

# THARPE & HOWELL

## INSURANCE COVERAGE & LITIGATION NEWSLETTER

RECENT DEVELOPMENTS

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### IN THIS ISSUE...

#### COVERAGE AND LITIGATION

<i>Insurer Need Only Defend Insured Against Infringement Claim Re Material Misappropriated Before Coverage if Later Use is “Substantially Distinct” from Prior Use</i> . . . . .	1
<i>Agent Assumes Additional Duty to Insured by Holding One’s Self Out as an Expert on the Product Necessary to Satisfy the Insured’s Needs</i> . . . . .	2
<i>Insurer That Denies Coverage Does Not Have Right to Intervene in Underlying Litigation</i> . . . . .	3
<i>Insured Versus Insured Exclusion in D&amp;O Policies Excludes Claims Made by Chapter 11 Debtor in Possession Against Directors and Officers of Insured Corporation</i> . . . . .	4
<i>Liability Insurer May Seek Declaratory Relief to Withdraw From Defense of Insured Following Exhaustion of Limits of Liability</i> . . . . .	4
<i>Insurer Not Responsible for Damages Caused by Subcontractors Where Insured Failed to Comply With Contractors Warranty Endorsement</i> . . . . .	5
<i>Assault and Battery by Insured is Not an “Accident” Within Meaning of Insuring Clause of Homeowner’s Insurance Policy</i> . . . . .	6
<i>Insurer is Not Required to Pay 100 Percent of Reasonable Repair Costs Incurred at Facility of Insured’s Choice</i> . . . . .	6

#### CLASS ACTIONS

<i>Hawaii Deceptive Practices Act Does Not Require a Showing of Individualized Reliance; Class Certification Appropriate</i> . . . . .	7
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#### INSURANCE REGULATIONS

<i>Montana Insurance Commissioner’s Practices Not Preempted by ERISA</i> . . . . .	8
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### COVERAGE AND LITIGATION

#### *Insurer Need Only Defend Insured Against Infringement Claim Re Material Misappropriated Before Coverage if Later Use is “Substantially Distinct” From Prior Use*

In *Kim Seng Co. v. Great American Ins. Co. of New York* (2009 WL 3791874 (Cal.App. 2 Dist)), Great River Food (“Great River”), an Asian food wholesaler sued Kim Seng Company (“Kim Seng”), another Asian food wholesaler for trademark infringement. Great River alleged that Kim Seng’s use of the term “Que Huong” (Vietnamese for “hometown” or “native land”) for rice noodles, rice

sticks, sauces, and fish sauces infringed Great River's trademark, "Que Huong," which it used for its frozen meats.

Kim Seng registered "Que Huong" in 1997 for its food products. The trademark application stated that the mark had been used in interstate commerce since at least March 1993. In 2000, Kim Seng registered a bearded farmer logo trademark "Old Man Que Huong Brand" for its products. The application stated that the mark had been used since at least January 1988.

Great River allegedly began using the "Que Huong" trademark for its food products in 1986, and alleged that Kim Seng's use of the "Que Huong" and "Old Man Que Huong Brand" marks infringed its trademark and sought an injunction. The jury found that only the "Que Huong" mark infringed Great River's rights and granted an injunction enjoining use of the term "Que Huong" in connection with Asian food products sold, distributed, or advertised in the United States. The parties appealed, and the appeal is still pending in the Ninth Circuit Court of Appeals.

Meanwhile, Kim Seng was insured by Great American Insurance Company of New York under a primary commercial liability policy effective October 6, 1997, through October 6, 1998. The policy covers "advertising injury," which included "misappropriation of advertising ideas or style of doing business" or "infringement of copyright, title or slogan." Kim Seng was also covered under an umbrella policy by American Allied Insurance Co., which covered "advertising injury" as well. The insurers denied coverage based upon the "prior publication exclusion" and refused to defend the action. The "prior publication exclusion" bars coverage for advertising injury that arises "of oral or written publication of material whose first publication of material took place before the beginning of the policy period."

The Court held that the exclusion applies to trademark infringement. It also held that because the claim against Kim Seng was for trademark infringement based on use of the words "Que Juong" prior to the policy period, and because Kim Seng's use of the words "Que Huong" during the policy period constituted a republication of the prior publication of the "Que Huong" mark, the "prior publication exclusion" applied, barring coverage.

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*Agent Assumes Additional Duty to Insured by Holding One's Self Out as an Expert on the Product Necessary to Satisfy the Insured's Needs*

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In *Williams v. HRH* (177 Cal. App. 4<sup>th</sup> 624 (2009)), the owners of a spray-on pickup truck bed lining dealership (Rhino-SFS), brought a successful action against an insurance agency after an injured worker brought a successful personal injury action against the dealership, alleging that the agency was negligent in advising on, procuring, and maintaining an insurance package for the dealership that did not include workers compensation coverage.

Rhino USA, the enterprise through whom the dealership was acquired, referred Rhino-SFS to insurance agent Robyn Thaw. The owners, who were from Oklahoma, contacted Thaw but were told a meeting would not be necessary because she was very familiar with Rhino dealerships and she "was the expert on the product necessary to satisfy his dealership's insurance needs." It was Rhino-SFS' understanding that Thaw had a custom made insurance package specific to the Rhino operations. After calling to report a fire which severely burned a worker, Rhino-SFS found out they did not have the necessary workers comp coverage. A successful civil action was brought by the worker against Rhino-SFS, and others. This action followed thereafter.

In affirming the trial court's ruling, the appellate court noted, "[t]he rule [that an insurance agent has a duty to use reasonable care, diligence, and judgment in procuring the insurance requested by an insured] changes, when-but only when-one of three things happen: . . . (c) the agent assumes an additional duty . . . by 'holding himself out' as having expertise in a given field of insurance being sought by the insured...." (*Fitzpatrick v. Hayes*, 57 Cal. App. 4<sup>th</sup> 916, 927 (1997)). Thaw's failure to advise Williams of the necessity for workers comp insurance and knowledge that it was not included in her package for Rhino dealerships, breached the duty she assumed by holding herself out as "the expert on the product necessary to satisfy Rhino-SFS's insurance needs." Thaw argued that she never held herself out as an expert in workers comp insurance, however, the court said the assumption Thaw had to hold herself out as such an expert is simply wrong because she claimed to be an expert in the insurance needs of Rhino dealerships, which in CA necessarily includes workers comp insurance.

The court further agreed that the action was not barred by the two year statute of limitations because actual injury did not occur until judgment was entered against Williams in the civil suit and not at the time when the worker was injured in the fire. As to assigning any fault to Williams based on a failure to read the policy, in addition to being a question of fact that is not properly considered on appeal, the court reasoned that "an insured should be able to rely on an agent's representations of coverage without independently verifying the accuracy of those representations by examining the relevant policy provisions."

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*Insurer That Denies Coverage Does Not  
Have Right to Intervene in Underlying  
Litigation*

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In *Hinton v. Beck* (176 Cal. App. 4<sup>th</sup> 1378 (2009)), the defendant's insurer moved to file a complaint in intervention after an entry of default judgment. The trial court granted the motion to intervene, set aside the default, and dismissed the action. Plaintiff appealed and the Court of Appeal reversed in part. On remand, defendant's insurer filed an amended complaint in intervention and plaintiff moved to strike the complaint. The trial court granted the motion to strike and the insurer appealed.

The California Court of Appeal held that the trial court acted within its discretion in striking the insurer's complaint in intervention. The Court concluded that the insurer, having denied coverage and having refused to defend the action on behalf of its insured, did not have a direct and immediate interest to warrant intervention in the litigation. The Court further stated that an insurer who denies coverage and refuses to defend its insured does not have a direct interest in the litigation between the plaintiff and the insured to warrant intervention. The rationale behind this rule is that by its denial, the insurer has lost its right to control the litigation. *Eigner v. Worthington*, 57 Cal. App. 4<sup>th</sup> 188, 196 (1997).

In effect, the Court's holding reaffirmed the holding in *Hamilton v. Maryland Cas. Co.*, 27 Cal. 4<sup>th</sup> 718 (2002), that a policyholder who has been denied a defense for covered claims by its liability insurer may make a reasonable settlement with the plaintiff, in good faith, and then maintain or assign an action against the insurer for breach of its defense duties. In such a situation, a reasonable settlement made by the insured to terminate the underlying claim against him may be used as presumptive evidence of the insured's liability on the underlying claim, and the amount of such liability.

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### *Insured Versus Insured Exclusion in D&O Policies Excludes Claims Made by Chapter 11 Debtor in Possession Against Directors and Officers of Insured Corporation*

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In *Biltmore Associates, LLC v. Twin City Fire Ins. Co.*, 572 F. 3d 663 (2009), an insured corporation, after filing a chapter 11 bankruptcy petition as “debtor and debtor in possession,” brought claims for breach of statutory and fiduciary duties against several directors and officers of the company. The directors and officers tendered these claims to insurers that issued directors and officers liability insurance policies to the insured corporation.

The policies issued to the insured corporation included an “insured versus insured” exclusion that provided the following: “The Insurer shall not be liable to make any payment for Loss in connection with any Claim made against the Directors and Officers . . . brought or maintained by or on behalf of an Insured in any capacity.” The insurers declined coverage for the claims on the ground that the insured versus insured exclusions in the policies barred coverage for the claims.

The insured corporation then assigned its claims against the directors and officers to a trust established for its creditors. The trustee then entered into a settlement with the directors and officers; the directors and officers then assigned their claims that they had against the directors and officers liability insurers to the trustee. The trustee then sued the directors and officers liability insurers.

The district court dismissed the action. On appeal the U.S. Court of Appeals for the Ninth Circuit upheld the dismissal. The court of appeal held that an “insured versus insured” exclusion in the directors and officers liability insurance policies barred coverage for the claims because a post-bankruptcy

debtor in possession acts in the same capacity as the pre-bankruptcy debtor. The court of appeal concluded that for purposes of the insured versus insured exclusion, the pre-filing company and the company as debtor in possession in chapter 11 are the same entity.

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### *Liability Insurer May Seek Declaratory Relief to Withdraw From Defense of Insured Following Exhaustion of Limits of Liability*

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In *Great American Ins. Co. v. Superior Court*, 178 Cal. App. 4<sup>th</sup> 221 (2009), a insured corporation, and its directors and officers, and a neighboring property owner sued each other for cleanup costs relating to groundwater contamination beneath both sites. Great American Insurance Company (“Great American”) issued a liability insurance policy to the insured corporation that had an aggregate limit of liability of \$500,000.

Great American paid \$500,000 toward the settlement of certain claims in the underlying action. Following payment, Great American filed a declaratory relief action against its insureds, seeking a declaration that it had exhausted its policy and was therefore no longer required to defend the underlying action. The insureds brought motions to stay the declaratory relief action. The trial court granted the motions to stay on the basis that the declaratory relief action implicates factual issues which are at issue in the underlying action.

Great American appealed. The court of appeal vacated the trial court’s stay order and remanded the matter to the trial court with directions to reconsider the motion for a stay.

The court of appeal explained that a trial court, in considering whether to stay a declaratory relief

action, must consider which issues are to be litigated in order to resolve the declaratory relief action, and whether those issues are related to factual issues yet to be litigated in the underlying action.

The court of appeal further explained that if the factual issues to be resolved in the declaratory relief action overlap with issues to be resolved in the underlying litigation, the trial court must stay the declaratory relief action. If, however, there is no factual overlap in the declaratory relief action with the issues to be resolved in the underlying case, a trial court must exercise its discretion on a motion to stay, balancing the insured's interest with the insurer's interest, *i.e.* paying defense costs which it may not owe and likely will not be able to recoup.

The court of appeal concluded that no issues raised in the declaratory relief action were relevant to the underlying action; although an issue of policy interpretation was raised, this issue did not have anything to do with who was responsible for the environmental contamination or any other factual matter at issue in the underlying action, and could be argued and resolved in the declaratory relief action. Therefore, the insureds failed to meet their burden of establishing that a stay of the declaratory relief action implicates factual issues which are at issue in the underlying litigation.

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*Insurer Not Responsible for Damages  
Caused by Subcontractors Where Insured  
Failed to Comply With Contractors  
Warranty Endorsement*

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In *North American Capacity Ins. Co. v. Claremont Liability Ins. Co.*, 177 Cal. App. 4<sup>th</sup> 272 (2009), North American Capacity Insurance Company ("NAC") filed an action for equitable contribution against Claremont Liability Insurance Company ("Claremont") arising out of payment by NAC and

Claremont toward settlement of an underlying action against their mutual insured, a general contractor, arising out of the defective construction of a home. Claremont issued CGL and umbrella policies to the insured. NAC contended that Claremont did not contribute its equitable share of the settlement.

At trial, the court found that NAC contributed less than its share and denied any recovery to NAC on its complaint. The trial court held that a "contractors warranty endorsement" in the Claremont policies applied and because the insured general contractor failed to comply with the endorsement, Claremont was not responsible for damages caused by independent contractors retained by the insured. NAC appealed the trial court's decision.

The court of appeal affirmed the trial court's judgment. The court noted that the Claremont contractors warranty endorsement provided that coverage afforded by the policy "shall not apply" to operations performed by independent contractors unless the insured (1) "has received a written agreement from each and every independent contractor holding the insured harmless from all liabilities incurred by the independent contractor" and (2) has obtained certificates of insurance from each and every independent contractor indicating that the independent contractor will maintain similar coverage as provided by this policy . . ." The court, citing *Scottsdale Ins. Co. v. Essex Ins. Co.*, 98 Cal. App. 4<sup>th</sup> 86 (2002), held that the contractors warranty endorsements were enforceable, conspicuous, plain and clear.

Additionally, the court held that the language of the endorsements in the Claremont policies, requiring the insured to obtain both a hold harmless agreement and a certificate of insurance from each independent contractor, represented conditions precedent to coverage, rather than exclusions to coverage.

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### *Assault and Battery by Insured is Not an “Accident” Within Meaning of Insuring Clause of Homeowner’s Insurance Policy*

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In *Delgado v. Interinsurance Exchange of the Automobile Club of Southern California*, 47 Cal. 4<sup>th</sup> 302 (2009), the Interinsurance Exchange of the Automobile Club of Southern California (“ACSC”) issued a homeowner’s insurance policy to its insured, who was sued by a third-party for two causes of action: (1) an intentional tort that the insured “in an unprovoked fashion and without any justification physically struck, battered and kicked” the third-party; and (2) and that the insured “negligently and unreasonably believed” he was engaging in self-defense” and unreasonably acted in self defense. The policy provided liability coverage for bodily injury caused by an “occurrence,” which was defined as “an accident . . . which, during the policy period, results in bodily injury . . .” The insured tendered the defense of the lawsuit to ACSC; ACSC denied coverage and refused to defend the insured.

The insured and the third-party plaintiff settled the action; the insured stipulated to the entry of judgment against him, and assigned his claims against ACSC to the third-party plaintiff. The third-party plaintiff then brought an action against ACSC.

The trial court sustained ACSC’s demurrer to the complaint without leave to amend. The California Court of Appeal reversed the decision, finding that allegations of harmful acts done with an unreasonable belief in self-defense describe “nonintentional tortious conduct” that potentially were an accident covered by the policy.

The Supreme Court of California reversed the decision of the California Court of Appeal. The court explained that an injury producing event is not an “accident” within the policy’s coverage language

when all of the acts, the manner in which they were done, and the objective accomplished occurred as intended by the actor. The court further explained that the insured’s assault and battery on the third-party plaintiff were done with the intent to cause injury; there was no allegation in the complaint that the acts themselves were merely shielding or the result of a reflex action.

Therefore, the injuries to the third-party plaintiff were not, as a matter of law, accidental, and consequently, there was no potential for coverage under the policy. Moreover, the court concluded that an insured’s unreasonable belief in the need for self-defense does not turn the resulting purposeful and intentional act of assault and battery into “an accident” within the policy’s coverage clause.

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### *Insurer is Not Required to Pay 100 Percent of Reasonable Repair Costs Incurred at Facility of Insured’s Choice*

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In *Maystruk v. Infinity Insurance Co.*, 175 Cal.App.4<sup>th</sup> 881 (2009), Infinity Insurance Company issued an “RSVP (Repair Satisfaction Vehicle Program) Physical Damage Only Policy” automobile insurance policy to Maystruk. The language of the policy provided two tiers of coverage: the policy would pay 100% of the reasonable repair costs if the insured used one of the RSVP repair shops, but would only pay 80% of the reasonable repair costs if the insured chose a shop not on the RSVP list.

Maystruk filed suit against Infinity alleging that the two tier coverage violated *Insurance Code* section 758.5(d)(2). This section prohibits an insurer from limiting or discounting “the reasonable repair costs based on charges that would have been incurred had the vehicle been repaired by the insurer’s chosen shop.” Infinity filed a

Demurrer to the Complaint on the basis that the policy language did not violate the statute. The Trial Court sustained the demurrer without leave to amend.

On appeal, Maystruk argued that the two-tiered coverage violated 758.5(d)(2) because it used coercive tactics to steer customers to particular body shops and that the stated legislative intent behind the statute was to prevent such a practice. The appellate court rejected this argument holding that the plain meaning of the statute does not require an insurer to pay 100% of the reasonable repair costs irrespective of the shop used. Rather, it only requires the insurer to pay 100% when the insured accepts the insurer's recommendation to take the vehicle to a specific repair facility. Further, as the operative pleading did not allege facts to support that the amount paid on repair at non-approved facilities was tied to the amount paid at approved facilities, the exact prohibition in the statute, the pleading was defective.

#### CLASS ACTIONS

### *Hawaii Deceptive Practices Act Does Not Require a Showing of Individualized Reliance; Class Certification Appropriate*

In *Yokoyama v. Midland Nat. Life Ins. Co.*, 2009 WL 2634770, plaintiffs, senior citizens who purchased indexed annuities from defendant, Midland National Life Insurance Company ("Midland"), brought a lawsuit against Midland alleging that the annuities were inherently deceptive, misleading, and fraudulent, in violation of Hawaii's Deceptive Practices Act. The lawsuit specifically targeted representations made in Midland's brochures, which promoted the annuities as appropriate for seniors.

The United States District Court for the District of Hawaii denied plaintiffs' request for class certification. The district court denied plaintiffs' request for class certification, holding that in order to succeed under Hawaii's Deceptive Practices Act, each plaintiff would have to show subjective, individualized reliance upon the deceptive practices within the circumstances of each plaintiff's purchase of an annuity. For this reason, the district court held that plaintiffs could not satisfy the requirements of Rule 23 of the Federal Rules of Civil Procedure that common issues predominate over individualized issues.

Plaintiffs appealed the district court's decision. The 9<sup>th</sup> Circuit Court of Appeal reversed and remanded the decision.

The central issue on appeal was whether Hawaii's Deceptive Practices Act required a showing of individualized reliance. Based on prior Hawaii case law, the court opined that the appropriate standard for determining the element of reliance under Hawaii's Deceptive Practice Act was an objective standard, *i.e.* "actual reliance" need not be established, rather the fact finder need only determine whether the alleged acts were capable of misleading a reasonable consumer. Based thereon, and as it pertained to the issue of class certification, the court ruled that the district court erred in denying class certification because there was no individualized issue of subjective reliance under Hawaii's Deceptive Practices Act. The court concluded that class issues predominated, and that a class action was a superior method to adjudicate the case, especially given that Hawaii's state courts have made it clear that Hawaii's consumer protection laws were flexible and could be enforced through the class action mechanism.

INSURANCE REGULATIONS

*Montana Insurance Commissioner's  
Practices Not Preempted By ERISA*

In *Standard Ins. Co. v. Morrison*, 2009 WL 3429501 (9<sup>th</sup> Cir. Mont.), the 9<sup>th</sup> Circuit held that the Insurance Commissioner of Montana's practice of disapproving discretionary clauses in an insurer's proposed disability insurance forms was not preempted by ERISA.

A state regulation required the commissioner to disapprove any insurance form that contained any "inconsistent, ambiguous, or misleading" clauses or exceptions that deceptively affect the risk to be assumed in the general coverage of the contract. The commissioner had interpreted this to require him to disapprove any insurance contract that contained a "discretionary" clause, which has been the commissioner's practice. The Insurance Commissioner of Montana denied an insurer's application for approval of its proposed disability insurance forms that contained discretionary clauses.

Under the Employee Retirement Income Security Act of 1974 (ERISA), insureds who believe that benefits have been wrongfully denied may sue in federal court. With certain exceptions, ERISA preempts state laws that relate to any covered employee benefit plan. (29 U.S.C. Section 1144(a)). ERISA's "savings clause" saves from preemption any state law which regulates insurance. (29 U.S.C. Section 1144(b)(2)(A)).

To fall within ERISA's savings clause, a regulation must satisfy a two-part test laid out by the

Supreme Court in *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 342 (2003): First, the state law must specifically be directed toward entities engaged in insurance; and Second, it must "substantially affect the risk pooling arrangement between the insurer and the insured."

The court determined that the commissioner's practice met the first "prong" of the two-pronged test for determining ERISA preemption. The practice was specific to the insurance industry even though it achieved some of the same ends as the common law rule that contracts are to be interpreted against their drafter, which is applied to a wide variety of contracts. The court noted that most contracts do not require approval by the state and discretionary clauses are an insurance specific problem that generally does not exist outside of insurance plants.

The court also determined that the commissioner's practice substantially affected the risk pooling arrangement - the spreading of losses over all risks to enable insurers to accept each risk. In this instance, by removing the benefit of a discretionary standard of review from insurers, it is likely the commissioner's practice will lead to a greater benefit of risk pooling for consumers. Therefore, the practice meets the second prong of the two-pronged test, which ensures that the regulation is targeted at insurance practices, not merely at insurance companies.

In concluding that the commissioner's practice does not impinge on ERISA's exclusive remedial scheme, the court observed that there is no additional remedy here provided, as insureds may only recover the value of the denied claim from their insurers. Further, the practice neither authorizes any form of relief in the state courts nor serves as an alternative enforcement mechanism outside of ERISA's enforcement provisions.

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