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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA – SAN JOSE DIVISION

NETSCAPE COMMUNICATIONS CORPORATION, a Delaware corporation; and AMERICA ONLINE, INC., a Delaware corporation; Plaintiffs, v. FEDERAL INSURANCE COMPANY, an Indiana corporation; ST. PAUL MERCURY INSURANCE COMPANY, a Minnesota corporation; EXECUTIVE RISK SPECIALTY INSURANCE COMPANY; a Connecticut corporation, and DOES 1 through 50, Defendants.	CASE NO. C-06-00198 PVT **DECLARATION OF SARA M. THORPE IN SUPPORT OF DEFENDANT ST. PAUL'S MOTION TO DISMISS PLAINTIFFS' NINTH CAUSE OF ACTION, MOTION TO STRIKE PRAYER, OR ALTERNATIVELY FOR MORE DEFINITE STATEMENT** **[F. R. Civ. P. 12(b)(6), 12(e), 12(f)]** **Date: February 27, 2006** **Time: 9:00 a.m.** **Judge: James Ware** **Dept.: Courtroom 8** **Complaint Filed: December 12, 2005**

I, Sara M. Thorpe, declare as follows:

1. I am an attorney licensed to practice law in the State of California and in the Northern District of California, and am a partner with the law firm of Gordon & Rees LLP, counsel of record for Defendant ST. PAUL MERCURY INSURANCE COMPANY (hereinafter "St. Paul") in the above-entitled action.

2. I have personal knowledge of the following facts, and if called as a witness, could and would testify competently thereto. I submit this declaration in support of St. Paul's Motion To Dismiss Plaintiffs' Ninth Cause Of Action, Motion To Strike Prayer, Or Alternatively For More Definite Statement.

3. Attached hereto as Exhibit A, is a true and correct copy of a letter dated January 13, 2006, I sent to Michael Bruce Abelson requesting that Plaintiffs voluntarily dismiss the Ninth Cause of Action.

4. Attached hereto as Exhibit B, is a true and correct copy of a letter dated January 17, 2006, from Leslie A. Pereira to Sara Thorpe and Terrence McInnis with a response to our request.

5. Attached hereto as Exhibit C, is a true and correct copy of a letter dated January 18, 2006, I sent back to Leslie A. Pereira explaining that the case upon which she relies (*Progressive v. Superior Court* (Preciado)) does not address our arguments for why the Ninth Cause of Action is unsustainable in the context of this case.

6. Prior to filing this motion, I did not receive any indication from Plaintiffs that they would agree to voluntarily dismiss their Ninth Cause of Action.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed on January 19, 2006 in San Francisco, California.

Sara M. Thorpe

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EXHIBIT “A”

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January 13, 2006

VIA FACSIMILE & U.S. MAIL

Michael Bruce Abelson
Abelson Herron
333 S. Grand Avenue, Suite 650
Los Angeles, CA 90071

Re: *Netscape Communications, Corp., et al. v. Federal Insurance Co., et al.*

Dear Mr. Abelson:

I am writing on behalf of our client, St. Paul Mercury Insurance Company, to initiate a meet and confer regarding the sufficiency of the allegations made in the Complaint filed by Netscape and AOL in the above-entitled action.

In the Ninth Cause of Action of the Complaint, Plaintiffs allege St. Paul has a purported "policy and practice of automatically denying claims," which amounts to an unfair business practice under Business & Professions Code § 17200. It is well-settled California law, however, that allegations of unfair and unlawful claim practices cannot support a claim under Section 17200 for several reasons.

First, Plaintiffs' Section 17200 claim is improper because it is nothing more than an attempt to bring a private cause of action for unfair insurance practices under Insurance Code Section 790.03. California courts hold that a private party cannot maintain an action for activities covered by Section 790.03 nor plead those activities as a basis for a claim under Section 17200. See, *Moradi-Shalal v. Fireman's Fund Insurance Cos.*, 46 Cal. 3d 287, 304-05 (1988); *Textron v. Financial Corp. v. National Union Fire Ins. Co.*, 118 Cal. App. 4th 1061, 1070 (2004). Consequently, Plaintiffs' Section 17200 claim fails as a matter of law.

Second, Plaintiffs cannot state a claim for relief under Section 17200 because it is clear from the allegations in Plaintiffs' Complaint that Plaintiffs already have an adequate remedy at law. See, *Heighley v. J.C. Penney Life Ins. Co.*, 257 F. Supp. 2d 1241, 1259-60 (C.D. Cal. 2003) (inadequacy of legal remedies is a necessary element to support a claim for equitable relief pursuant to Section 17200). Plaintiffs plead a claim for breach of contract and breach of the covenant of good faith and fair dealing, which provide adequate remedies if proven.

Third, Section 17200 provides for equitable relief, but does not allow the recovery of damages for unfair or unlawful business practices. *See Korea Supply Co. v. Lockheed Martin Corp.*, 29 Cal. 4th 1134, 1150 (2003). Plaintiffs' prayer for "disgorgement" is nothing more than a thinly disguised claim for damages for policy benefits allegedly due and owing to Plaintiffs and, therefore, is not proper under Section 17200.

Fourth, even if Plaintiffs could allege a claim under Section 17200, Plaintiffs fail to allege a violation of Section 17200 with sufficient particularity. See, *Khoury v. Maly's of California, Inc.*, 14 Cal. App. 4th 612, 618 (1993) (upholding dismissal of Section 17200 claim because complaint failed to describe with reasonable particularity facts supporting alleged violation). In the Section 17200 claim, Plaintiffs merely incorporate their breach of contract claims by reference and assert a *single* conclusory allegation, based solely on information and belief, that St. Paul has an alleged "policy and practice of automatically denying all claims that implicate 'personal injury' and/or 'Media Activities' coverages when privacy allegations are asserted against insureds." Complaint, ¶ 78. Even under the liberal pleading standards of F. R. Civ. P. 8, Plaintiffs' allegation is wholly insufficient to state a claim for unfair business practices. See, *Silicon Knights, Inc. v. Crystal Dynamics, Inc.*, 983 F. Supp. 1303, 1316 (N.D. Cal. 1997) ("plaintiff alleging unfair business practices under [Section 17200] 'must state with reasonable particularity the facts supporting the statutory elements of the violation'").

In addition, Plaintiffs' assertion of this inflammatory unfair business practice claim based on a *single*, vague and conclusory allegation runs afoul of F. R. Civ. P. 11. Rule 11 imposes a duty on attorneys to certify by their signature that a pleading is "well-grounded in fact." *Smith v. Ricks*, 31 F.3d 1478, 1488 (9th Cir. 1994). Given that the single conclusory allegation in the Complaint is based on information and belief, it does not appear that Plaintiffs conducted a reasonable investigation before asserting their Section 17200 claim or have a good faith basis on which to assert this claim. Thus, if Plaintiffs insist on proceeding with the Section 17200 claim, St. Paul reserves the right to seek all available remedies under Rule 11.

Please let us know by **5:00 p.m., Tuesday, January 17, 2005** whether Plaintiffs will voluntarily dismiss their Section 17200 claim and amend their Complaint accordingly. If you are interested in doing so, we will make ourselves available for a telephone conference with all parties to further discuss this issue prior to that time.

If Plaintiffs refuse to dismiss their Section 17200, St. Paul will file a motion to dismiss and pursue any other relief, as appropriate. In that regard, we will set a hearing date for the motion for the end of February. Please let us know if you are unavailable during that period of time.

Very truly yours,

SARA M. THORPE

cc: Daniel Bergeson, Esq.

Terry McInnis, Esq.
John Duchelle, Esq.
Counsel for Chubb & Executive Risk

Jeffrey M. Ratinoff, Esq.

EXHIBIT “B”

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Abelson Herron LLP

January 17, 2006

VIA FACSIMILE

Ms. Sara M. Thorpe
Gordon & Rees LLP
Embarcadero Center West
275 Battery Street, Suite 2000
San Francisco, CA 94111

Mr. Terrence R. McInnis
Ross, Dixon & Bell, LLP
5 Park Plaza, Suite 1200
Irvine, CA 92614-8592

Re: *Netscape Communications Corp., et al. v. Federal Ins. Co., et al.*

Dear Ms. Thorpe and Mr. McInnis:

We have carefully considered St. Paul's January 13, 2005 letter and the letter dated January 12, 2005 from Federal and Executive Risk (which was apparently not sent until January 17, 2005), and the authorities cited therein. For the following reasons, Netscape and AOL must respectfully decline Defendants' requests that they voluntarily dismiss the Ninth Cause of Action for Unfair Business Practices brought under California Business & Professions Code, § 17200 (hereinafter, the "Unfair Business Practices Claim"). Moreover, our further research suggests that a motion to dismiss along the lines set forth in Defendants' letters would be unsuccessful and would merely serve to waste the parties' and the court's resources and needlessly delay this action. Accordingly, we urge Defendants to consider the propriety and efficacy of such a motion in light of the authorities referenced below.

* * * * *

Just last month, the California Court of Appeal rejected an insurance company's attempt to dismiss an insured's unfair business practices claim under circumstances similar to those at issue here. See Progressive West Ins. Co. v. Superior Court (Preciado), 2005 DJDAR 14927 (December 28, 2005). For your convenience, a copy of this case is enclosed.

In Progressive, an insurance company sued its insured, Preciado, for reimbursement of medical payments. Preciado filed a cross-complaint alleging, among other things, a claim for unfair business practices under California Business and Professions Code Section 17200 based on his assertion that Progressive had a practice of making improper demands for reimbursement. In particular, Preciado included the following two allegations in his cross-complaint:

1. Progressive has a "pattern and practice of seeking med-pay reimbursement even though it never engaged in any discussion, analysis, or conclusion that the injured party has in fact been made whole" and "continues to seek[] sums it is not entitled to as a matter of law to further its unlawful scheme"; and

2. Progressive has a "pattern and practice of ignoring California law by seeking 100% reimbursement for the amounts paid under its med-pay provision. This systematic scheme is contrary to California law, and is nothing more than a sharp, illicit business practice."

The Progressive court held that Preciado sufficiently pled a claim for unfair business practices and, therefore, the trial court properly overruled Progressive's demurrer.[1] The court noted that claims for unfair business practices under Section 17200 can be based on conduct which is "fraudulent", "unfair" or "unlawful." Id. at 11. To satisfy the "fraud" prong, it is sufficient to allege that members of the public are "likely" to be deceived by the defendant's conduct. Id. at 12 ("Instead, it is only necessary to show that members of the public are likely to be deceived."). When determining whether a business practice is "unfair," the court must engage in a "balancing test" – i.e., it must examine the impact of the practice on the victim balanced against the justifications and motives of the alleged wrongdoer. Id. at 12. Finally, a business practice is "unlawful" when it is "forbidden by law." Id. at 14.

In terms of Preciado's allegations, the court held that he properly alleged a claim under the "fraud" and "unfair" prongs of the test. First, Preciado alleged that Progressive demands 100 percent reimbursement from its insureds without regard to whether the insured may have a set-off under common law principles. Id. at 12. This conduct, according to the court, "is likely to deceive the public" and, therefore, properly states a cause of action for unfair business practices. Id. Second, the court held that the same allegations by Preciado support his claim under the "unfair" prong since the balancing test is "fact intensive" and "not conducive to resolution at the demurrer stage" because "[t]he facts and evidence have not yet been adduced." Id. at 13.

Here, Netscape's and AOL's unfair business practices claim is analogous to Preciado's claim, and is sufficiently pled under the framework set forth in Progressive. In support of their claim, Netscape and AOL allege that Defendants "have a policy and practice of automatically denying all claims that implicate their 'personal injury' and/or 'Media Activities' coverages when privacy allegations are asserted against their insureds." See Complaint, ¶ 78. Netscape and AOL further allege that Defendants' practices are "unfair and present a continuing threat to Netscape, AOL and members of the public" because they "deprive policyholders of the insurance coverage they intend to purchase and believe they have purchased." See Complaint, ¶ 79. Plainly, these allegations support the "fraud" prong of the unfair business practices test set forth in Progressive because this conduct – selling "personal injury" and/or "Media Activities" coverages to policyholders when, in fact, the insurers have no intent to honor such coverage – is likely to deceive members of the public about the scope and nature of coverage purchased from Defendants. Further, these allegations also support the "unfair" prong of the test because Defendants' alleged conduct (which we expect to be borne out by facts revealed during discovery) can certainly be characterized as "immoral, unethical, oppressive, unscrupulous or substantially injurious to consumers" if not counter-balanced by Defendants' "justifications and motives" (also to be revealed during discovery). See Progressive West Ins. Co. v. Superior Court (Preciado), 2005 DJDAR 14927 (December 28, 2005).

[1] As you know, a "demurrer" is California's state court equivalent of a motion to dismiss made in federal court under FRCP 12(b)(6). See Cal. Code Civ. Proc., § 430.10; The Rutter Group, Federal Civil Procedure Before Trial, § 9:187.

As you see, Progressive plainly disposes of the pleading issues raised in your letter and establishes that Netscape's and AOL's Ninth Cause of Action is properly pled. If you disagree with some aspect of our analysis of that case, please let us know as soon as possible so that we may promptly reconsider our views.

Very truly yours,

Leslie A. Pereira
Of Abelson | Herron LLP

Enclosure

*2005 Cal. App. LEXIS 1979, *; 2005 Cal. Daily Op. Service 10923; 2005 Daily Journal DAR 14927*

PROGRESSIVE WEST INSURANCE COMPANY, Petitioner, v. YOLO COUNTY SUPERIOR COURT, Respondent; SIMON H. PRECIADO, Real Party in Interest.

C050149

COURT OF APPEAL OF CALIFORNIA, THIRD APPELLATE DISTRICT

2005 Cal. App. LEXIS 1979; 2005 Cal. Daily Op. Service 10923; 2005 Daily Journal DAR 14927

December 28, 2005, Filed

PRIOR HISTORY: [*1] Superior Court of Yolo County, No. CV042056, Thomas Edward Warriner, Judge.

CASE SUMMARY:

PROCEDURAL POSTURE: Petitioner insurance company sought a writ of mandate after respondent superior court overruled its demurrer to real party in interest insured's cross-complaint, alleging causes of action for breach of contract, breach of the covenant of good faith and fair dealing, and unfair business practices under Bus. & Prof. Code, § 17200.

OVERVIEW: The insurance company sought to recover money it paid the insured under a first-party medical payments provision of his automobile insurance policy. The court held that the insured failed to state a cause of action for breach of the implied covenant of good faith and fair dealing because the insured acknowledged that the insurance company paid him what was due under that policy. The insured also failed to state a cause of action for breach of contract because the insurance company did not have the burden to investigate or determine all of the facts required to ascertain the extent to which the made-whole rule and the common-fund doctrine could constitute a defense to the insurance company's right of reimbursement. The insured did state a cause of action of fraudulent business practices by alleging that the insurance company asserted its rights to 100 percent recovery of all moneys it paid to insureds, regardless of whether that reimbursement should be denied altogether or partially due to the made-whole rule and the common-fund doctrine. Further, the insured alleged that the insurance company misled its policyholders and made misrepresentations in connection with these activities.

OUTCOME: The court issued a writ of mandate, commanding the superior court to vacate its order overruling the demurrer and in its place enter a new order sustaining the demurrer without leave to amend as to the causes of action for breach of contract and breach of the covenant of good faith and fair dealing and overruling it as to the insured's cause of action for unfair business practices.

CORE TERMS: insured, insurer, reimbursement, fair dealing, subrogation, made-whole, covenant, unfair, common-fund, cause of action, coverage, demurrer, unreasonably, duty, third party, insurance policy, cross-complaint, tortfeasor, med-pay, insurance contract, unfair competition, consumer, investigate, settlement, implied covenant, deceived, balancing test, breached, prong, matter of law

LexisNexis(R) Headnotes

Insurance Law > Claims & Contracts > Subrogation

HN1 When an insurance company pays out a claim on a first-party insurance policy to its insured, the insurance company is subrogated to the rights of its insured against any tortfeasor who is liable to the insured for the insured's damages. Subrogation has its source in equity and arises by operation of law (legal or equitable subrogation). It can also arise out of the contractual language of the insurance policy (conventional subrogation). The subrogation provisions of most insurance contracts typically are general and add nothing to the rights of subrogation that arise as a matter of law.

Insurance Law > Claims & Contracts > Subrogation

HN2 Subrogation places the insurer in the shoes of its insured to the extent of its payment. In personal injury actions, however, the insurance company may not assert its subrogation claim directly against the third party tortfeasor on its own behalf. Moreover, the insurance company may not seek to "gang-press" a policyholder's personal injury attorney into service as a collection agent by suing the attorney to pay it any judgment or settlement proceeds from the third party that passes through that attorney's hands. Thus, to preserve its right of subrogation, the insurance company must either interplead itself into any action brought by the insured against the third party tortfeasor, or wait to seek reimbursement under the language of its policy from its insured to the extent that the insured recovers money from the third party.

Insurance Law > Claims & Contracts > Subrogation

HN3 Where an insurance company does not interplead itself into the underlying action, the insurance company's rights to recover any payments received by its insured are limited. Under the made-whole rule, when an insurer does not participate in the insured's action against a tortfeasor, despite knowledge of that action, the insurer cannot recover any funds obtained through settlement of the action unless the full amount received exceeds the insured's actual loss. Furthermore, the insured need not account to the nonparticipating insurer for more than the surplus remaining in his hands, after satisfying his loss in full and his reasonable expenses incurred in the recovery. Thus, when an insurer elects not to participate in the insured's action against a tortfeasor, the insurer is entitled to subrogation only after the insured has recouped his loss and some or all of his litigation expenses incurred in the action against the tortfeasor.

Insurance Law > Claims & Contracts > Subrogation

HN4 There is a technical difference between subrogation and reimbursement. Subrogation refers to the right of the insurance company to step into the shoes of the insured and assert the insured's rights against the third party. Reimbursement refers to the right to receive payment back of what has been expended by the insurance company. That same commentator, however, acknowledges that those terms are often used interchangeably in the cases. In California, both the subrogation rights and reimbursement rights of the insurance company fall within the rubric of subrogation. Thus, both of those rights are limited by the made-whole rule.

Insurance Law > Claims & Contracts > Subrogation

HN5 It is a general equitable principle of insurance law that, absent an agreement to the contrary, an insurance company may not enforce a right to subrogation until the insured has been fully compensated for his or her injuries, that is, has been made whole. There is authority that language in an insurance policy that grants the insurance company all rights of recovery to the extent of its payment" overrides the common law made-whole rule.

Insurance Law > Claims & Contracts > Subrogation

HN6 Under the common-fund rule, when a number of persons are entitled in common to a

specific fund, and an action brought by a plaintiff or plaintiffs for the benefit of all results in the creation or preservation of that fund, such plaintiff or plaintiffs may be awarded attorney's fees out of the fund. Under this rule, an insurance company that does not participate in the underlying action must pay a pro rata share of the insured's attorney fees and costs when it seeks reimbursement from its insured out of funds obtained by the insured from the responsible third party. That is, the insurance company's reimbursement must be reduced proportionately to reflect the attorney fees paid by the insured.

Contracts Law > Contract Interpretation > Good Faith & Fair Dealing

HN7 Every contract imposes on each party an implied duty of good faith and fair dealing. Simply stated, the burden imposed is that neither party will do anything which will injure the right of the other to receive the benefits of the agreement. Or, to put it another way, the implied covenant imposes upon each party the obligation to do everything that the contract presupposes they will do to accomplish its purpose. A breach of the implied covenant of good faith and fair dealing involves something beyond breach of the contractual duty itself, and it has been held that bad faith implies unfair dealing rather than mistaken judgment. For example, in the context of the insurance contract, it has been held that the insurer's responsibility to act fairly and in good faith with respect to the handling of the insured's claim is not the requirement mandated by the terms of the policy itself--to defend, settle, or pay. It is the obligation under which the insurer must act fairly and in good faith in discharging its contractual responsibilities.

Insurance Law > Bad Faith & Extracontractual Liability > Failure to Settle

HN8 An insurer must investigate claims thoroughly; it may not deny coverage based on either unduly restrictive policy interpretations or standards known to be improper; it may not unreasonably delay in processing or paying claims. These special duties, at least to the extent breaches thereof give rise to tort liability, find no counterpart in the obligations owed by parties to ordinary commercial contracts. The rationale for the difference in obligations is apparent. If an insurer were free of such special duties and could deny or delay payment of clearly owed debts with impunity, the insured would be deprived of the precise benefit the contract was designed to secure (i.e., peace of mind) and would suffer the precise harm (i.e., lack of funds in times of crisis) the contract was designed to prevent. To avoid or discourage conduct which would thus frustrate realization of the contract's principal benefit (i.e., peace of mind), special and heightened implied duties of good faith are imposed on insurers and made enforceable in tort. While these special duties are akin to, and often resemble, duties which are also owed by fiduciaries, the fiduciary-like duties arise because of the unique nature of the insurance contract, not because an insurer is a fiduciary.

Insurance Law > Claims & Contracts > Good Faith & Fair Dealing

HN9 Because the essence of the tort of the implied covenant of good faith and fair dealing is focused on the prompt payment of benefits due under the insurance policy, there is no cause of action for breach of the covenant of good faith and fair dealing when no benefits are due.

Insurance Law > Claims & Contracts > Subrogation

HN10 It is true the made-whole rule and the common-fund doctrine are incorporated into the contract as the common law of the State of California. Nothing in the cases which discusses those doctrines, however, places the burden on the insurance company to investigate or determine all of the facts required to ascertain the extent to which these rules might constitute a defense to the insurance company's right of reimbursement.

Insurance Law > Claims & Contracts > Policy Interpretation > Contract Interpretation Rules

HN11 The interpretation of the language in an insurance policy is a question of law. In resolving such a question courts look first to the plain meaning of the disputed term to ascertain the mutual intention of the parties. As a general rule of construction, the parties are presumed to know and to have had in mind all applicable laws extant when an agreement is made. These existing laws are considered part of the contract just as if they were expressly referred to and incorporated.

Insurance Law > Claims & Contracts > Subrogation

HN12 The made-whole rule and the common-fund doctrine are both doctrines of equity that limit what the insurance company is entitled to receive in reimbursement from its insured. There is nothing in any of the cases discussing the made-whole rule or the common-fund doctrine that requires the insurance company to conduct an investigation before demanding repayment.

Torts > Business & Employment Torts > Unfair Business Practices

HN13 See Bus. & Prof. Code, § 17200.

Torts > Business & Employment Torts > Unfair Business Practices

HN14 Bus. & Prof. Code, § 17200, establishes three separate types of unfair competition. The statute prohibits practices that are either unfair, or unlawful, or fraudulent.

Torts > Business & Employment Torts > Unfair Business Practices

HN15 Bus. & Prof. Code, § 17200, is not confined to anticompetitive business practices, but is also directed toward the public's right to protection from fraud, deceit, and unlawful conduct. Thus, unfair competition statutes have always been framed in broad, sweeping language, precisely to enable judicial tribunals to deal with the innumerable new schemes which the fertility of man's invention would contrive.

Torts > Business & Employment Torts > Unfair Business Practices

HN16 A fraudulent business practice under Bus. & Prof. Code, § 17200, is not based upon proof of the common law tort of deceit or deception, but is instead premised on whether the public is likely to be deceived. Stated another way, in order to state a cause of action under the fraud prong of § 17200, a plaintiff need not show that he or others were actually deceived or confused by the conduct or business practice in question. The "fraud" prong of § 17200, is unlike common law fraud or deception. A violation can be shown even if no one was actually deceived, relied upon the fraudulent practice, or sustained any damage. Instead, it is only necessary to show that members of the public are likely to be deceived.

Torts > Business & Employment Torts > Unfair Business Practices

HN17 The balancing test established to determine whether a practice was "unfair" under Bus. & Prof. Code, § 17200, should continue to apply in consumer cases.

Torts > Business & Employment Torts > Unfair Business Practices

HN18 The balancing test required by the unfair business practice prong of Bus. & Prof. Code, § 17200, is fact intensive and is not conducive to resolution at the demurrer stage. Unfairness is an equitable concept that cannot be mechanistically determined under the relatively rigid legal rules applicable to the sustaining or overruling of a demurrer.

Torts > Business & Employment Torts > Unfair Business Practices

HN19 An unlawful business practice under Bus. & Prof. Code, § 17200, is an act or practice, committed pursuant to business activity, that is at the same time

forbidden by law.

Criminal Law & Procedure > Criminal Offenses > Inchoate Crimes > Conspiracy
HN20 See Pen. Code, § 550, subd. (b)(3).

SUMMARY:
CALIFORNIA OFFICIAL REPORTS SUMMARY

The trial court overruled an insurance company's demurrer to an insured's cross-complaint, alleging causes of action for breach of contract, breach of the covenant of good faith and fair dealing, and unfair business practices under Bus. & Prof. Code, § 17200. The insurance company had filed suit to recover money it paid the insured under a first-party medical payments provision of his automobile insurance policy. (Superior Court of Yolo County, No. CV042056, Thomas Warriner, Judge.)

The Court of Appeal issued a writ of mandate, commanding the trial court to vacate its order overruling the demurrer and in its place enter a new order sustaining the demurrer without leave to amend as to the causes of action for breach of contract and breach of the covenant of good faith and fair dealing and overruling it as to the insured's cause of action for unfair business practices. The court held that the insured failed to state a cause of action for breach of the implied covenant of good faith and fair dealing because the insured acknowledged that the insurance company paid him what was due under that policy. The insured also failed to state a cause of action for breach of contract because the insurance company did not have the burden to investigate or determine all of the facts required to ascertain the extent to which the made-whole rule and the common-fund doctrine could constitute a defense to the insurance company's right of reimbursement. The insured did state a cause of action for fraudulent business practices by alleging that the insurance company asserted its rights to 100 percent recovery of all moneys it paid to insureds, regardless of whether that reimbursement should be denied altogether or partially due to the made-whole rule and the common-fund doctrine. Further, the insured alleged that the insurance company misled its policyholders and made misrepresentations in connection with these activities. (Opinion by Robie, J., with Blease and Sims, JJ., concurring.)

HEADNOTES:
CALIFORNIA OFFICIAL REPORTS HEADNOTES

Classified to California Digest of Official Reports

CA(1) **(1) Insurance Contracts and Coverage § 121--Subrogation.**--When an insurance company pays out a claim on a first-party insurance policy to its insured, the insurance company is subrogated to the rights of its insured against any tortfeasor who is liable to the insured for the insured's damages. Subrogation has its source in equity and arises by operation of law (legal or equitable subrogation). It can also arise out of the contractual language of the insurance policy (conventional subrogation). The subrogation provisions of most insurance contracts typically are general and add nothing to the rights of subrogation that arise as a matter of law.

CA(2) **(2) Insurance Contracts and Coverage § 121--Subrogation.**--Subrogation places the insurer in the shoes of its insured to the extent of its payment. In personal injury actions, however, the insurance company may not assert its subrogation claim directly against the third party tortfeasor on its own behalf. Moreover, the insurance company may not seek to "gang-press" a policyholder's personal injury attorney into service as a collection agent by suing the attorney to pay it any judgment or settlement proceeds from the third party that

passes through that attorney's hands. Thus, to preserve its right of subrogation, the insurance company must either interplead itself into any action brought by the insured against the third party tortfeasor, or wait to seek reimbursement under the language of its policy from its insured to the extent that the insured recovers money from the third party.

CA(3)**(3) Insurance Contracts and Coverage § 121--Subrogation--Made-whole Rule.**--Where an insurance company does not interplead itself into the underlying action, the insurance company's rights to recover any payments received by its insured are limited. Under the made-whole rule, when an insurer does not participate in the insured's action against a tortfeasor, despite knowledge of that action, the insurer cannot recover any funds obtained through settlement of the action unless the full amount received exceeds the insured's actual loss. Furthermore, the insured need not account to the nonparticipating insurer for more than the surplus remaining in his hands, after satisfying his loss in full and his reasonable expenses incurred in the recovery. Thus, when an insurer elects not to participate in the insured's action against a tortfeasor, the insurer is entitled to subrogation only after the insured has recouped his loss and some or all of his litigation expenses incurred in the action against the tortfeasor.

CA(4)**(4) Insurance Contracts and Coverage § 121--Subrogation--Reimbursement Contrasted.**--There is a technical difference between subrogation and reimbursement. Subrogation refers to the right of the insurance company to step into the shoes of the insured and assert the insured's rights against the third party. Reimbursement refers to the right to receive payment back of what has been expended by the insurance company. However, those terms are often used interchangeably in the cases. In California, both the subrogation rights and reimbursement rights of the insurance company fall within the rubric of subrogation. Thus, both of those rights are limited by the made-whole rule.

CA(5)**(5) Insurance Contracts and Coverage § 121--Subrogation--Made-whole Rule.**--It is a general equitable principle of insurance law that, absent an agreement to the contrary, an insurance company may not enforce a right to subrogation until the insured has been fully compensated for his or her injuries, that is, has been made whole. There is authority that language in an insurance policy that grants the insurance company all rights of recovery to the extent of its payment overrides the common law made-whole rule.

CA(6)**(6) Insurance Contracts and Coverage § 121--Subrogation--Common-fund Rule.**--Under the common-fund rule, when a number of persons are entitled in common to a specific fund, and an action brought by a plaintiff or plaintiffs for the benefit of all results in the creation or preservation of that fund, such plaintiff or plaintiffs may be awarded attorney's fees out of the fund. Under this rule, an insurance company that does not participate in the underlying action must pay a pro rata share of the insured's attorney fees and costs when it seeks reimbursement from its insured out of funds obtained by the insured from the responsible third party. That is, the insurance company's reimbursement must be reduced proportionately to reflect the attorney fees paid by the insured.

CA(7)**(7) Contracts § 23.1--Interpretation--Good Faith and Fair Dealing.**--Every contract imposes on each party an implied duty of good faith and fair dealing. Simply stated, the burden imposed is that neither party will do anything which will injure the right of the other to receive the benefits of the agreement. Or, to put it another way, the implied covenant imposes upon each party the obligation to do everything that the contract presupposes they will do to accomplish its purpose. A breach of the implied covenant of good faith and fair dealing involves something beyond breach of the contractual duty itself, and bad faith implies unfair dealing rather than mistaken judgment. In the context of the insurance contract, the insurer's responsibility to act fairly and in good faith with respect to the handling of the insured's claim is not the requirement mandated by the terms of the policy itself--to defend, settle, or pay. It is the obligation under which the insurer must act

fairly and in good faith in discharging its contractual responsibilities.

CA(8)**(8) Insurance Contracts and Coverage § 109--Extent of Loss of Insured and of Liability of Insurer--Adjustment--Duty of Insurer to Act in Good Faith--Special Duties.**--An insurer must investigate claims thoroughly; it may not deny coverage based on either unduly restrictive policy interpretations or standards known to be improper; it may not unreasonably delay in processing or paying claims. These special duties, at least to the extent breaches thereof give rise to tort liability, find no counterpart in the obligations owed by parties to ordinary commercial contracts. The rationale for the difference in obligations is apparent. If an insurer were free of such special duties and could deny or delay payment of clearly owed debts with impunity, the insured would be deprived of the precise benefit the contract was designed to secure (i.e., peace of mind) and would suffer the precise harm (i.e., lack of funds in times of crisis) the contract was designed to prevent. To avoid or discourage conduct which would thus frustrate realization of the contract's principal benefit (i.e., peace of mind), special and heightened implied duties of good faith are imposed on insurers and made enforceable in tort. While these special duties are akin to, and often resemble, duties which are also owed by fiduciaries, the fiduciary-like duties arise because of the unique nature of the insurance contract, not because an insurer is a fiduciary.

CA(9)**(9) Insurance Contracts and Coverage § 109--Extent of Loss of Insured and of Liability of Insurer--Adjustment--Duty of Insurer to Act in Good Faith.**--An insured failed to state a cause of action against an insurance company for the breach of the covenant of good faith and fair dealing. By pleading that the insurance company was seeking reimbursement under the policy, the insured acknowledged that the insurance company paid him what was due under that policy. No factual allegation in the insured's cross-complaint suggested that the insurance company unduly delayed in paying these benefits, or that it failed to properly investigate the claim in a manner that delayed the payment of those benefits to the detriment of its insured. Because the essence of the tort of the implied covenant of good faith and fair dealing is focused on the prompt payment of benefits due under the insurance policy, there is no cause of action for breach of the covenant of good faith and fair dealing when no benefits are due.

[2 Witkin, Summary of Cal. Law (10th ed. 2005) Insurance, § 240.]

CA(10)**(10) Insurance Contracts and Coverage § 121--Subrogation--Made-whole Rule--Common-fund Doctrine.**--It is true the made-whole rule and the common-fund doctrine are incorporated into the contract as the common law of the State of California. Nothing in the cases which discusses those doctrines, however, places the burden on the insurance company to investigate or determine all of the facts required to ascertain the extent to which these rules might constitute a defense to the insurance company's right of reimbursement.

CA(11)**(11) Insurance Contracts and Coverage § 11--Interpretation--Question of Law.**--The interpretation of the language in an insurance policy is a question of law. In resolving such a question courts look first to the plain meaning of the disputed term to ascertain the mutual intention of the parties. As a general rule of construction, the parties are presumed to know and to have had in mind all applicable laws extant when an agreement is made. These existing laws are considered part of the contract just as if they were expressly referred to and incorporated.

CA(12)**(12) Insurance Contracts and Coverage § 121--Subrogation--Made-whole Rule--Common-fund Doctrine.**--The made-whole rule and the common-fund doctrine are both doctrines of equity that limit what the insurance company is entitled to receive in reimbursement from its insured. There is nothing in any of the cases discussing the made-whole rule or the common-fund doctrine that requires the insurance company to conduct an

investigation before demanding repayment.

CA(13) **(13) Unfair Competition § 4--Acts Constituting.**--Bus. & Prof. Code, § 17200, establishes three separate types of unfair competition. The statute prohibits practices that are either unfair, or unlawful, or fraudulent.

CA(14) **(14) Unfair Competition § 4--Acts Constituting.**--Bus. & Prof. Code, § 17200, is not confined to anticompetitive business practices, but is also directed toward the public's right to protection from fraud, deceit, and unlawful conduct. Thus, unfair competition statutes have always been framed in broad, sweeping language, precisely to enable judicial tribunals to deal with the innumerable new schemes which the fertility of man's invention would contrive.

CA(15) **(15) Unfair Competition § 4--Acts Constituting.**--A fraudulent business practice under Bus. & Prof. Code, § 17200, is not based upon proof of the common law tort of deceit or deception, but is instead premised on whether the public is likely to be deceived. Stated another way, in order to state a cause of action under the fraud prong of § 17200, a plaintiff need not show that he or others were actually deceived or confused by the conduct or business practice in question. The "fraud" prong of § 17200, is unlike common law fraud or deception. A violation can be shown even if no one was actually deceived, relied upon the fraudulent practice, or sustained any damage. Instead, it is only necessary to show that members of the public are likely to be deceived.

CA(16) **(16) Unfair Competition § 4--Acts Constituting.**--The balancing test established to determine whether a practice was "unfair" under Bus. & Prof. Code, § 17200, should continue to apply in consumer cases.

CA(17) **(17) Unfair Competition § 4--Acts Constituting.**--The balancing test required by the unfair business practice prong of Bus. & Prof. Code, § 17200, is fact intensive and is not conducive to resolution at the demurrer stage. Unfairness is an equitable concept that cannot be mechanistically determined under the relatively rigid legal rules applicable to the sustaining or overruling of a demurrer.

CA(18) **(18) Unfair Competition § 4--Acts Constituting.**--An unlawful business practice under Bus. & Prof. Code, § 17200, is an act or practice, committed pursuant to business activity, that is at the same time forbidden by law.

COUNSEL: Farmer, Murphy, Smith & Alliston, Craig E. Farmer and Suzanne M. Nicholson for Petitioner.

Pillsbury Winthrop Shaw Pittman, Kevin M. Fong, Benjamin L. Webster and Michael J. Daponde for Federation of California as amicus curiae on behalf of Petitioner.

No appearance for Respondent.

Hayes, Davis, Ellingson, McLay & Scott, Stephen M. Hayes and Robert S. McLay for Real Party In Interest.

JUDGES: Robie, J., with Blease and Sims, JJ., concurring.

OPINIONBY: ROBIE

OPINION: ROBIE, J.--**Progressive West** Insurance Company filed an action against Simon H. **Preciado** to recover money it paid to **Preciado** under a first-party medical payments provision of his automobile insurance policy. In response, **Preciado** filed a cross-complaint

against Progressive for breach of the insurance contract, breach of the covenant of good faith and fair dealing, and unfair business practices. Generally, Preciado alleges that because Progressive may have been restricted from recovering some or all of the money from Preciado based on two common-law rules, its bad faith efforts to recover the funds [*2] without engaging in any investigation gives rise to Progressive's liability under the above three theories. Further, Preciado alleges Progressive made unreasonable and bad faith misrepresentations by asserting its right to recover 100 percent of the payments. Preciado further alleges that this is not an isolated instance but that Progressive has a pattern and practice of seeking 100 percent recovery from all of its policyholders regardless of its entitlement. The trial court overruled Progressive's demurrer. Petitioners filed a petition for writ of mandate and we issued an alternative writ.

As to Preciado's specific claims related to his insurance contract, we shall reverse the trial court's order overruling the demurrer as to the causes of action for breach of contract and breach of the covenant of good faith and fair dealing and direct the court to sustain the demurrer as to those causes of action without leave to amend. On Preciado's broader claims related to Progressive's handling of this issue generally, we shall affirm the court's order overruling the demurrer as to the cause of action for unfair business practices.

FACTUAL AND PROCEDURAL BACKGROUND

Our review of the trial [*3] court's ruling on the demurrer is governed by well-settled principles. A general demurrer challenges only the legal sufficiency of a complaint, not the truth or the accuracy of its factual allegations or the plaintiff's ability to prove those allegations. (*Ball v. GTE Mobilnet of California* (2000) 81 Cal.App.4th 529, 534-535 [96 Cal. Rptr. 2d 801].) " ' "We treat the demurrer as admitting all material facts properly pleaded, but not contentions, deductions or conclusions of fact or law. [Citation.] We also consider matters which may be judicially noticed." [Citation.] Further, we give the complaint a reasonable interpretation, reading it as a whole and its parts in their context. [Citation.]' " (*Zelig v. County of Los Angeles* (2002) 27 Cal.4th 1112, 1126 [119 Cal. Rptr. 2d 709, 45 P.3d 1171].) Our review of the legal sufficiency of the complaint is de novo, "i.e., we exercise our independent judgment about whether the complaint states a cause of action as a matter of law. [Citation.]" (*Montclair Parkowners Assn. v. City of Montclair* (1999) 76 Cal.App.4th 784, 790 [90 Cal. Rptr. 2d 598].)

Here, Progressive sued Preciado for reimbursement of Progressive's payment of medical payments to Preciado after Preciado [*4] recovered damages from the person who injured him in a car accident. In response, Preciado filed a cross-complaint against Progressive asserting causes of action for breach of the insurance contract, tortious breach of the covenant of good faith and fair dealing, and unfair business practices.

Preciado's cross-complaint alleges as follows:

Progressive issued a automobile insurance policy to Preciado. n1 That policy provided for medical payment coverage (med-pay coverage). Med-pay coverage is first-party coverage which pays reasonable and necessary medical expenses incurred due to an automobile accident. (See *Nager v. Allstate Ins. Co.* (2000) 83 Cal.App.4th 284, 289-290 [99 Cal. Rptr. 2d 348].) "Automobile med-pay insurance provides first-party coverage on a no-fault basis for relatively low policy limits (generally ranging from $ 5,000 to $ 10,000) at relatively low premiums. [Citations.] The coverage is primarily designed to provide an additional source of funds for medical expenses for injured automobile occupants without all the burdens of a fault-based payment system." (*Ibid.*) Progressive's policy also provides that when the insurer makes a payment under the med-pay provision, [*5] it retains the right of reimbursement.

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n1 "To state a cause of action for breach of contract, it is absolutely essential to plead the terms of the contract either in haec verba or according to legal effect." (*Twaite v. Allstate Ins. Co.* (1989) 216 Cal. App. 3d 239, 252 [264 Cal. Rptr. 598].) Nowhere in his pleading does **Preciado** allege the terms of the insurance policy which he contends has been breached. Because the policy is attached to Progressive's original complaint and Progressive sought judicial notice of that complaint as part of Progressive's demurrer, the provisions of the insurance contract are properly before us.

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In his cross-complaint, **Preciado** alleges that Progressive's right of reimbursement is limited by two common-law doctrines: the made-whole rule and the common-fund doctrine. Under the made-whole rule, **Preciado** alleges the insurer is not entitled to recover any of the payments made to its insured under the policy until the insured is made whole from the tortfeasor who caused [*6] the underlying injuries. He also alleges that Progressive failed to perform any analysis of whether he had been made whole. If it had engaged in that analysis, it would have discovered that he had not been made whole and thus Progressive was not entitled to recover any reimbursement from him.

Under the common-fund doctrine, **Preciado** alleges an insurance company that does not participate in the litigation to recover damages from the third party who caused its insured's injuries must pay a pro rata share of the attorney fees incurred by the insured to recover those funds when it seeks reimbursement. Thus, the insurance company's reimbursement must be reduced by the amount of attorney fees attributable to the recovery of the funds subject to the insurance company's right of reimbursement.

Preciado alleges he retained an attorney to recover funds and therefore Progressive "must acknowledge the common fund doctrine and deduct from the amount claimed a pro-rata reduction of attorney's fees and costs." "[C]ontrary to California law, PROGRESSIVE is seeking the full amount paid to **PRECIADO** under the relevant med-pay provision. . . . . [T] his attempt to recoup all monies paid is a blatant [*7] attempt to seize funds to which Progressive is not lawfully entitled, and amounts to fraud." **Preciado** pled in his first cause of action that Progressive's conduct regarding the made-whole rule and the common-fund doctrine breached the insurance contract.

He further pled Progressive breached the covenant of good faith and fair dealing "by engaging in the conduct alleged hereinabove including, without limitation, the following: a) unreasonably and in bad faith failing to investigate **PRECIADO's** claim properly; b) unreasonably and in bad faith failing and refusing to acknowledge the controlling law as it relates to insurance reimbursement in general, and med-pay reimbursement in particular; c) unreasonably and in bad [faith] failing and refusing to provide adequate, and informed communication as between an insurer and an insured/med-pay recipient; d) unreasonably and in bad faith failing and refusing to promptly and adequately explain the policy coverages; e) unreasonably and in bad faith misleading **PRECIADO** regarding his true obligations owed, if any to PROGRESSIVE; f) unreasonably and in bad faith misrepresenting to **PRECIADO** material facts concerning his claims and the valid and proper [*8] amount of benefits due under the Policy; g) unreasonably and in bad faith attempting to collect, through intimidation and coercion, amounts to which PROGRESSIVE is not entitled; and h) unreasonably and in bad faith failing and refusing to provide timely and full and complete benefits to **PRECIADO.**" Based on this conduct, **Preciado** alleges he "has suffered, and will continue to suffer in the future, economic and consequential damages" in an amount according to proof. **Preciado** also seeks punitive damages on his claim for breach of the covenant of good faith and fair dealing.

Finally, in an unfair business practice cause of action, Preciado alleges that Progressive's conduct violates Business and Professions Code n2 section 17200 as an unlawful, unfair or fraudulent business practice. The cross-complaint alleges Progressive has a "pattern and practice of seeking med-pay reimbursement even though it never engaged in any discussion, analysis or conclusion that the injured party has in fact been made whole" and "continues to seek[] sums it is not entitled to as a matter of law to further its unlawful scheme." Further, Preciado alleges that Progressive has a "pattern and practice of ignoring [*9] California law by seeking 100% reimbursement for the amounts paid under its med-pay provision. This systematic scheme is contrary to law, and is nothing more than a sharp, illicit business practice." Based on these key allegations, Preciado alleges Progressive fails to investigate claims, fails to properly explain policy benefits, misled Preciado and misrepresented material facts pertaining to his claim, imposes unacceptably high reimbursement amounts, and forced Preciado to retain attorneys and incur economic damages to receive proper benefits under the policy.

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n2 All further statutory references are to the Business and Professions Code unless otherwise indicated.

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Progressive filed a general demurrer to the cross-complaint. The trial court overruled Progressive's demurrer to these three causes of action. Progressive filed a petition for writ of mandate. We issued an alternative writ.

DISCUSSION

I

The Made-Whole Rule And The Common-Fund Doctrine

A

Made-Whole Rule

CA(1)(1) HN1When an insurance [*10] company pays out a claim on a first-party insurance policy to its insured, the insurance company is subrogated to the rights of its insured against any tortfeasor who is liable to the insured for the insured's damages. (See, e.g., *Plut v. Fireman's Fund Ins. Co.* (2000) 85 Cal.App.4th 98, 104 [102 Cal. Rptr. 2d 36] [" 'Subrogation is the insurer's right to be put in the position of the insured, in order to recover from third parties who are legally responsible to the insured for a loss paid by the insurer. [Citation.]' [Citation.]"]; *Hodge v. Kirkpatrick Dev., Inc.* (2005) 130 Cal.App.4th 540, 548 [30 Cal. Rptr. 3d 303].) Subrogation has its source in equity and arises by operation of law (legal or equitable subrogation). (*Sapiano v. Williamsburg Nat. Ins. Co.* (1994) 28 Cal.App.4th 533, 537, fn. 1 [33 Cal. Rptr. 2d 659].) It can also arise out of the contractual language of the insurance policy (conventional subrogation). (*Ibid.*) The subrogation provisions of most insurance contracts typically are general and add nothing to the rights of subrogation that arise as a matter of law. (*Id.* at p. 538.)

CA(2)(2) HN2Subrogation places the insurer in the shoes of its insured to the extent of its [*11] payment. (*Hodge v. Kirkpatrick Dev., Inc.*, *supra*, 130 Cal.App.4th at p. 548.) In personal injury actions, however, the insurance company may not assert its subrogation

claim directly against the third party tortfeasor on its own behalf. (*Fifield Manor v. Finston* (1960) 54 Cal.2d 632, 639-640, 643 [7 Cal. Rptr. 377, 354 P.2d 1073].) Moreover, the insurance company may not seek to "gang-press" a policyholder's personal injury attorney into service as a collection agent by suing the attorney to pay it any judgment or settlement proceeds from the third party that passes through that attorney's hands. (*Farmers Ins. Exchange v. Smith* (1999) 71 Cal.App.4th 660, 662 [83 Cal. Rptr. 2d 911].) Thus, to preserve its right of subrogation, the insurance company must either interplead itself into any action brought by the insured against the third party tortfeasor, or wait to seek reimbursement under the language of its policy from its insured to the extent that the insured recovers money from the third party. (*Plut v. Fireman's Fund Ins. Co., supra*, 85 Cal.App.4th at p. 104; *Hodge v. Kirkpatrick Dev., Inc., supra*, 130 Cal.App.4th at p. 548.)

CA(3) (3) HN3 Where the [*12] insurance company does not interplead itself into the underlying action, the insurance company's rights to recover any payments received by its insured are limited. Under the made-whole rule, "[w]hen an insurer does not participate in the insured's action against a tortfeasor, despite knowledge of that action, the insurer cannot recover any funds obtained through settlement of the action unless the full amount received exceeds the insured's actual loss. [Citation.] Furthermore, the insured need not account to the nonparticipating insurer 'for more than the surplus remaining in his hands, after satisfying his loss in full and his reasonable expenses incurred in the recovery.' [Citation.] Thus, when an insurer elects not to participate in the insured's action against a tortfeasor, the insurer is entitled to subrogation only after the insured has recouped his loss *and* some or all of his litigation expenses incurred in the action against the tortfeasor." (*Plut v. Fireman's Fund Ins. Co., supra*, 85 Cal.App.4th at pp. 104-105; see also *Hodge v. Kirkpatrick Dev., Inc., supra*, 130 Cal.App.4th at pp. 552-553.)

CA(4) (4) Progressive argues the made-whole [*13] rule does not apply here because it is seeking "reimbursement" from its insured, not "subrogation" from the party who injured **Preciado.** As explained by a leading commentator on insurance law, HN4 there is a technical difference between subrogation and reimbursement. (16 Couch, Insurance (3d ed. 2000) § 222:2, pp. 222-10 through 222-14.) Subrogation refers to the right of the insurance company to step into the shoes of the insured and assert the insured's rights against the third party. (*Id.* at p. 222-11.) Reimbursement refers to the right to receive payment back of what has been expended by the insurance company. (*Ibid.*) That same commentator, however, acknowledges that those terms are often used interchangeably in the cases. (*Ibid.*) In California, both the subrogation rights and reimbursement rights of the insurance company fall within the rubric of subrogation. (See *Plut v. Fireman's Fund Ins. Co.,supra*, 85 Cal.App.4th at pp. 104-105; *Textron Financial Corp. v. National Union Fire Ins. Co.* (2004) 118 Cal.App.4th 1061, 1077 [13 Cal. Rptr. 3d 586]; *Hodge v. Kirkpatrick Development, Inc., supra*, 130 Cal.App.4th at p. 553.) Thus, both of those [*14] rights are limited by the made-whole rule.

Progressive further argues the language of the policy abrogates the made-whole rule because it states that in the event of payment under the policy, Progressive "is entitled to all the rights of recovery that the insured person to whom payment was made has against another." We reject this claim.

CA(5) (5) " HN5 "It is a general equitable principle of insurance law that, *absent an agreement to the contrary*, an insurance company may not enforce a right to subrogation until the insured has been fully compensated for [his or] her injuries, that is, has been made whole. [Citations.]' [Citations.]" (*Plut v. Fireman's Fund Ins. Co., supra*, 85 Cal.App.4th at p. 104, italics added.) There is authority that language in an insurance policy that grants the insurance company "all rights of recovery to the extent of its payment" overrides the common law made-whole rule. (See, e.g., *Barnes v. Independent Auto. Dealers of California* (9th Cir. 1995) 64 F.3d 1389, 1393, 1396.) Indeed, in *Travelers Indem. Co. v. Ingebretsen*

(1974) 38 Cal. App. 3d 858, 865 [113 Cal. Rptr. 679], the parties executed a specific [*15] subrogation agreement which provided: "In consideration of and to the extent of said payment the undersigned *hereby assigns and transfers* to the said Company *all rights, claims, demands and interest which the undersigned may have against any party through the occurrence of such loss* and authorizes said Company to sue, compromise or settle in the name of the undersigned or otherwise all such claims and to execute and sign releases and acquittances in the name of the undersigned." The appellate court concluded the insured's assignment to the insurance company of "all rights" "to the extent of payment" gave the insurance company priority to any recovery obtained by the insured. (*Id.* at pp. 865-866.)

The more recent cases, however, require that the contractual provision that intends to vitiate this rule must "clearly and specifically [give] the insurer a priority out of proceeds from the tortfeasor regardless whether the insured was first made whole." (*Sapiano v. Williamsburg Nat. Ins. Co., supra*, 28 Cal.App.4th at pp. 538-539.) Thus, in *Sapiano*, the relevant provision of the insurance policy stated, "[i]f any person or organization to [*16] or for whom we make payment under this Coverage Form has rights to recover damages from another, those rights are transferred to us." (*Id.* at pp. 535-536.) That provision was not sufficient to overcome the made-whole rule. (*Id.* at pp. 538-539.) The *Sapiano* court concluded the language of the insurance contract at issue in *Samura v. Kaiser Foundation Health Plan, Inc.* (1993) 17 Cal.App.4th 1284, 1289-1290 [22 Cal. Rptr. 2d 20], however, provided a good example of the language necessary to abrogate the made-whole rule. (*Sapiano v. Williamsburg Nat. Ins. Co., supra*, 28 Cal.App.4th at p. 538.) The language in the Kaiser agreement provided, "'Health Plan (or its designee) shall be entitled to the payment, reimbursement, and subrogation as provided in this Section C(1) regardless of whether the total amount of the recovery of the Member (or his or her estate, parent or legal guardian) on account of the injury or illness is less than the actual loss suffered by the Member (or his or her estate, parent or legal guardian).'" (*Samura v. Kaiser Foundation Health Plan, Inc., supra*, 17 Cal.App.4th at pp. 1289-1290.)

Here, the policy [*17] states Progressive "is entitled to all the rights of recovery that the insured person to whom payment was made has against another." In a separate paragraph of the policy, the policy states, "When an insured person has been paid by us under this policy and also recovers from another person, entity, or organization, the amount recovered will be held by the insured person in trust for [Progressive] and reimbursed to [Progressive] to the extent of our payment." These two provisions, individually or taken together do not clearly indicate that Progressive's rights are first in priority. In addition, these two provisions do not explain that Progressive may seek reimbursement regardless of whether the insured was made whole by his recovery from the third party. Furthermore, unlike the provision in *Travelers Indem. Co. v. Ingebretsen, supra*, 38 Cal. App. 3d 858, 865, these provisions do not assign or transfer all rights to the insurer to the extent of the insurance company's payment. Thus, we conclude the made-whole rule is not vitiated by this policy language.

B

Common-Fund Doctrine

CA(6) (6) Progressive does not argue the common-fund doctrine does not apply [*18] here and thus, we provide a brief summary of that rule here. The common-fund doctrine is a second limitation on an insurance company's ability to recover funds from its insured where the insured obtains a judgment or settlement from the third party tortfeasor. HN6 Under the common-fund rule, " '[W]hen a number of persons are entitled in common to a specific fund, and an action brought by a plaintiff or plaintiffs for the benefit of all results in the creation or preservation of that fund, such plaintiff or plaintiffs may be awarded attorney's fees out of the fund.' " (*Lee v. State Farm Mut. Auto. Ins. Co.* (1976) 57 Cal. App. 3d 458, 467 [129 Cal. Rptr. 271].) " 'The bases of the equitable rule which permits surcharging a common fund with the expenses of its protection or recovery, including counsel fees, appear to be these:

fairness to the successful litigant, who might otherwise receive no benefit because his recovery might be consumed by the expenses; correlative prevention of an unfair advantage to the others who are entitled to share in the fund and who should bear their share of the burden of its recovery; encouragement of the attorney for the successful litigant, who [*19] will be more willing to undertake and diligently prosecute proper litigation for the protection or recovery of the fund if he is assured that he will be promptly and directly compensated should his efforts be successful.' [Citation.]" (*Id.* at pp. 467-468.) Under this rule, an insurance company that does not participate in the underlying action must pay a pro rata share of the insured's attorney fees and costs when it seeks reimbursement from its insured out of funds obtained by the insured from the responsible third party. (*Id.* at p. 469.) That is, the insurance company's reimbursement must be reduced proportionately to reflect the attorney fees paid by the insured. (*Hartford Accident & Indemnity Co. v. Gropman* (1984) 163 Cal. App. 3d Supp. 33, 39-40 [209 Cal. Rptr. 468].)

II

Preciado Has Not Stated A Cause Of Action For Breach Of The Covenant Of Good Faith And Fair Dealing

Progressive argues that Preciado failed to state a cause of action for breach of the implied covenant of good faith and fair dealing because he has not alleged and cannot allege that benefits are due under the policy. We agree.

In his cross-complaint, [*20] Preciado alleges Progressive breached the covenant of good faith and fair dealing by: "a) unreasonably and in bad faith failing to investigate PRECIADO's claim properly; b) unreasonably and in bad faith failing and refusing to acknowledge the controlling law as it relates to insurance reimbursement in general, and med-pay reimbursement in particular; c) unreasonably and in bad [faith] failing and refusing to provide adequate, and informed communication as between an insurer and an insured/med-pay recipient; d) unreasonably and in bad faith failing and refusing to promptly and adequately explain the policy coverages; e) unreasonably and in bad faith misleading PRECIADO regarding his true obligations owed, if any to PROGRESSIVE; f) unreasonably and in bad faith misrepresenting to PRECIADO material facts concerning his claims and the valid and proper amount of benefits due under the Policy; g) unreasonably and in bad faith attempting to collect, through intimidation and coercion, amounts to which PROGRESSIVE is not entitled; and h) unreasonably and in bad faith failing and refusing to provide timely and full and complete benefits to PRECIADO." Each of these allegations must be read [*21] in the context of the general allegations plead in the complaint which detail that each of these claimed breaches arises out of Progressive's demand for more money in reimbursement than it was entitled under the common-fund doctrine and/or the made-whole rule. When read in that context, this pleading fails to state a cause of action.

CA(7)4(7) HN74"Every contract imposes on each party an implied duty of good faith and fair dealing. [Citation.] Simply stated, the burden imposed is ' "that neither party will do anything which will injure the right of the other to receive the benefits of the agreement." ' [Citations.] Or, to put it another way, the 'implied covenant imposes upon each party the obligation to do everything that the contract presupposes they will do to accomplish its purpose.' [Citations.] A ' "breach of the implied covenant of good faith and fair dealing involves something beyond breach of the contractual duty itself," and it has been held that " '[b]ad faith implies unfair dealing rather than mistaken judgment. ...' [Citation.]" [Citation.]' [Citation.] [P] For example, in the context of the insurance contract, it has been held that the insurer's responsibility to act [*22] fairly and in good faith with respect to the handling of the insured's claim ' "is not the requirement mandated by the terms of the policy itself--to defend, settle, or pay. It is the obligation ... under which the insurer must act fairly and in good faith in discharging its contractual responsibilities." [Citation.]' [Citations.]" (*Chateau Chamberay Homeowners Assn. v. Associated Internat. Ins. Co.* (2001) 90 Cal.App.4th 335,

345-346 [108 Cal. Rptr. 2d 776].)

CA(8) (8) "Insurance contracts are unique in nature and purpose. [Citation.] An insured does not enter an insurance contract seeking profit, but instead seeks security and peace of mind through protection against calamity. [Citation.] The bargained-for peace of mind comes from the assurance that the insured will receive prompt payment of money in times of need. [Citation.] Because peace of mind and security are the principal benefits for the insured, the courts have imposed special obligations, consonant with these special purposes, *seeking to encourage insurers promptly to process and pay claims.* Thus, HN8 an insurer must investigate claims thoroughly [citation]; it may not deny coverage based on either unduly restrictive policy [*23] interpretations [citation] or standards known to be improper [citation]; it may not unreasonably delay in processing or paying claims [citation]." (*Love v. Fire Ins. Exchange* (1990) 221 Cal. App. 3d 1136, 1148 [271 Cal. Rptr. 246] (*Love*), italics added.) "These special duties, at least to the extent breaches thereof give rise to tort liability, find no counterpart in the obligations owed by parties to ordinary commercial contracts. The rationale for the difference in obligations is apparent. If an insurer were free of such special duties and could deny or delay payment of clearly owed debts with impunity, the insured would be deprived of the precise benefit the contract was designed to secure (i.e., peace of mind) and would suffer the precise harm (i.e., lack of funds in times of crisis) the contract was designed to prevent. [Citation.] To avoid or discourage conduct which would thus frustrate realization of the contract's principal benefit (i.e., peace of mind), special and heightened implied duties of good faith are imposed on insurers and made enforceable in tort. While these 'special' duties are akin to, and often resemble, duties which are also owed [*24] by fiduciaries, the fiduciary-like duties arise because of the unique nature of the insurance contract, *not* because an insurer is a fiduciary." (*Ibid.*)

In *Love*, the insureds sought to estop the insurance company from asserting the statute of limitations because the insurance company had an obligation to disclose that an excluded loss was a covered loss under certain circumstances. (*Love, supra,* 221 Cal. App. 3d at p. 1144.) The insureds claimed this duty arose out of the fact that the insurance company owed the insureds a fiduciary duty to disclose this legal argument that would provide them with coverage. (*Ibid.*) In rejecting this argument, the *Love* court stated, "we are unaware of any authority holding that an insurer is estopped to plead the statute of limitations merely because when it denied a claim it failed to inform its insured of pertinent laws or legal theories upon which the insured could rely in a later lawsuit challenging denial of the claim." (*Ibid.*) The court noted, "because of the 'special relationship' inherent in the unique nature of an insurance contract, the insurer's obligations attendant to its duty of good faith are heightened. [*25] Such obligations have been characterized as *akin* to fiduciary-type responsibilities. [Citation.] Because of this unique 'special relationship,' a breach of the obligation of good faith may give rise to tort (rather than mere contractual) remedies. [Citation.]" (*Id.* at p. 1147.) The court continued, "However, the California Supreme Court has never squarely held that an insurer is a *true* fiduciary to its insured." (*Ibid.*) The court pointed out that "[u]nique obligations are imposed upon true fiduciaries which are not found in the insurance relationship. For example, a true fiduciary must first consider and always act in the best interests of its trust and not allow self-interest to overpower its duty to act in the trust's best interests. [Citation.] An insurer, however, may give its own interests consideration equal to that it gives the interests of its insured [citation]; it is not required to disregard the interests of its shareholders and other policyholders when evaluating claims [citation]; and it is not required to pay noncovered claims, even though payment would be in the best interests of its insured [citation]." (*Id.* at pp. 1148-1149.) [*26] Thus, the court concluded the relationship between the insured and the insurance company did not give rise to an affirmative obligation for the insurer to "advise an insured of different legal theories or statutory provisions which an insured could use to avoid policy exclusions." (*Id.* at p. 1150.)

The *Love* court explained, "there are at least two separate requirements to establish breach of the implied covenant: (1) benefits due under the policy must have been withheld; and (2)

the reason for withholding benefits must have been unreasonable or without proper cause." (*Love, supra*, 221 Cal. App. 3d at p. 1151.) As a result, where no benefits are withheld or delayed, there is no cause of action for the breach of the covenant of good faith and fair dealing. (*Id.* at p. 1152.)

In *Jonathan Neil & Assoc., Inc. v. Jones* (2004) 33 Cal.4th 917, 923 [16 Cal. Rptr. 3d 849, 94 P.3d 1055], the insureds defended a collection action against them by their insurance company and filed a cross-complaint against the company for breach of the covenant of good faith and fair dealing when the insurance company "retroactively and knowingly charged [them] a substantially **[*27]** higher premium than was actually owed." Our Supreme Court declined to extend the tort remedies for the breach of the covenant to the insurance company's conduct in this instance. (*Id.* at p. 941.) Three factors counseled against the extension of tort liability to this postclaim practice. (*Id.* at p. 939.) First, the billing dispute, by itself, did not "deny the insured the benefits of the insurance policy the security against losses and third party liability." (*Ibid.*) Second, the "dispute [did] not require the insured to prosecute the insurer in order to enforce its rights, as in the case of bad faith claims and settlement practices." (*Ibid.*) And, third, "traditional tort remedies may be available to the insured who is wrongfully billed a retroactive premium," such as a malicious prosecution action, or a defamation action, or intentional interference with contract action. (*Ibid.*)

CA(9) (9) Here, these rules dictate that **Preciado** has not stated a cause of action against Progressive for the breach of the covenant of good faith and fair dealing. By pleading that Progressive is seeking *reimbursement* under the policy, **Preciado** acknowledges Progressive **[*28]** paid him what was due under that policy. No factual allegation in the cross-complaint suggests that Progressive unduly delayed in paying these benefits, or that it failed to properly investigate the claim in a manner that delayed the payment of those benefits to the detriment of its insured. HN9 Because the essence of the tort of the implied covenant of good faith and fair dealing is focused on the prompt payment of benefits due under the insurance policy, there is no cause of action for breach of the covenant of good faith and fair dealing when no benefits are due.

Moreover, each of the three factors enumerated in *Jonathan Neil & Assoc., Inc. v. Jones, supra*, 33 Cal.4th at page 939, supports the conclusion that the bad faith assertion of Progressive that it was entitled to the return of all of the money it paid to **Preciado** did not violate the covenant of good faith and fair dealing. First, as we have noted, Progressive did not deny **Preciado** the benefits of the insurance policy. Rather, it promptly paid those funds to **Preciado.** Second, the instant dispute did not require **Preciado** to sue the insurer to enforce its rights, as is the case of bad faith claims and settlement **[*29]** practices. Third, **Preciado** retains the traditional tort remedy of malicious prosecution in the event that Progressive's conduct was indeed malicious.

Preciado offers the rejoinder that Progressive withheld "policy benefits" when it "sought to take back benefits from **Preciado** that were lawfully his." We reject **Preciado's** characterization. Progressive's demand for return of the benefits it paid to **Preciado,** even to the extent that demand in bad faith exceeded the amount to which Progressive was entitled, does not constitute a withholding of the benefits at the critical time. Nor does it go to the heart of the policy reason behind the covenant of good faith and fair dealing--that is the prompt payment of benefits to the insured. Rather, this case is no different than any other garden variety contractual dispute between two parties to a contract. The covenant of good faith and fair dealing does not extend this far.

Preciado also argues that the insurer can violate the covenant of good faith and fair dealing even when it has paid out all of the benefits under the policy. He cites *Schwartz v. State Farm Fire & Casualty Co.* (2001) 88 Cal.App.4th 1329 [106 Cal. Rptr. 2d 523]; *Neal v. Farmers Ins. Exchange* (1978) 21 Cal.3d 910 [148 Cal. Rptr. 389, 582 P.2d 980]; **[*30]** *Johansen v. California State Auto. Assn. Inter-Ins. Bureau* (1975) 15 Cal.3d 9 [123 Cal. Rptr.

288, 538 P.2d 744]. None of these cases is instructive here.

In *Schwartz*, the insurer paid out the full benefits of the policy in a manner that favored one insured to the detriment of a second insured for the same benefits. (*Schwartz v. State Farm Fire & Casualty Co.*, *supra*, 88 Cal.App.4th at pp. 1333-1334.) The court concluded that "even an insurer that pays the full limits of its policy may be liable for breach of the implied covenant, if improper claims handling causes detriment to the insured." (*Id.* at p. 1339.) Here, this dispute about whether Progressive is entitled to less than all of the money it paid to **Preciado** cannot be properly characterized as "improper claims handling [that] cause[d] detriment to" **Preciado.**

In *Johansen*, the court concluded that the insurer breached the covenant of good faith and fair dealing when it refused to promptly accept a reasonable settlement offer that was within the policy limits. (*Johansen v. California State Auto. Assn. Inter-Ins. Bureau*, *supra*, 15 Cal.3d at p. 19.) In *Neal v.* [*31] *Farmers Ins. Exchange*, the insurance company refused to accept offers of settlement, and subsequently submitted the matter to its attorney for an opinion, all as a part of a conscious course of conduct designed force the settlement more favorable to the company than the facts would have otherwise warranted. (*Neal v. Farmers Ins. Exchange*, *supra*, 21 Cal.3d at pp. 922-923.) These facts do not come close to those at bar and offer no helpful analogy.

Lastly, in *Brizuela v. CalFarm Ins. Co.* (2004) 116 Cal.App.4th 578, 592 [10 Cal. Rptr. 3d 661], the court stated, "The gravamen of a claim for breach of the covenant of good faith and fair dealing, which sounds in both contract and tort, is the insurer's refusal, without proper cause, to compensate the insured for a loss covered by the policy." In rejecting the insured's claim of breach of this covenant, the court stated, "Some authorities have suggested hypothetical circumstances in which an insurance company might be liable for bad faith despite the insured's lack of a contract right to benefits under the insurance policy. (Ashley, Bad Faith Actions Liability and Damages (2d ed. 1997), § 5A:02, p. 5A-10 [insurer might [*32] be liable for bad faith if, instead of investigating a non-covered claim, insurer embarked on campaign to intimidate insured into settling]; see, e.g., *Murray v. State Farm Fire & Casualty Co.* (1990) 219 Cal. App. 3d 58, 65-66 [268 Cal.Rptr. 33] [insurance company might be liable if it unreasonably delayed investigating an [*sic*] noncovered claim].)" (*Id.* at p. 594.)

Here, there are no allegations in the pleadings that Progressive did anything other than pay out the benefits to **Preciado** in a timely fashion.

We will therefore issue a writ of mandate directing the trial court to sustain the demurrer without leave to amend as to the cause of action for breach of the covenant of good faith and fair dealing.

III

***Preciado** Has Not Stated A Cause Of Action For Breach Of Contract*

Progressive argues that **Preciado** has not alleged a breach of contract against it. We agree.

The allegations of the complaint are that Progressive breached the contract by "failing to engage in any analysis or discussion as to whether **PRECIADO** was Made Whole prior to instituting its improper collection efforts; [and] fraudulently seeking full reimbursement of its expended [*33] funds even though, as a matter of law, PROGRESSIVE must reduce the amount claimed pursuant to the Common Fund Theory."

CA(10)4(10) **Preciado** pleads no provision of the contract which places the burden on Progressive of engaging in analysis or discussion of whether **Preciado** was made whole, or

determining if the common-fund doctrine applies. HN10 It is true the made-whole rule and the common-fund doctrine are incorporated into the contract as the common law of the State of California. Nothing in the cases which discusses those doctrines, however, places the burden on the insurance company to investigate or determine all of the facts required to ascertain the extent to which these rules might constitute a defense to the insurance company's right of reimbursement.

CA(11) (11) The provisions of an insurance policy must be read in conjunction with the existing law. HN11 "The interpretation of the language in an insurance policy is a question of law. In resolving such a question courts look first to the plain meaning of the disputed term to ascertain the mutual intention of the parties. [Citation.] As a general rule of construction, the parties are presumed to know and to have had in mind all applicable laws extant when [*34] an agreement is made. These existing laws are considered part of the contract just as if they were expressly referred to and incorporated." (*Miracle Auto Center v. Superior Court* (1998) 68 Cal.App.4th 818, 821 [80 Cal. Rptr. 2d 587].) Existing law includes the common law of the state. (*In re Retirement Cases* (2003) 110 Cal.App.4th 426, 447 [1 Cal. Rptr. 3d 790].) Thus, the made-whole rule and the common-fund doctrine must be considered part of the insurance contract between Progressive and **Preciado.** n3

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n3 As we have already noted, the made-whole rule can be contractually vitiated by clear language demonstrating the insurance company's priority and entitlement to the proceeds. (*Sapiano v. Williamsburg Nat. Ins. Co.*, *supra*,28 Cal.App.4th at pp. 538-539.) That contractual limitation is not contained in this policy.

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CA(12) (12) Simply because these doctrines are part of the contract and may potentially restrict the amount of Progressive's reimbursement does not render the allegations of the complaint actionable. [*35] HN12 The made-whole rule and the common-fund doctrine are both doctrines of equity that limit what the insurance company is entitled to receive in reimbursement from its insured. (*Plut v. Fireman's Fund Ins. Co.*, *supra*, 85 Cal.App.4th at pp. 103-104 [made-whole rule gives rise to an equitable offset]; *Lee v. State Farm Mut. Auto. Ins. Co.*, *supra*, 57 Cal. App. 3d at p. 467 [common-fund doctrine is prime example of the court exercising its inherent power to create exceptions to the basic rule on attorney fees].) There is nothing in any of the cases discussing the made-whole rule or the common-fund doctrine (part I, *ante*) that requires the insurance company to conduct an investigation before demanding repayment.

It is a far cry from the limitations on the amount the insurance company may recover from its insured to the conclusion that the insurer must investigate, determine, and advise its insured (who is represented by counsel) about the applicability of these two equitable common-law doctrines before it seeks return of the money. **Preciado** cites no authority for the proposition that this duty falls on the insurance company's shoulders. Indeed, the [*36] language of *Love*, *supra*, 211 Cal. App. 3d at page 1150, that no case imposes a duty on the "insurer to advise an insured of the different legal theories or statutory provisions which an insured could use to avoid policy exclusions" supports a contrary conclusion. Moreover, the insurance company is entitled to consider its own interests especially in the context of conduct it engages in after it timely pays out benefits. (*Love*, *supra*, 221 Cal. App. 3d at pp. 1148-1149.) There is nothing in the insurance contract that requires this result either.

Logic dictates that this burden should remain firmly on the back of the insured, who has all of

the information required to determine whether either of these doctrines provides a defense to the insured. Here, Preciado knows that he has an attorney and what he paid that person. Further, he has the information as to what his total damages were, and whether he was made whole by the settlement with the third party tortfeasor.

Thus, we detect no actionable breach of contract in the allegations of the complaint. As a result, we shall issue a writ of mandate directing the trial court to sustain the demurrer without [*37] leave to amend.

IV

Preciado Has Stated A Cause Of Action For Unfair Or Fraudulent Business Practices

Progressive argues the trial court erred when it concluded Preciado stated a cause of action for unfair business practices. It is here we part company with Progressive.

In his cross complaint, Preciado alleges Progressive has a "pattern and practice of seeking med-pay reimbursement even though it never engaged in any discussion, analysis or conclusion that the injured party has in fact been made whole" and "continues to seek[] sums it is not entitled to as a matter of law to further its unlawful scheme." Further, Preciado alleges that Progressive has a "pattern and practice of ignoring California Law by seeking 100% reimbursement for the amounts paid under its med-pay provision. This systematic scheme is contrary to law, and is nothing more than a sharp, illicit business practice." Based on these key allegations, Preciado alleges Progressive fails to investigate claims, fails to properly explain policy benefits, misled Preciado and misrepresented material facts pertaining to his claim, imposes unacceptably high reimbursement amounts, and forced Preciado to retain an [*38] attorney and incur economic damages in order to receive proper benefits under the policy.

These practices, to the extent they are more general than the allegations of the breach of contract and breach of the covenant of good faith and fair dealing causes of action, state a cause of action. It may be that Preciado may not be able to adduce evidence as to this "pattern and practice" of activities. At this stage of the proceedings, however, we must affirm the overruling of Progressive's demurrer as to this cause of action.

CA(13)(13) Business and Professions Code section 17200 provides: HN13"[a]s used in this chapter, unfair competition shall mean and include any unlawful, unfair or fraudulent business act or practice and unfair, deceptive, untrue or misleading advertising and any act prohibited by Chapter 1 (commencing with Section 17500) of Part 3 of Division 7 of the Business and Professions Code." HN14This statute "establishes three separate types of unfair competition. The statute prohibits practices that are either 'unfair,' or 'unlawful,' or 'fraudulent.' [Citation.]" (*Pastoria v. Nationwide Ins.* (2003) 112 Cal.App.4th 1490, 1496 [6 Cal. Rptr. 3d 148].) [*39]

CA(14)(14) " HN15Section 17200 "is not confined to anticompetitive business practices, but is also directed toward the public's right to protection from fraud, deceit, and unlawful conduct. [Citation.]" ' "*Community Assisting Recovery, Inc. v. Aegis Security Ins. Co.* (2001) 92 Cal.App.4th 886, 891 [112 Cal. Rptr. 2d 304].) Thus, "unfair competition statutes have always been framed in 'broad, sweeping language, precisely to enable judicial tribunals to deal with the innumerable " 'new schemes which the fertility of man's invention would contrive.' " [Citation.]' [Citation.]" (*Id.* at p. 894.)

A

Fraudulent Business Practices

CA(15)[2](15) HN16[2]A fraudulent business practice under section 17200 "is not based upon proof of the common law tort of deceit or deception, but is instead premised on whether the public is likely to be deceived." (*Pastoria v. Nationwide Ins.*, *supra*, 112 Cal.App.4th at p. 1498.) Stated another way, "In order to state a cause of action under the fraud prong of [section 17200] a plaintiff need not show that he or others were actually deceived or confused by the conduct or business practice in question. 'The "fraud" prong of [section 17200] is unlike **[*40]** common law fraud or deception. A violation can be shown even if no one was actually deceived, relied upon the fraudulent practice, or sustained any damage. Instead, it is only necessary to show that members of the public are likely to be deceived.' [Citations.]" (*Schnall v. Hertz Corp.* (2000) 78 Cal.App.4th 1144, 1167 [93 Cal. Rptr. 2d 439].)

Thus, the court concluded the plaintiffs in *Pastoria v. Nationwide Ins.*, *supra*, 112 Cal.App.4th at pages 1496-1497, stated a claim for a fraudulent business practice that was likely to confuse consumers when they alleged the insurance company knew that it had decided to make material changes to its insurance policies, but refused to tell policyholders of those imminent changes until after it sold the policies to the customers.

In *People v. McKale* (1979) 25 Cal.3d 626, 630-631 [159 Cal. Rptr. 811, 602 P.2d 731], the state sued the owners of a mobile home park for unfair business practices. One of the alleged offending business practices was that the owners required the tenants to sign a copy of the park's rules and regulations that contained provisions that the owners were barred from enforcing as a matter of law. (*Id.* at p. 635.) **[*41]** The Supreme Court had no trouble concluding that these allegations were sufficient to state an actionable fraudulent business practice. (*Ibid.*) The owners' assertion of contract rights the owners did not have was likely to deceive the tenants who were forced to sign those documents. (*Ibid.*)

Here, **Preciado** alleges that Progressive engages in the pattern and practice of asserting its rights to 100 percent recovery of all moneys it pays to its insureds regardless of whether that reimbursement should be denied altogether or partially due to the made-whole rule and the common-fund doctrine. Further, **Preciado** alleges that Progressive made material misrepresentations and misled him (and presumably each of its customers it makes these same demands upon as a matter of course) in this regard. n4 This conduct is likely to deceive the public. For purposes of this pleading, we conclude that **Preciado** has stated a cause of action and the demurrer was properly overruled. n5

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n4 While not properly before us on the ruling on this demurrer, in his briefing, **Preciado** submitted a copy of the letter that Progressive sent to him. It shows the caption "FINAL NOTICE," and states that $ 5,000 is due. In a follow-up letter, Progressive asserts that *Lee v. State Farm Mut. Auto. Ins. Co.*, *supra*, 57 Cal. App. 3d 458, authorizes its reimbursement request, but omits anything about that case's application of the common-fund doctrine to that recovery. This letter appears likely to deceive the public to the extent that Progressive distributes it without regard to its knowledge of its insured's rights to these offsets. **[*42]**

n5 We express no opinion as to whether **Preciado's** attorney fees constitute "injury in fact" as required under section 17204. **Preciado** has alleged that the conduct has forced him to incur "economic damages" in addition to attorney fees.

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B

Unfair Business Practice

The state of the law on what constitutes an unfair business practice in consumer cases is somewhat unsettled in light of *Cel-Tech Communications, Inc. v. Los Angeles Cellular Telephone Co.* (1999) 20 Cal.4th 163 [83 Cal. Rptr. 2d 548, 973 P.2d 527].

Prior to *Cel-Tech*, whether a practice was "unfair" under section 17200 required the court to engage in a balancing test. (See, e.g., *Klein v. Earth Elements, Inc.* (1997) 59 Cal.App.4th 965, 969 [69 Cal. Rptr. 2d 623].) "Determination of whether a business practice or act is 'unfair' within the meaning of the UCA entails examination of the impact of the practice or act on its victim, ' "... balanced against the reasons, justifications and motives of the alleged wrongdoer. In brief, the court must weigh the utility of the defendant's conduct against the gravity of the harm to the alleged victim . **[*43]** ..." [Citation.]' [Citation.]" (*Id.* at pp. 969-970.)

In *Cel-Tech*, our Supreme Court concluded that in the context of a dispute between business competitors, this balancing test was "too amorphous and provide[d] too little guidance to courts and businesses." (*Cel-Tech Communications, Inc. v. Los Angeles Cellular Telephone Co., supra*, 20 Cal.4th at pp. 185, 187, fn. 12.) Thus, the court adopted the following test, "[w]hen a plaintiff who claims to have suffered injury from a direct competitor's 'unfair' act or practice invokes section 17200, the word 'unfair' in that section means conduct that threatens an incipient violation of an antitrust law, or violates the policy or spirit of one of those laws because its effects are comparable to or the same as a violation of the law, or otherwise significantly threatens or harms competition." (*Id.* at p. 187.) At the same time, the court declared, "This case involves an action by a competitor alleging anticompetitive practices. Our discussion and this test are limited to that context. Nothing we say relates to actions by consumers or by competitors alleging other kinds of violations **[*44]** of the unfair competition law such as 'fraudulent' or 'unlawful' business practices or 'unfair, deceptive, untrue or misleading advertising.' " (*Id.* at p. 187, fn. 12.) Thus, the court chose to leave for another day whether this test of unfairness applies to consumer cases as well.

The Courts of Appeal have struggled with which test should apply in the wake of *Cel-Tech*. In *Smith v. State Farm Mutual Automobile Ins. Co.* (2001) 93 Cal.App.4th 700, 717-719 [113 Cal. Rptr. 2d 399], the court used the original balancing test in a consumer action, concluding that the Supreme Court meant it when it said it was expressing no opinion on the application of the *Cel-Tech* test to consumer actions. In *Schnall v. Hertz Corp., supra*, 78 Cal.App.4th at pages 1166-1167, the appellate court adopted the *Cel-Tech* test in a consumer action concluding that an unfair business practice claim must be tethered to some " 'legislatively declared policy.' " Still other courts have failed to take a stance concluding that the unfair business practices before them offended either test. (*Pastoria v. Nationwide Ins.,supra*, 112 Cal.App.4th at p. 1497.)

CA(16) **(16)** We conclude **[*45]** that HN17 the balancing test should continue to apply in consumer cases. In *Cel-Tech*, the Supreme Court declined to extend its more narrow test to consumer cases. Moreover, it has yet to do so in the six years since that decision was announced. In addition, we believe section 17200's "unfair" prong should be read more broadly in consumer cases because consumers are more vulnerable to unfair business practices than businesses and without the necessary resources to protect themselves from sharp practices. One of the major purposes of section 17200 is to protect consumers from nefarious business practices.

Here, the allegations of the complaint are that Progressive has a pattern and practice of demanding 100 percent of any moneys it pays out to its policyholders under the med-pay

coverage without regard to the company's obligations under the made-whole rule or the common-fund doctrine. Further, **Preciado** alleges that Progressive misleads its policyholders and makes misrepresentations in connection with these activities. This alleged generalized practice fits the language often used in conjunction with unfair business practices as " 'immoral, unethical, oppressive, unscrupulous or substantially **[*46]** injurious to consumers.' [Citation.]" (*Smith v. State Farm Mutual Automobile Ins. Co.*, *supra*, 93 Cal.App.4th at p. 719.)

CA(17)(17) HN18The balancing test required by the unfair business practice prong of section 17200 is fact intensive and is not conducive to resolution at the demurrer stage. " '[U]nfairness' is an equitable concept that cannot be mechanistically determined under the relatively rigid legal rules applicable to the sustaining or overruling of a demurrer." (*Schnall v. Hertz Corp.*, *supra*, 78 Cal.App.4th at p. 1167.) The facts and evidence have not yet been adduced. Progressive has not yet had the opportunity to demonstrate its reasons, justifications, or motives for its conduct. Thus, we conclude the demurrer was properly overruled as to **Preciado's** cause of action for unfair competition.

C

Unlawful Business Practices

CA(18)(18) HN19An unlawful business practice under section 17200 is " 'an act or practice, committed pursuant to business activity, that is at the same time *forbidden by law.* [Citation.]' " (*Bernardo v. Planned Parenthood Federation of America* (2004) 115 Cal.App.4th 322, 351 [9 Cal. Rptr. 3d 197].)

Here, **Preciado** asserts his cross-complaint **[*47]** alleges a violation of Penal Code section 550, subdivision (b)(3). That section states, HN20"(b) It is unlawful to do, or to knowingly assist or conspire with any person to do, any of the following: [P] ... [P] (3) *Conceal,* or knowingly fail to disclose the occurrence of, an event that affects any person's initial or continued right or entitlement to any insurance benefit or payment, or *the amount of any benefit or payment to which the person is entitled.*" (Italics added.)

Preciado's cross-complaint does not allege that Progressive concealed the amount of benefits to which **Preciado** was entitled. It alleges that Progressive demanded more back from **Preciado** than it was entitled because of the operation of two separate equitable defenses. As we have explained, Progressive paid all of the benefits to **Preciado** to which he was entitled. Thus, the conduct alleged in the cross-complaint cannot be construed as concealing the amount of the benefits to which **Preciado** is entitled. No violation of this statute is pled in the cross-complaint.

Preciado further contends that his cross-complaint alleges that Progressive generally violates the court-made law of the **[*48]** common-fund doctrine and the requirements of the covenant of good faith and fair dealing. While this conduct may constitute fraudulent or unfair business practices, as framed by this cross-complaint, it does not rise to the level of an unlawful business practice. As we have already concluded, **Preciado** has not stated a cause of action for breach of the covenant of good faith and fair dealing against Progressive. Further, to the extent that these two common-law doctrines apply to **Preciado's** case, **Preciado** has not established there is a burden on Progressive to investigate the facts and circumstances of these doctrines and advise its insured on each of them. Thus, these allegations will not sustain a claim that Progressive breached these common-law doctrines.

DISPOSITION

The petition is granted in part and denied in part. The alternative writ, having served its

purpose, is discharged. Let a writ of mandate issue commanding the superior court to vacate its order overruling the demurrer and in its place enter a new order sustaining the demurrer without leave to amend as to the first and second causes of action and overruling it as to the third cause of action. The parties shall bear [*49] their own costs. (Cal. Rules of Court, rule 56(l)(2).)

Blease, J., and Sims, J., concurred.

EXHIBIT “C”

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January 18, 2006

Via Fax (213) 402-1901

Leslie Pereira, Esq.
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RE: *Netscape Communications Corp., et al. v. Federal Ins. Co., et al.*

Dear Ms. Pereira:

Thank you for your's of January 17, 2006 and the copy of the *Progressive v. Preciado* case. We request that you reconsider your position. The *Progressive* case does not address the issues and arguments we note in our earlier letter requesting that your client voluntarily dismiss its Ninth Cause of Action (violation of Section 17200). In fact, in *Progressive*, the court found that the insured there could not maintain a breach of contract or breach of covenant claim against the insurance company because no claim was being made that benefits were owed under the policy. As the court noted: "Here, there are no allegations in the pleadings that Progressive did anything other than pay out the benefits to Preciado in a timely fashion." Further, the court noted that: "we detect no actionable breach of contract in the allegations of the complaint."

While St. Paul does not agree that your client has a meritorious claim for coverage under the St. Paul policy, nonetheless, your client has pled breach of contract and breach of covenant causes of action against St. Paul based upon alleged denial of benefits owed under the insurance policy. As such, your client has an adequate remedy at law and is pursuing the claims it should in order to have this court determine whether there is coverage for the lawsuits filed and investigation conducted against your client.

We do not believe your Ninth Cause of Action to be viable under California law and request that you dismiss it so as to avoid the expense of bringing a motion to dismiss. We have to file our motion on Thursday (tomorrow) and therefore will proceed to do so. If you decide to voluntarily agree to dismiss that claim, please advise immediately so that the motion can be taken off calendar and instead an amended pleading can be prepared and responses made to an amended pleading.

Thank you for considering this further.

Sincerely,

Sara Thorpe

Sara Thorpe

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