No. S153852

IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

AMERON INTERNATIONAL CORPORATION,

Plaintiff and APPELLANT,

v.

INSURANCE COMPANY OF THE STATE OF PENNSYLVANIA, et al.,

Defendants and RESPONDENTS.

APPELLANT'S REPLY BRIEF on the Merits

After a Decision By the Court of Appeal, First Appellate District, Division Five, Case No. A109755, San Francisco County Superior Court, Case No. 419929

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APPELLANT'S NOTICE OF CHANGE OF ADDRESS

After a Decision By the Court of Appeal, First Appellate District, Division Five, Case No. A109755, San Francisco County Superior Court, Case No. 419929

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DATED: May 16, 2008

STANZLER FUNDERBURK & CASTELLON LLP

By: _____
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Attorneys for Appellant Ameron International Corporation

PROOF OF SERVICE
[C.C.P. § 1013, C.R.C.§ 2008, F.R.C.P. Rule 5]

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Dated: May 16, 2008

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Sharran L. Rodd

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases — Pages

STATUTES

INTRODUCTION

This appeal boils down to one single concept: adjudication. The Board of Contract Appeals adjudicates facts and law to determine damages. The Board's Administrative Law Judge issued a lengthy decision denying summary judgment[1] and conducted a twenty-one day trial. Witnesses testified under oath, subject to cross-examination. To the ordinary person, this adjudication is a "suit". To the ordinary person, this litigation is a "suit." To the U.S. Congress, this legal proceeding is a "suit." The ordinary insured would not distinguish between a court empowered to award money damages and a federal agency empowered to award money damages. In both situations, the ordinary insured reasonably expects that the insurance company will provide a defense to the adjudication of money damages. That, indeed, is the very purpose of liability insurance.

Nowhere do the insurance companies recognize the concept of adjudication. That word does not appear in their briefs and they never discuss the function of the Board of Contract Appeals. They focus instead upon minute differences between a trial before the Board and a trial before the Court of Claims – minute differences that a legal specialist might find interesting, but the ordinary insured would not even know that they existed. The insurance companies never come to grips with what this case is all about – the imposition of money damages through an adjudication.

The Board of Contract Appeals is not just the functional equivalent of the Court of Claims. The Board is the actual, statutory equivalent of the Court of Claims. Historically, the Board had the power to award money

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[1] The decision denying summary judgment appears at AA 2214-2257. The page citation in the opening brief is erroneous. We regret the error.

damages, just like the Court of Claims. Congress codified existing law in Contract Disputes Act of 1979, in which it specifically referred to litigation before the Board as a "suit", allowing a "suit" filed before the Board to be transferred to the Court of Claims; and a "suit" filed in the Court of Claims to be transferred to the Board. 42 U.S.C. §609(d). The ordinary insured would expect insurance coverage for both "suits." The ordinary insured would not make any distinction between a "suit" litigated in court and a "suit" litigated before the Board. There is nothing in the insurance policy that provides for any such distinction.

The basic argument of the insurance companies is that the Board is not a court. That is true, but it is of no import to the ordinary insured when facing the prospect of money damages being awarded in either one forum or the other forum. The insured would expect a defense in litigation seeking to adjudicate the insured's liability for money damages, regardless of which legal process was used.

The key here is the Board's authority to adjudicate liability and to award money damages against the insured. That is the essence of a "suit." The insurance companies do not cite a single case denying insurance coverage for litigation before an administrative agency that awarded money damages.

I. THE BOARD OF CONTRACT APPEALS FUNCTIONS IN A JUDICIAL CAPACITY EVEN THOUGH IT IS NOT A COURT

The insurance companies argue that a trial before an administrative agency can never be a "suit" and that an administrative agency can never adjudicate a "suit". That argument makes no sense where the agency has the authority to award money damages following an actual trial.

The ordinary layperson would see no difference, for insurance purposes, between a trial before a federal administrative law judge and a federal district court judge, when Congress has given the federal contractor the choice of forum. Lawyers for insurance companies can identify the technical differences between the two forums, but the test for insurance coverage is not what lawyers think but what the ordinary layperson would understand. *Cf. Safeco Ins. Co. of America v. Robert S.* (2001) 26 Cal. 4th 758, 765-766 ("an insured should not be expected to know the subtle legal distinctions between the concepts of negligence and gross negligence"); *TRB Invest, Inc. v. Fireman's Fund Insurance Company* (2006) 40 Cal. 4th 19 (dictionaries, legislative definitions, and administrative regulations used to interpret the term "construction" in "ordinary parlance").

The insurance companies refuse to recognize the fact that the Board of Contract Appeals acts in a judicial capacity and therefore is a "judicial" or quasi-judicial body. See *United States v. Utah Construction & Mining Co.* (1966) 384 U.S. 394, 422 ("the Board was acting in a judicial capacity when it considered the Pier Drilling and Shield Window Claims, the factual issues resolved were clearly relevant to the issues before it, and both parties had a full and fair opportunity to argue their version of the facts and an opportunity to seek court review of any adverse findings.")

The insurance companies decided not to define the term "suit." They could have done so easily if they wanted to restrict coverage to lawsuits in court. For example, the policy in *Mosquito Control District of Florida v. Coregis Insurance Company* (2002) 838 So. 2d 110 (Florida) provided that the insurance company had the right and duty to defend a "suit," which the policy defined as "a proceeding in a court of law where money damages may be awarded." That language made it clear that coverage was limited to

a lawsuit filed in a court of law. By choosing not to use that language, the insurance companies here provided coverage for a "suit" before an administrative agency.

School District No. 1 v. Mission Ins. Co. (1982) 650 P.2d 929, 58 Or. App. 692, 703 illustrates this point, in which the court concluded that the undefined term "suit" was broad enough to cover administrative proceedings in which money damages could be awarded.

> Northwestern also contends that it did not have a duty to defend these discrimination claims until there was a "suit *** seeking damages" and that "suit" means a proceeding in a court...
>
> "Suit" is not defined in the policy. It can have several meanings. *Webster's New International Dictionary* (1976) defines "suit" in pertinent part, as "the attempt to gain by legal process; prosecution of right before any tribunal", and more narrowly as "an action or process in a court for the recovery of a right or claim: a legal application to a court for justice."[2]
>
> The policy provides that the insurer will "pay on behalf of the insured all sums which the insured shall become legally obligated to pay" on account of certain claims. The Commissioner of the BOL [Bureau of Labor] was authorized to enter an order requiring the district to compensate victims of discrimination for the pecuniary losses they suffered [citations omitted].
>
> We believe that the terms "suits" as used in Northwestern's policy is sufficiently broad to coverage proceedings before the BOL and EEOC [Equal Employment Opportunity Commission].

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This is yet another edition of *Webster's* which defines "suit" in this fashion. See Ameron's Opening Brief at 21.

Similarly, *Continental Casualty Co. v. Cole* (1987) 809 F. 2d 891, 898 (D.C. Cir.) emphasized that the correct analysis of whether there is a "suit" depends on "[t]he substance of the action against the insured rather than on its form, recognizing that an insured who is being 'proceeded against,' albeit in an unorthodox fashion...is no less entitled to a defense than his insured contemporaries who are legally attacked in a more conventional manner." The court emphasized that:

> This view takes into account the legitimate and reasonable expectations of the insured, who would neither perceive the artificial distinction between a traditional lawsuit seeking damages and some other legal attempt to achieve the same result, nor anticipate such a distinction, if found, would make any difference so long as he was legally threatened because of activities for which he was covered. *Id.* at 898-899.

The court concluded that in the peculiar circumstances involved, a motion to vacate the remand of an appeal was a "suit" against the insured, even though the insured was not a party to the appeal, because the motion had "all the trappings of a suit against the insured." See also *Madawick Contracting Co. v. Travelers Ins. Co.* (1954) 307 N.Y. 111, 116, 120 N.E.2d 520 ("suit" is a "broad term" which includes arbitration within its scope and hence applies where no lawsuit was filed against the insured).

The insurance companies cite *Hackenthal v. National Casualty Co.* (1987) 189 Cal. App. 3d 1102, a case which actually supports Ameron. This case involved an administrative hearing to revoke a doctor's license. The doctor's malpractice insurance policy limited coverage to a "civil suit for damages." Because the revocation hearing did not involve the payment of money damages, the court found that there was no coverage: "The BMQA hearing simply did not result in 'damages' being assessed against Dr. Hackenthal." *Id.* at 1110. It was for this reason that the court concluded

there was no coverage – there was no payment of money ordered. The case did not turn on the interpretation of "suit" but clearly implied that there would have been a "suit" if the doctor had been ordered to pay damages.

The insurance companies do not cite a single case in which coverage has been denied for damages awarded by an administrative agency after an adjudication of liability. Contrast cases cited in Ameron's Opening Brief at 22-24.

II. THE LEGISLATIVE HISTORY RECOGNIZING THAT LITIGATION BEFORE THE BOARD OF CONTRACT APPEALS IS A "SUIT" SHOWS THAT THE ORDINARY LAYPERSON REGARDS A TRIAL AS A "SUIT"

The insurance companies have missed the point of the legislative history in which the United States Congress recognized that the Boards of Contract Appeal litigate "suits", described the Boards as "trial courts" and noted that the Boards provide federal contractors with their "day in court." See Ameron's Opening Brief at 25-27. The point is that the ordinary layperson regards a trial before the Board as a "suit," especially where members of Congress have come to the same understanding in the legislative history and statutory provisions.

The insurance companies "doth protest too much" in trying to disavow or belittle the Congressional history. They argue, for example, that Congress enacted into law a "scrivener's error" when Congress defined litigation before the Board as a "suit" in 41 U.S.C. §609 (d). Joint Answering Brief (hereafter "JAB") at 34-35. This argument conveniently ignores the legislative history which refers to Board proceedings as "suits" at several different points. See Ameron's Opening Brief at 26, quoting the use of the term "suits" to refer to Board proceedings in S. Rep. 95-118, 1978 Code Congressional and Administrative News 5265. Thus, the statute

repeats exactly what Congress had already recognized in the legislative history. There was no proofreading error when Congress used the term "suit" in both the legislative history and the statute.

The insurance companies also point out that Ameron made an election, specifically provided for under the Contract Disputes Act, to proceed under the law that existed prior to the enactment of that Act in 1979. That is beside the point. The point is that an actual trial took place before the Board seeking to impose money damages, and Congress recognized that the Boards, historically, had litigated "suits" under the old, pre-existing law. Moreover, the election did not change the nature, purpose, or scope of the trial and had only one consequence of no moment here: the election under pre-existing law meant that the Government could not appeal the Board's decision to a court even though Ameron could do so. See Ameron's Opening Brief at 28, n. 8.

The insurance companies make too much of technical distinctions between a trial before the Board and a trial before a federal court, such as the fact that a Board may admit hearsay (as if to say that a federal court can never admit hearsay). JAB at 25. But these very fine, lawyerly distinctions do not show what a layperson would understand by the term "suit." These are "artificial distinction[s] between a traditional lawsuit seeking damages and some other legal attempt to achieve the same result," to quote from *Continental Casualty Co. v. Cole, supra.*

Finally, the insurance companies make the throw- away argument that Ameron could never had any expectation of coverage anyway, since the trial before the Board involved damages flowing from a breach of contract, which, supposedly, were not covered until this Court decided *Vandenberg v. Superior Court* (1999) 21 Cal. 4th 815. This argument was not raised below. It cannot be made in a demurrer to a complaint which alleges that

there is coverage, and the allegation must be accepted as true at this point. *Vandenberg* specifically explained that a misreading of case law led some courts to believe, erroneously, that there was no coverage for claims pled as breach of contract. 21 Cal. 4th at 839. This point has nothing to do with the meaning of "suit." Moreover, Ameron purchased "contractual liability coverage" in many policies, so it did indeed have an expectation of coverage all along. *See, e.g.*, AA 297 (INA policy).

III. THE REASONABLE EXPECTATIONS OF THE ORDINARY INSURED WOULD BE MEANINGLESS IF THE "BRIGHT-LINE RULE" OF *FOSTER-GARDNER* IS APPLIED

Foster-Gardner, Inc. v. National Union Fire Ins. Co. of Pittsburgh, Pa., 18 Cal. 4th 857 (1998) addressed the issuance of an environmental cleanup order from an administrative agency, not a trial before an administrative agency empowered to award money damages. Given the fundamental difference in the facts, the reasoning of *Foster-Gardner* does not apply here.

This Court noted that the Determination and Order of the environmental agency did "not commence either a lawsuit in court or *an adjudicative procedure before an administrative tribunal.*" *Id.* at 878 (emphasis added, internal citation omitted). The clear implication was that an adjudicative proceeding before an administrative tribunal did constitute a "suit."

The insurance companies argue that this Court intended its "bright-line rule" as a sweeping pronouncement to preclude insurance coverage for any and all adjudications before any and all administrative tribunals, regardless of their nature, purpose, or content. This Court has never made such a sweeping pronouncement. The insurance companies tacitly concede this point when they go to great lengths to argue that a "trial-type"

proceeding "may take place" when a "PRP" in a DTSC proceeding presents rebuttal evidence. JAB 29. Perhaps. But there was no trial-type proceeding in *Foster-Gardner* of any kind. The agency simply issued an order. That case should therefore be limited to its facts.

The problem with the "bright-line rule" of *Foster-Gardner* comes when it is applied to a different set of facts. Each factual situation should be decided on its own merits. A blanket "bright-line rule" that excludes coverage for money damages -- simply and solely because the award was made by an administrative agency after an adjudication – defeats the very purpose of liability insurance.

Applying the "bright-line rule" to the facts in this case is like jamming a square peg into a round hole. It does not fit.

The insurance companies phophesize the proverbial floodgate of litigation if this Court rules in favor of Ameron. In fact, the *Foster-Gardner* decision has already caused a different floodgate of litigation. Policyholders now avoid compliance with administrative orders, lest they lose insurance by doing so. Consequently, policyholders in environmental cases must resort to one of two strategies to secure insurance coverage. They will invite lawsuits by regulatory agencies, to trigger insurance coverage; or they will file lawsuits against other potentially responsible parties, inviting counterclaims which will in turn trigger insurance coverage for the defense of the counterclaim. *Foster-Gardner* has thus created its own "floodgate" of environmental litigation.

IV. AMERON WAS THE REAL PARTY IN INTEREST BEFORE THE BOARD OF CONTRACT APPEALS AND SUES IN ITS OWN NAME AND AS THE ASSIGNEE OF KIEWIT

The insurance companies point out that the litigation before the Board of Contract Appeals was litigated in the name of the prime

contractor, Peter Kiewit, rather than in the name of Ameron. This is another "form over substance" argument. Ameron was the real party in interest in the trial before the Board. Ameron paid attorneys to defend against and settle the Government's claims and brings this lawsuit not only in its own name, but as an assignee of Kiewit, who is an insured under the policies sold to Ameron. Third Amended Complaint, paragraphs 30, 36 102, 118, AA 1054, 1064. See also the decision of the Court of Appeal, *Ameron International Corporation v. Insurance Company of the State of Pennsylvania* (2007), 150 Cal. App. 4th 1050, 1058. Thus Ameron sues for itself and for Kiewit.

The insurance companies elevate form over substance because they ignore the fact that the Government was complaining about defects in siphons manufactured by Ameron, pursuant to a subcontract between Kiewit and Ameron in which Ameron agreed to indemnify and defend Kiewit against the Government's claims. Hence, Ameron paid for attorneys to defend the Government's claims and paid $10 million to settle the Government's claims. This insurance coverage case involves monies that Ameron spent in connection with the defense and settlement of the Government's claims in the litigation before the Board. Ameron also proceeds as the assignee of Kiewit's rights. Therefore, it is of no moment that the litigation before the Board was brought in the name of Kiewit.[3] See also the Decision of Administrative Law Judge Cheryl Scott Rome noting at

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It is a peculiarity of the statutory framework that the only party that is liable under a federal contract is the prime contractor, who is the only party who can appeal the Contracting Officer's decision. The Complaint before the Board appears at AA 2180. The government's Answer and Counterclaim appear at AA 2191. (The page numbers were incorrect in Ameron's Opening Brief. Ameron regrets the error.)

page 2 that Kiewit "has appealed on its own behalf and on behalf of its subcontractor, Ameron, Inc." AA 2215.

Simon v. Maryland Casualty Company (1965) 353 F.2d 608 (5th Cir.) rejected this very "form over substance" argument. The Air Force, through its Contracting Officer, withheld money from the prime contractor due to negligence of the subcontractor. To get the money back, the subcontractor authorized the prime contractor to sue the Government in the Court of Claims and agreed to share costs and attorneys' fees. The insurance company denied coverage for defense costs because the Government had not sued the subcontractor. The Fifth Circuit ruled that the insurance company was not entitled to an "artificial windfall" simply because the litigation took an unorthodox form: "the Insurer got every protection it would have obtained had the litigation followed the traditional, orthodox pattern of a suit and judgment *against* the Assured-subcontractor". *Id.* at 613 (italics in original). The court also found, as a practical matter, that the subcontractor had no choice except to do what it did. Only " a party to a Government contract" may bring an action before the Board or the Court of Claims. See 41 U.S.C. sections 601, 606, 609. Thus actions must be brought in the name of the prime contractor. But that does not affect insurance coverage under the subcontractor's insurance policies. See also *Continental Cas. Co. v. Cole*, 809 F. 2d 89, 897 (D.C.Cir. 1987) noting that "[c]ourts have often found a duty to defend in instances where the insured was not a party to an action," collecting cases on that subject.

V. THE INA PRIMARY POLICY IN 1988-89 OBLIGATES INA TO REIMBURSE AMERON FOR "LOSS ADJUSTMENT EXPENSES" (EXPENSES INCURRED IN SETTLEMENT OF CLAIMS) WHERE A SETTLEMENT EXCEEDS THE DEDUCTIBLE AMOUNT

The plain language of the INA policy obligates INA to reimburse

Ameron for "Loss Adjustment Expenses" which are defined as attorneys' fees, court costs, and other expenses "in connection with investigation, defense or settlement of claims under this policy." This coverage is contained in the Deductible Endorsement, which shows that there is coverage for "claims" and not just for lawsuits.

This provision is part of a non-standard agreement between Ameron and INA, described in the INA policy. Ameron entered into a Claims Service Agreement with ESIS, Inc. (a company related to INA)[4] under which ESIS provided a defense to claims in the first instance; Ameron reimbursed ESIS for the costs that ESIS incurred in handling claims and then sought reimbursement from INA for those costs, under a mathematical formula set forth in the Deductible Agreement. Complaint, ¶46, AA 1056.

The policy obligates INA to reimburse these claim costs when it states that "All Loss Adjustment Expense incurred as a result of any Occurrence to which this policy applies shall be apportioned between the Named Insured [Ameron] and the Company [INA] as follows: (a) If the amount of the Judgment or settlement exceeds the amount of the Deductible-Per-Occurrence, all Loss Adjustment Expense in connection therewith shall be borne by the Named Insured and the Company in the same proportion as their respective obligations under this policy for payment of the amount of the judgment or settlement." AA 303-304 (emphasis added).

The words "shall be apportioned" are mandatory. Here, Ameron settled with the Government for $10 million. That amount exceeds the per-occurrence deductible ($100,000) in the ratio of $10 million to $100,000,

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The Claims Service Agreement required Ameron to pay a fee for each claim that was handled. The Agreement is an exhibit to the Complaint. AA 1115-1118.

or a ratio of 99%. The policy mandates INA to reimburse Ameron for 99% of Loss Adjustment Expenses.

The argument put forth in the Joint Answering Brief at 21 is an argument made for the first time on appeal – that INA is not required to reimburse Ameron at all. That is frivolous. In a single sentence, in passing, the brief argues that this provision applies "*if* INA incurs these expenses". (emphasis in original).The policy does not contain the word "if" – it contains the words "shall be apportioned." This is a mandatory provision, as *Travelers Indemnity Co. Of Illinois v. INA* (1995) 886 F. Supp. 1520, 1528 (S.D.Cal.) explains. INA must reimburse loss adjustment expenses if a claim loss exceeds the agreed upon amount: "The policy does obligate INA, under certain circumstances, to reimburse the insured in defending certain actions against the insured....This obligation to reimburse defense costs is thus incurred only if the insured incurs a claim loss exceeding the 'retained limit.'" Notably, INA does not mention or dispute this case.

Furthermore, the "if" argument flouts the Claims Servicing Agreement and the reasonable expectations of the parties. It is ESIS, not INA, that pays defense expenses in the first instance. INA is not called upon to pay defense expenses in the first instance – ESIS does that. Thus, there never will be a situation where INA incurs defense expenses itself. The notion in the Joint Answering Brief that INA will reimburse defense costs only "if" INA incurs defense costs renders the policy illusory, meaningless, and contrary to the parties' conduct, understanding, and the Claims Service Agreement, because INA itself has not incurred those expenses in the first instance and never will do so.

The insurance companies also argue that the definition of "damages" in the endorsement, to include money awarded in no-fault cases that never go to court, means nothing, because the definition is contained in the

endorsement. JAB at 41-42. This argument contradicts the black-letter law that an insurance policy must be read as a whole, with each clause giving meaning to the other, *see e.g.*, Civil Code section 1641, *Holz Rubber Co., Inc. v. American Star Ins. Co.* (1975) 14 Cal. 3d 45, 56; and that an endorsement controls when there is a conflict between the main body of the policy and the endorsement. *See, e.g., Continental Casualty Co. v. Phoenix Construction Co.* (1956) 46 Cal. 2d 423, 431.

The argument makes no sense for another reason. The endorsement does apply here, since it does come into play on this claim and very other claim where there is a settlement or a judgment. The use of the terms in that endorsement are thus relevant to understanding what the parties intended. The parties went out of their way to say that INA's duty to pay "damages" extends to no-fault cases that never reach a court. Thus, the parties explicitly intended that coverage was not limited to lawsuits filed in court. This is one more indication – along with the coverage for claims in the same endorsement – that the policy does not limit coverage to lawsuits filed in court.

VI. THE PURITAN AND OLD REPUBLIC POLICIES CONTAIN A SECOND INSURING AGREEMENT WHICH PROVIDES UMBRELLA COVERAGE FOR THE SETTLEMENT OF CLAIMS AND SUITS NOT COVERED BY PRIMARY INSURANCE

The issue here is whether there is one insuring agreement or two insuring agreements. The undeniable fact is that the Limit of Liability provision is Insuring Agreement II, as the policy plainly states on its face. See Ameron's Opening Brief at 38-39 (noting that the policy refers to Insuring Agreements in the plural) and at 43 (noting that the Cross-Liability provision refers to the "limit of liability under Insuring Agreement II"), AA 756 (Old Republic), and AA 544 (Puritan).

Moreover, the Limit of Liability Provision makes each policy an umbrella policy because it provides coverage for "ultimate net loss in respect of each occurrence not covered by underlying insurances..." Ameron's Opening Brief at 39-41.

The insurance companies have nothing to say on these points other than to make the bald, unsupported statement that there is only one insuring agreement. (JAB at 22; Old Republic Brief at 3). Just saying so does not make it so. Old Republic's separate brief avoids any mention of the two insurance agreements at all and proceeds to build a "straw man" argument that Insuring Agreement II, the Limit of Liability provision, is not an insuring agreement.

Accordingly, it is necessary to consider what the policy covers when it uses the term "ultimate net loss" in the second insuring agreement. The policy defines "ultimate net loss" as the "total sum" which the "Assured" shall become obligated to pay "through adjudication or compromise...and shall also include ...expenses for doctors, lawyers, nurses...and investigators...and for litigation, settlement, adjustment of claims and suits..." AA 544 (Puritan); AA 756 (Old Republic).

The policies clearly provide coverage for matters that are resolved outside of a court – since the policy refers to "adjudication or compromise" and since a compromise can take place outside of an adjudication and outside of a court. Moreover, the Board litigation is covered–either as a "claim" by the government against Ameron or as a "suit."

The policies do not define the term "suit" and hence the appeal falls within the scope of Ameron's Petition for Review, in which Ameron asks the Court to decide if the Board Proceeding constitute a "suit".

VII. THE GREAT AMERICAN, PACIFIC, AND 1992-95 ISOP POLICIES ARE PROPERLY INCLUDED WITHIN THE PETITION FOR REVIEW BECAUSE OF THE DEFENSE PROVISION IN WHICH "SUIT" IS NOT DEFINED

Each of the Great American and Pacific policies contains a provision that the insurance company will have "the right and duty to defend any suit against the insured ...and shall make such investigation of the any claim or suit as it deems expedient." The term "suit" is not defined. This language is similar to the language in *Foster-Gardner*, bringing these policies within the scope of the Petition for Review. We fail to understand the statement in the Joint Answering Brief that these policies are not included in the Petition for Review.

Similarly, the 1992-1995 policies of the Insurance Company of the State of Pennsylvania contain the provision that insurance company will defend a "suit," but does not define the term "suit." These policies also fall within the scope of the Petition for Review.

VIII. THE INSURANCE COMPANIES HAD A DUTY TO SPEAK, AS SET FORTH IN THE FAIR CLAIMS PRACTICES REGULATIONS

The gist of Ameron's appeal is that the Court of Appeal made an obvious error of law when it stated that "no regulation imposed an affirmative duty to speak to respondents." That error led the Court to rule that the insurance companies had no duty to speak. The Fair Claims Settlement Practices Regulations cited in Ameron's brief show that these regulations do in fact exist and do in fact apply here. See, *e.g.*, 10 C.C.R. §2695.7(b)(1) (insurance company must explain "all factual bases" for each reason given for denial of coverage; and must provide an "explanation" of each provision, condition, or exclusion relied upon). The Court of Appeal missed the point that if the insurance companies had spoken, as the

regulations required, Ameron would have and could have proceeded to the Court of Claims rather than the Board of Contract Appeals. Ameron would then have avoided this insurance coverage dispute altogether. This is a classic case of estoppel – Ameron relied to its detriment upon the silence of its insurance companies when they had a duty to communicate.

The insurance companies cannot refute, on a demurrer, the clear allegations in the operative complaint that the insurance companies knowingly failed to follow these regulations and knowingly failed to communicate with Ameron and/or Kiewit (an insured under the policies). The complaint alleges specifically that the insurance companies knowingly and intentionally failed to follow these regulations and to communicate their position that there was no coverage for a "suit" before the Board of Contract Appeals. Complaint ¶¶ 137-163, AA 1070 (INA); ¶¶233-242, AA 1078-1079 (Puritan); ¶¶256-261 (Old Republic); AA 1080-1081; ¶¶287-293, AA 1083 (Twin City); ¶¶356-362, AA 1090-1091 (Great American); ¶¶487-496, AA 1102-1103 (ISOP). INA went even further: it approved of Ameron's decision to settle with the Government and offered to pay $750,000 towards that settlement (AA 923) – without once mentioning that there was no coverage for litigation before the Board of Contract Appeals.[5] It was only after Ameron paid its settlement money and brought this coverage lawsuit that the insurance companies suddenly decided for the first time that there was no coverage because the proceeding before the Board was not a proceeding in a court.

5

Since we are at the demurrer stage, the Court can properly consider Ameron's ability to amend the pleadings to include the facts set forth in the Declaration of James Somberg, that INA encouraged Ameron to settle and offered to pay $750,000 to do so. AA 923. The complaint specifically alleges that the insurance companies set a "trap" for Ameron. ¶¶162, 239, 260, 292, 361 and 489.

Had Ameron known that this rug would be pulled out from under it, Ameron could have decided not to settle and could have decided to proceed to court. Ameron could have decided either: a) to file its case in the Court of Claims at the outset; b) to transfer the case, filed before the Board, to the Court of Claims; or c) to litigate before the Board and take an appeal to the Federal Court of Appeals. See Complaint, ¶161, AA 1070.

Ameron did none of these things, which it could have done, because it relied upon the insurance companies' silence when they had a duty to speak under the regulations. Ameron relied to its detriment on the failure of the insurance companies to speak. Had they spoken and said there is no coverage for Board proceedings, Ameron could have taken steps to avoid the Board and proceed to Court. These allegations state a valid cause of action for waiver and/or estoppel.

Ameron is not trying to create coverage where none exists. The insurance companies concede that Ameron always had coverage for a litigation in a court. If they truly believed that Ameron had no coverage for an adjudication before the Board, they could not stand by in silence and watch Ameron commit "insurance suicide." They had a duty to state their position, under the regulations. They had to accept coverage, deny coverage, or reserve their rights, and in any event they had to explain their reasons for taking their position. But they chose to remain completely silent. Some insurance companies said nothing at all (breaching their duty to communicate); INA affirmatively misled Ameron into believing that there was coverage for the settlement with the Government.

Since we are at the pleading stage, Ameron must be allowed to prove that the insurance companies intended to waive their rights given the very specific allegations of the complaint. Ameron is not precluded from doing

so under *Waller v. Truck Insurance Exchange* (1995) 11 Cal. 4th 1. This appeal does not depend upon "automatic waiver" or "implied waiver," the issues discussed in that case. Nor did *Waller* address the regulations at issue. Rather, this appeal is based upon specific allegations of willfull violations of the regulations and detrimental reliance that were not asserted in *Waller*. Stated simply, *Waller* did not deal with the knowing, intentional failure of insurance companies to follow the Fair Claims Settlement Practices Regulations, causing the insured to lose the insurance coverage that was always present.

CONCLUSION

The insurance companies do not concern themselves with the most fundamental fact in the case–that the Board of Contract Appeals adjudicates facts and law to determine money damages. That legal process is the essence of a "suit." The ordinary insured would see no difference between an order to pay money damages resulting from a trial before a federal administrative law judge or resulting from a trial before a federal judge. The "bright-line rule" in *Foster-Gardner* does not apply to these facts; or, if it does, the rule should be changed to reflect the reasonable expectations of the insured.

Respectfully submitted,
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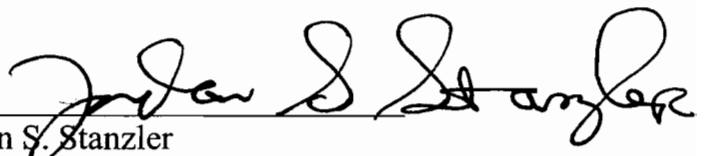
By: 
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CERTIFICATE OF WORD COUNT
(Rule 8.504(d), Cal. Rules of Court)

I certify that this Reply Brief is proportionately spaced and is prepared in "Times New Roman" 13 point font. The brief contains 5635 words.

Respectfully submitted,
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PROOF OF SERVICE
[C.C.P. § 1013, C.R.C.§ 2008, F.R.C.P. Rule 5]

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Dated: May 16, 2008

Sharran L. Rodd