

THARPE & HOWELL

INSURANCE COVERAGE & LITIGATION NEWSLETTER

RECENT DEVELOPMENTS

SPRING 2009 EDITION

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COVERAGE AND LITIGATION

First Publication Exclusion Applied To Infringement Claims

In *United National Insurance v. Spectrum*, Sunset Health hired Spectrum in 1997 to market the drink "Hollywood 48 Hour Miracle Diet." Thereafter, *Spectrum* formed *Celebrity* to market a similar drink called "The Original Hollywood Celebrity Diet." Spectrum then terminated its original contract with Sunset and began marketing *Celebrity Diet* and, in 1999, changed the labeling of *Celebrity Diet* to a very similar label to that of *Miracle Diet*.

Sunset filed suit for trade dress infringement and sought a TRO. A preliminary injunction was denied and Spectrum continued sales of Celebrity Diet. A settlement was subsequently reached between Spectrum and Sunset, and Spectrum sought indemnity for its payment under its insurance policies.

In 2001, United National Insurance issued a \$1 million third party liability policy to Spectrum, excess to a Monticello policy which included language indemnifying Spectrum for oral/written slander, oral/written privacy violations, misappropriation of advertising and infringement of copyright, title or slogan. The United National policy adopted this language but contained a separate exclusion for advertising injury where the first publication took place before the policy incept.

The 9th Circuit found the first publication exclusion in the United National policy to be clear and unambiguous. Spectrum argued on appeal that the exclusion only applied to claims for libel, slander and invasion of privacy and not to infringement claims. However, using the *Waller* “plain meaning” test, the Court found that the exclusion did indeed apply to infringement and found no coverage as the 1999 label predated the 2001 policy incept.

Of special interest, the Court also found Spectrum to be judicially estopped from making arguments on appeal as to when the infringement had occurred that were contradicted by arguments made in the preliminary injunction hearing.

In the hearing, Spectrum had argued that Sunset’s damages had arisen from 1999 labeling and Sunset waited too long to bring its damage claims. However, on appeal, Spectrum claimed that a later 2001 label was the basis of the infringement claim - in an attempt to bring the claim within the policy period. The Court found Spectrum to be estopped by its earlier arguments and applied the exclusion.

Real Property Transfer From LLC To Its Members May Terminate Title Insurance

In *Kwok v. Transnational Title Insurance Company*, Patrick and Maria Kwok formed an LLC which purchased real property. Transnational Title Insurance Company issued a policy to the LLC as the named insured - insuring title to the property and an easement. The policy defined “insured” as the named insured (the LLC) and “those who succeed to the interest of the named insured by operation of law as distinguished from purchase.” Coverage continued under the terms of the policy as long as the insured retained an interest in the land.

The Kwoks transferred the property by grant deed to themselves, as trustees of a family trust. Subsequently, the LLC was dissolved. Then, the Kwoks tendered defense of an easement dispute to Transnational which denied coverage because the title transfer was not “by operation of law” under the policy.

In the end, the Court found no coverage existed because the LLC was the only named insured and there was no endorsement adding the family trust as an insured. Therefore, coverage did not continue because title did not devolve to the Kwoks on dissolution of the LLC, but was instead transferred by grant deed to a separate legal entity. Further, the Kwoks’ interest in the LLC was not held through the trust, so their capacity as transferees was not the same as the capacity in which they would have held title as successors by operation of law upon dissolution of the LLC.

Court May Properly Refuse To Give Bad Faith Jury Instructions

In *McCoy v. Progressive West Ins. Co.*, the Appellate Court upheld a jury finding of bad faith and punitive damages against an auto insurer that denied the insured's claim of car theft and vandalism damage to the insured vehicle.

In this case, plaintiff McCoy alleged that his car had been stolen in Las Vegas, then burned and destroyed. He alleged that the theft was a covered loss under his policy, and that he had promptly reported the loss to his insurer, Progressive West. McCoy claimed that Progressive West breached the insurance contract and violated the covenant of good faith by, among other things, failing to promptly, fairly and fully investigate the claim; and by withholding policy benefits unreasonably and without proper cause. In its defense, Progressive West argued that its investigation was reasonable and within the standards for good claims handling.

In the first phase of the bifurcated trial, the jury returned a unanimous verdict in favor of McCoy on all the special verdict questions, including whether Progressive West had acted in bad faith and whether it acted with malice or oppression. In the second phase, which involved the sole issue of the amount of punitive damages, nine jurors agreed to an award of \$100,000.

Progressive West filed a motion for new trial and for judgment notwithstanding the verdict, which the Trial Court denied. In reaching its decision, the Trial Court reasoned that ample evidence supported the jury's verdicts that "in the colloquial sense . . . McCoy got a raw deal" and that, under clear and convincing evidence standard, the award of punitive damages was justified.

In its Appeal, Progressive West contended that the Trial Court committed prejudicial error by refusing to give its proposed jury instructions of the "genuine dispute" doctrine. However, the Court of Appeal found the Trial Court was not in error, and upheld the Trial Court's ruling which found that since there was no evidence that the insurer engaged in a genuine dispute over the validity of the claim, no special jury instruction on the "genuine dispute" defense was proper. The Court ruled such an instruction is subsumed by the standard CACI 2331 and 2332 bad faith instructions where there is no evidence of a "genuine dispute." The Court held a "genuine dispute" exists only where the insurer's position is maintained in good faith and on reasonable grounds - which did not exist here.

Additional Coverage Under Extended Replacement Provision Not "Gift" To Insured

In *Patrick A. Major, et al. v. Western Home Insurance Co.*, a \$1.3 million dollar jury verdict was rendered against Western Home in relation to its handling of a claim involving the insureds' home which had been destroyed in the 2003 Cedar Fire.

In this case, the Majors obtained a homeowners policy from Western Home for their house in El Cajon, California. The policy provided coverage of \$193,000 for their dwelling (coverage A), \$19,300 for other structures (coverage B), \$135,100 for personal property (coverage C), \$38,600 for living expenses (coverage D), and \$18,000 for mortgage disaster protection.

The policy was an "extended replacement cost" policy which held that, in the event of a covered loss, Western Home would repair or replace the Majors' home "up to [a] specified percentage over the policy's limits of liability" as specified in the declarations page of the policy. The declarations page specified that the extended replacement cost was 25% over the policy limits, meaning \$241,250 for coverage A, \$24,125 for coverage B, \$168,875 for coverage C, and \$48,250 for coverage D.

Western Home conditioned the extended replacement cost coverage on requiring that the dwelling coverage limits be equal to the cost to replace the home. To that end, the policy required the Majors to permit an inspection of the dwelling by Western Home to determine the replacement cost. However, Western Home did not send an inspector to the Majors' home until *after* the policy was issued and the coverage limits set.

The subsequent inspection report placed the replacement cost at \$235,578, approximately \$40,000 more than the dwelling coverage listed in the policy. Based on this valuation, the extended replacement cost coverage should have been \$305,216 for coverage A, \$30,522 for coverage B, \$213,651 for coverage C, and \$61,043 for coverage D.

Case files indicate although the fire claimed the Majors' home in October 2003, Western Home did not make its first payment until February 2004. Additionally, Western Home failed to make mortgage payments on time and the claims adjuster refused to provide the Majors with a copy of the policy, despite several requests. Additionally, despite the fact that the Majors submitted invoices for their personal property losses, inquired about replacing their pool and spa, and made several phone calls to inquire about their claim, the Western Home claims adjuster told the Majors their claim was "third in his stack" and that it was not his top priority. Plaintiffs alleged that there were no indications the adjuster had even reviewed the Majors' claim file.

The Majors retained counsel in October 2004. Coincidentally, fifteen days later, Western Home paid the total amount of personal property benefits due to the Majors. By a February 23, 2005 letter to the Majors' counsel, Western Home also increased the policy limits to correspond to the replacement costs set forth in the inspection report. This letter specifically stated that "[t]here may be additional benefits owed to the Majors." By April or May of 2005 (approximately 16 months after the October 2003 date of loss), Western Home had paid all policy benefits due under the policy.

At trial, the jury found in the Majors' favor on their causes of action for breach of insurance contract and bad faith. The jury awarded the Majors \$31,359.55 in personal property benefits, \$450,000 emotional distress damages, \$189,000 in Brandt attorney fees, and \$646,471.53 in *punitive damages*, for a total of \$1,316,831.

After the verdict, Western Home filed a motion for new trial and for judgment notwithstanding the verdict – which the Trial Court subsequently denied. In reaching its decision, the Trial Court stated there was sufficient evidence to support the judgment, and found that the non-economic and punitive damages were not excessive. Western Home argued that the insurance contract was *not* modified and that the additional coverage afforded to the Majors was a "*gift*." The Court, however, found substantial evidence to justify the additional coverage and subsequent payment was not a gift as alleged by Western Home.

The Court of Appeal affirmed, finding that Western Home had modified the policy to comply with the original terms of the policy by the February 23, 2005 letter which stated that the policy limits had been raised in light of the inspection report; and that no new consideration was necessary to support the modification. The Court also found that these were not courtesy benefits independent of the policy, but instead were

increases in coverage as dictated by the terms of the policy itself. Furthermore, the Court found that the non-economic damages were not excessive in that there was only a two-to-one ratio between them and the economic damages.

The Court noted Western Home's conduct was reprehensible because it knew the Majors were financially vulnerable as a result of their house burning down, a fact that supported the punitive damages award; and that the punitive damages awarded by the jury only amounted to slightly more than a one-to-one ratio to the tort damages.

Without Damages, No Standing Under California Consumers Legal Remedies Act

In *Meyer v. Sprint Spectrum*, subscribers to cellular telephone service sued the service provider alleging causes of action for violations of California's unfair competition law (Business and Professions Code section 17200, et seq.) and the California Consumer Legal Remedies Act ("CLRA"), and for declaratory relief. Plaintiffs alleged that the arbitration agreement and remedial provisions of the service provider's service agreement were unconscionable. After plaintiffs made multiple attempts to amend the complaint, the Trial Court sustained the demurrer to the fourth amended complaint with prejudice, concluding that plaintiffs had not shown that they were personally damaged or that the allegedly unconscionable or illegal provisions had been enforced against them.

The Court of Appeal affirmed the Trial Court's decision, holding that (1) plaintiffs could not demonstrate an "injury in fact," which is a prerequisite to asserting a claim under the CLRA; (2) without showing any damage, plaintiffs had no

standing to sue under the CLRA; and (3) plaintiffs had alleged no actual controversy between them and the service provider; therefore, declaratory relief was not available.

The Supreme Court of California sustained the Trial Court's demurrer to the fourth amended complaint. The Court, citing section 1780(a) of the California Civil Code, held that in order to bring a CLRA action, a consumer must not only be exposed to an unlawful practice, but some kind of damage must result. The Court explained that the expenditure of transaction costs to avoid the consequences of a deceptive practice falls within the broad meaning of suffering "any damage as a result of the use or employment" of an unlawful practice. However, because the service provider had not sought to enforce any unconscionable terms against plaintiffs, the service provider had not actually imposed additional transaction costs on plaintiffs. Thus, plaintiffs had not suffered "any damage" from the service provider's allegedly unconscionable terms in the service contract.

Additionally, the Court concluded that the plaintiffs' complaint did not sufficiently allege a cause of action for injunctive relief under the CLRA. The Court explained that subdivision (d) of section 1782 of the California Civil Code does not alter the basic requirements of section 1780(a) of the California Civil Code that a consumer bringing an action has suffered "damages" as the result of unlawful practices. The Court concluded that section 1780 is the only section of the CLRA that sets forth the available remedies, including injunctive relief. Furthermore, the Court concluded that plaintiffs did not sufficiently allege a cause of action for declaratory relief under California Code of Civil Procedure section 1060. The Court denied declaratory relief, explaining that plaintiffs did not allege with any particularity that the resolution of the declaratory relief action would have any practical consequences.

Disclaimer Is Insufficient Notice For Triggering Statute For Unfair Competition Claim

In *Broberg v. Guardian Life Ins. Co. of America*, the plaintiff/insured purchased a "vanishing premium" whole life insurance policy from the insurer. Prior to purchasing the policy, the plaintiff received a policy illustration that depicted the elimination of out-of-pocket premiums after the 12th year of the policy's life.

After plaintiff was informed he would be required to continue making out-of-pocket premium payments beyond the 11th year of the policy, he filed a lawsuit against his broker and insurer, alleging causes of action for fraud, negligent misrepresentation and unfair competition.

The Trial Court sustained the insurer's demurrer. In sustaining the demurrer, the Trial Court concluded that the insured's fraud and misrepresentation claims were time barred because the disclaimer in the policy illustration and policy language were sufficient to give plaintiff at least inquiry notice that earnings from the policy were not guaranteed. The Trial Court further concluded that the insured could not establish justifiable reliance on the alleged misrepresentations as a matter of law, and that plaintiff's CLRA cause of action was not viable because a contract for life insurance is not included within the CLRA's definition of "goods and services."

The California Court of Appeal reversed the Trial Court's demurrer to plaintiff's complaint as to the fraud, negligent misrepresentation and unfair competition claims. The Court explained that when a plaintiff reasonably should have discovered facts for purposes of the accrual of a cause of action or application of the delayed discovery rule, i.e. when

a reasonable person would have discovered the factual basis for a claim, is generally a question of fact, and decided as a matter of law only if the evidence can support only one conclusion. The Court concluded that because this case was at the demurrer stage, it could not agree that the disclaimers in the policy illustration were so clear and obvious that, as a matter of law, plaintiff's claims of delayed discovery and reasonable reliance must be rejected. The Court, however, upheld the Trial Court's ruling on the CLRA cause of action, concluding that insurance is not a "good" or "service" subject to the CLRA.

No Right To Relitigate Insured's Liability Under Third Party Judgment

In *Executive Risk Indemnity, Inc. v. Reese M. Jones*, Reese Jones arbitrated against STARS who was insured by Executive Risk Indemnity, Inc. ("ERII") to recover damages for faulty investment and financial planning advice. ERII refused to participate in the proceeding because its policy did not promise STARS a defense, only reimbursement of defense costs. Neither STARS nor ERII appeared at the arbitration and Jones was awarded \$22 million in damages. A Notice of Award of Arbitrator was served on ERII and judgment thereafter entered.

ERII brought a declaratory relief action seeking a declaration that the award and judgment did not bind it under principles of collateral estoppel. The Court concluded the award and judgment had no collateral estoppel effect on ERII because ERII did not participate in the arbitration proceeding and therefore was not in "privity" with STARS. The issue of STARS liability to Jones

was then tried a second time wherein the Court found no liability on the part of STARS and thus no obligation on the part of ERII to indemnify Jones even though Jones had previously obtained judgment against STARS.

The Court of Appeal reversed, finding that had ERII intended to limit its obligation to indemnify STARS for a loss only where it was in privity with STARS by actively defending the third-party claim, it should have written that into the policy. The Court concluded that when an insurer (1) is duly notified of the underlying claim against its insured; and (2) is given a full opportunity to protect its interests, the resulting judgment— if obtained without fraud or collusion— is binding against the insurer in any later coverage litigation on the claim involving its insured. This rule applies regardless of whether the insurer has a contractual duty to defend, or whether or not its refusal to participate in the underlying proceedings is legally justified.

CLASS ACTION LITIGATION

Sutter Health Uninsured Pricing

The California Court of Appeal has struck a blow to scavenger plaintiff's class action firms that seek to profit by copying and/or interfering with an on-going class action.

Sutter Health was sued by a class of uninsured patients who alleged that it improperly denied them the discounts it granted insured patients. Michael Stowers filed a similar but separate suit against Sutter Health purporting to represent a class of accident victims. The parties in the uninsured pricing case agreed to a settlement that they valued at \$276 million. Stowers, who was not a member of the uninsured class and whose separate action Sutter Health considered to be a weaker case and therefore

was not offered a separate settlement, objected to the proposed settlement of the uninsured class case and sought to intervene in that case. Both attempts to interfere with the uninsured class settlement were rejected by the trial court and the Court of Appeal affirmed, on the grounds that the trial court has broad discretion to determine whether a class settlement is fair and a presumption of fairness exists where the settlement is reached through arm's length bargaining after sufficient investigation and discovery by experienced counsel and where the percentage of objectors is small.

Here, the settlement was reached after extensive litigation and weeks of mediation with experienced counsel. Out of over 385,000 class members, 12 objected and 102 opted out. Also, as due regard should be given to what is otherwise a private consensual agreement; the Court of Appeal accepted the parties' valuation of the settlement, over Stowers' objection that Sutter Health was not actually paying \$276 million, and determined that the settlement was fair.

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