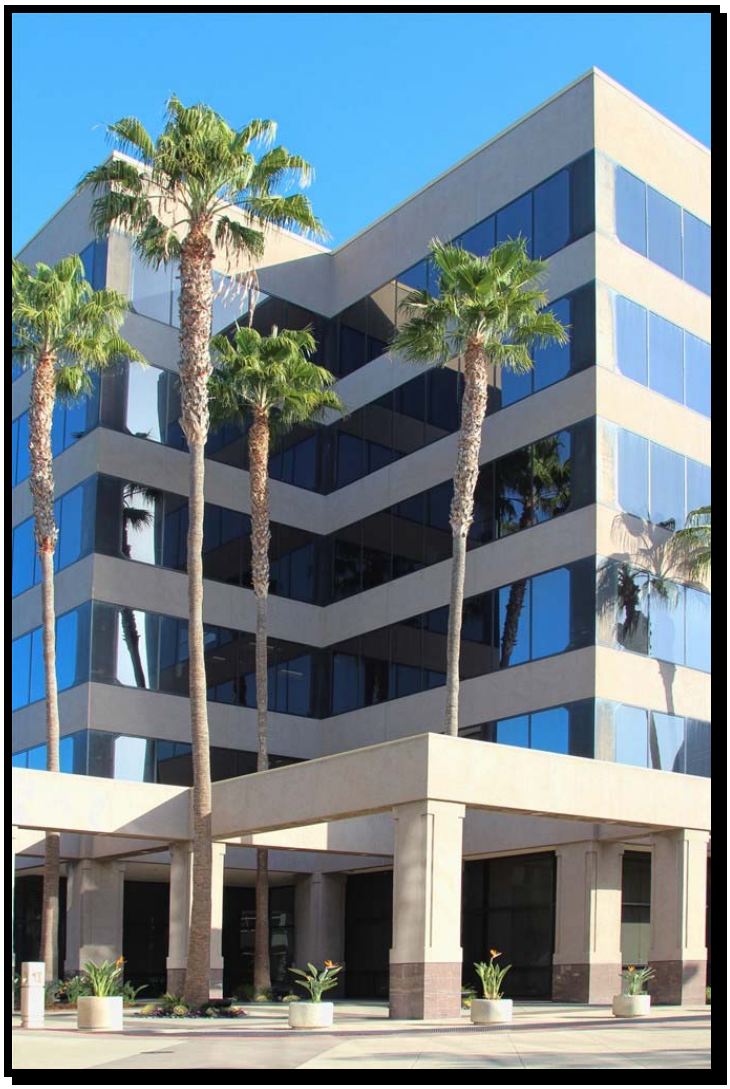
# 2016 ANNUAL REVIEW OF CALIFORNIA INSURANCE LAW

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# 2016 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 2015 through November 2016 that will impact your California claims next year.*

*Best wishes for the coming year.*

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## PENDING BEFORE THE CALIFORNIA SUPREME COURT

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

***Ace American Ins. Co. v. Fireman's Fund Ins. Co.*** (Case No. S237175) - When a primary insurer unreasonably refuses to settle an underlying action against its insured within policy limits and the underlying action later settles for the full amount of the primary policy as well as the full amount of an excess insurer's policy, can the excess insurer maintain an equitable subrogation action against the primary insurer to recover the amount it expended in settlement?

***Association of California Ins. Companies v. Jones*** (Case No. S226529) - 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?

***Liberty Surplus Ins. Co. v. Ledesma and Meyer Construction*** (Case No. S236765) – Is there an "occurrence" under an employer's commercial general liability policy when an injured third party brings claims against the employer for the negligent hiring, retention, and supervision of the employee who intentionally injured the third party?

***Migdal Ins. Co. v. Insurance Co. of the State of Pennsylvania*** (Case No. S236177) - (1) When two primary liability insurers agree that their policies cover the same loss, may the primary insurer whose policy contains an "excess" "other insurance" clause enforce that clause in an action for equitable contribution brought by the primary insurer who defended and settled the insured's claim and whose policy does not contain an "other insurance" clause? (2) When the amount paid by the primary insurer that settled the claim exceeds the non-settling primary insurer's liability policy limits, what is the effect, if any, of the non-settling insurer's "limits reduction" clause?

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## PROPERTY INSURANCE



## LIABILITY INSURANCE



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## MISCELLANEOUS



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## PROPERTY INSURANCE

### *Language in All-Risk Policy Did Not Override Predominant Cause Doctrine, and Insurer Bore Burden of Proving Collapse Exclusion and Negating Exception*

Where an all-risk policy contained an exclusion for collapse but an exception for collapse caused "only" by certain specified risks, the insurer had the burden of proving the exclusion and negating the exception, and the trial court was obligated to give the standard "predominant cause" jury instruction. (*Vardanyan v. Amco Insurance Company* (2015) 243 Cal.App.4th 779)

**Facts**

Artyun Vardanyan owned a rental property, and purchased insurance coverage from Amco Insurance Company. After Vardanyan's tenants moved out of the property, Vardanyan submitted a property damage claim, which Amco investigated with the assistance of an independent adjuster and an engineer.

The engineer found multiple potential leaks in the roof; gutters and downspouts that leaked and otherwise failed to channel drainage away from the house; exterior damage and decay caused by long-term leakage from a faucet or hose; interior damage and decay caused by long-term leakage from a toilet and bathtub; inadequate crawlspace ventilation; termite damage; mold; and floors that were sinking and not level in various places.

Amco denied Vardanyan's claim, citing exclusions for damage caused by seepage or leakage of water from a plumbing system, deterioration, mold, wet or dry rot, settling of foundations, walls or floors, earth movement, water damage, neglect, weather conditions, acts or decisions of any person, and faulty or defective design, workmanship, repair, construction, or maintenance. Vardanyan hired a public adjuster to challenge Amco, but Amco stood on its denial. Vardanyan then filed suit against Amco, alleging breach of contract and bad faith. Vardanyan specifically alleged the house collapsed and that the policy provided coverage for collapse.

The policy was an all-risk policy that excluded coverage for collapse, other than as provided in an "Other Coverage" for "collapse." The "Other Coverage" provided coverage for collapse of a building or part of a building "caused only by one or more" of various listed perils, including hidden decay, hidden insect damage, and weight of contents, equipment, or people.

During trial, the independent adjuster testified regarding the damage he observed during his investigation of the loss, and the engineer testified regarding his investigation of the loss and the causes of the damage to the house. Vardanyan and his former tenants testified regarding the condition of the house prior to the time Vardanyan reported the damage to Amco. In addition, Vardanyan's expert, a general contractor, testified regarding his opinions of the condition of the house and the cause of the damage.

Both parties presented evidence that there were multiple causes of the damage to the house. Vardanyan's theory was that the coverage for collapse due to hidden decay or hidden insect damage applied if either of those named perils was the predominant cause of the collapse of the structure. However, Amco's theory was that there was no coverage because the collapse provision stated it applied if the damage was "caused *only* by one or more" of the perils listed in the collapse provision.

Vardanyan requested that the trial court give a standard jury instruction providing that, when a loss is caused by a combination of covered and excluded risks, the loss is covered if the most important or predominant cause is a covered risk.

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However, Amco proposed a special jury instruction placing on Vardanyan the burden of proving the collapse of the house was "caused *only* by one or more" of the perils listed in the "collapse" provision. Amco's special instruction specifically stated there was no coverage if any peril *other* than those listed had partly caused the damage.

When the trial court indicated its intention to give part of Amco's proposed special instruction, Vardanyan objected and asserted that giving such an instruction was tantamount to directing a verdict in favor of Amco, because there was no dispute the damage to the house was at least partly caused by perils in addition to those listed in the "Other Coverage" for collapse. Amco then moved for a directed verdict on both causes of action. The trial court granted the motion, concluding Amco's proposed special instruction was legally correct, based on the unambiguous language of the Other Coverage provision of the policy. The trial court entered judgment in favor of Amco, and Vardanyan appealed.

**Holding**

The Court of Appeal reversed. Although the policy provided coverage for collapse "caused *only* by one or more" of the perils listed in the "collapse" provision, the fact that a non-listed peril might have contributed in some way to causing the damage did not automatically mean the loss was not covered. The trial judge should have given the jury the standard, approved jury instruction, which states that when "a loss is caused by a combination of covered and excluded risks under the policy, the loss is covered only if the most important or predominant cause is a covered risk." In other words, the jury should have been allowed to determine whether one of the listed perils (hidden decay, hidden insect damage, and weight of contents, equipment, or people) was the *predominant* cause of the damage, even if some other non-listed peril might have contributed to the damage.

Amco's special jury instruction also was improper because it required Vardanyan to prove that his loss fell within the "Other Coverage" for "collapse," and did not require Amco to prove that the loss was excluded. Here, the policy contained an all-risk insuring agreement, subject to a collapse exclusion that was, in turn, subject to an exception for collapse caused by certain listed perils. Thus, the burden was on Amco to prove not just collapse, but collapse *other* than as provided in the "Other Coverage" for collapse.

**Comment**

In California, the "predominant cause" (or "efficient proximate cause") doctrine is "the preferred method for resolving first party insurance disputes involving losses caused by multiple risks or perils, at least one of which is covered by insurance and one of which is not." (*Julian v. Hartford Underwriters Ins. Co*. (2005) 35 Cal.4th 747, 753.) If the policy provides all-risk coverage, then coverage exists unless an excluded cause is the *predominant* cause of the damage. Conversely, if the policy provides specified-risk coverage, then coverage exists if a listed cause is the *predominant* cause of the damage (even if a non-listed cause contributes in some way to causing the damage).

In an all-risk policy that excludes coverage for collapse but then restores coverage for collapse when caused by certain specified causes, the specified causes essentially operate as exceptions to the exclusion. (*Jordan v. Allstate Ins. Co.* (2004) 116 Cal.App.4th 1206.) In most instances, the insured bears the burden of proving an exception to an exclusion. However, when the policy provides all-risk coverage, California courts require the insurer to negate an exception to an exclusion. (See also *Strubble v. United Services Auto. Assn*. (1973) 35 Cal.App.3d 498.)

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## *Business Interruption and Extra Expense Coverage for Off Premises Damage to Property of "Direct Supplier" Did Not Apply Where Manufacturer Did Not Have Contractual Relationship with Supplier's Subcontractor*

An insured's business interruption and extra expense coverage for off premises damage to property of a "direct supplier" did not apply where the insured did not have a contractual relationship with the supplier's subcontractor, did not pay the subcontractor and did not receive goods directly from the subcontractor. (*DIRECTV v. Factory Mutual Ins. Co.* (C.D. Cal. 2016) 160 F.Supp.3d 1193)

**Facts**

DIRECTV distributes digital entertainment programming, primarily via satellite, to residential and commercial subscribers. DIRECTV satellite dishes pick up signals from satellites and transmit those signals to a set-top box, which in turn transmits the signals to the subscriber's television.

DIRECTV contracted with four companies to manufacture and supply set-top boxes. Some set-top boxes included, as a component part, hard disk drives. All four of the set-top box manufacturers used hard disk drives made by two companies, one of which was Western Digital Technologies, Inc.

DIRECTV categorized its four set-top box manufacturers as its "Tier 1" suppliers and characterized Western Digital as a "Tier 2" supplier. DIRECTV shared pricing and technical specification requirements with Western Digital, and DIRECTV instructed its set-top box manufacturers to use only certain Western Digital products. However, DIRECTV did not contract directly with Western Digital, purchase any hard disk drives directly from Western Digital or receive any hard disk drives directly from Western Digital.

Factory Mutual Insurance Company issued a property insurance policy to DIRECTV. The policy provided coverage for both property damage and time element (business interruption) losses. A "contingent time element" provision of the policy extended coverage, including business interruption and extra expense coverage, beyond DIRECTV's own property to certain "contingent time element locations." The policy's definition of such locations included any location "of a direct supplier, contract manufacturer or contract service provider."

Flooding damaged two of Western Digital's hard drive manufacturing facilities. Although the flooding did not affect any of the four set-top box manufacturers' facilities, DIRECTV alleged that the damage to the Western Digital facilities reduced the supply of hard disk drives available for incorporation into DIRECTV's set-top boxes. DIRECTV further claimed that the resulting price increase in Western Digital hard disk drives, as well as the expense of obtaining substitute hard disk drives from another manufacturer, caused DIRECTV approximately $22 million in losses and extra expenses.

DIRECTV made a claim under the Factory Mutual policy for contingent time element losses. Factory Mutual denied the claim on the basis that Western Digital was not DIRECTV's "direct supplier," and therefore did not fall within the ambit of the contingent time element location provision. DIRECTV then sued Factory Mutual in federal court, asserting that, despite the lack of any contractual relationship between Western Digital and DIRECTV, Western Digital was nevertheless a "direct supplier" because of the direct working relationship between the two. Factory Mutual moved for summary judgment against DIRECTV.

**Holding**

The federal district court granted Factory Mutual's motion.

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The only question before the court was whether the terms "direct supplier, contract manufacturer or contract service provider," as found in the policy, were applicable to the relationship between DIRECTV and Western Digital. The court concluded that DIRECTV's relationship with Western Digital did not fall within the meaning of these terms, because DIRECTV did not have a contract with Western Digital, never paid Western Digital anything, and never received any hard disk drives directly from Western Digital. Instead, Western Digital hard drives only flowed to DIRECTV as a component part of set-top boxes manufactured by third parties with whom DIRECTV did have a contractual relationship. Because Western Digital was not a "direct supplier, contract manufacturer or contract service provider" of DIRECTV, DIRECTV could not recover under the Factory Mutual policy.

**Comment**

The interpretation of a policy provision presents an issue of law, not an issue of fact. Hence, a dispute that turns on the interpretation of a policy provision is ripe for resolution by motion for summary judgment.

Here, DIRECTV argued that the phrase "direct supplier" should be defined according to its usage in the "electronics supply chain industry." However, DIRECTV was unable to point to any evidence that the parties intended the term "direct supplier" to have some technical or industry-specific definition, nor any usage of that phrase either within or outside the policy itself in a manner that would suggest a definition other than the ordinary and popular one.

The court noted that policy did include specialized definitions of otherwise ordinary terms, including "location," "occurrence," "wind," "earth movement," "flood," "terrorism," "contamination" and "normal." The court concluded that the fact that "direct supplier" was not defined anywhere in the policy suggests that the parties did not intend the term to carry any technical or specialized meaning. Thus, the court interpreted the term "direct supplier" according to its "ordinary and popular" meaning.

## *When Auto Insurer Elects to Repair Vehicle to Pre-Accident Condition, Insurer Is Not Also Required to Pay for Resulting "Diminution in Value" to Vehicle*

When an auto insurer elects to repair an insured vehicle to its pre-accident condition, the insurer is not also required to pay for any resulting "diminution in value" to the fully repaired vehicle. (*Baldwin v. AAA Northern California, Nevada & Utah Insurance Exchange* (2016) 1 Cal.App.5th 545)

**Facts**

William Baldwin's almost new Toyota Tundra Pickup sustained structural damage due to a collision caused by other motorists. Baldwin had an insurance policy through AAA Northern California, Nevada & Utah Insurance Exchange (AAA) covering collision-related damages to his pickup. Baldwin thus submitted a first-party claim to AAA.

AAA concluded that Baldwin's pickup was not a "total loss" and thus had the pickup repaired at a cost of $8,196. Baldwin contended that due to the collision and following the repairs, the pickup's future resale value was decreased by more than $17,000. However, AAA declined to pay Baldwin for any alleged diminution in value.

Baldwin subsequently filed a lawsuit against AAA asserting claims for breach of contract and bad faith. Baldwin alleged that the insurance policy required AAA to either (1) pay him the full pre-accident value of the pickup or (2) repair the pickup to its original pre-accident condition. Baldwin generally alleged that the repaired pickup did not match its pre-accident condition "with respect to safety, reliability, mechanics, cosmetics and

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performance," and further alleged that its future resale value had decreased by more than $17,000.

The trial court ruled that Baldwin essentially was seeking reimbursement for the diminution in value of his pickup following the repairs, and that such loss was not covered under the AAA policy. The trial court thus dismissed Baldwin's claims against AAA. Baldwin appealed.

**Holding**

The Court of Appeal affirmed. With respect to the policy's coverage for physical damage to Baldwin's car, the policy provided that AAA "*may* pay the loss in money *or* repair … damaged … property." Italics added. Further, the policy's "Limits of Liability" provision stated that AAA's responsibility for physical damage would not exceed "the lesser of" paying "the actual cash value of the … damaged property" *or "the amount necessary to repair … the property with similar kind and quality."* Italics added. Thus, pursuant to the terms of the policy, AAA could elect to repair Baldwin's vehicle to a similar condition if repair costs would be less than the actual cash value of the vehicle at the time of the loss. The court concluded that repairing a vehicle to its pre-accident condition does not mean restoring it to its original condition when it left the factory, because "no repair can ever restore a vehicle to its pristine factory condition," and applying such a standard would mean "no vehicle could be adequately repaired." Further, if the insurer could elect to make repairs but still had to pay for diminution in value following repairs, it would basically render meaningless the insurer's right to elect to repair rather than to pay the actual cash value of the vehicle at the time of loss.

The appellate court also noted that the AAA policy contained a specific exclusion for loss "*caused by diminution in value of your insured car … by reason of a loss otherwise covered by this policy*." Italics added. According to the appellate court, this exclusion was conspicuous, plain and clear and did not violate any public policy. The exclusion thus barred coverage for the diminution in value claim asserted by Baldwin. According to the court, "an insurer may cover the cost of repairing a car damaged in an accident, but exclude coverage for the accompanying decrease in the car's future resale value."

Based on the above, Baldwin did not have a viable claim against AAA for either breach of contract or bad faith.

**Comment**

The *Baldwin* case is consistent with several earlier California appellate cases, including *Carson v. Mercury Ins. Co.* (2012) 210 Cal.App.4th 409. Pursuant to these cases, when a first-party auto insurer elects to repair a vehicle to the vehicle's pre-accident condition, the insurer is not also required to pay for any diminution in value to the vehicle which might remain after the vehicle is fully repaired.

## *Insurer Properly Cancels Auto Policy Due to "Substantial Increase in Hazard Insured Against" After Insured Fails to Respond to Insurer's Request For Information Needed To Underwrite Risk*

An insurer properly cancelled an automobile policy due to a "substantial increase in the hazard insured against" after the insured failed to respond to the insurer's request for information necessary to accurately underwrite or classify the risk. (*Mills v. AAA Northern California, Nevada and Utah Insurance Exchange* (2016) 3 Cal.App.5th 528

**Facts**

Effective March 18, 2004, AAA Northern California, Nevada and Utah Insurance Exchange (AAA) issued an auto policy to Jeff and Denise Fields for a one-year period. The policy identified Mr. and Mrs. Fields and their daughter Krystal as insured

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drivers. It provided that AAA could cancel the policy for any permissible reason by mailing notice to Mr. and Mrs. Fields at least 20 days prior to the date of cancellation.

On February 5, 2005 (shortly before the end of the policy period), Mr. and Mrs. Fields' son Patrick collided with a parked vehicle while driving one of the cars listed on the AAA policy. At the time of the collision, Patrick was not listed as an insured driver on the policy.

On March 18, 2005, AAA renewed the policy for a one-year period. However, a few days later, on March 23, 2005, AAA sent Mr. and Mrs. Fields a letter stating that AAA needed information necessary to underwrite their policy accurately. The letter stated that Mr. and Mrs. Fields could exclude their son Patrick from coverage by completing and returning an enclosed form. The letter further stated that if instead Mr. and Mrs. Fields wanted to add Patrick to the policy or if they had other questions, they needed to call AAA. The letter concluded by stating that if Mr. and Mrs. Fields did not respond by April 22, 2005, AAA would cancel the policy. Mr. and Mrs. Fields did not respond to AAA's letter.

On April 28, 2005, AAA sent Mr. and Mrs. Fields a second letter stating that it was cancelling their policy effective May 28, 2005. According to AAA's letter, the cancellation was "based on the refusal or failure to provide necessary information to accurately underwrite your policy following the request for the same." Again Mr. and Mrs. Fields did not respond.

On July 6, 2005, Mr. and Mrs. Fields' daughter Krystal was driving one of the listed cars with Trent Mills riding as a passenger. They were involved in an accident caused by an uninsured motorist, resulting in severe injuries to Mills.

Mills obtained a $12.7 million default judgment against the uninsured motorist who had caused the accident. Mills then requested UM benefits under Mr. and Mrs. Fields' policy through AAA. AAA denied coverage on the ground that it had canceled the policy before the accident occurred.

Mills sued AAA for breach of contract and bad faith. The trial court found that AAA had validly cancelled the policy before the accident and granted summary judgment in favor of AAA. Mills appealed.

**Holding**

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

The appellate noted that under California law, an insurer has the right to cancel an automobile insurance policy prior to its expiration due to "a substantial increase in the hazard insured against." (Cal. Ins. Code § 1861.03(c)(1).) A "substantial increase in the hazard insured against" can occur when the insured refuses or fails to provide the insurer, "within 30 days after reasonable written request to the insured, information necessary to accurately underwrite or classify the risk." (10 Cal. Code Regs. § 2632.19(b)(1).) The insurer's written request for information must inform the insured that "his or her failure to provide the requested information within the time required may result in the cancellation or nonrenewal of his or her policy." (*Ibid*.)

Here, AAA's March 23, 2005 was a "reasonable" written request for information necessary to underwrite or classify AAA's risk. The letter was not arbitrary or unrelated to AAA's needs. Rather, it arose because a car AAA insured incurred damage in an accident by a family member (Patrick) who was not listed on the policy. It was reasonable for AAA to attempt to seek information to determine whether Patrick would be a regular driver of a family vehicle or, if not, to seek to have Patrick excluded from coverage.

Mills argued that AAA's letter was not "reasonable" because it did not request any specific information from Mr. and Mrs. Fields. The court disagreed. AAA's letter asked if Mr. and Mrs. Fields intended

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to exclude or include Patrick from coverage. If they were willing to exclude Patrick from coverage, then AAA would not need any additional information as AAA's risk would remain unchanged. If, however, Mr. and Mrs. Fields wished to include Patrick on the policy, then AAA would need additional information to determine whether to continue underwriting the policy.

Accordingly, AAA had validly cancelled Mr. and Mrs. Fields' auto policy prior to the accident in which Mills had been injured. As such, Mills was not entitled to UM coverage under the AAA policy.

**Comment**

The California Insurance Code sets forth limited grounds on which an insurer may cancel an auto insurance policy prior to its termination. One of the allowable grounds is "a substantial increase in the hazard insured against." Although the Insurance Code does not define what constitutes a "substantial increase in the hazard insured against," Department of Insurance regulations state that such an increase occurs when the insured fails "to provide to the insurer, within 30 days after reasonable written request to the insured, information necessary to accurately underwrite or classify the risk."

In this case, the appellate court held that in order to be a "reasonable" written request for information necessary to underwrite or classify the risk accurately, the request must be "rational, appropriate for the circumstance, and necessary to the insurer's ability to evaluate the risk of offering the policy." Here, AAA's written request satisfied that test and thus AAA had validly cancelled the policy.

## LIABILITY INSURANCE

### *"Non-Owned" Auto Coverage Does Not Apply Where Non-Owned Vehicle Is "Furnished or Available" for Insured's "Regular Use"*

An auto policy's "non-owned" auto coverage did not apply where the non-owned vehicle the insured was driving at the time of the accident was "furnished or available" for the insured's "regular use." (*Nationwide Mutual Insurance Co. v. Shimon* (2015) 243 Cal.App.4th 29)

**Facts**

Phillip Lionudakis ("Mr. Lionudakis") and his former wife, Kristen Doornenbal ("Mrs. Doornenbal"), were the parents of a teenaged daughter, Simone Lionudakis ("Simone"). Mr. Lionudakis and Mrs. Doornenbal lived ten minutes apart, and Simone split her time between them.

When Simone turned 16, Mr. Lionudakis bought a GMC pickup truck for Simone to drive. Although Mr. Lionudakis was the registered owner of the pickup truck, Simone was (with inconsequential exceptions) the only person who drove the truck. If Simone was not driving the truck, it sat parked. Although Simone had exclusive use of the truck, Mr. Lionudakis and Mrs. Doornenbal did some put some restrictions on Simone's use of the vehicle (e.g., she had to maintain her grades at school, she could not drive outside a certain geographic area without permission, etc.). In order to save money, Mr. Lionudakis excluded Simone from Mr. Lionudakis' own auto insurance policy.

In February 2008, Mr. Lionudakis and Mrs. Doornenbal placed Simone on restriction for poor grades, and temporarily prohibited her from driving the pickup truck. However, despite the fact that Simone was on restriction, Simone took the truck out and, while driving it outside of her normal

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geographical boundaries, caused an accident in which Aweia and Flora Shimon ("the Shimons") were injured.

The Shimons later filed a personal injury lawsuit against various parties, including Simone. The personal injury lawsuit settled, with an agreement that the court would determine whether there was insurance coverage for Simone under an auto insurance policy which her mother, Mrs. Doornenbal, had through Nationwide Mutual Insurance Company ("Nationwide"). The Nationwide policy covered Simone's use of a "non-owned" auto, *unless* the non-owned auto was "furnished or available" for her "regular use."

Nationwide filed a declaratory relief action seeking a determination that the non-owned pickup truck Simone was driving at the time of the accident *was* "furnished or available" for her "regular use," and that Simone therefore was *not* entitled to coverage under the non-owned auto provisions of the Nationwide policy. The trial court ruled that the GMC pickup truck was furnished or available for Simone's regular use and that the Nationwide policy therefore did not cover Simone's liability to the Shimons. The Shimons appealed.

**Holding**

The Court of Appeal affirmed the finding of no coverage. The appellate court reasoned that non-owned auto insurance coverage is meant to allow coverage for an insured's occasional use of a non-owned automobile, and the exclusion for regular use is meant to prevent an insured from regularly using a non-owned vehicle without paying insurance premiums for the vehicle. According to the appellate court, Simone's use of the GMC pickup truck in this case fell squarely within the purpose of the regular use exclusion. The GMC pickup was basically available for Simone's exclusive use, and yet no one insured the vehicle for her use.

The Shimons nevertheless argued that the GMC pickup truck was not furnished or available for Simone's regular use because Simone's parents had placed her on restriction such that she should not have been driving the truck at the time and place the accident occurred. The appellate court rejected that argument. According to the court, although Simone drove the truck in defiance of her parents' instructions, that did not render the "regular use" exclusion inapplicable. Rather, the court held that where a driver such as Simone is the exclusive user of the vehicle, "regular use" cannot vary with each trip the driver takes.

In short, because the GMC pickup truck was furnished or available for Simone's regular use, the Nationwide policy did not cover Simone's liability to the Shimons.

**Comment**

"Non-owned" auto coverage is intended to provide coverage for an insured's occasional use of a non-owned vehicle without requiring the payment of additional premiums. By the same token, the exclusion of coverage for "regular use" of non-owned vehicles is intended to prevent abuse by precluding the insured and family members from regularly driving two or more vehicles while only insuring one vehicle. Coverage is not intended to include the "*regular use"* of non-owned cars because the insurer would necessarily bear an increased risk without receiving any premium for the increased risk.

## *"Following Form" Excess Liability Policy Does Not Include Uninsured Motorist/Underinsured Motorist Coverage Provided In Underlying Primary Policy*

A "following form" excess liability policy did not include uninsured motorist/underinsured motorist coverage that was provided in the underlying primary policy. (*Haering v. Topa Insurance Company* (2016) 244 Cal.App.4th 725)

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**Facts**

Larry Haering was the owner of California Fleet, Inc. California Fleet was the named insured under a State National Insurance Company primary policy which provided various types of coverage, including garage operations coverage with a $1 million limit and uninsured motorist/underinsured motorist (UM/UIM) coverage with a $1 million limit. The State National policy's UM/UIM endorsement stated that State National would "pay all sums that the insured is legally entitled to recover as compensatory damages from the driver of an uninsured motor vehicle."

California Fleet was also the named insured on a Topa Insurance Company excess liability policy with a $1 million limit. The Topa excess policy provided that Topa would "indemnify the insured for the amount of loss which is in excess of the applicable limits of liability … of the Underlying Insurance [i.e., the State National policy]." The Topa policy further provided that "the provisions of the immediate underlying policy are incorporated as a part of this policy except for … any other provisions therein which are inconsistent with the provisions of this policy." The Topa policy defined "loss" as "the sum paid in settlement of losses for which the insured is liable…."

Haering was seriously injured in a motor vehicle accident caused by a negligent driver who had an auto policy with a $25,000 liability limit. Haering settled his claim against the negligent driver by accepting the $25,000 policy limit from the negligent driver's insurer.

Haering then submitted a UIM claim to State National pursuant to the $1 million UM/UIM endorsement to the State National policy. Eventually, Haering recovered the UIM policy limit from State National.

Thereafter, Haering submitted a claim to Topa for $1 million in excess coverage. Haering argued that the Topa policy "followed form" to the State National policy and thus "incorporated" the State National policy's UM/UIM coverage. Topa denied Haering's claim, asserting among other things that the Topa policy's insuring agreement limited coverage to third party liability claims and did not cover first party UM/UIM claims.

Following Topa's denial of coverage, Haering sued Topa for breach of contract and bad faith. The trial court concluded that the Topa excess policy only covered third party liability claims, not first party UM/UIM claims. Thus, the trial court entered judgment in favor of Topa. Haering appealed.

**Holding**

The California Court of Appeal affirmed the judgment in favor of Topa. According to the appellate court, the Topa excess policy's insuring agreement plainly "limits the insurer's indemnity obligation to 'losses for which the insured is liable,' i.e., third party liability claims." The appellate court thus concluded that Haering's "claim for first party UM/UIM benefits does not come within the scope of that agreement."

Haering nevertheless argued that the Topa policy was a "following form" excess policy that provided coverage on the identical terms as the underlying State National policy, including the UM/UIM coverage provided under the endorsement to the State National policy. The appellate court rejected that argument. The court reasoned that the language of the Topa policy that incorporated the provisions of the State National policy also expressly excepted from incorporation those provisions "which are inconsistent with" the Topa policy. Because the Topa policy's insuring agreement expressly limited coverage to third party liability claims, first party UM/UIM coverage would be "inconsistent" with that limitation.

**Comment**

The appellate court in this case relied on the distinction between first party insurance, which provides coverage for loss sustained *directly by the insured*, and third party insurance, which provides

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coverage for liability *of the insured to a third party*. The court held that UM/UIM coverage is first party coverage, not third party coverage, because the insurer's duty is to compensate its insured for his or her losses, rather than to indemnify the insured for losses sustained by others.

## *Insurer Has Duty to Defend Insured Bedding Manufacturer in Class Action Lawsuit Arising from Sale of Allegedly Defective Mattresses*

A general liability insurer had a duty to defend its insured, a bedding manufacturer, against a consumer class action lawsuit arising from the insured's sale of allegedly defective mattresses. (*Hartford Fire Ins. Co. v. Tempur-Sealy International, Inc.* (N.D. Cal. 2016) 158 F.Supp.3d 877)

**Facts**

Several individual plaintiffs filed a federal court class action lawsuit against Tempur-Sealy International, Inc. (Tempur-Sealy). In their complaint, the plaintiffs alleged that Tempur-Sealy failed to inform consumers that (1) Tempur-Sealy mattresses "emit a chemical odor caused by volatile organic compounds … off-gassing from" the mattresses; (2) the odor contains formaldehyde, a known human carcinogen; and (3) exposure to the odor causes consumers to suffer bodily injury (such as respiratory problems and allergic reactions) and property damage (such as contamination of pajamas and other items of clothing). The plaintiffs alleged that if they had known the true facts, they "would not have purchased [Tempur-Sealy] products for the retail price paid." The plaintiffs also specifically alleged that they "do not seek damages for physical injuries." The plaintiffs' complaint contained claims against Tempur-Sealy based on various state consumer protection statutes, including California's Unfair Competition Law, False Advertising Law, and Consumers Legal Remedies Act.

Tempur-Sealy tendered the defense of the class action lawsuit to its general liability insurer, Hartford Fire Insurance Company (Hartford), under consecutive policies which were in effect between 2004 and 2013. The policies provided that Hartford would defend Tempur-Sealy against suits seeking damages because of "bodily injury" or "property damage" caused by an "occurrence" and not otherwise excluded. Hartford agreed to defend Tempur-Sealy in the class action lawsuit, subject to a reservation of rights.

Hartford then filed a federal court declaratory relief action seeking a ruling that Hartford had no duty to defend Tempur-Sealy in the class action lawsuit. Hartford and Tempur-Sealy later filed cross-motions for summary judgment on the duty to defend issue.

**Holding**

The federal district court, applying California law, held that Hartford was obligated to defend Tempur-Sealy against the plaintiffs' claims in the underlying class action lawsuit.

According to the federal district court, the plaintiffs in the class action lawsuit were *potentially* seeking damages against Tempur-Sealy because of both "bodily injury" (which the policies defined as "bodily injury, sickness or disease sustained by a person") and "property damage" (which the policies defined as "physical injury to tangible property" and "loss of use of tangible property that is not physically injured"). The court reasoned that the complaint in the underlying class action lawsuit included detailed factual allegations describing the bodily injuries and property damage caused by Tempur-Sealy's products. According to the court, on their face, the "facts alleged" in the underlying complaint "clearly demonstrate the potential for liability" under the policies. It was irrelevant that the plaintiffs in the underlying suit expressly alleged that they were not seeking damages for bodily injury, because "the third-party plaintiff cannot be the arbiter of coverage." Moreover, while the policies' "product" exclusions would bar coverage for any property damage to Tempur-Sealy's *own products* (i.e., the

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mattresses themselves), the product exclusions would not bar coverage for property damage to *other property* (e.g., pajamas and other items of clothing).

The federal district court also concluded that the plaintiffs' claims against Tempur-Sealy in the underlying class action lawsuit were potentially caused by an "occurrence" (which the policies defined as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions"). According to the court, this was not a situation where Tempur-Sealy could *only* be held liable for purely economic damages caused by "misrepresentations" (which would not qualify as "occurrences"). Rather, the allegations in the underlying class action complaint suggested that Tempur-Sealy could also *potentially* be held liable for bodily injury or property damage directly caused by an allegedly "defective product" (which would qualify as an "occurrence").

Because the plaintiffs in the underlying class action lawsuit were "potentially" seeking covered damages from Tempur-Sealy, Hartford had a duty to defend.

**Comment**

The federal district court liberally construed California's already broad duty to defend standard. The court reasoned that although "product defect" causes of action were not explicitly pled in the underlying complaint, there was a "potential" that such causes of action could be added by future amendment. The court distinguished earlier cases such as *Low v. Golden Eagle Ins. Co.* (2002) 99 Cal.App.4th 109, *The Upper Deck Co., LLC v. Fed. Ins. Co.* (9th Cir.2004) 358 F.3d 608 and *Sony Computer Entertainment America Inc. v. American Home Assurance Co.* (9th Cir.2008) 532 F.3d 1007, all of which had held that insurers were not obligated to defend insureds in underlying consumer class action cases. According to the federal district court, in the *Low*, *Sony and Upper Deck* cases, none of the underlying complaints actually contained *factual allegations* that would support covered claims for bodily injury or property damage. Here, by contrast, the federal district court characterized the underlying complaint as being replete with factual allegations that would support covered claims for bodily injury or property damage. As such, the insurer had a duty to defend.

## *In Suit Alleging Property Damage Occurring Over Multiple Years, Successive Primary Insurers Must Contribute Toward Insured's Defense Costs, Notwithstanding "Other Insurance" Language in One Insurer's Policy*

In a construction defect suit involving allegations that an insured was liable for continuous and progressive property damage occurring over a period of years, successive primary insurers were obligated to contribute toward the insured's defense costs, notwithstanding "other insurance" language contained in one insurer's policy. (*Certain Underwriters at Lloyds, London v. Arch Specialty Ins. Co.* (2016) 246 Cal.App.4th 418)

**Facts**

Between 1999 and 2002, KB Home Sacramento, Inc. and KB Home North Bay, Inc. (collectively KB) entered into subcontracts with Framecon, Inc. (Framecon) pursuant to which Framecon performed carpentry and framing work on homes being developed by KB.

Following completion of construction, various homeowners filed lawsuits against KB seeking to recover for alleged construction defects, including defects allegedly attributable to Framecon's work. In each lawsuit, KB filed a cross-complaint for indemnity against Framecon. The construction defect litigation involved allegations of property damage that potentially occurred over several years.

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Framecon was the named insured, and KB was an additional insured, on consecutive primary general liability policies issued by Certain Underwriters at Lloyds, London (Underwriters) for the period of October 2000 through October 2002, and Arch Specialty Insurance Company (Arch) for the period of October 2002 through October 2003. Framecon and KB thus tendered the defense of the construction defect litigation to both insurers. In response, Underwriters agreed to defend Framecon and KB. Arch, on the other hand, declined to participate in the defense of Framecon and KB because (1) the Arch policy's insuring agreement stated that Arch would only defend an insured if "no other insurance affording a defense … is available" to the insured, and (2) the Arch policy's conditions section stated that "if other insurance is available to an insured for a loss we cover," the Arch policy would be "excess" and Arch "will have no duty … to defend…."Arch asserted that since "other insurance" (i.e., the Underwriters policies) was "available" for the defense of Framecon and KB, Arch had no duty to participate in defending Framecon and KB.

Eventually, the underlying construction defect lawsuits were settled. Although Arch did not contribute anything toward Framecon's and KB's defense costs, Arch did contribute approximately $143,000 on behalf of Framecon toward the settlements.

Following the settlements, Underwriters filed an equitable contribution lawsuit against Arch. In the equitable contribution lawsuit, Underwriters sought to recover from Arch a share of the defense costs that Underwriters had paid on behalf of Framecon and KB in the underlying construction defect litigation. Arch moved for summary judgment, contending that because Underwriters had been obligated to defend Framecon and KB in the underlying litigation, the Arch policy's "other insurance" language excused Arch from defending. The trial court agreed with Arch and entered summary judgment in favor of Arch. Underwriters appealed.

**Holding**

The Court of Appeal reversed, and held that Underwriters was entitled to contribution from Arch.

According to the appellate court, the "other insurance" language in the insuring agreement and conditions sections of the Arch policy essentially functioned as an "escape" clause. That is, the Arch policy provided that Arch would defend an insured against a covered claim unless "*other insurance affording a defense … is available" to the insured.* The appellate court emphasized that "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." Arch could not avoid that result simply by including "other insurance" language in both the insuring agreement and the conditions sections of the Arch policy.

The appellate court also emphasized that Underwriters and Arch provided primary coverage to Framecon and KB at *different times* (i.e., Underwriters was on the risk from October 2000 through October 2002, while Arch was on the risk from October 2002 through October 2003). In the underlying construction defect litigation, the homeowners had sought damages from Framecon and KB for property damage that potentially occurred during both Underwriters' and Arch's policy periods. Thus, giving effect to Arch's "other insurance" provisions would "unfairly impose on Underwriters the burden of paying defense costs attributable to claims arising from a time when Arch was the *only* insurer" for Framecon and KB. In short, Arch could not rely on its "other insurance" language to deny a defense against allegations of property damage that occurred during periods of time when there was no "other insurance."

Based on the above, Underwriters was entitled to recover from Arch a share of the defense costs that Underwriters had paid on behalf of Framecon and KB in the underlying construction defect litigation. The appellate court thus remanded the

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case to the trial court for a determination of the amount owed by Arch.

**Comment**

The above case, decided by the Third Appellate District, is consistent with an earlier case entitled *Underwriters of Interest Subscribing to Policy Number A15274001 v. ProBuilders Specialty Ins. Co.* (2015) 241 Cal.App.4th 721, decided by the Fourth Appellate District. Both cases stand for the proposition that "escape" type "other insurance" language will not excuse one primary insurer from contributing toward defense costs which another primary insurer is required to pay on behalf of an insured in a case involving allegations of continuous and progressive property damage. This is true whether the "other insurance" language is included in the insuring agreement, the conditions, or both.

## *Insurer Has No Duty to Defend Insured Developer Against Suit Alleging Fraudulent Concealment of Construction Defects*

A commercial general liability insurer had no duty to defend its insured, a developer, against a suit alleging fraudulent concealment of construction defects. (*Swiss Re Int'l SE v. Comac Investments, Inc.* (N.D. Cal. 2016) --- F.Supp.3d ----, 2016 WL 5394087)

**Facts**

Comac Investments, Inc. ("Comac") was a developer that built a condominium project known as "Portola Drive." The project was completed in 1996.

In 2014 (approximately 18 years after the project was completed), the Portola Drive Homeowners Association ("Association") sued Comac for alleged construction defects, including reverse sloped decks, negative sloping of wall caps, open roof eaves, and lack of sealant on lag bolts. The Association alleged that those defects resulted in significant water damage to the premises.

Pursuant to California Code of Civil Procedure section 337.15, lawsuits for latent construction defects are subject to a ten-year statute of limitations which commences upon substantial completion of the construction. The only exception to that statute of limitations is section 337.15(f), which allows a lawsuit for latent defects to be filed after ten years if the lawsuit is based on "willful misconduct or fraudulent concealment." In order to avoid the ten-year statute of limitations, the Association alleged that during construction, Comac's management personnel observed defective workmanship by subcontractors working on the subject premises, but in order to save money, chose not to correct the defects. In other words, the Association alleged that Comac's conduct fell within the "willful misconduct or fraudulent concealment" exception to the ten-year statute of limitations.

Comac was the named insured on four consecutive general liability policies issued by the predecessor to Swiss Re International SE ("Swiss Re"). Comac tendered defense of the construction defect action to Swiss Re, which agreed to defend Comac under a reservation of rights.

Swiss Re then filed a federal court declaratory judgment action against Comac, seeking a determination that Swiss Re had no duty to defend or indemnify Comac in the underlying construction defect action. Swiss Re moved for summary judgment.

**Holding**

The federal district court, applying California law, granted summary judgment in favor of Swiss Re and held that Swiss Re had no duty to defend or indemnify Comac in the construction defect action.

The court noted that in the construction defect action, the Association alleged that Comac willfully

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and fraudulently covered up construction defects in order to avoid the cost of fixing those defects. Those allegations of willful misconduct and fraudulent concealment were not allegations of an "occurrence," or "accident," as required by the insuring agreement of the Swiss Re policies. Absent an "occurrence," or "accident," the Swiss Re policies did not apply.

Further, the Association's allegations that Comac engaged in willful misconduct and fraudulent concealment triggered the Swiss Re policies' exclusion for property damage which was "expected or intended" by the insured. According to the federal district court, the policies' exclusion for injury that was "expected or intended" by the insured operated the same way as Insurance Code section 533's exclusion for losses caused by the "willful act" of the insured. The court concluded that the Association's allegations of intentional misconduct by Comac fell within both the express exclusion found in the policies and the implied exclusion set forth in the statute. For this independent reason, the Swiss Re policies did not apply.

**Comment**

The only way the plaintiff in the underlying action could get around the ten-year statute of limitations was to plead "willful misconduct" or "fraudulent concealment" by the insured. That, in turn, effectively eliminated any possibility of coverage. In other words, either the plaintiff would prevail in the underlying action and the insured's liability would not be covered, or the insured would prevail in the underlying action and the insured would not have any liability at all. However, in either scenario, the insurer would not have any obligation to indemnify the insured. Since there was "no potential" for indemnity, there was no duty to defend.

## *CGL Policy's "Mold" Exclusion Does Not Relieve Insurer of Duty to Defend Insured Against Suit Alleging Property Damage Arising from Both Water Intrusion and Mold*

A commercial general liability policy's "mold" exclusion did not relieve an insurer of a duty to defend its insured, a general contractor, against a lawsuit alleging property damage resulting from both water intrusion and mold. (*Saarman Construction, Inc. v. Ironshore Specialty Insurance Company* (N.D. Cal. 2016) --- F.Supp.3d ----, 2016 WL 4411814)

**Facts**

The Westborough Court Condominiums is a condominium project that was built in the late 1990's. Following completion, the project experienced significant problems with water intrusion. The Westborough Court Condominiums Homeowners Association thus hired Saarman Construction, Inc. to perform repairs at the project.

John and Stella Lee owned a unit in the condominium development, and the Lees leased their unit to Tiffany Molock. Later, Molock filed a state court lawsuit against the Lees and the HOA. In her complaint, Molock alleged that the Lees and the HOA were responsible for various problems with the unit, including mold, plumbing leaks, and water intrusion.

The Lees and the HOA in turn filed cross-complaints for indemnity against Saarman. The Lees and the HOA both alleged that Saarman had negligently performed repair work at the condominium project, resulting in water intrusion and water damage that contributed to mold growth.

Saarman was the named insured on a commercial general liability policy issued by Ironshore Specialty Insurance Company. The policy provided

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in relevant part that Ironshore would indemnify Saarman against damages because of bodily injury and property damage not otherwise excluded, and that Ironshore would defend Saarman against any suit seeking covered damages. Ironshore declined to defend Saarman in the lawsuit, based in part on a "Mold, Fungi or Bacteria Exclusion" endorsement in the policy. That endorsement provided that the policy did not apply to "to any claim, demand, or *'suit' alleging*" bodily injury or property damage "arising out of, *in whole or in part*, the actual, alleged, or threatened discharge, inhalation, ingestion, dispersal, seepage, migration, release, escape or *existence of any mold*, mildew, bacteria or fungus, or any materials containing them, at any time." Italics added.

Following Ironshore's refusal to defend Saarman, Saarman filed a federal court lawsuit against Ironshore for breach contract and bad faith. Saarman then moved for partial summary judgment that Ironshore had a duty to defend Saarman in the underlying state court lawsuit.

**Holding**

The federal district court, applying California law, held that Saarman was entitled to a defense from Ironshore in the underlying lawsuit. The court thus entered partial summary judgment in favor of Saarman and against Ironshore on the duty to defend issue.

The district court reasoned that in the underlying lawsuit, there were allegations that Saarman had caused water intrusion damage (and hence "property damage") to the condominium unit occupied by Molock. Because those allegations fell within the scope of the policy's basic insuring agreement, Ironshore had the burden of establishing that the policy's "mold" exclusion conclusively eliminated any potential for coverage.

Ironshore argued that the policy's mold exclusion barred coverage not just for "claims" that include mold allegations "in whole or in part," but also for "suits" that include mold allegations "in whole or in part." Ironshore argued that the underlying action was such a "suit," and that the mold exclusion thus relieved Ironshore of any duty to defend Saarman as to the entire underlying "suit."

The federal district court rejected Ironshore's argument. The court acknowledged the seeming conflict between the mold exclusion (which relieves the insurer of any duty to defend a "suit" that includes both mold allegations and non-mold allegations) and California case law (which requires an insurer to defend any "mixed action" that includes both covered claims and uncovered claims). Ultimately, the district court held that Ironshore "cannot contract around California law that requires insurers to defend the entire action if there is any potentially covered claim." The court concluded that, to the extent the mold exclusion purported to bar a defense for "any … 'suit' alleging [property damage] arising out of, in whole or in part, the ... alleged ... existence of any mold," the exclusion was "unenforceable."

The court also noted that under California's "concurrent causation" doctrine, coverage can exist when an insured commits two negligent acts – one covered and one uncovered – that combine to cause one loss. Here, Saarman's alleged conduct potentially involved a "single negligent act" that resulted in "two categories of damages – one category that is covered [i.e., water intrusion damage] and one category that is not covered [i.e., mold damage]." According to the court, California law prevents an insurer from escaping a duty to defend a mixed action simply because the insured's negligent act happens to result in both covered and uncovered damage. Thus, Ironshore had a duty to defend Saarman in the underlying lawsuit "for both the covered water damage claims and the non-covered mold damage claims."

**Comment**

The federal district court was faced with a conflict between the policy's mold exclusion (which on its face relieved the insurer of any duty to defend a "suit" based in whole or in part on mold allegations) and California case law (which holds that an

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insurer has a duty to defend any "mixed action" that includes both covered and uncovered claims). The court resolved the conflict by adhering to the case law requiring an insurer to defend a mixed action in its entirety. According to the court, an insurer has a duty to defend an insured against a mixed action, and the insurer cannot circumvent that rule by policy language that purports to make the duty to defend disappear if the "suit" includes an uncovered claim.

Ironshore also sought to avoid a duty to defend based on a separate policy exclusion that barred coverage for "continuous or progressive injury or damage" (i.e., injury or damage that begins before the policy period and then gets progressively worse during the policy period). However, in a separate part of the opinion, the district court held that the continuous or progressive injury or damage exclusion did not relieve Ironshore of a duty to defend Saarman in the underlying lawsuit.

## BAD FAITH

### *In Calculating Ratio of Punitive Damages to Compensatory Damages, Compensatory Damages Should Include* Brandt *Fees, Whether Such Fees Are Awarded by Jury as Part of Verdict or by Trial Judge after Verdict*

In calculating whether the ratio of punitive damages to compensatory damages is constitutionally excessive, the amount of compensatory damages should include attorney's fees awarded pursuant to *Brandt v. Superior Court* (1985) 37 Cal.3d 813, whether those fees are awarded by the jury as part of its verdict or by the trial judge after the verdict. (*Nickerson v. Stonebridge Life Ins. Co.* (2016) 63 Cal.4th 363)

**Facts**

On February 11, 2008, Thomas Nickerson, who is paralyzed from the chest down, broke his leg when he fell from the wheelchair lift on his van. Because Nickerson was a veteran, he received medical care at no cost from a Department of Veteran Affairs hospital. Due to complications from the injury, Nickerson was not discharged from the VA hospital until May 30, 2008. Thus, he was hospitalized for a total of 109 days.

Following his discharge from the hospital, Nickerson sought benefits from Stonebridge Life Insurance Company under an indemnity benefit policy that stated it would pay him $350 per day for each day he was confined in a hospital for the necessary care and treatment of a covered injury. Upon receipt of the claim, and without consulting Nickerson's treating physicians, Stonebridge determined that Nickerson's hospitalization was "medically necessary" only from February 11th through February 29th. Stonebridge thus sent Nickerson a check for $6,450, which represented payment of $150 for one visit to the emergency room and $6,300 for 18 days of hospitalization at $350 per day.

Nickerson then sued Stonebridge alleging that Stonebridge had (1) breached the insurance contract by failing to pay him benefits for the full 109 days of his hospital stay and (2) breached the implied covenant of good faith and fair dealing by acting unreasonably in denying him his full policy benefits. Before trial, the parties stipulated that if Nickerson succeeded on his complaint, the trial court could determine the amount of attorney fees to which Nickerson was entitled under *Brandt v. Superior Court* (1985) 37 Cal.3d 813, as compensation for having to retain counsel to obtain the policy benefits. At trial, neither party presented to the jury evidence concerning the claim for, or amount of, *Brandt* fees.

At the close of Nickerson's case, the trial court granted Nickerson's motion for a directed verdict on the breach of contract cause of action and awarded him $31,500 in unpaid policy benefits.

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With respect to the bad faith cause of action, the jury returned a special verdict finding that Stonebridge's failure to pay policy benefits was unreasonable and awarded Nickerson $35,000 in damages for emotional distress. The jury also found Stonebridge had acted with "fraud" and awarded $19 million in punitive damages. After the jury rendered its verdict, the parties stipulated that the amount of attorney fees to which Nickerson was entitled under *Brandt* was $12,500, and the court awarded that amount.

Stonebridge then filed a motion for an order reducing the $19 million punitive damage award on the ground that the award was constitutionally excessive. Relying primarily on *State Farm Mut. Automobile Ins. Co. v. Campbell* (2003) 538 U.S. 408, the trial court concluded that the ratio of punitive damages to compensatory damages could not exceed 10 to 1. Thus, the trial court granted Stonebridge's motion and reduced the punitive damages award to $350,000. In calculating the permissible amount of punitive damages, the trial court included only the $35,000 in compensatory damages the jury had awarded on the bad faith cause of action, and excluded the $12,500 in *Brandt* fees the trial court had awarded after the jury's verdict.

Nickerson appealed to the California Court of Appeal, which held that in determining whether the ratio of punitive damages to compensatory damages is constitutionally excessive, the amount of compensatory damages should not include the $12,500 in *Brandt* fees awarded by the trial judge after the verdict. Nickerson then sought review in the California Supreme Court, which agreed to consider the matter.

**Holding**

The Supreme Court held that in calculating whether the ratio of punitive damages to compensatory damages is constitutionally permissible, the amount of compensatory damages should include *Brandt* fees whether those fees are awarded by the jury as part of the verdict *or* by the trial judge after the verdict. The Supreme Court emphasized that in a bad faith case, *Brandt* fees constitute compensatory damages. Thus, there is "no reason to exclude the amount of *Brandt* fees from the constitutional calculus merely because they were determined, pursuant to the parties' stipulation, by the trial court after the jury rendered its punitive damages verdict." In fact, to exclude such fees from consideration "would mean overlooking a substantial and mutually acknowledged component of the insured's harm."

The Supreme Court thus remanded the case to the Court of Appeal for further proceedings regarding the amount punitive damages to which Nickerson is entitled from Stonebridge.

**Comment**

While there is no absolute bright line rule for evaluating punitive damage awards, courts have generally held that when the ratio of punitive damages to compensatory damages exceeds 10 to 1, the punitive damage award is presumed excessive and thus unconstitutional. Likewise, in *Nickerson*, the trial judge applied, and the Court of Appeal affirmed, a punitive-to-compensatory ratio of 10 to 1. Thus, given the prior proceedings in *Nickerson*, one can probably expect that on remand the existing punitive damage award of $350,000 will be increased by another $125,000 (i.e., *Brandt* fees of $12,500 x 10 = $125,000).

In reaching its decision in *Nickerson*, the Supreme Court disapproved the Court of Appeal's earlier decision in *Amerigraphics, Inc. v. Mercury Casualty Co.* (2010) 182 Cal.App.4th 1538. In *Amerigraphics*, the Court of Appeal held, without elaboration or citation, that in evaluating the ratio of punitive damages to compensatory damages, compensatory damages should not include *Brandt* fees when awarded by the trial court after the jury's verdict.

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## *Mere Breach of Contract, Without More, is Not Sufficient to Establish "Wrongful" Retention of Policy Benefits Under Financial Elder Abuse Statute*

An insurer's alleged breach of contract, without more, is not sufficient to establish "wrongful" retention of policy benefits under California financial elder abuse statutes, and the existence of the same "genuine dispute" that defeated the insureds' bad faith claim also defeated their financial elder abuse claim. (*Paslay v. State Farm General Insurance Company* (2016) 248 Cal.App.4th 639)

**Facts**

Clayton and Traute Paslay were insureds on a homeowner policy issued by State Farm General Insurance Company. During a period of heavy rain, a roof drain failed, causing water to damage the house's master bedroom ceiling as well as other parts of the residence. At the time of the loss, Clayton was 60 years old and Traute was 80 years old.

State Farm paid policy benefits for repair of the house, and State Farm paid for the Paslays to live in a rental house while repairs were underway. Although State Farm paid approximately $248,000 for (1) repair of the dwelling, (2) additional living expense and (3) damage to personal property, State Farm denied coverage for certain items, including work undertaken in the master bathroom, replacement of drywall ceilings and installation of a new electrical panel.

The policy included coverage up to $5,000 for costs of mold remediation. During an inspection, the Paslays voiced concern about the *possibility* that mold had developed in wall and ceiling cavities in the bathroom, but did not expressly make a claim for mold damage. Nonetheless, State Farm paid the $5,000 mold limit. Later, the Paslays' contractor removed some drywall and cabinets in the bathroom, allegedly to determine if any hidden mold existed. During the course of this work, the Paslays and their contractor allegedly discovered hidden water damage. Before State Farm could inspect the allegedly-hidden water damage, the Paslays' contractor demolished a substantial portion of the bathroom. Later, the Paslays provided State Farm with photographs showing the alleged hidden water damage before the demolition. However, State Farm's construction consultant advised State Farm that the allegedly hidden water damage would not have required demolition of the bathroom.

In addition, the policy included limited coverage for costs of upgrades required by the building code. Without State Farm's approval, the Paslays' contractor had a subcontractor remove all drywall on the ceilings (even those with no water damage), asserting this was necessary because the ceilings' texture contained asbestos that required abatement. However, State Farm's construction consultant advised State Farm that the water damage would not have required removal of all drywall on the ceilings, and that the asbestos could have been abated by scraping the texture from the ceilings.

State Farm authorized a six-month lease of a rental property in which the Paslays could live during repairs. After the initial six-month period expired, State Farm authorized month-to-month extensions. Ultimately, the landlord elected to rent the property to other tenants, and the Paslays resumed living in their own home, which by then was partly (but not completely) repaired. There was no evidence that, after the landlord terminated the lease, the Paslays requested that State Farm pay for another rental residence.

The Paslays ultimately sued State Farm for breach of contract, bad faith and financial elder abuse. They alleged State Farm failed to pay certain policy benefits and forced them to move back into their house while it was still under construction. The complaint also included a prayer for punitive damages.

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State Farm moved for summary adjudication on all claims. In support, State Farm submitted detailed evidence outlining the handling of the claim and the amounts paid under the policy. In opposition, the Paslays submitted evidence in an effort to rebut some (but not all) of State Farm's assertions. The trial court entered judgment in favor of State Farm, and the Paslays appealed.

**Holding**

The Court of Appeal upheld the trial court's dismissal of the claims for bad faith and financial elder abuse, as well as the prayer for punitive damages. However, the Court of Appeal determined the Paslays' evidence was sufficient to raise triable issues regarding certain items for which State Farm failed to pay, namely the demolition and reconstruction of the master bathroom and the removal of drywall ceilings throughout the house. Among other things, the Court noted that the policy's $5,000 mold limit (which State Farm paid) did not shield State Farm from liability for allegedly hidden *water* damage discovered in the course of mold remediation of the master bathroom, including "exploratory" demolition undertaken to locate mold.

Although the Court held there were triable issues of fact regarding the Paslays' breach of contract claim, the Court held there were no triable issues of fact about whether State Farm had acted reasonably. Among other things, the evidence established that State Farm had relied upon a construction consultant, who promptly evaluated the claimed damage. In short, the Court concluded that even though State Farm's denial of coverage for the costs of demolition and reconstructing the bathroom and the ceilings might have been "mistaken" (i.e., might constitute a breach of contract), State Farm's denial of coverage for those items was *not unreasonable* (i.e., did not amount to bad faith), largely because there was a "genuine dispute" about the amount due under the policy.

With regard to Mrs. Paslay's claim for financial elder abuse, the Court of Appeal concluded there was no evidence that, by failing to pay certain policy benefits, State Farm had engaged in a "wrongful" retention of policy benefits, an "intent to defraud" or some "undue influence." As such, that claim failed.

**Comment**

As stated, Mrs. Paslay was 80 years old at the time of the loss.Under the Elder Abuse and Dependent Adult Civil Protection Act (Welfare & Institutions Code, section 15600 et seq.), an elder is "any person residing in [California], 65 years or older." This Act broadly defines financial abuse of an elder as occurring when a person or entity "[t]akes, secretes, appropriates, obtains, or retains real or personal property of an elder" for "a wrongful use," with an "intent to defraud" or by "undue influence."

The Court found no evidence that State Farm retained policy benefits with an "intent to defraud" or by "undue influence." Thus, the key question was whether there was a triable issue regarding a "wrongful use" of policy benefits.

The Elder Abuse and Dependent Adult Civil Protection Act (specifically, 15610.30(b)) provides that a person or entity is "deemed to have taken, secreted, appropriated, obtained, or retained property for a wrongful use if, among other things, the person or entity takes, secretes, appropriates, obtains, or retains possession of property and the person or entity *knew or should have known* that this conduct is *likely to be harmful* to the elder … adult." Under existing California case law, a party may engage in elder abuse by misappropriating funds to which an elder is entitled under a contract. The issue, according to the Court of Appeal, is whether a merely incorrect denial of policy funds under the circumstances shown here may constitute a "wrongful use" of those funds for purposes of an elder abuse claim.

The Court noted that the Act requires proof "the person or entity *knew or should have known* that this conduct is likely to be harmful to the elder … adult." In view of the italicized phrase, the Court of Appeal concluded an insurer's "wrongful use" (i.e.,

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wrongful retention of policy benefits) occurs only when the insurer who breaches the contract actually knows that it is engaging in a harmful breach, or reasonably should be aware of the harmful breach. The same evidence that established a "genuine dispute" sufficient to defeat the Paslays' bad faith claim was sufficient to defeat Mrs. Paslay's financial elder abuse claim.

## *Insurer's Failure to Accept Policy Limit Demand That Preserved Claimants' Right to Recover Criminal Restitution Against Insured Renders Insurer Liable for Subsequent "Excess Judgment"*

A liability insurer's failure to accept a policy limit demand that preserved the claimants' right to recover court-ordered criminal restitution against the insured rendered the insurer liable for the full amount of a subsequent "excess judgment" entered against the insured. (*Barickman v. Mercury Cas. Co.* (2016) 2 Cal.App.5th 508)

**Facts**

Timory McDaniel, driving while intoxicated, ran a red light and struck Shannon Mcinteer and Laura Beth Barickman, both of whom were pedestrians in a crosswalk. As a result, Mcinteer and Barickman suffered serious injuries.

The District Attorney's office filed criminal charges against McDaniel. The court in the criminal case later sentenced McDaniel to a prison term and ordered her to pay $165,000 in restitution to Mcinteer and Barickman.

At the time of the accident, McDaniel was insured on a Mercury Casualty Company auto policy with bodily injury liability limits of $15,000 each person / $30,000 each accident. A few weeks after the accident, Mercury offered to pay its policy limits in settlement of any liability McDaniel had to Mcinteer and Barickman. In connection with Mercury's settlement offer, Mercury sent standard "general releases" to the attorney who was jointly representing Mcinteer and Barickman.

Mcinteer and Barickman, through their attorney, eventually informed Mercury that they would accept Mercury's policy limits in settlement. Mcinteer's and Barickman's attorney returned the signed general releases to Mercury, but on each release added a sentence stating "This does not include court-ordered restitution," and also set a deadline by which Mercury had to fund the settlements.

Mercury sought clarification from Mcinteer's and Barickman's attorney as to the effect of the additional language in the releases. The attorney responded that the additional language in the releases was only intended to ensure that the releases did not "wipe out" Mcinteer's and Barickman's basic right to court-ordered restitution, and was not intended to preclude McDaniel from using Mercury's insurance payments as an "offset" against the amounts McDaniel owed as restitution. Mercury apparently did not communicate this explanation to McDaniel, and as result McDaniel initially was opposed to the additional language in the releases. Ultimately, Mercury did not agree to the modified releases or fund the settlements within the time limit set by Mcinteer and Barickman, and Mcinteer's and Barickman's settlement demands against McDaniel expired without being accepted.

Mcinteer and Barickman then filed a personal injury lawsuit against McDaniel. That lawsuit ended with Mcinteer obtaining a judgment against McDaniel for $2,200,000 and Barickman obtaining a judgment against McDaniel for $800,000, for a total of $3,000,000. Mcinteer and Barickman agreed not to execute on the judgments against McDaniel in exchange for an assignment of any rights McDaniel might have against Mercury.

Mcinteer and Barickman, as assignees of McDaniel, then filed a bad faith action against

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Mercury. Mcinteer and Barickman essentially alleged that Mercury had an opportunity to settle Mcinteer's and Barickman's claims against McDaniel for the policy limits, but failed to do so, thus resulting in the excess judgment against McDaniel.

Mcinteer, Barickman and Mercury stipulated to have the bad faith case decided by a referee. After trial, the referee found that Mercury had breached the implied covenant by refusing to accept the form releases with the additional "restitution" language inserted by the attorney for Mcinteer and Barickman. The referee thus awarded Mcinteer and Barickman damages in the amounts of the judgment in the underlying case (i.e., $2,200,000 for Mcinteer and $800,000 for Barickman), plus interest. Mercury appealed.

**Holding**

The Court of Appeal affirmed.

The appellate court agreed that Mercury had initially acted in good faith by offering its policy limits on behalf of McDaniel in exchange for a general release of all claims by Mcinteer and Barickman. However, that by itself did not relieve Mercury of further obligations to McDaniel.

The court observed that when Mcinteer's and Barickman's attorney eventually sent Mercury the signed form releases with the added language (i.e., "this does not include court-ordered restitution"), Mercury's adjuster sought clarification from the attorney regarding the effect of the additional language. In response, Mcinteer's and Barickman's attorney told Mercury's adjuster that Mcinteer and Barickman were only trying to preserve their "basic restitution rights" and were not seeking to eliminate McDaniel's right to use Mercury's insurance payment as an "offset" against the amount McDaniel owed as restitution. However, Mercury's adjuster failed to communicate that explanation to McDaniel.

The appellate court rejected Mercury's contention that it was only trying to protect McDaniel's right to use any insurance payment as an offset against the amount McDaniel owed as restitution. According to the court, under established case law, the right to an offset already existed. Further, if Mercury was concerned about expressly preserving McDaniel's right to an offset , Mercury could have simply suggested a further revision to the release (e.g., "and does not affect the insured's right to offset"), but Mercury did not do so.

The appellate court observed that the reasonableness of the insurer's claims-handling conduct was a question of fact to be resolved following a trial. While there was conflicting evidence on many issues, there was evidence supporting the referee's finding that Mercury had breached the implied covenant of good faith and fair dealing by failing to agree to a release with the additional language and/or failing to modify it to clarify the parties' mutual intent. Because Mercury's conduct caused the insured, McDaniel, to suffer a judgment in excess of the policy limits in the underlying action, Mercury was liable for the full amount of that judgment (i.e., $3,000,000 plus interest)

**Comment**

According to the appellate court, the modified release language that the plaintiffs' counsel wanted (i.e., "this does not include court-ordered restitution") was simply an expression of existing law (i.e., a civil settlement does not eliminate a victim's right to restitution ordered by the criminal court, but the defendant is entitled to an offset for any payments to the victim by the defendant's insurance carrier for items included within the restitution order). (See, e.g., *People v. Bernal* (2002) 101Cal.App.4th 155, 167-168; *People v. Vasquez* (2010) 190Cal.App.4th 1126, 1133.) Thus, Mercury should either have simply agreed to the additional language or sought to modify it so that the parties' intent was clear. Mercury's failure to do so was deemed to be a proximate cause of the excess judgment that was entered against the insured, McDaniel, in the underlying action.

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## *Where Primary Insurer Fails to Settle Within Primary Policy Limits, Forcing Excess Insurer to Contribute to Eventual Settlement, Lack of "Excess Judgment" Does Not Bar Excess Insurer's Suit Against Primary Insurer*

Where a primary insurer failed to accept a reasonable settlement demand within the primary insurer's policy limits, and as a result an excess insurer was required to contribute to an eventual settlement, the lack of an "excess judgment" against the insured did not prevent the excess insurer from pursuing an equitable subrogation action against the primary insurer for failure to settle. (*Ace American Ins. Co. v. Fireman's Fund Ins. Co*. (2016) 2 Cal.App.5th 159)

**Facts**

John Franco was working on a film set when a special effects accident caused him to suffer catastrophic injuries. Thereafter, Franco and his wife sued Warner Brothers Entertainment, Inc. for personal injuries and loss of consortium.

At the time of the accident, Warner Brothers had a $2 million primary policy issued by Fireman's Fund Insurance Company; a $3 million umbrella policy also issued by Fireman's Fund; and a $50 million excess policy issued by Ace American Insurance Company.

Fireman's Fund defended Warner Brothers against the Francos' lawsuit. While that lawsuit was pending, the Francos made settlement demands against Warner Brothers that were within the combined $5 million limits of the two Fireman's Fund policies, but Fireman's Fund failed to accept those demands. Later, the Francos settled their lawsuit against Warner Brothers for an amount "substantially in excess" of the $5 million limits of the Fireman's Fund policies. As part of the settlement, Fireman's Fund paid its $5 million limits and Ace American contributed the amount in excess of the Fireman's Fund limits.

Ace American then sued Fireman's Fund for equitable subrogation and breach of the covenant of good faith and fair dealing. Ace American alleged that in the underlying lawsuit the Francos had made reasonable settlement demands against Warner Brothers within the limits of the Fireman's Fund policies; that there was a substantial likelihood that a jury verdict against Warner Brothers would exceed the limits of the Fireman's Fund policies; and that due to Fireman's Fund's wrongful failure to settle the underlying lawsuit within the Fireman's Fund policy limits, Ace American as excess insurer was compelled to contribute toward the eventual settlement in the underlying lawsuit.

The trial court dismissed Ace American's lawsuit against Fireman's Fund at the pleading stage. The trial court reasoned that because the Francos' lawsuit was *settled* and there was no excess *judgment* against Warner Brothers, neither Warner Brothers (as insured) nor Ace American (as subrogated excess insurer) could recover against Fireman's Fund. Ace American appealed.

**Holding**

The Court of Appeal reversed. According to the appellate court, it was irrelevant whether the underlying action was resolved by a settlement or by a judgment. As long as the insured (or a subrogated excess insurer) is liable for an amount beyond the limits of the primary policy due to the primary insurer's bad faith refusal to settle within policy limits, the insured (or the subrogated excess insurer) is entitled to pursue the primary insurer for failure to settle. In this situation, the insured (or the insured's assignee) may sue the primary insurer "despite the absence of a litigated excess judgment." The court stated, "We see no persuasive reason to hold that either Warner Brothers or its assignee, Ace American, must suffer the loss with no remedy simply because the

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case reached an eventual settlement instead of being litigated through trial [with a resulting excess judgment]."

Accordingly, Ace American had stated a cause of action against Fireman's Fund, and Ace American was entitled to move forward with its case against Fireman's Fund.

**Comment**

California appellate courts have dealt with the same issue in prior cases but have reached conflicting results. Thus, in *Fortman v. Safeco Insurance Co*. (1990) 221 Cal.App.3d 1394, the court held that an excess insurer *could* pursue an equitable subrogation action against a primary insurer that initially breached its duty to settle a case within policy limits, resulting in a *settlement* that exceeded the primary policy limits. By contrast, in *RLI Insurance Company v. CNA Casualty of California* (2006) 141 Cal.App.4th 75, the court held that an excess insurer could *not* pursue an equitable subrogation action against the primary insurer under those same circumstances, because the insured's (and hence the subrogated excess insurer's) cause of action against the primary insurer "hinges upon a *judgment* in excess of policy limits."

The appellate court in the above *Ace American* case followed the reasoning of *Fortman* rather than that of *RLI*. Thus, according to the *Ace American* court,if an excess insurer is required to contribute to a settlement of an underlying case due to the primary insurer's failure to reasonably settle within the primary policy limits, the lack of an excess judgment against the insured in the underlying case does *not* bar the excess insurer's action for equitable subrogation and breach of the duty of good faith and fair dealing against the primary insurer.

## BROKERS

### *Uninsured Tortfeasor Can Assign Claim Against Broker, and Rule of Superior Equities Does Not Apply to Contractual Assignment*

An uninsured tortfeasor can assign a negligence claim against a broker for failing to obtain insurance, and the rule of superior equities that might apply in equitable subrogation does not apply to an independent contractual assignment. (*AMCO Insurance Company v. All Solutions Insurance Agency, LLC* (2016) 244 Cal.App.4th 883)

**Facts**

Amarjit Singh (Singh) owned a commercial building that, due to Singh's negligence, caught fire. The fire caused substantial damage to Singh's property and spread to two adjacent commercial properties owned by others.

AMCO Insurance Company (AMCO) was the first-party insurer of the owner of one of the adjacent properties. AMCO paid its insured for the property damage caused by Singh's negligence, and then filed a subrogation action against Singh. The owners of the other adjacent property also filed a separate action against Singh to recover for the damages they had suffered.

Singh tendered both of the lawsuits to a liability insurer, but the insurer denied coverage on the grounds Singh did not have a policy in force at the time of the fire. Singh asserted that the lack of coverage was due to negligence by All Solutions Insurance Agency, LLC (All Solutions), a broker that had allegedly failed to procure insurance Singh requested prior to the fire.

Later, Singh entered into settlement agreements with AMCO and the owners of the other property. As part of the settlements, Singh stipulated to a

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judgment totaling about $371,000 in favor of AMCO and a judgment totaling about $194,000 in favor of the owners of the other property. In addition, Singh assigned to AMCO and the owners of the other property all of Singh's rights against All Solutions.

Acting as Singh's assignee, AMCO and the owners of the other property filed separate actions for negligence against All Solutions. The trial court ordered that the two lawsuits be consolidated.

The trial court granted summary judgment in favor of All Solutions. Among other things, the trial court ruled that (1) Singh's claims against All Solutions were not assignable and (2) even if the claims were assignable, they were barred by the doctrine of superior equities. AMCO and the owners of the other property appealed.

**Holding**

The Court of Appeal reversed. First, the appellate court held that Singh was indeed able to assign his negligence claim against the broker.

Second, the appellate court held that, in the context of insurance law, the doctrine of superior equities applies to a contractual assignment *only* if the assignee is an insurance company *and* the assignor was that insurance company's policyholder. Here, AMCO (an assignee) was an insurer, but Singh (the assignor) was never AMCO's policyholder. Further, the owners of the other property (also assignees) were not insurers. Thus, because the rights of AMCO and the owners of the other property arose by virtue of contractual assignment (not equitable subrogation), the doctrine of superior equities could not apply.

**Comment**

In this case, the appellate court reiterated that, as a general rule, a negligence claim against an insurance broker can be assigned to a third party. In fact, based on various statutes and prior case law, most claims can be assigned to a third party. (Although most claims can be assigned, notable exceptions exist for claims for personal injury; slander; malicious prosecution; legal malpractice; and certain claims for fraud.)

In addition, the appellate court pointed out the distinction between "equitable subrogation" (which arises by operation of law where an insurer has paid a loss to its insured) and "contractual assignment" (which is based on a voluntary agreement between the party transferring the rights and the party receiving the rights). Under existing California law, when an insurer acquires rights by equitable subrogation, the insurer generally does not acquire any additional rights by a contractual assignment (because the contractual assignment is viewed as being redundant).

One of the elements of equitable subrogation is the rule of superior equities, which holds that the right of equitable subrogation may be invoked against a third party only if that party is guilty of some wrongful conduct which makes the party's equity inferior to that of the insurer. The rule of superior equities is partly based on the idea that the insurer already has been compensated (by receipt of premiums) for issuing the policy and should not be allowed to shift the very loss contemplated by the policy to a third party, even though that third party, as between itself and the insured, would be liable. All Solutions argued (successfully in the trial court but unsuccessfully in the appellate court) that its equitable position was superior to AMCO's equitable position, because All Solutions did not cause the fire but, instead, allegedly failed to procure coverage for Singh (who actually caused the fire).

The appellate court noted that AMCO and the owners of the adjoining property did not issue an insurance policy to Singh and, therefore, their rights did not arise by equitable subrogation. Instead, the rights of AMCO and the owners of the adjoining property arose solely by virtue of an independent contractual assignment that was not subject to the rule of superior equities.

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## MISCELLANEOUS

### *Controlling Shareholder of Insured Corporation Does Not Have "Standing" to Seek Declaratory Relief Against Corporation's Insurers*

The controlling shareholder of an insured corporation did not have sufficient legal "standing" to pursue a claim for declaratory relief against the corporation's liability insurers. *(D. Cummins Corporation v. United States Fidelity & Guaranty Company* (2016) 246 Cal.App.4th 1484)

**Facts**

For many years, D. Cummins Corporation (Cummins Corp.) installed asbestos containing products in California. Later, hundreds of persons filed lawsuits against Cummins Corp. alleging bodily injury based on exposure to asbestos containing products.

Cummins Corp. was the named insured on primary and excess insurance policies issued by United States Fidelity & Guaranty Company (USF&G) for the period of July 1969 through January 1987 and United States Fire Insurance Company (US Fire) for the period of February 1988 through January 1992. Cummins Corp. thus tendered the defense of the asbestos lawsuits to USF&G and US Fire. Later, various disputes arose between Cummins Corp., on the one hand, and USF&G and US Fire, on the other hand, regarding defense and indemnity for the asbestos lawsuits.

On January 17, 2014, D. Cummins Holding LLC (Cummins Holding) was formed and became the parent and controlling shareholder of Cummins Corp. Six days later, on January 23, 2014, Cummins Corp. and Cummins Holding jointly filed a declaratory relief action against USF&G and US Fire in order to obtain rulings regarding USF&G's and US Fire's obligations to defend and indemnify Cummins Corp. in the underlying asbestos lawsuits.

USF&G and US Fire demurred to Cummins Holding's cause of action for declaratory relief, asserting that Cummins Holding was not an "insured" under the policies and thus did not have "standing" to sue the insurers for declaratory relief. The trial court sustained the insurers' demurrers without leave to amend and dismissed Cummins Holding from the case. Cummins Holding appealed.

**Holding**

The California Court of Appeal affirmed. California Code of Civil Procedure section 1060 provides that "[a]ny *person interested* under a written instrument … or under a contract … may, in cases of *actual controversy relating to the legal rights and duties of the respective parties*, bring an original action … for a declaration of his or her rights and duties …." A related statute, Code of Civil Procedure section 1061, provides that "[t]he court may refuse to exercise the power granted by this chapter in any case where its declaration or determination is *not necessary or proper* at the time under all the circumstances." Italics added.

Here, Cummins Corp. as named insured was a "person interested" who had legal standing to sue the insurers for a declaration of rights under the insurance policies. By contrast, Cummins Holding as controlling shareholder of Cummins Corp. did *not* qualify as a "person interested" who had sufficient standing to sue for a declaration of rights under the policies. Even if Cummins Holding was the sole entity responsible for managing the affairs of Cummins Corp., that indirect interest did not translate into "a legally cognizable theory of declaratory relief." Cummins Corp. could pursue its own rights, and Cummins Holding as shareholder would profit indirectly. Thus, the trial court did not abuse its discretion in ruling that Cummins Holding had failed to state a claim for declaratory relief against USF&G and US Fire.

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**Comment**

Here, Cummins Holding was not an insured, did not have an assignment from an insured, and was not a judgment creditor of an insured. As such, Cummins Holding could not demonstrate the existence of any actual controversy between it and the insurers. The only party who had standing to pursue a declaratory relief action was the actual insured, Cummins Corp.

This case is consistent with prior California appellate cases holding that a corporation's shareholders generally do not have standing to sue the corporation's insurer. (See, e.g., *Seretti v. Superior Nat. Ins. Co.* (1999) 71 Cal.App.4th 920, 922-924; *C & H Foods Co. v. Hartford Ins. Co.* (1984) 163 Cal.App.3d 1055, 1068.)

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