut. Auto. Ins. Co. v. Progressive Marathon Ins. Co.*, 148 Cal.App.4th Supp. 1 (2007))

#### Facts

An uninsured motorist injured Julie Deam, who was a passenger in a Volkswagen Jetta that a third party owned. Progressive Marathon Insurance Company insured the Jetta pursuant to a policy that provided passengers like Deam with UM/UIM coverage limits of \$15,000/\$30,000.

At the time of the accident, Deam was a resident of her parents' household and therefore qualified as an "insured" on a policy State Farm Mutual Automobile Insurance Company had issued to Deam's parents. State Farm's policy had UM/UIM coverage limits of \$25,000/\$50,000.

The two insurers agreed to settle Deam's UM claim for \$9,800. Progressive paid \$3,626 and State Farm paid \$6,174, representing each insurer's pro rata share of the settlement amount based on policy limits. At the time of the settlement, State Farm reserved the right to seek reimbursement from Progressive.

After the settlement, State Farm filed a complaint against Progressive for equitable contribution and indemnity. In its complaint, State Farm asserted that Progressive's UM coverage was "primary," that Progressive should have borne the entire loss and that Progressive was obligated to reimburse State Farm for the amount State Farm paid on Deam's claim. The trial court ruled in favor of Progressive, holding that Progressive and State Farm were liable for a pro rata share of the settlement amount based on their respective policy limits.

#### Holding

The Appellate Division of the Superior Court affirmed. According to the Court, resolution of the dispute turned, in part, on the interpretation of Insurance Code section 11580.9 (d), which provides that "where two or more policies affording valid and collectible *liability*

insurance *apply to* the same motor vehicle ... in an occurrence out of which a *liability loss* shall arise, it shall be conclusively presumed that the insurance afforded by that policy in which the motor vehicle is described or rated as an owned automobile shall be primary and the insurance afforded by any other policy or policies shall be excess." After an exhaustive review of various statutes, the Court held that the term "liability" insurance does include uninsured motorist coverage. However, the Court held that although the Progressive policy clearly did "apply" to the Jetta, the State Farm policy did not "apply" to the Jetta. Thus, since both policies did not "apply" to the Jetta, section 11580.9 (d) did not make Progressive's policy primary.

The Court then noted that Insurance Code section 11580.2 (d) -- which specifically governs UM/UIM coverage -- states that "the policy...may provide that if the insured has insurance available to the insured under more than one uninsured motorist coverage provision, any damages shall not be deemed to exceed the higher of the applicable limits of the respective coverages, and *the damages shall be prorated between the applicable coverages as the limits of each coverage bear to the total of the limits.*"

Here, each policy contained a pro rata "other insurance" clause, and each insurer paid a pro rata amount based on limits. Thus, State Farm was not entitled to reimbursement of the portion paid toward the settlement.

#### Comment

This is a case of first impression in California. The Court ultimately concluded that in light of the specific language of section 11580.2 (d) and the language of the policies themselves, the UM loss should be prorated between the insurers based on their respective policy limits.

#### *No UM Benefits Due When Vehicle Owner and Operator are Covered by Personal Umbrella Policy*

The California Court of Appeal has held that a vehicle is not "uninsured" where a personal umbrella policy provides bodily injury liability coverage to the owner and operator of an otherwise uninsured motor vehicle. (*California Capital Ins. Co. v. Nielsen*, 153 Cal.App.4th 1221 (2007))

#### Facts

Carla Brown owned a vehicle which she loaned to her son, Bryan Jones. Jones drove the vehicle while intoxicated and with a suspended license. When

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Jones lost control of the vehicle and crashed into a pole, Douglas Nielsen, a passenger, was thrown from the car and rendered a quadriplegic.

At the time of the accident, the vehicle was not covered by any auto liability insurance policy. However, Brown had a \$1 million personal liability umbrella policy with State Farm which provided coverage for both Jones and Brown. State Farm paid Nielsen \$1 million in settlement of Nielsen's action against Jones and Brown.

At the time of the accident, Nielsen's father had an auto liability policy issued by California Capital Insurance Company (CCIC). The CCIC policy provided uninsured motorist coverage of \$100,000 to family members, and defined an "uninsured motor vehicle" as one "[t]o which no bodily injury liability bond or policy applies at the time of the accident." Nielsen made a claim CCIC. However, CCIC declined to provide uninsured motorist benefits to Nielsen, asserting that the vehicle Jones owned and Brown operated was not an "uninsured motor vehicle" in light of the State Farm personal liability umbrella policy. CCIC filed then a declaratory relief action against Nielsen. The trial court ruled that the vehicle that Jones owned and Brown operated was not an "uninsured motor vehicle," and Nielsen appealed.

### Holding

The Court of Appeal affirmed, holding that where alleged tortfeasors have bodily injury liability insurance applicable to cover their liabilities pursuant to a personal umbrella policy, a vehicle is not an "uninsured motor vehicle" and an injured person is not entitled to uninsured motorist benefits. CCIC's policy defined an "uninsured motor vehicle" as one "[t]o which no bodily injury liability bond or policy applies at the time of the accident," and this definition was substantially similar to the definition of "uninsured motor vehicle" contained in Insurance Code section 11580.2 (b).

### Comment

This case illustrates that when a person injured in an automobile accident recovers against an owner's or operator's liability policy—even if the policy is not an auto liability policy—the involved vehicle cannot be considered an "uninsured motor vehicle."

### *Auto Insurer Has No Duty to Defend Shuttle Company in Suit Arising from Employee's Sexual Assault of Passenger*

The California Court of Appeal has held that a business auto insurer had no duty to defend its insured, a shuttle company, against a personal injury lawsuit arising from an employee's sexual assault of a passenger. (*R.A. Stuchbery & Others Syndicate 1096. v. Redland Ins. Co.*, 154 Cal.App.4th 796 (2007))

### Facts

M&M Luxury Shuttle, Inc. (M&M) was a shuttle service operator. One of M&M's drivers picked up a 16-year-old runaway girl who wanted a ride to a teen shelter. M&M's driver agreed to drive the girl to the shelter, but instead of taking her there, took her to his apartment. M&M's driver then convinced the girl to go inside his apartment, where he raped her.

The victim later filed a lawsuit against M&M and the M&M driver who perpetrated the attack, alleging claims for common carrier liability, negligent hiring, sexual battery, etc. M&M tendered the lawsuit to its commercial general liability insurer, R.A. Stuchbery & Others Syndicate 1096 as Underwriters at Lloyd's (Stuchbery), which agreed to defend M&M under reservation of rights. M&M also tendered defense of the lawsuit to its business auto insurer, Redland Insurance Company (Redland), but Redland denied coverage.

Stuchbery paid approximately \$525,000 in defending and indemnifying M&M in the victim's lawsuit. Following resolution of that lawsuit, Stuchbery filed a coverage action against Redland, alleging that Redland was either solely or partially responsible for the costs of defending and indemnifying M&M. The trial court ruled that the claims against M&M in the underlying lawsuit were not potentially covered under the Redland auto policy, and that Redland thus had no duty to pay any portion of the costs of defending and indemnifying M&M. Stuchbery appealed.

### Holding

The Court of Appeal affirmed. The Redland auto policy only covered damages M&M owed because of bodily injury "resulting from the ... use" of an M&M shuttle. Here, M&M's driver had used the shuttle to transport the victim to the apartment where the rape took place. However, under California's "predominating cause/substantial factor" test, the mere use of a vehicle as transportation to the scene of the injury

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does not establish a sufficient causal connection between the “use” of the vehicle and the injury. Thus, the victim’s claims against M&M in the underlying lawsuit did not trigger any potential for coverage under the Redland auto policy.

Further, M&M’s status as a common carrier did not warrant a different result. The court agreed that but for the fact that M&M was a common carrier, M&M would not have had any relationship at all with the victim and, hence, M&M’s driver would not have been in a position to injure the victim. However, the court noted that M&M’s driver had not attacked the victim inside the shuttle, but rather, had attacked her in his apartment after she had voluntarily exited the shuttle. The court concluded that under such circumstances, the causal connection between the use of the M&M shuttle and the rape inside the apartment was simply “too attenuated” to trigger Redland’s duty to defend or indemnify.

### Comment

Under California law, an auto liability policy is not triggered unless the vehicle is a “predominating cause” or “substantial factor” in the victim’s injury. Causation cannot be proved simply by establishing that the vehicle played some role in the chain of events leading to the injury. According to the California courts, a contrary rule would allow auto policies to be converted into general liability policies.

### *Where Two UM Policies Have Different Limits, Pro-Rata Provision in One Policy Controls Over Excess Provision in Other Policy*

The California Court of Appeal has held that, where two uninsured motorist policies have different limits, a pro-rata provision in one policy will control over an excess provision in the other policy. (*Allstate Ins. Co. v. Mercury Ins. Co.*, 154 Cal.App.4th 1253 (2007))

### Facts

Meyan Mendoza was a passenger in an automobile driven by Ivanrey Capistrano. An uninsured motorist struck the vehicle and Mendoza was injured in the accident.

Mendoza made a UM claim under Capistrano’s auto policy through Mercury Insurance Company. The Mercury policy provided UM coverage of \$30,000 and included a “pro-rata” coverage provision. Mendoza also made a UM claim under her own auto policy through Allstate Insurance Company. The

Allstate policy provided UM coverage of \$250,000 and included an “excess” coverage provision.

Allstate filed a declaratory relief action seeking a judicial determination that its policy was excess to the Mercury policy. The trial court ruled in favor of Mercury, holding that the two policies had to contribute to Mendoza’s claim on a pro-rata basis. Allstate appealed.

### Holding

The Court of Appeal affirmed. It reasoned that Insurance Code section 11580.2(d) permits an uninsured motorist policy to require pro-ration if an insured has UM insurance available under more than one policy. While a policy is not required to include a pro-rata provision, if the policy does so, it must be given effect. Here, since Mercury’s policy contained a pro-rata provision, it prevailed over Allstate’s excess provision.

### Comment

This case illustrates that courts will give effect to an uninsured motorist policy which follows the statutory pro-rata provision, even where another applicable uninsured motorist policy includes an excess provision.

### *Primary Auto Insurer Entitled to Contribution from Excess Auto Insurer for Defense Fees Pursuant to Insurance Code Section 11580.9(g)*

The California Court of Appeal has ruled that a primary auto insurer was entitled to contribution from an excess auto insurer for defense fees the primary insurer paid to defend a mutual insured, pursuant to Insurance Code Section 11580.9(g). (*Mercury Cas. Co. v. Scottsdale Indem. Co.*, 156 Cal.App.4th 1212 (2007))

### Facts

Mercury and Scottsdale each issued personal automobile policies to the same insured. Mercury’s policy was primary and Scottsdale’s policy was excess. Scottsdale’s policy contained a provision stating that it had no duty to defend a suit unless “no other insurer has an obligation to do so.”

The insured was involved in an auto accident with a third party, who filed suit against the insured. Mercury defended the insured and paid its policy limits toward a settlement of the case. Scottsdale funded the remaining portion of the settlement.

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Mercury then sued Scottsdale to obtain contribution for defense fees, pursuant to Insurance Code Section 11580.9(g). That statute states that “Where two or more personal policies affording ... liability insurance apply to the same motor vehicle in an occurrence out of which a loss shall arise, and one policy ... is primary ... and one [is] excess ... each insurer shall pay ... the percentage of the total defense costs equal to the amount of damage paid by that insurer as a percentage of total damages paid by all insurers ....”

The trial court granted summary judgment to Mercury based on the terms of the statute, and Scottsdale appealed.

### **Holding**

The Court of Appeal affirmed, holding that Mercury was entitled to contribution based on the terms of the statute. The Court also stated that the purpose of the statute is to spread the burden of defense costs in auto liability lawsuits and to encourage excess auto liability insurers to involve themselves in settlement discussions at an earlier time. The Court rejected Scottsdale’s argument that Insurance Code Section 11580.9(g) is unconstitutional, and held that the trial court properly denied Scottsdale’s request to continue hearing of the motion to allow discovery pertaining to that issue.

### **Comment**

The Insurance Code governs allocation and “order of coverage” issues in automobile liability insurance and will take priority over contrary terms in auto insurance policies. Further, in light of the purpose of Section 11580.9(g), excess auto liability carriers would be wise to become involved early in evaluating high-damage auto liability claims and perhaps offer settlement funds with the primary carrier prior to the claimant’s filing of a suit and, if necessary, negotiate a defense-fee sharing agreement with the primary auto carrier in those cases that have gone to lawsuit.

Section 11580.9(b) formerly provided that where two or more insurance policies applied to the same loss and one policy afforded coverage to a named insured “engaged in the business of renting or leasing motor vehicles without operators,” it was conclusively presumed that such policy would be “excess” to any other valid and collectible insurance policies. At least one California appellate court interpreted the language “engaged in the business of renting or leasing vehicles” to require something more than a single or occasional lease. In response to such court rulings, the California Legislature has now amended section 11580.9(b).

The amended section provides that where two or more insurance policies apply to the same loss and one policy affords coverage to a named insured “who in the course of his or her business rents or leases motor vehicles without operators,” it is conclusively presumed that such policy shall be excess to the other valid and collectible insurance policies. This change became effective January 1, 2007.

The Legislature has also added a new section to the statute. That new section—11580.9(h)—provides that when two or more insurance policies apply to the same loss and one policy affords coverage to a person engaged in the business of a “trucker,” that policy shall be primary for both the power unit and the trailer or trailers, and the insurance afforded by the other policies shall be excess. This new section is intended to clarify the priorities between insurers following truck accidents in which the power unit is insured by one insurer and the trailer is insured by another. This amendment also became effective January 1, 2007.

## **INSURANCE LEGISLATION AND REGULATIONS**

### ***Auto Insurance***

California Insurance Code section 11580.9 sets forth a series of rules that are intended to govern the priorities of multiple insurers covering the same insured allegedly responsible for a motor vehicle accident.