Annual Life, Health & Disability Law Report

Developments in Life, Health & Disability Case Law 2009

FOCUS: California

A summary prepared by Gordon & Rees LLP of the holdings, alphabetized by topic, of the cases published in 2009 by California state and federal courts, and select other courts, which address the rights and duties of the life, health & disability industry.

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DEVELOPMENTS IN CALIFORNIA CASE LAW 2009: LIFE, HEALTH & DISABILITY INSURANCE

March 2010

Abstention

A trial court's decision to abstain is reviewed under an abuse of discretion standard. *Blue Cross of California, Inc. v. Super. Ct.*, 180 Cal.App.4th 1237 (2009).

A court may abstain from adjudicating an action that seeks equitable remedies if granting the requested relief would require a trial court to assume the functions of an administrative agency, or to interfere with the functions of an administrative agency. *Blue Cross of California, Inc. v. Super. Ct.*, 180 Cal.App.4th 1237 (2009).

A court may abstain from adjudicating a suit that seeks equitable remedies if the lawsuit involves determining complex economic policy, which is best handled by the Legislature or an administrative agency. *Blue Cross of California, Inc. v. Super. Ct.*, 180 Cal.App.4th 1237 (2009).

A court may abstain from adjudicating a suit that seeks equitable remedies if granting injunctive relief would be unnecessarily burdensome for the trial court to monitor and enforce given the availability of more effective means of redress. *Blue Cross of California, Inc. v. Super. Ct.*, 180 Cal.App.4th 1237 (2009).

Among the principles applied in determining the enforcement of an arbitration agreement by or against non-signatories are: incorporation by reference; assumption; agency; veil-piercing/alter ego; and estoppel. *Mundi v. Union Sec. Life Ins. Co.*, 555 F.3d 1042 (9th Cir. 2009).

Appeals & Writs: Notice of Appeal

Rules of Court, Rule 8.100(a)(1) requires a party to properly file a notice of appeal if a specific claim for appeal is to be considered. *Bosetti v. U.S. Life Ins. Co.*, 175 Cal.App.4th 1208 (2009).

Appeals & Writs: Standard of Review

The denial of a motion to compel arbitration is reviewed de novo. *Mundi v. Union Sec. Life Ins. Co.*, 555 F.3d 1042 (9th Cir. 2009).

The existence of subject matter jurisdiction is a question of law that is reviewed *de novo*. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941 (9th Circuit 2009).

A trial court's decision to not refer a claim to an administrative agency under doctrine of primary jurisdiction is reviewed under an abuse of discretion standard. *Blue Cross of California, Inc. v. Super. Ct.*, 180 Cal.App.4th 1237 (2009).

A trial court's decision to abstain is reviewed under an abuse of discretion standard. *Blue Cross of California, Inc. v. Super. Ct.*, 180 Cal.App.4th 1237 (2009).

Discretion is abused whenever, in its exercise, the court exceeds the bounds of reason, all of the circumstances before it being considered. *Blue Cross of California, Inc. v. Super. Ct.*, 180 Cal.App.4th 1237 (2009).

The burden is on the party complaining to establish an abuse of discretion, and unless a clear case of abuse is shown and unless there has been a miscarriage of justice a reviewing court will not substitute its opinion and thereby divest the trial court of its discretionary power. *Blue Cross of California, Inc. v. Super. Ct.*, 180 Cal.App.4th 1237 (2009).

The Ninth Circuit Court of Appeals reviews "the district court's interpretation of an ERISA plan *de novo* and that court's factual findings for clear error." *Dupree v. Holman Prof'l. Counseling Ctrs*., 572 F.3d 1094 (9th Cir. 2009).

The appellate court reviews questions of statutory construction, such as the proper construction of the Healthcare Lien Act, independently. *Weston Reid, LLC v. American Ins. Group, Inc.*, 174 Cal.App.4th 940 (2009).

The Court of Appeals reviews *de novo* a district court's "choice and application" of the appropriate standard for reviewing benefits decisions made by an ERISA plan administrator. *Sznewajs v. U.S. Bancorp Amended & Restated Supplemental Benefits Plan*, 572 F.3d 727 (9th Cir. 2009).

Arbitration

Ninth Circuit affirms district court's denial of insurer's motion to compel arbitration on the grounds that: (1) insurer was not a party to the arbitration agreement; and (2) equitable estoppel was inapplicable where the insurance policy was not intertwined with the contract providing for arbitration and the contract providing for arbitration did not mention or incorporate by reference the insurance policy. *Mundi v. Union Sec. Life Ins. Co.*, 555 F.3d 1042 (9th Cir. 2009).

In determining whether parties have agreed to arbitrate a dispute, Ninth Circuit applies general state law principles of contract interpretation, while giving due regard to the federal policy in favor of arbitration by resolving ambiguities as to the scope of arbitration in favor of arbitration. *Mundi v. Union Sec. Life Ins. Co.*, 555 F.3d 1042 (9th Cir. 2009).

The presumption in favor of arbitration does not apply if contractual language is plain that arbitration of a particular controversy is not within the scope of the arbitration provision. *Mundi v. Union Sec. Life Ins. Co.*, 555 F.3d 1042 (9th Cir. 2009).

General contract and agency principles apply in determining the enforcement of an arbitration agreement by or against non-signatories. *Mundi v. Union Sec. Life Ins. Co.*, 555 F.3d 1042 (9th Cir. 2009).

Among the principles applied in determining the enforcement of an arbitration agreement by or against non-signatories are: incorporation by reference; assumption; agency; veil-piercing/alter ego; and estoppel. *Mundi v. Union Sec. Life Ins. Co.*, 555 F.3d 1042 (9th Cir. 2009).

A non-signatory can seek to enforce an arbitration agreement as a third party beneficiary. *Mundi v. Union Sec. Life Ins. Co.*, 555 F.3d 1042 (9th Cir. 2009).

Attorney's Fees – See Also California Code of Civ. Proc. § 1038

Under Code of Civil Procedure section 1038, a defendant in a proceeding under the California Tort Claims Act or for express or implied indemnity or for equitable contribution who prevails on summary judgment may obtain all defense costs, including reasonable attorney's fees if the trial court determines the action was not brought in good faith. *Bosetti v. U.S. Life Ins. Co.*, 175 Cal.App.4th 1208 (2009).

Bad Faith

The linchpin of a bad faith claim is that the denial of coverage was unreasonable. *McCoy v. Progressive West Ins. Co.*, 171 Cal.App.4th 785 (2009).

Before an insurer can be found to have acted in bad faith for its delay or denial in the payment of policy benefits, it must be shown that the insurer acted unreasonably or without proper cause. *McCoy v. Progressive West Ins. Co.*,171 Cal.App.4th 785 (2009).

In the insurance bad faith context, a dispute is not "legitimate" unless it is founded on a basis that is reasonable under all the circumstances. *McCoy v. Progressive West Ins. Co.*, 171 Cal.App.4th 785 (2009).

Punitive damages are proper in an insurance bad faith action. *McCoy v. Progressive West Ins. Co.*, 171 Cal.App.4th 785 (2009).

A disability insurer's failure to notify the insured of the specific basis for its approval of benefits at the time of approval is not bad faith where the insured cannot show she was harmed by that failure. *Bosetti v. U.S. Life Ins. Co.*, 175 Cal.App.4th 1208 (2009).

Bad faith cases are analyzed in a three step process: First, was there a breach at all so as to warrant contract damages? Second, was the breach unreasonable so as to warrant tort damages? Third, was the breach so egregious that there is evidence of "oppression, fraud or malice" under Civil Code section 3294 subdivision (a) so as to warrant punitive damages? *Griffin Dewatering Corp. v. N. Ins. Co.*, 176 Cal.App.4th 172 (2009).

If an insurer's denial of coverage is reasonable, as show by substantial case law in favor of its position, there can be no bad faith even though the insurer's position is later

rejected by the California Supreme Court. *Griffin Dewatering Corp. v. N. Ins. Co.*, 176 Cal.App.4th 172 (2009).

If the coverage decision is reasonable, no lawyer has power to charm a jury into awarding any tort damages against the insurance company based on that coverage decision. *Griffin Dewatering Corp. v. N. Ins. Co.*, 176 Cal.App.4th 172 (2009).

Where the reasonableness of the legal position taken by the insurer depends entirely on an analysis of legal precedent and statutory language, the issue is one of law to be determined by the court and not a fact to be determined by the jury. *Griffin Dewatering Corp. v. N. Ins. Co.*, 176 Cal.App.4th 172 (2009).

The basic rule of reasonability of a coverage decision holds for both first and third party insurance policies. *Griffin Dewatering Corp. v. N. Ins. Co.*, 176 Cal.App.4th 172 (2009).

In asserting a contractual position, an insurer must take a reasonable position under rules of contract interpretation, which rules generally favor insureds. *Griffin Dewatering Corp. v. N. Ins. Co.*, 176 Cal.App.4th 172 (2009).

Bad Faith: Damages – *Brandt* (Attorney's) Fees

Brandt fees are clearly tort damages which cannot be awarded if an insurer acts reasonably, though incorrectly. *Griffin Dewatering Corp. v. N. Ins. Co.*, 176 Cal.App.4th 172 (2009).

Bad Faith: Damages – Emotional Distress

Emotional distress is recoverable in a bad faith action where the insureds meet a threshold showing of financial loss. *Major v. Western Home Ins. Co.*, 169 Cal.App.4th 1197 (2009).

Bad Faith: Genuine Dispute

There is no bad faith where there is a genuine dispute as to the denial of policy benefits. *Bosetti v. U.S. Life Ins. Co.*, 175 Cal.App.4th 1208 (2009).

Where there is a genuine issue as to the insurer's liability under the policy for the claim asserted by the insured, there can be no bad faith liability imposed on the insurer for advancing its side of that dispute. *McCoy v. Progressive West Ins. Co.*, 171 Cal.App.4th 785 (2009).

The "genuine dispute" doctrine may be applied where the insurer denies a claim based on the opinions of experts. *McCoy v. Progressive West Ins. Co.*, 171 Cal.App.4th 785 (2009).

Although an insurer may rely on experts, summary judgment on a bad faith claim must be denied where the evidence shows a dispute as to whether the insurer dishonestly selected its experts, the insurer's experts were unreasonable, or the insurer failed to conduct a thorough investigation. *McCoy v. Progressive West Ins. Co.*, 171 Cal.App.4th 785 (2009).

The genuine dispute rule does not relieve an insurer from its obligation to thoroughly and fairly investigate, process, and evaluate the insured's claim. A genuine dispute exists only where the insurer's position is maintained in good faith and on reasonable grounds. *McCoy v. Progressive West Ins. Co.*, 171 Cal.App.4th 785 (2009).

If a trial court provides instructions to the jury on the issue of reasonableness pursuant to CACI 2331 and 2332, it does not commit error by refusing to provide special jury instructions on the genuine dispute doctrine. *McCoy v. Progressive West Ins. Co.*, 171 Cal.App.4th 785 (2009).

California Business & Professions Code Section 17200, et seq.: Unfair Competition Law (The UCL)

A business practice is fraudulent if a plaintiff can show that members of the public are likely to be deceived. *Kaldenbach v. Mutual of Omaha Life Ins. Co.*, 178 Cal.App.4th 830 (2009).

The UCL, which on its face applies to all "businesses" and does not expressly except or exempt insurers, does authorize any injured person to sue for the violation of its requirements and/or prohibitions – that is, for "unfair competition." *Zhang v. Super. Ct.*, 178 Cal. App. 4th 1081 (2009). ***Not citable. Review granted.***

"Unfair competition" is defined in Business and Professions Code section 17200 to "include any unlawful, unfair or fraudulent business act or practice and unfair, deceptive, untrue, or misleading advertising. . . ." *Zhang v. Super. Ct.*, 178 Cal. App. 4th 1081 (2009). ***Not citable. Review granted.***

False advertising and fraud are recognized basis for suit under the UCL both expressly as provided in the statutes and in case law. *Zhang v. Super. Ct.*, 178 Cal. App. 4th 1081 (2009) . ***Not citable. Review granted.***

No reason appears why an insurer company should not be subject to liability under the UCL if it engages in false advertising. *Zhang v. Super. Ct.*, 178 Cal. App. 4th 1081 (2009). ***Not citable. Review granted.***

An insurer's allegedly fraudulent conduct in violation of the Unfair Insurance Practices Act may give rise to a private civil cause of action under the UCL. *Zhang v. Super. Ct.*, 178 Cal. App. 4th 1081 (2009). ***Not citable. Review granted.***

California Business & Professions Code Section 17200 et seq.: UCL - Remedies

Although a private citizen can sue under Section 17200 et seq., only equitable remedies are available (e.g., injunction, restitution) and damages are not an available remedy. *Kaldenbach v. Mutual of Omaha Life Ins. Co*., 178 Cal.App.4th 830 (2009).

Enhanced remedy available under Section 3345 in senior citizen suit alleging unfair practices was also applicable to action seeking restitution for unfair competition. *Clark v. Super. Ct.*, 174 Cal.App.4th 82 (2009). ***Not citable. Review granted.***

California Business & Professions Code section 17206.1 is not superfluous to Civil Code section 3345. *Clark v. Super. Ct.*, 174 Cal.App.4th 82 (2009). ***Not citable. Review granted.***

Applying Civil Code section 3345 to treble restitution remedy does not violate rule against awarding damages in unfair competition claims. *Clark v. Super. Ct.*, 174 Cal.App.4th 82 (2009). ***Not citable. Review granted.***

Restitution is intended to deter unfair competition. *Clark v. Super. Ct.*, 174 Cal.App.4th 82 (2009). ***Not citable. Review granted.***

Court has discretion as to the amount of restitution to award, based on consideration of the equities. *Clark v. Super. Ct.*, 174 Cal.App.4th 82 (2009). ***Not citable. Review granted.***

The fact that there are alternative remedies under a specific statute does not preclude claims under the unfair competition and false advertising laws, unless the statute itself provides that the remedy is to be exclusive. *Blue Cross of California, Inc. v. Super. Ct*., 180 Cal.App.4th 1237 (2009).

California Business & Professions Code Section 17200 et seq.: UCL - Standing

Plaintiff must establish injury-in-fact and loss of money or property in order to have standing to assert a claim for unfair competition. *Walker v. USAA Cas. Ins. Co*., 558 F.3d 1025 (9th Cir. 2009).

A private person may pursue representative claims or relief on behalf of others only if the claimant meets the standing requirements and complies with Code of Civil Procedure section 382. *Kaldenbach v. Mutual of Omaha Life Ins. Co*, 178 Cal.App.4th 830 (2009).

A private person has standing to sue only if he or she has suffered injury in fact and has lost money or property as a result of such unfair competition. *Kaldenbach v. Mutual of Omaha Life Ins. Co*., 178 Cal.App.4th 830 (2009).

The city attorney has express statutory authority to file suit on behalf of the people of California under the statutory unfair competition laws. *Blue Cross of California, Inc. v. Super. Ct.*, 180 Cal.App.4th 1237 (2009).

The city attorney has authority to sue under the unfair competition and false advertising laws for violation of Health and Safety Code section 1389.3 (i.e., the Knox-Keene Act's prohibition of post-claims underwriting) because there is no statute that expressly precludes the city attorney from doing so. *Blue Cross of California, Inc. v. Super. Ct.*, 180 Cal.App.4th 1237 (2009).

When a statute grants enforcement authority to a particular government agency and does not grant it to anyone else, a local law enforcement official can still pursue unfair competition and false advertising claims based on conduct made unlawful by the statute. *Blue Cross of California, Inc. v. Super. Ct.*, 180 Cal.App.4th 1237 (2009).

The contention that a plaintiff does not have standing to prosecute an Unfair Competition Law cause of action can be raised at any time, including on appeal because it goes to the existence of the cause of action. *Troyk v. Farmers Group Inc.*, 171 Cal.App.4th 1305 (2009).

Standing to assert an Unfair Competition Law cause of action requires the plaintiff to prove he or she personally suffered an invasion or injury to a legally protected interest. *Troyk v. Farmers Group Inc.*, 171 Cal.App.4th 1305 (2009).

A summary allegation of causation of damages is sufficient for pleading purposes (although a more specific factual allegation regarding causation is preferable). *Troyk v. Farmers Group Inc.*, 171 Cal.App.4th 1305 (2009).

California Civil Code Section 1750 (Consumer Legal Remedies Act)

Life insurance policies are neither "goods" nor "services" under the Consumers Legal Remedies Act. Thus, consumers do not have a valid claim against the issuers of their life insurance policies under the terms of the Consumers Legal Remedies Act. *Fairbanks v. Super. Ct.*, 46 Cal.4th 56 (2009).

California Civil Code Section 3045.2 (Hospital Lien Act)

The Hospital Lien Act was, by it own terms, not intended to include first party insurance coverage, such as uninsured motorist coverages. *Weston Reid, LLC v. American Ins. Group, Inc.*, 174 Cal.App.4th 940 (2009).

The purpose of the Hospital Lien Act is to secure part of the patient's recovery from liable third persons to pay his or her hospital bill, while ensuring that the patient retains sufficient funds to address other losses resulting from the tortious injury. *Weston Reid, LLC v. American Ins. Group, Inc.*, 174 Cal.App.4th 940 (2009).

California Civil Code section 3045.2 creates a statutory non-possessory lien in favor of a hospital against third persons liable for the patient's injuries. *Weston Reid, LLC v. American Ins. Group, Inc.*, 174 Cal.App.4th 940 (2009).

Hospital lien arises because of, and applies to, a payor fund created by the liability of a third party tortfeasor for the injures which gave rise to the needed medical services. *Weston Reid, LLC v. American Ins. Group, Inc.*, 174 Cal.App.4th 940 (2009).

California Civil Code Section 3294 – See Also Punitive Damages

In a civil case not arising from the breach of a contractual obligation, the jury may award punitive damages "where it is proven by clear and convincing evidence that the defendant has been guilty of oppression, fraud, or malice." *Roby v. McKesson Corp.*, 47 Cal.4th 686 (2009).

Malice is defined as intentional injury or "despicable conduct which is carried on by the defendant with a willful and conscious disregard of the rights or safety of others." Cal. Civ. Code section 3294. *Roby v. McKesson Corp.*, 47 Cal.4th 686 (2009).

Oppression is defined as "despicable conduct that subjects a person to cruel and unjust hardship in conscious disregard of that person's rights." Cal. Civ. Code section 3294. *Roby v. McKesson Corp.*, 47 Cal.4th 686 (2009).

California Code of Civil Procedure Section 382 (Class Actions) - See Also Class Actions: Class Certification

Code of Civil Procedure section 382 authorizes class suits in California when the question is one of a common or general interest of many persons or when the parties are numerous and it is impracticable to bring them all before the court. *Kaldenbach v. Mutual of Omaha Life Ins. Co.*, 178 Cal.App.4th 830 (2009).

To obtain certification under California Code of Civil Procedure section 382, a party must establish the existence of both an ascertainable class and a well–defined community of interest among the class members. The community of interest requirement involves three factors: (1) predominant common questions of law or fact; (2) class representatives with claims or defenses typical of the class; and (3) class representatives who can adequately represent the class. *Kaldenbach v. Mutual of Omaha Life Ins. Co.*, 178 Cal. App.4th 830 (2009).

It is the plaintiff's burden to prove the propriety of class certification. *Kaldenbach v. Mutual of Omaha Life Ins. Co.*, 178 Cal.App.4th 830 (2009).

The requisites for class certification are numerosity, ascertainability, typicality and commonality. It is the plaintiff's burden to prove the propriety of class certification. *Kaldenbach v. Mutual of Omaha Life Ins. Co.*, 178 Cal.App.4th 830 (2009).

Class certification is inappropriate where individualized issues predominate over common ones. *Kaldenbach v. Mutual of Omaha Life Ins. Co.*, 178 Cal.App.4th 830 (2009).

A private person may pursue representative claims or relief on behalf of others only if the claimant meets the standing requirements and complies with Code of Civil Procedure section 382. *Kaldenbach v. Mutual of Omaha Life Ins. Co.*, 178 Cal.App.4th 830 (2009).

It is the plaintiff's burden to prove the propriety of class certification. *Kaldenbach v. Mutual of Omaha Life Ins. Co.*, 178 Cal. App. 4th 830 (2009).

California Code of Civil Procedure Section 1038 (Attorney's Fees) – See Also Attorney's Fees

Under Code of Civil Procedure section 1038, a defendant in a proceeding under the California Tort Claims Act or for express or implied indemnity or for equitable contribution who prevails on summary judgment may obtain all defense costs, including reasonable attorney's fees if the trial court determines the action was not brought in good faith. *Bosetti v. U.S. Life Ins. Co.*, 175 Cal.App.4th 1208 (2009).

California Health & Safety Code Section 1371.4 (Knox-Keene Act)

Codified as Health & Safety Code section 1371.4, the Knox-Keene Act requires a plan or insurer to reimburse the provider of emergency care to an insured. *Coast Plaza Doctors Hospital v. Blue Cross of California*, 173 Cal.App.4th 1179 (2009).

California Health & Safety Code section 1371.4, of the Knox-Keene Act requiring a plan or insurer to reimburse the provider of emergency care to an insured or plan beneficiary, comes under the saving clause of ERISA and is therefore not preempted because it is specifically directed toward the insurance industry and substantially affects the risk pooling arrangement between the insurer and insured. *Coast Plaza Doctors Hospital v. Blue Cross of California*, 173 Cal.App.4th 1179 (2009).

California Health & Safety Code Section 1389.3 (Knox-Keene Act – Post-Claims Underwriting)

The city attorney has authority to sue under the unfair competition and false advertising laws for violation of Health and Safety Code section 1389.3 (i.e., the Knox-Keene Act's prohibition of postclaims underwriting) because there is no statute that expressly precludes the city attorney from doing so. *Blue Cross of California, Inc. v. Super. Ct.*, 180 Cal.App.4th 1237 (2009).

When a statute grants enforcement authority to a particular government agency and does not grant it to anyone else, a local law enforcement official can still pursue unfair

competition and false advertising claims based on conduct made unlawful by the statute. *Blue Cross of California, Inc. v. Super. Ct.*, 180 Cal.App.4th 1237 (2009).

California Insurance Code Section 790.03 (Unfair Insurance Practices Act)

Insurance Code section 790.03 does not create a private right of action against "insurers who commit the unfair practices enumerated in that provision." *Zhang v. Super. Ct.*, 178 Cal.App.4th 1081 (2009). ***Not citable. Review granted.***

If a plaintiff relies on conduct that violates the Unfair Insurance Practices Act but is *not otherwise prohibited*, a civil action under the Unfair Competition Law is barred. *Zhang v. Super. Ct.*, 178 Cal.App.4th 1081 (2009). ***Not citable. Review granted.***

To construe the Unfair Insurance Practices Act as immunizing insurers from the consequence of misconduct that other business must suffer would simply make no sense. *Zhang v. Super. Ct.*, 178 Cal.App.4th 1081 (2009). ***Not citable. Review granted.***

California Insurance Code Section 1850.4, et seq. (Proposition 103)

Assuming for purposes of argument that an award of compensation is limited to expenses incurred in proceedings "permitted or established" pursuant to California Insurance Code sections 1850.4, *et seq*., judicial review of a Proposition 103 regulation is such a proceeding. *Ass'n of California Ins. Co. v. Poizner*, 180 Cal.App.4th 1029 (2009).

Proposition 103 regulations allowing recovery of compensation by consumer interveners for their participation in rate proceedings other than public rate hearings, are consistent with Proposition 103 and thus valid. *Ass'n of California Ins. Co. v. Poizner*, 180 Cal.App.4th 1029 (2009).

The absence of specific statutory provisions in Proposition 103 relating to the resolution of a rate application without a public hearing (e.g., as by way of a settlement) does not mean that regulations permitting such resolution exceed statutory authority, but only that the electorate deferred to and relied on the expertise of the Insurance Commissioner as to such matters. *Ass'n of California Ins. Co. v. Poizner*, 180 Cal.App.4th 1029 (2009).

California Insurance Code section 1861.05(c) only sets out the circumstances under which a rate change application may be deemed approved without a rate hearing; it does not address the proceedings that may occur after the Insurance Commissioner determines to hold a hearing or after an intervener submits a petition to intervene or a petition for a hearing. *Ass'n of California Ins. Co. v. Poizner*, 180 Cal.App.4th 1029 (2009).

The only statutory requirements for receiving compensation for participation in the rate-setting process established by Proposition 103, codified as section 1861.01, *et seq*. are stated in subdivision (b) of California Insurance Code section 1861.10: that the intervener

represent consumers' interests and make a "substantial contribution" to the outcome of the process. *Ass'n of California Ins. Co. v. Poizner*, 180 Cal.App.4th 1029 (2009).

California Insurance Code section 1861.10(b) does not expressly or by implication require that the order, regulation, or decision of the Insurance Commissioner be adopted only after a public hearing, or only after any specific procedure. *Ass'n of California Ins. Co. v. Poizner*, 180 Cal.App.4th 1029 (2009).

Pursuant to California Insurance Code section 1861.10(b), a compensation award must be paid by the insurer where the award is for advocacy that occurs in response to a rate change application; in all other circumstances, whether the award is payable by the insurer is discretionary. *Ass'n of California Ins. Co. v. Poizner*, 180 Cal.App.4th 1029 (2009).

Insurance Code section 12979 is not intended to shift liability for compensation, awarded pursuant to section 1861.10(b), from insurers to the Department of Insurance because Section 12979 deals only with administrative and operational costs of the Department, and not awards of compensation for expenses of consumer interveners. *Ass'n of California Ins. Co. v. Poizner*, 180 Cal.App.4th 1029 (2009).

California Insurance Code Section 12979

Insurance Code section 12979 is not intended to shift liability for compensation, awarded pursuant to section 1861.10(b), from insurers to the Department of Insurance because section 12979 deals only with administrative and operational costs of the Department, and not awards of compensation for expenses of consumer interveners. *Ass'n of California Ins. Co. v. Poizner*, 180 Cal.App.4th 1029 (2009).

Class Actions: Class Certification – See Also California Civ. Code § 382

Code of Civil Procedure section 382 authorizes class suits in California when the question is one of a common or general interest of many persons, or when the parties are numerous and it is impracticable to bring them all before the court. *Kaldenbach v. Mutual of Omaha Life Ins. Co.*, 178 Cal.App.4th 830 (2009).

To obtain certification under Code of Civil Procedure section 382, a party must establish the existence of both an ascertainable class and a well–defined community of interest among the class members. The community of interest requirement involves three factors: (1) predominant common questions of law or fact; (2) class representatives with claims or defenses typical of the class; and (3) class representatives who can adequately represent the class. *Kaldenbach v. Mutual of Omaha Life Ins. Co.*, 178 Cal.App.4th 830 (2009).

The requisites for class certification are numerosity, ascertainability, typicality and commonality. It is the plaintiff's burden to prove the propriety of class certification. *Kaldenbach v. Mutual of Omaha Life Ins. Co.*, 178 Cal.App.4th 830 (2009).

Class certification is inappropriate where individualized issues predominate over common ones. *Kaldenbach v. Mutual of Omaha Life Ins. Co.*, 178 Cal.App.4th 830 (2009).

A private person may pursue representative claims or relief on behalf of others only if the claimant meets the standing requirements and complies with Code of Civil Procedure section 382. *Kaldenbach v. Mutual of Omaha Life Ins. Co.*, 178 Cal.App.4th 830 (2009).

It is the plaintiff's burden to prove the propriety of class certification. *Kaldenbach v. Mutual of Omaha Life Ins. Co.*, 178 Cal. App. 4th 830 (2009).

Consumer Legal Remedies Act – See California Civil Code § 1750

Contract Interpretation

However broad may be the terms of a contract, it extends only to those things concerning which it appears that the parties intended to contract. *Mundi v. Union Sec. Life Ins. Co.*, 555 F.3d 1042 (9th Cir. 2009).

That an ERISA plan exclusion violates the Internal Revenue Code does not permit the court to rewrite the plan or to enlarge benefits beyond the clear, unambiguous language of the plan. *Bellah v. American Airlines, Inc.*, 656 F. Supp. 2d 1207 (E.D. Cal. 2009).

An ERISA beneficiary was not entitled to recover benefits under an equitable estoppel theory where the language of the plan was clear and unambiguous, notwithstanding subsequent miscommunications between the beneficiary and plan administrator regarding the beneficiary's eligibility for benefits. *Bellah v. American Airlines, Inc.*, 656 F. Supp. 2d 1207 (E.D. Cal. 2009).

An exclusion providing that an employee not at work because of a disability at the time coverage becomes effective is not covered for Long Term Disability benefits "until you return to work and deductions are taken from your pay," clearly and unambiguously excludes an employee who was on disability leave at the time the Long Term Disability plan became effective; therefore, subsequent miscommunications between the plan administrator and the beneficiary regarding her benefits were irrelevant. *Bellah v. American Airlines, Inc*., 656 F. Supp. 2d 1207 (E.D. Cal. 2009).

When reviewing an ERISA plan courts "'apply contract principles derived from state law . . . guided by the policies expressed in ERISA and other federal labor laws'" which require courts to "look to the [policy's] language in context and construe each provision in a manner consistent with the whole such that none is rendered nugatory." Where a policy unambiguously covers only treatment received from a contracted residential treatment center, the insurer correctly denies coverage for an insured's stay at a non-contracted residential treatment center. *Dupree v. Holman Prof'l. Counseling Ctrs*., 572 F.3d 1094 (9th Cir. 2009).

An ERISA plan's repeated assertion that certain activities are not covered creates a "default presumption of no coverage that must be then overcome by a showing of" coverage. An insurer's specific inclusion of names of affiliated (contracted) medical treatment centers, created a presumption that the insured's decision to select and seek treatment from non-contracted treatment center was deemed not covered under the plan. *Dupree v. Holman Prof'l. Counseling Ctrs.*, 572 F.3d 1094 (9th Cir. 2009).

Contract Interpretation: Contra Proferentum

If an ERISA plan is ambiguous, it must be "'construed against the drafter and in favor of the insured;'" however "[i]f a reasonable interpretation favors the insurer and any other interpretation would be strained, no compulsion exists to torture or twist the language of the policy." An insurer's interpretation of the ERISA plan to exclude treatment with non-contracted facilities was reasonable. *Dupree v. Holman Prof'l. Counseling Ctrs*., 572 F.3d 1094 (9th Cir. 2009).

Contract Interpretation: Reasonable Expectations of Insured Doctrine

The doctrine of the reasonable expectations of the insured stems from the law of adhesion contracts and construction of ambiguities in insurance policies and applies only to insurance contracts, including ERISA insurance contracts. *Scharff v. Raytheon Co. Short Term Disability Plan*, 581 F.3d 899 (9th Cir. 2009).

Demurrer

A third party claims administrator can successfully demur to a breach of contract action by an insured where no contract exists between the insured and the third party administrator. *Bosetti v. U.S. Life Ins. Co.*, 175 Cal.App.4th 1208 (2009).

Disability: Fibromyalgia

Fibromyalgia is a disease presenting various symptoms including chronic soft tissue pain. Afflicted individuals subjectively suffer differing amounts of pain, while objective evidence of the disease is more difficult to establish. *Minton v. Deloitte and Touche USA LLP Plan*, 631 F. Supp. 2d 1213 (N.D. Cal . 2009).

Disability: Mental or Emotional Disorders

A provision in a disability policy which limit benefits for mental or emotional disorders is ambiguous and does not apply to a situation where the claimant suffers disability with both physical and mental components. *Bosetti v. U.S. Life Ins. Co*, 175 Cal.App.4th 1208 (2009).

Disability: Subjective Evidence of Pain

Subjective evidence of pain caused by fibromyalgia is sufficient to qualify the suffering individual for total disability insurance benefits. *Minton v. Deloitte and Touche USA LLP Plan*, 631 F. Supp. 2d 1213 (N.D. Cal . 2009).

Fibromyalgia is a disease presenting various symptoms including chronic soft tissue pain. Afflicted individuals subjectively suffer differing amounts of pain, while objective evidence of the disease is more difficult to establish. *Minton v. Deloitte and Touche USA LLP Plan*, 631 F. Supp. 2d 1213 (N.D. Cal . 2009).

Disclaimers

The adequacy of a disclaimer in the context of an action for fraud is judged by reference to the plaintiff's knowledge and experience. *Broberg v. Guardian Life Ins. Co.*, 171 Cal.App.4th 912 (2009).

To be enforceable, disclaimer language in a policy must be "conspicuous, plain and clear." *Broberg v. the Guardian Life Ins. Co.*, 171 Cal.App.4th 912 (2009).

Disclaimer language is "conspicuous" when it: (1) includes a heading in capitals; and (2) is in a larger or contrasting type, color or font. *Broberg v.Guardian Life Ins. Co.*, 171 Cal.App.4th 912 (2009).

Equitable Estoppel

Equitable estoppel precludes a party from claiming the benefits of a contract while simultaneously attempting to avoid the burdens that contract imposes. *Mundi v. Union Sec. Life Ins. Co.*, 555 F.3d 1042 (9th Cir. 2009).

An ERISA beneficiary was not entitled to recover benefits under an equitable estoppel theory where the language of the plan was clear and unambiguous, notwithstanding subsequent miscommunications between the beneficiary and plan administrator regarding the beneficiary's eligibility for benefits. *Bellah v. American Airlines, Inc*., 656 F. Supp. 2d 1207 (E.D. Cal. 2009).

Among the principles applied in determining the enforcement of an arbitration agreement by or against non-signatories are: incorporation by reference; assumption; agency; veil-piercing/alter ego; and estoppel. *Mundi v. Union Sec. Life Ins. Co.*, 555 F.3d 1042 (9th Cir. 2009).

DEVELOPMENTS IN CALIFORNIA CASE LAW 2009: LIFE, HEALTH & DISABILITY INSURANCE

March 2010

ERISA

ERISA's statutory scheme allows plan administrators to look at the plan documents and records conforming to them to get clear distribution instructions without going into court. *Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 129 S. Ct. 865 (2009).

ERISA's statutory scheme allows plan administrators to distribute plan benefits in accordance with plan documents and without being forced to examine a multitude of external documents that might purport to affect the dispensation of benefits. *Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 129 S. Ct. 865 (2009).

Where a designated ERISA plan beneficiary waived her right to plan benefits in a divorce decree but failed to disclaim her right to plan benefits via the manner provided by the plan, the plan administrator acted properly when it distributed plan benefits to her. *Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 129 S. Ct. 865 (2009).

The summary plan description constitutes part of the plan documents and must be considered by the court in determining plan requirements. *Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 129 S. Ct. 865 (2009).

After *Abatie v. Alta Health & Life Insurance Co*., 458 F.3d. 955 (9th Cir. 2006), district courts are required to weigh evidence according to the traditional rules of summary judgment. As such, evidence outside the administrative record submitted by a party must be examined in the light most favorable to the non-moving party. *Nolan v. Heald College*, 551 F.3d 1148 (9th Cir. 2009).

ERISA does not explicitly define "marital property rights." *Owens v. Automotive Machinists Pension Trust*, 551 F.3d 1138 (9th Cir. 2009).

Under ERISA, a qualified domestic relations order ("QDRO") is defined as a domestic relations order that creates or recognizes the existence of an alternate payee's right to receive benefits with respect to a participant under a plan. A "domestic relations order" applies to: any judgment or order that relates to the provision of child support, alimony payments, or marital property rights to a spouse, former spouse, child or other dependent of a participant, and is issued pursuant to a state domestic relations law. (29 U.S.C. section 1056(d)(3)(B)(ii)(I).) *Owens v. Automotive Machinists Pension Trust*, 551 F.3d 1138 (9th Cir. 2009).

Congress did not intend, under 26 U.S.C. section 410 or 414, to expand employee rights to benefits under ERISA. *Bellah v. American Airlines, Inc*., 656 F. Supp. 2d 1207 (E.D. Cal. 2009).

The tax qualification provisions of the Internal Revenue Code, and the Treasury Regulations promulgated thereunder, do not modify an ERISA benefit plan to mandate

inclusion of employees whom the plan has permissibly excluded. *Bellah v. American Airlines, Inc*., 656 F. Supp. 2d 1207 (E.D. Cal. 2009).

A letter from the plan administrator stating that "the company will provide benefits for you at active rates," but which letter does not mention the Long Term Disability policy or any modification of the Long Term Disability policy, did not constitute a "representation" to a beneficiary that she would be eligible for long term disability benefits for which she was not otherwise eligible under the terms of the Long Term Disability plan. *Bellah v. American Airlines, Inc*., 656 F. Supp. 2d 1207 (E.D. Cal. 2009).

That a plan exclusion violates the Internal Revenue Code does not permit the court to rewrite the plan or to enlarge benefits beyond the clear, unambiguous language of the plan. *Bellah v. American Airlines, Inc*., 656 F. Supp. 2d 1207 (E.D. Cal. 2009).

An ERISA beneficiary was not entitled to recover benefits under an equitable estoppel theory where the language of the plan was clear and unambiguous, notwithstanding subsequent miscommunications between the beneficiary and plan administrator regarding the beneficiary's eligibility for benefits. *Bellah v. American Airlines, Inc*., 656 F. Supp. 2d 1207 (E.D. Cal. 2009).

An exclusion providing that an employee not at work because of a disability at the time coverage becomes effective is not covered for Long Term Disability benefits "until you return to work and deductions are taken from your pay," clearly and unambiguously excludes an employee who was on disability leave at the time the Long Term Disability plan became effective; therefore, subsequent miscommunications between the plan administrator and the beneficiary regarding her benefits were irrelevant. *Bellah v. American Airlines, Inc*., 656 F. Supp. 2d 1207 (E.D. Cal. 2009).

An ERISA top hat plan is an unfunded plan maintained by an employer primarily to provide "deferred compensation for a select group of management or highly compensated employees." *Sznewajs v. U.S. Bancorp Amended & Restated Supplemental Benefits Plan*, 572 F.3d 727 (9th Cir. 2009).

An ERISA plan participant or beneficiary may enforce his or her rights by bringing a cause of action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." Thus, a claim rises or falls according to the terms of the plan, Section 1132(a)(1)(B). *Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 129 S. Ct. 865 (2009).

The Ninth Circuit Court of Appeals reviews "the district court's interpretation of an ERISA plan *de novo* and that court's factual findings for clear error." *Dupree v. Holman Prof'l.Counseling Ctrs*., 572 F.3d 1094 (9th Cir. 2009).

A letter from the plan administrator stating that "the company will provide benefits for you at active rates," but which letter does not mention the Long Term Disability policy or any modification of the Long Term Disability policy, did not constitute a "representation" to a beneficiary that she would be eligible for Long Term Disability benefits for which she was not otherwise eligible under the terms of the Long Term Disability plan. *Bellah v. American Airlines, Inc*., 656 F. Supp. 2d 1207 (E.D. Cal. 2009).

When reviewing an ERISA plan, courts "'apply contract principles derived from state law . . . guided by the policies expressed in ERISA and other federal labor laws'" which require courts to "look to the [policy's] language in context and construe each provision in a manner consistent with the whole such that none is rendered nugatory." Where a policy unambiguously covers only treatment received from a contracted residential treatment center, the insurer correctly denies coverage for an insured**'**s stay at a non-contracted residential treatment center. *Dupree v. Holman Prof'l.Counseling Ctrs*., 572 F.3d 1094 (9th Cir. 2009).

An ERISA plan's repeated assertion that certain activities are not covered creates a "default presumption of no coverage that must be then overcome by a showing of" coverage. An insurer's specific inclusion of names of affiliated (contracted) medical treatment centers, created a presumption that the insured's decision to select and seek treatment from non-contracted treatment center was deemed not covered under the plan. *Dupree v. Holman Prof'l.Counseling Ctrs*., 572 F.3d 1094 (9th Cir. 2009).

If an ERISA plan is ambiguous, it must be "'construed against the drafter and in favor of the insured;'" however "[i]f a reasonable interpretation favors the insurer and any other interpretation would be strained, no compulsion exists to torture or twist the language of the policy." An insurer's interpretation of the ERISA plan to exclude treatment with non-contracted facilities was reasonable. *Dupree v. Holman Prof'l. Counseling Ctrs*., 572 F.3d 1094 (9th Cir. 2009).

ERISA's remedial system emphasizes a balance between protecting employees' right to benefits and incentivizing employers to offer benefit plans. *Standard Ins. Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009).

The reasonable expectations doctrine was adopted into ERISA federal common law for the interpretation of insured plans. Self-funded employee benefits plans are not insurance policies and the Ninth Circuit law on the application of the doctrine to self-funded plans is uncertain. *Scharff v. Raytheon Co. Short Term Disability Plan*, 581 F.3d 899 (9th Cir. 2009).

Where a self-funded ERISA disability plan contains a one year contractual statute of limitations provision and the provision meets ERISA's statutory and regulatory requirements and meets the average plan participant's reasonable expectations, the

provision is enforceable to bar the plaintiff's claims as untimely. *Scharff v. Raytheon Co. Short Term Disability Plan*, 581 F.3d 899 (9th Cir. 2009).

While an estate seeking the decedent's pension benefits suggested a plan administrator could resolve such disputes by interpleader actions, requiring a plan administrator to do so "would destroy a plan administrator's ability to look at the plan documents and records conforming to them to get clear distribution instructions, without going into court." *Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 129 S. Ct. 865 (2009).

When an ERISA plan administrator has discretionary authority to construe plan terms and interprets an ambiguous plan term reasonably, the court must resolve the ambiguity in favor of the administrator's interpretation. *Sznewajs v. U.S. Bancorp Amended & Restated Supplemental Benefits Plan*, 572 F.3d 727 (9th Cir. 2009).

When reviewing a claim administrator's decision, the court must give full effect to the entire pension plan, including provisions granting the administrator discretionary authority over interpretation of plan provisions. *Sznewajs v. U.S. Bancorp Amended & Restated Supplemental Benefits Plan*, 572 F.3d 727 (9th Cir. 2009).

A district court may award pre-judgment interest on past-due benefits in ERISA cases when a balancing of the equities so provides. Prejudgment interest is calculated at a rate equal to the weekly average 1-year constant maturity Treasury yield, as published by the Board of Governors of the Federal Reserve System, for the calendar week preceding the date of the judgment. *Minton v. Deloitte and Touche USA LLP Plan*, 631 F. Supp. 2d 1213 (N.D. Cal . 2009).

The doctrine of the reasonable expectations of the insured stems from the law of adhesion contracts and construction of ambiguities in insurance policies and applies only to insurance contracts, including ERISA insurance contracts. *Scharff v. Raytheon Co. Short Term Disability Plan*, 581 F.3d 899 (9th Cir. 2009).

ERISA: Anti-Alienation Provision

Where the designated beneficiary of an ERISA plan waived her right to such benefits in a divorce decree, her waiver was simply a disclaimer of benefits. It did not operate as an assignment or alienation of benefits, such that it was made void by ERISA's anti-alienation provision under section 1056(d)(1). *Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 129 S. Ct. 865 (2009).

ERISA's anti-alienation provision does not nullify a disclaimer or waiver of benefits where no attempt is made to transfer or assign benefits to another. *Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 129 S. Ct. 865 (2009).

ERISA: Civil Actions

If a participant or beneficiary believes that benefits promised to him under the terms of the plan are not provided, he can bring suit under section 502(a)(1)(B) seeking provision of those benefits. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941 (9th Cir. 2009).

Under section 502(a)(1)(B) a participant or beneficiary can also bring suit to enforce his rights under the plan or to clarify any of his rights to future benefits. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941 (9th Cir. 2009).

An ERISA plan participant or beneficiary may enforce his or her rights by bringing a cause of action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." Thus, a claim rises or falls according to the terms of the plan, section 1132(a)(1)(B). *Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 129 S. Ct. 865 (2009).

ERISA: Conflict of Interest

Where a plan administrator operates under a conflict of interest, the conflict must be weighed as a factor in determining whether there is an abuse of discretion and the proper standard is to temper the abuse of discretion standard with skepticism commensurate with the conflict. *Nolan v. Heald College*, 551 F.3d 1148 (9th Cir. 2009).

A district court can consider evidence outside the record to decide a conflict of interest's effect on the decision-making process by the plan administrator. *Nolan v. Heald College*, 551 F.3d 1148 (9th Cir. 2009).

A plaintiff is entitled to have evidence of bias outside the administrative record examined by the district court at a bench trial for a full and detailed inquiry. *Nolan v. Heald College*, 551 F.3d 1148 (9th Cir. 2009).

A structural conflict of interest is present where the plan administrator is also the payor of benefits. *Montour v. Hartford Life & Accident Ins. Co.*, 582 F.3d 933 (9th Cir. 2009).

Structural conflict of interest occurs where language in the insurance plan grants discretionary authority to the administrator, and the plan is administered and funded by the insurance carrier as described in *Abatie v. Alta Health & Life Insurance Co*., 458 F.3d. 955 (9th Cir. 2006). Structural conflict of interest is weighed as a factor in determining whether an insurance carrier has abused its discretion in denying disability benefits. The district court will review the insurance carrier's decision under an abuse of discretion standard with moderate skepticism to temper the administrator's incentive to pay as little in benefits as possible to plan participants. *Minton v. Deloitte and Touche USA LLP Plan*, 631 F. Supp. 2d 1213 (9th Cir. 2009).

ERISA: Effect of Contrary Decision by Social Security Administration

A plan administrator for an ERISA governed plan is not bound by any determination of the Social Security Administration. However, complete disregard is improper and a plan administrator should explain why it reached a different conclusion. *Montour v. Hartford Life & Accident Ins. Co.*, 582 F.3d 933 (9th Cir. 2009).

ERISA: Plan Administration

ERISA generally obligates administrators to manage ERISA plans "in accordance with the documents and instruments governing them," (section 1104(a)(1)(D)) and ERISA provides no exemption for this duty when it comes to the payment of benefits. *Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 129 S. Ct. 865 (2009).

ERISA's general requirement that administrators manage ERISA plans "in accordance with the documents and instruments governing them," (section 1104(a)(1)(D)), applies even when those documents call for the payment of benefits to a designated beneficiary that waived benefits in a divorce decree when that decree is not a qualified domestic relations order, section 1056(d)(3). *Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 129 S. Ct. 865 (2009).

ERISA: Preemption

A provision of state law may "relate to" an ERISA benefit plan, and may therefore be conflict preempted under section 514(a) of ERISA. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941 (9th Cir. 2009).

The question whether a law or claim "relates to" an ERISA plan is not the test for complete preemption under section 502(a)(1)(B), but rather is the test for conflict preemption under section 514(a). *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941 (9th Cir. 2009).

The general rule is that a defense of federal preemption of a state-law claim, even conflict preemption under section 514(a) of ERISA, is an insufficient basis for original federal question jurisdiction under section 1331(a) and removal jurisdiction under section 1441(a). *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941 (9th Cir. 2009).

If the doctrine of complete preemption does not apply, even if the defendant has a defense of "conflict preemption" within the meaning of section 514(a) of ERISA because the plaintiff's claims "relate to" an ERISA plan, the district court is without subject matter jurisdiction. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941 (9th Cir. 2009).

A state law cause of action is completely preempted if (1) plaintiff, at some point in time, could have brought the claim under ERISA section 502(a)(1)(B), and (2) where there is no other independent legal duty that is implicated by a defendant's actions. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941 (9th Cir. 2009).

The two prong test for complete preemption is conjunctive and a state law cause of action is preempted by section 502(a)(1)(B) only if both prongs of the test are satisfied. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941 (9th Cir. 2009).

If there is some other independent legal duty beyond that imposed by an ERISA plan, a claim based on that duty is not completely preempted under section 502(a)(1)(B). *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941 (9th Cir. 2009).

If claims were not brought, and could not have been brought, under section 502(a)(1)(B), there can be no complete preemption. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941 (9th Cir. 2009).

There is no complete preemption where health care provider asserts state law claims for payment that are not based on provisions of an ERISA plan but are based on independent obligations arising from an alleged oral contract. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941 (9th Cir. 2009).

Complete preemption under section 502(a) is really a jurisdictional rather than a preemption doctrine as it confers exclusive federal jurisdiction in certain instances where Congress intended the scope of a federal law to be so broad as to entirely replace any state law claim. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941 (9th Cir. 2009).

Complete preemption removal is an exception to the otherwise applicable rule that a plaintiff is ordinarily entitled to remain in state court so long as its complaint does not, on its face, affirmatively allege a federal claim. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941 (9th Cir. 2009).

While federal preemption is ordinarily a federal defense to the plaintiff's suit, Congress had clearly manifested an intent to make causes of action within the scope of the civil enforcement provisions of section 502(a) removable to federal court. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941 (9th Cir. 2009).

A party seeking removal based on federal question jurisdiction must show either that the state law causes of action are completely preempted by section 502(a) of ERISA, or that some other basis exists for federal question jurisdiction. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941 (9th Cir. 2009).

Where the court found a self-funded plan containing a one year contractual statute of limitations provision met ERISA's statutory and regulatory requirements, it held ERISA

preempted state insurance regulation of self-funded plans pursuant to ERISA's deemer clause, and refused to adopt the California state insurance regulation, California Code of Regulations, Title, 10, section 2695.4(a), which requires insurers to provide notice of any time limits that may apply to the claim presented by the claimant. *Scharff v. Raytheon Co. Short Term Disability Plan*, 581 F.3d 899 (9th Cir. 2009).

With certain exceptions, ERISA preempts any and all state laws insofar as they may now or in the future relate to any covered employee benefit plan. *Standard Ins. Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009).

A state insurance commissioner's practice of disapproving insurance policies with discretionary clauses is not preempted by ERISA's exclusive remedial scheme. *Standard Ins. Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009).

Three provisions of ERISA address preemption issues: 1) the preemption clause under section 514(a); 2) the savings clause under section 514(b)(2)(A); and 3) the deemer clause under section 514(b)(2)(B). *Coast Plaza Doctors Hospital v. Blue Cross of California*, 173 Cal.App.4th 1179 (2009).

ERISA and the Federal Employee Health Benefits Act ("FEHBA"), 5 U.S.C. section 8901, are different federal statutes but their preemption provisions are analytically similar. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941 (9th Cir. 2009).

ERISA's savings clause protects from preemption any state law that regulates insurance, banking, or securities. *Standard Ins. Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009).

The historic police powers of the states were not meant to be superseded by ERISA. Federal courts have also interpreted ERISA as directing them to make substantive law as well. *Standard Ins. Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009).

To fall under the savings clause within ERISA, a regulation must meet a two prong test. First, the regulation must be specifically directed toward the entities engaged in insurance. Second, the regulation must substantially affect the risk pooling arrangement between the insurer and the insured. *Standard Ins. Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009).

The U.S. Supreme Court has established a two-part test to determine whether a state law is subject to the savings clause under ERISA to avoid preemption. First, the state law must be specifically directed toward entities engaged in insurance and second, the state law must substantially affect the risk pooling arrangement between the insurer and insured. *Coast Plaza Doctors Hospital v. Blue Cross of California*, 173 Cal.App.4th 1179 (2009).

Health & Safety Code section 1371.4, of the Knox-Keene Act requiring a plan or insurer to reimburse the provider of emergency care to an insured or plan beneficiary, comes under the savings clause of ERISA and is therefore not preempted because it is specifically directed toward the insurance industry and substantially affects the risk pooling arrangement between the insurer and insured. *Coast Plaza Doctors Hospital v. Blue Cross of California*, 173 Cal.App.4th 1179 (2009).

The deemer clause of ERISA prevents the saving clause from applying to state laws that regulate self-funded ERISA plans. A self-funded plan is one that does not purchase an insurance policy from any insurance company in order to satisfy its obligations. *Coast Plaza Doctors Hospital v. Blue Cross of California*, 173 Cal.App.4th 1179 (2009).

ERISA: Standard of Review

A plan administrator's decision is reviewed *de novo* unless the benefit plan gives the administrator discretionary authority to determine eligibility for benefits. *Montour v. Hartford Life & Accident Ins. Co.*, 582 F.3d 933 (9th Cir. 2009).

When there is no conflict of interest, the vesting of discretion in the plan administrator requires a straightforward application of the abuse of discretion standard. In such circumstances, the administrator's decision can be upheld if is grounded on any reasonable basis, including a single persuasive medical opinion. *Montour v. Hartford Life & Accident Ins. Co.*, 582 F.3d 933 (9th Cir. 2009).

Structural conflict of interest occurs where language in the insurance plan grants discretionary authority to the administrator, and the plan is administered and funded by the insurance carrier as described in *Abatie v. Alta Health & Life Insurance Co*., 458 F.3d. 955 (9th Cir. 2006). Structural conflict of interest is weighed as a factor in determining whether an insurance carrier has abused its discretion in denying disability benefits. The district court will review the insurer's decision under an abuse of discretion standard with moderate skepticism to temper the administrator's incentive to pay as little in benefits as possible to plan participants. *Minton v. Deloitte and Touche USA LLP Plan*, 631 F. Supp. 2d 1213 (9th Cir. 2009).

If an insurance contract contains a discretionary clause, the decisions of the insurer are reviewed under an abuse of discretion standard. Absent a discretionary clause, review is *de novo. Standard Ins. Co. v. Morrison*, 584 F.3d 837 (9th Cir. 2009).

Where an ERISA plan administrator denied a plaintiff's request to be recognized as the surviving spouse of her ex-husband's life annuity, the administrator's decision was reasonable and was not tainted by financial self-interest since it was actuarially neutral at the time it was made. *Sznewajs v. U.S. Bancorp Amended & Restated Supplemental Benefits Plan*, 572 F.3d 727 (9th Cir. 2009).

When a plan assigns discretionary authority to an administrator to make claim determinations, the court applies an informed abuse of discretion standard of review, which requires discounting the amount of deference given to the administrator's decision to the extent that decision appears to have been influenced by a conflict of interest. *Sznewajs v. U.S. Bancorp Amended & Restated Supplemental Benefits Plan*, 572 F.3d 727 (9th Cir. 2009).

An ERISA plan administrator's decision must be upheld under the abuse of discretion standard of review if it was made in good faith and based upon a reasonable interpretation of plan terms. *Sznewajs v. U.S. Bancorp Amended & Restated Supplemental Benefits Plan*, 572 F.3d 727 (9th Cir. 2009).

When an ERISA top hat plan grants a claim administrator discretionary authority to determine eligibility for benefits and construe plan terms, the administrator's decision is reviewed for an abuse of discretion. *Sznewajs v. U.S. Bancorp Amended & Restated Supplemental Benefits Plan*, 572 F.3d 727 (9th Cir. 2009).

When the administrator of an ERISA top hat plan has discretionary authority to make claim determinations and its interpretation of an ambiguous Plan term is reasonable, the court must resolve the ambiguity favor of the administrator's interpretation. *Sznewajs v. U.S. Bancorp Amended & Restated Supplemental Benefits Plan*, 572 F.3d 727 (9th Cir. 2009).

Where a plan grants the administrator unambiguous discretion to interpret the Plan and determine eligibility, the proper standard of review is abuse of discretion. *Nolan v. Heald College*, 551 F.3d 1148 (9th Cir. 2009).

Where a plan administrator operates under a conflict of interest, the conflict must be weighed as a factor in determining whether there is an abuse of discretion and the proper standard is to temper the abuse of discretion standard with skepticism commensurate with the conflict. *Nolan v. Heald College*, 551 F.3d 1148 (9th Cir. 2009).

Where a conflict of interest is present and appears to have influenced the claim review process, a modicum of evidence supporting a plan administrator's decision is insufficient against the conflict of interest presented. A more complex analysis taking multiple factors into consideration is appropriate. *Montour v. Hartford Life & Accident Ins. Co.*, 582 F.3d 933 (9th Cir. 2009).

Where there is a conflict of interest, the district court must consider the following factors in determining whether the plan administrator abused its discretion in making a benefits determination: the extent to which the conflict motivates an administrator's decision, quality and quantity of medical evidence, whether there was an in-person medical evaluation or only file review of medical records, whether the administrator provided its experts with all the evidence, and whether the administrator considered a contrary

determination by the Social Security Administration. *Montour v. Hartford Life & Accident Ins. Co.*, 582 F.3d 933 (9th Cir. 2009).

Failure of administrator to submit extrinsic evidence of its efforts to achieve claims administration neutrality may be considered. *Montour v. Hartford Life & Accident Ins. Co.*, 582 F.3d 933 (9th Cir. 2009).

Extrinsic evidence of bias can include rate of claims denials and the frequency with which insurer contracted with the file reviewers it employs. *Montour v. Hartford Life & Accident Ins. Co.*, 582 F.3d 933 (9th Cir. 2009).

When an ERISA plan administrator has discretionary authority to construe plan terms and interprets an ambiguous plan term reasonably, the court must resolve the ambiguity in favor of the administrator's interpretation. *Sznewajs v. U.S. Bancorp Amended & Restated Supplemental Benefits Plan*, 572 F.3d 727 (9th Cir. 2009).

When reviewing a claim administrator's decision, the court must give full effect to the entire pension plan, including provisions granting the administrator discretionary authority over interpretation of plan provisions. *Sznewajs v. U.S. Bancorp Amended & Restated Supplemental Benefits Plan*, 572 F.3d 727 (9th Cir. 2009).

ERISA: Summary Plan Description

ERISA benefit plans must provide plan participants with a Summary Plan Description, which is an employee's primary source of information regarding benefits and the statutorily established means of informing participants of the terms of the plan and its benefits. *Scharff v. Raytheon Co. Short Term Disability Plan*, 581 F.3d 899 (9th Cir. 2009).

Where a one year contractual statute of limitations provision in a Summary Plan Description was placed at the end of the disability chapter, after the discussion of disability benefits, it met ERISA regulatory requirements under 29 C.F.R. section 2520.102-2(b), which provide that limitations must to be disclosed in close conjunction to benefits provisions in the Summary Plan Description. *Scharff v. Raytheon Co. Short Term Disability Plan*, 581 F.3d 899 (9th Cir. 2009).

Where a one year contractual statute of limitations provision contained in an Summary Plan Description was placed in the chapter entitled Disability, under the large-typeface, bolded and italicized heading, ***"Claims Appeal Procedure,"*** the court held it was not obscured or relegated to fine print and satisfied 29 U.S.C. section 022(b), which requires any description of limitations to plan benefits not be minimized in the Summary Plan Description. *Scharff v. Raytheon Co. Short Term Disability Plan*, 581 F.3d 899 (9th Cir. 2009).

A one year contractual limitations provision in an ERISA plan falls within the purview of 29 U.S.C. section 1022(b), requiring Summary Plan Description to contain information regarding any "circumstances which may result in disqualification, ineligibility, or denial or loss of benefits" and must therefore satisfy 29 U.S.C. section 1022(a). *Scharff v. Raytheon Co. Short Term Disability Plan*, 581 F.3d 899 (9th Cir. 2009).

The summary plan description constitutes part of the plan documents and must be considered by the court in determining plan requirements. *Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 129 S. Ct. 865 (2009).

Exclusions

An exclusion providing that an employee not at work because of a disability at the time coverage becomes effective is not covered for Long Term Disability benefits "until you return to work and deductions are taken from your pay," clearly and unambiguously excludes an employee who was on disability leave at the time the Long Term Disability plan became effective; therefore, subsequent miscommunications between the plan administrator and the beneficiary regarding her benefits were irrelevant. *Bellah v. American Airlines, Inc.*, 656 F. Supp. 2d 1207 (E.D. Cal. 2009).

An ERISA plan's repeated assertion that certain activities are not covered creates a "default presumption of no coverage that must be then overcome by a showing of" coverage. An insurer's specific inclusion of names of affiliated (contracted) medical treatment centers, created a presumption that the insured's decision to select and seek treatment from non-contracted treatment center was deemed not covered under the plan. *Dupree v. Holman Prof'l.Counseling Ctrs*., 572 F.3d 1094 (9th Cir. 2009).

A provision in a disability policy which limit benefits for mental or emotional disorders is ambiguous and does not apply to a situation where the claimant suffers disability with both physical and mental components. *Bosetti v. U.S. Life Ins. Co.*, 175 Cal.App.4th 1208 (2009).

Federal Pleading Requirements: Well-Pleaded Complaint Rule

Generally speaking, a cause of action arises under federal law only when the plaintiff's well-pleaded complaint raises issues of federal law. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941 (9th Cir. 2009).

The well-pleaded complaint rule is the basic principle marking the boundaries of the federal question jurisdiction of the federal district courts. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941 (9th Cir. 2009).

There is an exception to the well-pleaded complaint rule for state-law causes of action that are completely preempted by section 502(a) of ERISA. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941 (9th Cir. 2009).

Fraud: Reliance

A non-party to an insurance contract cannot state a claim for fraud where there is no possibility the non-party would detrimentally change its position based on the insurer's representations. *Mega Life And Health Ins. Co. v. Super. Ct.*, 172 Cal.App.4th 1522 (2009).

Hospital Lien Act – See California Civ. Code § 3045.2

Insurance Credit Scoring

Federal law does not reverse-preempt a claim of disparate impact race discrimination in insurer's practice of computing insured's credit scoring for purposes of determining premiums. *Ojo v. Farmers Group, Inc.*, 565 F.3d 1175 (9th Cir. 2009). ***Not citable. Rehearing, en banc, granted.***

In Texas and other states, laws that prohibit insurers from unfairly discriminating against insureds through a credit scoring system, an insured may maintain a lawsuit for violation of the federal Fair Housing Act. *Ojo v. Farmers Group, Inc.*, 565 F.3d 1175 (9th Cir. 2009). ***Not citable. Rehearing, en banc, granted.***

Insureds

A health insurer does not owe a legal duty to the non-party spouse of the insured. *Mega Life and Health Ins. Co. v. Super. Ct.*, 172 Cal. App.4th 1522 (2009).

Internal Revenue Code

The tax qualification provisions of the Internal Revenue Code, and the Treasury Regulations promulgated thereunder, do not modify an ERISA benefit plan to mandate inclusion of employees whom the plan has permissibly excluded. *Bellah v. American Airlines, Inc.*, 656 F. Supp. 2d 1207 (E.D. Cal. 2009).

Congress did not intend, under 26 U.S.C. section 410 or 414, to expand employee rights to benefits under ERISA. *Bellah v. American Airlines, Inc.*, 656 F. Supp. 2d 1207 (E.D. Cal. 2009).

Interpleader

While an estate seeking the decedent's pension benefits suggested a plan administrator could resolve such disputes by interpleader actions, the Supreme Court held this merely restated the problem with the estate's position, i.e., "it would destroy a plan administrator's ability to look at the plan documents and records conforming to them to get clear distribution instructions, without going into court." *Kennedy v. Plan Adm'r for DuPont Sav. & Inv. Plan*, 129 S. Ct. 865 (2009).

Knox-Keene Act – See California Health & Safety Code §§ 1371.4 and 1389.3

Life Insurance

Life insurance policies are neither "goods" nor "services" under the Consumers Legal Remedies Act ("CLRA"). Thus, consumers do not have a valid claim against the issuers of their life insurance policies under the terms of the CLRA. *Fairbanks v. Super. Ct.*, 46 Cal.4th 56 (2009).

Misrepresentation – See Also Rescission

A misrepresentation or concealment of a material fact in connection with an application for insurance is grounds for rescission of the insurance contract. Such a misrepresentation can also provide a defense in an action by the insured on the contract. *Superior Dispatch, Inc. v. Ins. Corp. of New York,* 176 Cal.App.4th 12 (2009). ***Not citable. Rehearing granted.***

A letter from the plan administrator stating that "the company will provide benefits for you at active rates," but which letter does not mention the LTD policy or any modification of the LTD policy, did not constitute a "representation" to a beneficiary that she would be eligible for LTD benefits for which she was not otherwise eligible under the terms of the LTD plan. *Bellah v. American Airlines, Inc.*, 656 F. Supp. 2d 1207 (E.D. Cal. 2009).

An ERISA beneficiary was not entitled to recover benefits under an equitable estoppel theory where the language of the plan was clear and unambiguous, notwithstanding subsequent miscommunications between the beneficiary and plan administrator regarding the beneficiary's eligibility for benefits. *Bellah v. American Airlines, Inc.*, 656 F. Supp. 2d 1207 (E.D. Cal. 2009).

An exclusion providing that an employee who is not at work because of a disability at the time coverage becomes effective is not covered for LTD benefits "until you return to work and deductions are taken from your pay" clearly and unambiguously excludes an employee who was on disability leave at the time the LTD plan became effective; therefore, subsequent miscommunications between the plan administrator and the beneficiary regarding her benefits were irrelevant. *Bellah v. American Airlines, Inc.*, 656 F. Supp. 2d 1207 (E.D. Cal. 2009).

Prejudgment Interest

A district court may award pre-judgment interest on past-due benefits in ERISA cases when a balancing of the equities so provides. Prejudgment interest is calculated at a rate equal to the weekly average 1-year constant maturity Treasury yield, as published by the Board of Governors of the Federal Reserve System, for the calendar week preceding the

date of the judgment. *Minton v. Deloitte and Touche USA LLP Plan*, 631 F. Supp. 2d 1213 (N.D. Cal . 2009).

Primary Jurisdiction Doctrine

A trial court's decision to not refer a claim to an administrative agency under doctrine of primary jurisdiction is reviewed under an abuse of discretion standard. *Blue Cross of California, Inc. v. Super. Ct.*, 180 Cal.App.4th 1237 (2009).

The doctrine of primary jurisdiction comes into play whenever enforcement of claim requires the resolution of issues which, under a regulatory scheme, have been placed within the special competence of an administrative body; in such a case the judicial process is suspended pending referral of such issues to the administrative body for its views. *Blue Cross of California, Inc. v. Super. Ct.*, 180 Cal.App.4th 1237 (2009).

The doctrine of primary jurisdiction applies to claims properly cognizable in court that contain some issue within the special competence of an administrative agency. It requires the court to enable a "referral" to the agency, staying further proceedings so as to give the parties reasonable opportunity to seek an administrative ruling. *Blue Cross of California, Inc. v. Super. Ct.*, 180 Cal.App.4th 1237 (2009).

The doctrine of primary jurisdiction is subject to a futility exception: It is improper to invoke the primary jurisdiction of an administrative agency if it is clear that further proceedings within that agency would be futile. *Blue Cross of California, Inc. v. Super. Ct.*, 180 Cal.App.4th 1237 (2009).

Proposition 103 – See California Ins. Code § 1850.4, *et seq.*

Punitive Damages – See Also California Civ. Code § 3294

Employees of insurer can bind insurer for purposes of punitive damages where employees possess a degree of discretion in making decisions that ultimately determine corporate policy. *Major v. Western Home Ins. Co.*, 169 Cal.App.4th 1197 (2009).

When insurer's employees dispose of insureds' claims with little, if any, supervision, they possess sufficient discretion for the law to impute their actions concerning those claims to the insurer. *Major v. Western Home Ins. Co.*, 169 Cal.App.4th 1197 (2009).

Award of punitive damages against insurer was appropriate where insurer acted with oppression; malice was not required to award punitive damages. *Major v. Western Home Ins. Co.*, 169 Cal.App.4th 1197 (2009).

Punitive damages are proper in an insurance bad faith action. *McCoy v. Progressive West Ins. Co.*, 171 Cal.App.4th 785 (2009).

In a civil case not arising from the breach of a contractual obligation, the jury may award punitive damages "where it is proven by clear and convincing evidence that the defendant has been guilty of oppression, fraud, or malice." Cal. Civ. Code section 3294. *Roby v. McKesson Corp.*, 47 Cal.4th 686 (2009).

Malice is defined as intentional injury or "despicable conduct which is carried on by the defendant with a willful and conscious disregard of the rights or safety of others." Cal. Civ. Code section 3294. *Roby v. McKesson Corp.*, 47 Cal.4th 686 (2009).

Oppression is defined as "despicable conduct that subjects a person to cruel and unjust hardship in conscious disregard of that person's rights." Cal. Civ. Code section 3294. *Roby v. McKesson Corp.*, 47 Cal.4th 686 (2009).

Punitive Damages: Due Process

The due process clause of the Fourteenth Amendment to the United States Constitution places constraints on state court awards of punitive damages. The imposition of grossly excessive or arbitrary awards is constitutionally prohibited, for due process entitles a tortfeasor to fair notice of the conduct that will subject him to punishment and of the severity of the penalty that a state may impose. *Roby v. McKesson Corp.*, 47 Cal.4th 686 (2009).

Reasonable Expectations of the Insured Doctrine – See Contract Interpretation

Removal

The burden of establishing federal subject matter jurisdiction falls on the party invoking removal. *Marin Gen. Hosp. v. Modesto & Empire Traction Co.*, 581 F.3d 941 (9th Cir. 2009).

Rescission – See Also Misrepresentation

A misrepresentation or concealment of a material fact in connection with an application for insurance is grounds for rescission of the insurance contract. Such a misrepresentation can also provide a defense in an action by the insured on the contract. *Superior Dispatch, Inc. v. Ins. Corp. of New York,* 176 Cal.App.4th 12 (2009). ***Not citable. Rehearing granted.***

Standing

A non-party to a health insurance contract, including a surviving spouse, lacks standing to sue for fraud. *The Mega Life And Health Ins. Co. v. Super. Ct.*, 172 Cal.App.4th 1522 (2009).

Statute of Limitations: Delayed Discovery

When a plaintiff should have discovered facts for purposes of accrual of a cause of action is generally a question of fact but is properly decided as a matter of law on demurrer if the allegations in the complaint and the facts properly subject to judicial notice can support only one reasonable conclusion. *Broberg v. Guardian Life Ins. Co.*, 171 Cal.App.4th 912 (2009).

Statutes: Validity

A facial challenge is "the most difficult challenge to mount successfully" since the challenger must establish that no set of circumstances exists under which the law would be valid. *Ass'n of California Ins. Co. v. Poizner*, 180 Cal.App.4th 1029 (2009).

A moving party that raises a facial challenge to the validity of a statute or regulation must show that the challenged statutes or regulations "inevitably pose a present total and fatal conflict" with applicable prohibitions. *Ass'n of California Ins. Co. v. Poizner*, 180 Cal.App.4th 1029 (2009).

Unfair Competition Laws – See California Bus. & Prof. Code § 17200

Statutory Interpretation

In statutory construction, the fundamental task is to ascertain the Legislature's intent and thereby effectuate the purpose of the statute. *Clark v. Super. Ct.*, 174 Cal.App.4th 82 (2009). ***Not citable. Review granted.***

The statutory language is generally the most reliable indication of legislative intent. If there is no ambiguity in the statutory language, then courts presume the lawmakers meant what they said, and the plain meaning of the language governs. *Clark v. Super. Ct.*, 174 Cal.App.4th 82 (2009). ***Not citable. Review granted.***

Only if the statutory language is ambiguous may the court look to extrinsic sources for statutory construction, including the ostensible objects to be achieved by the statute and the legislative history. *Clark v. Super. Ct.*, 174 Cal.App.4th 82 (2009). ***Not citable. Review granted.***

When a statute is ambiguous, courts must consider all laws *in pari materia*, meaning they are to consider all laws related to the subject of the act and the general system of legislation of which the act forms a part. *Ojo v. Farmers Group, Inc.*, 565 F.3d 1175 (9th Cir. 2009). ***Not citable. Rehearing, en banc, granted.***

"The cardinal principle of statutory construction is to save and not to destroy. It is the court's duty to give effect, if possible, to every clause and word of a statute, rather than to

emasculate an entire section . . . ." *Ojo v. Farmers Group, Inc.*, 565 F.3d 1175 (9th Cir. 2009). ***Not citable. Rehearing, en banc, granted.***

The absence of specific statutory provisions in Proposition 103 (codified as California Insurance Code sections 1861.01, *et seq.*) relating to the resolution of a rate application without a public hearing (e.g., as by way of a settlement) does not mean that regulations permitting such resolution exceed statutory authority, but only that the electorate deferred to and relied upon the expertise of the Insurance Commissioner as to such matters. *Ass'n of California Ins. Co. v. Poizner*, 180 Cal.App.4th 1029 (2009).

A facial challenge to a statute is "the most difficult challenge to mount successfully," since the challenger must establish that no set of circumstances exists under which the law would be valid. *Ass'n of California Ins. Co. v. Poizner*, 180 Cal.App.4th 1029 (2009).

A moving party that raises a facial challenge to the validity of a statute or regulation must show that the challenged statutes or regulations "inevitably pose a present total and fatal conflict" with applicable prohibitions. *Ass'n of California Ins. Co. v. Poizner*, 180 Cal.App.4th 1029 (2009).

Summary Judgment

After *Abatie v. Alta Health & Life Insurance Co*., 458 F.3d. 955 (9th Cir. 2006), district courts are required to weigh evidence according to the traditional rules of summary judgment. As such, evidence outside the administrative record submitted by a party must be examined in the light most favorable to the non-moving party. *Nolan v. Heald*

Third Party Administrators

A third party claims administrator can successfully demur to a breach of contract action by an insured where no contract exists between the insured and the third party administrator. *Bosetti v. U.S. Life Ins. Co.*, 175 Cal.App.4th 1208 (2009).

Unfair Competition Law - See California Bus. & Prof. Code § 17200

Washington Law

The State of Washington recognizes quasi-marital relationships for the purposes of property division. *Owens v. Automotive Machinists Pension Trust*, 551 F.3d 1138 (9th Cir. 2009).

Washington law limits property distributed at the end of a quasi-marital relationship to that which would have been categorized as community property if the couple been married. *Owens v. Automotive Machinists Pension Trust*, 551 F.3d 1138 (9th Cir. 2009).

ERISA does not explicitly define "marital property rights." *Owens v. Automotive Machinists Pension Trust*, 551 F.3d 1138 (9th Cir. 2009).

Under ERISA, a Qualified Domestic Relations Order ("QDRO") is defined as a domestic relations order that creates or recognizes the existence of an alternate payee's right to receive benefits with respect to a participant under a plan. A QDRO applies to any judgment or order that relates to the provision of child support, alimony payments, or marital property rights to a spouse, former spouse, child or other dependent of a participant, and is issued pursuant to a state domestic relations law. (29 U.S.C. section 1056(d)(3)(B)(ii)(I).) *Owens v. Automotive Machinists Pension Trust*, 551 F.3d 1138 (9th Cir. 2009).

"Dependent" is defined as an individual, other than a spouse, that for the taxable year of the taxpayer shares the same principal place of abode with the taxpayer and is a member of the taxpayer's household. (I.R.C. section 152(d)(2(H).) *Owens v. Automotive Machinists Pension Trust*, 551 F.3d 1138 (9th Cir. 2009).

"The Internal Revenue Code ("IRC") defines dependant as: "[a]n individual (other than … the spouse … of the taxpayer) who, for the taxable year of the taxpayer, has the same principal place of abode as the taxpayer and is a member of the taxpayer's household." *Owens v. Automotive Machinists Pension Trust*, 551 F.3d 1138 (9th Cir. 2009).

GORDON & REES LLP

RESPONSIVE • RESOURCEFUL • RESULTS™

National Office Locations

ARIZONA

Phoenix
111 W. Monroe Street
Suite 1111
Phoenix, AZ 85003
Phone: (602) 794-2460
Fax: (602) 265-4716

CALIFORNIA

San Francisco
275 Battery Street
Suite 2000
San Francisco, CA 94111
Phone: (415) 986-5900
Fax: (415) 986-8054

San Diego
101 W. Broadway
Suite 2000
San Diego, CA 92101
Phone: (619) 696-6700
Fax: (619) 696-7124

Los Angeles
633 West Fifth Street
Suite 4900
Los Angeles, CA 90071
Phone: (213) 576-5000
Fax: (213) 680-4470

Orange County
2211 Michelson Drive
Suite 400
Irvine, CA 92612
Phone: (949) 255-6950
Fax: (949) 474-2060

Sacramento
655 University Avenue
Suite 200
Sacramento, CA 95825
Phone: (916) 565-2900
Fax: (916) 920-4402

COLORADO

Denver
555 Seventeenth Street
Suite 3400
Denver, CO 80202
Phone: (303) 534-5160
Fax: (303) 534-5161

FLORIDA

Miami
201 S. Biscayne Blvd.
28th Floor
Miami, FL 33131
Phone: (305)668-4433
Fax: (877)634-7245

ILLINOIS

Chicago
One North Franklin
Suite 800
Chicago, IL 60606
Phone: (312) 565-1400
Fax: (312) 565-6511

NEVADA

Las Vegas
3770 Howard Hughes Parkway
Suite 100
Las Vegas, NV 89169
Phone: (702) 577-9300
Fax: (702) 255-2858

NEW JERSEY

Florham Park
18 Columbia Turnpike
Suite 220
Florham Park, NJ 07932
Phone: (973) 549-2500
Fax: (973) 377-1911

NEW YORK

Long Island
50 Charles Lindbergh Blvd.
Uniondale, NY 11553
Phone: (516) 229-2246
Fax: (516) 229-2350

New York
90 Broad Street, 23rd Floor
New York, NY 10004
Phone: (212) 269-5500
Fax: (212) 269-5505

OREGON

Portland
601 SW 2nd Avenue
Suite 2300
Portland, OR 97204
Phone: (503) 222-1075
Fax: (503) 907-6636

TEXAS

Dallas
2100 Ross Avenue
Suite 2800
Dallas, TX 75201
Phone: (214) 231-4660
Fax: (214) 461-4053

Houston
3D/International Tower
1900 West Loop South
Suite 1000
Houston, TX 77027
Phone: (713) 961-3366
Fax: (713) 961-3938

WASHINGTON

Seattle
701 Fifth Avenue
Suite 2100
Seattle, WA 98104
Phone: (206) 695-5100
Fax: (206) 689-2822