INSURANCE LAW

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Mindful of the obligation of the carrier to undertake a thorough and reasonable investigation, the common thread that weaves itself through the cases discussed below is that policy language controls and efforts to sidestep that language will be thwarted, no matter how creative the argument.

THE GENUINE DISPUTE RULE DOES NOT RELIEVE AN INSURER FROM ITS OBLIGATION TO THOROUGHLY AND FAIRLY INVESTIGATE, PROCESS, AND EVALUATE THE INSURED'S CLAIM; A GENUINE DISPUTE EXISTS ONLY WHERE THE INSURER'S POSITION IS MAINTAINED IN GOOD FAITH AND ON REASONABLE GROUNDS. In Reagan Wilson v. 21st Century Insurance Company (2007) 42 Cal.4th 713, 68 Cal.Rptr.3d 746, the California Supreme Court affirmed a judgment of the Court of Appeal, Second Appellate District, reversing summary judgment in favor of an underinsured motorist ("UIM") insurer in a bad faith action. In this first party insurance bad faith action, the question on review was whether summary judgment was properly granted for the insurer. Eight months after Reagan Wilson was injured in an automobile accident by a drunk driver, her insurer, 21st Century Insurance Company, rejected her demand for payment of the $100,000 policy limit on her underinsured motorist coverage. Although Wilson's treating physician had opined that the 21-year-old woman had "degenerative disk changes as a result of occult disk injury at the levels in her neck from her high speed motor vehicle accident," and that these spinal changes were atypical for her age and "almost certainly" caused by the automobile accident, 21st Century rejected the claim on the asserted ground that she had suffered only soft tissue injuries in the collision and had "preexisting" degenerative disk disease. Because, based on the undisputed facts in the summary judgment record, a jury could reasonably find 21st Century reached this medical conclusion without a good faith investigation of the claim and without a reasonable basis for genuine dispute, the Supreme Court agreed with the Court of Appeal that summary judgment on Wilson's bad faith cause of action was improper. The Supreme Court observed that while an insurer has no obligation to accept every claim, an insurer acts unreasonably when it ignores evidence that supports the claim and focuses solely on facts justifying denial. The Supreme Court concluded Wilson had demonstrated a triable issue whether 21st Century's initial denial was unreasonable and in bad faith. 21st Century offered no medical evidence that would have allowed it to ignore Wilson's physician's conclusion that the probable source of her injuries was the accident. While 21st Century argued its denial rested on a genuine dispute as to the true value of Wilson's claim, the Supreme Court held the doctrine only applies when an insurer has discharged its obligation to thoroughly investigate and fairly evaluate a claim.

CALIFORNIA SUPREME COURT GRANTS REVIEW TO DETERMINE STATUS OF CLAIMS ADJUSTERS AS EXEMPT ADMINISTRATIVE EMPLOYEES. On November 28, 2007, the California Supreme Court granted review of Harris v. Superior Court (2007) 154 Cal.App. 4th 164, which involved four coordinated class actions against Liberty Mutual Insurance Company and Golden Eagle Insurance Corporation by claims adjusters employed by defendants, alleging that defendants improperly classified them as exempt from the overtime compensation requirements under California law. Plaintiffs seek to recover the unpaid overtime to which they are allegedly entitled. The Court of Appeal, Second District, held that plaintiffs are not exempt administrative employees.

AN ISSUE CONCERNING AN "OTHER INSURANCE" CLAUSE IN A POLICY CAN ARISE ONLY BETWEEN CARRIERS ON THE SAME LEVEL OF COVERAGE, SUCH AS TWO PRIMARY CARRIERS. In JPI Westcoast Construction, L.P. v. RJS & Associates, Inc. (2007) 156 Cal.App.4th 1448, 68 Cal.Rptr.3d 91, the Court of Appeal for the First Appellate District affirmed the trial court's rulings on motions for summary judgment finding a subcontractor's excess carrier was not obligated to contribute to the settlement of a wrongful death action until both the subcontractor's and general contractor's primary insurance was exhausted, regardless of an indemnity provision in a subcontract requiring the subcontractor to indemnify the general contractor. JPI Westcoast Construction, L.P. (JPI), the general contractor on a large construction project, hired RJS & Associates (RJS) as a subcontractor on a phase of the project. The construction contract between JPI and RJS contained an indemnity clause in favor of JPI. During the course of the work undertaken by RJS, a worker was killed in an accident. In the underlying action, the worker's family sued JPI, RJS and others for wrongful death. RJS's insurers assumed defense of the action on behalf of JPI and RJS. A jury found that JPI was 20% at fault for the accident and RJS was 70% at fault This appeal arises from the subsequent round of litigation between JPI and its primary insurance carrier, Transcontinental Insurance Company (Transcontinental) and RJS and its excess carrier, Great American Insurance Company (Great American), over contributions to the settlement of the underlying action. On stipulated facts, the trial court ruled in favor of RJS and Great American, and against JPI and Transcontinental, on four separate motions for summary judgment. In affirming the trial court's summary judgment rulings, the Court of Appeal reasoned that there is a fundamental distinction between primary and excess insurance coverage: "primary coverage" is coverage whereby, under terms of the policy, liability attaches immediately upon the happening of an occurrence that gives rise to liability, and "excess coverage" or "secondary coverage" is coverage whereby, under the terms of the policy, liability attaches only after a predetermined amount of primary coverage has been exhausted. Thus California law requires primary policies to exhaust before excess policies must pay.

COMPANY THAT ENCOURAGED ITS EMPLOYEES TO VOLUNTEER WITH NON-PROFIT CORPORATION'S RECONSTRUCTION PROJECT WAS NOT ADDITIONAL INSURED ON CORPORATION'S LIABILITY POLICY ENTITLED TO RECOVER COSTS FOR DEFENSE OF UNSUCCESSFUL LAWSUIT AGAINST COMPANY BROUGHT BY VOLUNTEER INJURED WHILE WORKING ON PROJECT. In Boeing Co. v. Continental Casualty (2007), 157 Cal.App.4th 1258, 69 Cal. Rptr.3d 322, the Court of Appeal for the Second Appellate District held that an employer which encouraged its employees to volunteer with a non-profit corporation's reconstruction project was not additional insured on the non-profit corporation's liability policy where an employee sought recovery for personal injuries sustained while performing volunteer

work on behalf of the non-profit corporation. Christmas in April USA (CIA) is a nonprofit corporation which enlists volunteers to repair and rehabilitate the homes of low-income, elderly and disadvantaged persons. CIA solicits companies such as Boeing to encourage its employees to volunteer for reconstruction projects. Todd Black (Black), an employee of California State University at Long Beach, allegedly was injured while working as a volunteer on a CIA project. Black filed suit against Boeing, CSULB and others. Boeing embarked on a search for insurance coverage. It learned that CIA was insured under a CGL policy issued by Continental Casualty Company. Thereafter, Boeing tendered its defense in Black to Continental. Unsurprisingly, Continental declined the tender in a letter which stated in relevant part: "[Continental] insured [CIA] under the above-referenced policy, however, this policy does not identify [Boeing] as an additional insured. We have confirmed with our insured that they did not have a legal requirement to name [Boeing] as an additional insured nor did [Boeing] request to be added as an additional insured on [CIA's] policy.... [¶] We have also confirmed that no contract exists as between your client and our insured. At this time, [Continental] respectfully rejects your request to defend and indemnify [Boeing]." The trial court sustained Continental's demurrer without leave to amend and dismissed complaint. The Court of Appeal held, as a matter of law, Boeing did not qualify as an additional insured under Continental's CGL policy. The court found no ambiguity in the additional insured endorsement.

CLAIMS THAT INSURED HOMEOWNER'S DEFAMATION OF CLAIMANT RESULTED IN EMOTIONAL AND PHYSICAL AILMENTS DID NOT TRIGGER INSURANCE COVERAGE FOR "BODILY INJURY" UNDER HOMEOWNER'S POLICY, SINCE UNDERLYING DEFAMATION CLAIM WAS NOT COVERED UNDER POLICY COVERING "ACCIDENT." In Stellar v. State Farm General Ins. Co. (2007) 157 Cal.App.4th 1498, 69 Cal.Rptr.3d 350, the Court of Appeal for the Second Appellate District held that a defamation action against insured homeowners did not allege a covered "occurrence," which the policy defined as an "accident" because the Plaintiff specifically alleged that the insureds' conduct was willful and intentional, and arose from an evil and improper motive. Moreover, the insureds offered no extrinsic evidence to support their characterization of their conduct as negligent. Accordingly, the trial court properly granted summary judgment in State Farm's favor on the ground that the underlying action did not involve a covered "occurrence" triggering State Farm's duty to defend.

LIABILITY INSURERS' EQUITABLE CONTRIBUTION CLAIM AGAINST NON-SETTLING INSURERS AROSE FROM EQUITY, NOT CONTRACT, AND, THUS, INSURERS WERE NOT REQUIRED TO STAND IN INSURED'S SHOES AND FULFILL ITS CONTRACTUAL OBLIGATION TO ARBITRATE DISPUTES WITH NON-SETTLING INSURERS. In Crowley Maritime Corp. v. Boston Old Colony Ins. Co. (2008), 158 Cal.App.4th 1061, 70 Cal. Rptr.3d 605, the Court of Appeal for the First Appellate District held that where an insurance policy contains a mandatory arbitration provision governing disputes between the insured and insurer, that provision does not apply to equitable contribution claims brought by insurers who were not signatories to the policy. In this case, the Court was asked to consider the relationship, if any, between domestic and foreign insurance agreements in an arbitration dispute involving equitable contribution between insurance companies. The insured, Crowley Maritime Corporation, received indemnification for claims from two of its insurers. These two carriers in turn sought equitable contribution from other insurers of Crowley. One of the carriers thereafter petitioned to compel arbitration of another carrier's equitable contribution claim under English law, based upon arbitration agreements the petitioning carrier had with Crowley. The trial court denied the petition on two grounds: (1) the equitable contribution claim does not arise from contract; and (2) each of the carriers were not signatories to the arbitration agreements, and the general rule under both California and federal law is that non-signatories cannot be compelled to arbitrate. The Court of Appeal concluded that an equitable contribution claim does not arise from contract, but from equity. Although there are exceptions to the general rule against compelling non-signatories to arbitrate, those exceptions were not found by the Court to be applicable.

HOMEOWNERS INSURER'S DENIAL OF CLAIM FOR MOLD DAMAGE STEMMING FROM TOILET OVERFLOW DID NOT VIOLATE THE EFFICIENT PROXIMATE CAUSE DOCTRINE IN LIGHT OF INSURANCE POLICY'S EXPRESS EXCLUSION "UNDER ANY CIRCUMSTANCES" FOR MOLD DAMAGE, EVEN IF RESULTING FROM COVERED PERIL OF A SUDDEN AND ACCIDENTAL DISCHARGE OF WATER. In De Bruyn v. Superior Court (2008) 158 Cal.App.4th 1213, 70 Cal.Rptr.3d 652, the Court of Appeal for the Second Appellate District upheld the application of a mold exclusion in an "all risk" property policy to mold resulting from the overflowing of toilet. A homeowner with an "all-risk" homeowners insurance policy returned home from vacation to find that a toilet had overflowed, causing significant water damage to his home. As a result of the water damage, the house became contaminated by mold. The homeowner made a claim under the policy for all of the damage, including the mold damage. Although the policy covered losses resulting from a sudden and accidental discharge of water from plumbing or household appliances, the insurer denied the claim for the mold damage based upon terms in the policy that provide that any loss resulting from mold is always excluded, however caused. The question raised in this case was whether an insurer may rely upon an "absolute" mold exclusion to deny coverage for mold damage resulting from the covered discharge of water, in light of the "efficient proximate cause doctrine." Under that doctrine, when a loss is caused by a combination of a covered and specifically excluded risks, the loss is covered if the covered risk was the efficient proximate cause of the loss, but the loss is not covered if the covered risk was only a remote cause of the loss, or the excluded risk was the efficient proximate, or predominate, cause. Here, the Court of Appeal held that because the policy at issue in this case "plainly and precisely communicate[d]" that mold damage is not covered even when it results from a covered sudden and accidental discharge of water, the insurer's denial of coverage did not violate the efficient proximate cause doctrine.