Be an insurance Myth Buster!

Three myths – or soon to be myths – of insurance law in California

By Jeffrey I. Ehrlich

One definition of *myth* is a "widely held but false belief or idea." In this article I outline three widely followed insurance-related rules developed by the Court of Appeal that I think meet this definition of "myth." The view that two of these rules qualified as "myths" has so far been borne out by the California Supreme Court's rejection of those rules. It is perhaps too soon to call the third one a myth, since it has not yet been "busted," but it is currently under consideration by the California Supreme Court.

Busted Myth #1: An insurer's breach of its common-law duties cannot support a claim under the UCL

In *State Farm Fire & Casualty Co. v. Superior Court* (*Allegro*) (1996) 45 Cal.App.4th 1093, 1108, 53 Cal.Rptr.2d 229, 237, Division 3 of the Second Appellate District held that common-law claims for insurance bad faith or fraud would provide a predicate for a claim against an insurer under the unfair competition law (UCL), Business & Professions Code § 17200, et seq. But in *Textron Financial Corp. v. National Union Fire Ins. Co. of Pittsburgh* (2004) 118 Cal.App.4th 1061, 1071, 13 Cal.Rptr.3d 586, 594, Division 3 of the Fourth Appellate District held that *Allegro* had been abrogated by the California Supreme Court's decision in *Cel-Tech Communications, Inc. v. Los Angeles Cellular Telephone Co*. (1999) 20 Cal.4th 163, 83 Cal.Rptr.2d 548, and that common-law duties could not support a UCL claim.

This was a myth, since the *Cel-Tech* Court expressly stated that its opinion dealt only with UCL actions between business competitors, and that "Nothing we say relates to actions by consumers or by competitors alleging other kinds of violations of the unfair competition law such as 'fraudulent' or 'unlawful' business practices or 'unfair, deceptive, untrue or misleading advertising.'" (*Cel-Tech*, 20 Cal.4th at p. 187, n. 12.)

The myth was busted nine years after *Textron* was decided, by the decision in *Zhang v. Superior Court* (2013) 57 Cal.4th 364, 378, 159 Cal.Rptr.3d 672, which noted that *Textron* created a split of authority when it declined to follow *Allegro*. The Supreme Court resolved the split in favor of the *Allegro* approach, explaining that, "bad-faith insurance practices may qualify as any of the three statutory forms of unfair competition. [Citation omitted.] They are unlawful; the insurer's obligation to act fairly and in good faith to meet its contractual responsibilities is imposed by the common law, as well as by statute. [Citations omitted.] They are unfair to the insured; unfairness lies at the heart of a bad-faith cause of action. [Citation and footnote omitted.] They may also qualify as fraudulent business practices." (*Zhang*, 57 Cal.4th at p. 380.)

Busted Myth #2: A trial court's post-trial award of *Brandt* fees cannot be included in the due-process ratio of compensatory-to-punitive damages

In *Brandt v. Superior Court* (1985) 37 Cal.3d 813, 817, 210 Cal.Rptr. 211, the Supreme Court held that a successful policyholder plaintiff in an insurance bad-faith case could recover, as an element of its tort damages for bad faith, the attorney's fees incurred in obtaining the policy benefits that had been wrongfully withheld by the insurer. The *Brandt* Court explained that the preferred manner of awarding these fees would be via a post-trial award by the trial court. (*Id*., 37 Cal.3d at p. 819-820.) But because they represented an item of damages, the parties would have to stipulate to this procedure. (*Id*.) If they did not, then the plaintiff would have to prove the *Brandt* fees as part of the case in chief, just like any other disputed element of damages. (*Ibid*.)

In *BMW of North America, Inc. v. Gore* (1996) 517 U.S. 559, 568, 116 S.Ct. 1589, and *State Farm Mut. Automobile Ins. Co. v. Campbell* (2003) 538 U.S. 408, 426, 123 S.Ct. 1513, the U.S. Supreme Court held that the due process clause prohibited grossly excessive awards of punitive damages, and that one aspect of the due process inquiry into whether such an award was grossly excessive involved a comparison of the amount of compensatory damages awarded to the punitive-damage award. "Absent special justification, ratios of punitive damages to compensatory damages that greatly exceed 9 or 10 to 1 are presumed to be excessive and therefore unconstitutional. (*Simon v. San Paolo U.S. Holding Co., Inc.* (2005) 35 Cal.4th 1159, 1182, 29 Cal.Rptr.3d 379.)

Since *Brandt* fees are an element of the plaintiff's damages in a bad-faith case, it makes sense that they should be included in the ratio between compensatory and punitive damages. And in *Major v. Western Home Ins. Co.* (2009) 169 Cal.App.4th 1197, 1224, 87 Cal.Rptr.3d 556, the court confirmed this logical proposition. In *Major*, the *Brandt* fees had been awarded by the jury, not by the trial court in post-trial proceedings.

In *Amerigraphics, Inc. v. Mercury Casualty Co.* (2010) 182 Cal.App.4th 1538, 1565, 107 Cal.Rptr.3d 307, a case where

the trial court awarded the *Brandt* fees post trial, the appellate court refused to include the *Brandt*-fee award in the ratio, concluding, "the trial court properly excluded the amount of *Brandt* fees in determining the compensatory damages award, since the *Brandt* fees were awarded by the court after the jury had already returned its verdict on the punitive damages." (*Ibid*.) No further citation to authority or rationale for this holding was provided, but it became the rule in bad-faith cases.

In *Nickerson v. Stonebridge Life Insurance Company* (2013) 219 Cal.App.4th 188, 215, 161 Cal.Rptr.3d 629, 650, *review granted and opinion superseded sub nom. Nickerson v. Stonebridge Life Ins.* (Cal. 2013) 165 Cal.Rptr.3d 61, and *rev'd* (2016) 63 Cal.4th 363, 203 Cal.Rptr.3d 23, the Court of Appeal followed *Amerigraphics* and refused to include a court-determined *Brandt*-fee award in the punitive-damages ratio. Hence, the rule became that *Brandt* fees would be included in the punitive-damage ratio only when they had been awarded by the jury.

This was a myth because, for the purposes of reviewing the constitutionality of a punitive-damage award, there is no basis to distinguish between whether a *Brandt*-fee award was made by the jury or the trial court. This myth was busted by the California Supreme Court in *Nickerson v. Stonebridge Life Ins. Co.* (2016) 63 Cal.4th 363, 370, 203 Cal.Rptr.3d 23, 28, which disapproved *Amerigraphics* on this point.

Myth #3 (hopefully on the verge of being busted): For the purposes of coverage, an "accident" cannot include the unexpected consequences of the insured's deliberate acts

Almost all liability coverage sold in California extends only to bodily injury or property damage caused by an *occurrence*, which the policies define as an *accident*. In *Delgado v. Interinsurance Exchange of Automobile Club of Southern California* (2009) 47 Cal.4th 302, 308, 97 Cal.Rptr.3d 298, the Supreme Court explained that, "In the context of liability insurance, an accident is an unexpected, unforeseen, or undesigned happening *or consequence* from either a known or an unknown cause." (Emphasis added and internal quotation marks omitted.) Absent a different definition stated in the policy, this common-law definition of *accident* is read into all liability policies in California. (*Ibid*.)

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A *consequence* is "a result that follows as an effect of something that came before." (Black's Law Dictionary (10th Ed., 2014.) Accordingly, the definition of *accident* would seem to include the unexpected *consequences* of the insured's deliberate acts. In fact, the California Supreme Court's decisions in both first-party and third-party cases confirm that it does.

For example, in *Richards v. Travelers' Ins. Co.* (1891) 89 Cal. 170, 175, a first-party case, the Court approved the use of a jury instruction telling the jury that the insured's death from a head injury could be considered an accident if the person who struck the blow had not intended it to be fatal. In *Rock v. Travelers' Ins. Co. of Hartford, Conn.* (1916) 172 Cal. 462, 465, the Court stated that deliberate acts could produce "unforeseen consequences" that would produce "what is commonly called accidental death." Likewise, in *Olinsky v. Railway Mail Ass'n* (1920) 182 Cal. 669, 672-673, the Court explained that "[w]here the death is the result of some act, but was not designed and not anticipated by the deceased, though it be in consequence of some act voluntarily done by him, it is accidental death."

The Court has used the same approach in third-party cases. In *Geddes & Smith, Inc. v. St. Paul-Mercury Indem. Co.* (1959) 51 Cal.2d 558, 334 P.2d 881, the Court held that the unexpected

consequences of the insured's sale of defective doors – property damage to the houses in which the doors were installed – qualified as an accident. Similarly, in *Hogan v. Midland National Ins. Co.* (1970) 3 Cal.3d 553, the Court held that the inadvertent cutting of boards below their specified thickness qualified as an *accident*.

This is not to say that *all* unexpected consequences from any act that an insured might commit qualify as an accident. *Hogan* held that claims related to lumber that had been deliberately sawn too wide were not covered because the overcutting was "calculated and deliberate" and therefore not an accident. (*Id*., 3 Cal.3d at pp. 559-560.) Likewise, the consequences of "acts done with intent to cause injury" cannot be viewed as the product of an accident, as a matter of law. (*Delgado*, 47 Cal.4th at pp. 311-312.) And regardless of intent, some acts, such as sexual misconduct, are deemed inherently harmful and therefore uninsurable. (See, e.g., *J. C. Penney Casualty Ins. Co. v. M. K.* (1991) 52 Cal.3d 1009, 1026, 278 Cal.Rptr. 64 ["Some acts are so inherently harmful that the intent to commit the act and the intent to harm are one and the same. The act is the harm."])

Based upon what I have told you so far, you might think that the law in this area is fairly clear. And it is, as long as you only read decisions by the California Supreme Court. The picture becomes far murkier, however, once you start reading decisions by the California Court of Appeal, which has developed an entirely different approach to what qualifies as an *accident*, and hence what constitutes an *occurrence* that triggers coverage under a liability policy. The prevailing view in the Court of Appeal, which the Ninth Circuit has adopted, holds that the term *accident* "refers to the nature of the insured's conduct, and not to its unintended consequences." (*Albert v. Mid-Century Insurance Company* (2015) 236 Cal.App.4th 1281, 1291, 187 Cal.Rptr.3d 211.) In other words, if the insured does something on purpose, and is then sued as a result of the consequences of that deliberate act, there is no potential coverage for the claim because the unintended and unexpected consequences of that deliberate act do not constitute an *accident*.

This approach effectively functions as an all-purpose exclusion in liability policies, which has allowed insurers to avoid defending or indemnifying insureds in a wide variety of contexts. These include claims against a homeowner based on negligently trimming trees (*Alpert*, 236 Cal.App.4th at p. 1291); claims against a homeowner for building a structure that mistakenly encroached on a neighbor's lot (*Fire Ins. Exchange v. Superior Court* (2010) 181 Cal.App.4th 388, 104 Cal.Rptr.3d 534); claims against the insured who, during "horseplay," negligently struck his friend and caused injury (*State Farm General Ins. Co. v. Frake* (2011) 197 Cal.App.4th 568, 581, 128 Cal.Rptr.3d 301); claims against the insured for negligently failing to rescue the victim from a sexual assault (*Gonzalez v. Fire Insurance Exchange* (2015) 234 Cal.App.4th 1220, 1234, 184 Cal.Rptr.3d 1220); claims based on an MRI machine's failure to restart after being "ramped down" (*MRI Healthcare Center of Glendale, Inc. v. State Farm General Ins. Co.* (2010) 187 Cal.App.4th 766, 781 115 Cal.Rptr.3d 27); and damages resulting from wrongful termination (*Commercial Union Ins. Co. v. Superior Court* (1987) 196 Cal.App.3d 1205, 242 Cal.Rptr. 454). In each of these cases the appellate court held that there was no potential for coverage because the insured's conduct that generated the claim was deliberate, and it was therefore irrelevant if the consequences of that conduct were unexpected.

The most influential appellate opinion on this subject is *Merced Mutual Ins. Co. v. Mendez* (1989) 213 Cal.App.3d 41, 50 ("*Merced*"), which holds that the relevant inquiry focuses on whether the insured's *acts* are "unforeseen, involuntary, [and] unexpected;" not on whether the consequences of those acts are unexpected. The key passage in *Merced* says

> We reject appellants' argument that in construing the term "accident," chance or foreseeability should be applied to the resulting injury rather than to the acts causing the injury. In terms of fortuity and/or foreseeability, both "the *means* as well as the result must be unforeseen, involuntary, unexpected and unusual." (*Unigard Mut. Ins. Co. v. Argonaut Insurance Co.* (1978) 20 Wash.App. 261, 579 P.2d 1015, 1018, fn. omitted, emphasis added.)
>
> We agree coverage is not always precluded merely because the insured acted intentionally and the victim was injured. An accident, however, is never present when the insured performs a deliberate act unless some additional, unexpected, independent, and unforeseen happening occurs that produces the damage. (*Ibid.*)

This analysis of *accident* has become the template used in the California and federal courts, having been cited directly in at least 66 cases and having indirectly influenced many more. The ultimate finding of no coverage in *Merced* certainly seems correct, since the insured's claim was essentially that he had been unaware that his sexual battery of the woman suing him had been unwelcome.

Given the wide acceptance of the *Merced* analysis, and the fact that the case was correctly decided, how can it be viewed as a "myth?" There are two reasons. First, its analysis is inconsistent with 125 years of California Supreme Court precedent, as explained above. Second, the analysis is the product of a mistake, which can be plainly identified with a little sleuthing.

Look back at the passage from *Merced* cited above. You will see that its explanation of what constitutes an *accident* is drawn from a decision by the Washington Court of Appeal in *Unigard Mut. Ins. Co. v. Argonaut Insurance Co.* (1978) 20 Wash.App. 261, 579 P.2d 1015. The *Merced* court cited *Unigard* accurately; that is, *Unigard* says exactly what the *Merced* court cited it for. The problem is that the cases on which the *Unigard* court relied when it articulated the legal propositions that the *Merced* court cited did not involve insurance policies that provided

coverage for losses caused by an *accident*. Instead, the *Unigard* court mistakenly relied on the rules that govern a different, more limited type of insurance coverage, called "accidental means."

The distinguishing feature of "accidental means" coverage is that it does not cover the unintended consequences resulting from the insured's deliberate acts. This is why the insurance industry created it in the first instance – to provide coverage that was more limited than policies that cover losses resulting from accidents. (*Weil v. Federal Kemper Life Assurance Co.* (1994) 7 Cal.4th 125, 135 n. 7, 27 Cal.Rptr.2d 316 ("*Weil*").)

In light of the differences between the two types of coverage, the California Supreme Court has consistently and scrupulously rejected attempts by insurers and policyholders alike to apply "accidental means" rules to policies that cover accidents, and vice versa. (See, e.g., *Fidelity & Cas. Co. of New York v. Industrial Acc. Commission of Cal*. (1918) 177 Cal. 614, 616 [refusing to construe the term *accident* in worker's compensation statute as though it said "accidental means"]; *Weil*, 7 Cal.4th at p. 139 [refusing to construe policy limited to death resulting from "accidental means" as if it covered death caused by an "accident"].)

Weil clearly illustrates the difference between the two types of coverage. The insured in that case deliberately ingested cocaine and inadvertently died from an overdose. The policy beneficiaries argued that the death was plainly an accident – something that the insured had not expected or intended – and urged the Court to apply its precedents defining an *accident* to find coverage. The Supreme Court did not dispute that the insured's death was an accident. The problem was, the policy in *Weil* did not promise coverage for death caused by an "accident;" it covered death resulting from "accidental means." The Court expressly declined to abandon the distinction between the two types of policies, stating:

> Unless the limitation of coverage of 'accidental means' policies to a narrower class of cases than is covered by 'accidental death' insurance would violate a particular statute or other express public policy, it is not our proper role to mandate that the two types of policies be interpreted as coextensive. By repudiating the distinction, the court in effect would be ignoring the fact that the policy does employ the word 'means.' (*Id*., 7 Cal.4th at p. 139.)

Now, look back again at the passage from *Merced* cited above, and particularly at the statement, "both the *means* as well as the result must be unforeseen, involuntary, unexpected and unusual." This is the definition of "accidental means." Likewise, the statement in *Merced* that "[a]n accident . . . is never present when the insured performs a deliberate act unless some additional, unexpected, independent, and unforeseen happening occurs that produces the damage" is inaccurate, because it describes the test for what constitutes "accidental means." This becomes clear if you read the cases that the *Unigard* court cites in support of these propositions.

In short, the *Unigard* court erroneously transposed the definitions of *accident* and "accidental means." The *Merced* opinion then unwittingly transplanted that error into California law, where it quickly took root and spread throughout the Court of Appeal and into the Ninth Circuit.

Happily, the prospects for correction of the error seem good. The California Supreme Court accepted review in response to the Ninth Circuit's certified question in *Liberty Surplus Ins. Corp. v. Ledesma and Meyer Construction Co*., No. 2236765. The issue for review is "Whether there is an 'occurrence' under an employer's commercial general liability policy when an injured third party brings claims against the employer for the negligent hiring, retention, and supervision of the employee who intentionally injured the third party." Since CGL policies define *occurrence* as an "accident," it is likely that the Court will bring some clarity to this issue. (Full disclosure – the author represents the insured in *Ledesma*, and has raised the issues described above in the briefing. In response, the insurer has not argued that the unexpected consequences of the insured's negligent conduct cannot be an accident; it has staked its defense on causation.)

Conclusion – It's your turn to bust a myth

Once an appellate court announces a rule, stare decisis makes it difficult to convince other courts that the rule is flawed and should not be followed. Hence, it can take years, and multiple attempts to bust a myth. But the Supreme Court's decisions in *Zhang* and *Nickerson* show that it is possible.

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