

# Daily Journal

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MONDAY, JANUARY 29, 2018

PERSPECTIVE

## Several big insurance decisions in 2017 for policyholders

By Rex Heeseman

Recent months have yielded decisions which will impact some aspects of insurance litigation. Set forth below are case summaries, with comments, of four of those decisions, which favor the policyholder.

**Tidwell Enterprises, Inc. v. Financial Pacific Insurance Co., 6 Cal. App. 5th 100 (2016).** Financial Pacific covered Tidwell from 2003 to 2010. During that time, Tidwell installed in Fox's home a fireplace, including a custom made "shroud." Months after expiration of that coverage, a fire damaged the home. After paying benefits, State Farm (Fox's then insurer) advised Tidwell the fireplace may have caused the fire. Tidwell tendered State Farm's potential claim to Financial Pacific, which received the report of State Farm's consultant indicating the shroud's installation precipitated the fire.

State Farm sued Tidwell for negligent installation of the fireplace. Financial Pacific declined the tender on the ground the fire happened after expiration of its coverage. Tidwell sued, arguing "construction of the fireplace and the continuous burning of fires therein create[d] the potential for continuous and repeated exposure to the same general harmful conditions."

The Court of Appeal held that, even though State Farm did not seek to recover damages directly from Tidwell, a potential for coverage existed "under the language of Financial Pacific's policies because the excessive heat in the chimney, for which Tidwell may have been responsible, might have caused physical injury to the wood framing the chimney case and that physical injury might have occurred during one or more [Financial Pacific's] policy periods.... which would be sufficient to trigger [such] coverage ...."

*Comment:* This decision goes "back in time" to find a potential for coverage and hence a duty to defend. How often will such an approach be successful? This decision, which also adds to the law of "what is accident?" was later analyzed in *Travelers Property Casualty Co. v. Actavis, Inc.*, 2017 DJAR 10578.

**Zubillaga v. Allstate Indemnity Co., 12 Cal. App. 5th 1017 (2017).** After settling with the other driver's insurer, Zubillaga sought underinsured motorist benefits, demanding the remainder of Allstate's \$35,000 policy limits. Allstate offered \$10,000. After Zubillaga pointed to her radiating back pain and likely need for an epidural injection, Allstate increased its offer to \$12,084.

Allstate retained an orthopedic surgeon, who opined that Zubillaga had no back pain or injection need. Relying on that opinion, Allstate declined to pay more. Zubillaga submitted further medical records, reflecting her receipt of an epidural injection, with the diagnosis of a need for future injections. Allstate increased its offer to \$14,500, but did not forward those records to the surgeon.

The claim proceeded to arbitration, with an award of all policy limits. Zubillaga sued Allstate. The trial judge granted Allstate's genuine dispute motion, mainly due to its reliance on the surgeon's opinions. The Court of Appeal reversed, emphasizing that, while Allstate was not obligated to accept Zubillaga's claimed need of epidural injections "without scrutiny or investigation," triable issues of fact existed regarding whether Allstate failed to adequately investigate by not forwarding Zubillaga's further medical records to the surgeon.

*Comment:* A "genuine dispute" opinion, focusing once more, if appropriate under the facts, on the insurer's duty of continuing to investigate and evaluate an insured's claim.

**Navigators Specialty Insurance Co. v. Moorefield Construction, 6 Cal. App. 5th 1258 (2016).** After issuance of Navigators' policies, Moorefield agreed to construct a building. Years later, the building's owner sued Moorefield and the developer about the flooring. The developer cross-complained for indemnity. Navigators accepted the tender of the complaint and the cross-complaint, subject to a reservation of rights.

The evidence indicated the most likely cause of the flooring's failure was installation of tiles on top of a concrete slab, which emitted excessive moisture. Moorefield knew of those emissions,

yet directed the flooring subcontractor to install anyway.

After paying its \$1 million limits, Navigators sued. The Court of Appeal found no "accident" because of Moorefield's deliberate decision; Navigators thus had no duty to indemnify. Still, Navigators owed a duty to defend due to the potential of coverage. Regarding indemnity, the court emphasized that, as the related damages were exactly \$377,404, Moorefield had to reimburse Navigators only for the portion of that \$1 million attributable to those damages.

*Comment:* Beyond issues related to deliberate conduct, this decision explores the relationship among the loss, the damages and the insurer's duties.

**Pulte Home Corp. v. American Safety Indemnity Co., 14 Cal. App. 5th 1086 (2017).** Pulte required its subcontractors to purchase liability insurance, with completed operations coverage, naming Pulte as an additional insured. American Safety issued policies to some of Pulte's subcontractors, with an endorsement (AIE) naming Pulte as an additional insured "but only with respect to liability arising out of 'your work' and only as respects ongoing operations performed by the Named Insured for the Additional Insured." Relying upon that language, American Safety denied the defense because the AIE deleted completed operations coverage for Pulte, an additional insured, even though retaining it for the named insured.

The trial judge concluded that American Safety breached its duty to defend, especially in light of the AIE's reference to "ongoing operations" which did not expressly exclude completed operations coverage. Pulte was thus entitled to recover its defense fees and costs. And, in unreasonably interpreting the AIE in light of contrary court decisions known to American Safety, it was also liable for bad faith. The judge awarded punitive damages in a one-to-one ratio to his award of *Brandt* fees.

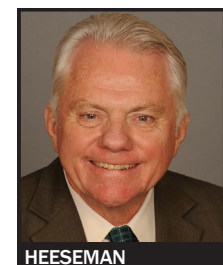
The Court of Appeal rejected American Safety's main coverage argument, as the "subject AIEs were issued during construction, while the subcontractors were still working on different phases of projects. Both sets of insureds could

reasonably have expected that if the contactors had bought completed operations coverage for the work, it also applied to vicarious liability" of Pulte. If American Safety intended to exclude completed operations coverage for that additional insured, it needed to expressly say so.

Substantial evidence, the Court of Appeal continued, supported the finding of bad faith and award of punitive damages. But the trial judge erred in calculating the *Brandt* fees. The insured bears the burden of demonstrating the apportionment of legal work attributable to the contract and the tort claims; in the case of a contingency fee arrangement, the trier of fact must determine the percentage of legal fees for each such claim. Here, after the trial, Pulte changed that arrangement to an hourly fee. Yet, because of the exposure American Safety faced during trial, the arrangement "in effect during trial should have controlled over the recent changes to it." The trial judge thus had to recalculate the amount of the *Brandt* fees and the punitive damages.

*Comment:* An interesting precedence in cases where the insurer knew or should have known about the "weakness" of its policy construction assertions. Moreover, this decision gives further guidance on the manner in which to prove *Brandt* fees.

**Rex Heeseman left the Los Angeles County Superior Court bench in August 2015. He has addressed arbitrations and mediations, as well as special master and reference matters, at JAMS in Los Angeles, rheseman@jamsadr.com. He co-authors TRG's practice guide on "Insurance Litigation," and, for 12 years, taught a class on "California Business Torts" and on "Insurance Law" at Loyola Law School.**



HEESEMAN