CAIIA Status Report

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November 2018

Single Per Person Limit

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

In *Jones v. IDS Property Casualty Ins. Co.* (No. C084065, filed 9/25/18), a California appeals court found that while there is a split of authority in the case law, under the insurer's applicable policy wording a wife's claim for loss of consortium was subject to the same per person limit of the defendant's insurance policy as her husband's claim for bodily injury.

In *Jones*, the insured was sued for an auto accident, and stipulated to a judgment of $1.35 million for the other driver and $150,000 for loss of consortium for the other driver's wife. The insured's policy with IDS had limits of $250,000 per person and $500,000 per accident, and after IDS paid its $250,000 per person limit, the other driver and his wife sued for declaratory relief, arguing that IDS owed them the full $500,000 per accident limit.

The trial court denied a summary judgment motion by IDS, finding the case controlled by *Abellon v. Hartford Ins. Co.* (1985) 167 Cal.App.3d 21, which held that a spouse's claim for loss of consortium was not subject to the same per person policy limit as the injured spouse's damages. The *Jones* case was then expanded with bad faith claims by the insured and claims for fraud and negligent misrepresentation of policy benefits – the policy limits - against IDS by the victim and his wife.

However, prior to a jury trial, a different judge ruled on the declaratory relief cause of action, finding that a single $250,000 per person limit applied, relying on *United Services Automobile Assn. v. Warner* (1976) 64 Cal.App.3d 957, *Mercury Ins. Co. v. Ayala* (2004) 116 Cal.App.4th 1198 and the dissenting opinion in *Abellon*. A motion for nonsuit was then granted on all of the other claims.

The appeals court affirmed. Noting the split in authorities with some cases finding that a single limit applies and other cases reaching the opposite result, the *Jones* court said that "each case turns on the language of the policy at issue." The IDS policy stated that:

1. The bodily injury liability limits for each person is the maximum we will pay as damages for bodily injury, including damages for care and loss of services, to one person per occurrence.

Subject to the bodily injury liability for each person, the bodily injury liability limit for each occurrence is the maximum we will pay as damages for bodily injury, including damages for care and loss of services, to two or more persons in one occurrence. We will pay no more than these maximums regardless of the number of vehicles described in the declaration, Insured persons, claims, claimants, policies, or vehicles involved in the occurrence.

In *Warner*, the limitation of liability portion of the policy read: "The limit of bodily injury liability stated in the declarations as applicable to 'each person' is the limit of the company's liability for all damages, including damages for care and loss of services, arising out of bodily injury sustained by one person as the result of any one occurrence." The *Warner* court found that the term "loss of services" covered loss of consortium and held that under the policy's wording, a single per person limit "applies to *'all damages, including damages for care and loss of services, arising out of bodily injury sustained by one person....'"*

In *Abellon*, the majority reached the opposite result, holding that the wife's loss of consortium claim was a separate bodily injury and subject to the per occurrence limits of the policy, saying that "If [the insurer] wants to limit liability in accidents where loss of consortium damages are sought, it should expressly provide that such damages are subject to the 'per person' limitation."

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President's Message

It's a bit strange wishing all of you a Happy Thanksgiving while preparing this presidents message in late October. That being said, I've always enjoyed Thanksgiving, not because it is an American holiday, but because it has become (in my opinion) a nonsectarian holiday celebrated by almost all. Regardless of what political or religious affiliation we may have, we all give thanks for what we have.

John Ratto
CAIIA President

Which I think segues nicely into how we handle claims.

Too often (and as we age… all of you not me!) we sometimes jump to conclusions when it comes to a person's age, culture, ethnicity, or background. Similar to the beat cop (maybe not the best example), we utilize these instincts in order to better prepare ourselves to handle/manage a claim. While I would expect all of us to be culturally sensitive to others, it is sometimes difficult to prevent that "little voice" from defining a particular individual or group. How many times have we handled the claim for the "forgetful little old lady" claiming that the jewelry was stolen when in fact it was simply misplaced? Perhaps this one time it really was stolen. When we were younger we learned to generalize people and things, which helped us better to learn and navigate the world around us. However, (and we are all guilty of it) we tend to formulate ideas sometimes in an over-simplistic manner. Even at 53 years of age I'm still surprised by the world around me. By no means am I a saint, but have tried to be aware of this unconscious bias in my day-to-day life and work (certainly, not to make light of it, but living a mile from the Berkeley border doesn't hurt!). By being aware of this unconscious bias we can immediately start to reduce our reliance on generalizations or stereotypes. I would ask that all of us take the time to step back for a moment, reevaluate, and remember the mantra "people are people." It makes us better people and better adjusters.

Now on a lighter note…. I have been doing my best to clear my desk so that I can be prepared for the winter season (expected to be warm according to NOAA). As many of you know, when it comes to mid-January, there just isn't time to do anything but put your nose to the grind stone and be prepared to work harder than ever.

That brings me full circle to being grateful for having enough work while having our doors open for the last 16 years. There were slim times, but in general it has been bountiful and for that I am grateful.
Happy Thanksgiving to all of you.

John Ratto,

CAIIA President

NEWS FROM AND FOR OUR MEMBERS

SAVE THE DATE

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

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

Editors note: This note was sent to us along with a copy of the Assembly bill. See bill on page 4.

A bill recently signed into law would require insurers handling claims in California to cooperate with the Department of Child Services to identify claimants who are delinquent on child support payments and "would require an insurer to identify and report a claimant if his or her claim seeks an economic benefit" The Department of Child Services will then provide notice to the insurer of a child support lien or income withholding order. This law is expected to go into effect on January 1, 2020

Sheri Csom
NAIIA Executive Director

DOI Curriculum Board Update from Richard Kern

I attended the California Department of Insurance Curriculum Board Meeting on October 18, 2018.

This was my first meeting having taken over from Peter Schifrin who apparently left with his reputation intact.

During Peter's last meeting a number of insurance bills relating to homeowner's insurance were moving through the system. As of this meeting, all were passed and signed in to law by Gov. Brown. These include AB 1772, eff immediately, extends the amount of time to rebuild after declared emergency from two to three years; AB 1797, eff 7/1/19, requires an insurer to provide an estimate, on an every other year basis, of the cost necessary to rebuild or replace the insured structure; AB 1799, eff 1/1/19, requires insurers to provide a free complete copy of a residential insurance policy to an insured after a loss; AB 1800, eff immediately, clarifies the current laws that an insurer must pay out the full extended replacement cost benefit regardless if rebuild at same location, new location, or purchase an already built home; AB 2594, eff immediately, extends an insured's right to sue their insurer following a declared disaster from 12 to 24 months; SB 894, eff 1/1/19, allows an insured to combine portions of their policy to rebuild their home and extend the time to collect ALE from 24 to 36 months; SB 917, eff 1/1/19, requires that if a loss results from a combination of perils, one of which is a landslide, mudslide, mudflow, debris flow, or other similar earth movement, coverage be provided if an insured peril is the efficient proximate cause of the loss.

This is a brief overview but there was much legistative activity in light of the recent fires and mudflows in the State.
So far in 2018, 1,267 course applications have been approved, 2,278 course renewals were approved and 250 new providers and renewals were processed. Second half testing statistics will be available at the next meeting in February 2019.

Richard Kern CAIIA – Secretary/Treasurer and Education Provider/Director

Assembly Bill No. 2802:

CHAPTER 439

An act to add Article 8 (commencing with Section 13550) to Chapter 2 of Division 3 of the Insurance Code, relating to insurance.

[Approved by Governor September 17, 2018. Filed with Secretary of State September 17, 2018.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2802, Friedman. Insurance payments: interception.

Existing law creates the Department of Child Support Services and provides for the interception of funds from state tax refunds, lottery winnings, unemployment compensation benefits, and benefits under the Public Employees' Retirement System that otherwise would be paid to a person owing past due child support. Existing law creates the Department of Insurance, headed by the Insurance Commissioner, and prescribes the department's powers and duties.

This bill would, beginning January 1, 2020, require an insurer to cooperate with the Department of Child Support Services to identify claimants who are also obligors who owe past-due child support, and to report those claimants to the department. The bill would require an insurer to identify and report a claimant if his or her claim seeks an economic benefit, as defined, but would exempt specified economic benefits, including a payment to the mortgagee or lienholder of the property or a payment from an accelerated death benefit, and would limit withholding from a qualifying disability insurance payment to 50% of the claim for the benefits. The bill would require an insurer to comply with the requirements of a notice from the Department of Child Support Services that a reported insurance claim is payable to an obligor who owes past-due child support, unless the notice is received after the insurer has paid the claim. The bill would provide that an insurer, specified agent, specified insured, and a central reporting organization, as defined, that releases information in accordance with this bill, withholds payments, as specified, and makes disbursements, as specified, is immune from liability under certain circumstances. The bill would also require that the data obtained by the department, or by an insurer or its designated agent, only be used for the purpose of identifying claimants who are also obligors who owe past-due child support, and would specify that various laws protecting the privacy and security of data apply. The bill would authorize an insurer to use a central reporting organization to automate its claims identifying process, and would require an insurer that does not use a central reporting organization to determine if a claimant owes past-due child support before paying a claim, as specified.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

HAPPY THANKSGIVING TO YOU AND YOURS!

Regulation defining unfair claims settlement practice as including a single violation is valid. Credit to McCormick Barstow Fresno, CA

Pacificare Life and Health Ins. Co. v. Dave Jones, as Insurance Commissioner **(4th Dist. Ct. App. 2018) ___ Cal. App. 5th ___, 2018 DJDAR 9621, Case No. G053914**

BACKGROUND FACTS

The California Department of Insurance filed an administrative enforcement action against Pacificare alleging it had engaged in numerous unfair settlement practices. The Insurance Commissioner found Pacificare had engaged in over 900,000 acts and practices in violation of the Insurance Code. Penalties were imposed exceeding $173 million. Pacificare filed a petition for writ of mandate and complaint for declaratory and injunctive relief in state court. It challenged the Commissioner's application of several regulations found in Title 10 of the California Administrative Code which, according to Pacificare, were at odds with the Insurance Code, including regulation 2695.1 (a) ("'enumerat[ing] sixteen claims settlement practices that, when either knowingly committed on a single occasion, or performed with such frequency as to indicate a general business practice, are considered to be unfair claims settlement practices...'"), regulation 2695.2(1) (defining "knowingly committed" as "'performed with actual, implied or constructive knowledge, including but not limited to, that which is implied by operation of law'"), and regulation 2695.2(y) (defining "willful" or "willfully" as "'simply a purpose or willingness to commit the act or make the omission....It does not require any intent to violate law, or to injure another, or to acquire any advantage'").

The trial court agreed with Pacificare and granted its motion for judgment on the pleadings on the claim for declaratory relief, declaring all three regulations in conflict and inconsistent with Insurance Code sections 790.03(h) and 790.035. Pacificare moved for a preliminary injunction preventing the Commissioner from continuing to enforce the regulations and the court issued the requested injunction. The Commissioner petitioned for a writ of supersedeas and the appellate court issued an order suspending the injunction pending resolution of the present appeal.

THE APPELLATE COURT'S RULING

The appellate court first noted that the Commissioner is expressly authorized under Insurance Code section 790.10 to adopt regulations related to implementation of the Unfair Insurance Practices Act (UIPA). The appellate court next addressed Pacificare's contention that regulation 2695.1(a) conflicts with Insurance Code section 790.03 by including single violations knowingly committed. The court noted that the California Supreme Court clearly held in *Royal Globe Ins. Co. v. Superior Court* (1979) 23 Cal. 3d 880 that section 790.03(h) applies to such violations. Although *Royal Globe* was overturned in *Moradi-Shalal v. Fireman's Fund Ins. Companies* (1988) 46 Cal. 3d 287,it was overturned on another ground and thus the appellate court determined that it was still binding precedent on the issue of whether 790.03(h) applies to a single violation knowingly committed. The appellate court also found that the interpretation of the statutory language in *Royal Globe* was correct.

With respect to regulation 2695.2(y), Pacificare argued that "knowingly committed" as defined by the regulation is inconsistent with section 790.03(h) because implied or constructive knowledge is inconsistent with deliberate conduct as anticipated by the Insurance Code. Although the appellate court agreed with Pacificare that knowingly committing an act implies the act was deliberate, it disagreed that the regulation's inclusion of implied or constructive knowledge was inconsistent with the need to establish deliberate conduct. This is due to the fact that insurance companies act knowingly or deliberately based on the knowledge or acts of those authorized to act on their behalf.

Finally, with respect to regulation 2695.2(y), Pacificare contended that this regulation is inconsistent with Insurance Code section 790.035 which sets forth the penalties applicable to section 790.03 violations, including enhanced penalties for willful violations. Pacificare argued that the regulation blurred the distinction between willful and non-willful violations under the Insurance Code. The appellate court found that the regulation did not render meaningless or inoperative the statute's distinction between willful and non-willful violations. The court found that the distinction between willful and non-willful violations of all of the acts and omissions prohibited by section 790.03(h) are readily apparent. Therefore, the appellate court concluded, as applied to section 790.03(h), the definition of willful or willfully set forth in the regulation did not blur the distinction between willful and non-willful violations.

Based on the foregoing, the appellate court reversed the trial court order imposing a preliminary injunction prohibiting enforcement of the regulations. The case was also remanded to the trial court with directions to reverse its order granting the motion for judgment on the pleadings.

EFFECT OF THE COURT'S RULING

This case is significant in that it upholds regulation 2695.1(a) as applying to single violations knowingly committed. The appellate court here recognized that the California Supreme Court had "struggled" with the question of whether its ruling in *Royal Globe* on this point was correct. (See *Moradi-Shalal, supra.*) However, it determined that, to the extent *Royal Globe* held that a single violation knowingly committed is sufficient, that holding has never been overturned and is controlling. Although it is not anticipated that the Insurance Commissioner would expend time and resources pursuing an insurer who has engaged in a single violation as opposed to insurers who do so on a regular and consistent basis, it does sanction the Commissioner's authority to do so.

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The *Jones* court went on to consider *State Farm Mutual Auto. Ins. v. Ball* (1981) 127 Cal.App.3d 568; *Hauser v. State Farm Mut. Auto. Ins. Co.* (1988) 205 Cal.App.3d 843; *Mid-Century Ins. Co. v. Bash* (1989) 211 Cal.App.3d 431; *Ayala, supra*; and *Allstate Ins. Co. v. Fibus* (9th Cir. 1988) 855 F.2d 660, saying that "[t]he core of this dispute is whether the policy language here is sufficient to aggregate one spouse's damages for loss of consortium with the damages for bodily injury to the injured spouse."

Turning to the IDS policy, the *Jones* court concluded that "the IDS policy does provide the per person limit applies where there is bodily injury to only one person." The court pointed out that the IDS policy stated that "The bodily injury liability limits for each person is the maximum we will pay as damages for bodily injury, including damages for care and loss of services, to one person per occurrence" and, further, that "the per person limit applies to damages for bodily injury to one person, 'regardless of the number of . . . claims, claimants ....'" Therefore, "[t]The reasonable interpretation is that 'to one person' modifies 'bodily injury.' Thus, the per person limit applies to all damages, including loss of consortium, arising from 'bodily injury' 'to one person.' This language has the same effect and meaning as the phrase "arising out of bodily injury sustained by one person" in the policies at issue in *Warner*… *Ball*… *Bash*… and *Ayala*."

The *Jones* court stated that: "Our interpretation is also supported by the last antecedent rule [which] provides that 'qualifying words, phrases and clauses are to be applied to the words or phrases immediately preceding and are not to be construed as extending to or including others more remote.'"

The *Jones* court then rejected the plaintiffs' argument that a separate limit was mandated by the financial responsibility law's requirement of a second minimum limit per person for bodily injury on a theory that "loss of consortium qualifies as bodily injury." The *Jones* court stated that "[t]he assertion that loss of consortium qualifies as bodily injury under the financial responsibility law has been repeatedly rejected." (Citing *Vanguard Ins. Co. v. Schabatka* (1975) 46 Cal.App.3d 887, 894; *Warner, supra*.)

Having concluded that there was no second limit applicable, the *Jones* court also found that there was no problem with two different judges reaching opposite results in the same case, saying that one had ruled on a summary judgment motion while the other had rendered a declaratory ruling at trial, which did not constitute an improper "overruling" of the summary judgment denial. Plus, the *Jones* court pointed out that the plaintiffs had stipulated to the trial judge issuing a declaratory ruling prior to commencement of a jury trial, which forfeited the right to attack any error on appeal.

Yoga Instructor's Professional Standard of Care
Credit to: Tyson & Mendes, La Jolla, CA

In the recent case entitled *Webster v. Claremont Yoga* (2018 WL 3913660), a yoga participant alleged she was injured when an instructor adjusted her posture and brought a resulting negligence suit. The Second District Court of Appeal affirmed expert opinion was required to rebut defendant yoga instructor's expert's declaration that the instructor's conduct in adjusting a yoga participant's posture during class was consistent with standard of care in the yoga industry, because a lay person's common knowledge did not include the conduct required of a yoga instructor in a particular situation.

Background

Plaintiff, Amalia Webster ("Webster") attended a yoga class at Claremont Yoga taught by Kurt Bumiller ("Bumiller"). According to plaintiff, Bumiller injured her several times during the class by placing a belt around her waist and right leg to help her position her right leg over her left, which plaintiff claimed was painful. Bumiller pushed down on her lower back while she was in a "cow position," which plaintiff claimed hurt her knee. Plaintiff further contended while she was laying on her back, Bumiller twisted her neck to both sides three times, which she asserted caused her pain. At no point did plaintiff inform Bumiller that she was in pain or ask him to stop what he was doing.

Plaintiff filed a complaint against defendants alleging a single cause of action for negligence. Defendants moved for summary judgment, arguing defendants complied with the relevant standard of care for yoga facilities and instructors and Bumiller's actions did not cause or contribute to plaintiff's alleged injuries. In support of their motion, defendants filed declarations from Jeffrey Deckey, M.D. ("Deckey"), and Jonathan Simons, Psy.D ("Simons").

Deckey, an orthopedic surgeon, declared plaintiff 's injuries were due to "chronic degenerative disc disease and arthritic changes," not "a traumatic injury or acute injury" occurring during the yoga class. Deckey opined plaintiff 's medical records and level of activity following the yoga class were "not consistent with a traumatic or forceful injury at the hands of her yoga instructor."

Simons, a psychotherapist and yoga instructor, opined Bumiller's actions as alleged by plaintiff "were within the standard of care for a yoga instructor teaching a Restorative yoga class." He declared it was "quite common for yoga teachers to touch students during class and assist them when they are improperly doing yoga positions. Further, yoga instructors often adjust students and help them stretch during certain poses." Simons stated "[t]he majority of yoga students desire the touching and assistance with poses described … by [plaintiff]. This is a regular part of the yoga practice and an instructor would not know the student was unhappy or felt any pain unless the student so advised the instructor."

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Plaintiff opposed the motion but did not file any witness declarations. She objected to Simons's declaration as lacking foundation and the Deckey declaration as "inherently unbelievable." Plaintiff disputed the conclusions in those declarations, citing her own deposition testimony and medical records as well as the deposition of one of Claremont Yoga's owners.
The trial court overruled plaintiff 's objections to the Simons and Deckey declarations and granted the motion for summary judgment, finding plaintiff failed to produce evidence disputing Simons's conclusion that Bumiller's conduct met the applicable standard of care. The trial court further found defendants established they had not caused plaintiff's injuries, and plaintiff failed to provide any competing expert testimony. Plaintiff appealed from the judgment.

Legal Standard for Standard of Care
Generally, in negligence cases arising from the rendering of professional services, the standard of care against which the professional's acts are measured remains a matter peculiarly within the knowledge of experts. Only their testimony can prove it, unless the layperson's common knowledge includes the conduct required by the particular circumstances." (*Unigard Ins. Group v. O'Flaherty & Belgum* (1995) 38 Cal.App.4th 1229, 1239; see *Sanchez v. Brooke* (2012) 204 Cal.App.4th 126, 127, ["Generally, expert testimony is required to establish the standard of care that applies to a professional."].) ' "When a defendant moves for summary judgment and supports his motion with expert declarations that his conduct fell within the community standard of care, he is entitled to summary judgment unless the plaintiff comes forward with conflicting expert evidence.' " (*Hanson v. Grode* (1999) 76 Cal.App.4th 601, 607.)

California Court of Appeal Unpersuaded by Plaintiff Arguing No Applicable Standard of Care
Defendant's expert Simons explained in his declaration the normal practices of yoga instructors is touching students to adjust their position and help them stretch, and opined Bumiller's conduct was consistent with those practices and met the standard of care in the industry. The trial court overruled plaintiff's objection to Simons's declaration and plaintiff does not challenge that ruling on appeal. Therefore, Simons's opinion, "if uncontradicted, would constitute a preponderance of evidence that an essential element of the plaintiff 's case," namely breach of the standard of care, "cannot be established." (*Kids' Universe v. In2Labs (2002)* 95 Cal.App.4th 870, at p. 879.)
It was incumbent on plaintiff to contradict this evidence with competing expert testimony but plaintiff did not do so. The Court of Appeal noted there was no suggestion in the record, nor did plaintiff argue on appeal, that she herself is an expert on the standard of care in the yoga instruction industry. And the owner, even if she could be considered an expert, did not opine on the standard of care or whether Bumiller met it. The portion of the owner's testimony cited by plaintiff simply stated that Bumiller "has a very gentle touch. I have never seen him touch in a way that would suggest otherwise." The Court of Appeal rejected plaintiff's suggestion that her testimony that Bumiller was aggressive, contrasted with Riel's testimony that Bumiller normally was gentle, was sufficient to show a deviation from the standard of care absent expert testimony as to what the appropriate standard of care was.
Plaintiff further argued that yoga teachers are not subject to the rules for professional negligence, and there is no standard of care for all practitioners of yoga, just "many methods and … means by which one may be a practitioner of yoga." However, "the layperson's common knowledge" would not include "the conduct required by the particular circumstances" of a yoga instructor in Bumiller's position, and an expert's opinion on the question would be of benefit. (*Unigard, supra*, 38 Cal.App.4th at p. 1239.)
Although many cases discussing standard of care involve medical malpractice, the rule requiring expert testimony to establish the standard of care has been applied in other industries as well. (See, e.g., ibid. [legal malpractice]; *Stonegate Homeowners Assn. v. Staben* (2006) 144 Cal.App.4th 740, 749 [construction defects].) As for plaintiff's contention that the yoga instruction industry has no uniform standard of care, she cited no evidence to support her contention. An expert would be needed on this point as well.
The Court of Appeal noted the causation issue was complex. In moving for summary judgment, defendants contended, per the Deckey declaration, plaintiff's injuries "were due to chronic degenerative disc disease and arthritic changes" as opposed to "an acute or traumatic injury." It would be beyond the ability of a lay juror to determine, in the absence of expert testimony, whether plaintiff's injuries were caused by Bumiller's actions, a chronic condition, or some other mechanism. Plaintiff cited no authority to the contrary. The Court of Appeal noted the trial court did not err in concluding that proof of causation in this case required expert testimony.
Plaintiff's medical records did not satisfy this requirement. Setting aside the question whether medical records alone can substitute for expert testimony, the records here did not indicate any medical professional had concluded plaintiff's injuries were caused by Bumiller. Plaintiff identified several records she claimed establish causation, but at most they reflected plaintiff had neck pain she herself believed was caused by Bumiller.
Absent additional explanatory testimony from plaintiff 's treating physicians or a medical expert, the medical records identified by plaintiff establish nothing more than that she had neck pain and believed her yoga instructor had caused it. The records do not contain any sort of competent expert opinion regarding causation; they only document plaintiff 's non-expert opinion, with no indication whether the treating professionals agreed with that opinion. The records therefore were insufficient to show a triable issue of material fact as to causation. The trial court properly granted summary judgment on that basis as well.

Takeaway
Make sure your Motion or Opposition has the necessary supporting expert declaration especially if the standard of care is it is at issue. The failure of plaintiff to substantiate the standard of care of defendants by use of expert consultants in this matter was fatal to her action.

DOI Press Release

Insurance commissioner calls on industry to ease inventory requirement for 2018 wildfire survivors

SACRAMENTO, Calif. - Due to the staggering losses suffered by thousands of residents from the 2018 wildfires, Insurance Commissioner Dave Jones is asking insurers to assist overwhelmed wildfire survivors by voluntarily easing detailed personal property home inventory requirements and following the lead of other insurers providing at least 75 percent and up to 100 percent of contents (personal property) coverage limits without the submission of a detailed inventory.

The notice issued today, acknowledges that the department is aware of and applauds the efforts of certain insurers that have already gone above and beyond the Voluntary Expedited Claims Handling Procedures and have made significant efforts to assist and accommodate survivors by offering, in some cases, up to 100 percent contents limits payment without a personal property inventory.

However, due to the massive scale of these wildfires Jones is requesting all other property insurers follow suit by providing similar accommodations and is asking insurers to notify the department by October 31, 2018 whether they will comply and what percentage they will provide. 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 Carr and Mendocino Complex fires rank among the most destructive wildfires in California's history," said Insurance Commissioner Dave Jones. "Entire communities were decimated with residents suffering staggering losses of not only property, but tragically loss of life and injuries. I'm asking property insurers to ease the burden on traumatized survivors by voluntarily providing at least 75 percent of contents coverage without the onerous requirement of a detailed home inventory, so survivors may get on with patching their lives back together."

The commissioner's request applies to all insured homes that suffered a total loss, unless the insurer has reason to believe the home was not furnished. 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 personal property home inventory.

Strict Liability– Custom and Practice

Credit to Low, Ball & Lynch , San Francisco, CA

In Jae Kim v. Toyota Motor Corporation, 6 Cal. 5th 21 (2018), the California Supreme Court broke with 40+ years of court of appeal precedent barring manufacturers from using evidence of their compliance with industry custom and practice to prove their designs were not defective. The Court held that such evidence is not inadmissible, but neither is it categorically admissible.

In design defect cases, evidence of industry custom and practice compliance has historically been barred as irrelevant and prejudicial. However, in the Kim case, such evidence was deemed relevant to prove that the failure to include Vehicle Stability Control (VSC) as standard equipment in a 2005 Toyota Tundra light truck was not a design defect under the risk-benefit test.

Plaintiff William Jae Kim was severely injured after he lost control of his Toyota Tundra pickup truck and drove off an embankment. He brought a strict products liability suit against defendant Toyota Motor Corporation. At trial, he sought to exclude evidence of custom and practice, but his motion in limine was denied by the court. Toyota prevailed at trial, and the Court of Appeal affirmed the decision denying his motion.

The Supreme Court accepted discretionary review solely to determine whether admission of the custom evidence was reversible error, and affirmed, holding that the custom evidence was properly admitted. The Court declined to categorically opine that custom and practical evidence is always admissible. The Court instead required sound justification that depends on the evidence offered and the purpose for which it is offered, meaning that the admissibility of such evidence will need to be determined on a case by case basis.

Specifically, the Supreme Court held that evidence that a manufacturer's design conforms with industry custom and practice is not relevant, and therefore not admissible, to show that the manufacturer acted reasonably in adopting a challenged design and therefore cannot be held liable. Under strict products liability law, a product may contain precisely the same safety features as other products on the market and still be defective. However, even though evidence of industry custom and practice cannot be dispositive of the issue, it may nevertheless be relevant to the strict products liability inquiry, including the jury's evaluation of whether the product is as safely designed as it should be, considering the feasibility and cost of alternative designs. The Supreme Court agreed with the Court of Appeal that the evidence in this case was properly admitted for that limited purpose.

Attorneys practicing in the area of torts who regularly deal with design defect claims against private entities, may be able to overcome such claims where they can show that their clients' were complying with an established custom and practice in the field. This is a stark contrast from past cases, and will impact lower courts' future ruling on admissible evidence for trial and attorneys' analysis of exposure for these kinds of claims. There will also undoubtedly be future cases flushing out the extent to which this kind of evidence is relevant.

CONCLUSION

The California Supreme has ruled that evidence of industry custom and practice compliance in design defect claims may be admissible. Attorneys who deal with design defect claims regularly will need to be abreast of the changing law in order to properly advise their clients about potential exposure based on this case and its progeny.

On the lighter side...

Now that I'm older, here's what I've discovered:
1. I started out with nothing, and I still have most of it.
2. My wild oats are mostly enjoyed with prunes and all-bran.
3 Funny, I don't remember being absent-minded.
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5. If all is not lost, then where the heck is it?
6. It was a whole lot easier to get older, than it was to get wiser.
7. I wish the buck really did stop here; I sure could use a few of them.
8. It is hard to make a comeback when you haven't been anywhere.
9. If God wanted me to touch my toes, he'd have put them on my knees.
10. When I'm finally holding all the right cards, everyone wants to play chess.
11. It is not hard to meet expenses . . . They're everywhere.
12. The only difference between a rut and a grave is the depth.
13. These days, I spend a lot of time thinking about the hereafter . . . I go somewhere to get something, and then wonder what I'm "here after".
14. Funny, I don't remember being absent-minded.
15. Have I posted this before...or did I get it from you?