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**IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA  
THIRD APPELLATE DISTRICT  
(Sacramento)**

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CSAC EXCESS INSURANCE AUTHORITY,

Plaintiff and Respondent,

v.

CALIFORNIA INSURANCE GUARANTEE  
ASSOCIATION,

Defendant and Appellant.

C081775

(Super. Ct. No.  
34-2014-00160890-CU-MC-GDS)

Plaintiff CSAC Excess Insurance Authority (hereafter CSAC),<sup>1</sup> a joint powers authority (see Gov. Code, § 6500 et seq.) formed to cover the workers’ compensation obligations of its member counties through a combination of risk retention and excess

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<sup>1</sup> The acronym “CSAC” is not defined by the parties. Given the proximity of CSAC’s headquarters to this court, we take judicial notice that the plaintiff entity (respondent) operates under the auspices of the California State Association of Counties. (See *Contra Costa County v. Workers’ Comp. Appeals Bd.* (2015) 240 Cal.App.4th 746, 749, fn. 1.)

insurance, ultimately sought a declaration in the present action that its workers' compensation payments for two of its members in excess of the agreed retention (\$500,000) with a now defunct insurer—the Protective National Insurance Company of Omaha (hereafter Protective)—are within the statutory definition of unpaid “covered claims” that defendant California Insurance Guarantee Association (hereafter CIGA) has an obligation to reimburse (Ins. Code, § 1063 et seq.).<sup>2</sup> On stipulated facts, CSAC sought summary judgment. The trial court issued a ruling in February 2016 that CIGA had breached its statutory duty to reimburse CSAC for the excess workers' compensation coverage due under the Protective policy.

On appeal, CIGA argues in essence that Protective did not *incur* an obligation under its policy to reimburse excess workers' compensation payments until after CSAC had exhausted its retention limit, which occurred after what one might call the statutory “drop-dead” date for reimbursement from CIGA: no later than 30 days after the appointment of the liquidator for Protective in Nebraska. (§ 1063.1, subd. (c)(1)(D) (hereafter section 1063.1(c) and its subparts).) CIGA further argues that the liquidator's 2012 termination of Protective's corporate existence and injunction against any further claims ended any statutory obligation on CIGA's part to reimburse CSAC, even if these had previously been covered claims. Finally, CIGA asserts the liquidator's administrative decisions denying submitted claims from CSAC somehow has preclusive effect in the present action because CSAC did not seek judicial review in a Nebraska forum.

We shall affirm the judgment.

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<sup>2</sup> Undesignated statutory references are to the Insurance Code.

## FACTUAL AND PROCEDURAL BACKGROUND

As this case involves only the legal significance of undisputed facts, we can depart from the historic tripartite paradigm for the review of a motion for summary judgment. (*County of Sacramento v. Superior Court* (2012) 209 Cal.App.4th 776, 778-779.)

CIGA is a statutory nonprofit unincorporated association to which insurance companies must belong as a condition of doing business in California. Its primary objective is to pay covered claims arising from the failure of an insolvent insurer to meet its obligations under its policies. (*Biggs v. California Ins. Guarantee Assn.* (1981) 126 Cal.App.3d 641, 644.) *In addition to* seeking recovery from the liquidation estate of a member as an assignee of the member's policyholders (*Middleton v. Imperial Ins. Co.* (1983) 34 Cal.3d 134, 137), CIGA assesses the costs of covering an insolvent's obligations against its membership, which in turn recovers this cost through premium surcharges on policies; this spreads the costs of insolvency across the entirety of the insurance market (*R. J. Reynolds Co. v. California Ins. Guarantee Assn.* (1991) 235 Cal.App.3d 595, 600). While covered claims *arise* out of the terms of the policy of the insolvent insurer, the obligations of CIGA are not parallel to those of the insolvent insurer; they are limited to the statutory definition of covered claims. (*Ibid.*)

CSAC obtained workers' compensation excess insurance policies from Protective with terms running from November 1981 to November 1984. The policies promised to *indemnify* CSAC for amounts actually paid in excess of \$500,000 for any "occurrence" during the policy period, which was defined as injuries giving rise to workers' compensation liability or damages.

On behalf of member Fresno County, CSAC paid workers' compensation benefits for an employee injury occurring in February 1984. The total amount of payments exceeded the \$500,000 retention in March 2007. On behalf of member Mendocino County, CSAC paid workers' compensation benefits for a series of injuries to an

employee that occurred in 1984 and 1986. The parties were not able to stipulate to the amount of payments attributable to the injuries occurring during the Protective policy period. The amount paid on behalf of Mendocino County first exceeded the \$500,000 retention in March 2014; it is not clear from the stipulated facts whether this was limited to injuries during the policy period or overall payments.

Meanwhile, a Nebraska court filed a declaration of insolvency with respect to Protective in February 2004. It required all potential claimants to file a proof of claim no later than February 2005. CSAC filed a proof of claim for the Fresno case in January 2005; the Nebraska liquidator denied the claim in June 2005 on the ground that CSAC had inadequately documented its exhaustion of the retention (which is not surprising given that it is stipulated that this did not occur until 2007). CSAC also filed its proof of claim for the Mendocino case in January 2005. The Nebraska liquidator deferred to CIGA in ruling on the claim in March 2005, noting, however, that the payments were unlikely to have exceeded the retention by the February 2005 deadline. In June 2012, the liquidation court entered a closing order dissolving Protective and enjoining any further claims against it.

In March 2005, Protective forwarded CSAC's claim for excess workers' compensation payments in the Mendocino County case to CIGA. CIGA denied the claim in April 2005 on the ground that covered claims did not include policies for excess workers' compensation insurance. After the addition of section 1063.1(c)(13) in 2005 *specifically* "expand[ed] the definition of 'covered claims' to include the obligations of an insolvent insurer to indemnify" self-insured employers under such policies (Legis. Counsel's Dig., Assem. Bill No. 817 (2005-2006 Reg. Sess.) 4 Stats. 2005, Summary Dig., ch. 395, pp. 195-196),<sup>3</sup> in February 2007 CIGA retracted its denial. However,

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<sup>3</sup> As noted in the legislative history, this enactment codified a compromise reached between CIGA and the self-insured community, after an appellate decision that found a

CIGA never made any payments in connection with the Mendocino County workers' compensation case before March 2013, when it cited the Nebraska closing order in a letter as a basis for concluding that a covered claim was no longer at issue. As a result, it disregarded a request for reimbursement from CSAC in 2014 after the retention limit was apparently reached.

After finally reaching the retention limit on the Fresno County workers' compensation case in March 2007, CSAC applied to CIGA for reimbursement. Initially, CIGA reimbursed CSAC for its payments on the Fresno claim in a total amount of \$144,000 (rounded) through September 2012. CIGA ceased payments on its receipt of the Nebraska closing order, asserting in another March 2013 letter that this terminated any further liability under Protective's policies. As of December 2014, CSAC had \$71,000 (rounded) in unreimbursed payments on the Fresno County workers' compensation case.

## DISCUSSION

### **1.0 The Obligation for Excess Insurance Is Incurred on the Date of Injury, Not on the Date of the Exhaustion of the Retention**

CIGA runs far afield from the controlling legislative text, which we set out.

Covered claims generally include “the obligations of an insolvent insurer . . . that satisfy

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self-insured employer solely liable for workers' compensation benefits (*Denny's Inc. v. Workers' Comp. Appeals Bd.* (2003) 104 Cal.App.4th 1433) somehow raised a doubt at least in CIGA's mind as to whether excess workers' compensation insurance policies came within the definition of covered claims. (Sen. Rules Com., Off. of Sen. Floor Analyses, 3d reading analysis of Assem. Bill No. 817 (2005-2006 Reg. Sess.) as amended Sept. 2, 2005, pp. 1-2.) *Denny's* did *not* involve CIGA's liability for an insolvent excess workers' compensation insurer; it is thus unclear how this led to the discord in the workers' compensation insurance community. (*City of Laguna Beach v. California Ins. Guarantee Assn.* (2010) 182 Cal.App.4th 711, 714, 718-720 [§ 1063.1(c)(13) does not have any effect on *Denny's* actual holding regarding a self-insured employer *without* excess insurance].)

all [seven] of the requirements: . . .” (§ 1063.1(c)(1)(A)-(G).) The only requirement that CIGA puts at issue provides that the claim must be “incurred prior to the date coverage under the policy terminated and [no later than] 30 days after the date [a] liquidator was appointed.” (§ 1063.1(c)(1)(D).) While section 1063.1(c)(13), which adds (or clarifies) that excess workers’ compensation policies for self-insured employers are among the policies giving rise to covered claims in “all pending and future insolvencies” (§ 1063.1(c)(13)(C), 2d par.), CIGA’s duty is nonetheless subject to “the exclusions and limitations of this article with respect to covered claims” (§ 1063.1(c)(13)(B)).

In an argument that did not appear to surface in its processing of CSAC’s claims until this litigation, CIGA contends Protective did not “incur” an “obligation” to indemnify until the retention limits were reached, which did not occur until *after* the drop-dead date for presenting claims in section 1063.1(c)(1)(D). (It is not clear why CIGA focuses on the date of the liquidator’s appointment, because under its argument this claim is not covered in any event because it did not arise during the expired policy’s period.) This is contrary to the policy language, which specifically provides that an occurrence during the policy period is the *injury* giving rise to excess workers’ compensation payments, and *not* the exceeding of the retention limit.

As a result, CIGA must establish that the statutory language has a much narrower meaning than the policy. As CIGA acknowledges, *Fluor Corp. v. Superior Court* (2015) 61 Cal.4th 1175, 1206 has noted (in the context of assignability of liability policies) that it is the rule that the duty to *indemnify* an insured arises on the date of an incident during the coverage period as opposed to the date on which the inchoate right to recover for the injury is ultimately reduced to a settlement or judgment. CIGA does not give a cogent reason for failing to ascribe an intent to incorporate this general principle to the

Legislature in enacting this statute.<sup>4</sup> CIGA first points out an empty distinction, noting that an excess insurer has only the duty to indemnify, not to defend. That does not explain why the duty to indemnify for an excess insurer should arise at some date different than the primary insurer absent *contractual* language to that effect. It then purports to establish another empty distinction, contending a personal injury claimant has an immediate right to the present value of all damages and a workers' compensation claimant is limited only to periodic payments, and thus "there is no certainty" that excess workers' compensation payments will ever be made. Even if we were to accept the legal basis for this distinction, CIGA does not explain why the manner of payment has legal consequence in this context, or why the fact that liability under the policy *might* not ever arise prevents the incurrence of a *contingent* liability at the time of an injury during the policy period.

We also reject CIGA's argument that to interpret "incurred" as including an excess insurance liability during the policy term would create a surplusage with section 1063.1(c)(1)(A) (which requires a claim be "[i]mposed by law and within the coverage of an insurance policy of the insolvent insurer"). It is true that provision (A) is essentially restated in the first part of section 1063.1(c)(1)(D), but the latter would still cover the

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<sup>4</sup> CIGA's repeated invocation of *Trope v. Katz* (1995) 11 Cal.4th 274 is mystifying; regardless of the language CIGA finds supportive on page 280, the *context* of the case rejects the idea that an attorney appearing in pro se "incurs" legal fees for purposes of a contractual provision allowing for the recovery of legal fees, which does not shed any light on CIGA's statutory interpretation in the present case. (*DeVore v. Department of California Highway Patrol* (2013) 221 Cal.App.4th 454, 461 [we must view scope of holding through lens of underlying facts].) Similarly, its citation of *Olympic Ins. Co. v. Employers Surplus Lines Ins. Co.* (1981) 126 Cal.App.3d 593, 600 in a footnote in its reply brief is unavailing. Again, the helpful general language on which CIGA would rely—that "liability" for excess insurance does not "attach" until primary insurance is exhausted—is asserted in the context *not* of when the liability was *incurred* but when it finally accrued.

distinct situation of a claim arising during the course of an *existing* policy at the time liquidation proceedings commence (as opposed to an expired policy coming only within provision (A)), cutting off any claims under such policies more than 30 days later. (Again, given that an expired policy is at issue in the present case, it is unclear why CIGA focuses on the timing of the appointment of the liquidator in provision (D), since the apparent premise of its argument—that a covered claim was *never* incurred within the policy term—would seem equally to apply to provision (A).)

CIGA’s interpretation is also at odds with the manner in which a rational Legislature goes about its business. We assume that with the subject of workers’ compensation excess insurance called to its attention, and the need to add (or clarify) its inclusion among policies subject to reimbursement for insurer insolvency, the Legislature would make express provision for a departure from the general rule governing when liability for excess insurance is incurred, as opposed to leaving it to a court to *imply* a significant departure from this rule *solely* for excess workers’ compensation insurers in the *unamended* language of section 1063.1(c)(1)(D) that does not otherwise distinguish among policies. We do not take an interpretive route under which the Legislature acted in “a very roundabout and obscure way . . . to accomplish such an end, [as] drafters of legislation are not presupposed to hide the elephant of . . . a major element inside . . . [a separate] mouse hole, when it would have been so much more straightforward to [make a provision in the statute] itself.” (*Covarrubias v. Cohen* (2016) 3 Cal.App.5th 1229, 1238.)

In short, CIGA does not provide authority for its reading of section 1063.1(c)(1)(D). We accordingly reject its argument.



## **2.0 A Liquidation Termination Order Does Not Extinguish CIGA’s Obligations Under California Law**

In an argument that apparently reflects the genesis of its March 2013 letters, CIGA contends (without expressly so admitting) that *even* if the Mendocino and Fresno workers’ compensation payments were covered excess claims within the meaning of section 1063.1(c), they “ceased to be” once the liquidator ended Protective’s existence and cut off any further claims against it. CIGA chides the trial court for concluding that “once a claim is a covered claim, subsequent events can never cause it to lose that status,” since an *assigned* claim can expressly lose its covered status. (§ 1063.1(c)(9).)

CIGA conflates an *express* statutory provision for *defeating* the covered status of an *assigned* claim—in a context where the Legislature could reasonably have concluded that *buyer beware* trumps, over remediation of an innocent purchaser—with an *unexpressed* provision to the same effect that would apply in *all* claims proffered to CIGA, without erecting any sort of analogical bridge that would compel us to reach such an extrastatutory result.

Rather, the sole support CIGA would give for our leap over this chasm of logic is its inability to recover from the liquidation estate once it is closed. It does not identify any statutory provision or judicial decision that concludes recovery from a liquidation estate is the *sine qua non* for relief under section 1063 et seq. That this may be an *alternative* recourse lessening the assessment against CIGA’s members for one of their failed cohorts is an insufficient basis for us to engage in judicial legislation on its behalf.

## **3.0 CIGA Fails to Establish That Issue Preclusion Applies**

In an argument that fails to incorporate *any* of the criteria for the application of issue preclusion to a collateral proceeding, CIGA notes that CSAC never sought judicial review of the Nebraska liquidator’s denial of the proofs of claim filed for the Fresno and Mendocino workers’ compensation cases, as is apparently provided under Nebraska law.

(This presumes the *referral* of the Mendocino workers’ compensation claim to CIGA with dicta rejecting the claim in any event constitutes a denial.) CIGA therefore argues CSAC is precluded from claiming in the present action that these represent obligations within the meaning of section 1063.1(c)(1)(D).<sup>5</sup>

This superficial argument absolves us of any duty to respond in plenary fashion. (See *People v. Oates* (2004) 32 Cal.4th 1048, 1068, fn. 10; *Sourcecorp, Inc. v. Shill* (2012) 206 Cal.App.4th 1054, 1061) We thus simply observe that issue preclusion operates “against the party against whom [a prior unchallenged administrative determination] was obtained as a[] . . . conclusive adjudication *as to those issues in the second action [that] were actually litigated and determined in the first action*”; thus, “[u]nless the administrative decision is challenged, it binds the parties *on the issues litigated* and if those issues are fatal to a civil suit, the plaintiff cannot state a viable cause of action.” (*Knickerbocker v. City of Stockton* (1988) 199 Cal.App.3d 235, 242; *id.* at pp. 243-244; all italics added.) As a result, to the extent that the plaintiff’s cause of action in *Knickerbocker* rested on an improper *firing*, as opposed to a *demotion* upheld in administrative proceedings, issue preclusion did not apply. (*Knickerbocker*, at p. 245.)

CIGA fails to demonstrate that the Nebraska administrative decision considered either California law or any fact pertinent to a “covered claim” under our law. *All it* determined was the failure to establish timely *accrued* payments in excess of the retention so as to allow a claim against *Protective’s estate* as of February 2005 under the

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<sup>5</sup> We note section 1063.18, effective January 1, 2016, makes the right to recover from a defendant independent of any “final determination [and approval] of a claim in an insolvent insurer’s liquidation proceeding” (*id.*, subd. (a)); the legislative history—which we leave to an applicable case to detail—again indicates this was in response to an appellate case that had suggestions to the contrary. As we do not find issue preclusion to be appropriate, we do not need to consider any application of this recent statutory enactment to this case.

terms of the liquidation. That is not a relevant fact or issue for *incurring* a covered claim on which CIGA is obligated under section 1063.1(c)(1)(D).

**DISPOSITION**

The judgment is affirmed. Respondent CSAC shall recover its costs on appeal.  
(Cal. Rules of Court, rule 8.278(a)(1), (2).)

\_\_\_\_\_ BUTZ \_\_\_\_\_, J.

We concur:

\_\_\_\_\_ BLEASE \_\_\_\_\_, Acting P. J.

\_\_\_\_\_ HULL \_\_\_\_\_, J.