CAIIA

Status Report

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January 2019

Workers' Compensation & UM Claim

Credit to Haight, Brown & Bonesteel, Los Angeles, CA

In *Case v. State Farm Mutual Automobile Ins. Co., Inc.* (No. B281732, filed 11/21/18, ord. pub. 12/18/18), a California appeals court held that the allowable reduction from uninsured motorist (UM) benefits for "payable" workers' compensation benefits meant "eligible," whether the insured sought the benefits or not. As a result, the court found that a genuine dispute over resolution of the insured's workers' compensation claim negated a claim for bad faith delay in payment of UM benefits as a matter of law.

In 2013, after being involved in an accident while in the course and scope of her employment, the *Case* plaintiff made a workers' compensation claim through her employer. In 2014, she made a demand for uninsured motorist (UM) benefits from her own insurer, State Farm, which responded by requesting verification of a final lien for workers' compensation medical expenses. When State Farm would not pay UM benefits, the plaintiff demanded arbitration. In May 2015, she sued State Farm for breach of contract and bad faith, asserting improper delay of arbitration or settlement for UM benefits, alleging that she had verified a final workers' compensation lien for medical expenses in November 2014. But the plaintiff did not submit proof that she had finally exhausted any possibility for additional workers' compensation benefits until September 2015 and State Farm settled her UM claim for $35,000 in November 2015.

State Farm sought summary adjudication on the claim for breach of contract, arguing that it had paid all benefits due. Relying on *Rangel v. Interinsurance Exchange* (1992) 4 Cal.4th 1, State Farm also sought adjudication of the bad faith claim, arguing that there was no breach of the policy or bad faith in declining to pay or arbitrate the UM claim before the claim for workers' compensation benefits had been resolved.

The trial court granted State Farm's motion and the appeals court agreed. The evidence showed that the plaintiff's demand for UM benefits included medical expenses that had not been paid under workers' compensation. Although her attorney represented that her condition had achieved "stationary and ratable" status, the workers' compensation administrator advised State Farm that the plaintiff had never been discharged from care and could still seek additional medical treatment. There was some back-and-forth communication between the plaintiff's counsel and State Farm, and the case finally resolved when the plaintiff's counsel provided State Farm an email dated September 2015 in which the workers' compensation administrator rejected a request by the plaintiff for reimbursement of certain medical expenses, stating that the treatment had been "self-procured" and without authorization. At that point, State Farm settled the UM claim.

First, the *Case* court dealt with the issue of whether the statutory right to reductions from UM benefits for workers' compensation benefits required actual payment by workers' compensation. The court noted that both the policy and the UM statute used the word "payable," which the court said meant "eligible," whether the employee sought workers'

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President's Message

As predicted, I am deep into the end-of-the-year rush and as such will make this month's President Message short…

As independent adjusters we often use the term "feast or famine" however I truly cannot remember the last time I was hungry! Oftentimes I hear from people, "oh, well that's a good problem to have"… not realizing how much this job can take away from the other important parts of life.

John Ratto

CAIIA President

In the dedicating ourselves to the job of adjusting and helping people (see last month's message), it often happens that there is little time left for other important aspects of an adjuster's life such as family, friends, good health, peace of mind, (add your own items here).

After nearly 30 years of adjusting claims, some of the best advice that I can give is to pace yourself and force yourself to take time to include what is important for you and for your family. For me, I make the time to swim five to six days a week by waking up at 5:30 AM. I have found, as many of you who work-out know, that if I do not do it first thing in the morning, it will never get done. The key is to make time for the things that we feel are important with the eye towards the goal of a life in balance. Someone once said "8 hours of work, 8 hours of rest and 8 hours to create". Now I am often guilty of stretching out the first share by a couple of hours each day including sneaking in a Saturday (more often lately than I wish).

When you find yourself buried in work and you just cannot take another phone call or answer another email, my suggestion is to simply shut it down. Walk around the block or gather every piece of paper on your desk and reorganize. Like a computer, it is important to push that re-set button.

The midterm is coming up and we are looking to schedule for late March. We are strongly leaning towards San Luis Obispo but I have also heard suggestions of Monterey….

Additionally, we should soon have a better update for all members regarding the historic change in the bylaws and will keep you apprised.

As we head into the new year, a natural time for a re-set, keep up the good work, keep your head down, but don't forget to look up every once in a while… reorganize, refresh and re-set as needed. Wishing you all a balanced and prosperous New Year!

John Ratto President

CAIIA President

NEWS FROM AND FOR OUR MEMBERS

SAVE THE DATE

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

March 5 & 6, 2019 Combined Claims Conference, Hyatt Regency, Orange County

March (Date TBD) CAIIA Midterm Meeting, location TBD

Cheers to a wonderful 2019!

DOI Announcement

Detectives escort adjusters and survivors into Paradise

Insurers able to start writing checks to policyholders after property damage assessed

Due to multiple hazards and blocked roadways, many Camp Fire survivors were unable to return to the restricted burn area to assess their losses. To assist in getting homeowners and insurance company adjusters access to the damaged and destroyed properties as soon as possible, detectives with the California Department of Insurance (CDI) have assisted Paradise residents by taking fire survivors and insurance adjusters into restricted areas decimated by the Camp Fire.

The restricted access and hazards were leading to delays in claims processing, so the department's enforcement team stepped in to assist. For the past two weeks, CDI's law enforcement officers have escorted insurance claims adjusters into restricted areas. Department detectives escorted adjusters and homeowners to 1,271 properties, more than 1,100 of which were completely destroyed. The team's efforts resulted in allowing more than a dozen insurers begin processing 1,243 claims for property and auto coverage.

"I deployed our detectives to assist homeowners in gaining access to their properties so they could take the first step in the very difficult recovery process," said Insurance Commissioner Dave Jones. "The response to this disaster has been extraordinary. Communities, agencies and law enforcement have come together to help the survivors of the most destructive fire in California's history, and my department remains committed to assisting Butte County residents through this trying time."

Due to the magnitude of the Camp Fire, the Butte County Sheriff's Office asked for assistance in escorting adjusters into the area in order to help residents of Paradise begin receiving policy benefits/payments. The department frequently works with local law enforcement and other state and federal agencies during and after disasters to provide assistance, help survivors and offer expertise. The detective's expertise is also helpful in spotting potential scams or fraud.

Following disasters the department deploys the Disaster Assistance Response Team (DART) to canvas neighborhoods looking for unlicensed contractors, adjusters and other scam artists that target vulnerable wildfire survivors. With few homes still standing in Paradise, detectives have attended town halls and community meetings in lieu of going door to door in order to reach homeowners and deliver warnings about scam artists and provide information to assist with their recovery. Detectives have also met with residents one on one to address concerns and get information to help them spot a potential scam.

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compensation benefits or not: "[T]he term 'payable' necessarily encompasses medical expenses eligible for payment through the workers' compensation system, regardless of whether the insured has submitted a claim for them…. Accordingly, the provision authorized State Farm to request a determination regarding the extent to which her past and future medical expenses could be paid through that system."

Having concluded that State Farm had the right to require proof of all "payable" workers' compensation benefits, the *Case* court proceeded to find that a genuine dispute over the reduction negated bad faith. Although the plaintiff argued that there was a triable issue of fact about when State Farm knew the answer, and whether that was reasonable, the appeals court agreed with the trial court that State Farm's conduct was reasonable as a matter of law, citing *Chateau Chamberay Homeowners Assn. v. Associated Internat. Ins. Co.* (2001) 90 Cal.App.4th 335 and *Wilson v. 21st Century Ins. Co.* (2007) 42 Cal.4th 713.

The *Case* court walked through all of the exchanges that had occurred between the plaintiff's counsel, the workers' compensation administrator and State Farm, and found that State Farm only had sufficient information to determine the allowable reduction at the point when the plaintiff's counsel had disclosed that treatment was completed and the workers' compensation administrator had confirmed that the past medical expenses listed in the original demand were not eligible for payment under workers' compensation:

"The facts crucial to establishing the loss payable – namely, the extent to which Case was entitled to worker's [sic] compensation benefits – were fully known by State Farm only in September 2015, when Bassett Gallagher [sic] made the requested determination. Because State Farm resolved Case's claim shortly after that determination, no triable issues exist regarding bad faith…. The existence of bad faith hinges on when State Farm knew the determination of Case's eligibility for workers' compensation benefits, not on the determination itself. The record discloses only that State Farm resolved Case's promptly after learning of her ineligibility for future Workers' Compensation benefits."

Insurance Coverage for the Estate of Insured
Credit to Haight, Brown & Bonesteel, Los Angeles, CA

In *Meleski v. Estate of Hotlen* (No. C080023, filed 11/29/18), a California appeals court held that an insurer is subject to the penalties for failure to accept a statutory offer to compromise under Code of Civil Procedure 998, even though the estate of its deceased insured is the named defendant in an action that the insurer defends under Probate Code sections 550, et seq.

In *Meleski*, the insured was at fault in an accident, but died before suit was filed. The complaint named his estate, although he did not leave one. Probate Code sections 550 through 555 allow an action to establish a decedent's liability for which the decedent was covered by insurance to be continued against the estate without the need to join the decedent's personal representative or successor in interest. (Prob. Code, §§ 550, et seq.)

Under the statutory scheme, the estate must be named as the defendant, but service is on the insurance company. (Prob. Code, § 552(a).) Any judgment does not adjudicate rights by or against the estate, unless the personal representative of the estate is joined as a party. (Prob. Code, § 553.) Also, unless the personal representative is joined as a party, no damages may be recovered outside the policy limit; a judgment in favor of the plaintiff in the action is enforceable only from the insurance coverage and not against the estate. (Prob. Code, § 554(a).)

Allstate was not named as a defendant in the *Meleski* action, but defended the action in the name of the deceased insured. In the process, Allstate failed to accept a statutory offer to compromise under Code of Civil Procedure section 998, and the plaintiff recovered a more favorable judgment in excess of the policy limit. Allstate moved to strike or tax the plaintiff's cost bill, which included significant expert witness fees and costs pursuant to Code of Civil Procedure section 998. Allstate argued that it could not be forced by section 998 to pay costs because it was not a party to the action, and that in any event, Probate Code sections 550 through 555 limit the amount a plaintiff can recover to the coverage limits of the decedent's policy.

The appeals court disagreed. The court noted that Code of Civil Procedure section 998 expressly applies to "parties" and that Probate Code section 550 provides that "an action to establish the decedent's liability for which the decedent was protected by insurance may be commenced or continued against the decedent's estate without the need to join as a party the decedent's personal representative or successor in interest." Further, without joinder of a personal representative, a judgment does not adjudicate any rights against the estate and recovery in excess of the policy limits is waived. (Prob. Code, § 554.) Thus, Code of Civil Procedure section 998 only applies to parties and the insurer is not a party in the Probate Code section 550 action; nonetheless, the court held that Allstate was subject to section 998 penalties. Continued on page 5

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The appeals court resolved the apparent conflict stating that:

"We consider Allstate a party for purposes of section 998 because, '[a] person who is not a party to an action but who controls or substantially participates in the control of the presentation on behalf of a party is bound by the determination of issues decided as though he were a party.' (Rest.2d Judgments, § 39.) Not only did Allstate have complete control of the litigation of this matter, it also was the only entity opposing Meleski that risked losing money in the litigation. The named party, the estate, was not at risk for payment of damages, which were limited to the Allstate policy. . . . In actuality, Allstate is the party litigating the case, inasmuch as it alone is at risk of loss and it alone controls the litigation."

The court said that to hold otherwise would permit Allstate to force the matter to trial without penalty, and frustrate the purpose of Code of Civil Procedure section 998, which is to promote settlements and judicial economy. Plus, the court noted that Allstate's position could lead to absurd results, because Allstate had served its own section 998 offer, and could have enforced the code section's penalties without question, since the plaintiff was obviously a party to her own action.

In addition to finding that Allstate was a de facto party for purposes of section 998, the *Meleski* court also rejected an argument that Allstate's total liability was limited to its policy limit regardless. The court noted that Probate Code section 554 provides that: "[E]ither the damages sought in an action under this chapter shall be within the limits and coverage of the insurance, or recovery of damages outside the limits or coverage of the insurance shall be waived." However, the *Meleski* court pointed out that "costs are not damages." Consequently, Allstate was liable for the cost award in addition to damages up to the policy limits, which added another $66,000 on top of the $100,000 policy limit.

Inability to Confirm Coverage Supports Setting Aside Insured's Default Judgment on Grounds of Extrinsic Mistake
Credit to Haight, Brown & Bonesteel, Los Angeles, CA

In *Mechling v. Asbestos Defendants* (No. A150132, filed 12/11/18), a California appeals court affirmed the trial court's grant of an insurer's motion to set aside default judgments entered against its defunct insured pursuant to the trial court's inherent, equitable power to set aside defaults on the ground of extrinsic mistake, thereby allowing the insurer to intervene and defend its own interests in the case.

In *Mechling,* Fireman's Fund insured Associated Insulation of California, which was named as a defendant in asbestos litigation filed in 2009. Associated had ceased operating in 1974, but was somehow successfully served with the complaint and defaulted, leading to default judgments of several million dollars. Notice of the judgments was served on Associated but not Fireman's Fund.

After entry of the default judgments, Fireman's Fund located insurance policies it thought might cover Associated. Fireman's Fund moved to set aside the defaults and default judgments on equitable grounds, arguing that the litigation presented a classic case of "extrinsic mistake" because service of the complaint on Associated did not provide notice to Fireman's Fund, "resulting in a default judgment to a fault free party." According to Fireman's Fund, Associated was a suspended corporation and "could not and did not defend itself" and, as a result, Fireman's Fund "never had the opportunity to participate in [the] lawsuit."

Although the plaintiffs had given notice to Fireman's Fund for two of the four lawsuits, they ignored the fact that Fireman's Fund had responded by writing that it could not locate any policies covering Associated. Instead, the plaintiffs argued that Fireman's Fund could not claim ignorance and seek equitable relief without any showing of extrinsic mistake or diligence.

The trial court granted Fireman's Fund's motion to set aside, and the appeals court agreed. The court said that a trial court has inherent power to vacate a default judgment on equitable grounds, including extrinsic mistake—which is when circumstances extrinsic to the litigation have unfairly cost a party a hearing on the merits. The court stated that:

"To qualify for equitable relief based on extrinsic mistake, the defendant must demonstrate: (1) a meritorious case; (2) a satisfactory excuse for not presenting a defense to the original action; and (3) diligence in seeking to set aside the default once the fraud or mistake had been discovered." (Citing *In re Marriage of Stevenot* (1984) 154 Cal.App.3d 1051.)

The *Mechling* court said that a meritorious case does not require showing certainty of success, but only "facts indicating a sufficiently meritorious claim to entitle it to a fair adversary hearing." And the court found that it was a reasonable inference from the facts that the plaintiffs' damages award would have been impacted had Fireman's Fund presented a defense and challenged plaintiffs' proof of causation and damages.

The court rejected an argument that showing a meritorious case required attaching a proposed pleading in intervention or a declaration with "evidence" showing a meritorious defense. The court accepted Fireman's Fund's arguments as sufficient and stated that Fireman's Fund would obviously file a responsive pleading if granted a set aside.
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The *Mechling* court also found that Fireman's Fund had articulated a satisfactory excuse for not presenting a defense to the lawsuits. It was not a named party and was not served with the complaints or other relevant pleadings. Although it had received notice, it had notified the plaintiffs that it had "searched all available records" and had "not located any reference or policies of insurance issued to Associated." Fireman's Fund had invited the plaintiffs to provide information showing Fireman's Fund issued insurance policies to Associated, but they did not respond. The court found that Fireman's Fund's letter to the plaintiffs supported the conclusion that Fireman's Fund had a satisfactory excuse for not defending the lawsuits: "It did not believe Associated was its insured."

Thus, the court affirmed the order setting aside the default judgments, stating that: "In our view, this case presents exceptional circumstances warranting equitable relief. Fireman's Fund was denied an opportunity to present its case in court because it was not served with any of the relevant pleadings, did not have notice of two of the lawsuits, and did not believe it had a duty to defend Associated. We conclude the trial court did not abuse its discretion by granting Fireman's Fund's motion for equitable relief."

Going and Coming Ruling
Credit to: Tyson and Mendes, La Jolla, CA

In *Newland v. County of Los Angeles*, the Court of Appeal reversed the trial court's judgment imposing liability on an employer where an employee injured a third party while driving home from work on a day he did not have any job duties outside of the office. It held the evidence showed there was no liability on the employer for the tortious conduct since at the time of the accident, the employee's use of his personal vehicle was not required by the employer, and the employee's travel did not otherwise provide a benefit to the employer. The Court found, the "vehicle use" exception applied and the employer was entitled to judgment as a matter of law.

The origin of the "vehicle use" exception sprung from the concept that "an employment relationship is suspended from the time an employee leaves work until he or she returns, since the employee is not ordinarily rendering services to an employer while traveling." (*Jeewart v. Warner Brothers Entertainment, Inc.* (2009) 177 Cal. App. 4th 427, 435.) However, this concept of a suspended relationship is quickly becoming outdated. Today, many employers do not consider their working relationship with their employees as suspended from the time the employee leaves the often until they return. This legal decision initially viewed as a win for employers may actually turn out to be a double-edged sword. The ruling highlights the increased potential for liability exposure created by advancements in technology such as smart cars, smart phones, and recent developments in company culture in which employees are arguably rendering services to an employer 24/7 and are never really "off the clock."

Naturally, the *Newland v. County of Los Angeles* decision will also give rise to more questions as to what specific scenarios may qualify as "providing a benefit to an employer." Companies in California need to undergo a paradigm shift to keep up with modern technology and the ever-changing California legal landscape. Individuals making liability risk assessments for employers and their insurance carrier should give more serious consideration to these potential exposure issues. Employees have the opportunity to work remotely due to modern technologies and conversely, employers specifically require their employees to use mobile devices at all times in order to carry out their job duties even when (1) the employee is not physically at work, (2) outside of traditional business hours, (3) the employee is simultaneous engaging in another non-work related activity, and (4) the employer does not allow the employee the authority or discretion to be truly unavailable to perform work outside business hours. These four factors make it more likely to trigger employer liability, and decrease the applicability of "the going and coming rule" in cases where employees engage in tortious acts while commuting to and from work. The lines of "purely personal activity" are becoming increasingly blurred.

Many employers follow the *Labor Code* and provide reimbursement to employees for the cost of utilizing their cell phones. This essentially provides even more basis for a finding of a direct benefit to the employer and ammunition for a plaintiff looking to establish evidence an employee was within the course and scope of employment at the time of an accident, especially in instances where there is an allegation the driver was distracted.