SUPREME COURT: There were no new insurance cases accepted for review or decided by the California Supreme Court.

COURT OF APPEAL: The California Court of Appeal recently published the following decisions that may be of interest to attorneys practicing insurance law:

1. Where plaintiffs sue a health maintenance organization (HMO) for common law torts based on the theory that the contractual structure through which the HMO arranged medical services gave medical care providers an undue financial incentive to deny medically reasonable services, but plaintiffs did not dispute any adverse determination of Medicare benefits or seek payment or reimbursement of Medicare claims, the Medicare Act does not preempt the lawsuit and plaintiffs were not required to exhaust administrative remedies before filing suit. (Cotton v. Starcare Medical Group, Inc. (Mar. 30, 2010, G040920, G041809) __Cal.App.4th__ [2010 WL 1213139] [Fourth Dist., Div. Three].) Plaintiffs sued health maintenance organization for negligence, breach of fiduciary duty, bad faith, and fraudulent concealment, primarily based on a theory that the contractual structure through which defendant arranged to provide medical services gave medical care providers an undue financial incentive to deny medically reasonable services. The district court sustained defendant’s demurrer, on the basis that plaintiffs’ claims were preempted by federal law.

The Court of Appeal reversed, holding that only plaintiffs’ constructive fraud claim, based on the physician incentive plan, was preempted. Because plaintiffs might have been able to prove some or all of their causes of action without regard, or only incidentally, to Medicare coverage determinations, and none of causes of action sought payment or reimbursement of a Medicare claim or fell within the Medicare administrative review process, the claims were not preempted. With regard to those claims, plaintiffs were not required to exhaust their administrative remedies provided by the Medicare Act because the harm that plaintiffs allegedly suffered was not remediable within the administrative process. The court explained that Congress intended Medicare Act to preempt only “positive state enactments”—laws and administrative regulations, not the common law.

2. “Step-down” provision reducing 100/300 liability limits in automobile policy to the minimum 15/30 coverage for permissive users is enforceable where the policy contained multiple emphasized references to coverage limitations. (Dominguez v. Financial Indemnity Co. (Mar. 30, 2010, A125133) __Cal.App.4th__ [2010 WL 1208459] [First Dist., Div. Five].)


4. The mere fact that insurer defended insured under one policy did not necessarily insulate it from liability for allegedly breaching its duty to defend and settle under a second policy, where this potentially increased the insured’s exposure to personal liability. (Risely v. Interinsurance Exch. of the Automobile Club [Mar. 26, 2010, D054866] __Cal.App.4th__ [2010 WL 1135780] [Fourth Dist., Div. One].) Risely was a passenger in the insured’s automobile. Following an auto accident, she sued the insured for negligence and false imprisonment (and other claims), alleging inter alia that the insured failed to heed her demands to take her home and instead wrongfully held her against her will, causing her to suffer severe, debilitating injuries. The insured tendered his defense to Auto Club, under both his auto policy (which had liability limits of $50,000) and his homeowners’ policy (which had liability limits of $300,000). Auto Club agreed to defend the insured against all of Risely’s claims under the auto policy, but
declined to defend him under the homeowner’s policy and declined Risely’s offer to settle her lawsuit for the $300,000.

The insured then agreed to entry of a $434,000 stipulated judgment and assigned his rights against the Auto Club to Risely. Risely sued Auto Club for breach of contract, insurance bad faith, and as a judgment creditor under Insurance Code section 11580. The trial court granted Auto Club’s motion for summary judgment, ruling that its refusal to defend under the homeowner’s policy was of “no consequence” because it was providing the insured with a full defense against all claims under the auto policy.

The Court of Appeal reversed, holding that the fact an insurer provided its insured with a defense under one policy does not necessarily insulate it from liability for its alleged breach of the duty to defend and settle under a second policy where the refusal to defend exposes the insured to increased personal liability. The court explained, “To the extent that the homeowner’s policy provided indemnity coverage for Risely’s false imprisonment claim, Auto Club’s alleged wrongful failure to defend under that policy denied [the insured] his right to have Auto Club accept a reasonable settlement demand of the claim within the policy limits of the homeowner’s policy.” However, the court declined to reach “the more difficult question of whether Risely can establish that [the insured] suffered damages from Auto Club’s alleged breach of the duty to defend even if the homeowner’s policy does not provide indemnity coverage for Risely’s false imprisonment claim.”

5. Trial court abuses its discretion by granting insurer’s petition to compel binding arbitration of an alleged Cumis fee dispute under Civil Code section 2860, subdivision (c), in a breach of contract and bad faith action arising from the insurer’s alleged failure to promptly acknowledge its duty to pay Cumis counsel to defend the insured in an underlying action. (Intergulf Development v. Superior Court (Interstate Fire & Cas. Co.) (Mar. 24, 2010, D055459) __ Cal.App.4th __ [2010 WL 1052745] [Fourth Dist., Div. One].)

6. A stay must be issued when an insurer seeks declaratory relief that it has no duty to defend an insured in underlying lawsuit, and the insured would be required to marshal evidence that established liability in the underlying actions. (United Enterprises, Inc. v. Superior Court of San Diego County (Mar. 24, 2010, D055879) __ Cal.App.4th __ [2010 WL 1076134] [Fourth Dist., Div. One].)

Insurer filed a complaint for declaratory relief, alleging that it had no duty to defend insured in an underlying environmental contamination action under the terms of the insurance policy, moving for summary judgment. Insured sought a stay of further proceedings, arguing that it would be required to marshal evidence establishing its liability in the underlying environmental contamination action in order to oppose the insurers’ summary judgment motion in the declaratory relief action. The trial court denied the stay, but sealed the record relating to the motion for summary judgment. The insured petitioned for a writ of mandate.

The Court of Appeal granted writ relief, explaining that the insurer’s motion for summary judgment was “putting the insured in the position to prove some of the things that they are actually trying to defend themselves from.” The court concluded that, because a stay was required in these circumstances, it did not need to decide whether the trial court abused its discretion by sealing the record.

7. Where insured’s policy covering the insured’s suspended business operations stated that insurer would pay insured the “Net Income (Net Profit or Loss before income taxes) that would have been earned or incurred if no physical loss or damage had occurred . . . and . . . [c]ontinuing normal operating expenses incurred, including payroll,” insured was entitled to be paid under both provisions without offsetting the two amounts in the event operating expenses exceeded net income. (Amerigraphics, Inc. v. Mercury Cas. Co., 182 Cal.App.4th 1538[Second Dist., Div. Two].)

8. Insurer who rescinded insureds’ healthcare coverage was not entitled to summary judgment in insurer’s lawsuit for breach of contract, bad faith, and violation of Business and Professions Code section 17200, because the insurer failed to establish as a matter of law that: (1) it made reasonable efforts to ensure the insureds’ application was accurate and complete, or (2) the insureds willfully misrepresented
Insureds, a married couple who spoke little English, secured health coverage through an independent agent who completed their application for them, but omitted required information that the wife was undergoing in vitro fertilization treatment. Eight months later, the wife gave birth to premature twins, who required about $1 million in healthcare services over the next 10 months. The insurer determined that the insureds' application contained material misrepresentations and rescinded the policy on that ground. The insureds sued the insurer for breach of contract, bad faith, and violation of Business and Professions Code section 17200. The trial court granted the insurer's motion for summary judgment.

The Court of Appeal reversed, following the analysis in *Hailey v California Physicians' Service* (2007) 158 Cal.App.4th 452 (Hailey). Under Hailey, a health care service plan may only rescind a plan contract on the basis of material representations if one of the two conditions are met: (1) the plan completed medical underwriting, including "reasonable efforts to ensure a potential subscriber’s application is accurate and complete," before issuing the plan contract, or (2) the subscribers willfully made material misrepresentations in their application.

The Court of Appeal held that the insurer's summary judgment papers failed to establish either of these conditions as a matter of law. First, the insurer failed to establish that, as a matter of law, it made reasonable efforts to ensure that the insureds' application was accurate and complete because, prior to approving the application, the insurer merely made sure there were no blanks in the application and checked its own database for prior applications, membership, or claims history for the same insureds, but failed to take steps to confirm the accuracy of the information in the application.

Second, the insurer did not establish as a matter of law that the insureds willfully misrepresented or omitted material information in their application. Insureds had weak English language skills and relied on an insurance broker to assist them in completing the applications. Based on the record, the insurer was not entitled to summary judgment because a reasonable jury could find that the insureds had honestly trusted an insurance professional to accurately complete the application.


9. When an insurer provides an insured a defense under a reservation of rights, and the insured subsequently reaches a private settlement with the third party claimant without the insurer's participation, the insurer may intervene in the underlying action brought by the claimant to protect its own interests—including the right to seek a set-off of the judgment against the insured based on the claimant's prior settlement with a former co-defendant. (*Gray v. Begley* (2010) 182 Cal.App.4th 1509 [Second Dist., Div. Three].)

Gray sued Begley and Begley's employer Granite for injuries suffered in an auto accident. CNA (Granite's primary insurer) and Westchester (Granite's excess insurer) paid $8 million to settle Gray's claim against Granite. Gray's case against Begley proceeded to trial, where CNA defended him under a reservation of rights. The jury awarded Grey $4.5 million. The court entered judgment on the verdict. Begley filed a motion to vacate the judgment to afford the court an opportunity to hear a motion to set-off the amount of the prior settlement with Granite. Before the motion could be heard, Gray and Begley reached a private agreement, without CNA's participation, in which Begley agreed to withdraw his motion to vacate in exchange for Gray's covenant not to execute on the judgment against Begley.

CNA filed a motion to intervene and join in Begley's motion to vacate the judgment, as the real party in interest. The trial court granted CNA's motion to intervene. Since Begley had already withdrawn his motion to vacate the judgment, CNA filed motions to vacate the judgment and determine the setoff amount. Although CNA's jurisdictional deadline to appeal from the $4.5 million judgment was about to
lapse, the trial court denied CNA’s motion to vacate on the ground it did not have sufficient evidence before it to justify vacating the judgment.

CNA appealed from the judgment and from the denial of its motion to vacate the judgment. The Court of Appeal held that the trial court did not abuse its discretion in allowing CNA to intervene. “[A]n insurer providing a defense, even though subject to a reservation of rights, may intervene in the action when the insured attempts to settle the case to the potential detriment of the insurer. In contrast to the insurer that refuses to defend, an insurer providing a defense under a reservation of rights has not ‘lost its right to control the litigation,’ [citations] and therefore retains a direct interest in the case.” CNA’s request for intervention was simply an attempt to pursue its defense—including a motion for set-off—after Begley chose to no longer comply with CNA’s chosen strategy.

The Court of Appeal also held that CNA had standing to appeal. When its motion to intervene was granted, it became a party. When the trial court denied its motion to vacate and thus precluded a hearing on its motion for setoff, CNA was aggrieved.

Finally, the Court of Appeal held that CNA had a right to a hearing on its motion for set-off. The trial court erroneously entered judgment while Begley’s original motion for setoff was pending, and should have vacated the judgment to permit CNA’s setoff motion to be heard. CNA’s motion for setoff raised factual issues that had to be resolved by the trial court in the first instance.

NINTH CIRCUIT: The Ninth Circuit Court of Appeals recently published the following decision that may be of interest to attorneys practicing insurance law:

1. Insurer who is obligated to defend insured against advertising injury claims must defend the insured against a claim that it misappropriated a third party’s patented marketing methods or marketing systems because the patent infringement claim was causally connected to the insured’s advertisements. (Hyundai Motor America v. Nat. Union Fire Ins. Co. of Pittsburgh (9th Cir., Apr. 5, 2010, No. 08-56527) __ F.3d __ [2010 WL 1268234].)

After Hyundai Motor America placed a “build your own vehicle” feature on its website, a third party sued Hyundai for patent infringement. Hyundai tendered its defense to its liability insurer under its advertising injury coverage, but the insurer declined the tender. Hyundai defended itself, then sued its insurer to recover its defense costs. The district court granted summary judgment to insurer on the ground the patent infringement action was not an “advertising injury” under the terms of the insurance policy.

The Ninth Circuit reversed, holding that the patent infringement suit constituted a “misappropriation of advertising ideas” within the meaning of the insurance policy, triggering the insurer’s duty to defend. A causal connection existed because the advertising itself constituted the injurious use of the patented method. Here, the patented “build your own vehicle” feature was itself an infringement of the patent, and it was that use that caused the injuries alleged by the third party.