CAIIA Status Report

AUGUST 2008

Weekly Law Resume

Submitted by Low, Ball & Lynch, San Francisco, CA

Duty to Defend - Cumis Obligations

Jay B. Long v. Century Indemnity Company, et al., (June 7, 2008)Court of Appeal, Second District

Civil Code §2860 governs the appointment of independent counsel where there is a conflict between an insurer and its insured over the conduct of the defense. In this case, the insured contended the statute was only triggered where panel counsel was appointed by the insurer.

G. Harris International, a recycling company ("Harris"), was sued by the California Department of Toxic Substances Control. Jay B. Long, Harris' attorney, tendered defense of the matter to Insurance of North America ("INA"), which insured Harris. INA agreed to defend pursuant to a reservation of rights. Long was asked to defend Harris in the litigation. A dispute arose over the hourly rate of pay for Long. Eventually, Long and INA agreed that Long would defend the litigation under the hourly rate INA contended was applicable, with Long reserving the right to seek a higher hourly rate later. After the litigation was settled, Long sued INA for breach of contract and breach of the covenant of good faith and fair dealing. He sought the difference between the amount he was paid and the amount he contended he should have been paid at his regular hourly rate.INA demurred to the complaint, claiming the fee dispute was subject to the mandatory arbitration provisions set forth in §2860(c). The trial court sustained the demurrer without leave to amend. It rejected Long's argument that §2860 was applicable only where the insurer had appointed panel counsel. Long appealed.

The Court of Appeal affirmed. The Court noted that under §2860, the obligation to provide independent counsel for the insured arises where an insurer reserves its rights on a given issue and the outcome of that coverage issue can be controlled by counsel retained by the insurer for the defense of the litigation. A reservation based on coverage disputes that have nothing to do with the issues being litigated in the underlying litigation do not give rise to a conflict of interest and no duty to appoint independent counsel. Where independent counsel must be appointed, §2860(c) limits the obligation of the insurer to the amount actually paid by it to attorneys retained by it in the ordinary course of business in the defense of similar actions in the community where the action arose or was being defended. Disputes concerning attorneys' fees to be paid to Cumis counsel must be submitted to arbitration.

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PRESIDENT'S MESSAGE

One of our goals this year has been to increase the distribution list for the Status Report. Unfortunately we have not seen much success in that area.

Our preference is to increase our email address list, as it is obviously far more cost effective to send the Status Report via that method.

As a result, we will be offering a $200.00 gift card to the member who provides the most new recipient email addresses between now and the end of September. Please send your lists to list@caiia.com.

Please only send me email addresses for individuals who would benefit from receiving the Status Report. Please be assured that the addresses will only be used for this purpose.

Our Golf Tournament and Annual Convention are coming up soon. If you are planning on attending, the Silverado Resort has great rates set aside for us. Just mention "CAIIA" when you call to book.

I should also mention that due to his recent knee injury, Tiger Woods will be unable to play in this year's Tournament. We are hopeful of convincing him to drive the drink cart.

We still have scholarship funds to award to California insurance professionals looking to advance their careers. If you run across a potential recipient, please refer them to the CAIIA website where the application is available.

I am reminded often that we are an organization run solely by volunteers, who give generously of their time. I for one have definitely seen the benefit of doing so. We are always looking for "new blood". Please contact me or any of the Board members if you wish to get more involved. We can definitely find you something fun to do.

Special thanks this month to Sam Hooper, who has done a great job on membership renewals.

If you have any suggestions, questions or just want to say hello, please don't hesitate to call or email me.

PETER SCHIFRIN
President - CAIIA 2007-2008

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Long asserted that despite these provisions, the Cumis statute was contingent upon the insurer retention of panel counsel first. The Court rejected this approach, stating that it was not the presence of insurer-selected counsel that created the conflict, but rather, the existence of a conflict creating the need for independent or Cumis counsel. The Court stated that while the statute does not preclude other situations giving rise to a Cumis appointment, it can only arise in situations consistent with the section.

There was nothing in the section to require the appointment of separate counsel to represent the insurer's interest in the third-party litigation as a prerequisite to triggering the insurer's duty to provide Cumis counsel. An insurer may elect not to retain counsel to protect its own interests and still be obligated to provide Cumis counsel if a conflict or potential conflict exists. The Court stated it would make little sense to require an insurer who identifies a potential coverage dispute that turns on an evaluation of its insured's conduct in the underlying litigation to retain panel counsel before its duty to provide independent counsel arose. That duty exists when a potential conflict arises, whether or not the insurer has retained its own counsel. Thus, §2860 applied whether or not the insurer elected to forego its right to be represented in the third-party litigation. Long's appropriate remedy thus was to pursue arbitration of the fee dispute. Because Long could not amend his complaint to cure these defects, the order dismissing the action was affirmed.

COMMENT

This opinion is an excellent discussion of the Cumis statute, the instances where it is triggered, and how conflicts under it are to be resolved. The argument that panel counsel must be appointed in every case where Cumis counsel was required was rejected by this Court.

Duty to Defend - Accident - Intentional Act

State Farm Fire and Casualty Co. v. Superior Court of Los Angeles County, (May 31, 2008)Court of Appeal, Second District

The obligation of an insurer to defend its insured for acts that bridge the line between intentional and negligent acts continually causes problems. This case analyzes that situation.

Joshua Wright and Jeffrey Lint attended a party together. During the evening, they began to argue. They both went outside next to a pool, where Lint grabbed Wright, picked him up and threw him into the shallow end of the pool. Wright landed on the pool steps, and fractured his right clavicle. Lint apologized to Wright, and told him he did not mean to hurt him. However, he was arrested and pled nolo contendere to a charge of misdemeanor battery.

Lint's parents were insured under a homeowners policy issued by State Farm. It contained the standard coverage provision, providing insurance for an "occurrence" which was defined as an "accident." There were the standard exclusions for expected or intended harm and willful and malicious acts.

When Wright sued Lint alleging negligence, State Farm refused to defend or indemnify. At Lint's deposition, he testified he did not intend to harm Wright, but did intend to throw Wright into the pool to get him wet.

Lint filed a declaratory relief action against State Farm, seeking defense and indemnity. Meanwhile, Lint and Wright stipulated to a judgment of $60,000 and Lint assigned all of his rights to Wright.

At trial of the declaratory relief action, the court determined State Farm owed a duty to defend. Once the ruling was announced, State Farm filed a petition for writ of mandate. The Court of Appeal granted the writ for purposes of a hearing.

The Court of Appeal, however, denied State Farm's petition and affirmed the trial court ruling. While noting that the meaning of the term "accident" in insurance law is unsettled, the Court stated the fact that an individual deliberately and volitionally did an act is not the end of the question. The term "accident" also refers to unintended or unexpected consequences of an intentional act. The Court stated that coverage is not always precluded merely because an insured acted intentionally and someone was injured. Where some additional, unexpected and unforeseen happening occurs that produces damage, that likewise can be an accident.

Here, Lint deliberately picked up Wright and threw him

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in the pool. He did not intend that Wright would land on a step and be injured. This was an unforeseen or undesigned happening or consequence and thus was fortuitous. Furthermore, the bodily injury was neither expected nor intended, nor the result of a willful or malicious act. The Court held that to hold otherwise would make all accident-based policies illusory. The Court finally noted that even though there was a plea to a misdemeanor battery, this did not resolve the issue because intent to commit bodily injury was not an element of misdemeanor battery. Thus, potential coverage existed for the claim, requiring State Farm to provide a defense.

The Court therefore denied the petition for writ of mandate and sent the matter back to the trial Court.

COMMENT

This is the first case we know to thoroughly discuss this issue of the definition of accident and whether it applies to both the intent to act and the intent to injure. It is well worth reading.

Damages - Medical Specials Cannot Be Reduced Absent Clear Evidence

Olsen v. Reid, (June 23, 2008)Court of Appeal, Fourth District

We have continually reported on the efforts by California courts to define the proper amount of medical bills that may be claimed by a plaintiff in a personal injury lawsuit. In *Hanif v. Housing Authority* (1988) 200 Cal App. 3d. 635 and *Nishihama v. City and County of San Francisco* (2001) 93 Cal. App. 4th 298, courts held that plaintiffs in tort actions could not recover more than the amount of medical expenses paid or incurred, even if the billable or market value of the medical expenses was a greater sum. In *Greer v. Buzgheia* (2006) 141 Cal App. 4th 1150, the Third District Court of Appeal held that a jury should receive evidence of the total amount of medical expenses charged to a plaintiff. The Third District ruled that a trial court could reduce the amount of medical expenses awarded to a plaintiff as economic damages in a post-trial motion pursuant to *Hanif and Nishihama*. This case addresses a Defendant's burden in proving that certain medical specials have been "written-off."

Plaintiff Margaret Olsen was injured when Defendant Lynn Reid struck her from behind with a motorized wheelchair. Olsen sued Reid for personal injuries arising out of the accident. Prior to trial, Olsen filed a motion to admit evidence to the jury of the full amount her medical providers billed her for treatment. The trial court granted this motion. Reid, on the other hand, filed a pretrial motion, seeking to admit evidence of the amount Olsen actually paid for her treatment. The court denied this motion, stating that any reduction in the amount of medical expenses would be handled after the trial. Olsen was billed over $62,000 for medical care. The jury awarded that amount, as part of a total verdict of $250,000.

After trial, Reid filed a motion to reduce the jury's verdict, relying on *Hanif and Nishihama*. Reid claimed that she was entitled to a reduction in the verdict of approximately $57,000, because Olsen's providers had written off that portion of the bills. In support of the motion, Reid submitted a hospital bill which referenced adjustments. The document also included handwritten notes from an unclear source. The trial court granted Reid's motion. Both parties appealed.

The Fourth District Court of Appeal found that the trial court erred in reducing the amount of the jury verdict. The court held that Reid had not laid a foundation for the documents and had not proven, with admissible evidence, that there had been a write-off. The Court of Appeal, therefore, reversed the trial court order and directed the trial court to enter a new judgment reflecting the full amount of the jury's verdict.

COMMENT

This case makes it more difficult for defendants to prove that a *Hanif/Nishihama* reduction is appropriate. It appears that a declaration or testimony from a doctor, custodian, or PMK of the health care provider or insurance company will be needed to establish admissible evidence regarding the write-off of medical charges.

This decision also included lengthy concurring opinions, calling into question the propriety of the *Hanif/Nishihama* line of cases, and the erosion of the Collateral Source Rule. We continue to believe that the California Supreme Court will need to clarify this issue before too long.

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Coverage - Claims-Made Policy - Definition

Westrec Marina Management, Inc. v. Arrowood Indemnity Company, (June 16, 2008)Court of Appeal, Second District

The definition of a "claim" in a claims-made policy is critical for determining whether a policy must respond. This case deals with that issue in the context of a directors and officers liability insurance policy.

Arrowood Indemnity Company, formerly known as Royal Indemnity Company, issued a directors and officers liability policy to Westrec Marina Management, Inc. from July 1, 2002 to July 1, 2003 and from July 1, 2003 to July 1, 2004. Each policy provided coverage for losses incurred in connection with claims first made during the policy period and reported within 30 days after expiration of the policy. The policy defined a claim as a written demand for civil damages. The policy also provided that all claims arising from the same event or series of events would be deemed a single claim.

Bette Clark filed a complaint with the Department of Fair Employment and Housing ("DFEH") on April 14, 2003, alleging employment discrimination by Westrec. The DFEH issued a right-to-sue notice on April 15, 2003. Westrec did not notify Arrowood of these events. On June 24, 2003, Clark's attorney sent a letter to Westrec indicating a desire to negotiate a resolution of the claim. Westrec did not notify Arrowood of this letter. Clark filed a complaint against Westrec on December 19, 2003. Westrec notified Arrowood on January 30, 2004. Arrowood declined to defend and indemnify. The basis was the failure to provide timely notice of the claim.

Westrec sued Arrowood for breach of contract and breach of the implied covenant of good faith and fair dealing. Westrec moved for summary judgment, which was denied. The trial court conducted a non-jury trial on the count for breach of contract, and concluded Arrowood was entitled to a defense judgment. Westrec appealed.

The Court of Appeal affirmed. The Court stated the ordinary meaning of a "claim" is a demand or request for something asserted as a matter of right or an insistence on some course of action. The initial letter from the Clark attorney clearly stated an intent to sue Westrec for employment discrimination unless an appropriate settlement could be reached. Although a specific amount was not stated, the intent of the letter was clear to demand compensation. The letter was therefore a "claim" as defined by the policies.

Westrec tried to argue that the letter constituted a circumstance which might give rise to a claim. The Court rejected that argument because the attorney letter was a claim within the meaning of the policy definition.

The lawsuit filed was based on and arose from the same events or related series of facts as the prior claim set forth in the attorney letter. The lawsuit and the letter constituted a single claim that was first made at the time of the attorney letter. Westrec tried to argue that the lawsuit was a separate claim, and was made within the second policy period. The Court stated the policy language indicated that two events constituting a claim under the policy definition, such as a written demand followed by the filing of a lawsuit, was a single claim. Westrec received the attorney demand during the first policy period, but failed to notify Arrowood of the claim within that policy period or 30 days thereafter. The lawsuit during the second policy period concerned the same claim and was therefore untimely. Westrec was not entitled to coverage because it failed to timely report the claim. The Court concluded that Arrowood properly rejected the claim and Westrec was not entitled to coverage. The judgment was affirmed.

COMMENT

This opinion notes the importance of the policy language in defining a claim and in determining when notice must be given to the insurer of the claim. It also re-emphasizes the need for strict compliance with policy terms.

Insurance Commissioner Poizner Announces Auto Fraud Perpetrator Busted – Ordered to Pay More than $400,000 Restitution

EL CAJON Insurance Commissioner Steve Poizner today announced that a fraud perpetrator has pled guilty to 11 felony counts including grand theft and insurance fraud. On June 11, Tam Lai, aka Timmy Lai, 33, of Louisville, Kentucky, was sentenced to five years in prison and ordered to pay $415,292.96 in restitution to eight different insurance companies.

Insurance fraud is not a victimless crime," said Commissioner Poizner. "In fact, it results in a $500 tax on every man, woman and child in the State of California. My Department investigators work closely with local and state enforcement officials to find scam artists and put them behind bars, where they belong."

''Prosecution of insurance fraud is a top priority in our office," San Diego County District Attorney Bonnie M. Dumanis said. "This case is an example of the commitment we have to work together with the Department of Insurance to aggressively prosecute insurance fraud cases."

In December 2004, the Auto Club of Southern California notified the California Department of Insurance (CDI) that they suspected a group of individuals were involved in filing fraudulent claims. The insurer discovered that duplicate claims were being filed for the same vehicles with the same damages, and each had a similar story. The insurer also observed that all vehicle repairs were completed by the same body shop, Marshall Auto Body in El Cajon. Shortly after receiving the tip, CDI opened an investigation, which involved more than 50 auto insurance claims and 14 different vehicles.

The CDI investigation revealed that multiple claims were filed with various insurance companies. Most of the claims came from Marshall Auto Body. Lai was the owner of the body shop, and allegedly orchestrated the fraudulent claims-filing scheme. Lai and his accomplices purportedly purchased vehicles, obtained insurance policies on the vehicles, and staged non-injury accidents with them. Lai and his accomplices would then allegedly file multiple claims with insurance companies. They commonly reported that the insured was traveling on a two-lane road in San Diego County when they were involved in a hit and run collision, or that they hit a fixed object. Lai and his accomplices endorsed and deposited claims checks from insurance companies into multiple different bank accounts in an attempt to avoid detection.

The investigation also revealed that insurance claims were pursued by Lai and his accomplices until insurance companies began to question the legitimacy of the claim or opened an investigation. When this occurred, the questionable claim was withdrawn.

This investigation was conducted by the California Department of Insurance Fraud Division, California Highway Patrol, San Diego County District Attorney's Office and the National Insurance Crime Bureau. This case was prosecuted by the San Diego County District Attorney's Office.

Insurance Commissioner Poizner Announces Quarter Million Dollar Settlement with Mercury Insurance Group for Alleged Claims Handling Violations

SACRAMENTO Insurance Commissioner Steve Poizner today announced a quarter-million dollar settlement with Mercury Insurance Group for alleged claims handling violations.

"It is vital that insurance companies put their customers first," said Commissioner Poizner. "I'm pleased that Mercury has agreed to this settlement, which demonstrates that claims handling violations will not be tolerated in California. Mercury recently announced that it is reducing rates for policyholders, and I am hopeful that the company will continue to put its customers first. The Department of Insurance continues to make sure that all insurance companies are obeying the laws in place to protect consumers. "

The California Department of Insurance (CDI) conducted a review of consumer complaints filed with the Department against Mercury Insurance, Mercury Casualty, and California Automobile Insurance Companies, collectively known as Mercury Insurance Group. Of the 121 files reviewed, a total of 258 violations were discovered to have occurred from January 2004 through December 2005. These violations involved several of the company's claims-handling practices, including unreasonable delays in affirming or denying coverage and issuing claim payments.

Mercury Insurance Group will pay the Department of Insurance $250,000 in monetary penalties, as well as $50,000 for CDI's legal fees and enforcement costs associated with the case. Additionally, if Mercury Insurance does not improve its performance standards - as evidenced by a 15% reduction in justified complaints - by December 31, 2008, it may be ordered to pay an additional $200,000.

When You Need to Know What Really Happened

Submitted by Garrett Engineers, Inc. - Forensic Division, Long Beach, CA

Case of the Month: The Fuel Tank Repair

The case of the month involves a fuel tank located in a petroleum distribution terminal in a very remote area. The tank was 48 feet high and 65 feet in diameter, with a gross capacity of over 28 thousand barrels. Normally it was filled with premium unleaded gasoline. It was constructed by welding 5/16 inch thick, 8 feet wide by 24 feet long steel plates together, in 6 horizontal courses. The tank was over thirty years old and had seen its share of bad weather. Corrosion and pitting were proportionate to the tank's age. The last typhoon it experienced damaged the tank, which required repairs.

As a result a consultant was engaged to evaluate the tank. He did a life expectancy analysis and recommended the tank be strengthened. His proposed solution was to install stiffening rings, angle iron curved into sections that matched the curve of the tank. These sections would then be joined to each other at their ends and welded around the tank to form rings around the tank (roughly in the upper third). These encircling bands would strengthen the tank against future damage. Unfortunately, the owners of the tank decided it was an expense they didn't want to make at that time.

Since the tank was to remain empty for a while, they decided to fill it with water to act as ballast against the approaching winds of the next typhoon. Their solution worked against the storm winds-the tank sat solid as a stone.

However that region was well known for being seismically active, as well as being subject to typhoons. A while after the last typhoon hit, an earthquake rumbled through the terminal and the sloshing water within the tank buckled the tank walls. The water was drained out and the tank was surveyed. The tank had bulges in and out of its sides. It was similar to gently squeezing an empty coke can- some portions of the wall bulge inward, and some outward. For the fuel tank, maximum measured deflection was more that two inches in some sections, and about 25% of the circumference was affected. At this point, our expert was brought in to recommend repairs for the damage **caused by the earthquake.**

The first thing he noted was the use of water as ballast for the tank. Typically in the construction of new tanks, when they are completed, they are filled with water for a short time to test for leaks and then they are pumped dry. This is a form of stress testing-and if there are leaks, you want them to be water, not 98 octane gasoline. The specific gravity of water is 1.0, by definition. The specific gravity of gasoline is .74. This means that for an equal volume, gasoline weighs 26% less than water. The design of the walls of the tank was to support the long term loads imposed by the lighter fluid (gasoline), not the heavier fluid (water). Keeping water in the tank for an extended period of time exceeded the design strength of the wall thickness for the lower two courses. Thus a seismic event at an over stressed wall and buckling occurs.

Seasoned operators of a distribution facility should have known better than to overstress a 30 plus year old tank. He also noted that had the recommended ring stiffening procedure been completed, and if the tank had not been filled with an overloading fluid, the tank would have been fine in both the storms and in the earthquake.

That being said, our expert recommended cutting out the damaged sections, and welding in new sections, one 4 by 8 plate at a time. The total strip replacement area would be approximately 4 feet by 56 feet. As might have been expected, the operators of the plant wanted a new tank, and not just a repair (but they wanted someone else to pay for said new tank). They then came back with a list of criticisms of our expert's recommendations, saying he greatly underestimated the cost of the repair. Of course, there is a vast disparity between the cost of a repair and the cost of a new tank.

First, they said that his repair recommendations ignored the damage to the roof and floor of the tank. The response was that while there was damage to the floor and the roof structures, the damage was due to weather and water corrosion, not the earthquake.

Then they said the estimate did not provide for scaffolding costs, nor for removal and replacement of the internal pontoon roof during the repair period. As it happens, there was no need to remove the internal pontoon roof as the scaffolding would be supported from the shell, and the work could be done from the outside.

The next criticism was it would be prohibitively expensive to fly in X-ray equipment to X-ray the welds to inspect and verify weld quality. The response was that there are other, equally reliable methods of verifying weld quality. These alternative methods include ultrasonic, magnetic particle testing, and dye checking. Dye checking would entail grinding smooth sections of weld, applying the dye, inspecting, and then applying a cover pass weld over those inspected areas. About one foot in twenty feet of weld would provide a sufficient statistical sample to verify weld quality for the repair.

The final criticism was the estimate did not address the failure of the coatings inside the tank. As our expert observed, the interior tank coating was an after-market product that had been poorly applied. Now that the tank was empty, it was easy to see portions of the coatings sliding down the interior wall, leaving whole sections unprotected and thusly corroding. The earthquake had nothing to do with the interior coating.

BELIEVE it or not, these are REAL 911 Calls!

Dispatcher: 9-1-1 What is your emergency?

Caller: I heard what sounded like gunshots coming from the brown house on the corner.

Dispatcher: Do you have an address?

Caller: No, I have on a blouse and slacks, why?

Dispatcher: 9-1-1 What is your emergency?

Caller: Someone broke into my house and took a bite out of my ham and cheese sandwich.

Dispatcher: Excuse me?

Caller: I made a ham and cheese sandwich and left it on the kitchen table and when I came back from the bathroom, someone had taken a bite out of it.

Dispatcher: Was anything else taken?

Caller: No, but this has happened to me before and I'm sick and tired of it!

Dispatcher: 9-1-1 What is the nature of your emergency?

Caller: I'm trying to reach nine-eleven but my phone doesn't have an eleven on it.

Dispatcher: This is nine-eleven.

Caller: I thought you just said it was nine-one-one.

Dispatcher: Yes, ma'am nine-one-one and nine-eleven are the same thing.

Caller: Honey, I may be old, but I'm not stupid.

My Personal Favorite!!!

Dispatcher: 9-1-1 What is the nature of your emergency ?

Caller: My wife is pregnant and her contractions are only two minutes apart.

Dispatcher: Is this her first child?

Caller: No, you idiot! This is her husband!

And the winner is . . .

Dispatcher: 9-1-1

Caller: Yeah. I'm having trouble breathing. I'm all out of breath. Darn . . . I think I'm going to pass out.

Dispatcher: Sir, where are you calling from?

Caller: I'm at a pay phone. North and Foster.

Dispatcher: Sir, an ambulance is on the way. Are you an asthmatic?

Caller: No.

Dispatcher: What were you doing before you started having trouble breathing?

Caller: Running from the Police.