Insurance Law Update

By James M. Roth, Esq.
THE ROTH LAW FIRM

Three recent appellate decisions — two from the Fourth District and one from the Ninth Circuit — highlight the continued efforts to judicially refine the law relative to the insurance arena. The Fourth District recently found that (1) an insured's purported assignment of liability insurance policies written on an "occurrence" basis to the insured's spinoff company required the insurers' consent, notwithstanding Insurance Code § 520, which provides that an "agreement not to transfer the claim of the insured against the insurer after a loss has happened, is void if made before the loss," and *even if the events giving rise to liability occurred before the assignment, where the policies prohibited assignment without the insurers' consent*; and (2) an insurer waived the right to seek arbitration under an agent's contract when the *insurer actively litigated the agent's statutory claims for more than a year before seeking arbitration*. The Ninth Circuit recently interpreted California law to impose a duty on insurers to effectuate settlement where liability is reasonably clear *even in the absence of a settlement demand*.

Anti-Assignment Provisions in Liability Policies Remain Enforceable in California

In the case styled *Fluor Corporation v. Superior Court* (2012) 2012 WL 3741979, the Fourth District Court of Appeal (Division 3) held that an insured's purported assignment of liability insurance policies written on an "occurrence" basis to the insured's spinoff company required the insurers' consent, notwithstanding Insurance Code § 520, which provides that an "agreement not to transfer the claim of the insured against the insurer after a loss has happened, is void if made before the loss," and even if the events giving rise to liability occurred before the assignment, where the policies prohibited assignment without the insurers' consent.

Plaintiff, Fluor Corporation, is the second of two corporations named Fluor Corporation. Plaintiff, described here as Fluor-2, was created in 2000 as the result of a corporate restructuring transaction called a "reverse spinoff" in which Fluor-1 transferred various assets to Fluor-2. Following the transaction, both Fluor-1 and Fluor-2 continued to operate as independent companies with neither having ownership interest in the other.

Between 1971 and 1986, Hartford Accident & Indemnity Company (Hartford) issued 11 comprehensive general liability policies to the original Fluor Corporation. The policies all were "occurrence" policies that obligated the insurer to defend and indemnify against liability for bodily injury or property damage, provided the injury or damage occurs during the policy's coverage period. Between 2001 and 2008, Hartford had paid defense and indemnity costs on behalf of both Fluor-2 and Fluor-1 in lawsuits alleging injuries suffered as a result of exposure to asbestos at the original Fluor Corporation's work sites before Fluor's corporate restructuring in 2000. However, in 2009, Hartford questioned whether Fluor-2 was covered under the policies issued to Fluor-2's predecessor. Fluor-2 argued that the Hartford policies were assigned to it as part of the restructuring transaction, while Hartford maintained that any such assignments were invalid because the policies all contain consent-to-assignment provisions prohibiting any assignment of any interest in the policies without Hartford's consent.

Hartford sought a declaratory judgment that it was neither obliged to defend nor indemnify Fluor- 2 for the subject asbestos claims, and it asked to be reimbursed for defense costs and indemnity payments already made on Fluor-2's behalf. Fluor-2 filed a motion for summary adjudication based on the purported invalidity of the consent-to-assignment provisions. As the court of appeal later observed, Hartford's case for the enforceability of the consent-to-assignment provisions should have been "open-and-shut," given the California Supreme Court's decision in *Henkel Corp. v. Hartford Accident & Indemnity Co.* (2003) 29 Cal.4th 934, 129 Cal.Rptr.2d 828, upholding such provisions under similar factual circumstances. Fluor-2, however, challenged the validity of *Henkel* based on the supreme court's failure to consider a "statutory directive" that none of the scores of briefs filed with the Supreme Court had cited and that only one court has cited in the 130 years since its enactment. Originally enacted in 1872 as part of the original codification of California law and later moved to the Insurance Code in 1935, the provision on which Fluor-2 relied, Insurance Code § 520, provides: "An agreement not to transfer the claim of the insured against the insurer after a loss has happened, is void if made before the loss..."

The trial court passed on the opportunity to disregard *Henkel,* and denied Fluor-2's motion, "[The Supreme Court] can be dead wrong," observed the trial judge, "but they are still the

Supreme Court." After the Fourth Appellate District denied Fluor-2's motion for a writ of mandate, Fluor-2 petitioned the California Supreme Court for review. The supreme court granted the petition for review and directed the appellate court to vacate its order denying mandate and to issue an order to show cause why summary adjudication should not be granted Fluor-2.

The Fourth Appellate District has now explained that Insurance Code § 520 has no bearing on the validity of *Henkel* "for the simple reason that liability insurance did not exist in 1872." When the language of § 520 was adopted by the California Legislature, insurance covered only first party property damage losses, which are easily identifiable. The court determined that the legislature "cared not a wit" about the more difficult question of when a loss occurs under an occurrence-based liability policy: when a judgment is entered against the insured giving rise to the insurer's contractual duty to indemnify, or injury or damage occurs triggering coverage under the policy. Accordingly, the court concluded that it was bound by the supreme court's ruling in Henkel that the date of the loss for purposes of determining the enforceability of a consent-to-assignment clause in a liability policy is the date on which the insured sustains a loss for purposes of bringing an action for breach of contract: The date on which a judgment is entered against the insured. "If the rule of law in *Henkel* is to be vitiated," the court observed, "the Legislature in the 21st century, not the Legislature in the 19th century, must do it."

Insurer Waived Right to Arbitrate Agent's Statutory Claims by Participating in Litigation

In the case styled *Hoover v. American Income Life Insurance Co.* (2012) 206 Cal.App.4th 1193, 142 Cal.Rptr.3d 312, the Fourth District Court of Appeal (Division 2) held that an insurer waived the right to seek arbitration under an agent's contract when the insurer actively litigated the agent's statutory claims for more than a year before seeking arbitration.

Plaintiff worked as a sales agent for four months for defendant American Income Life Insurance Co. (AIL). Plaintiff's relationship with AIL was partly governed by a collective bargaining agreement between AIL and an employees union. The agreement provided that agent compensation would be in conformity with an agent contract that was incorporated into the agreement. The agent contract that plaintiff signed contained an arbitration clause requiring the parties to arbitrate unresolved disputes relating to the contract.

After plaintiff left AIL she claimed that she had been hired as an employee and was entitled to minimum wage, reimbursement of work-related expenses, and prompt payment of earned wages upon termination, as provided by California Labor Code §§ 203, 1194, and 2802. AIL contended that plaintiff was an independent contractor who was not entitled to minimum wage, reimbursement, or earned wages. Plaintiff brought a class-action complaint against AIL alleging that AIL had hired her and similarly situated persons to sell insurance as employees, then failed to pay and reimburse them, in violation of statutory rights under the Labor Code. Plaintiff also alleged unfair business practices. AIL litigated the claims, participated in discovery, and twice attempted to remove the matter to federal court. More than a year into the litigation, AIL made a demand for arbitration that plaintiff rejected. AIL then moved to compel arbitration and to stay litigation of plaintiff's individual claims, based on the arbitration provision in the agent contract.

The trial court denied the motion to compel arbitration, ruling that plaintiff's statutory wage claims were not subject to arbitration because neither the arbitration agreement nor the collective bargaining agreement in which it was incorporated referred to the arbitration of statutory rights. The court also ruled that AIL waived its rights to arbitrate by participating in the litigation process.

The court of appeal affirmed, concluding that AIL waived the right to seek arbitration by actively litigating the action for more than a year and causing prejudice to plaintiff. AIL did not introduce the question of arbitration for almost a full year and conducted its litigation in a style inconsistent with the right to arbitrate, the court observed, noting that AIL twice attempted to remove the case to federal court and gave recalcitrant responses to plaintiff's discovery requests. This suggested that AIL's policy was one of delay rather than one of seeking a prompt and expeditious resolution as might occur through arbitration. At the same time, AIL availed itself of discovery mechanisms like depositions not available in arbitration and solicited class members in an effort to reduce the size of the class. This combination of ongoing litigation and discovery with delay in seeking arbitration could result in prejudice. The record accordingly supported the trial court's determination that the right to arbitrate was waived by prejudicial delay.

Even if AIL had not waived its right to assert arbitration, the court of appeal stated that it would decide AIL could not compel arbitration of plaintiff's claimed Labor Code violations. Labor Code §§ 2802 and 2804 provided that an employee could not waive the right to reimbursement from an employer for employment-related expenses, while §§ 203, 219, and 229 provided that the right to timely payment of earned wages upon

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termination could not be contravened by private agreement. The court rejected AIL's argument that federal law, the Federal Arbitration Act, and the strong national policy favoring arbitration preempted the California statutes. AIL failed to demonstrated that the agent contract involved interstate commerce, thus triggering preemption. Even though AIL was based in Texas, there was no evidence in the record that the relationship between plaintiff and AIL had a specific effect on interstate commerce. Plaintiff did not work in other states or engage in loan negotiations with banks headquartered in another state. Further, the agent contract did not waive a judicial forum for statutory claims. The contract did not mention the arbitration of statutory claims or identify any statutes, but applied only to "disputes." Plaintiff's lawsuit represented an effort to enforce non-waivable rights, not an attempt to enforce compliance with the agent contract or the collective bargaining agreement, the court concluded. Neither the contract nor the agreement required plaintiff to arbitrate her statutory claims.

Insurers Have a Duty to Effectuate Settlement Where Liability Is Reasonably Clear Even in the Absence of a Settlement Demand

In the case styled *Yan Fang Du v. Allstate Ins. Co.* (9th Cir. 2012) 681 F.3d 1118, the U.S. Ninth Circuit Court of Appeals interpreted California law to impose a duty on insurers to effectuate settlement where liability is reasonably clear even in the absence of a settlement demand.

The subject motor vehicle accident occurred on June 17, 2005. The insured negligently collided with another vehicle injuring four occupants of that vehicle. The Allstate insurance policy had policy limits of $100,000 per person with a maximum accident aggregate of $300,000. Following the motor vehicle accident, Deerbrook Insurance Company (an Allstate Company) attempted to obtain medical documentation for one of the injured victims and a statement from its own insured but was unsuccessful. Notwithstanding the absence of cooperation by the victim and the insured in providing the documentation requested, Deerbrook eventually evaluated the claim file on February 15, 2006 concluding that its insured was liable for the accident. Deerbrook was aware that one of the victims was seriously injured. Nevertheless, no settlement demands or offers were made by any of the claimants until June 9, 2006 when the claimants' attorney (representing all four plaintiffs) made a global demand of settlement for $300,000. For the first time, the attorney documented the seriously injured victim's medical expenses in excess of $100,000. The medical specials for the remaining three victims were not significant in comparison.

When the demand was made, the adjuster told the attorney that Deerbrook had insufficient information about the three lesser injured victims and suggested that the seriously injured victim's claim be settled separately with Deerbrook paying the $100,000 per person limit. In August 2006 the attorney rejected Deerbrook's $100,000 settlement offer as being "too little too late." Thereafter, the seriously injured victim filed a personal injury lawsuit against the insured and received a jury verdict in excess of $4 million. Deerbrook paid its $100,000 per person limit to partially satisfy the judgment. The insured then assigned his bad faith to the seriously injured victim in exchange for a covenant not to execute.

The case was decided through trial with the jury concluding that Deerbrook did not unreasonably or without proper cause, fail to accept a reasonable settlement demand for an amount that was within policy limits. The verdict was appealed.

The issue before the Ninth Circuit Court of Appeals was whether an insurer had a duty, after liability of the insured had become reasonably clear, to attempt to effectuate a settlement in the absence of a demand from the claimant. The Ninth Circuit recognized that California courts had commonly applied the duty to settle to situations in which the insurer unreasonably rejected a settlement offer within policy limits. However, the issue before the court was whether the duty to settle in California more broadly required an insurer to effectuate settlement when liability was reasonably clear, even in the absence of a settlement demand. The Ninth Circuit concluded that the duty to settle was that broad.

The court began its analysis by recognizing that in those situations where there was a substantial risk of an insured's exposure in excess of the policy limits, the interests of the insurer and the insured diverge creating a conflict of interest. To ameliorate the conflict of interest, the covenant of good faith and fair dealing required insurance companies to consider the interests of the insured, in good faith, equally with its own interests and to evaluate settlement offers within policy limits as though the insurance company alone carried the entire risk of the loss. The court noted that the conflict of interest that animates the duty to settle exists irrespective of whether a settlement demand is made by the injured party.

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emphasis in the legal advocacy and consultation of business owners and companies working in or related to the construction, transportation and hospitality industries.

BUTZ DUNN & DESANTIS ANNOUNCES THE ADDITION OF TWO NEW ASSOCIATES

Butz Dunn & DeSantis has hired Joy L. Shedlosky and Emily M. Straub as associates.

Ms. Shedlosky is a 2008 graduate of the University of San Diego School of Law where she was awarded The Order of Barristers and American Board of Trail Advocates Award. She received her B.A. in Communication with a Minor in Spanish Literature from the University of California San Diego. Ms. Shedlosky practices in the areas of professional liability, general business litigation, insurance coverage and employment law matters.

Ms. Straub received her Juris Doctor in 2008 from Duquesne University School of Law and her Bachelor of Arts in English, magna cum laude, from Clark University. Ms. Straub's practice includes professional liability, design professional liability, commercial litigation and employment litigation.

Butz Dunn & DeSantis specializes in civil litigation with an emphasis on complex business and commercial litigation, professional liability, unfair competition, employment advisement and litigation, public sector law and catastrophic personal injury. >

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The Ninth Circuit concluded that an insurer can violate the duty of good faith and fair dealing by failing to attempt to effectuate a settlement within policy limits after liabilities become reasonably clear notwithstanding the fact that no settlement demand has been made. The question revolves around whether there was a reasonable opportunity to settle within the limits.

The Ninth Circuit rejected Deerbrook's argument that the "genuine dispute" rule insulated it from bad faith because the law was unsettled regarding Deerbrook's obligation to settle the case without first being presented with a settlement demand. The court responded to Deerbrook's argument by limiting the "genuine dispute" rule to first party insurance cases where courts are required to determine whether the insurer has refused to pay policy benefits unreasonably and without cause. Settlement in third-party insurance cases was different. >

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Court of Appeal Revisits When Loss of Consortium Claims Accrue Broadcast

granting summary judgment on the loss of consortium cause of action. The court held that the first element of a loss of consortium cause of action — the existence of a marriage at the time of injury to the plaintiff's spouse — is satisfied if the plaintiff's marriage to the injured spouse predates discovery of symptoms, or diagnosis, of an asbestos-related disease. According to the Court of Appeal, "[t]his is so even if the marriage postdates the spouse's exposure to the asbestos that ultimately results in the injury." (Ibid.) The court reasoned that just like a legal malpractice case, there must be appreciable or actual injury before a right of action can arise with respect to a latent disease. Therefore, "for purposes of creation of a loss of consortium cause of action, injury to the spouse in the latent disease context occurs when the illness or its symptoms are discovered or diagnosed, not at the time of the tortious act causing the harm."

While Vanhooser may not prove to be a groundbreaking decision, it provides an update on this area of the law. >