CAIIA Status Report

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January 2018

Certificate of Merit

Credit to: Manning& Kass, Los Angeles, CA

In California, before filing a complaint against a design professional, a plaintiff is required to timely file and serve a Certificate of merit on or before the date of service of the complaint, stating that the attorney has consulted with and received an opinion from an expert demonstrating the claim has merit. California Code of Civil Procedure (C.C.P. §411.35).

In Curtis Engineering Corporation v. Superior Court, plaintiff Sutherland filed a personal injury case asserting negligence against an engineer. The engineer objected to the amended complaint based on the lack of a Certificate of merit being filed within the relevant statute of limitations. (In this case, two years under C.C.P. §339(1)). C.C.P. §411.35b(1) states that if an attorney was unable to obtain the consultation or file the certificate before the statute of limitations ran, they must file their certificate "within 60 days after filing the complaint."

In this case, the plaintiff filed his lawsuit in a timely fashion, but did not file his amended Complaint with a Certificate of merit until seven months after filing the original complaint. The trial court overruled the objections based on timeliness of the engineering company, which then sought appellate relief.

Plaintiff s argument was that the amended complaint, which included the Certificate of merit, "related back" to the date of the original complaint the appellate court found that the "plain language of Section 411.35 does not allow application of the relation back doctrine."

The relation back doctrine means that courts may deem a later filed pleading to have "related back" to the time of filing of the original complaint, providing the amended complaint is based on the same general facts.

The Court reasoned that to allow a Certificate of merit to be filed more than 60 days after the filing of the original complaint would give a plaintiff "virtually an unlimited amount of time to obtain the necessary consultation as long as the plaintiff files the certificate of merit with an amended complaint that relates back to the original complaint."

This case presents an excellent holding for design professionals, in that plaintiffs' lawyers who are unsophisticated in design professional malpractice suits often fail to file a Certificate of merit. The defense lawyer should therefore consider filing an answer raising this as an affirmative defense, and then if the Certificate of merit is not filed and served within 60 days thereafter, filing a motion for judgment on the pleadings.

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Inside this issue…..

CAIIA Newsletter
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To add other insurance professionals to our e-mail list, please go to CAIIA. com or e-mail a request to statusreport@caiia.com.

President's Message

Happy New Year 2018!

Let me help you make your first New Year Resolution, and one that I hope you will not break. As we revive our organization, participation from the membership is crucial.

Resolution #1: Attend the CAIIA Mid-term meeting.

Our Mid Term meeting is being held on Friday, April 6, 2018, in South Lake Tahoe. We are finalizing our plans to meet at Tahoe Resort Hotel; www.tahoeresorthotel.com Plan on arriving Thursday afternoon and join us for a gathering over dinner. The next day, we will offer a 3-hour CA DOI approved CE class. Our business meeting will follow and hopefully will include a vote on a membership change to grow our organization.

Paul Camacho

CAIIA President

Now the fun part. I contacted Peter Evans, who was the CAIIA president in 1999-2000, to write this month's President's Message. Thankfully, he agreed and provided his picture. I asked him for a little background information and was told that he started in the insurance business when 17 years old. That is an accomplishment that few can attest, and Peter is still working at it with some very loyal clients.

Paul Camacho

CAIIA President 2017-2018

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I have worked in the insurance industry for more than 40 years, beginning in London with an insurance company, as a broker at Lloyd's and as a loss adjuster. I have lived and worked in the US since 1978 as a large loss property adjuster and as a consultant dealing with claims handling issues in disputed or litigated matters. I was privileged to serve as President of the CAIIA in 1999-2000 and was a founding director of the RPA.

Though there have been many changes in the technical aspects of claims adjustment, particularly with the introduction and almost universal use of estimating programs and management systems, basic requirements and obligations remain the same – the claims adjuster is and always has been something of a generalist, and needs an inquiring mind and the means to deal intelligently with many different types of claims. These will involve all facets of personal lines and commercial losses, quite apart from knowledge of coverages and procedures.

While technical training is invaluable, there seems to be less emphasis on an extremely important part of the overall job, people skills and the projection of confidence dealing with insureds, claimants and their representatives. It is often said that the first five minutes of a meeting or interview is the adjuster's opportunity to "sell" him- or herself in such a way that the insured or claimant is likely to work cooperatively towards a mutually acceptable conclusion of the claim. It seems strange to me that few of the efforts to provide training to those beginning work as claims adjusters include emphasis on communication skills.

Organizations such as the CAIIA play essential part of the continued training process, and members can be of real help to less experienced adjusters in mentoring not only their own employees but others as well. The plan to open a form of membership to adjusters who are not proprietors is a really important step toward spreading experience and knowledge across the industry.

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NEWS FROM AND FOR OUR MEMBERS

SAVE THE DATE

The CAIIA is proud to be exhibiting at or sponsoring the following upcoming events:

March 6-7, 2018 **Combined Claims Conference, Garden Grove, CA**

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CAIIA President Paul Camacho and all of those who take the time to manage and support the Association are to be congratulated for all of their work and I am excited to see the CAIIA expand its membership and knowledge base.

Peter Evans, CAIIA Past President (1999-2000)

Peter Evans, CAIIA Past President (1999-2000)

DOI Press Release

Insurance regulator steps in to help hundreds of wildfire survivors with claims

Jones' formal notice requests insurers lift requirements for detailed home inventories

SACRAMENTO, Calif. — In the midst of the holiday season, Insurance Commissioner Dave Jones is asking insurers to help California wildfire survivors who are overwhelmed with the task of navigating the claims process by providing relief from detailed home inventories and following the lead of other insurers providing up to 100 percent of contents (personal property) coverage limits without a detailed inventory.

"These families have endured unimaginable loss and pain," said Insurance Commissioner Dave Jones. "I'm asking insurers to ease their burden by providing up to 100 percent payment for contents coverage without the onerous requirement of a detailed home inventory, so they may get on with rebuilding their lives."

The notice, issued today to insurers, comes after the department held a claims workshop in Santa Rosa on December 9 and heard from several hundred policyholders that they were burdened with insurer requirements for detailed home inventories in order to receive payment for personal property coverage.

The notice, does point out that the department is aware and applauds the efforts of some insurers that have gone above and beyond the Voluntary Expedited Claims Handling Procedures and have made significant efforts to accommodate insured by offering, in some cases, up to 100 percent contents limits payment without an inventory.

While Jones applauds these efforts to put insured first, he is requesting all other insurers follow suit by providing similar accommodations and is asking insurers to notify the department by January 8, 2018 whether they will comply. Those insurers offering an amount less than 100 percent should allow policyholders the ability to recover additional benefits, if the policyholder subsequently completes a full inventory.

The department advises policyholders already working with a claims adjuster to develop a settlement plan that best serves their needs, which may include taking the time to complete a home inventory.

Insurer Entitled to a Writ of Attachment
Credit : Haight, Brown & Bonesteel, Los Angeles, CA

In *Santa Clara Waste Water Co. v. Allied World Nat'l. Assur. Co.* (No. B279679, filed 12/20/17), a California appeals court affirmed the grant of a right to attach order and a writ of attachment against the policyholder for $2.5 million plus costs and interest in a coverage action, on the ground that the insurer had established the probable validity of its claims as required by the attachment statute, Code of Civil Procedure section 484.090.

In *Santa Clara Waste Water* the insured owned a wastewater treatment facility in Santa Paula. In applying for environmental liability insurance, the insured represented that it did not accept, process, transport, or discharge hazardous waste. The resulting $2 million primary and $5 million umbrella policies covered "'environmental damage"' or "emergency response expenses" arising out of a "pollution incident." The policies also contained an "intentional noncompliance" provision, which excluded coverage for damages resulting from the "intentional disregard of or deliberate willful or dishonest noncompliance" with law or regulations.

After obtaining coverage from Allied, a vacuum truck owned by the insured exploded at the facility when a truck driver mixed wastewater with a chemical (sodium chlorite). Chemical spillage from the explosion spontaneously combusted and caused a fire. The insured submitted a claim to cover the cleanup costs, which was denied.

The parties entered mediation and reached a partial settlement including a "Payment Term Sheet." The Payment Term Sheet provided that Allied would pay $2.5 million to the insured but if Allied obtained a judgment that it was not obligated to pay the insured's damages under its policy, then the insured would reimburse Allied. Allied paid the $2.5 million. The insured sued Allied for failing to pay damages up to the policy limit. Allied filed a first amended cross-complaint for declaratory relief, reimbursement of defense costs and expenses, unjust enrichment, fraud, rescission, and unlawful business practices.

With the coverage action pending, Allied then filed applications for a right to attach order and writ of attachment against the insured for $2.5 million plus costs and interest based on an express contract (the Payment Term Sheet) and implied contract theories of unjust enrichment and rescission. In support of its applications, Allied presented evidence showing that the intentional noncompliance policy exclusion applied because the insured violated laws and regulations when it stored and concealed the presence of sodium chlorite at the facility. Allied also presented evidence showing that the policy should be rescinded because the insured misrepresented that it did not accept, process, transport, or discharge hazardous waste.

The trial court granted the applications and the appeals court affirmed. Under the attachment statute, a party seeking a prejudgment attachment must demonstrate the probable validity of its claim. (Code Civ. Proc., § 484.090, subd. (a).) Probable validity means that "more likely than not" the plaintiff will obtain a judgment on that claim. (Code Civ. Proc., § 481.190.) The *Santa Clara Waste Water* court stated:

"Allied established the probable validity of its unjust enrichment claim. Where an insurer pays an amount not covered under its policy, it has a right of reimbursement that is implied-in-law under an unjust enrichment theory. (*Buss v. Superior Court* (1997) 16 Cal.4th 35, 51.) Allied had a right of reimbursement because the intentional noncompliance policy exclusion applied.... [The insured] failed to comply with law and regulations when they stored sodium chlorite at the facility. They were required to report and update a 'Hazardous Materials Business Plan' within 30 days of receiving a 275-gallon container of sodium chlorite. (Health & Saf. Code, § 25508.1.) They did not do so.... Moreover, [the insured] failed to comply with law when they concealed chemicals from inspectors. Employees testified that they consolidated and cleaned chemical totes before inspections to hide the presence of unreported chemicals at the facility. Employees removed labels from chemical totes that identified their contents or indicated they were hazardous materials. [The] environmental compliance manager admitted that he ordered employees to move unreported chemicals to a trucking yard before an inspection in order to hide them from the inspectors. The storage of these chemicals at the trucking yard violated [the insured's] lease with the City of Santa Paula."

The *Santa Clara Waste Water* court went on: "Although the unjust enrichment claim alone is sufficient to support an order for prejudgment attachments, Allied also established the probable validity of its rescission claim. Misrepresentation or concealment of a material fact in connection with an insurance application is grounds for rescission of the policy. (Ins. Code, § 359; *Superior Dispatch, Inc. v. Insurance Corp. of New York* (2010) 181 Cal.App.4th 175, 191.) 'Each party to a contract of insurance shall communicate to the other, in good faith, all facts within his knowledge which are or which he believes to be material to the contract.' (Ins. Code, § 332.) In determining whether a fact is material, we consider the 'probable and reasonable' effect a misrepresentation of that fact has on the insurer. (Ins. Code, § 334.)

Here, [the insured's] representation that they did not accept, process, transport or discharge hazardous waste was a material fact because Allied asked questions regarding hazardous waste in its application and related correspondence, including whether [they] transported hazardous waste, the type of waste they disposed of, and several questions regarding their history of hazardous waste discharge. An Allied executive declared that Allied would not have issued a policy under the same terms if [they] had represented that 'it accepted, stored, or disposed of hazardous waste at any of its facilities....' Substantial evidence supports the finding that [the insured] misrepresented and concealed this material fact."

In that regard, the *Santa Clara Waste Water* court rejected an argument that Allied could not prevail on its rescission claim because it was required but failed to give proper notice and to offer to restore premiums prior to bringing its rescission claim: "[F]iling the action was sufficient to meet those requirements here. [] 'When notice of rescission has not otherwise been given or an offer to restore the benefits received under the contract has not otherwise been made, the service of a pleading in an action or proceeding that seeks relief based on rescission shall be deemed to be such notice or offer or both.' (Civ. Code, § 1691.)"

Finally, the *Santa Clara Waste Water* court affirmed an award of prejudgment interest, running from the date that Allied had paid the $2.5 million.

Malpractice Claim
Credit : Haight, Brown & Bonesteel, CA

In *Admiral Ins. Co. v. Superior Court* (No. D072267, filed 11/21/17, ord. pub. 12/12/17), a California appeals court held that an application question about prior knowledge of facts that could give rise to a "malpractice claim" did not create a triable issue of fact over policy interpretation where the policy only provided coverage on the condition that, prior to inception, no insured knew, nor could reasonably foresee, that a "professional incident" might give rise to a claim.

Admiral provided claims-made professional liability insurance to a company matching surrogates and egg donors with infertile families. The policy provided coverage for claims made during the policy period arising from a "professional incident ... provided that prior to the inception date of the policy, no insured knew, nor could have reasonably foreseen, that the professional incident might result in a claim."

Before Admiral was on the risk, a couple utilized the insured's services to locate an egg donor and a surrogate. The surrogate had a baby who developed a retinoblastoma, a rare cancer of the eye. In June 2012, the couple retained counsel who sent the insured letters citing Code of Civil Procedure section 364 and stating an intent to file a complaint alleging "negligent and unprofessional ... conduct, while in the performance of professional duties, intentionally or recklessly causing physical and emotional harm" and for "medical negligence and lack of informed consent."

On receiving the letters, the insured consulted with its insurance broker. Interpreting the letters as something less than an actual "claim," and concerned about a possible increase in premiums, it decided not to notify its current insurer. In October 2012, the insured applied to Admiral for a new business policy. The application asked whether the applicant was "aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit?" The company responded, "No." Nor was there any other disclosure to Admiral, which issued the policy.

The policy covered "damages caused by a professional incident ... for which a claim is first made against the insured during the policy period." "Professional incident" was defined as "a negligent act, error or omission in the rendering of or failure to render professional services by the insured." And Admiral was obligated to pay only if "prior to the inception date of the policy, no insured knew, nor could have reasonably foreseen, that the professional incident might result in a claim."

The couple's lawsuit followed in March 2013. Admiral denied coverage and moved for summary judgment in the resulting bad faith lawsuit on the ground that prior to the inception of the policy the insured knew or reasonably could have foreseen that the services it provided to the couple might result in a claim. Admiral also asserted material misrepresentation in the application.

The insured argued that there was a fact question because the application was "wholly inappropriate for the kind of business" it operated, emphasizing that it was not a licensed health care provider and did not employ doctors, nurses, or other health care professionals. The trial court agreed, finding triable issues of fact about Admiral's reliance on an application form that was designed for "medical laboratories, medical imaging centers and blood plasmapheresis centers." The court found a disputed fact question whether the insured could truthfully answer "no" to the question whether it was aware of anything that might result in a malpractice claim, since it was not a health care provider that rendered professional medical services. The court also found an issue of fact "as to whether Admiral could rely on the 'prior notice' condition to deny coverage."

The appeals court reversed. First, the court stated the rule that interpretation of a written contract, such as an insurance policy, is generally a question of law for the court unless the foundational extrinsic evidence is in conflict. And "here, although the parties 'dispute the inferences to be drawn from [the] extrinsic evidence, the evidentiary facts themselves are not in conflict.' [] With no conflict in the foundational extrinsic evidence, it is left to the court to decide the question of law by determining the meaning of the contract in light of the undisputed evidence and the objectively reasonable expectations of the insured."

The appeals court said that although the insured was probably truthful in arguing that it was unaware of the basis for a "malpractice claim," since it was admittedly not a healthcare provider, "the application form and the responses to the questions on it are largely a red herring because the policy (i.e., the parties' agreement) itself explains there is no coverage for a claim arising from a 'professional incident' if, prior to the inception of the policy, the insured 'knew' or 'could have reasonably foreseen, that the professional incident might result in a claim.'"

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The court rejected an argument that the application's use of the term "malpractice claim" provided the "context" for interpreting the policy because "[t]he ultimate question, however, is whether the document and surrounding context will support a meaning to which the language of the instrument is reasonably susceptible." But the court held that the insured failed to offer a reasonable meaning for the language of the policy:

"The 'prior notice' provision is an integral part of the insuring agreement itself. It specifies there is no coverage if the insured knew or reasonably could have foreseen that the professional incident might result in a claim.... The policy provides coverage for amounts the insured is required to pay as damages 'caused by a professional incident.' If 'professional incident' were construed to mean 'medical malpractice,' [the insured] (which is concededly not a licensed health care provider) would have no coverage for anything. Such a result would be inconsistent with the reasonable expectations of all the parties....

Here, the undisputed facts demonstrate that [the insured] had notice prior to the inception of the policy that [the couple] intended to file a lawsuit for breach of contract and negligence. Even if there was some confusion as to whether [they] properly labeled their claim as a 'medical negligence' action or invoked the appropriate code section, the policy only requires that the insured be able to foresee that a claim 'might' be made. Counsel's June 2012 letters provided indisputable notice to [the insured] that its professional services rendered to [the couple] 'might result in a claim.' Accordingly, by the clear terms of the policy, there was no coverage."

DOI Press Release

Santa Clara County brothers arrested for running staged auto accident ring

20 suspects, 18 staged crashes, over $200,000 and 81 felony counts

SANTA CLARA, Calif. - Brothers Angel Topete, 36, and Joshua Topete, 34, both of San Martin were arrested on numerous felony charges for allegedly running an organized auto insurance fraud scam involving more than 20 individuals and 18 staged collisions netting conspirators $210,000 in fraudulent auto insurance claims.

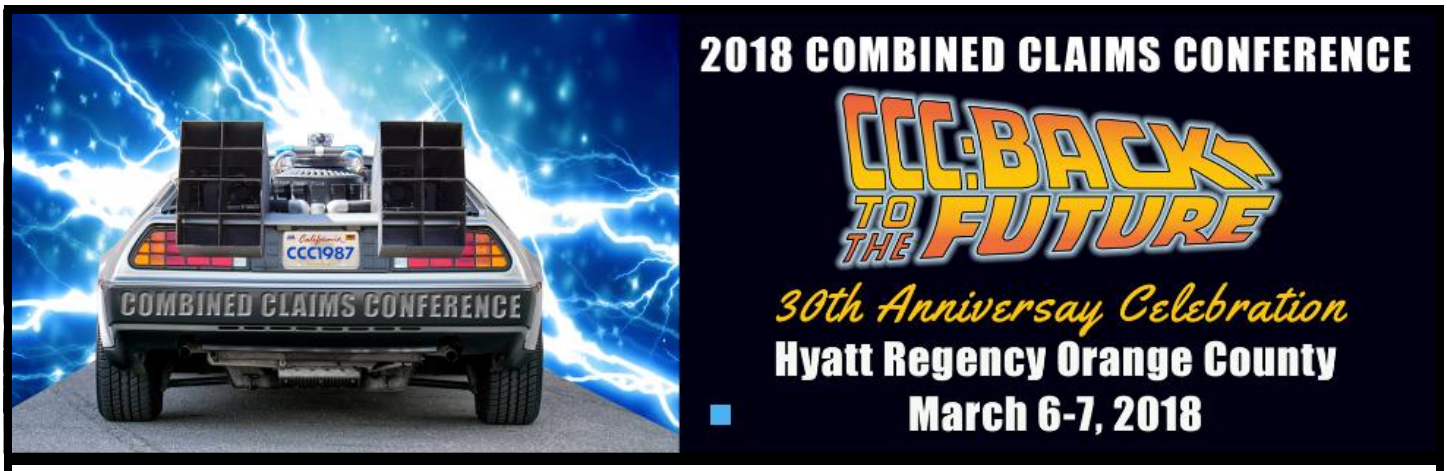
"This large ring of family and friends allegedly conspired to defraud insurers out of hundreds of thousands of dollars," said Insurance Commissioner Dave Jones. "The cost of insurance fraud is shouldered by consumers who pay higher premiums when insurers pass along their losses. Working with our task force partners is critical in combating the multi-billion dollar problem of insurance fraud."

Silicon Valley Automobile Insurance Fraud Task Force investigators initially received information about the crime ring in 2015. The two-year investigation revealed the Topete brothers conspired with family, friends and associates who posed as insurance consumers and filed fraudulent claims with six different insurers for collisions that were either staged or never occurred at all.

Evidence revealed many of the claims involved salvaged vehicles, new insurance policies and variations of a name used on other similar claims. In some cases, suspects purchased insurance policies and then intentionally crashed cars into one or more vehicles owned by co-conspirators. All parties then filed fraudulent claims, which resulted in insurers paying the full value of the vehicles after it was declared a total loss.

To date, 18 of the 22 suspects have been arrested and booked. Many are due in court this week.

The Silicon Valley Automobile Insurance Fraud Task Force, which is comprised of investigators from the California Department of Insurance (CDI) Fraud Division, the Santa Clara County District Attorney's Office, and the California Highway Patrol investigates crimes involving organized automobile insurance fraud in Santa Clara County.



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Early Bird Deadline is January 3, 2018

To register and for more info: http://www.combinedclaims.com/registration

Happy New Year to all of you from the CAIIA !