2015 ANNUAL REVIEW OF CALIFORNIA INSURANCE LAW

SMITH SMITH & FEELEY LLP

INSURANCE LAWYERS

1401 Dove Street, Suite 610
Newport Beach, California 92660
949.263.5920
www.insurlaw.com

SMITH SMITH & FEELEY LLP
INSURANCE LAWYERS

2015 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 from December 2014 through November 2015 that will impact your California claims next year.

Best wishes for the coming year.

SMITH SMITH & FEELEY LLP

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

We closely monitor the courts and the legislature for changes in insurance laws, and report on them in the Insurance Law Alert, our free electronic newsletter. To receive your copy by email, visit our subscribepage.

SMITH SMITH & FEELEY LLP
1401 Dove Street, Suite 610
Newport Beach, CA 92660
Tel: 949.263.5920
Fax: 949.263.5925

PENDING BEFORE THE CALIFORNIA SUPREME COURT

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

Association of California Ins. Companies v. Jones (Case No. S226529) - (1) Does the Unfair Insurance Practices Act (Ins. Code, § 790, et seq.) give the Insurance Commissioner authority to promulgate a regulation that sets forth requirements for communicating replacement value and states that noncompliance with the regulation constitutes a misleading statement, and therefore an unfair trade practice for purposes of the act? (2) Does the Insurance Commissioner have the statutory authority to promulgate a regulation specifying that the communication of a replacement cost estimate that omits one or more of the components in subdivisions (a) (e) of section 2695.183 of title 10 of the California Code of Regulations is a "misleading" statement with respect to the business of insurance?

Gradillas v. Lincoln General Ins. Co. (Case No. S227632) - For purposes of coverage under an automobile insurance policy, what is the proper test for determining whether an injury arises out of the "use" of a vehicle?

Nickerson v. Stonebridge Life Ins. Co. (Case No. S213873) - Is an award of attorney fees under *Brandt v. Superior Court* (1985) 37 Cal.3d 813 properly included as compensatory damages where the fees are awarded by the jury, but excluded from compensatory damages when they are awarded by the trial court after the jury has rendered its verdict?

PROPERTY INSURANCE

LIABILITY INSURANCE

BAD FAITH

MISCELLANEOUS

PROPERTY INSURANCE

Where Insurer's Failure to Pay Property Claim Prevents Insured From Making Repairs, Insured is Entitled to "Conditional" Award of Replacement Cost, But Ultimately Must Still Complete Repairs in Order to Recover Replacement Cost Benefits

Where an insurer's failure to pay a property claim prevents the insured from making repairs, the insured is entitled to a "conditional" award of replacement cost, but the insured ultimately must still complete repairs in order to qualify for replacement cost benefits. (*Stephens & Stephens XII, LLC v. Fireman's Fund Insurance Company* (2014) 231 Cal.App.4th 1131)

Facts

Stephens & Stephens XII, LLC (Stephens XII) owned a building and purchased a property insurance policy from Fireman's Fund Insurance Company (Fireman's Fund). While the policy was in force, Stephens XII discovered that burglars had damaged the building by stripping electrical wiring, plumbing pipes and other components from the building.

Stephens XII sought reimbursement for the damage from Fireman's Fund, but Fireman's Fund delayed resolving the claim for a period of years. Stephens XII then filed suit. Fireman's Fund ultimately denied coverage, but not until one month before trial. At the time trial started, Stephens XII still had not repaired the damage.

The policy provided two different measures for payment of covered damages. The first measure was the actual cash value of the damaged portions of the building (i.e., replacement cost less depreciation). The second measure was the full cost of repairing or replacing the damaged property *if* repairs were actually made "as soon as reasonably possible" after the loss or damage.

During trial, Stephens XII presented no evidence of the actual cash value of the damaged property and, in fact, expressly disclaimed any intent to seek recovery under this measure. Nevertheless, the jury awarded Stephens XII the full cost of repairing or replacing the property. The trial court granted Fireman's Fund judgment notwithstanding the verdict, finding that the award was not permitted under the policy.

Holding

The Court of Appeal reversed. The Court concluded that Stephens XII was not entitled to an immediate award for the costs of repairing the damage, but that Stephens XII was entitled to a conditional judgment awarding these costs if the repairs are actually made. The Court concluded that Fireman's Fund's delayed resolution and ultimate denial of the claim materially hindered Stephens XII's ability to repair or even make plans for the property. As a result, Stephens XII was excused from the requirement that the damage be repaired "as soon as reasonably possible after the loss or damage."

When Stephens XII expressly disclaimed recovery of actual cost value damages, it waived an award based on this measure. However, Stephens XII nonetheless remained entitled to a judgment awarding replacement cost consistent with the repair requirement if Stephen XII actually completed the repairs "as soon as reasonably possible" after the judgment becomes final.

Comment

Courts in some jurisdictions have excused the insured from repairing damaged property when the insurer failed to pay the claim or otherwise hindered repairs. However, courts in other

jurisdictions have concluded that an insurer's failure to pay a claim excuses the insured from complying with the policy's *procedural* requirements, such as time restrictions, but do not entirely excuse the insured from the underlying obligation to repair the property. These courts have held that the insured was entitled to a judgment requiring the insurer to pay actual cost value immediately and to pay replacement costs conditionally on the insured's completion of repairs promptly from the date of the judgment. In effect, these courts have granted specific performance of the insurance policy, requiring the insurer to make good on its contractual obligation to pay full replacement cost only upon the insured's satisfaction of the condition precedent of repairing the property.

Transient's "Warming" Fire That Became Uncontrolled Is Not "Vandalism" For Purposes of "Vacancy" Exclusion

Where a transient started a fire on the floor of a house in an apparent effort to keep warm but then lost control of the fire, the fire was not an act of "vandalism" for purposes of a "vacancy" exclusion. (*Ong v. Fire Insurance Exchange* (2015) 235 Cal.App.4th 901)

Facts

Hung Van Ong (Ong) owned a rental dwelling property. The tenants moved out, and the gas and electric utilities were turned off. About twenty months later, a fire destroyed the property.

Ong submitted a claim to his insurer, Fire Insurance Exchange (FIE). As part of its investigation, FIE retained an investigator to determine the origin and cause of the fire. In a written report, FIE's investigator concluded the fire originated on the floor of the kitchen, and likely was a "warming" fire that became uncontrolled and spread. Similarly, FIE's claim adjuster's log notes indicated that it was likely a transient had started a "warming fire [that] got out of hand."

The policy provided "all risk" (sometimes called "open peril") coverage for the dwelling. However, the policy excluded coverage for damage to the dwelling caused by "Vandalism or Malicious Mischief … if the dwelling has been vacant for more than 30 consecutive days just before the loss." The policy did not define "Vandalism" or "Malicious Mischief."

FIE denied coverage for Ong's claim. In its denial letter, FIE stated as follows: "Our investigation indicates that this loss was the result of vandalism. A trespasser entered the vacant dwelling and intentionally set a fire.…"

Ong sued FIE for breach of contract and bad faith, and FIE moved for summary adjudication on the grounds that the vacancy exclusion barred coverage. The trial court granted FIE's motion, stating that "[t]he unauthorized person or persons who intentionally set the fire … certainly created an obvious hazard to the dwelling without justification, excuse or mitigating circumstances." The trial court also agreed with FIE's assertion that the "malice in law" concept (sometimes used in criminal arson cases) established the requisite intent to damage the property. Ong appealed.

Holding

The Court of Appeal reversed. Although someone intentionally set the fire, there was a triable issue of fact as to whether the fire was a "warming" fire that became uncontrolled, or whether the fire was intended to be an act of destruction. Based on dictionary definitions, the ordinary and popular meaning of "vandalism" is the willful destruction of property or the destruction of property with a desire to cause harm. This commonly-understood meaning of "vandalism" is very different from the "malice in law" concept that arises when intentional conduct gives rise to unintended damage. (For example, under the "malice in law" concept, a person who throws a firecracker onto a dry hillside

and starts a brushfire can be guilty of the crime of arson, even though the person did not intend to start a fire.) Because there was a triable issue of fact as to whether the fire was intended to be an act of destruction, the appellate court remanded the case to the trial court for further proceedings.

Comment

The vacancy exclusion in FIE's policy was limited to "vandalism" and "malicious mischief." This required FIE to prove that the person(s) who started the fire *intended* to damage the building. The appellate court noted that FIE could have drafted the vacancy exclusion to extend to fire, which would have eliminated the need to prove intent to damage the property. In this regard, Insurance Code section 2071 (California's standard form fire insurance policy) allows insurers to exclude coverage for fire after a building has been "vacant or unoccupied" for more than 60 consecutive days.

This was not a unanimous opinion. One of the justices on the appellate panel dissented, arguing that because the fire started on the kitchen floor, there was sufficient evidence that the transient intended to deface the property, even if the fire ultimately grew to unintended proportion.

Appraisers of Building Fire Damage Not Required to Assign Loss Values to Items That Are Undamaged or Demonstrably Never Existed

A court may not require appraisers to assign loss values to items that are undamaged or that demonstrably never existed. (*Lee v. California Capital Insurance Company* (2015) 237 Cal.App.4th 1154)

Facts

Li-Lin Sung Lee owned an apartment building with four units on each of three levels (for a total of twelve units). A fire started in one of the first-floor units. At the time of the fire, California Capital Insurance Company insured Lee's interest in the building.

Lee retained a public adjuster to assist in the presentation of her claim. The public adjuster asserted that all the interior rooms of six of the twelve apartment units needed to be completely dismantled and then replaced. In addition, the public adjuster asserted that a portion of the building's stucco exterior needed to be removed and replaced. Further, the repair estimate the public adjuster submitted included windows that, according to California Capital, did not even exist.

Because of their dispute about the scope of the damage, Lee and California Capital could not agree on the cost of repairs. Therefore, Lee obtained a court order compelling appraisal. Each party selected an appraiser and, after the two appraisers could not agree on an umpire, the court appointed an umpire.

Eventually, the court ordered the three-member appraisal panel to determine the amount of loss to items that both Lee and California Capital agreed had fire damage *and* to additional (disputed) items that Lee asserted had fire damage. The court expressly directed the panel not to make any causation or coverage determinations, and further stated that the parties could resolve in separate litigation issues such as "whether an appraised item was covered by the policy, whether the item was damaged, and whether the item was damaged by the fire."

Ultimately, the appraisal panel issued an award attached to which were two exhibits. "Exhibit A" (based on California Capital's scope of loss) listed a replacement cost figure of $190,505.21 and an actual cash value figure of $186,041.74. "Exhibit B" (based on Lee's scope of loss) listed a

replacement cost loss figure of $813,884.89 and an actual cash value figure of $788,057.02. The award specifically stated that it did not address "whether the items claimed existed" or "whether items claimed were in fact damaged/destroyed by the fire."

Over California Capital's objection, the trial court confirmed the appraisal panel's award. The award specifically stated that it did not address "whether the items claimed existed" or "whether items claimed were in fact damaged/destroyed by the fire." California Capital appealed.

Holding

The Court of Appeal reversed the judgment confirming the appraisal award. The Court held that, where the appraisal panel is able to assess a damaged item without simply having to rely on the insured's representations about the item, the appraisal panel has authority to determine whether the claimed item existed and whether the claimed item was in fact damaged. The Court further held that, irrespective of what an insured might assert about an item, if the panel determines the item has no damage of any kind, the panel has authority to state on the face of the award that item has no damage.

The Court also held that, if there is a factual dispute about whether a claimed item ever existed and the panel cannot independently assess the item (e.g., because the item allegedly was stolen or allegedly was completely consumed by fire), the panel *cannot* determine the item did (or did not) exist. However, the panel *can* determine a value for such an item based on the insured's description, although the insurer remains free to contest coverage for the item in a separate forum (e.g., litigation).

Comment

This is an important case for several reasons. First, this case dispels the notion that the parties need to agree on the scope of damage before either one can compel appraisal. Second, this case reinforces the principle that, although appraisers cannot determine coverage issues (such as the *cause* of damage), appraisers can determine that specific items have no damage from *any* cause. Third, this case reinforces the principle (set forth in *Safeco Ins. Co. v. Sharma* (1984) 160 Cal.App.3d 1060) that, if a claimed item is not available for the appraisal panel's inspection (e.g., because the insured claims the item was stolen or burned out of sight), the appraisal panel must render an award based on the insured's description of the item – even though the insurer remains free to contest coverage at the conclusion of the appraisal process. Fourth, this case illustrates the importance of requiring the appraisal panel to issue a detailed, itemized award, especially if there are issues regarding the cause of damage or scope of repairs.

The *Lee* court specifically noted that, in order to avoid disputes about whether a panel exceeded its authority by assigning a value of zero to certain claimed items of loss, the better practice is to explain in the award why nothing was awarded. In other words, instead of simply placing a "zero" next to certain items of loss (thus leaving open to debate whether the panel based its decision upon an improper coverage determination), the panel could indicate "undamaged" next to a particular item, or it could clarify in notes accompanying the award that items assigned a loss value of zero were not damaged or did not exist at the property.

Property Insurer Had No Obligation to Reimburse Mitigation Expenses in Absence of Otherwise Covered Loss

A property insurer had no express or implied obligation to reimburse an insured for emergency mitigation expenses in the absence of an otherwise covered loss. (*Grebow v. Mercury Insurance Company* (2015) 241 Cal.App.4th 564)

Facts

Arthur and Helen Grebow owned a house with an attached rear deck that extended over a patio. Because of evidence of water damage to the deck, the Grebows asked a general contractor and structural engineer to inspect the deck. The contractor and engineer discovered severe decay and corrosion in various steel beams, which, with steel poles, supported the deck and other parts of the house. The decay and corrosion previously had been hidden by the deck floor and patio ceiling.

Both the contractor and engineer concluded the beams and poles no longer could support the upper portion of the house, and that a large portion of the house was in danger of falling. The Grebows then arranged for installation of temporary shoring and arranged for completion of permanent repairs.

The Grebows submitted a claim for reimbursement to their insurer, Mercury Insurance Company (Mercury). The Mercury policy contained standard exclusions for corrosion, rust and deterioration. The policy also contained a standard provision that extended coverage for "collapse" caused by various risks, including "hidden decay."

The policy defined "collapse" as the "sudden and complete breaking down or falling in or crumbling into pieces or into a heap of rubble or into a flattened mass." The policy also stated that collapse did not include "a substantial impairment of the structural integrity of a structure or building, nor a condition of imminent danger of collapse of a structure or building." In addition, the policy contained a mitigation condition that provided that, "[i]n case of a loss to which this insurance may apply, [an insured must] protect the property from further damage."

Mercury denied coverage for the claim on the grounds that there had been no "collapse" within the meaning of the policy, and that the policy otherwise excluded the causes of damage (i.e., rust, corrosion and deterioration). Mercury also denied coverage for the costs of the temporary shoring and other mitigation measures the Grebows had undertaken to prevent further damage. The Grebows filed suit for breach of contract and bad faith, but the trial court granted summary judgment in favor of Mercury.

Holding

The Court of Appeal upheld the trial court's finding that there was no "collapse" within the meaning of the policy, which covered only *actual* collapse, not *imminent* collapse. Because there was no coverage for the damage, there was no coverage for the cost of the emergency mitigation measures the insureds undertook to prevent an actual collapse from occurring.

Although the policy provided the insureds had a duty to mitigate in case of a "loss to which this insurance may apply," the Court of Appeal held that this express duty to mitigate – and the insurer's duty to reimburse for mitigation expenses – arises only after a *covered* loss occurs. The Court further found there was no implied-in-law requirement that Mercury reimburse the Grebows for such mitigation expenses.

Comment

In this case, the insureds apparently prevented an actual collapse from occurring because they arranged for installation of temporary shoring. However, the Court ruled that the insurer had neither an express nor implied obligation to reimburse the insureds for their mitigation expenses, since no covered loss (i.e., no actual collapse) had ever occurred. The Court noted that requiring an insurer to reimburse an insured for mitigation expenses in the absence of an otherwise covered loss would essentially convert a property policy into a maintenance contract.

The Court's holding that no actual "collapse" occurred is consistent with various prior California appellate decisions regarding this issue. Very briefly, if a policy does *not* specifically require a "collapse" to be a "complete" or "actual" falling

down, then an "imminent" (i.e., impending) collapse is sufficient to trigger coverage. (*Doheny West Homeowners' Assn. v. American Guarantee & Liability Ins. Co.* (1997) 60 Cal.App.4th 400.) However, if a policy *does* specifically require a "collapse" to be a "complete" or "actual" falling down, then an "imminent" collapse is not sufficient. (*Rosen v. State Farm General Ins. Co.* (2003) 30 Cal.4th 1070; *Jordan v. Allstate Ins. Co.* (2004) 116 Cal.App.4th 1206.)

LIABILITY INSURANCE

Underinsured Motorist Benefits May Be Reduced Not Only By Recovery From Negligent Driver's Insurer, But Also By Recovery From Another Alleged Tortfeasor

As authorized by statute, underinsured motorist benefits may be reduced not only by the amount recovered from the negligent driver's insurer, but also by the amount recovered from another alleged tortfeasor. (*Elliott v. Geico Indemnity Co.* (2014) 231 Cal.App.4th 789)

Facts

Christina Elliott's husband was killed when his motorcycle was struck by a vehicle driven by a drunk driver, Lesa Shaffer. At the time of the accident, Shaffer was returning home from her job at a bar known as Peterson's Corner, where she had been drinking. In a subsequent wrongful death action, Elliott recovered a total of $265,000, consisting of $15,000 from Shaffer's auto insurer and $250,000 from Peterson's Corner's general liability insurer.

Following resolution of the wrongful death action, Elliott sought recovery under the underinsured motorist section of her own auto policy issued by Geico Indemnity Company. According to Elliott, because Elliott's UIM coverage through Geico had limits of $100,000, and because Elliott had only recovered $15,000 from Shaffer's insurer, Elliott was entitled to recover the $85,000 difference from Geico. Geico denied Elliott's UIM claim on the ground that Elliott's total recovery in the wrongful death action was $265,000, and Geico's policy allowed Geico to deduct from the UIM coverage limits "the amount paid to the insured by or for *any person or organization that may be held legally liable for the injury*."

Elliott sued Geico for breach of contract and bad faith. The trial court ruled in favor of Geico, finding that Geico's UIM benefits could be reduced not only by the amount recovered from the insurer of the negligent driver (Shaffer), but also by the amount recovered from the other alleged tortfeasor (Peterson's Corner). Elliott appealed.

Holding

The Court of Appeal affirmed. The appellate court emphasized that the language of Geico's UIM coverage mirrored the language of Insurance Code section 11580.2 (p)(4). That statute provides that "the maximum liability of the insurer providing the underinsured motorist coverage shall not exceed the insured's underinsured motorist coverage limits, less the amount paid to the insured by or for *any person or organization that may be held legally liable for the injury*." According to the court, this provision allows UIM benefits to be reduced not only by the amount recovered from the negligent driver's insurer, but also by the amount recovered from another alleged tortfeasor. Thus, Geico's maximum liability was the UIM coverage limits ($100,000) *less* amounts paid by Shaffer's insurer ($15,000) *and* amounts paid by Peterson's Corner's insurer ($250,000). Since $265,000 is more than $100,000, Elliott was not entitled to any payment from Geico.

Elliott argued that an "explanatory document" she received with the policy created an inconsistency which entitled her to coverage. The explanatory document stated among other things that Geico's UIM coverage would pay "the difference between your [UIM] limits and the *at-fault driver's* bodily injury limits." Relying on this language, Elliott

maintained that Geico could deduct only the $15,000 recovered from "at fault" driver, Shaffer, not the $250,000 recovered from the other alleged tortfeasor, Peterson's Corner. The appellate court rejected Elliott's argument, reasoning that the explanatory document was not part of the Geico policy. Because the explanatory was not part of the policy, it could not be used to create an ambiguity which did not exist on the face of the policy itself.

Comment

Generally speaking, cases involving UM or UIM coverage will depend on whether the policy language is consistent with, or differs from, the language used in the statute. In this case, the offset claimed was expressly provided for by statute, and was clearly spelled out in the policy. As such, the appellate court held that the offset was valid.

"Prior Publication" Exclusion Relieves Insurer of Duty to Defend Insured Against Trademark Infringement Suit

A "prior publication" exclusion relieved a general liability insurer of any duty to defend an insured in a suit alleging trademark infringement, because the insured published at least one advertisement using the claimant's advertising idea before the policy period, and the insured's subsequent advertisements were substantially similar. (*Street Surfing, LLC v. Great American E & S Ins. Co.* (9th Cir. 2014) 776 F.3d 603)

Facts

Around December 2004, Street Surfing, LLC began selling a skateboard called the "Wave." In August 2005, Street Surfing applied for commercial general liability coverage with Great American E&S Insurance Company. In its application for insurance, Street Surfing represented that "all [of its] products display the Street Surfing Logo." Great American approved Street Surfing's application and provided general liability insurance to Street Surfing from August 2005 until September 2007.

Rhyn Noll owned the registered trademark "Streetsurfer." In June 2008, Noll sued Street Surfing for trademark infringement, unfair competition and unfair trade practices. In his complaint, Noll alleged that Street Surfing used Noll's advertising idea in Street Surfing's advertisements "since at least on or about January of 2005, or such other date as may later be determined." Relying on various policy provisions, Great American denied Street Surfing's tender.

In July 2011, Street Surfing filed a federal court declaratory relief action against Great American, seeking a determination that Great American was obligated to defend and indemnify Street Surfing in the underlying action brought by Noll. Great American moved for summary judgment based on the policy's "prior publication" exclusion, which barred coverage for personal and advertising injury "arising out of oral or written publication of material whose first publication took place before the beginning of the policy period." The district court concluded that the Great American policy's "prior publication" exclusion relieved Great American of any duty to defend Street Surfing against Noll's lawsuit. Street Surfing appealed.

Holding

The Ninth Court of Appeals, applying California law, affirmed. The appellate court noted that the straightforward purpose of the "prior publication" exclusion is to "bar coverage when the wrongful behavior began prior to the effective date of the insurance policy."

Here, Noll had alleged in the underlying action that Street Surfing used Noll's advertising idea in advertisements "since at least on or about January of 2005, *or such other date as may later be determined*." According to the appellate court, those allegations left open the possibility that Street Surfing's conduct actually started *after*

inception of the Great American policy in August 2005.

Nevertheless, the appellate court held that the undisputed extrinsic evidence conclusively showed that Street Surfing published at least one advertisement using Noll's advertising idea *before* the Great American policy began in August 2005. Specifically, the court noted that in Street Surfing's insurance application, submitted before the policy period, Street Surfing represented that "all [of its] products display the Street Surfing Logo." Because Street Surfing's logo advertisement predated the Great American policy period, the prior publication exclusion applied to any injuries arising from affixing the logo on the Wave skateboard during the policy period. The advertisements Street Surfing published during the policy period fell within the scope of the prior publication exclusion because they were "substantially similar" to the advertisements Street Surfing had published before the policy period.

In short, the prior publication exclusion relieved Great American of any duty to defend because Street Surfing's post-coverage publications were part of a single, continuing wrong that began before Great American's policy went into effect.

Comment

This case basically involved an insured who began engaging in wrongful conduct, obtained insurance coverage, continued its course of conduct, got sued for the conduct, and then sought defense and indemnification for the conduct from its insurer. Even giving the insurer's "prior publication" exclusion a narrow construction, the exclusion defeated coverage in these circumstances.

Although Homeowners Insurer Has No Duty to Defend Insured Against "Personal Injury" Claims Arising From Sexual Assault Committed By Others, Personal Umbrella Insurer Does Have Such Duty

Although a homeowners insurer had no duty to defend an insured against various "personal injury" claims arising from an alleged sexual assault committed by others, a personal umbrella insurer did have a duty to defend the insured against such claims. (*Gonzalez v. Fire Insurance Exchange* (2015) 234 Cal.App.4th 1220)

Facts

Jessica Gonzalez filed a civil lawsuit against Stephen Rebagliati and nine other members of the De Anza College baseball team. In her complaint, Gonzalez alleged the following:

Gonzalez, age 17 attended a party held by Rebagliati and other members of the De Anza College baseball team. During the party, Gonzalez consumed alcohol, passed out, and was then sexually assaulted by an unknown number of men as she lay unconscious in a room. Rebagliati and several other named defendants were inside the room where Gonzalez was assaulted. Some of the men in the room took photographs and cheered while the assault took place. Three women who witnessed the assault attempted to help Gonzalez but were prevented by men inside the room. Following the assault, Rebagliati and other defendants told third parties that Gonzalez had consented to the assault.

The above factual allegations supported causes of action for negligence for inviting Gonzalez to the party, negligence for serving her alcohol, negligence for failing to rescue her from the assault, false imprisonment, invasion of privacy, slander per se, battery, sexual battery, rape,

unlawful intercourse, forcible acts, oral copulation, and conspiracy. Most of the causes of action were pleaded as to Rebagliati "and/or" each of the other named defendants.

At the time of the alleged events Rebagliati was insured under a homeowners policy issued by Fire Insurance Exchange (Fire). The Fire homeowners policy provided that Fire would indemnify and defend Rebagliati against claims of "bodily injury, property damage or *personal injury* resulting from an *occurrence* to which this coverage applies…." The policy defined "personal injury" so as to include "false imprisonment," "invasion of privacy" and "slander," and defined "occurrence" as an "accident."

Rebagliati was also insured under a personal umbrella policy issued by Truck Insurance Exchange (Truck). The Truck umbrella policy provided that Fire would indemnify (and if there was no other insurance, defend) Rebagliati against claims resulting from an "occurrence" and not otherwise excluded. The umbrella policy defined an "occurrence" as either (a) "an accident that results in bodily injury or property damage" *or* (b) the commission of various "personal injury" offenses, including "false imprisonment," "invasion of privacy" and "slander."

Rebagliati tendered the defense of the lawsuit to both Fire and Truck. Although Rebagliati denied any wrongdoing, both Fire and Truck refused to provide Rebagliati with a defense.

Following the insurers' refusal to defend, Gonzalez entered into a settlement with Rebagliati. Pursuant to the settlement, Gonzalez obtained a monetary judgment against Rebagliati, and an assignment of any rights Rebagliati might have against Fire and Truck.

Gonzalez as assignee of Rebagliati then filed a bad faith action against Fire and Truck. The trial court ruled that neither Fire nor Truck had a duty to defend Rebagliati in the underlying lawsuit brought by Gonzalez, and the trial court thus granted summary judgment to Fire and Truck. Gonzalez appealed.

Holding

The California Court of Appeal affirmed as to Fire (the homeowners insurer), but reversed as to Truck (the personal umbrella insurer).

The appellate court reasoned that the Fire homeowners policy covered various "personal injury" offenses (e.g., false imprisonment, invasion of privacy and slander), but only if caused by an "occurrence" (i.e., an accident). Here, however, none of Rebagliati's alleged conduct was an "accident." Rebagliati's alleged acts of confining Gonzalez to the room where she was assaulted, taking photos of her during the assault, telling others that she consented to the assault, etc., were all deliberate, intentional acts for which coverage was not available. Because Rebagliati's alleged conduct was not covered by the insuring agreement of the Fire homeowners policy, there was no need to analyze whether any exclusions applied.

However, the appellate court reached a different conclusion as to the Truck personal umbrella policy. Unlike the Fire homeowners policy, the Truck umbrella policy covered the "personal injury" offenses of false imprisonment, invasion of privacy and slander *without* any requirement of an "occurrence," or accident. Thus, Gonzalez's claims against Rebagliati *were* covered by the insuring clause of the Truck umbrella policy.

Moreover, none of the exclusions in the Truck umbrella policy conclusively eliminated the potential for coverage. For example, although the Truck umbrella policy excluded coverage for damages arising out molestation by an "insured," Gonzalez's complaint in the underlying action suggested the possibility that Rebagliati might "be held liable for damages resulting from his alleged slander, false imprisonment, or invasion of Gonzalez's privacy arising from molestation *undertaken by the other named defendants* in the

civil lawsuit." Similarly, although the umbrella policy excluded coverage for damages that are "either expected or intended from the standpoint of an insured," Truck had not met its burden of showing that Rebagliati subjectively expected or intended to harm Gonzalez. Because Truck "failed to conclusively demonstrate its policy exclusions eliminated all potential for coverage," Truck had a duty to defend Rebagliati against Gonzalez's underlying lawsuit.

Comment

The Fire homeowners policy was somewhat unusual in that it covered various "personal injury" offenses only if resulting from an "accident." Standard liability policies covering "personal injury" offenses do *not require* an "accident."

On the other, hand, the Truck personal umbrella policy contained the more traditional formulation of "personal injury" coverage that was not dependent on an "accident." Because some of Gonzalez's claims against Rebagliati fell within the scope of the insuring agreement of the Truck umbrella policy, and because Truck did not conclusively establish that all of Gonzalez's claims against Rebagliati were excluded, Truck had a duty to defend Rebagliati under the personal umbrella policy.

Insurer's Alleged Right to Equitable Offset Does Not Affect Amount of Damages Suffered *By Insured, Only Amount of Damages That Can Be* Recovered *By Insured*

A non-defending insurer's alleged right to equitably offset settlement amounts paid by other non-defending insurers does not affect the amount of damages *suffered* by the insured, only the amount of damages that can be *recovered* by the insured at trial. (*McMillin Companies, LLC v. American Safety Indemnity Co.* (2015) 233 Cal.App.4th 518)

Facts

McMillin Construction Services, L.P. (McMillin) served as the general contractor for a residential development in Temecula, California. Later, 117 homeowners from the development filed a construction defect lawsuit against McMillin. In response, McMillin sought defense and indemnity from its subcontractors' commercial general liability insurers, arguing that it qualified as an additional insured on the subcontractors' policies. However, the insurers denied coverage and McMillin thus defended itself in the construction defect action.

McMillin subsequently filed suit against the insurers alleging that their failure to defend constituted a breach of contract and a breach of the implied covenant of good faith and fair dealing. McMillin eventually settled with all of the insurers except one, American Safety Indemnity Company (ASIC). The settlements amounted to $690,154, of which $274,154 was allocated to defense expenses and $416,000 was unallocated. McMillin claimed that even with the settlements, it still had $309,957 in unreimbursed defense expenses.

In advance of trial, the parties filed motions in limine that addressed, among other issues, the admissibility of McMillin's prior settlements. Specifically, ASIC argued that because McMillin had recovered more in settlement proceeds than it had incurred in defense fees in the underlying action, McMillin could no longer prove an essential element of its cause of action for breach of contract – namely, damages. ASIC further argued that because McMillin could not recover for breach of contract, McMillin could not recover for breach of the implied covenant of good faith and fair dealing.

The trial court granted ASIC's motion in limine and, based on the effect of that ruling, entered judgment in ASIC's favor. McMillin appealed.

Holding

The Court of Appeal reversed. With respect to the offset issue, the court held that the parties had

demonstrated a "basic misunderstanding" of equitable offsets. The court clarified that an equitable offset does not affect the amount of damages *suffered*, but rather affects the amount of damages that can be *recovered* at trial. Thus, the court held that ASIC's right to an equitable offset did not impact whether McMillin suffered damages as a result of ASIC's alleged breach of contract and bad faith. Based on the foregoing, the court held that ASIC's right to an offset did not defeat McMillin's right to proceed to trial on its breach of contract and bad faith causes of action.

Comment

McMillin makes clear that an insurer may utilize an equitable offset to reduce or eliminate the amount of damages awarded to an insured at trial in an action for breach of contract and bad faith. However, the insurer cannot use an equitable offset as a complete defense to the action itself because an equitable offset does not affect whether the insured suffered damages in the first place.

The *McMillin* court distinguished the earlier case of *Emerald Bay Community Assn. v. Golden Eagle Ins. Corp.* (2005) 130 Cal.App.4th 107. According to the court, there is a difference between a situation where other insurers provide the insured with a complete defense and thus the insured suffers no damage at all (i.e., *Emerald Bay*), and a situation where the insured is without a complete defense and thus suffers damage, but then, following litigation, recovers payments from other insurers which arguably compensate the insured (i.e., *McMillin*).

General Liability Policy's "Intellectual Property" Exclusion Bars Coverage for Insured's Alleged Misappropriation of Claimant's Name

A commercial general liability policy's "intellectual property" exclusion relieved the insurer of any duty to defend or indemnify its insured against a suit alleging commercial misappropriation of the claimant's name. (*Alterra Excess and Surplus Insurance Company v. Snyder* (2015) 234 Cal.App.4th 1390)

Facts

R. Buckminster "Bucky" Fuller (Fuller) was an architectural engineer and inventor who was known for popularizing the geodesic dome. After Fuller died in 1983, Fuller's estate became the successor-in-interest to all of Fuller's rights. Fuller's estate subsequently entered into licensing agreements with various businesses pursuant to which the businesses paid to use Fuller's nickname "Bucky" in their marketing activities.

Maxfield & Oberton Holdings, LLC (Maxfield) manufactured and sold desktoys which were "inspired by" Fuller and which were known as known as "Buckyballs" and "Buckycubes." However, Maxfield used the "Bucky" name without ever entering into any licensing agreement with Fuller's estate. Thus, Fuller's estate filed a lawsuit against Maxfield alleging claims for (1) unfair competition in violation of 15 United States Code section 1125(a) (Lanham Act), (2) invasion of privacy (appropriation of name and likeness), (3) unauthorized use of name and likeness in violation of California Civil Code section 3344.1, and (4) violation of California Business and Professions Code section 17200 et seq.

Maxfield tendered the lawsuit to its general liability insurer, Alterra Excess and Surplus Insurance Company (Alterra). In response, Alterra agreed to

defend Maxfield under a reservation of rights. Among other things, Alterra reserved the right to deny coverage based on the policy's "intellectual property" exclusion, which barred coverage for personal and advertising injury "arising out of the infringement of copyright, patent, trademark, trade secret or other intellectual property rights."

Alterra then filed a declaratory relief action against both Maxfield and Fuller's estate. Maxfield did not contest the declaratory relief action, but Fuller's estate did. Eventually, the trial court ruled that the Alterra policy's "intellectual property" exclusion barred coverage for Maxfield's alleged liability to Fuller's estate in the underlying action. Fuller's estate appealed.

Holding

The California Court of Appeal affirmed the judgment in favor of Alterra. According to the appellate court, Alterra's "intellectual property" exclusion was "conspicuously" placed in the policy and "plainly and clearly" barred coverage for Maxfield's alleged liability to Fuller's estate in the underlying action. The court emphasized that all of the claims Fuller's asserted against Maxfield were based on allegations that Maxfield infringed on "rights of publicity" belonging to Fuller's estate. According to the court, any such right of publicity was an "intellectual property right." Thus, all of the claims Fuller's estate asserted against Maxfield fell within Alterra's exclusion for claims arising out of "infringement of copyright, patent, trademark, trade secret *or other intellectual property rights*." There was no potential for coverage, and hence no duty to defend.

Comment

Alterra case is consistent with an earlier case entitled *Aroa Marketing, Inc. v. Hartford Ins. Co. of the Midwest* (2011) 198 Cal.App.4th 781. In *Aroa*, another California appellate court held that a similarly-worded "intellectual property" exclusion relieved a general liability insurer of any duty to defend its insured, a marketing company, against claims that it had misappropriated a model's name and likeness. Both cases hold that an intellectual property exclusion bars coverage for claims based on the "right of publicity," as any such right is an "intellectual property" right.

Professional Liability Insurer Has No Duty to Defend Securities Brokerage Firm Against Third-Party Claims Where, At Time Firm Applied for Policy, Firm Was Aware of Facts That Might Result In Claims

A professional liability insurer had no duty to defend or indemnify a securities brokerage firm against various third-party claims where, at the time the brokerage firm applied for the policy, the firm was aware of facts or circumstances that might result in the claims. (*Crown Capital Securities, L.P. v. Endurance American Specialty Ins. Co*. (2015) 235 Cal.App.4th 1122)

Facts

Crown Capital Securities, L.P. (Crown Capital) is a securities brokerage firm. Over a period of time, various Crown Capital broker-dealers advised clients to invest in DBSI, Inc. (DBSI), a commercial real estate investment company.

In November 2008, DBSI filed for bankruptcy. In October 2009, a bankruptcy examiner issued a report in which the bankruptcy examiner concluded that DBSI had engaged in a long-term "Ponzi scheme" to defraud investors. Later that same month (October 2009), Crown Capital client George Bou-Sliman sent Crown Capital a letter in which he made a claim against Crown Capital for monetary losses he had sustained as a result of DBSI investments. Bou-Sliman also enclosed a copy of the bankruptcy examiner's report stating that DBSI had engaged in a Ponzi scheme.

About six months later, Crown Capital submitted an application for professional liability insurance to Endurance American Specialty Insurance Company (Endurance). Question 9 of the application asked whether any "claims, suits or proceedings" had been made against Crown Capital during the past five years. In response, Crown Capital answered "yes" and disclosed the Bou-Sliman claim. Question 10 then asked whether Crown Capital was "*aware of any fact, circumstance, incident, situation, or accident … that may result in a claim being made against*" Crown Capital. In response to that question, Crown Capital answered "no." The application further stated that "any claim or lawsuit against [Crown Capital] arising from *any fact, circumstance, act, error or omission* disclosed or *required to be disclosed in response to Questions 9, 10 and/or 11, is hereby expressly excluded from coverage under the proposed insurance policy,*" and that "this Application … shall be considered physically attached to and become part of" any policy which might be issued. After receiving the application, Endurance issued a professional liability policy to Crown Capital for the period of April 1, 2010 through April 1, 2011.

Shortly after Endurance issued the policy to Crown Capital, three other Crown Capital clients – Kurt Bochner, Susan Biles and Linda Grana – all made claims against Crown Capital relating to the DBSI Ponzi scheme. Crown Capital tendered all three claims to Endurance for defense and indemnity. However, Endurance denied coverage for the three claims, asserting that Crown Capital had failed to disclose its knowledge of the DBSI Ponzi scheme to Endurance at the time Crown Capital applied for the Endurance policy.

Crown Capital subsequently sued Endurance for breach of contract and bad faith arising from Endurance's refusal to defend Crown Capital against the Bochner, Biles and Grana claims. The trial court granted summary judgment in favor of Endurance based on the exclusionary language in the application, which was deemed part of the policy. Crown Capital appealed.

Holding

The Court of Appeal affirmed the summary judgment in favor of Endurance.

The appellate court agreed that at the time Crown Capital applied for the Endurance policy, Crown Capital knew of the potential for future claims related to the DBSI Ponzi scheme. The court emphasized that when Crown Capital submitted the application to Endurance, Crown Capital was aware: (1) that DBSI had declared bankruptcy and allegedly had been operating a Ponzi scheme; (2) that Bou-Sliman had claimed a Crown Capital broker-dealer was negligent in recommending a DBSI investment to him; and (3) that other Crown Capital broker-dealers had recommended DBSI investments to other customers. According to the appellate court, those facts and circumstances indicated that other investors – such as Bochner, Biles and Grana – might also make claims against Crown Capital relating to the DBSI Ponzi scheme. As such, the claims which Bochner, Biles and Grana eventually did make against Crown Capital were excluded from coverage under the Endurance policy. It was irrelevant that the Bochner, Biles, and Grana claims did not involve the same investor, broker-dealer or investment that was at issue in the Bou-Sliman claim.

Comment

Note that the exclusion in this case was contained in the application, and the application was then attached to and deemed a part of the policy itself. Under such circumstances, the insurer could deny coverage because the claims fell within the scope of the *exclusion*. The insurer did not need to go through the separate process of *rescinding* the policy due to misrepresentations in the application.

Insured's Act of Pruning Neighbor's Trees Is Not an "Occurrence"

An insured's act of pruning her neighbor's trees was not an "occurrence," or "accident," within the meaning of a homeowners policy. (*Albert v. Mid-Century Insurance Company* (2015) 236 Cal.App.4th 1281)

Facts

Shelly Albert and Henri Baccouche were neighbors. In 2009, the Los Angeles Fire Department sent Ms. Albert a notice stating that she needed to trim brush and trees located within 200 feet of her house. In response, Ms. Albert hired a tree trimming contractor to prune some trees which were located either on, or near, the boundary between her property and Mr. Baccouche's property.

Mr. Baccouche subsequently sued Ms. Albert, alleging that Ms. Albert acting through her contractor had "hacked, cut and pruned" trees located on Mr. Baccouche's property. Mr. Baccouche's complaint against Ms. Albert included causes of action for trespass, private nuisance and negligence.

Ms. Albert tendered the defense of the lawsuit to her homeowners insurer, Mid-Century Insurance Company. During Mid-Century's investigation of the claim, Ms. Albert asserted that the trees her contractor had pruned were on the boundary line between the two properties, and that the fire department had required her to trim the trees. Mid-Century denied Ms. Albert's tender, asserting among other things that her alleged liability was not the result of an "occurrence," or "accident," as required by the Mid-Century policy.

Ms. Albert sued Mid-Century for breach of contract and bad faith. The trial court entered summary judgment for Mid-Century, citing the lack of an "occurrence." Ms. Albert appealed.

Holding

The Court of Appeal affirmed the summary judgment in favor of Mid-Century, finding that Ms. Albert's alleged liability to Mr. Baccouche in the underlying action was not the result of an "occurrence," or "accident."

Ms. Albert argued that her contractor may have been "negligent" in "excessively cutting" the trees. The appellate court rejected this argument, reasoning that Ms. Albert's contractor had intended to prune the trees, and that there were no facts suggesting that some unforeseen accident (such as a slip of the chainsaw) had caused the damage to the trees. The critical fact was that Ms. Albert – acting through her contractor – had intended to prune the trees.

Ms. Albert also argued that Mr. Baccouche's allegations in the underlying action supported a claim that Ms. Albert had "negligently supervised" the tree trimmers. The appellate court rejected that argument, reasoning that were no allegations or extrinsic facts in the underlying action supporting the elements of a claim for negligent supervision. The court emphasized that an insured cannot speculate about unpled claims in order to manufacture a potential for coverage.

Comment

The appellate court accepted the insured's claim that she believed she co-owned the trees, and that she was required to trim them. That, however, did not convert the insured's conduct into an "occurrence," or "accident." The dispositive fact was that the insured, acting through her contractor, had intended to trim the trees, and such conduct was not accidental. There was no potential for coverage and, hence, no duty to defend.

Insurer's Reservation of Rights as to Additional Insured in Construction Defect Lawsuit Does Not Require Insurer to Provide "Independent Counsel" to Additional Insured

An insurer's reservation of rights letter as to an additional insured in a construction defect lawsuit did not trigger a conflict of interest sufficient to require the insurer to provide "independent counsel" to the additional insured. (*Centex Homes v. St. Paul Fire and Marine Insurance Company* (2015) 237 Cal.App.4th 23)

Facts

Centex Homes (Centex) was the developer of a residential housing project. In connection with the project, Centex hired various subcontractors, including Oak Leaf Landscape, Inc. (Oak Leaf), to assist with construction.

After the project was completed, some of those who purchased homes in the project sued Centex for construction defects. Centex in turn sought coverage as an additional insured on a general liability policy which Oak Leaf had obtained through St. Paul Fire & Marine Insurance Company (St. Paul). In response to Centex's tender, St. Paul agreed to provide "panel defense counsel" to defend Centex under a reservation of rights. Among other things, St. Paul reserved its right to seek reimbursement from Centex of defense costs that were not related to covered "property damage" arising from the work of the named insured, Oak Leaf.

Centex filed a declaratory relief action against St. Paul seeking a determination that St. Paul was obligated to provide "independent counsel" to Centex. Centex alleged that a conflict of interest requiring independent counsel existed because, among other things, St. Paul might instruct panel defense counsel to (1) file a cross-complaint against the named insured, Oak Leaf, (2) determine whether Oak Leaf had any liability to the homeowners in the underlying litigation, (3) determine whether Oak Leaf's work caused "property damage" which would be covered under the St. Paul policy, etc. Centex alleged that to the extent panel defense counsel could challenge Oak Leaf's liability in the underlying litigation, such challenge would enhance St. Paul's reimbursement claim against Centex, thus triggering a conflict of interest requiring independent counsel.

St. Paul demurred to Centex's complaint, arguing that Centex had failed to state a cause of action against St. Paul. The trial court sustained the demurrer and dismissed Centex's claim against St. Paul. Centex appealed.

Holding

The Court of Appeal affirmed the dismissal of Centex's claims against St. Paul. According to the appellate court, Centex had not alleged specific facts indicating an actual, present conflict of interest requiring independent counsel. Centex had merely alleged "anticipated circumstances" that "have not yet occurred in the underlying action." In short, Centex had not pled facts demonstrating a conflict of interest that would give Centex the right to have independent counsel at St. Paul's expense. Further, at least at this juncture, there was no indication that Centex could plead any such facts.

Comment

The mere fact that an insurer has issued a reservation of rights letter does not necessarily create a conflict of interest requiring the insurer to provide the insured with independent counsel. However, an insurer may have an obligation to provide independent counsel when the insurer "reserves its rights on a given issue and the outcome of that coverage issue can be controlled by counsel first retained by the insurer for the defense of the claim." (Civ. Code § 2860 (b).) Even in that circumstance, however, the conflict must be "significant, not merely theoretical, actual, not

merely potential." (*Dynamic Concepts, Inc. v. Truck Ins. Exchange* (1998) 61 Cal.App.4th 999, 1007.) According to the appellate court in this case, the additional insured, Centex did not plead specific facts demonstrating an actual, present conflict of interest requiring independent counsel.

Insurer May Seek Reimbursement of Allegedly Excessive Legal Fees Directly from Independent "Cumis" Counsel

A liability insurer may seek reimbursement of allegedly excessive legal fees directly from independent *"Cumis"* counsel in order to prevent the latter from being unjustly enriched. (*Hartford Casualty Ins. Co. v. J.R. Marketing, LLC* (2015) 61 Cal.4th 988)

Facts

Hartford Casualty Insurance Company (Hartford) issued a commercial general liability policy to J.R. Marketing, LLC (J.R. Marketing) for the period of August 18, 2005 to August 18, 2006.

In September 2005, third parties sued J.R. Marketing and others for fraud, breach of fiduciary duty, unfair competition, defamation, interference with business relationships and conspiracy. J.R. Marketing promptly tendered the lawsuit to Hartford for defense. Hartford initially refused to defend J.R. Marketing, asserting, among other things, that the acts complained of had occurred before the policy's inception date.

Following Hartford's denial of a defense, J.R. Marketing retained the law firm of Squire Sanders USA LLP (Squire Sanders) to represent J.R. Marketing's interests. J.R. Marketing (through Squire Sanders) defended the underlying litigation. In addition, J.R. Marketing (again through Squire Sanders) filed a bad faith lawsuit against Hartford.

In January 2006, Hartford reconsidered its initial coverage position and appointed panel counsel to defend J.R. Marketing subject to a reservation of rights. However, Hartford refused to pay any defense costs J.R. Marketing had incurred before January 2006, and refused to provide J.R. Marketing with independent "*Cumis*" counsel in place of Hartford's appointed panel counsel.

In the bad faith action, the trial court ruled that Hartford owed a duty to defend J.R. Marketing from the initial tender of the underlying action in September 2005, and that Hartford was obligated to provide J.R. Marketing with *Cumis* counsel.

Thereafter, the trial court in the bad faith action issued a separate "enforcement order" requiring Hartford to pay Squire Sanders's bills promptly upon submission. The enforcement order provided that, while Squire Sanders' bills had to be "reasonable and necessary," Hartford as a "breaching insurer" was barred from invoking the protections that are usually available to insurers under California Civil Code section 2860. The order further provided that upon conclusion of the underlying litigation, Hartford could seek reimbursement of amounts it deemed excessive (although the order did not say *from whom* Hartford might seek any such reimbursement).

Subsequently, J.R. Marketing's independent counsel, Squire Sanders, submitted over $15 million in bills to Hartford. Hartford paid the bills.

In October 2009, the underlying litigation against J.R. Marketing was resolved. Upon resolution of the underlying litigation, Hartford filed a cross-complaint against the insured, J.R. Marketing, *and its independent counsel, Squire Sanders*. In its cross-complaint, Hartford alleged that it was entitled to reimbursement of all "abusive, excessive, unreasonable or unnecessary" fees and costs which had been billed to and paid by Hartford. Squire Sanders demurred to Hartford's cross-complaint, arguing that while Hartford might have a right to seek reimbursement from J.R. Marketing, Hartford had no legal right to seek reimbursement directly from Squire Sanders. The

trial court and the Court of Appeal agreed with Squire Sanders and dismissed Squire Sanders from the litigation. Hartford then sought, and obtained, review by the California Supreme Court.

Holding

The California Supreme Court reversed, and held that Hartford *was* entitled to seek reimbursement of the allegedly excessive fees directly from Squire Sanders as independent counsel for J.R. Marketing. Hartford alleged that Squire Sanders had charged Hartford for fees and costs that were objectively unreasonable and unnecessary for J.R. Marketing's defense. Those facts, if proven, would give Hartford the right to recover against Squire Sanders on a theory of "unjust enrichment." That is, Hartford had adequately alleged that Squire Sanders had unjustly enriched itself at Hartford's expense, and that Squire Sanders thus owed Hartford reimbursement for the overbilled amounts.

The Supreme Court rejected Squire Sanders' argument that Hartford should only be able to pursue reimbursement against J.R. Marketing (the insured) and not against Squire Sanders (independent counsel). According to the Court, to the extent that Squire Sanders charged Hartford for fees and costs that were not reasonable and necessary for the defense of J.R. Marketing, it was Squire Sanders, not J.R. Marketing, who was "unjustly enriched."

The Supreme Court also rejected Squire Sanders' argument that allowing an insurer to seek reimbursement directly from *Cumis* counsel would unduly interfere with *Cumis* counsel's independence and undermine the attorney-client privilege. According to the Court, while *Cumis* counsel must indeed retain the necessary independence to make reasonable choices when representing insureds, "such independence is not inconsistent with an obligation of counsel to justify their fees." Indeed, California Civil Code section 2860, which codifies the *Cumis* doctrine, "contemplates that *[Cumis]* counsel will be called upon to justify their fees" and further suggests that this can occur "in a proceeding directly against counsel."

In sum, Hartford adequately pled that Squire Sanders had charged excessive fees, that Squire Sanders had been unjustly enriched, and that Squire Sanders was thus obligated to reimburse Hartford for the overbilled amounts. The Court thus remanded the case to allow Hartford to proceed against Squire Sanders.

Comment

The Supreme Court emphasized that its decision in this case turned on the narrow facts of the case. The Court noted that the case involved an "enforcement order" requiring the insurer to pay for "reasonable and necessary" costs of independent *Cumis* counsel but allowing the insurer to subsequently seek reimbursement of any such costs that were not "reasonable and necessary." The Supreme Court stated that in light of the enforcement order, there was no need to consider (1) whether an insurer who breaches its defense obligations has *any right at all to recover* excessive fees paid to *Cumis* counsel, (2) whether, in general, a dispute over allegedly excessive fees is more appropriately decided through a court action or an arbitration, and (3) whether, in general, resolution of such a fee dispute should be resolved before or after the conclusion of the underlying litigation.

Notwithstanding the above, the opinion in this case contains some language suggesting that insurers may be able to seek reimbursement directly against *Cumis* counsel in other scenarios. Thus, even in the more common Civil Code section 2860 arbitration, if an insurer proves that *Cumis* counsel's fees were patently and objectively unreasonable and unnecessary, the insurer may be able to pursue recovery against *Cumis* counsel on an unjust enrichment theory. However, no matter what the setting, the insurer will apparently have the burden of proving that *Cumis* counsel's fees were unreasonable and unnecessary.

Pursuant to Insurance Code Section 520, Once "Loss" Happens, Insured May Assign Right to Recover to Third Party

Pursuant to California Insurance Code section 520, once a covered "loss" has happened, the insured may assign its right to recover to a third party. (*Fluor Corporation v. Superior Court* (2015) 61 Cal.4th 1175)

Facts

In 1924, the original Fluor Corporation ("Fluor-1") was created. Between 1971 and 1986, Fluor-1 obtained general liability insurance coverage through Hartford Accident & Indemnity Company ("Hartford"). Each policy contained a "consent-to-assignment" clause stating that "assignment of interest under this policy shall not bind the [insurer] until its consent is endorsed hereon."

Starting in the mid-1980's, various third parties sued Fluor-1 for injuries arising from exposure to asbestos-containing materials. The third parties' injuries occurred, in part, during the time that Fluor-1's policies through Hartford were in effect. Hartford thus participated in defending Fluor-1 against the asbestos suits.

In 2000, as part of a corporate restructuring transaction called a "reverse spinoff," a second Fluor Corporation ("Fluor-2") was created. In the reverse spinoff, Fluor-1 transferred its engineering, procurement and construction services to Fluor-2. Fluor-1 retained various coal mining and energy operations and renamed itself "Massey Energy Company." As part of the transaction, Fluor-1 allegedly assigned its rights under the Hartford policies to Fluor-2, but did not obtain Hartford's consent to the assignment. Fluor-1 and Fluor-2 became independent public companies, with neither having an ownership interest in the other.

Between 2001 and 2008, Hartford contributed toward the costs of defending and indemnifying both Fluor-1 and Fluor-2 against the asbestos lawsuits. That is, Hartford paid claims on behalf of Fluor-2 for injuries Fluor-1 had allegedly caused to third parties during the Hartford policy periods.

Eventually, Fluor-2 and Hartford became involved in coverage litigation arising from the underlying asbestos lawsuits. In the coverage litigation, Hartford asserted, among other things, that it only insured Fluor-1; that the Hartford policies contained "consent-to-assignment" provisions prohibiting any assignment of the policies without Hartford's written consent; and that Hartford had never consented to any assignment of Fluor-1's policies to Fluor-2. Hartford thus sought a ruling that it had no duty to defend or indemnify Fluor-2 against the asbestos lawsuits.

In response, Fluor-2 moved for an order that Hartford's "consent-to-assignment" clauses were invalid under California Insurance Code section 520. That statute provides that "an agreement not to transfer the claim of the insured against the insurer after a loss has happened, is void if made before the loss…." The trial court, citing the California Supreme Court's prior decision in *Henkel Corp. v. Hartford Accident & Indemnity Co.* (2003) 29 Cal.4th 934, held that Hartford's consent-to-assignment clauses were valid and thus denied Fluor-2' motion. The Court of Appeal, also relying on *Henkel,* affirmed the trial court's ruling. Fluor-2 then sought, and obtained, review by the California Supreme Court.

Holding

The California Supreme Court reversed, finding that Hartford's "consent-to-assignment" clauses conflicted with Insurance Code section 520. As noted above, section 520 prohibits any policy provision which bars an insured from transferring a claim against the insurer "after a loss has happened."

The Supreme Court rejected Hartford's contention that section 520 only applies to first-party property policies. Rather, after an exhaustive review of

statutory and case law from California and other jurisdictions, the Supreme Court held that section 520 applies to both first-party property policies *and* third-party liability policies.

The Supreme Court then held that, with respect to third-party liability policies, a "loss" arises at the time of the "occurrence" that results in injury or damage to the third party, even though the dollar amount of that loss may be unknown and unknowable until much later. Thus, section 520 does *not* require that the third party claimant obtain a money judgment against, or reach a settlement with, the insured before the insured may assign a claim for the "loss" without the insurer's consent. Rather, once a third party has sustained a "loss" that is covered by the insured's policy, and for which the insured *may* be liable, the insured may assign a claim for the loss *without* the insurer's consent.

The Supreme Court held that in light of the above, and given California's "continuous injury" trigger of coverage, the loss "happened" after a third party's exposure to asbestos resulted in bodily injury between *1971 and 1986*, when Fluor-1 was insured by Hartford. Therefore, in *2000*, Fluor-1 had the authority, without Hartford's consent, to assign to Fluor-2 the right to defense and indemnification under the Hartford policies for bodily injury that had occurred during the policy periods. In short, Hartford could not rely on its "consent-to-assignment" clauses to defeat Fluor-2's claim for coverage.

In reaching this result, the Supreme Court in *Fluor* expressly overturned its earlier decision in *Henkel*. The Supreme Court noted that in *Henkel*, the litigants had not cited, and the Supreme Court had not considered, the effect of section 520 on a "consent-to-assignment" clause. The Supreme Court also observed that the *Henkel* decision has been widely criticized by other courts and commentators, and clearly represented a minority view. After reviewing the relevant statutory and case law, the Supreme Court determined that *Henkel* had been incorrectly decided.

Comment

The *Fluor* decision is in accord with the general principle that an insurer *may* prohibit an insured from assigning the *policy itself* to another person *before* the loss occurs. That is because insurance is considered a *personal contract*, with the insurer having the right to choose who it will insure.

However, *after* a covered loss occurs, the insured may assign to another person the *right to recover* from the insurer for the loss *which has already occurred*. This latter situation involves only the payment of a claim for a loss the insurer agreed to cover, and the insured is thus entitled to designate another person to receive the *policy proceeds*.

"Escape" Type "Other Insurance" Clause Does Not Excuse Insurer from Contributing Toward Defense Costs Which Another Insurer Pays on Behalf of Mutual Insured

A so-called "escape" type "other insurance" clause did not excuse an insurer from contributing toward defense costs which another insurer paid on behalf of a mutual insured in an underlying construction defect case. (*Underwriters of Interest Subscribing to Policy Number A15274001 v. ProBuilders Specialty Insurance Company* (2015) 241 Cal.App.4th 721)

Facts

Pacific Trades Construction & Development, Inc. (Pacific Trades) was a general contractor that constructed multiple single family homes. Following construction of the homes, numerous homeowners sued Pacific Trades alleging that Pacific Trades was responsible for construction defects in the homes. The litigation involved property damage that potentially occurred over several years.

Pacific Trades was an insured under commercial general liability policies issued by Underwriters of Interest Subscribing to Policy Number A15274001 (Underwriters) for the period of October 23, 2001 through October 23, 2003 and ProBuilders Specialty Insurance Company (ProBuilders) for the period of December 9, 2002 through December 9, 2004. Pacific Trades thus tendered the defense of the construction defect lawsuit to both insurers. Underwriters agreed to defend Pacific Trades in the lawsuit. ProBuilders, on the other hand, declined to participate in the defense of Pacific Trades because the ProBuilders policies contained "other insurance" clauses stating that ProBuilders would only defend Pacific Trades if "*no other insurance affording a defense … is available to you [i.e., Pacific Trades]."* ProBuilders asserted that since there was "other insurance" (i.e., the Underwriters policies) "available" for the defense of Pacific Trades, ProBuilders had no duty to participate in defending Pacific Trades.

Eventually, the underlying construction defect lawsuit was settled. Although ProBuilders did not contribute to Pacific Trades' defense costs, ProBuilders did contribute $270,000 on behalf of Pacific Trades toward the settlement.

Following the settlement, Underwriters filed an equitable contribution lawsuit against ProBuilders. In the equitable contribution lawsuit, Underwriters sought to recover from ProBuilders a portion of the defense costs that Underwriters had incurred on behalf of Pacific Trades in the underlying construction defect action. ProBuilders moved for summary judgment, asserting that ProBuilders' "other insurance" clauses excused ProBuilders from defending Pacific Trades in the underlying action because another insurer (i.e., Underwriters) had been obligated to defend Pacific Trades in that action. The trial court agreed with ProBuilders and thus entered summary judgment in favor of ProBuilders. Underwriters appealed.

Holding

The Court of Appeal reversed. The appellate court characterized ProBuilders' "other insurance" clause as an "escape" clause. That is, ProBuilders' "other insurance" clause provided that ProBuilders would be liable to pay defense costs on behalf of Pacific Trades, but then purported to extinguish that obligation when "other insurance affording a defense … is available to [Pacific Trades]." The appellate court emphasized that in California "escape" type "other insurance" clauses are "disfavored," and that "the modern trend is to require equitable contributions on a pro rata basis from all primary insurers regardless of the type of 'other insurance' clause in their policies."

The appellate court also noted that Underwriters and ProBuilders provided primary coverage to Pacific Trades at *different times* (i.e., Underwriters was on the risk from October 23, 2001 through October 23, 2003, while ProBuilders was on the risk from December 9, 2002 through December 9, 2004). In the underlying construction defect action, the homeowners had sought damages from Pacific Trades for property damage that potentially occurred during both insurers' policy periods. Thus, giving effect to ProBuilders' "other insurance" provision would unfairly impose on Underwriters the burden of paying "defense costs attributable to claims arising from a time when ProBuilders was the *only* liability insurer covering Pacific Trades…." Stated differently, ProBuilders could not rely on its "other insurance" clause to deny coverage during periods of time when there was no "other insurance."

Based on the above, the appellate court held that the trial court had erred in granting summary judgment to ProBuilders. The appellate court thus remanded the case to the trial court for further proceedings.

Comment

On appeal, ProBuilders also argued that Underwriters' equitable contribution lawsuit against ProBuilders was barred by the applicable two-year statute of limitations because Underwriters filed the lawsuit more than two years after ProBuilders' initial refusal to defend, and more than two years after the court in the underlying lawsuit confirmed

that the settlement between the homeowners and Pacific Trades was a good faith settlement.

However, the appellate court rejected ProBuilders' statute of limitations argument, noting that Underwriters' equitable contribution lawsuit was filed less than two years after the insurers contributed their payments to fund the settlement, less than two years after the homeowners finally dismissed their suit as to Pacific Trades, and less than two years after Underwriters made its final payment to the defense counsel hired to represent Pacific Trades. According to the appellate court, "although an action for equitable contribution can *accrue* when the noncontributing insurer first refuses to participate in the defense of a common insured, the statute of limitations should be equitably *tolled* until the plaintiff insurer makes the last payment in the underlying suit for which the plaintiff insurer is seeking contribution."

Liability Insurer Has No Duty to Defend Tile Subcontractors Against Claims Arising from Fracturing of Tiles Caused By Alleged Improper Installation

A commercial general liability insurer had no duty to defend its insureds, two tile subcontractors, against claims arising from fracturing of floor tiles caused by alleged improper installation of the tiles. (*American Home Insurance Company v. SMG Stone Company, Inc.* (N.D. Cal. 2015) --- F.Supp.3d ----)

Facts

Olympic & Georgia Partners LLC (Olympic), a developer, hired Webcor Construction LP (Webcor), a general contractor, to construct a 54-story hotel and condominium project in Los Angeles. Webcor, in turn, hired SMG Stone Company, Inc. (SMG) and Colavin & Son, Inc. (Colavin), both subcontractors, to install stone floor tiles at the project.

Before the project was completed, Olympic discovered that fractures had developed in some of the tiles which had been installed. An investigation showed that the fractures were caused by improper installation of the tiles. The fractured tiles were removed and replaced during a remediation process which required removing and replacing portions of the concrete subfloor and drywall installed by other contractors. Olympic contended that as a result of the floor tile problems, Olympic sustained delays in selling condominium units, which delays caused Olympic to incur over $39 million in damages.

Olympic subsequently initiated an arbitration proceeding against Webcor, SMG and Colavin. SMG and Colavin separately sued Webcor for failing to pay amounts allegedly owed to SMG and Colavin under the subcontracts, and Webcor in turn cross-complained against SMG and Colavin for damages caused by the alleged improper installation of the floor tiles.

SMG and Colavin tendered defense of the arbitration proceeding and lawsuit to their commercial general liability insurer, American Home Assurance Company (American Home). American Home asserted it had no duty to defend SMG and Colavin.

American Home subsequently filed a federal court declaratory relief action against SMG and Colavin, seeking a ruling that American Home did not have any duty to defend or indemnify SMG and Colavin in the construction defect arbitration proceeding and lawsuit. American Home then moved for summary judgment.

Holding

The federal district court granted American Home's motion for summary judgment, holding that under California law, American Home had no duty to defend or indemnify SMG and Colavin in the underlying arbitration proceeding and lawsuit.

The district court began by stating that it had "serious doubts" whether the underlying claims against SMG and Colavin constituted claims for "property damage," which the American Home policy defined as (1) "physical injury to tangible property" and (2) "loss of use of tangible property damage that is not physically injured." With regard to the first prong of the "property damage" definition (i.e., "physical injury to tangible property"), the court stated it was unlikely that either the fractures to the floor tiles themselves or the damage to the concrete subfloors and interior walls during the removal and reinstallation process could be deemed "physical injury to tangible property." With regard to the second prong of the "property damage" definition (i.e., "loss of use of tangible property that is not physically injured"), the court likewise believed it was unlikely that mere delay in completion of the project and sale of the units could be considered "loss of use of tangible property that is not physically injured."

However, the court found that even if any of the claims against SMG and Colavin could be considered claims for "property damage," various policy exclusions applied to defeat coverage. For example, exclusion j(5) barred coverage for property damage to "that particular part of real property on which you … are performing operations, if the property damage arises out of those operations." Similarly, exclusion j(6) precluded coverage for property damage to "that particular part of any property that must be restored, repaired or replaced because 'your work' was incorrectly performed on it" (although this exclusion had an exception for property damage included in the "products-completed operations hazard"). Here, the facts indicated that SMG's and Colavin's tile work was not "complete" when the tiles fractured, which meant that exclusions j(5) and j(6) barred coverage. Further, even if SMG's and Colavin's and tile work was "complete" when the tiles fractured, coverage would be barred by exclusion l. That exclusion (as amended by endorsement) barred coverage for property damage to that part of "your work" that "is defective or actively malfunctions" even after the work is complete. Because the policy exclusions eliminated any possibility of coverage, American Home had no duty to defend SMG and Colavin in the underlying construction defect arbitration proceeding and lawsuit.

Comment

The federal district court's suggestion that there might not have been any "property damage" at all is perhaps debatable. The insureds' alleged improper installation caused *fractures* to *floor tiles*, which would appear to constitute "physical injury" to "tangible property." Nevertheless, it appears that any such property damage was indeed excluded from coverage by the "faulty workmanship" and "work" exclusions in the policy. Thus, while the district court may have conflated to some extent the issue of whether there was "property damage" in the first instance with the separate issue of whether any such property damage was "excluded," it appears that the district court reached the correct result.

Liability Policy's Exclusion for "Subsidence" Resulting From Insured's "Operations" Bars Coverage for Landslide Allegedly Resulting From Insured's Maintenance and Construction Activities

A commercial general liability policy's exclusion for "subsidence" resulting from the insured's "operations" barred coverage for a landslide that allegedly resulted from the insured's maintenance and construction activities. (*Philadelphia Indemnity Insurance Company v. Lakeside Heights Homeowners Association* (N.D. Cal. 2015) --- F.Supp.3d ----)

Facts

In 2013, a landslide caused extensive damage to property owned by various parties, including the Lakeside Heights Homeowners Association (HOA)

and the County of Lake (County). The HOA subsequently filed a state court lawsuit against the County for inverse condemnation and dangerous condition of public property, apparently alleging that the landslide was caused by leaks in water pipes owned by the County. In response, the County cross-complained against the HOA, alleging that the landslide occurred because, among other things, the HOA: (1) negligently constructed improvements over an ancient slide area; (2) negligently failed to maintain its sprinkler system and private storm drain, causing water to saturate its property and surrounding properties; and (3) negligently failed to maintain its landscaping, causing loss of lateral support to surrounding properties.

The HOA tendered defense of the cross complaint to the HOA's general liability insurer, Philadelphia Indemnity Insurance Company (Philadelphia). In response, Philadelphia agreed to defend the HOA, but Philadelphia reserved its right to assert that the policy's "subsidence" exclusion barred coverage for any liability the HOA might have to the County. The policy's "subsidence" exclusion provided that there was no coverage for property damage "caused by, resulting from, attributable or contributed to, or aggravated by the subsidence of land as a result of landslide, mudflow, earth sinking or shifting, resulting from operations of the named insured or any subcontractor of the named insured."

Philadelphia then filed a federal court declaratory relief action seeking a determination that the policy's "subsidence" exclusion relieved Philadelphia of any duty to defend the HOA against the County's cross-complaint. Eventually, Philadelphia moved for summary judgment against the HOA based on the exclusion.

Holding

The federal district court, applying California law, granted Philadelphia's motion for summary judgment. The policy's "subsidence" exclusion barred coverage for property damage "caused by … subsidence … *resulting from operations of the named insured* …." According to the court, the HOA's "operations" included maintaining the HOA's common areas such as irrigation systems, drainage systems, landscaping, etc. Those "operations" in turn, allegedly led to the landslide that caused the property damage claimed by the County. All of the theories that the County alleged against the HOA were dependent upon the HOA's "operations," and thus fell within the Philadelphia policy's "subsidence" exclusion. As such, Philadelphia had no duty to defend or indemnify the HOA against the County's underlying cross-complaint.

Comment

In an earlier case, *City of Carlsbad v. Insurance Company of the State of Pennsylvania* (2009)180 Cal.App.4th 176, a California state appellate court upheld an arguably broader, simpler "subsidence" exclusion. The subsidence exclusion in *City of Carlsbad* applied to "any property damage arising out of land subsidence *for any reason whatsoever*."

In the above *Lakeside Heights Homeowners Association* case, the subsidence exclusion was perhaps narrower in that it only barred coverage for property damage caused by "subsidence … *resulting from operations of the named insured or any subcontractor of the named insured*." Nevertheless, according to the federal district court, all of the claims against the insured involved subsidence that allegedly resulted from the insured's "operations." As such, the exclusion defeated any potential for coverage.

BAD FAITH

Defending Insurer Not Liable for Excess Judgment Where Settlement Demand Exceeded Applicable Policy Limits and Insured Stipulated to Judgment Without Insurer's Consent

A liability insurer which provided a defense to its insured was not liable for an excess judgment where (1) the settlement demand against the insured exceeded the applicable policy limits, and (2) in any event, the insured stipulated to the judgment without the insurer's consent. (*21st Century Insurance Company v. Superior Court* (2015) 240 Cal.App.4th 322)

Facts

Cy Tapia's grandfather owned a pickup truck which he allowed Tapia to drive as Tapia pleased. The pickup truck was a covered vehicle, and Tapia was a listed driver, on a 21st Century Insurance Company auto policy with liability limits of $100,000.

Tapia lived with his grandmother and aunt, both of whom had 21st Century auto policies with liability limits of $25,000. The two $25,000 auto policies covered "resident relatives" (which included Tapia) while driving "non-owned automobiles" (defined as any vehicle "not owned *nor available for regular use by* you*, a relative or a resident of the same household in which you reside*, used with the permission of the owner").

Tapia was driving the pickup truck when he caused an accident which resulted in severe injuries to his passenger, Cory Driscoll. Driscoll subsequently sued Tapia. 21st Century accepted coverage for Tapia under the $100,000 auto policy and retained defense counsel to represent Tapia. Several months later, 21st Century offered the $100,000 policy in settlement of Tapia's alleged liability to Driscoll.

Driscoll rejected the $100,000 settlement offer because he believed that Tapia was also covered under the two $25,000 policies which 21st Century had issued to Tapia's grandmother and aunt. Driscoll thus communicated a $150,000 settlement offer to Tapia's defense counsel. However, Tapia's defense counsel allegedly failed to communicate the $150,000 settlement offer to 21st Century, and as a result 21st Century failed to timely accept that settlement offer.

Shortly thereafter, 21st Century affirmatively offered the "full" $150,000 limit of all three policies in settlement of Tapia's liability to Driscoll. Driscoll responded by serving a $3,000,000 statutory offer to compromise on Tapia. Shortly before the expiration of the $3,000,000 statutory offer, 21st Century sent Tapia a letter warning Tapia that 21st Century would not agree to be bound if Tapia accepted the statutory offer.

Notwithstanding the above, Tapia stipulated to the entry of a $3,000,000 judgment in favor Driscoll. At that point, 21st Century partially satisfied the judgment against Tapia by paying Driscoll $150,000 (the amount of all three policies).

Driscoll and Tapia then entered into an agreement pursuant to which Driscoll received an assignment of any rights Tapia had against 21st Century. As part of this agreement, Driscoll promised not to execute on the judgment against Tapia's personal assets.

Driscoll as assignee of Tapia then filed a bad faith action against 21st Century. 21st Century moved for summary judgment, asserting that (1) Driscoll's $150,000 settlement demand against Tapia exceeded the applicable policy limits, and (2) in any event, Tapia's stipulation to a judgment without 21st Century's consent vitiated any claim in excess of the policy limits. The trial court denied 21st Century's motion. 21st Century sought appellate review.

Holding

The Court of Appeal ruled that 21st Century was entitled to summary judgment, for two reasons.

First, Driscoll's excess judgment against Tapia was based on 21st Century's alleged failure to timely accept a $150,000 settlement offer on behalf of Tapia. In fact, however, Driscoll's $150,000 settlement offer to settle to *exceeded* the $100,000 limit of the only 21st Century policy that applied. The two $25,000 policies that 21st Century had issued to Tapia's grandmother and aunt did *not* apply because those policies only covered Tapia while he was driving a vehicle that was *not* available for his "regular use." Here, Tapia had "regular use" of the pickup truck, and thus the pickup truck was *not* an insured vehicle on the two $25,000 auto policies. As a result, Driscoll's alleged "policy limit demand" of $150,000 was actually a demand that *exceeded* the applicable policy limit of $100,000. Thus, 21st Century had not failed to accept a reasonable "settlement demand within limits." The fact that 21st Century had eventually offered and paid $150,000 was not a waiver of 21st Century right to contest coverage under the two $25,000 policies.

Second, and more importantly, following 21st Century's alleged failure to timely accept the $150,000 settlement offer on behalf of Tapia, Tapia – without 21st Century's consent – had *stipulated* to the entry of a $3,000,000 judgment in favor Driscoll. Because 21st Century *was* providing a legal defense to Tapia, Tapia was *not* entitled to stipulate to a judgment in favor of Driscoll. Rather, if Tapia believed that 21st Century had breached its duty to settle, Tapia could have assigned his rights to Driscoll, such assignment to become operative *in the event a trial in the underlying action* resulted in an *excess judgment* against Tapia. Here, the $3,000,000 judgment was not the product of an adversarial proceeding between Driscoll and Tapia, but rather was simply the product of an agreement between Driscoll and Tapia.

Comment

This case underscores two points in situations where a liability insurer's alleged failure to accept a "reasonable settlement demand within policy limits" leads to an "excess judgment" against the insured.

First, the plaintiff's attorney should attempt to ensure that the purported "settlement demand within policy limits" is indeed "within policy limits." A demand in excess of the policy limits may simply allow the insurer to argue that the insurer had no contractual duty to accept such a demand. (However, note that the insurer may nevertheless have a duty to communicate the "excess" demand to the insured so that the insured can attempt to come up with the additional funds necessary to meet the demand.)

Second, if an insurer is *providing a defense* to its insured, the insured may not, without the insurer's consent, stipulate to a judgment in favor of the plaintiff. If the insurer is defending the insured, and the insurer allegedly breaches its duty to accept a reasonable settlement demand within the policy limits, the insurer's breach becomes actionable only after a *trial* results in an excess judgment against the insured. (See, *Hamilton v. Maryland Casualty Co.* (2002) 27 Cal.4th 718.)

MISCELLANEOUS

Statute of Limitations May Be Tolled Where Alleged Tortfeasor or Liability Insurer Makes Advance Payment to Injured Person Without Notifying Such Person of Applicable Limitations Period

The statute of limitations may be tolled where an alleged tortfeasor or its liability insurer makes an advance payment to an injured person without notifying such person of the applicable limitations

period. (*Blevin v. Coastal Surgical Institute* (2015) 232 Cal.App.4th 1321)

Facts

On September 1, 2010, Charles Blevin had knee surgery at Coastal Surgical Institute. After the surgery, Blevin's knee became infected allegedly due to unsterile surgical equipment used during the surgery.

On October 12, 2010, Coastal paid Blevins over $4,000 for the medical expenses he had incurred in treating the knee infection. At the time Coastal made the payment, Blevins was not represented by counsel, and Coastal did not give Blevins written notice of the applicable statute of limitations for a medical malpractice action. Blevins did not sign any agreement releasing Coastal from liability.

On January 24, 2012, more than 15 months after Blevin's receipt of Coastal's payment, Blevins filed a medical malpractice action against Coastal. Coastal responded by asserting that Blevin's lawsuit was time-barred by Code of Civil Procedure section 340.5. That section provides that the statute of limitations in a medical malpractice action is "three years after the date of injury, or one year after the plaintiff discovers or through the use of reasonable diligence should have discovered the injury, whichever occurs first."

The trial court concluded that the shorter one-year period in Code of Civil Procedure section 340.5 was "tolled" because Coastal had paid Blevin's medical expenses without simultaneously informing Blevin of the applicable statute of limitations. The trial court thus allowed Blevin's case against Coastal to be heard by a jury, which returned a verdict in favor of Blevin and against Coastal. Coastal appealed, again asserting that Blevin's lawsuit was barred by the applicable statute of limitations.

Holding

The Court of Appeal affirmed. The appellate court reasoned that pursuant to Insurance Code section 11583, "[n]o advance payment or partial payment of damages made by any person, or made by his insurer ..., as an accommodation to an injured person ... shall be construed as an admission of liability by the person claimed against, or of that person's or the insurer's recognition of such liability.... *Any person, including any insurer, who makes such an advance or partial payment, shall at the time of beginning payment, notify the recipient thereof in writing of the statute of limitations applicable to the cause of action which such recipient may bring against such person as a result of such injury.... Failure to provide such written notice shall operate to toll any such applicable statute of limitations or time limitations from the time of such advance or partial payment until such written notice is actually given*. That notification shall not be required if the recipient is represented by an attorney." (Italics added.)

According the appellate court, the tolling provisions of Insurance Code section 11583 could extend the shorter *one-year* statute of limitations set forth in Code of Civil Procedure section 340.5 up to a maximum of *three years* from the date of injury. Here, at the time Coastal had made the advance payment to Blevin, Blevin did not have a lawyer, and Coastal did not inform Blevin of the applicable statute of limitation. That had the effect of tolling the statute of limitations applicable to Blevin's claim against Coast. Blevin ultimately filed his medical malpractice lawsuit against Coastal *after* the shorter one-year statutory period had expired, but *before* the three-year maximum period had expired. As such, Blevin's lawsuit against Coastal was timely.

Comment

As Insurance Code section 11583 make clear, if an alleged tortfeasor or its insurer makes an advance or partial payment of damages to an injured party who is not represented by counsel, the alleged tortfeasor or its insurer is required to give the

injured party written notice of the applicable statute of limitations. A failure to do so tolls the statute of limitations until notice is actually given. The rationale is that an advance or partial payment by the alleged tortfeasor or its insurer reasonably suggests that the alleged tortfeasor or its insurer intend to cooperate with the injured party, which can thus lull the injured party into a false sense of complacency about the need to sue.