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Insurance Coverage Update

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PHILADELPHIA INDEMNITY INSURANCE COMPANY vs. MONTES-HARRIS

(Excess Insurer For Rental Car Company Is Entitled To Decline Coverage Of Rental Car Customer Where Customer's Driver's License Was Inspected And Signature Verified)

In *Philadelphia Indemnity Ins. Co. v. Montes-Harris, et al.*, 40 Cal.4th 151 (December 7, 2006), the California Supreme Court answered a certified question from the United States Court of Appeals for the Ninth Circuit addressing the following question: "Does the duty of an insurer to investigate the insurability of an insured, as recognized by the California Supreme Court in *Barrera v. State Farm Mut. Automobile Ins. Co.* (1969) 71 Cal.2d 659 (*Barrera)*, apply to an automobile liability insurer that issues an excess liability insurance policy in the context of a rental car transaction?"

In response to the Ninth Circuit Court of Appeals' question, the California Supreme Court held that Philadelphia Indemnity Insurance Company ("Philadelphia"), as an excess insurer for Budget Rent-a-Car ("Budget"), was not obligated to afford coverage to a rental car customer who had misrepresented to Budget that he had a valid driver's license. In fact, the driver's license of the rental car customer had been suspended over two months prior to the rental of the automobile from Budget.

The coverage dispute arose out of an underlying automobile accident involving the rental car customer. The claimants filed suit in state court against Budget and the rental car customer to recover damages arising out of the accident. In turn, Philadelphia filed a declaratory relief action in United States District Court seeking a judgment declaring that it had no liability for the damages alleged in the underlying personal injury lawsuit. Philadelphia contended that the "misrepresentation exclusion" in its policy applied to preclude coverage of the rental car customer.

As part of its insurance program for Budget, Philadelphia authorized Budget to make rental car customers additional insureds under a master excess policy issued in excess of minimum statutory amounts of $15,000 per person and $30,000 per occurrence for bodily injury as required under the California Financial Responsibility Law. (Vehicle Code §16000, *et seq*.). Pursuant to statute, Budget is required to inspect a rental car customer's driver's license and verify the signature on such license.

The claimants in the underlying personal injury lawsuit argued that Philadelphia was barred from denying coverage of their claims, wherein, Philadelphia failed to reasonably and timely investigate the insurability of rental car customers. Under the *Barrera* analysis, absent timely investigation of insurability, an insurer is barred from denying a third party's claim for personal injury.

In response, Philadelphia argued that it had complied with the investigation requirements set forth in *Barrera* based on Budget's review of rental car customers' driver's licenses and verifications of their signatures. Further, under Vehicle Code §14608, Budget's inspection of rental car customers' driver's licenses and verification of their signatures should be deemed sufficient to satisfy any duty to investigate insurability regarding the validity of a customer's driver's license.

In finding that such review and verification of signature was adequate for purposes of determining insurability, the Supreme Court stated as follows:

> Specifically, we hold that an insurer selling supplemental liability coverage in excess of the minimum statutory amounts, in the context of a rental transaction, does not forfeit any statutory or contractual right to rely on a rental car customer's misrepresentation

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> in tendering a facially valid but suspended driver's license as a basis for avoiding liability under an excess policy, if there has been compliance with the mandate of Section 14608 to inspect the driver's license and verify the signature of the customer.

The Supreme Court went on to find as follows:

> Here, there is no dispute that Budget's rental car agent, who acted as an agent for Philadelphia for the limited purpose of facilitating the excess insurance transaction, rented a car and offered the excess policy to Burke only after Burke presented a facially valid Arizona driver's license, and the agent inspected the license and verified Burke's signature in compliance with section 14608, subdivision (b). Under these circumstances, Philadelphia's failure to conduct a further inquiry into the validity of Burke's license did not result in a forfeiture of its contractual rights under the excess policy's exclusion for accidents caused by the use of a vehicle obtained through fraud or misrepresentation.

O'HANESIAN
vs.
STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY

(Default Judgment Taken In Underlying Tort Action Does Not Bind Insurer Affording Underinsured Motorist Coverage)

In *O'Hanesian v. State Farm Mut. Automobile Ins. Co.*, 145 Cal.App.4th 1305 (December 19, 2006) (Petition For Review Granted (March 14, 2007)), the California Fourth District Court of Appeal affirmed the trial court's order dismissing a bad faith lawsuit filed by Charles Michael O'Hanesian against State Farm. O'Hanesian contended that State Farm was bound by a default judgment entered against the driver of a vehicle which had rear-ended O'Hanesian's vehicle. The judgment was in the amount of $3,751,000. As a result of the judgment, O'Hanesian collected $100,000 from the insurer of the underinsured vehicle. He then made a claim under his State Farm primary automobile and personal umbrella policies for underinsured benefits totaling $1.1 million. In response, State Farm requested him to submit to a physical examination and to provide additional information regarding his alleged injuries. O'Hanesian refused to provide State Farm with such information and insisted that it pay the default judgment entered in the underlying tort lawsuit. State Farm refused to pay underinsured motorist benefits. As such, O'Hanesian filed a complaint for bad faith against State Farm. In response, State Farm filed a demurrer arguing that O'Hanesian's claim should be dismissed as of law because he failed to complete arbitration proceedings as required by Insurance Code §11580.2 and the State Farm policies. The trial court agreed and filed an order dismissing O'Hanesian's complaint.

In affirming the trial court's decision, the Court of Appeal found that 11580.2 applies to both uninsured and underinsured motorist claims. Further, pursuant to 11580.2, subdivision (f), an insured is required to arbitrate underinsured and uninsured motorist claims.

BOUTON
vs.
USAA CASUALTY INSURANCE COMPANY

(Whether An Individual Qualifies As An Insured Entitled to Uninsured Motorist Benefits Is Subject To Arbitration As Required By Insurance Code §11580.2, Subdivision (f))

In *Bouton v. USAA Cas. Ins. Co.*, 145 Cal.App.4th 1441 (December 21, 2006) (Petition For Review Granted (March 14, 2007)), the California Fourth District Court of Appeal reversed the trial court's order denying Bouton's motion to compel arbitration of an uninsured motorist dispute. USAA argued that Bouton was not an insured under an automobile insurance policy issued to Bouton's sister, Samela Bouton. Bouton submitted a declaration stating that at the time of the automobile accident for which he was claiming uninsured motorist benefits, he was a permanent resident of the household of and a blood relative of his sister, Samela Bouton. USAA argued that Insurance Code §11580.2, subdivision (f) applied to the arbitration of whether an insured is legally entitled to damages. Such code section does not apply to coverage issues such as whether the individual seeking coverage qualifies as an insured under the automobile policy. In addition, USAA relied on the following language in its policy:

> "If [USAA] and a covered person disagree as to: 1. Whether a covered person is legally entitled to recover [bodily injury] or [property damage] damages from the owner or operator of an uninsured motor vehicle or an underinsured motor vehicle; or 2. The amount of [bodily injury] damages that the covered person is legally entitled to collect from that owner; then, that disagreement shall be arbitrated, provided both parties so agree. *This arbitration shall be limited to the two aforementioned factual issues, and shall not address, including [,] but not limited to, coverage questions*. Any arbitration finding that goes beyond the two aforementioned factual issues shall be voidable by [USAA] or a covered person. . . ." (Italics added.)

In reversing the trial court's decision, the Court of Appeal noted that the issue of whether Bouton qualified as an insured under the USAA policy constituted a "jurisdictional fact" coming within the ambit of the arbitration requirements of Insurance Code §11580.2(f). The court also relied on the California Supreme Court's decision in *Van Tassel v. Superior Court* (1974) 12 Cal.3d 624.

The Court of Appeal also rejected the exclusionary language in the arbitration clause included in the USAA policy. The Court of Appeal stated as follows:

> To the extent the Policy's language excluding arbitration of "coverage questions" excludes arbitration of "jurisdictional facts," as that term is used and/or interpreted in *Orpustan, Van Tassel*, and *Freeman*, it is contrary to the mandatory arbitration of "jurisdictional facts" that those California Supreme Court cases hold section 11580.2, subdivision (f) requires. As Bouton asserts, any language in the Policy that attempts to restrict the scope of arbitration of disputes required by section 11580.2, subdivision (f) is void and unenforceable as contrary to public policy. (Cf. *Daun v. USAA*

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> *Casualty Ins. Co., supra*, 125 Cal.App.4th at p. 610 ["The exemption USAA seeks to enforce is void as against public policy because it imposes a limitation upon UM and UIM coverage required by section 11580.2. The Legislature did not require insurers to provide such coverage to their 'insured,' only to allow them to take part of that coverage away through exclusions and exceptions not contained in the statute."]; *Mid-Century Ins. Co. v. Gardner* (1992) 9 Cal.App.4th 1205, 1220 ["[A] policy which purports to provide a more restrictive coverage than that set forth in [section 11580.2] will not be given effect."].) Accordingly, despite any arguable applicable exclusionary or restrictive language in the Policy (e.g., exclusion of "coverage questions"), arbitration of the instant dispute whether Bouton is an insured (or "covered person") under the Policy is "*required* because that dispute involves one of the "jurisdictional facts" subject to mandatory arbitration under section 11580.2, subdivision (f), and cannot be restricted or limited by policy language. (*Van Tassel, supra,* 12 Cal.3d at pp. 626-627; *Orpustan, supra,* 7 Cal.3d at p. 992; *Daun,* at p. 610; *Mid-Century Ins. Co.,* at p. 1220.) *Freeman*, as discussed *ante*, does *not* hold otherwise. We conclude the trial court erred by denying the Petition.

AIRBORNE FREIGHT CORPORATION
vs.
ST. PAUL FIRE & MARINE INSURANCE COMPANY

(Insuring Agreement In Cargo Policy Should Be Interpreted Broadly To Afford Coverage To Policyholder Which Used United States Postal Service For Delivery To The Final Consignee. A Per Claim Deductible Included In The Policy Did Not Apply On A Per Package Basis.)

In *Airborne Freight Corp. v. St. Paul Fire & Marine Ins. Co.*, 472 F.3d 634 (9th Cir. December 26, 2006), the United States Court of Appeals for the Ninth Circuit reversed the District Court's entry of summary judgment in favor of St. Paul against Airborne Freight Corporation ("Airborne"). St. Paul insured Airborne under a first party cargo policy. Airborne sought indemnification from St. Paul after it settled lawsuits with National Fulfillment, Inc., ("NFI") and Sur Law Table ("Sur") for lost and damaged packages. St. Paul refused to indemnify Airborne based on the $500 per claim deductible in its policy and the argument that the claims did not come within the insuring agreement for the St. Paul policy as Airborne did not "supervise" the United States Postal Service ("USPS") with respect to the delivery of the packages to NFI and Sur.

In reversing the District Court's entry of summary judgment, the Court of Appeals stated as follows:

> St. Paul's proposed interpretation that care, custody, and control requires "supervision" would be inconsistent with the basic purpose and intent of cargo liability insurance, namely to protect the carrier for the entire time it remains liable to the shipper. *See Koury,* 145 A. at 450. Moreover, it would render illusory the specific insurance

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> contract between St. Paul and Airborne, which on its face covers loss or damage by independent third parties in the shipment process.
>
> Nor is "care, custody, and control" dependent on a formal agency relationship between the primary carrier and any independent contractors. A third party carrier serving under contract can function as an "agent" of the primary carrier, even where the primary carrier does not control the manner of the agent's performance and would not be liable for the agent's independent torts on a *respondeat superior* theory. *See O'Brien v. Haffer,* 93 P.3d 930, 934 n. 36 (Wash. Ct. App. 2004) (explaining difference between servant and nonservant agents); Restatement of Agency §1, cmt.e (1958)(same), St. Paul concedes that the insurance policy covered Airborne's legal liability while packages were being processed or delivered by third party contract agents and common carriers. The record fails to demonstrate that USPS was in a fundamentally different position with respect to Airborne from those whose loss or damage St. Paul concedes would be covered.
>
> Finally, the policy notes that "[i]nsurance is to attach from the moment the Assured becomes responsible and/or liable and continues until such responsibility or liability ceases," a statement consistent with the common understanding of "care, custody and control" in a cargo liability policy *Cf., Koury,* 145 A. at 450. Although the contract between Air borne and USPS is not part of the record, the language of the @ Home Service Agreement between Airborne and its shippers, the Airborne Express United States Service Guide, and the deposition testimony could allow a reasonable jury to find that Airborne remained financially and legally liable while the USPS was in physical possession of the packages during the final leg of delivery. Construing these facts in the light most favorable to the nonmoving party, *Moran*, 447 F.3d at 753, there was a genuine issue of material fact for trial and summary judgment was improvidently granted.

The Court of Appeals also rejected St. Paul's argument that it was not obligated to indemnify Airborne because the per claim deductible in the policy applied on a per package basis. The Court of Appeal noted that Washington Courts interpreted the term "claim" to apply to a specific demand for benefits as provided by the policy. The Court of Appeals noted that there was no language in the cargo policy limiting the deductible on a per package basis. Hence, the Court of Appeals affirmed the District Court's denial of St. Paul's motion for summary judgment based on the per claim language in its policy.

ZEMBSCH
vs.
THE SUPERIOR COURT/HEALTHNET OF CALIFORNIA, INC. ("REAL PARTY IN INTEREST")

(Failure to Prominently Display Arbitration Provision In Enrollment Form Bars Enforcement Of Arbitration Agreement)

In *Zembsch v. The Superior Court of Alameda County/HealthNet of California, Inc. (Real Party In Interest)*, 146 Cal.App.4th 153 (December 27, 2006), the California First District of Appeal granted a Petition for Review and Issued a Peremptory Writ of Mandate directing the trial court to vacate its order compelling arbitration and to enter a new and different order denying HealthNet of California, Inc.'s ("HealthNet") and Alta Bates Medical Group, Inc.'s (" Alta Bates") motions to compel arbitration in connection with a dispute arising out of the treatment of the son of an enrollee in the City of Berkeley health plan. The petitioner, Mark Zembsch, is an attorney employed by the City of Berkeley. As an employee of the City, Zembsch and his family were eligible for group health insurance coverage under a group hospital and professional service agreement between the City and HealthNet of California, Inc. ("HealthNet"). On May 9, 2002, Zembsch filed a form enrolling himself, his wife and his two children in a HealthNet plan affording HMO coverage. Such plan contemplates that most medical care will be provided by the contracting physician group. However, the plan permits members to receive a "standing referral" to a specialist. The enrollment form that Zembsch signed when he joined the HealthNet plan is a one-page document entitled Member Enrollment and Change Form. This form included a paragraph entitled "Arbitration Agreement" immediately above the signature line on the form. The language in the agreement is printed in the smallest typeface used on the form.

The Zembschs' five-year old son, Jack, suffers from a life threatening condition known as Metatropic Dysphasia. Metatrophic Dysphasia is an extremely rare form of dwarfism characterized by shortened limbs and a badly deformed spine. There are very few physicians in the United States with any substantial experience in treating it. As a consequence, in August, 2004, the Zembschs sought a standing referral to Dr. William G. MacKenzie at the Alfred I. Dupont Hospital for Children in Wilmington, Delaware. Alta Bates denied the Zembschs' request because Dr. MacKenzie was an out of network provider and Alta Bates determined that the services requested were available "within the Alta Bates Medical Group Network".

The Zembsch filed a number of appeals of Alta Bates' decision, all of which were denied by HealthNet. As such, on November 7, 2005, the Zembschs filed an action against HealthNet and Alta Bates in the Superior Court of Alameda County. Thereafter, HealthNet issued a standing referral for Jack Zembsch to obtain ongoing consultations with Dr. MacKenzie. However, the Zembschs contended that such standing referral was inadequate because it was for "consultation only". Thereafter, the Zembschs filed a First Amended Complaint on December 5, 2005 alleging breach of contract and a number of other causes of action arising out of HealthNet's alleged refusal to honor their obligations under the HealthNet HMO plan. As a result, HealthNet moved to compel arbitration and to stay the Zembschs' action. Petitioners opposed the motion to compel by raising various defenses, including the defense that the arbitration disclosure on HealthNet's enrollment form failed to comply with Health and Safety Code Section 1363.1 because the arbitration disclosure was not prominently displayed on the enrollment form signed by Zembsch. The Zembschs also argued that HealthNet had failed to establish the existence of an arbitration agreement applicable to their claims.

Subsequently, the trial court granted HealthNet's and Alta Bates' motions to compel arbitration. As such, on June 16, 2006, the Zembschs filed a Petition for Writ of Mandate and/or Prohibition in the Court of Appeal seeking review of the trial court order compelling arbitration. On June 22, 2006, the Court of Appeal issued an Order staying the underlying action and permitting the parties to file points and authorities in opposition to the Zembschs' Petition.

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In issuing its Writ of Mandate, the Court of Appeal held that the Zembschs properly filed a Petition for Writ of Mandate seeking to overturn the trial court's order compelling arbitration.

In addition, the Court of Appeal found that the arbitration agreement applicable to the enrollment agreement for 2002 to 2004 for the HealthNet HMO plan did not apply to members or enrollees. Hence, HealthNet could not move to compel arbitration under the enrollment form executed by Mr. Zembsch.

As respects the enrollment form applicable to the 2005 agreement with the City and HealthNet to afford health insurance, such form includes an arbitration agreement which applies to enrollees and members of the health plan. However, the Court of Appeal found that the arbitration clause included in the enrollment form did not comply with Health & Safety Code §1363.1, subdivision (b). This subdivision requires that the arbitration disclosure required by the statute be "prominently displayed on the enrollment form signed by each subscriber or enrollee." The Court of Appeal found that the arbitration disclosure set forth on the enrollee agreement for 2002 executed by Mr. Zembsch did not stand out and was not readily noticeable. In order to be considered "prominent", the Court of Appeal held that the disclosure must "stand out or project beyond a surface or line, or be 'readily noticeable'". Because the disclosure was not "prominently displayed", it did not comply with the terms of Section 1363.1(b). Hence, HealthNet was barred from enforcing the arbitration provision.

The Court of Appeal also rejected HealthNet's argument that the arbitration provision need only substantially comply with the statute. According to the Court of Appeal, because the provision was not "prominently displayed", there could be no substantial compliance with the statute. Lastly, the Court of Appeal rejected HealthNet's argument that violation of the disclosure requirements of Section 1363.1 does not entitled private parties to avoid arbitration.

STATE OF CALIFORNIA
vs.
UNDERWRITERS AT LLOYD'S LONDON

(In Pollution Coverage Case Involving the Stringfellow Acid Pits, The Court of Appeal Found That Defendant Insurers Were Not Estopped From Invoking The Sudden And Accidental Pollution Exclusion. Further, A Two Hundred Year Storm Taking Place In 1969 Constituted A "Sudden and Accidental" Discharge, While A 1978 Rain Storm Did Not Constitute A Sudden and Accidental Discharge. The Watercourse Exclusions In The Defendant Insurers' Policies Did Not Apply To Exclude Coverage Of The Clean-Up Claim. The State Was Not Required To Allocate Damages Caused By Sudden and Accidental Discharges In Order To Obtain Indemnity For A Covered Claim.)

In *State of California v. Underwriters At Lloyd's London*, 146 Cal.App.4th 851 (December 28, 2006) (Petition for Review Granted (April 18, 2007)), the California Fourth District Court of Appeal reversed the trial court's entry of summary judgment in favor of four liability insurers, Allstate Insurance Company, Century Indemnity Company, Columbia Casualty Company and Westport Insurance Corporation (collectively "Insurers") in connection with a dispute relative to indemnity coverage for the clean-up of pollution underlying and extending from the Stringfellow Acid Pits located near the City of Glendora in Riverside County, California ("Stringfellow Site" or "Site"). The Insurers contended that the qualified pollution exclusions in their policies as well as a watercourse exclusion applied to bar coverage of the Stringfellow Site clean-up claims. In

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response, the State of California argued that major storms in 1969 and 1978 causing the overflow of waste pits at the Site in 1969 and 1978 constituted sudden and accidental discharges of pollutants coming within the exception to the qualified pollution exclusion in the Insurers' policies such that coverage was afforded under such policies for the clean-up of contamination underlying and extending from the Stringfellow Site.

The Stringfellow Site is a former Class 1 Hazardous Waste Site near Glen Avon in Riverside County. The Stringfellow Site was opened by the State of California in 1956. The Site was located above two buried alluvial channels, wherein, water moved through bed rock that consisted of decomposed granite and broken rock. As a result, the Site was not impermeable or underlayed by unusable water.

The State designed the Site, which included a concrete barrier dam eight feet high, diversion channels and ponds. The State admitted it negligently investigated, selected, designed and supervised the construction of the Site, failing to ensure adequate diversion channels and other safe guards to prevent or protect against heavy rains.

The Stringfellow Site operated for about 16 years. During that time, with the knowledge and consent of the State, more than 30 million gallons of liquid industrial waste were deposited directly into unlined evaporation ponds at the Site.

In March 1969, a heavy rain storm inundated the Stringfellow Site, causing polluted rain water to overflow and contaminate the environment. Additional damage to the environment occurred during later rains when surface soils repeatedly migrated. According to the State, the 1969 discharge happened when heavy rains caused industrial waste to escape from the Site through a washed out section of a dike.

In 1972, the State found contamination in the groundwater and the Site was closed. Beginning in 1973, signs of leaking were observed at the Site. The leakage was worse by 1975.

By the beginning of the 1978-1979 rainy season, remediation procedures for preventing the flow of waste out of the Site had not been implemented by the State. After heavy rains in early 1978, all of the ponds at the Site were full. On March 5, 1978, they began to overflow. The State decided to make a "controlled discharge" of waste from the Site. The waste from the controlled discharge went directly into Pyrite Creek and from there across a roadway, down a channel, across a street and just below a school, and into the Santa Ana River.

Three days after the first controlled discharge, a section of the dam had given away and was moving, and there was a 50 foot crack in the dam as well. To prevent the failure of the dam, the State made another controlled discharge, again discharging waste directly into Pyrite Creek and affecting areas as much as six miles downstream from the Site. The two controlled discharges in March, 1978 released more than one million gallons of rain diluted waste into the environment. In addition, during later rains, the contaminants and the downstream surface soils repeatedly migrated and further damaged the environment. By December 1979, the contaminant plume had reached a street in the adjacent community. The release of waste in 1978 would not have occurred if the State had installed the hydraulic barrier and cap called for in studies made by the State's Chief Hydrologist in 1974.

In 1983, the United States of America and State brought a civil action in federal district court against companies which had disposed of waste at the Stringfellow Site. The companies counterclaimed against the State for damages caused by progressive environmental contamination

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occurring at and emanating from the Site. In September, 1998, the United States District Court held the State 100% liable for past and future costs of cleaning up the contamination at the Stringfellow Site.

The Insurers issued excess liability policies to the State for the period of September, 1976 to May, 1978. The policies included qualified pollution exclusions that excluded coverage for damage “arising out of the discharge, dispersal, release or escape of smoke, vapors, soot, fumes, acids, alkalis, toxic chemicals, liquids or gases, waste materials or other irritants, contaminants or pollutants into or upon land or the atmosphere, but this exclusion does not apply if such discharge, dispersal, release or escape is sudden and accidental.

Other than the Columbia policy, each of the defendant Insurers’ policies also included a separate “watercourse exclusion.” The Columbia policy included the watercourse exclusion in its sudden and accidental pollutant exclusion.

In September, 2002, the State filed an action for declaratory relief against numerous insurance companies, including the defendant Insurers. In October, 2004, the Insurers moved for summary judgment based on the pollution exclusions in their policies. In December, 2004, the trial court granted summary judgment in favor of the Insurers.

In reversing the trial court’s entry of summary judgment, the Court of Appeal held that the Insurers were not estopped from relying on the pollution exclusions in their policies. In addition, the Court of Appeal found that the sudden and accidental exception to the pollution exclusion unambiguously meant abrupt, unintended and unexpected discharges of pollutants and not gradual pollution.

The Court of Appeal went on to find that the 1969 discharge of waste from the Stringfellow Site as a result of heavy rains constituted a sudden and accident discharge of pollutants. The Court of Appeal reasoned as follows:

> Insurers suggest several reasons why the 1969 discharge should not be considered "sudden and accidental." First, they contend that because the discharge came after several weeks of rain, it was not sudden. This argument confuses the discharge of wastes with the events that led up to the discharge. The "sudden and accidental" exception applies if the "discharge, dispersal[,] release or escape" of pollution is sudden. It does not require that the events causing the discharge be sudden. Here, it is at least inferable that the 1969 discharge occurred suddenly, because according to Insurers, it did not rain on the day the discharge occurred and therefore the discharge could not have occurred as part of a gradual process of water accumulation and release.
>
> Second, Insurers argue that *Travelers Casualty & Surety Co. v. Superior Court, supra,* 63 Cal.App.4th 1440 stated that “the expected natural phenomena of rain falling upon a landfill and causing migration of contaminants cannot constitute sudden and accidental discharge of pollution.” (*Id.* at 1463.) It is evidenced from the context of that statement, however, that the court was referring to the *gradual* migration of contaminants as rain soaks a landfill and the contents start to seep from the landfill. As noted, *ante*, the

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groundwater contamination in *Travelers* resulted from leachate seepage, not an overflow into the surrounding area. (*Id.* at pp. 1445-1446.)

Third, Insurers argue, the 1969 discharge was not "accidental" because it was not unexpected. Rather, the State had known years before that heavy rains could cause the site to overflow. However, theoretically it can be said that any party operating an uncovered site "knows" that if it rains enough, the contents of the site will be washed outside of its boundaries. That does not mean the party is bound to have "expected" a discharge that results when an unprecedented period of rain occurs.

Here, it is not disputed that the rainfall leading up to the 1969 discharge was more than 200 percent of normal, and the storm of some 20 inches was a once-in-50-year event. Nothing in the record indicates the site had ever overflowed before, though it had operated for 13 years. In any ordinary, reasonable sense of the word, the State cannot be held to have "expected" that the site would overflow and cause the 1969 discharge.

Finally, Insurers note that under *Travelers Casualty & Surety Co. v. Superior Court, supra,* 63 Cal.App.4th 1440 a loss caused by an intervening event is only "sudden and accidental" if the event did not arise from the ordinary course of business and caused an "appreciable" amount of damage over and above routine dumping into the disposal site. Here, Insurers assert, the 1969 discharge arose out of the routine dumping over the years, because it would not have happened had the dumping not occurred. Further, because the State admitted it could not differentiate damage caused by the 1969 discharge from damage caused by routine (see part II.F, *post*), it could not show the 1969 discharge caused any "appreciable" amount of damage over and above the routine damage.

While Insurers are correct that the 1969 discharge would not have occurred *but for* the routine dumping, it is simply unrealistic to claim the discharge "arose" out of the dumping. As we have noted, the discharge did not occur until extraordinary amounts of rain filled the site, and even then apparently did occur until the dirt washed out.

Moreover, there was at least enough evidence to create a triable issue whether the 1969 discharge caused an "appreciable" amount of damage. The State's expert concluded in 2004, "[I]t is reasonable to expect that much of the soil contamination detected [after the 1978 discharges] was from the 1969 event." At his deposition, the expert explained the basis for his conclusion:

"[I]n 1965 [*sic*; 1969] the site was still active and so the ponds contained mostly waste liquids. In '78, the site had been shut down for some considerable period of time, about six years, actually, and so the fluid that would have overflowed in 1978 would have, at a

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> minimum, been diluted from the time when the site was active." He further explained that by 1978, the fluid would have been diluted by "the influx of variety of rainfalls" between 1969 and 1978.
>
> The expert's conclusion that the more concentrated wastes that were released in 1969 were likely responsible for much of the soil contamination detected later was at least sufficient to support an inference "that an appreciable amount of environmental damage was caused by the intervening event," i.e., the 1969 overflow, "over and above that caused by routine dumping into the disposal site." (*Travelers Casualty & Surety Co. v. Superior Court, supra,* 63 Cal.App.4th 1460.)
>
> In sum, construing the "sudden and accidental" exception "broadly in favor of the insured" (*Aydin Corp. v. First State Ins. Co., supra,* 18 Cal.4th at p. 1192), we view the overflow of a liquid waste site due to massive rains as an event within the exception. We therefore conclude the policies covered the 1969 discharge.

On the other hand, the Court of Appeal found that the discharge of waste from the Stringfellow Site after the 1978 rains did not constitute an unexpected event and therefore, was not accidental. The Court of Appeal reasoned as follows:

> In sum, years before the 1978 discharges, the State knew at least that (1) there was a risk of the site becoming inundated by rain and overflowing, as actually happened in 1978; (2) the site had already overflowed and released pollutants before; and (3) it needed to place a cap on the site to prevent this from happening again. Courts applying the "sudden and accidental" exception have recognized that "[w]here a discernable pattern of releases of hazardous waste has occurred at the same site over a period of time, it becomes difficult to maintain that those releases were 'unexpected,' even if they were not deliberate or intentional." (*Quaker State Minit-Lube, Inc. v. Fireman's Fund Ins. Co.* (D. Utah 1994) 868 F.Supp. 1278 F.Supp.2d 629, 637 ['evidence of the pollutant container's design, licensing, and past violations is probative as to whether there was an expectation of containment"].)
>
> Here, though there was a theoretical chance that after 1969 it would never again rain heavily enough to cause any discharge, if that were enough to make a discharge "accidental," the term would cease to have any practical meaning. A person who digs a 20-foot pit on his or her property with no warning sign and no fence around it theoretically may not "expect" anyone to fall in, since no one may pass that way. However, it would not be reasonable to suggest that if someone did fall in, the event was "unexpected" by the owner.
>
> Considering all of the circumstances from the closure of the site in 1972 up to the 1978 discharges, a reasonable trier of fact could not conclude the discharge was "unexpected." Consequently, the court correctly ruled that the 1978 discharges were not covered.

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The Court of Appeal also found that the watercourse exclusion in the Insurers' policies was ambiguous and did not apply to bar coverage of soil contaminated as a result of run off from Pyrite Creek. In addition, the Court found that groundwater did not fall within the scope of the exclusion.

Lastly, the Court of Appeal rejected the holdings in *Golden Eagle Refinery Co. v. Associated International Ins. Co.* (2001) 85 Cal.App.4th 1300 ("*Golden Eagle*") and *Lockheed Corp. v. Continental Ins. Co.* (2005) 134 Cal.App.4th 187 ("*Lockheed*") which found that absent damages caused solely by sudden and accidental discharges of pollutants, the pollution exclusion applied to exclude coverage of environmental clean-up claims. In the *Golden Eagle* and *Lockheed* cases, the policyholders admitted that they were unable to differentiate expenses they had paid to remedy damage caused by the pollutants due to both sudden and accidental and non-sudden and accidental discharges. Similarly, the State admitted that it could not differentiate the work performed to date to remedy property damage at the Stringfellow Site caused by the escape of contaminants due to sudden and accidental discharges from work performed to date to remedy pollution caused by non-sudden and accidental discharges. In other words, the State could not differentiate damage caused by the 1969 and 1978 discharges of pollutants from the Stringfellow Site.

In rejecting the holdings in *Golden Eagle* and *Lockheed*, the Court of Appeal relied on the California Supreme Court's decision in *State Farm Mut. Auto. Ins. Co. v. Partridge* (1973) 10 Cal.3d 94 ("*Partridge")*. The California Supreme Court found that so long as damages were caused by concurrent causes, one covered and one not covered, coverage was afforded by a general liability policy. The Court of Appeal noted that the *Golden Eagle* and *Lockheed* decisions are incompatible with the holding in *Partridge* to the extent that they held that insurers are not required to indemnify for any damages not caused by a covered event. On the other hand, the *Partridge* decision requires insurers to afford coverage to a policyholder so long as an insured risk constitutes a concurrent proximate cause of the alleged damages. Thus, under *Partridge*, the policyholder is entitled to coverage even if the damages were partially caused by an uncovered risk. The Court of Appeal rejected the holdings in *Golden Eagle* and *Lockheed* as follows:

> The holding of the *Golden Eagle* and *Lockheed* courts that an insured must prove the damages for which it seeks coverage were caused *solely* by a covered cause and not by a combination of covered and uncovered causes also is contrary to the Supreme Court's interpretation of *Partridge in Garvey*. The *Garvey* court stated that the Court of Appeal in that case had *misinterpreted Partridge* by concluding "that in order for coverage to be found under *Partridge*, the concurrent event *alone* must have been a 'sufficient condition' of the loss -- i.e., capable of producing damage itself." (*Garvey, supra,* 48 Cal.3d. at p. 409, fn. omitted.) If the insured need not show that the concurrent cause was capable of producing damage by itself, then it follows that, contrary to *Golden Eagle* and *Lockheed*, the insured cannot be required to trace the damages for which it seeks coverage to one cause and one cause only.
>
> Finally, as was made clear in both *Partridge* and *Garvey*, the *Partridge* court adopted a tort liability analysis in determining coverage in third party cases. Because the insured's negligent modification of the gun was sufficient by itself "to render him fully liable for the resulting injuries," the damages to the passenger were "'sums which the Insured . . . [become] legally obligated to pay'

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> because of the negligent filing of the trigger mechanism . . . ." (*Partridge, supra,* 10 Cal.3d at p. 103.) The criterion for coverage is not, therefore, whether the insured can differentiate between the amount of the damages that are allocable to the covered and uncovered causes, but whether the insured would be held liable in tort for the damages. Where, as in *Partridge* and in this case, the damages are indivisible, the insured is liable for all the damages and hence is covered for the entire amount.

The Court of Appeal went on to conclude as follows relative to application of the *Partridge* analysis to the claims arising out of the Stringfellow Site clean-up.

> For these reasons, we conclude *Partridge's* analysis should govern this case. Under that analysis, the State is not required to allocate its liability based on the cause of the underlying damage, as long as a covered cause is a concurrent contributing cause. Since there is at least evidence raising a reasonable inference that the 1969 discharge contributed to the damage for which the State was held liable under *Partridge* the State's liability was covered.

AUGUST ENTERTAINMENT, INC.
vs.
PHILADELPHIA INDEMNITY INSURANCE COMPANY

(D&O Policy Did Not Afford Coverage For Contractual Debt Or Breach Of Contract)

In *August Entertainment, Inc. v. Philadelphia Indem. Ins. Co.*, 146 Cal.App.4th 565 (January 8, 2007), the Second District Court of Appeal affirmed the trial court's entry of judgment in favor of Philadelphia after sustaining a demurrer without leave to amend with respect to a coverage dispute arising out of an underlying claim for breach of contract. The parties' dispute arose out of a contract negotiated by an officer of Philadelphia's named insured, InternetStudios.Com, Inc. ("InternetStudios"). The officer, Robert MacLean, negotiated a contract with the president of August Entertainment for the distribution rights to certain films. MacLean sent a letter to the president of August Entertainment advising that InternetStudios was prepared to pay a minimum guarantee of $2.0 million with respect to film titles for which it sought distribution rights. The president of August Entertainment wrote on a letter sent by MacLean offering the $2.0 million that he accept MacLean's offer and dated it March 24, 2000.

In subsequent correspondence, InternetStudios informed August Entertainment that it would not go forward with the proposed acquisition and distribution rights outlined in MacLean's March 24 letter because, "as a result of our due diligence, it became clear that InternetStudios was unable to actually acquire all of August's distribution rights in the subject films." InternetStudios went on to assert that there was no agreement in place between the parties and that InternetStudios does not have any liability to August Entertainment. In response, August Entertainment insisted that it had a binding agreement with InternetStudios.

Subsequently, in September, 2000, August Entertainment filed an action against

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InternetStudios for breach of contract. In November, 2000, it filed a second amended complaint against InternetStudios alleging causes of action for breach of contract and anticipatory repudiation. Subsequently, InternetStudios' officer, MacLean, was added as a "DOE defendant". By letter dated September 5, 2001, August Entertainment argued that MacLean was personally liable for the breach of contract because he did not state in his March 24, 2000 letter that he was signing on behalf of InternetStudios, and the letterhead he used did not indicate that InternetStudios was a corporation. Hence, according to August Entertainment, the general rule is that an agent who signs a contract in his or her own name, rather then that of the principal, becomes personally liable even though he or she intends to bind only the principal, since, by so acting, the agent makes the contract his or her own.

On September 11, 2001, InternetStudios tendered the defense of the August Entertainment lawsuit to Philadelphia under an "Executive Safeguard Policy" issued to InternetStudios for the period of April 10, 2000 to April 10, 2001. The policy consisted of four parts numbered as follows: (1) Directors and Officers Liability & Company Reimbursement Insurance; (2) Employment Practices Liability Insurance; (3) Fiduciary Liability Insurance; and (4) Special Risk Insurance. Part one provided $3.0 million in D&O coverage and contained two insuring agreements: Under "Insuring Agreement A," entitled Directors and Officers Liability Coverage, Philadelphia agreed to pay for any 'loss' on behalf of an 'insured' based on a claim first made during the policy period for a 'wrongful act,' except for a 'loss' that InternetStudios had actually paid on behalf of the insured as indemnification."

The term "insured" was defined to include any elected director or officer of InternetStudios. "Loss" was defined as "defense costs and any money the insured is legally obligated to pay as damages or in settlement, but does not include criminal or civil fines, penalties imposed by law, taxes, matters uninsurable under the law or punitive damages". The term "wrongful act" meant any "actual or alleged error, misstatement, misleading statement, act, omission, neglect, or breach of duty committed by an insured, individually or otherwise, in his or her capacity as a director or officer of InternetStudios; or matter claimed against an insured solely in his or her capacity as such."

Under Insuring Agreement B, entitled "Company Reimbursement Coverage," Philadelphia agreed to pay on behalf of the Company, i.e., InternetStudios, any "loss" from a claim made during the policy period for "wrongful acts" by an "insured" to the extent that InternetStudios had indemnified an "insured" pursuant to law, contract, or InternetStudios' charter or bylaws. This coverage, unlike Insuring Agreement A, excluded "any actual or alleged liability of the Company under any express contract or agreement.

By letter dated November 12, 2001, Philadelphia denied the claim. It denied coverage to InternetStudios, relying on the exclusion for causes of action based on an express contract or agreement. It denied coverage as to MacLean, stating that his potential liability was based on actions he allegedly undertook in his individual capacity, not as an officer or director of InternetStudios. Philadelphia contended that it was not obligated to pay for any "loss" under the policy, including defense costs.

Subsequently, InternetStudios became insolvent. Shortly after Philadelphia denied coverage, InternetStudios, August Entertainment and MacLean decided to settle the case. Pursuant to a written settlement agreement dated November 21, 2001, they agreed: (1) MacLean was acting as an officer of InternetStudios when he wrote the March 24, 2000 letter to Cascante (i.e., officer of August Entertainment), (2) MacLean and InternetStudios intended that InternetStudios alone be bound by the offer in the letter, (3) InternetStudios and MacLean owed

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August Entertainment $2.0 million under the resulting contract, (4) August Entertainment would dismiss its claims against InternetStudios, (5) MacLean would pay August Entertainment $2.0 million plus pre-settlement interest, (6) MacLean would assign to August Entertainment all of his rights and claims against Philadelphia under the insurance policy, (7) subject to narrow exceptions, August Entertainment would look solely to its recovery against Philadelphia, if any, in satisfaction of MacLean's payment and (8) under certain circumstances, judgment would be entered against MacLean for $2.0 million plus interest. Subsequently on July 8, 2002, pursuant to stipulation, judgment was entered against MacLean in the amount of $2,162,500.

In October, 2004, August Entertainment filed an action against Philadelphia alleging claims for breach of contract, bad faith and fraud. In response, Philadelphia filed a demurrer contending that the policy afforded no potential coverage because MacLean's alleged liability was based on conduct he committed in his individual capacity. In response, August Entertainment filed opposition arguing that coverage extended because MacLean had committed a "wrongful act" within the meaning of the policy by mistakenly signing the contract without stating he was an agent of InternetStudios. The trial court sustained the demurrer with leave to amend, explaining that "broken down to its essentials, this an attempt to force the insurance company to pay for a corporate breach of contract." August Entertainment filed a first amended complaint substantially similar to the first one. Again, Philadelphia demurred on the same ground as before. The trial court sustained the demurrer without leave to amend reasoning that "plaintiff is seeking to have an insurance company pay for a business debt under an errors and omissions policy where the alleged wrongful act of the officer consists of signing a contract without indicating he is signing an as officer of the corporation."

In affirming the trial court's entry of judgment, the Court of Appeal found that the August Entertainment lawsuit did not involve a loss caused by a "wrongful act." The Court of Appeal reasoned as follows:

> Based on the foregoing authorities, we conclude that, under the policy in this case, the insurer was not liable for the underlying settlement or judgment. To hold otherwise would make it a de facto party to a corporate contract and require it to pay the *full* contract price (plus interest), letting the corporation completely off the hook. Performance of a contractual obligation — here the payment of $2 million — is a debt the corporation voluntarily accepted. It is not a loss resulting from a wrongful act within the meaning of the policy.
>
> When the D&O policy was issued, neither the insurer nor the insured could have reasonably expected that insurance benefits would be available to cover the contract price of a business deal gone wrong. Such an expectation would expand the scope of the insurer's liability enormously and unpredictably without corresponding compensation. (See *Tombs NJ Inc. v. Aetna Cas. & Sur., supra,* 404 Pa.Super. at p. 476 [591 A.2d at p. 306].) And it would create a moral hazard problem, encouraging corporations to risk a breach of their contractual obligations, knowing that, in the event of a breach, the D&O insurer would ultimately be responsible for paying the debt. (See *May Dept. Stores Co. v. Federal Ins. Co., supra*, 305 F.3d at p. 601.)

LONDON MARKET INSURERS
vs.
THE SUPERIOR COURT
(TRUCK INSURANCE EXCHANGE, ET AL.
REAL PARTIES IN INTEREST)

(Number of Occurrences in Bodily Injury Asbestos Claims Is Determined by a Claimant's Exposure to Asbestos)

In *London Market Insurers v. The Superior Court (Truck Insurance Exch., et al Real Parties In Interest)*, 146 Cal.App.4th 648 (January 9, 2007), the California Second District Court of Appeal reversed the trial court's order granting Truck Insurance Exchange's motion for summary adjudication that thousands of bodily injuries asbestos claims pending against its insured, Kaiser Cement & Gypsum Corporation ("Kaiser"), constituted a single occurrence based on the manufacturer and sale of a defective product, *i.e.,* asbestos. Kaiser's excess insurers, the London Market Insurers ("LMI") filed a Petition for Writ of Mandate requesting the Court of Appeal to reverse the trial court's decision and find that each individual claimant's exposure to asbestos constituted a separate occurrence. In response, the Court of Appeal held that the number of occurrences is determined by the number of asbestos exposures sustained by a claimant.

However, in the context of the Truck policies, the Court of Appeal went on to find that its holding did not necessarily mean that number of occurrences corresponded with the number of claimants asserting claims under the Truck policies. Rather, the Court of Appeal remanded the case to the trial court to interpret the "one lot" and "premises location" provisions in the Truck policies. The Court noted that such provisions may limit the number of occurrences found under the Truck policies.

RAPPAPORT-SCOTT
vs.
INTERINSURANCE EXCHANGE OF THE AUTOMOBILE CLUB

(Because Insurer's Conduct Was Reasonable As of Law, Bad Faith Complaint For Failure to Settle Underinsured Motorist Claim Was Properly Dismissed By Trial Court)

In *Rappaport-Scott v. Interinsurance Exchange of the Automobile Club,* 146 Cal.App.4th 831 (January 11, 2007), the California Second District Court of Appeal affirmed the trial court's dismissal of *Rappaport-Scott's* complaint for bad faith after sustaining the Interinsurance Exchange of the Automobile Club's ("Automobile Club") demurrer to plaintiff's First Amended Complaint without leave to amend. The parties' dispute arose out of an underlying automobile accident, wherein, Rappaport-Scott was rear-ended by another vehicle operated by an underinsured motorist. Rappaport-Scott settled the lawsuit against the underinsured motorist for $25,000 and then submitted a claim for underinsured motorist benefits to Automobile Club under her automobile policy.

Rappaport-Scott made a demand for arbitration of her claim against the Automobile Club

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pursuant to the arbitration provision in the policy and Insurance Code §11580.2, subdivision f. During the pendency of her claim, she demanded $75,000 from the Automobile Club contending that she sustained damages in the amount of $346,732.34. Hence, she contended that she was entitled to the entire underinsured motorist policy limits afforded by the Automobile Club policy less her $25,000 recovery from the underinsured motorist. The Automobile Club rejected Rappaport-Scott's offer and, instead, offered only $7,000 to settle her claim. Subsequently, in August, 2003, the parties participated in an arbitration hearing resulting in a gross award of $63,000 to Rappaport-Scott. After deducting the underinsured motorist settlement of $25,000 and payment of medical benefits in the amount of $5,000, the Automobile Club paid Rappaport-Scott $33,000 in satisfaction of the arbitration award. Subsequently, Rappaport-Scott filed a complaint for bad faith arguing that the Automobile Club breached its duty of good faith and fair dealing owed to her by failing to negotiate in good faith. She also argued that Automobile Club breached the duty of good faith and fair dealing by rejecting her offer of $75,000 and unreasonably refusing to settle her claim.

In affirming the trial court's entry of dismissal, the Court of Appeal noted that Rappaport-Scott complaint was based on an improper standard for breach of the implied covenant of good faith and fair dealing with respect to first party claims. The Court of Appeal noted that Rappaport-Scott had based her complaint on the standard for breach of the implied covenant of good faith and fair dealing which applied to third party claims. The Court of Appeal noted that such standard involved an insurer's duty to accept a reasonable settlement offer in circumstances where the insured's exposure to liability is in excess of coverage afforded to the insured. The Court of Appeal stated as follows:

> Contrary to the argument advanced by Rapport-Scott, it is well established that an insurer's tort liability for failure to accept a reasonable settlement offer can arise only with respect to third party, or liability, coverage. As explained in *Gruenberg v. Aetna Ins. Co.* (1973) 9 Cal.3d 566: "[I]n *Comunale* and *Crisci [v. Security Ins. Co.* (1967) 66 Cal.2d 425] we made it clear that '[liability is imposed [on the insurer] not for a bad faith breach of the contract but for failure to meet the duty to accept reasonable settlements, a duty included within the implied covenant of good faith and fair dealing.' (*Crisci, supra,* at p. 430.) In those two cases, we considered the duty of the insurer to act in good faith and fairly in handling *the claims of third persons* against the insured, described as a 'duty to accept reasonable settlements'; in the case before us we consider the duty of an insurer to act in good faith and fairly in handling *the claims of the insured*, namely a duty not to withhold unreasonably payments due under a policy. These are merely two different aspects of the same duty." (*Id.* at p. 573, italics added; see also *Austero v. National Cas. Co.* (1978) 84 Cal.App.3d 1, 26-32 [distinguishing an insurer's obligations under the implied covenant in third party and first party cases], disapproved on another point in *Egan v. Mutual of Omaha Ins. Co.* (1979) 24 Cal.3d 809, 824, fn. 7.) Clearly, the rules for determining an insurer's liability under the implied covenant based on the failure to pay a first party claim differ from the rules for determining the obligations of a liability insurer based on the rejection of a reasonable settlement offer by a third party.
>
> An insurer's obligations under the implied covenant of good faith

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> and fair dealing with respect to first party coverage include a duty not to unreasonably withhold benefits due under the policy. in *Gruenberg v. Aetna Ins. Co.*, supra, 9 Cal.3d at p. 575.) An insurer that unreasonably delays, or fails to pay, benefits due under the policy may be held liable in tort for breach of the implied covenant. *(Chateau Chamberay Homeowners Assn. v. Associated Internat. Ins. Co.* (2001) 90 Cal.App.4th 335, 346-347.) The withholding of benefits due under the policy may constitute a breach of contract even if the conduct was reasonable, but liability in tort arises only if the conduct was unreasonable, that is, without proper cause. (*Ibid.*) In a first party case, as we have here, the withholding of benefits due under the policy is not unreasonable if there was a genuine dispute between the insurer and the insured as to coverage or the amount of payment due. (*Id.* at pp. 347-348.)

Based on the proper standard for breach of the implied covenant of good faith and fair dealing applied to first party cases, the Court of Appeal held that Rappaport-Scott's complaint failed to allege facts supporting a claim for breach of the implied covenant of good faith and fair dealing as a matter of law. In particular, the Court found that Rappaport-Scott claimed that she had sustained $346,732.34 in losses as a result of her automobile accident. While the Automobile Club had only offered $7,000 the Court noted the disparity between Rappaport-Scott' claimed damages and the amount of the arbitration award. At a minimum, the Court found that the disparity between the amount of plaintiff's claim and the resulting award establishes that there was a "genuine dispute between Rappaport-Scott and the Automobile Club precluding an action for bad faith".

ACS SYSTEMS, INC.
vs.
ST. PAUL FIRE & MARINE INSURANCE COMPANY

(Sending of Unsolicited Advertisements to Fax Machines In Violation of the Federal Telephone Consumer Protection Act of 1991 Did Not Trigger Potential Advertising Injury Or Property Damage Coverage As Afforded By General Liability Insurer)

In *ACS Systems, Inc. v. St. Paul Fire & Marine Ins. Co.*, 147 Cal.App.4th 137 (January 29, 2007), the California Second District Court of Appeal affirmed the trial court's order sustaining St. Paul's Demurrer to plaintiff's complaint for breach of contract and bad faith relative to St. Paul's failure to defend ACS Systems, Inc. ("ACS") and its parent and successor company in an underlying class-action lawsuit alleging violations of the Telephone Consumer Protection Act of 1991 ("TCPA"). ACS allegedly violated the TCPA by sending unsolicited advertisements to fax machines.

ACS tendered the defense of the underlying class-action lawsuit to St. Paul on January 25, 2000. On April 4, 2000, St. Paul denied coverage of the class-action stating that its policy did not cover the type of "invasion of privacy" alleged in the class-action lawsuit. Subsequently, on November 3, 2003, ACS filed a complaint for breach of contract, equitable subrogation, and implied indemnity and declaratory relief against St. Paul. The trial court dismissed the *ACS* lawsuit after sustaining St. Paul's second demurrer to ACS's First Amended Complaint without leave to amend.

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St. Paul issued a commercial package policy to ACS for the period of February 1, 1998 to April 1, 2000. The St. Paul policy includes the following relevant policy language:

> "Bodily injury and property damage liability. We'll pay amounts any protected person is legally required to pay as damages for covered bodily injury, property damage, or premises damage that:"
>
> - "happens while this agreement is in effect;" and
> - "is caused by an event."
>
> "Advertising injury liability. We'll pay amounts any protected person is legally required to pay as damages for covered advertising injury that:"
>
> - "results from the advertising of your products, work or completed work;" and
> - "is caused by an advertising injury offense committed while this agreement is in effect."
>
> "*Advertising injury* means injury, caused by an advertising injury offense:"
>
> - "Libel or slander."
> - "Making known to any person or organization written or spoken material that belittles the products, work or completed work of others."
> - "Making known to any person or organization written or spoken material that violates an individual's right of privacy."
> - "Unauthorized taking or use of any advertising idea, material, slogan, style or title of others."
>
> "*Advertising* means attracting the attention of others by any means for the purpose of seeking customers or increasing sales or business."
>
> "*Property damage* means:
>
> - "physical damage to tangible property of others, including all resulting loss of use of that property;" or
> - "loss of use of tangible property of others that isn't physically damaged."
>
> "*Event* means an accident, including continuous or repeated exposure to substantially the same general harmful conditions."

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The underlying lawsuit alleged that ACS used the services of a company known as DataMart Information Services Corporation ("DataMart") to send 13,919 unsolicited faxes to 8,216 recipients in 1998 and 1999. The class-action lawsuit alleged causes of action for breach of contract, property damage based on actual losses incurred by recipients of unwanted faxes which included use of recipients' paper and loss of use of fax machines while they printed fax advertisements. The class-action lawsuit also alleged claims for equitable subrogation and indemnity.

In affirming the trial court's order, the Court of Appeal analyzed the tort of invasion of privacy and found that it applied in two instances: the first tort of invasion of privacy involves an invasion of a person's right to seclusion, a second type of invasion of privacy tort involves the divulging of the content of material by a party to others which is private in nature. The Court of Appeal explained the different types of invasion of privacy as follows:

> The courts have found it analytically helpful to identify two meanings for "the right of privacy:" "secrecy" and "seclusion." (*Resource Bankshares Corp. v. St. Paul Mercury Ins. Co.* (4th Cir. 2005) 407 F.3d 631, 640-641 (*Resource Bankshares); American States Ins. Co. v. Capital Associates of Jackson County* (7th Cir. 2004) 392 F.3d 939, 941 (*American States).* "A person who wants to conceal a criminal conviction, bankruptcy, or love affair from friends or business relations asserts a claim to privacy in the sense of secrecy. A person who wants to stop solicitors from ringing his doorbell and peddling vacuum cleaners at 9 p.m. asserts a claim to privacy in the sense of seclusion." (*Ibid.*) Thus a person claiming the privacy right of seclusion asserts the right to be free, in a particular location, from disturbance *by* others. A person claiming the privacy right of secrecy asserts the right to prevent disclosure of personal information *to* others. Invasion of the privacy right of seclusion involves the *means, manner, and method* of communication in a location (or at a time) which disturbs the recipient's seclusion. By contrast, invasion of the privacy right of secrecy involves the *content* of communication that occurs when someone's private, personal information is disclosed to a third person. (*Id.* at p. 943.)

The Court of Appeal then went on to hold that the class-action lawsuit did not involve the disclosure of privacy content material to a third party. Hence, the class-action lawsuit did not allege invasion of privacy as referred to in the definition of advertising injury in the St. Paul policy. The Court of Appeal explained its decision as follows:

> Nothing in the *content* of the "written or spoken material" in unsolicited faxed advertisements violated the recipient's secrecy right of privacy. The faxes contained no facts about the recipients, and did not disclose or "make known" any private information about the recipients to third parties. (See *St. Paul Fire and Marine Ins. v. Brunswick Corp.* (N.D.Ill. 2005) 405 F.Supp.2d 890.) Analyzing the same St. Paul policy language as that in this appeal, *Resource Bankshares, supra*, 407 F.3d 631, concluded: "It requires undue strain to believe that sending an unsolicited fax ad that has no private information or content (but rather simply advertised fairly the sender's wares) can reasonably be said to 'mak[e] known'

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> material that violates a person's right to privacy. . . . [T]he plainest and most common reading of the phrase indicates that making known' implies telling, sharing or otherwise divulging, such that the injured party is the one whose private material is *made known*, not the one *to whom* the material is made known." (*Id*. at p. 641, fn. omitted.)
>
> Therefore the faxes did not violate the recipient's right of privacy so as to constitute an "advertising injury offense," and this provision of the St. Paul policy did not provide a potential for coverage.

The Court of Appeal also found that the class-action did not allege potential "property damage" as defined in the St. Paul policy as such property damage was not caused by an "event" as that term was defined in the St. Paul policy. In addition, such property damage was expected or intended by the insured. The Court of Appeal reasoned as follows:

> ACS argues that facts alleged in the *Kaufman* action–that faxing unsolicited ads consumes the recipients' ink and paper–constitute "physical damage to tangible property of others," and also "loss of use of tangible property of others" while a fax machine receives the unsolicited advertisement. ACS therefore claims that allegations in the *Kaufman* complaints implicate both definitions of "property damage," that this property damage was alleged to have happened during the terms of the St. Paul policies, and that the trial court erroneously found that those facts did not constitute an "event" necessary to trigger insurance coverage.
>
> The *Kaufman* complaint did not specifically cite the consumption of ink and paper by unsolicited faxed advertisements, but instead referred to "a shifting of advertisement costs from defendants onto the person, businesses and entities who have received theses faxes." The Kaufman complaint asserted statutory damages for TCPA violations under section 227(b)(3) of the TCPA.
>
> Assuming without deciding that the *Kaufman* complaint alleged "property damage," the St. Paul policy did not provide coverage, for two reasons. First, this property damage was not caused by an "event" because the fax transmissions were not an "accident." An "accident" requires unintentional acts or conduct. (*Ray v. Valley Forge Ins. Co*. (1999) 77 Cal.App.4th 1039, 1045.) ACS intended the fax transmissions to occur. "[W]here the insured intended all of the acts that resulted in the victim's injury, the event may not be deemed an 'accident' merely because the insured did not intend to cause injury." (*Merced Mutual Ins. Co. v. Mendez* (1989) 213 Cal.App.3d 41, 50; see also *Quan v. Truck Ins. Exchange* (1998) 67 Cal.App.4th 583, 598-599.)
>
> Second, the St. Paul policy expressly excludes '[i]ntentional bodily injury or property damage" from coverage. A section of the policy captioned "Exclusions - What This Agreement Won't Cover" states, in relevant part: "We won't cover bodily injury or property damage that's expected or intended by the protected person." This exclusion reiterates the concept that the St. Paul policy does not cover property damage not caused by an "event" –that is, which is not accidental.

SAFECO INSURANCE COMPANY OF AMERICA
vs.
FIREMAN'S FUND INSURANCE COMPANY

(Third Party Lawsuit Alleging Damage Sustained By Home Due to a Continuing Landslide Did Not Trigger Multiple Policies for Purposes of Indemnity Coverage)

In *Safeco Ins. Co. of America v. Fireman's Fund Ins. Co.,* 148 Cal.App.4th 620 (March 14, 2007), the California Second District Court of Appeal affirmed the trial court's entry of judgment in favor of Fireman's Fund relative to a claim for equitable subrogation brought by Safeco Insurance Company in connection with the settlement of an underlying lawsuit involving damage sustained by homes due to a landslide allegedly caused by Fireman's Fund's and Safeco's insured.

The parties' dispute arose out of an underlying judgment entered in favor of downhill homeowners in the amount of $4.0 million for a landslide that inundated their backyards with dirt and debris. Fireman's Fund and Safeco insured the uphill homeowner who allegedly caused the landslide.

Immediately after the landslide, the City of Los Angeles determined that the neighbors' backyards were unusable and ordered the insured to repair the slope. But the slope went unrepaired for years, and the backyards remained unusable during the Fireman's Fund policy periods.

Fireman's Fund issued four successive primary homeowner's policies to its insured which covered an occurrence of property damage, defined as "an accident, including continuous exposure to the same conditions resulting in a loss of use during the policy period." The policy separately covered an "occurrence of personal injury," which included "an act that occurs during the policy period and which results in wrongful entry or eviction." Each of the Fireman's Fund primary policies have limits of $500,000 per occurrence. Safeco issued a personal umbrella policy to the insured for the period of July 9, 1997 to July 9, 1998. It was renewed annually up to July 9, 2000. The Safeco policies cover property damage and personal injury caused by an occurrence. The limit of liability were $5.0 million per occurrence. The Safeco coverage did not apply to an occurrence until an underlying Fireman's Fund policy had exhausted its available limits.

Ultimately, in order to settle the underlying lawsuits against their mutual insured, Fireman's Fund paid a single limit of $500,000 and Safeco paid $1,540,000. As a result of such settlement, in July, 2002, Safeco filed a declaratory relief action against Fireman's Fund wherein it claimed that the Fireman's Fund policies provided their mutual insured with $500,000 in coverage for property damage and an additional $500,000 in coverage for personal injury during each of Fireman's Fund's four policy periods for a total of $4.0 million. In response, Fireman's Fund filed a cross-complaint against Safeco requesting a declaration that it owed its insured $500,000 in indemnity for a single occurrence and sought to recover defense costs it had paid after it had exhausted its $500,000 policy limit.

In February, 2004, the insurers filed cross-motions for summary judgment arguing the points made in their respective pleadings. The trial court granted Fireman's Fund's motion concluding that there was a single occurrence during a single policy period, resulting in $500,000 in coverage for the slope failure. The trial court denied Safeco's motion. The trial court also awarded Fireman's Fund the $265,000 it had expended in defense costs in the underlying lawsuits against the insured.

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In affirming the trial court's decision, the Court of Appeal reasoned as follows:

> Fireman's Fund's liability under the policies is determined on a "per occurrence" basis. In determining policy limits, "*occurrence* has generally been held to mean the underlying cause of the injury, rather than the injury or claim itself; otherwise, the insurer's effort to limit its liability per occurrence would be substantially weakened." *(Whittaker Corp. v. Allianz, Underwriters, Inc., supra,* 11 Cal.App.4th at p. 1242, italics added; see *id.* at pp. 1241-1243 [discussing causation analysis]; *EOTT Energy Corp. . Storebrand Internat. Ins. Co.* (1996) 45 Cal.App.4th 565, 575-578 [discussing cases].) "When there is a single cause of multiple injuries (or a number of causes that result in greater number of injuries), courts often look to the cause rather than the injuries in determining the *amount* of insurance coverage. In such a case, the result is a finding of only one claim, i.e., the court looks to the single cause rather than to the multiple injuries." (*Bay Cities Paving & Grading, Inc. v. Lawyers' Mutual Ins. Co.* (1993) 5 Cal.4th 854, 863, italics added; see *id.* at pp. 862-865 [discussing causation analysis].)
>
> "Liability policies invariably contain limits on the insurer's liability for covered events. Such limits are usually stated in terms of a certain amount for *each* 'occurrence,' 'accident' or 'claim' during the policy period." (Croskey et al., Cal. Practice Guide: Insurance Litigation (The Rutter Group 2006 ¶ 7:361, p[. 7A-115.) For this purpose, "[t]he number of 'occurrences' ... depends on the *cause* of injury rather than the number of injurious effects." (*Id.* ¶ 7:369, p. 7A-117.) "[Where *one* proximate, uninterrupted, and continuing cause results in injuries . . . to . . . property, there is a *single* accident or occurrence within the meaning of the 'per accident' clause in the liability insurance policy limiting the insurer's liability to a certain amount for each accident or each occurrence." (12 Couch on Insurance (3d ed. 2005) § 172:12, p. 172-19, italics added; accord, *Hyer v. Inter-Insurance Exchange, etc.* (1926) 77 Cal.App. 343, 350.)
>
> "When all injuries emanate from a common source . . ., there is only a single occurrence for purposes of policy coverage. It is irrelevant that there are multiple injuries or injuries of different magnitudes, or that the injuries extend over a period of time. Conversely, when a cause is interrupted, or when there are several autonomous causes, there are multiple "occurrences" for purposes of determining policy limits and assessing deductibles.'" (*Caldo Oil Co. v. State Water Resources Control Bd.* (1996) 44 Cal.App.4th 1821, 1828, italics added; accord, *State Farm Fire & Cas. Co. v. Kohl* (1982) 131 Cal.App.3d 1031, 1035.)
>
> In sum, "[f]or purposes of determining the number of policy limits (or deductibles) available, 'occurrence' focuses on the event or events causing the injury. But in determining . . . which policy or policies provide coverage [for property damage] – the focus is on the timing

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> of the injury or damage; i.e., whether the injury or damage took place during the policy period." (Croskey et al., Calk. Practice Guide: Insurance Litigation, *supra* ¶¶ 7:375, p. 7A-119.)
>
> Here, there was one uninterrupted cause or event – the landslide – that resulted in all damage. Some of the damage – loss of use – may have continued into subsequent policy periods. But the existence of only one cause or event means there was only one occurrence for determining policy limits. E.g., *Montrose II, supra*, 10 Cal.4th at p. 672 [freight train derailment is one occurrence for determining policy limits]; *Caldo Oil Co. v. State Water Resources Control Bd., supra,* 44 Cal.App.4th at pp. 1826-1829 [leakage from two storage tanks located on different sites constituted two occurrences for purposes of policy limits].)

The trial court also found that to trigger personal injury coverage under the Fireman's Fund policy did not mean that a separate personal injury coverage limit applied to the underlying claim. Rather, the Court of Appeal found that as follows:

> Our interpretation of the policy – that there was one occurrence – is consistent with the reasonable expectations of the insured. According to Safeco, when the landslide happened, it simultaneously gave rise to personal injury and property damage in a variety of ways. As the mud and debris initially crossed the Rauches' property line, it caused a wrongful entry; as it moved onto their property, it caused physical injury; and after it ended, it resulted in a wrongful eviction and an ongoing loss of use. Yet, notwithstanding these various types of harm, the insured would perceive them all as the result of a single discrete event – the landslide. Nor would the insured believe that by paying annual premiums of around $1,600, he was entitled to an additional $500,000 per year, for a total of $2 million, based on conditions that remained static after the landslide: The insured's slope and the Rauches' backyard were unchanged during the successive policy periods, resulting in a jury award of around $88,000 for loss of use.

The Court of Appeal also explained the difference between "trigger of policies" as opposed to an actual indemnity obligation owed under a policy for a claim involving continuous loss. Lastly, the Court of Appeal noted that its decision related to homeowner's policies which did not include language typically found in comprehensive general liability policies which require an insured to "pay on behalf of the insured **all sums** which the insured shall become legally obligated to pay as damages because of property damage." The Court of Appeal noted that such language may support an argument that the insured is entitled to the policy limits under successive policies even though there is only one occurrence by "stacking coverage."

ZENITH INSURANCE COMPANY
vs.
COZEN O'CONNOR

(Reinsurer Is Barred From Asserting a Claim for Legal Malpractice Against Ceding Insurer's Counsel)

In *Zenith Ins. Co. v. Cozen O'Connor*, 148 Cal.App.4th 998 (March 21, 2007), the California Second District Court of Appeal affirmed the trial court's entry of dismissal of Zenith Insurance Company's ("Zenith") claim for legal malpractice against Cozen O'Connor in connection with the firm's failure to file a contribution action against other insurers for recoupment of defense and indemnity expenses incurred in settling underlying pollution claims. Cozen O'Connor was retained by Royal Insurance Company ("Royal") to represent it in connection with coverage issues raised by the Environmental Protection Agency's claim against Royal's insured, Dillingham Corporation ("Dillingham") for the environmental clean-up of the "Middle Waterway of Commencement Bay" in Tacoma, Washington "Middle Waterway Claim." Zenith reinsured 100% of the limits of the underlying Royal policies issued to Dillingham. However, Royal retained the exclusive right to settle claims under the policies.

Ultimately, Royal settled the Middle Waterway Claim against Dillingham for $2.8 million along with a payment of $1.0 million for defense costs. Thereafter, Royal demanded reimbursement from Zenith pursuant to the terms of a reimbursement agreement executed between Royal and Zenith in conjunction with Zenith's reinsurance of the Royal policies.

On July 28, 2004, Zenith filed an action against Royal for breach of contract and declaratory relief. Zenith alleged that Royal had mishandled the adjustment of the Middle Waterway Claim and failed to timely pursue contribution and indemnification claims against other insurers of Dillingham. Subsequently, Zenith amended its complaint to add a third cause of action against Cozen O'Connor ("Cozen") for professional negligence. Cozen demurred arguing that there were insufficient allegations to demonstrate any attorney-client relationship between the law firm and Zenith. The trial court sustained Cozen's demurrer with leave to amend and directed Zenith to attach a copy of the reinsurance agreement to any future pleadings. Zenith attempted to amend its complaint on two subsequent occasions. Both times, the trial court sustained demurrers brought by Cozen and ultimately did so without leave to amend. The court then issued an order dismissing Zenith's complaint against Cozen.

In affirming the trial court's dismissal of Zenith's lawsuit against Cozen, the Court of Appeal explained the nature of reinsurance as follows:

> Insurance Code section 620 defines reinsurance as a "contract . . . by which an insurer procures a third person to insure him against loss or liability by reason of such original insurance." A reinsurance contact is presumed to be a contract of indemnity for the benefit of the ceding insurance company, not the party insured under that insurer's policy (*Ascherman v. General Reinsurance Corp.* (1986) 183 Cal.App.3d 307, 311.) "Reinsurance is a special form of insurance obtained by insurance companies to help spread the burden of indemnification. A reinsurance company typically contracts with an insurance company to cover a specified portion of the insurance

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> company's obligation to indemnify a policyholder in the event of a valid claim. This excess insurance, as it is called, enables the insurance companies to write more policies than their reserves would otherwise sustain since [it] guarantees the ability to pay a part of all claims. *The reinsurance contract is not with the insured/ policyholder*. When a valid claim is made, the insurance company pays the first level insured, and the reinsurance company pays the insurance company. The reinsurance company's obligation is to the insurance company, and the insurance company vis-a-vis the reinsurer is thus the insured, or more appropriately the 'reinsured.'" (*Excess & Cas. Reinsurance Ass'n. v. Insurance Com'r, Etc.* (9th Cir. 1981) 656 F.2d 491, 492, italics added.)
>
> Reinsurance does not alter the ceding insurer's relationship with its policyholder. It still remains responsible with its policyholder. It still remains responsible for defending, settling and paying covered claims against the insured. The ceding insurer pays the *full* amount of the claim, including the costs of defense, and then seeks reimbursement from the reinsurer for the reinsured portion of the claim. The reinsurer's liability is limited to the terms of its agreement with the ceding insurer. (*Ascherman v. General Reinsurance Corp., supra,* 183 Cal.App.3d at 312.) In this case, Royal expressly retained the *exclusive* power to investigate, defend and settle any claim on such terms as it, in its *discretion,* deemed expedient. Under such provision, Zenith had no right or authority to participate therein. It's obligation to Royal was one of reimbursement.
>
> It is well settled that where, as here, a reinsurance contract fails to provide otherwise, a reinsurer has no control over claims settlement. Consequently, if the ceding insurer decides to settle and pay a claim, the reinsurer cannot raise coverage defenses to avoid paying its share of the loss. Absent fraud or collusion with the insured, the reinsurer must "follow the fortunes" of the ceding insurer on any claims under the policy . . . and most reinsurance contracts, including the one before us, expressly so provide. (*Pacific Mutual Life Ins. Co. of Calif. v. Pacific Surety Co* (1924) 69 Cal.App. 730, 735; *Nat. American Ins. Co. of Calif or. v. Underwriters* (9th Cir. 1996) 93 F.3d 529, 536-537.)

After explaining the nature of reinsurance, the Court of Appeal found that Zenith did not have an attorney-client relationship with Cozen. At best, Zenith was an incidental beneficiary to the attorney-client relationship between Royal and Cozen. The Court of Appeal also rejected Zenith's argument that an implied contract existed between the parties. In particular, Zenith's complaint did not allege facts establishing that Cozen's conduct inferred the existence of an attorney-client relationship.

GOLDEN EAGLE INSURANCE CORP.
vs.
CEN-FED LTD.

(Breach of Lease Agreement Does not Implicate Potential Property Damage Or Personal Injury Coverage Afforded By General Liability Policy)

In *Golden Eagle Ins. Corp. v. Cen-Fed Ltd.*, 148 Cal.App.4th 976 (March 21, 2007), the California Second District Court of Appeal affirmed the trial court's judgment in favor of Golden Eagle Corporation relative to the absence of the duty to defend and indemnify Cen-Fed, Ltd. ("Cen-Fed") in connection with an underlying lawsuit for breach of lease brought by a commercial lessee of a building owned by Cen-Fed. The Court of Appeal amended the trial court's judgment so as to strike any obligation on the part of Golden Eagle to pay for plaintiff's attorneys' fees awarded in connection with the judgment entered in the underlying breach of lease lawsuit.

The parties' dispute arose out of a underlying lawsuit brought by Washington Mutual Bank ("WMB") against Cen-Fed for breach of lease for commercial premises owned by Cen-Fed. The lease ran from November 1979 to November 2004. WMB had an option to extend the lease. The lease required Cen-Fed to maintain the structural elements of the building in a first class condition, keep the lease premises and the common areas in a clean and sanitary condition, and maintain, for WMB, a certain number and type of parking spaces. The lease also included an attorneys' fees clause providing for an award of attorneys' fees to a prevailing party should a lawsuit be filed.

Subsequently, WMB sued Cen-Fed for breach of the lease and declaratory relief alleging that Cen-Fed had failed to maintain and repair the lease premises in accordance with the terms and conditions of the lease, thereby depriving WMB of a part of its lease space, which required WMB to move its safe deposit boxes from the basement to the first floor, decrease the number of boxes WMB was able to rent out, and deprive WMB of the use of that first floor space for other purposes. WMB's complaint also alleged that the air conditioning, elevator service, and basement restrooms were not in good working order; the landscaping, common areas, and interior walls and painting were not maintained to the extent required by the lease; and Cen-Fed did not meet its obligations regarding parking.

Golden Eagle insured Cen-Fed for the period of September 1997 to September 2002 under commercial general liability policies affording coverage for property damage caused by an occurrence and personal injury offenses which took place during the policy periods.

Cen-Fed tendered the defense of the *WMB* lawsuit to Golden Eagle and it undertook the defense of Cen-Fed under a complete reservation rights. In addition, while the action was pending, Golden Eagle filed a declaratory relief action against Cen-Fed seeking a declaration that Golden Eagle had no duty to indemnify Cen-Fed for damages that might be awarded to WMB in connection with the claims alleged in *WMB's* lawsuit against Cen-Fed. Golden Eagle also requested that the court declare that it had no duty to defend Cen-Fed in the *WMB* lawsuit.

Subsequently, WMB obtained a judgment for breach of lease against Cen-Fed in the amount of $505,440.

After the judgment was rendered in the underlying *WMB* lawsuit, the trial court in the Golden Eagle declaratory relief action granted Golden Eagle's motion for summary adjudication

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with respect to its obligation to indemnify Cen-Fed for the WMB judgment. In addition, the trial court held that Golden Eagle was not obligated to defend Cen-Fed in the *WMB* lawsuit. However, the trial court found that Cen-Fed was obligated to pay the plaintiff's attorneys' fee award in the underlying *WMB* lawsuit.

In affirming the trial court's decision with respect to the absence of defense and indemnity coverage under the Golden Eagle policy, the Court of Appeal held that the damages claimed by WMB constituted economic loss which did not involve potential property damage as that term was defined in the Golden Eagle policy. The Court of Appeal stated as follows:

> Thus, WMB's complaint and theory of recovery against Cen-Fed did not constitute claims for "physical injury to tangible property" and therefore they did not constitute claims for "property damage." Rather, they amounted to claims for *economic harm* suffered by WMB *due to Cen-Fed's failure to perform its contractual obligations*. As stated in *Waller*: "The property loss section of the standard policy provides coverage for 'physical injury or destruction of tangible property which occurs during the policy term.' The focus of coverage for property damage is therefore the property itself, and does not include intangible economic losses, violation of antitrust laws or nonperformance of contractual obligations. (See, e.g., *Gulf Ins. Co. v. L.A. Effects Group, Inc.* (9th Circ. 1987) 827 F.2d 574, 578 [no coverage under business general liability policy for insured's alleged nonperformance of contractual obligations . . .]; . . . *Montrose Chemical Corp. v. Superior Court* (1993) 6 Cal.4th 287, 303 [recognizing that 'a suit seeking recovery for injuries to intangible economic interests is not a suit "of the nature and kind" covered by a CGL policy']. . . . As *Giddings* observed [*v. Industrial Indemnity Co.* (1980) 112 Cal.App.3d 213, 217] . . . 'strictly economic losses like lost profits, loss of goodwill, loss of the anticipated benefit of a bargain, and loss of an investment, do not constitute damage or injury to tangible property covered by a comprehensive general liability policy. . . ." (*Waller, supra*, 11 Cal.4th at p. 17; italics in original; see also *Miller v. Western General Agency, Inc.* (1996) 41 Cal.App.4th 1144 [suit based upon sellers' failure to disclose defective plumbing was not an action seeking recovery for "property damage"].)
>
> Conceptually, Cen-Fed's claim that the failure to maintain its building in the condition in which it contracted to maintain it is no more a "property damage" claim than the claim of any property buyer who fails to obtain tangible property in the condition promised or warranted. Such claims are for economic loss, not "property damage." For example, in *St. Paul Fire & Marine Ins. Co. v. Coss* (1978) 80 Cal.App.3d 888, 892, the court held the insured's failure to construct and provide a home in a workmanship manner did not constitute "property damage." Similarly, in *Fresno Economy Import Used Cars, Inc. v. United States Fid. & Guar. Co.* (1977) 76 Cal.App.3d 272, the court held claims against the insured dealer arising from the lease and sale of cars allegedly in breach of implied warranties and express representations as to their condition were not "property damage" claims. The court explained: "There are no

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> allegations suggesting that appellant's representations caused injury or damage to the automobiles. To the contrary, the damage was to the plaintiffs' pecuniary interests – the out-of-pocket loss caused by the fact that plaintiffs did not receive full value for the money paid for the purchase and lease of the automobile. Such loss of anticipated value does not constitute an "injury to or destruction of tangible personal property' as defined in the policy." (*ID.*, at p. 279; see also *Warner v. Fire Ins. Exchange* (1991) 230 Cal.App.3d 1029, 1034.)

The Court of Appeal also held that the *WMB* lawsuit did not allege "personal injury" as defined in the Golden Eagle policy as the offenses of "wrongful evictions/entry into/invasion of the right of occupancy of a room, dwelling or premises" only applies to persons occupying the premises, as opposed to corporations or entities. Hence, Golden Eagle's personal injury coverage did not apply to the *WMB* lawsuit.

Lastly, the Court of Appeal found that Golden Eagle was not obligated to pay the plaintiff's attorneys' fees awarded in the underlying lawsuit as "supplemental costs" because Golden Eagle was never obligated to defend Cen-Fed in the underlying *WMB* lawsuit in the first instance. Absent a duty to defend in the first instance, supplemental costs were not owed under the Golden Eagle policy.

MARY ANN JORDAN
vs.
ALLSTATE INSURANCE COMPANY

(Prior Court of Appeal Decision Finding That Insurer's Interpretation of Exclusions Was Reasonable Does Not Bar a Claim for Bad Faith Based on Other Alleged

In *Mary Ann Jordan v. Allstate Inc. Co.,* 148 Cal.App.4th 1062 (March 22, 2007), the California Second District Court of Appeal reversed the trial court's entry of summary judgment in favor of Allstate relative to a bad faith claim alleged by Mary Ann Jordan in connection with a claim for coverage under Allstate's policy for dry rot damages sustained by her home. Allstate had issued a homeowner's policy to Jordan covering a 70 year old home in Santa Monica, California. The Court of Appeal had previously interpreted the language in the Allstate policy with respect to Jordan's claim in a decision entitled *Jordan v. Allstate Ins. Co.* (2004) 116 Cal.App.4th 1206 ("*Jordan I*") and held that the dry rot exclusions relied upon by Allstate in originally denying coverage of Jordan's claim were ambiguous. As such, the Court of Appeal found that the additional coverage afforded by the Allstate policy for the "entire collapse" of the building could potentially apply to afford coverage to Jordan if she established that the building had, in fact, entirely collapsed.

In bringing its motion for summary judgment in the *Jordan* lawsuit after it had been remanded from the Court of Appeal, Allstate argued that since the Court of Appeal had found in *Jordan I* that its interpretation of the language was reasonable (although incorrect), Jordan **could not** maintain a claim for bad faith against Allstate. The trial court agreed and entered summary judgment in favor of Allstate with respect to plaintiff's claim for bad faith. Subsequently, so as to test the trial court's decision, the parties stipulated to the dismissal of plaintiff's claims for breach of contract and declaratory relief. Thereafter, the trial court's decision with respect to Jordan's bad faith cause of action was appealed.

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In reversing the trial court's decision, the Court of Appeal found that although Allstate's argument that its interpretation of the policy language was reasonable based on its decision in *Jordan I*, there were numerous other questions of fact raised in connection with Allstate's investigation of Jordan's claim such that it was not entitled to summary judgment on plaintiff's claim for bad faith. In particular, the Court of Appeal found that Allstate had failed to investigate whether plaintiff's home had, in fact, entirely collapsed. Absent such investigation, a question of fact existed as to whether Allstate had acted in bad faith in connection with adjusting plaintiff's claim for property damage sustained by her home.

The Court of Appeal also found that the trial court's decision to allow plaintiff's expert to testify as to how Allstate violated the Fair Claims Practices Act (10 Cal. Code Regs. §2695.1 *et. seq.)* was proper. The Court of Appeal found that alleged violations supported plaintiff's common law claim that Allstate had acted unreasonably in adjusting her property damage claim.

In addition, the Court of Appeal explained in detail as to what plaintiff needed to prove in order to prevail on her bad faith claim upon remand to the trial court. Because the Court of Appeal's discussion provides a good overview of the requirements for a first party bad faith lawsuit, they are set forth in full below.

6. *Jordan's Only Remaining Claim Is For Bad Faith*

> As we will reverse this case and remand it for a trial of the contested issues, it is important to make clear that in order for Jordan to recover on her remaining claim of bad faith, it will be necessary for her to first establish a basis for coverage. Indeed, this was the whole point of our remand in *Jordan I*. Her coverage claim rests upon the proposition that there was an "entire collapse" of all or a part of her home. This claim is disputed by Allstate. Before Jordan can successfully assert her claim for damages arising from Allstate's alleged bad faith claims handling activities, she must first demonstrate that there is in fact coverage under the policy. An insurer's failure to investigate, upon which Jordan's claim of bad faith entirely rests, is *not* separately actionable if there is no coverage. If there is no coverage, then any failure by Allstate to properly investigate would not have caused Jordan any damage. (*Waller v. Truck Ins. Exchange, Inc.* (1995) 11 Cal.4th 1, 36; *Love v. Fire Ins. Exchange* (1990) 221 Cal.App. at pp. 221 Cal.App.3d 1136, 1151.)
>
> If Jordan proves that an "entire collapse: (as that term has been construed in *Jordan I, supra*, 116 Cal.App.4th at pp. 1221-1222) has occurred, then in order to recover any damages at all, she will next have to prove that Allstate acted in bad faith. It appears that she has abandoned her claim for breach of contract and therefore the establishment of coverage under the policy is a necessary but not a sufficient basis for recovery against Allstate. If she establishes her bad faith claim, then she may be entitled to recover, in addition to any unpaid policy benefits found to be due to her, certain extra-contractual tort remedies according to proof. These would include emotional distress damages attorney's fees and punitive damages.
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> In first party cases, such as this one, the insured may seek damages

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for emotional distress resulting from the insurance company's unreasonable withholding of policy benefits and any abusive or coercive conduct in so doing. (*Cates Construction, Inc. v. Talbot Partners* (1999) 21 Cal.4th 28, 43-44 ["In the insurance policy setting, an insured may recover damages not otherwise available in a contract action, such as emotional distress damages resulting from the insurer's bad faith conduct"].)

Normally, each party to a civil action must bear his or her own legal fees (Code of Civ. Proc., § 1021). However, fees reasonably incurred by an insured to compel payment of benefits due under an insurance policy, as distinguished from fees attributable to proving the insurer's "bad faith, are recoverable as damages in, a bad faith action against the insurer." (*Brandt v. Superior Court* (1985) 37 Cal.3d 813, 817; *Cassim v. Allstate Ins. Co.* (2004) 33 Cal.4th 780, 806.) The insured is entitled to recover all policy benefits unreasonably withheld "undiminished by the expenses incurred in retaining, an attorney to recover under the policy." *(Essex Ins. Co. v. Five Star Dye House, Inc.* (2006) 38 Cal.4th 1252, 1258.)

In order to recover such *Brandt* fees, however, the insured is required to plead and prove (1) the amount to which, the insured was entitled to recover under the policy, (2) that the insurer: withheld payment unreasonably or without proper cause; (3) the amount that the insured paid or incurred in legal fees and expenses, in establishing the insured's right to contract benefits" and (4) the reasonableness of the fees and expenses so incurred. The important caveat to this award of fees, which we emphasize, is that they "may not exceed the amount attributable to the attorney's efforts to obtain the rejected payment due on the insurance contract." (*Brandt v. Superior Court, supra*, 37 Cal.3d at p. 819.) Of course, in a case like the one before us, there may be some unavoidable intertwining or overlap of the contract and bad faith issues; in such event, a fair and equitable apportionment would be appropriate.

Finally, Jordan may be entitled to recover punitive damages if she can prove that Allstate not only denied or delayed the payment of policy benefits unreasonably or without proper cause, but, in doing so, was guilty of malice, oppression or fraud: (*Moradi-Shalal v. Fireman's Fund Ins. Companies, supra*, 46 Cal.3d at p. 305.) The acts constituting such malice, oppression or fraud must be proven by clear and convincing evidence. (Civ. Code, § 3294, subd. (a).) In other words, it will not be enough to show, by a preponderance of the evidence, that Allstate had engaged in bad faith claims handling practices. (*Mock v. Michigan Millers Mutual Ins. Co.* (1992) 4 Cal.App.4th 306, 328.) Jordan, in order to recover punitive damages, must also demonstrate by clear and convincing evidence that Allstate I acted with malice, oppression or fraud as these terms are used in Civil Code, section 3294, subdivision (a) and have been construed and applied in relevant case law. (*Ibid.*, see also Croskey et al., Cal. Practice Guide: Insurance Litigation (The Rutter Group 2006) ¶¶ 13:310 et. seq.)

INTERINSURANCE EXCHANGE OF THE AUTOMOBILE CLUB vs. THE SUPERIOR COURT

(Interest Charged On Installment Payments for Premium on Automobile Policies Is Not Included Within the Meaning of "Premium" As Set Forth in Subdivision (f) of Insurance Code §381)

In *Interinsurance Exchange of the Automobile Club v. The Superior Court of San Diego County (Tawndra Williams Real Party In Interest)*, 148 Cal.App.4th 1218 (March 26, 2007), the California Fourth District Court of Appeal affirmed the trial court's entry of summary judgment in favor of the Automobile Club with respect to a class-action brought by Real Party In Interest, Tawndra Williams, relative to the Automobile Club's practice of charging fees (*i.e.,* interest) in connection with installment payments made on premiums charged for automobile policies. Williams class-action lawsuit alleged that the Automobile Club had violated Insurance Code §381, subdivision (f), by charging fees which were not stated as being part of the "premium" charged for the Automobile Club's policies.

In affirming the trial court's decision, the Court of Appeal interpreted the term "premium" and found that it did not include interest charged for installment payments on a premium for an insurance policy. The Court of Appeal stated as follows in support of its decision:

> We conclude the fee Exchange charges for making payments of the annual premium in installments is interest for the time value of money and the plain and ordinary meaning of the term "premium," 'as used in section 381, subdivision (f), does *not* include interest charged for the time value of money. It is commonly understood that a premium is the amount paid for certain insurance for a certain period of coverage. For example, in this case Exchange charged Williams an annual premium of $986 for renewal of her automobile insurance coverage for the period from January 2004 through January 2005. As section 480 confirms, a premium is to be paid on commencement of the period of insurance coverage. Section 480 provides: "An insurer is entitled to payment of the premium as soon as the subject matter insured is exposed to the peril insured against." Therefore, in the case of an annual period of renewal of insurance coverage, an insurer is entitled to payment of the annual premium in one lump sum at the beginning of the policy period. (§ 480.) To the extent an insurer provides an insured with the option of paying that one lump sum in installments of partial premium payments together with interest on the unpaid premium balance, the interest charged for the time value of money for the option of making payments of premium over time is not considered part of the premium paid for insurance coverage.
>
> In this sense, a premium is analogous to the principal amount of a loan. In a loan situation, the principal loan amount is often paid in

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> installments of partial principal payments together with interest accrued on the unpaid principal balance. In that context, it is commonly understood, and cannot reasonably be argued otherwise, that payment of the interest charged is not payment of part of the unpaid principal amount, but rather for the time value of the unpaid principal amount. The same concept of time value of money applies in this case, in which Exchange provided Williams with the option of paying her annual lump sum premium in installments of partial premium amounts together with interest on the unpaid premium balance.

TRANSCONTINENTAL INSURANCE COMPANY vs. THE INSURANCE COMPANY OF THE STATE OF PENNSYLVANIA

(Subcontractor Primary Insurer Is Entitled to Reimbursement of Defense Costs Incurred in Construction Defect Lawsuit Based on Equitable Subrogation)

In *Transcontinental Ins. Co. v. The Ins. Co. of The State of Pennsylvania,* 148 Cal.App.4th 1296 (March 27, 2007), the California Fourth District Court of Appeal affirmed the trial court's entry of judgment in favor of CNA Insurance Company ("CNA") with respect to a claim for equitable subrogation against Insurance Company of the State of Pennsylvania ("ISOP) in connection with a claim for reimbursement of defense costs incurred in defending ISOP's named insureds; Barratt America, Inc., Windsong Partners, and Pacific Gateway Homes (collectively, "Barratt") as developer defendants in a construction defect lawsuit. CNA had issued primary policies to various subcontractors which performed work on the Barratt project. Each of these policies made Barratt an additional insured for Barratt's liability arising out of the work of CNA subcontractors. ISOP issued four excess policies to Barratt. Each of these policies included an obligation to defend upon exhaustion of underlying insurance.

The construction defect lawsuit was ultimately settled for $5.5 million. ISOP paid $1.5 million in indemnity. It paid no defense costs. On behalf of the subcontractors, CNA paid less than $150,000 in indemnity. Subsequently, CNA filed a complaint for declaratory relief and equitable contribution against ISOP and several other insurers. Thereafter, ISOP filed a motion for summary judgment arguing that CNA was obligated to pay for all of the defense costs incurred on behalf on Barratt in the construction defect lawsuit based on the argument that, as an excess insurer, it was not obligated to defend Barratt so long as there was primary insurance available to afford such defense. ISOP argued that since CNA's insured Barratt as an additional insured under its primary policies, CNA was obligated to defend Barratt in the construction defect lawsuit.

The trial court denied ISOP's motion concluding that the CNA additional insured endorsements provided coverage for only "derivative risk" and not for Barratt's direct negligence, and consequently there was no defense obligation. The trial court noted that ISOP insured Barratt for a wide spectrum of risks, including its direct negligence, and the defense obligation was therefore triggered. The trial court's decision was based on the theory of "equitable subrogation", rather than "equitable contribution".

Subsequently, the parties stipulated to the amount of defense costs incurred for the defense of Barratt in the underlying *Windsong* action and to a judgment to be entered in favor of CNA so as to expedite the appeal of the trial court's decision.

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In affirming the trial court's entry of judgment in favor of CNA, the Court of Appeal explained the theories of equitable subrogation and equitable contribution as follows:

> "Equitable subrogation allows an insurer that, paid coverage or defense costs to be placed in the insured's position to pursue a full recovery from another insurer who was primarily responsible for the loss. [Citation.] Because this doctrine shifts the entire cost burden, the moving party insurer must show the other insurer was *primarily* liable for the loss and that the moving party's equitable position is *inferior* to that of the second insurer. [Citations.]" (*Maryland, supra,* 81 Cal.App.4th at pp. 1088-1089.)
>
> "Equitable contribution, on the other hand, applies to apportion costs among insurers that share the same level of liability on the same risk as to the same insured. [Citation.] It 'arises when several insurers are obligated to indemnify or defend the same loss or claim, and one insurer has paid more than its share of the loss or defended the action without any participation by the others.' [Citation.] 'The purpose of this rule of equity is to accomplish substantial justice by equalizing the common burden shared by coinsurers, and to prevent one insurer from profiting at the expense of others.' [Citation.]" (*Maryland, supra,* 81 Cal.App.4th at p. 1089.)
>
> In this case, equitable contribution cannot apply because CNA and ISOP did not share the same level of liability and were not obligated to defend the same loss or claim. CNA's level of liability was as a primary insurer for several subcontractors and the developer (as an "additional insured"). However, its overall risk was limited to claims "arising out of" the particular subcontractor's own work on the project. CNA never agreed to be obligated for liability totally unrelated to the work of those subcontractors.
>
> As an excess carrier, ISOP bargained for a different kind of liability, and its potential obligation for coverage was limited differently than CNA's, ISOP agreed to pay only when the various underlying insurance became exhausted on any "covered claims[.]" This obligation potentially could include claims involving the Barratt's torts, as well as liability arising from the subcontractors' work.
>
> As ISOP points out, ordinarily there is no *contribution* between a primary and an excess carrier (the rule of horizontal exhaustion). "Primary coverage is insurance coverage whereby, under the terms of the policy, liability attaches immediately upon the happening of the occurrence that gives rise to liability. . . . [¶] 'Excess' of secondary coverage is coverage whereby, under the terms of the policy, liability attaches only after a predetermined amount of primary coverage has been exhausted." (*Olympic Ins. Co. v. Employers Surplus Lines Ins. Co* (1981) 126 Cal.App.3d 593, 597-598, italics & fn. omitted.)
>
> However, there can be equitable subrogation between a primary and excess carrier in limited circumstances: "[W]here different insurance carriers cover differing risks and liabilities, they may proceed against each other for reimbursement by subrogation rather than by contribution. [Citation.]" (*Reliance Nat. Indemnity Co. v. General*

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Star Indemnity Co. (1999) 72 Cal.App.4th 1063, 1077-1079; *Commercial Union Assurance Companies v. Safeway Stores, Inc.* (1980) 26 Cal.3d 917-918.) Such is the case here. The issue presented in this case is whether CNA were entitled to equitable subrogation against ISOP for reimbursement of defense costs.

The Court of Appeal went on to find that since several of the causes of action alleged in the underlying lawsuit did not implicate coverage afforded to CNA subcontractors, CNA was entitled to reimbursement of defense costs incurred in defending Barratt for such uncovered causes of action. As such, under the doctrine of equitable subrogation, CNA was entitled to reimbursement of defense costs for which ISOP was primarily responsible for paying.

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