Insurance Law

By Jim Roth, Esq.
The Roth Law Firm

As the conclusion of 2008 approached, the Appellate Courts were of a collective view that statutes must be strictly and unconditionally applied. To the extent that insurers sought to create a less than level playing field with its insureds, the courts were firm in dispensing relief to the aggrieved insureds.

An Insurer Which Undertakes a Biased Claims Investigation May Not Shield Itself from "Bad Faith" Exposure Behind the "The Genuine Dispute" Doctrine Does Not Apply.

In Brehm v. 21st Century Insurance Company (2008) 166 Cal.App.4th 1225, the Court of Appeal, Second District, held that an underinsured motorist (UIM) insurer's contractual right to arbitrate UIM claims did not relieve it from its obligation to deal with its insured in good faith by honestly assessing the insured's claim and making a reasonable effort to resolve any dispute as to the amount of the insured's damages before invoking the right to arbitration.

Factually, Brehm and his parents were all seriously injured in a traffic accident caused by Natalie Aguirre, who struck the rear of the Brehm automobile while it was stopped at a red light. Brehm and his parents settled with Aguirre's insurer for $30,000, her full policy limits; Brehm received $10,000; each of his parents also received $10,000. Thereafter, Brehm made a UIM claim as an additional insured to his parents' insurer, 21st Century. That policy provided UIM benefits of $100,000 for one person and an additional $5,000 in medical benefits. Brehm submitted medical reports and assessments, bills and diagnostic test results to 21st Century that showed, as a result of the accident with Aguirre, he had suffered among other injuries, "a severe shoulder injury that would require costly surgery and related costs and expenses."

After the parties failed to reach an agreement on Brehm's claim, the issue apparently only being the extent of his injuries and thus the amount to which he was entitled, an arbitration was scheduled. Before the scheduled arbitration, Brehm made a demand for $85,000 plus medical payments pursuant to CCP §998. 21st Century rejected the demand and made a counteroffer of $5,000 plus previously paid medical benefits. In rejecting Brehm's demand, 21st Century stated its position, based on an evaluation conducted by its retained medical expert, that Brehm's injuries were limited to soft tissue and the surgeries recommended by Brehm's medical provider "are not necessary." To persuade 21st Century to pay a reasonable settlement, Brehm submitted to a medical examination by a highly credentialed board-certified orthopedic surgeon, whose resulting report stated Brehm had suffered a cervical strain, lumbar strain and right shoulder rotator cuff strain. That report presented to 21st Century opined Brehm needed further treatment and concluded it was "more likely than not" that surgery would be required on his right shoulder, which would cost approximately $15,575 and post-surgical physiotherapy approximately $3,600.

Following a continuance of the arbitration date to allow 21st Century to subpoena and review those medical records, Brehm made a $90,000 policy limit demand ($100,000 less the $10,000 Brehm had recovered from Aguirre), plus $5,000 in medical payments. In response, 21st Century offered $5,000 plus the balance of the full policy maximum of $5,000 in medical payments. Brehm rejected the counteroffer. Brehm received an arbitration award of $91,186; the award was reduced by stipulation to the $90,000 policy limit. 21st Century paid Brehm the $90,000 shortly after the award was made. Brehm filed a complaint against 21st Century and, after the court sustained a demurrer, a first amended complaint asserting causes of action for breach of the implied covenant of good faith and fair dealing and breach of contract, alleging 21st Century had unreasonably failed to make a good faith effort to resolve Brehm's UIM claim after its liability for payment of benefits was clear.

The appellate court began its analysis by landscaping the playing field: California law recognizes in every contract, including insurance policies, an implied covenant of good faith and fair dealing. In the insurance context the implied covenant of good faith and fair dealing requires the insurer to refrain from injuring its insured's right to receive the benefits of the insurance agreement. The failure to accept a reasonable offer to settle a claim against its insured exposes an insurer to liability in both contract and tort, regardless of its fulfillment of the express terms of the insurance policy. An insurer denying or delaying the payment of policy benefits due to the existence of a genuine dispute with its insured as to the amount of the claim cannot be liable in bad faith. However, the genuine dispute doctrine does not relieve an insurer from its obligation to thoroughly and fairly investigate, process and evaluate the insured's claim. A genuine dispute exists only when the insurer's position is maintained in good faith and on reasonable grounds. In reversing the trial court's demurrer without leave to amend, the court concluded that Brehm's allegations of 21st Century's bias in the investigation of Brehm's claim would support Brehm's claim of "bad faith," precluding the trial court from sustaining 21st Century's demurrer, where 21st Century allegedly retained a biased medical expert to examine Brehm, where that expert allegedly ignored the medical symptoms and in opining that Brehm suffered no significant injury and would not require future surgery, and Brehm's offer totaling less than $10,000 allegedly was unreasonably low in light of the medical evidence in Brehm's possession.

It cannot ever be overly stressed that every claim must be subjected to a stand alone analysis.

The concept of an "independent medical examination" is more frequently being abandoned for a variety of business reasons. This decision is a vivid and graphic lesson of bad decision making when the results of a medical examination are seemingly ignored because of the potential loss amount.

The Trial Court Lacked Subject Matter Jurisdiction to Review a Private Arbitrator's Stay of Uninsured Motorist Insurance Arbitration Pending a Determination of the Insured's Entitlement to Workers' Compensation.

In Briggs v. Resolution Remedies (2008) 168 Cal.App.4th 1395, the Court of Appeal, First District, held that the trial court lacked subject matter jurisdiction to review a private arbitrator's stay of uninsured motorist insurance arbitration pending a determination of the insured's entitlement to workers' compensation.

Factually, Ms. Briggs suffered injuries when an uninsured motorist rear ended her while she was driving on work-related business in

a company car provided to her by her employer. Although the accident took place while Ms. Briggs was acting in the scope of her employment, she declined to file a workers' compensation claim. The parties were not able to agree on whether her insurer, GEICO, had a duty to pay Ms. Briggs before there was a determination of her entitlement to workers' compensation benefits. Ms. Briggs demanded arbitration with GEICO, which filed a motion to stay the arbitration, arguing that it was entitled to a stay until after Ms. Briggs pursued workers' compensation benefits. The arbitrator ruled that in light of the language of Ms. Briggs insurance policy and Insurance Code section 11580.2, GEICO was entitled to a stay of the arbitration until Ms. Briggs filed a workers' compensation claim. The arbitrator's order stated: "If a court of competent jurisdiction orders me to vacate this Order, I will, of course, do so upon being so advised by both counsel." Ms. Briggs thereafter filed a petition to stay the arbitration ruling, alleging that she would be "severely prejudiced" if the court did not "immediately review" the decision to stay the arbitration proceedings. The trial court's tentative ruling stated that the petition was denied because the arbitrator properly stayed arbitration pursuant to Insurance Code section 11580.2 and the parties' insurance policy.

In seeking to untangle the rulings of the arbitrator and trial court, the appellate court began by stating that uninsured motorist arbitration is a form of contractual arbitration governed by the California Arbitration Act, and that all disputes arising under the uninsured motorist coverage should be subject to the decision by the arbitrator. Once a dispute is submitted to arbitration, the California Arbitration Act contemplates only limited judicial involvement (i.e., such as the capacity to resolve discovery disputes or enforcement of the award). Under the California Arbitration Act, it is the job of the arbitrator, not the court, to resolve all questions needed to determine the controversy. Consequently, the trial court lacked subject matter jurisdiction to review the private arbitrator's stay of uninsured motorist insurance arbitration pending a determination of insured's entitlement to workers' compensation.

A Service Charge Imposed for the Payment in Full of the Stated Premium for an Automobile Insurance Policy's One-Month Term Was Part of That Policy's "Premium," and Thus the Insurer's Failure to Disclose the Service Charge in That Policy Violated Insurance Code Requiring Insurance Policies to State the Premium for Insurance Coverage.

In Troyk v. Farmers Group, Inc. (2008) 168 Cal.App.4th 1337, the Court of Appeal, Fourth District, Division 1, held that a service charge imposed for the payment in full of the stated premium for an automobile insurance policy's one-month term was part of that policy's "premium," and thus insurer's failure to disclose the service charge in that policy violated insurance code requiring insurance policies to state the premium for insurance coverage.

Factually, Thomas E. Troyk filed a class action against Farmers Group, Inc., doing business as Farmers Underwriters Association (FGI), and Farmers Insurance Exchange (FIE) (together Farmers) alleging causes of action for breach of contract and violation of Business and Professions Code section 17200 (Unfair Competition Law). He alleged FIE required him to pay a service charge for the payment of the premium for his automobile insurance policy's one-month term and, because the service charge was not stated in his policy, FIE violated the requirement of Insurance Code section 381, that a "premium" shall be stated in an insurance policy. Troyk's complaint sought injunctive relief against Farmers and full restitution from Farmers of the service charges paid by members of the class and the general public. The trial court granted Troyk's motion for class certification. It was apparently determined there were about 975,000 members in the certified class.

Stated Justice McDonald for the appellate court in San Diego: "Based on our independent interpretation of the relevant statutory language, we conclude the clear and unambiguous meaning of the term 'premium,' as used in section 381, subdivision (f), includes a service charge imposed for payment in full of the stated insurance premium for a one-month term policy" and "none of the cases or other authorities cited by Farmers persuade us the term 'premium,' as used in section 381, subdivision (f), does not include a service charge imposed for payment in full of the stated premium for a period of coverage (e.g., a one-month term)."

A Coverage Action Need Not Be Stayed until the Third Party Action Is Resolved If it Does Not Require Factual Determinations That Would Prejudice the Insured in the Third Party Action.

In GGIS Insurance Services, Inc. v. The Superior Court of Los Angeles County (2008) 168 Cal.App.4th 1493, the Court of Appeal, Second District, held that a coverage action need not be stayed until the third party action is resolved if it does not require factual determinations that would prejudice the insured in the third party action.

Factually, GGIS was a California corporation that acted as a general agent in California for various insurers. In March 2002, the Commonwealth Court of Pennsylvania issued orders of rehabilitation, appointing the Pennsylvania insurance commissioner as rehabilitator of certain insurers to which GGIS was a general agent. The court ordered all persons in possession of those insurers' assets not to dispose of the assets without the prior written consent of the commissioner. It also ordered all persons who had collected premiums on behalf of the insurers to "account for all earned premiums and commissions" and "account for and pay all premiums and commissions unearned due to policies canceled in the normal course of business, directly to the Rehabilitator." After it became aware of the rehabilitation orders, GGIS ceased retaining "commissions" from the premiums collected and instead retained "administrative fees" in the amount of $180,000 per week. An attorney representing the Pennsylvania insurance commissioner sent a letter to GGIS demanding remittance of over $6 million in premiums collected by them and purportedly retained improperly as administrative fees. The letter also stated that GGIS had improperly paid to or for the benefit of reinsurers over $3.5 million of premiums collected. The letter demanded repayment of over $9.5 million to the commissioner and an accounting of all premium amounts for the canceled policies. Refusing to return any amounts, suit was filed against GGIS, which then notified its insurer, Capitol, of the action and requested a defense. Capitol responded with a reservation of rights. Capitol later agreed to pay GGIS's defense costs while reserving its rights to deny any right to coverage or a defense under the policy. Capitol thereafter terminated its payment of defense costs

Cont'd on page 12

Cont'd from page 11
after paying a total of $25,000 in defense costs. GGIS filed suit against Capitol and others alleging a broad variety of clauses of action and then sought to stay its action against its insurer until the underlying action was resolved. The trial court denied GGIS's motion to continue or stay.

Teeing up its holding, the appellate court first noted that an insurer or its insured may sue to determine whether the insurer has a duty to defend or indemnify its insured in an action by a third party. A coverage action by an insurer or its insured, to determine whether the insurer has a duty to defend or indemnify its insured in an action by a third party, should not proceed if it may result in factual determinations that would prejudice the insured in the third party action. Conversely, a coverage action to determine whether an insurer has a duty to defend or indemnify its insured in an action by a third party may proceed only if the coverage question is logically unrelated to the issues of consequence in the underlying case. Threading those two rules together, if the trial court may resolve the question of whether the insurer has a duty to defend or indemnify its insured in an action by a third party as a matter of law, without making any factual determinations that would prejudice the insured in the third party action, the coverage action need not be stayed until the third party action is resolved.

All Independent Cumis Counsel Fee Disputes Raised By an Insured Against its Insurer Are Subject to Mandatory Statutory Arbitration Unless the Parties' Insurance Policy Provides for an Alternative Dispute Resolution Procedure, Even If Other Claims or Issues Are Also Alleged.

In Compulink Management Center, Inc. v. St. Paul Fire and Marine Insurance Company (2008) 169 Cal.App.4th 289, the Court of Appeal, Second District, held that any and all independent Cumis counsel fee disputes are subject to mandatory statutory arbitration unless the parties' insurance policy provides for an alternative dispute resolution procedure, even if other claims or issues are also alleged.

Factually, Compulink was insured under a general liability policy issued by St. Paul. The policy included a provision styled "Expenses incurred by protected persons." That provision stated that St. Paul will "pay all reasonable expenses that any protected person incurs at [its] request while helping [it] investigate or settle, or defend a protected person against, a claim or suit." During the policy period, Compulink filed suit against a former distributor of Compulink and a new vendor of that former distributor. In turn, both defendants then cross-complained against Compulink, which then tendered the defense of the cross-complaints to St. Paul. Subject to a reservation of rights, St. Paul agreed to defend Compulink. Because St. Paul believed the reservation of rights created a conflict of interest with Compulink, St. Paul agreed to allow Compulink to select independent counsel to defend it in the third party suit. After the case settled, Compulink filed suit against St. Paul, asserting a variety of claims including "bad faith" and St. Paul's failure to fully pay Cumis counsel selected by Compulink. The trial court denied St. Paul's efforts to compel arbitration, finding that Compulink's complaint included allegations beyond a mere attorney's fees dispute.

After dispensing with the factual background, the appellate court began its analysis by stating that generally, an insurer owes a duty to defend its insured against third party claims covered under an indemnity policy. An insurer's duty to defend its insured includes the duty to provide competent defense counsel and to pay all reasonable legal fees and costs. Pursuant to Cal. Civ.Code § 2860, where a conflict of interest arises between an insurer and its insured because the carrier provides a defense under a reservation of rights, the carrier has a duty to provide its insured with independent counsel of the insured's choosing – "Cumis counsel." In this context, the court held that the plain language of § 2860 contains no limitation that the arbitration provision only applies when the sole issue in dispute is the amount or rate of Cumis counsel's fees. Rather, Cumis fees questions must be arbitrated. Notwithstanding the inclusion of other issues that could not be arbitrated in Compulink's complaint, any contested issues concerning the amount of attorney's fees allegedly owed by St. Paul for Compulink's independent counsel are subject to mandatory arbitration under § 2860. While Compulink's complaint alleged wrongful conduct beyond the mere failure to pay attorney's fees, the parties did not dispute that the amount of attorney's fees owed by St. Paul was a contested issue in that action. Pursuant to § 2860, that issue must be resolved by an arbitrator, not by any other trier of fact. As such' all other issues fell outside the scope of § 2860's arbitration provision and are to be adjudicated in the trial court.

A Subrogation Waiver in a Commercial Real Property Lease Between a Landlord and Tenant-insured Is Imputed Against the Tenant-insured's General Liability Carrier.

In Fireman's Fund Insurance Company v. Sizzler USA Real Property, Inc. (2008) 169 Cal.App.4th 415, the Court of Appeal, Second District, held that a commercial lease's subrogation waiver remained enforceable against a party's carrier notwithstanding the other party's failure to obtain insurance coverage required by the commercial lease.

Factually, a commercial lease agreement provided in pertinent part that: "The parties release each other and their respective authorized representatives from any claims for damage to any person or property of either Landlord or Tenant ... about the Premises that are caused by or result from risks insured against under any insurance policies carried by the parties...." The lease further provided that "The parties further agree that neither party shall be liable to the other for any damage caused by fire or any of the risks insured against under any insurance policy and each party shall cause each insurance policy obtained by it to provide that the insurance company waives all right of recovery by way of subrogation against either party in connection with any covered damage."

At the commencement of its legal analysis, the appellate court noted that subrogation waivers often appear together with or on account of waivers or releases of rights between contracting parties, with respect to claims covered by insurance. Waiver of subrogation provisions exist explained the court, as part and parcel of a risk allocation agreement whereby liability is shifted to the insurance carriers of the parties to the agreement. Importantly, a party's failure to obtain the contractually required insurance coverage does not invalidate or otherwise void the lease's subrogation waiver which, in this case, unambiguously provided that liability and subrogation will be waived as to all risks covered by "any insurance policies carried by the parties."