The Courts have continued a mostly favorable view of interpreting the law of insurance contracts.

Insurance Law, by Jim Roth

STATUTORY AMENDMENT EXTENDING LIMITATIONS PERIOD FROM ONE YEAR TO TWO YEARS FOR CLAIM ON UNINSURED MOTORIST COVERAGE DID NOT APPLY RETROACTIVELY TO CLAIM BASED ON ACCIDENT OCCURRING BEFORE STATUTE'S EFFECTIVE DATE. In Bullard v. California State Automobile Association 129 Cal.App.4th 211, 28 Cal.Rptr.3d 225 (2005) the California Court of Appeal for the Third Appellate District affirmed a trial court decision rejecting the insureds' petition to compel CSAA to arbitrate a claim under the insureds' uninsured motorist policy, concluding, among other things, that the petition was untimely under the provisions of Insurance Code section 11580.2 in effect at the time of the accident. The court ruled that a subsequent amendment to section 11580.2 expanding the limitations period did not apply retroactively. The court noted that a statute may be applied retroactively only if it contains express language of retroactivity or if other sources provide a clear and unavoidable implication that the Legislature intended retroactive application. No such express or implied intent of retroactivity applied to the statute at issue. While an "A" for effort applies, it is what it is.

HEALTH PLAN SUBSCRIBER COULD NOT ASSERT AN ERISA CLAIM AGAINST THE HMO FOR A THIRD-PARTY SERVICE PROVIDER'S ERRONEOUS BILLS. In Cohen v. Health Net of California, Inc. (2005)129 Cal.App.4th 841, 29 Cal.Rptr.3d 46, Cohen sued his health insurer asserting various claims including fraud, unfair business practices, intentional infliction of emotional distress, insurance bad faith, and negligence, arising from his receipt of balance billing statements and dunning notices after emergency hospital medical services were rendered to Cohen's son, for which services Cohen owed only a copayment under his employee health plan. The California Court of Appeal for the Fourth Appellate District affirmed a trial court decision granting summary judgment in favor of the defendant HMO, holding that all of the claims asserted by Cohen against his health insurer were related to Cohen's employee benefit plan, and thus were preempted by ERISA. Doesn't everybody know that a state law cause of action that duplicates, supplements, or supplants the civil enforcement remedy provided by ERISA is preempted? That's rhetorical, don't answer.

LIABILITY INSURER HAD DUTY TO DEFEND INSURED MANUFACTURER OF LATEX USED IN CARPETS AGAINST CARPET COMPANY'S PRODUCT LIABILITY LAWSUIT THAT INVOLVED LATEX PRODUCTS SUPPLIED BOTH BY INSURED AND BY OTHER COMPANY THAT MERGED WITH INSURED, NOTWITHSTANDING "PREMISES AND OPERATIONS" EXCLUSION RELATING TO OTHER COMPANY AS HARM ALLEGED IN LAWSUIT RESULTED FROM COMPLETED AND DISTRIBUTED PRODUCTS AND THUS IMPLICATED ONLY POLICIES' "PRODUCTS-COMPLETED OPERATION" COVERAGE FOR WHICH EXCLUSION DID NOT APPLY. Did you get all of that? In Travelers Cas. and Surety Co. v. Employers Ins. of Wausau (2005) 130 Cal.App.4th 99, 29 Cal.Rptr.3d 609, the California Court of Appeal for the First Appellate District affirmed in part and reversed in part trial court rulings relating to products-completed operations coverage. Travelers insured R&D, a carpet manufacturer, from February 24, 1988 to February 24, 1989. R&D merged with Mydrin in August of 1990 and Mydrin was the surviving corporation. Wausau insured only Mydrin from October 1, 1990 to March 31, 1992. An action filed by Royalty alleged damages caused by defective latex carpet backing purchased from R&D during a business relationship with R&D from 1988 until October of 1989. An action filed by Western alleged damages from defective latex purchased from Mydrin from May 15, 1988 through January of 1992. Travelers defended the actions and Wausau did not. Travelers sued Wausau for contribution. The Royalty action alleged damages caused solely by products supplied by R&D before the merger with Mydrin. The Wausau policy exclusion for R&D products precluded any possibility of coverage for these claims and the trial court correctly entered judgment for Wausau on the Royalty claim. The Western complaint alleged that products distributed by Mydrin failed after distribution and caused damage in the hands of Western's customers during the Wausau policy period. The court concluded that these facts triggered Wausau's duty to defend. The Wausau policies excluded coverage for liability arising out of R&D products that had been distributed and for liability arising prior to completion of the product before it left the R&D premises. The court further concluded that there was no indication that Wausau intended to exclude every future act by Mydrin solely because it used the former R&D facility to manufacture latex.

BINDING ARBITRATION CLAUSE IN DISABILITY POLICY WAS NOT DECEPTIVE. In Boghos v. Certain Underwriters at Lloyd's of London, (2005) 36 Cal.4th 495, the Supreme Court considered the effect and enforceability of an arbitration clause in a contract for disability insurance. The Supreme Court reversed the lower court and remanded the case for further proceedings. The insured had contended that the arbitration clause was unenforceable because it required him to pay costs he would not have had to pay were he suing in court. The court, in reaching its decision that the insured was

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required to arbitrate, stated that "[a] reasonable person reading the application and policy would understand that it would be required to arbitrate all disputes arising under the policy" (i.e. contract and tort claims).

INSURER WAS ENTITLED TO INTERVENE TO PROTECT ITS INTERESTS FOLLOWING PARTIAL PAYMENT TO INSUREDS FOR LOSS. In Hodge v. Kirkpatrick Development, Inc., (2005) 130 Cal.App.4TH 540, the Fourth District Court of Appeal in Orange County reversed the trial court's ruling by Judge C. Robert Jamison, that State Farm could not intervene in a construction defect action brought by its insured against third party tortfeasors. The appellate court determined that because State Farm had obtained partial subrogation rights against third parties by paying a portion of its insured's claims for property damage to their house, it had a statutory right to intervene in the construction defect action under C.C.P. § 387(b). State Farm issued the Hodges a homeowners insurance policy (we'll call it the "Policy") covering certain risks to their house in Laguna Beach. The Policy granted State Farm subrogation rights against third parties who cause covered losses. In December 2002, the Hodges submitted a claim to State Farm under the Policy for water and mold damage to their house allegedly caused by the negligence of third parties. The Hodges contended the cost to repair the water damage was about $685,000. The Hodges made a total demand on State Farm for water and mold damage for $1,699,680, the Policy's limits. State Farm denied the Hodges' claim for mold damage and paid the Hodges about $150,000 on the claim for water damage. In September 2003, the Hodges filed a construction defect lawsuit against the former owner, the developer, the general contractor, and one subcontractor who constructed the Hodges' house. The complaint alleged defendants caused the water and mold damage. In November 2003, the Hodges filed a complaint for bad faith against State Farm. State Farm moved for leave to intervene in the construction defect lawsuit to file a subrogation complaint. The trial court denied the motion, and State Farm appealed. Pursuant to C.C.P. § 387(b), a nonparty has a right to intervene in a pending action "if the person seeking intervention claims an interest relating to the property or transaction which is the subject of the action and that person is so situated that the disposition of the action may as a practical matter impair or impede that person's ability to protect that interest, unless that person's interest is adequately represented by existing parties." The appellate court determined that State Farm, as a partially subrogated insurer, has an interest "relating to the property or transaction" that is the subject of the construction defect lawsuit. The court reasoned that under the doctrine of subrogation, "State Farm has stepped into the Hodges' shoes and, to the extent it has made payments under the Policy, has the same rights as the Hodges against the various defendants and tortfeasors in the construction defect lawsuit. As an insurance carrier with a right of partial subrogation, State Farm has a direct pecuniary interest in the Hodges' action against the allegedly responsible third parties."

INJURED EMPLOYEE OF INSURED WAS NOT AN "INSURED" UNDER AUTOMOBILE POLICY WHOSE COVERAGE WOULD HAVE OTHERWISE BEEN EXCLUDED BECAUSE EMPLOYEE WAS NOT OPERATING COMMERCIAL VEHICLE WHEN LOSS OCCURRED. In Scottsdale Ins. Co. v. State Farm Mut. Auto. Ins. Co. (2005) 130 Cal.App.4th 890, the Second Appellate District Court of Appeal reversed the trial court's order granting summary judgment in favor of State Farm and Commercial Underwriters (we all refer to them as "CU"), finding that the operator of a cherry picker was not an insured and therefore an exclusion for bodily injury to an insured was not applicable. Llamas (the employee, not the animal we all remember from Dr. Dolittle) was injured when the bucket of a "cherry picker" in which he was riding fell. JMSD owned the cherry picker and the truck to which it was attached. Llamas filed suit against JMSD. Scottsdale issued a CGL and an excess policy to JMSD. State Farm issued an auto policy to JMSD. CU issued an excess auto policy to JMSD. The Llamas action settled for $1.375 million with Scottsdale paying $620,000, State Farm paying $655,000, and CU paying nothing. Scottsdale filed a declaratory relief action against State Farm and CU. The trial court ruled that Scottsdale's policy covered the accident and was primary. It reasoned that there was no coverage under the State Farm policy because Llamas was an insured under the policy and the accident fell within a policy exclusion for bodily injury to an insured and that the excess CU policy followed form. Scottsdale appealed. Scottsdale contended Llamas was not an insured because California Insurance Code § 11580.06(g) provides "The term 'use' when applied to a motor vehicle shall only mean "operating, maintaining, loading, or unloading a motor vehicle." Subdivision (f) states "operated by" or "when operating" describes the conduct of the person sitting directly behind the steering controls of the motor vehicle. The Court of Appeal held that subdivision (f) defines what constitutes the operation of a motor vehicle and is not restricted to situations where the terms "operated by" or "when operating" appear in the code. Thus, subdivision (f) applies to define "operating . . . a motor vehicle," which constitutes "use" of a motor vehicle within 11580.06(g). The Court of Appeal held that these terms applied to someone sitting directly behind the steering controls of the truck. Llamas was not, he was in the cherry picker.

NOTICE-PREJUDICE RULE, WHICH RELIEVES INSURED FROM FAILURE TO GIVE TIMELY NOTICE OF CLAIM UNLESS INSURER SHOWS PREJUDICE, DOES NOT APPLY GENERALLY TO MALPRACTICE "CLAIMS MADE AND REPORTED" INSURANCE POLICES, WHICH REQUIRE INSURED TO REPORT CLAIM WITHIN POLICY PERIOD; RATHER,

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INSUREDS MAY BE EQUITABLY EXCUSED FROM TIMELY REPORTING IN APPROPRIATE CASES. In Root v. American Equity Specialty Ins. Co., (2005) 130 Cal.App.4th 926, the Fourth District Court of Appeal in Orange County reversed the trial court's ruling by Judge James M. Brooks, concluding that the reporting requirement in a "claims made and reported" legal malpractice policy can be excused so that a claim reported to the insurer after the policy expired may be covered. The insured received possible notice of a claim at the very end of his policy period, i.e., a telephone call from a reporter inquiring of the insured's reaction to a suit filed against him. The insured dismissed it as a crank call. Immediately after the policy expired the insured became aware of the claim, after reading about the suit in a legal newspaper, and reported it to the insurer under the expired policy. The insured also reported the claim to his current insurer (different from the prior insurer.) The first insurer denied coverage because the claim was reported after the policy expired and the current insurer denied because the claim was made prior to the inception of the policy. The court agreed that a claim was made against the insured during the first insurer's policy period. However, the insured reported the claim to the first insurer only a "de minimis" time after the policy expired. Significantly, the insurer of the expiring policy did not offer the insured an opportunity to purchase an extended reporting endorsement. The reporting requirement was a condition, and not a condition precedent to coverage, that could be excused where equity required particularly in these circumstances where the insured was "whipsawed" by the two insurers. Since a triable issue of fact was presented whether the reporting requirement should be excused, the insurer's summary judgment was reversed. Although the court excused the reporting condition, it refused to apply a blanket "prejudice" requirement to claims made and reported policies, such that an insurer could only decline coverage for failure to report if it was prejudiced by the late notice. Nonetheless, the decision certainly blurs the line when late notice is grounds for denying coverage.

INSURED FAILED TO SHOW CONTRACT DAMAGES AGAINST ITS NON-DEFENDING INSURER FOR CLAIMS INSURED SETTLED WHEN SETTLEMENT AND COSTS WERE PAID FOR BY SEPARATE INSURER OF INSURED. In Emerald Bay Community Ass'n v. Golden Eagle Ins. Corp., (2005) 130 Cal.App.4th 1078, the Fourth District Court of Appeal in Orange County affirmed the trial court's ruling by Judge David R. Chaffee, dismissing an insured's claims for breach of contract and bad faith because the insured failed to plead or prove any compensable loss. The insured homeowners association (which we all lovingly refer to as the "HOA") was sued by unit-owners over a dispute involving efforts to construct unit improvements. The HOA tendered the suit to Golden Eagle which issued a general liability policy providing $2 million in primary limits. The HOA also tendered to Federal which issued D&O policies providing $1 million in self-liquidating primary limits and $10 million in excess limits. Federal agreed to defend the HOA. Golden Eagle allegedly delayed in responding to the HOA's tender, but eventually agreed to defend under reservation. After the underlying plaintiffs filed an amended complaint, Golden Eagle withdrew from the defense, but nonetheless eventually paid $200,000 towards the HOA's defense costs. The HOA sued Golden Eagle for breach of contract and bad faith. It sought recovery of approximately $600,000 in defense costs paid by Federal. Federal subsequently paid $2 million to settle the underlying action on the HOA's behalf. The HOA then entered into an agreement with Federal under which it agreed to reimburse Federal for its defense and indemnity payments, but only from amounts recovered from Golden Eagle in the coverage lawsuit (which we'll call the "Post Settlement Agreement"). Golden Eagle filed a motion for summary judgment against the HOA in the coverage action contending that the HOA suffered no damages. The trial court concluded triable issues existed and denied the motion. The action was then transferred to another department for trial. During trial, the court generously suggested that the HOA amend its complaint to allege that it received Federal's claims through an assignment. The HOA in its unique wisdom declined to amend its complaint and at the conclusion of its case, the trial court granted Golden Eagle's motion for nonsuit. The court concluded that the HOA had no supportable damages as a matter of law and failed to allege or to prove an assignment of Federal's claims against Golden Eagle. Curiously, the HOA appealed. The appellate court affirmed the trial court's finding of no damages. It recognized that the HOA could not show that it suffered damages because the defense and indemnity payments alleged in its complaint had been paid for in full by insurance. It also rejected the HOA's reliance on the Post Settlement Agreement reasoning that "the mere fact that Federal and plaintiff agreed between themselves to characterize Federal's payments as a loan does not alter the legal effect of what occurred. [Golden Eagle's] alleged liability for breach of its contractual obligations was reduced to the extent both it and Federal paid the [underlying] litigation expenses, and by the amount Federal paid to settle that case." The appellate court also relied on the fact that the HOA had not alleged an assignment from Federal. It noted that even if an assignment had been alleged, that assignment could only be of Federal's equitable contribution claim against Golden Eagle and that such a claim was inconsistent with the breach of contract and bad faith claims asserted by the HOA.