Insurance Law

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■ Introduction

In 2020, policyholders scored a significant victory at the California Supreme Court, which ruled in favor of vertical exhaustion in the context of continuous loss claims. The year also saw numerous reversals of summary judgment on coverage and bad faith issues, mostly in favor of policyholders. A notable exception to the policyholder winning streak was the almost unanimous rejection by trial courts of efforts to secure coverage for COVID-19 business interruption losses; however, those cases have not yet percolated to the Courts of Appeal, and are thus not addressed in this year's update. In addition, several cases wrestled with civil procedure issues in the context of insurance policies, including arbitration, choice of law and forum selection. Finally, the door for insurance broker liability was cracked open in cases where the broker holds itself out as having expertise in a specialized area of insurance.

■ Insurer v. Insurer

California Supreme Court Endorses "Vertical Exhaustion" in Order to Trigger Upper-Level Excess Insurance

Montrose Chemical Corp. ("Montrose") manufactured DDT at its Torrance facility from 1947-1982. Montrose purchased primary and excess commercial general liability policies from 1961-1985. In 1990, the United States and the State of California sued Montrose for environmental contamination, leading to a consent decree for environmental cleanup pursuant to which Montrose has expended more than $100 million. Montrose sought coverage from its primary and excess insurers, leading to years of litigation and multiple published decisions, culminating most recently in *Montrose Chemical v. Superior Court*, in which the Supreme Court considered the sequence in which Montrose may access its excess insurance policies.[1]

The question presented in *Montrose III* was whether the insured had to exhaust all underlying policies spread over the years before accessing an excess policy for a given year, or whether it was sufficient to just exhaust the relevant year's underlying policies (primary and excess). The former type of exhaustion, advocated for by the excess insurers, is known as "horizontal exhaustion," whereas the latter, advocated for by the insured, is called "vertical exhaustion" or "elective stacking."

The parties agreed that all of Montrose's primary insurance had been exhausted, but only some first level excess policies had been. The question was thus whether all of the first level excess policies needed to be exhausted before second level excess policies could be accessed. The excess policies all provided that the insured must exhaust the limits of its underlying insurance in the same policy period before coverage triggered. All of the excess policies also contained "other insurance" clauses, which required exhaustion "of any other underlying insurance."

The trial court granted summary adjudication to the insurers, finding that horizontal exhaustion should apply. After Montrose filed a writ petition, the Court of Appeal affirmed. However, the Supreme Court reversed, finding that vertical exhaustion applied: "The insured has access to any excess policy once it has exhausted other directly underlying excess policies with lower attachment points, but an insurer called upon to indemnify the insured's loss may seek reimbursement from other insurers that issued policies covering relevant policy periods."[2]

The Court found that, while the insurers' interpretation of their other insurance clauses to refer to all other available insurance was not unreasonable, the clauses could also be read to refer only to other directly underlying insurance in the same policy period. The Court noted that other insurance clauses have generally been used to address allocation questions with respect to overlapping concurrent policies, not among successive insurers. Moreover, excess policies explicitly state their attachment point by referencing a specific dollar amount of underlying insurance and/or specific underlying policies. Accordingly, the objectively reasonable expectation of the insured favored vertical exhaustion.

In addition, because each year's policy terms and conditions varied, a rule of horizontal exhaustion would create practical obstacles to securing indemnification: "Horizontal exhaustion would create as many layers of additional litigation as there are layers of policies."[3] Montrose was thus not required to exhaust excess insurance at lower levels for all periods triggered by continuous injury before obtaining coverage from higher level excess insurance.

1 (2020) 9 Cal.5th 215 ("*Montrose III*").

2 *Id.* at p. 226.

3 *Id.* at p. 235.

Following *Montrose III*, Vertical Exhaustion Held to Apply to First Level Excess Insurance

The *Montrose III* case left undecided the question of whether horizontal exhaustion applies to all primary insurance before first level excess insurance can be triggered, although several earlier Court of Appeal cases had held that it does.[4] However, following the logic of *Montrose III*, the Court of Appeal, First Appellate District, found in *SantaFe Braun, Inc. v. Insurance Co. v. North America* that vertical exhaustion generally applies.[5]

SantaFe Braun ("Braun") was sued for asbestos-related bodily injury claims spread over multiple policy years. Braun sought a declaration that its excess insurers were obligated to defend and indemnify. The trial court ruled that horizontal exhaustion was required unless the excess policy expressly provided for vertical exhaustion. While the case was on appeal, the Supreme Court issued its decision in *Montrose III.*

Following *Montrose III*, the Court of Appeal found that the "other insurance" clauses in Braun's excess policies were similarly ambiguous as to whether the exhaustion requirement applied only to directly underlying insurance. The *SantaFe* court rejected insurers' argument that differences between primary and excess policies compelled a different result than *Montrose III*, noting that the policy language interpreted in *Montrose III* was the same whether the underlying insurance was primary or excess. Accordingly, the Court held absent an explicit policy provision to the contrary, "the insured becomes entitled to the coverage it purchased from the excess carriers once the primary policies specified in the excess policy have been exhausted."[6] Notwithstanding the prior Court of Appeal decisions to the contrary, the Supreme Court denied review, thus presumably settling the issue in light of its holding in *Montrose III*.

Ninth Circuit Rejects Excess Insurer's Theory That Primary Policy Was Improperly Eroded by Paying to Settle Uncovered Losses

In *AXIS Reinsurance Co. v. Northrop Grumman Corp*., an excess carrier asserted that underlying carriers had paid for uncovered settlements, thereby "improperly eroding" policy limits.[7] Northrup Grumman carried Employee Benefit Plan Fiduciary Liability Insurance: (1) $15 million primary with National Union; (2) $15 million excess with Continental Casualty; and (3) $15 million second excess with AXIS Reinsurance Company ("AXIS").

4 *Community Redevelopment Agency v. Aetna Casualty & Surety Co*. (1996) 50 Cal.App.4th 329 and *Padilla Construction Co., Inc. v. Transportation Ins. Co*. (2007) 150 Cal.App.4th 984.

5 (2020) 52 Cal.App.5th 19 ("*SantaFe*").

6 *Id.* at p. 701.

7 (9th Cir. 2020) 975 F.3d 840.

National Union contributed to a settlement with the Department of Labor alleging pension plan violations, exhausting its policy. Continental contributed to a subsequent settlement of a lawsuit brought on behalf of two Northrop employee plans, exhausting its policy and triggering the AXIS policy. AXIS paid the remainder of the settlement ($9.7 million), but sued Northrop seeking a declaration that the first settlement was not for a covered loss, thereby improperly eroding the underlying limits. The district court granted summary judgment in favor of AXIS.

The Ninth Circuit reversed, noting that there was no circuit precedent for the "improper erosion" theory. The Court held that, absent specific language in the excess policy, the excess insurer may not contest payments made at prior levels of insurance unless there is an indication of bad faith or fraud. In response to AXIS' argument that the underlying settlement was for a disgorgement claim that was uninsurable under California law, the Court noted that its "holding that excess insurers generally may not second-guess the payment decisions of underlying insurers applies even in cases where, as here, those prior payments arguably were for loss that is uninsurable as a matter of state public policy."[8]

Landlord's Insurer Awarded Equitable Contribution Against Tenant's Insurer After Settling Restaurant Patrons' Action For Injuries When Car Crashed Into Restaurant

Patrons who were injured when a car crashed into a restaurant where they were eating sued the restaurant for their injuries. They subsequently added the landlord on the theory that after a similar prior accident the landlord should have protected the property to prevent a vehicle from entering. In *Truck Ins. Exchange v. AMCO Ins. Co.*, the landlord's insurer ("TIE") sued the restaurant's carrier. [9] TIE tendered the patrons' suit to AMCO based on indemnity provisions in the restaurant's lease, but AMCO rejected the tender, contending the plaintiffs' claims "did not arise out of its insured's use or occupancy of the premises" because the restaurant had "no responsibility for a vehicle losing control on the street and crashing into the restaurant" or for taking measures to protect the property.[10]

Both the restaurant and the landlord moved for summary judgment. The trial court granted the restaurant's motion, but it denied that of the landlord due to evidence of the earlier incident of which the landlord, but not the restaurant, had notice. TIE settled the underlying action, then sued AMCO for equitable subrogation, equitable indemnification, equitable contribution, and declaratory relief.

8 *Id.* at p. 849.

9 (2020) 56 Cal.App.5th 619.

10 *Id.* at p. 624.

TIE alleged that the parties' lease contained a provision requiring the restaurant to indemnify, defend, and hold landlord harmless against claims and damages asserted against landlord "as may be related or incidental to Tenants [*sic*] operations."[11] TIE also alleged the lease required landlord to be listed as an additional insured on the restaurant's commercial general liability ("CGL") policy, and the policy contained an additional insured endorsement covering "[a]ny person or organization from whom you [restaurant] lease premises . . . but only with respect to their liability arising out of your use of that part of the premises leased to you."[12]

TIE stated that AMCO's denial of TIE's tender erroneously "equate[d] 'arising out of the use' of the Property with 'arising out of the liability of the named insured.'"[13] The trial court agreed with TIE, declining to "engage in extensive analysis to state the obvious. The lawsuits by the injured patrons arose out of their being patrons of the restaurant leased from the landlords . . . The claims against both the restaurant and the landlords arose out of the use of the premises."[14] The trial court entered judgment for TIE in the amount of $418,684.08, half of the costs of defending and settling the underlying action. AMCO appealed, and the Court of Appeal affirmed.

AMCO argued that the summary judgment for its insured, the restaurant, established that the liability of TIE's insured, the landlord, did not "arise from" the restaurant's "use" of premises. But the Court of Appeal noted the phrase "arising out of" in insurance policies is typically broadly construed to include any "minimal causal connection or incidental relationship."[15] Coverage under the additional insured endorsement in the policy AMCO issued to the restaurant did not rely on the parties' relative liabilities.

The distinction between legal liability and the conditions required for additional insured coverage is a fairly elementary issue of insurance law: virtually any experienced practitioner would know legal liability is not required for an additional insured to be covered for claims "arising out of" the named insured's use of the premises. But the Court of Appeal ordered its opinion published, so the Justices must have believed it met the statutory standards.[16] And, perhaps most importantly, if AMCO had accepted TIE's additional insured tender, it could have ended up paying the full amount of defense and settlement costs. By making TIE sue, AMCO cut its exposure in half.

11 *Ibid.*
12 *Id.*
13 *Id.* at p. 625
14 *Id.* at p. 627.
15 *Id.* at p. 630, quoting *Acceptance Ins. Co. v. Syufy Enterprises* (1999) 69 Cal. App.4th 321, 328.
16 California Rules of Court, Rule 8.1105, subd. (c).

General Contractor's Insurer May Recover Allocated Defense Costs from Subcontractors Pursuant to Contractual Indemnity Clause Via Equitable Subrogation

In *Pulte Home Corp. v CBR Electric, Inc.*,[17] the Fourth District Court of Appeal considered the intersection of an insurer's claim for equitable subrogation and a subcontractor's contractual duty to defend. Pulte Home Corp. ("Pulte") acted as the general contractor on three developments which spawned construction defect lawsuits. Pulte's insurer, St. Paul, defended the suits and then sought reimbursement of defense costs against the subcontractors under an equitable subrogation theory based on the subcontracts, which required the subcontractors to defend Pulte for claims related to their work.

At trial, St. Paul presented expert testimony allocating the fees incurred to the work performed by the subcontractors, as well as "mixed" or joint defense costs. The trial court ruled in favor of subcontractors, citing *Patent Scaffolding Co. v. William Simpson Construction Co.*,[18] which had denied reimbursement to a subcontractor from a general contractor for damages caused by a fire at a construction site because the general contractor had not caused the fire. The trial court further found that equitable subrogation is an "all-or-nothing" claim.[19]

The Court of Appeal reversed, holding that an insurer may have an equitable subrogation claim against "other parties who are legally liable to the insured for the harm suffered by the third party (such as by an indemnification agreement) under a contractual indemnity theory."[20] The Court then analyzed the eight elements of an insurer's cause of action for equitable subrogation, including that "justice requires that the loss be entirely shifted from the insurer to the defendant, whose equitable position is inferior to that of the insurer."[21] However, the Court found that the term "entirely shifted" in this element refers not to the total amount St. Paul paid, but the claimed loss that St. Paul was seeking from the subcontractors. Since St. Paul alleged that defendants failed to pay their "equitable share" of defense costs, and presented evidence as to each defendant's equitable share, the "entirely shifted" requirement was not a bar to recovery.

With respect to another factor, balancing the equities, the Court considered, as between the parties to the subrogation action, which party had the greater causal connection

17 (2020) 50 Cal.App.5th 216 ("*Pulte*").
18 (1967) 256 Cal.App.2d 506 ("*Patent Scaffolding*").
19 *Pulte, supra*, 50 Cal.App.5th at p. 227.
20 *Id.* at p. 228.
21 *Id.* at p. 229.

to the loss. The Court found that the subcontractors had a greater causal connection to the loss because it was their work that was alleged to be negligent. Moreover, public policy favored subrogation, as subcontractors would otherwise be incentivized to breach their indemnity agreements with general contractors.

The trial court's reliance on *Patent Scaffolding* was misplaced because it read that case as requiring it to ask whether the failure to accept the general contractor's tender caused the construction defect actions, rather than whether the failure caused the general contractor to incur defense costs. The proper inquiry was whether the subcontractors' contractual breaches caused Pulte to incur the defense costs St. Paul sought to recover, which they did. Accordingly, the Court remanded the case with instructions to determine the amount of defense costs to shift to each subcontractor.[22]

■ Third Party Policies

Additional Insured: Court of Appeal Determines Convention Center Manager Is "Insured" Under Policy, Grants Petition of Carrier for Arbitration of Coverage Dispute

In *Philadelphia Indemnity Ins. Co. v. SMG Holdings, Inc.*,[23] the Future Farmers of America ("FFA") held an event at Fresno Convention Center, under a license agreement with SMG Holdings, Inc. ("SMG"), the property manager. The license agreement required FFA "to 'secure and deliver to SMG' a 'comprehensive general liability insurance policy in a form acceptable to SMB,' and to name SMB, and the City of Fresno as additional insureds in the policy."[24]

The CGL policy FFA obtained from Philadelphia Indemnity Insurance Co. ("Philadelphia") did not expressly name SMG or Fresno as insureds, but a "deluxe endorsement" extended coverage to "managers, landlords, or lessors of premises" for "'liability arising out of the ownership, maintenance or use of that part of the premises leased or rented' to the named insured[, and] covered 'any person or organization where required by a written contract executed prior to the occurrence' but only for liability arising from the name insured's negligence."[25] The policy also included a binding arbitration endorsement providing either party with the right to make a written demand for arbitration when the carrier and "the insured" disagreed whether coverage was provided "for a claim made against the insured."[26]

Someone attending the FFA event was injured when he tripped and fell in the parking lot, and he sued. SMG tendered the lawsuit under FFA's policy, and Philadelphia rejected the tender because FFA hadn't licensed or used the parking lot for its event and there was no indication that the plaintiff's injury resulted from any negligence of FFA. SMG disagreed, so Philadelphia demanded arbitration, and then petitioned the Superior Court to compel it.

SMG argued Philadelphia was estopped from demanding arbitration because it had denied coverage on the grounds that SMG was not an insured. The trial court denied the petition. Philadelphia appealed, and the Court of Appeal reversed.

The Court of Appeal found that SMG, though not a signatory to the insurance contract, was a third-party beneficiary, because the license required SMG be an additional insured. The Court noted SMG had tendered the lawsuit to Philadelphia, showing SMG believed it was a third-party beneficiary. Because SMG had made a knowing claim for policy benefits, the Court held, it was "estopped from disclaiming applicable contract burdens such as the arbitration clause."[27]

The Court noted Philadelphia denied coverage because the claim was not covered, not because SMG was not an insured. In fact, the Court found, SMG was "an 'insured' by virtue of it being a manager and a party required by contract to be covered."[28]

No Collateral or Judicial Estoppel Effect of Rhode Island Court Proceeding or Ruling Years Earlier Re: Choice of Law

In *Textron, Inc. v. Travelers Cas. & Surety Co.*,[29] Esters, a California resident, sued Textron after being diagnosed in 2010 with mesothelioma. Esters alleged her condition was caused by exposure to asbestos at Textron facilities in California where her mother worked from 1950 to 1983. Textron tendered Esters' claim to Travelers, which defended and settled the case under a reservation of rights.

Textron sued Travelers for judgment declaring it was covered for Esters' claim. Travelers cross-complained for reimbursement, and Textron cross-complained for breach of the implied covenant of good faith and fair dealing ("bad faith").

Textron's policies with Travelers covered the period from January 1, 1966 to January 1, 1987. Because Esters' mesothelioma diagnosis was in 2010, Travelers argued her claim wasn't covered. At issue was the "coverage trigger."

22 Just a few weeks after *Pulte* was decided, the First District Court of Appeal denied equitable subrogation under virtually identical facts in *Carter v. Pulte Home Corp*. (2020) 52 Cal.App.5th 571. However, the reason for the denial was not a disagreement with *Pulte*, but rather because the insurer sought total recovery of its defense costs from the subcontractors instead of allocated costs, which was greater relief than allowed under the subcontracts.

23 (2019) 44 Cal. App.5th 834.

24 *Id.* at p. 838.

25 *Ibid.*

26 *Ibid.*

27 *Id.* at p. 842.

28 *Id.* at p. 843.

29 (2020) 45 Cal.App.5th 733 ("*Textron*").

Since CGL policies cover injuries caused by an occurrence, "'trigger of coverage' is a term of convenience used to describe what must happen in the policy period to give rise to insurance coverage."[30] California courts apply "continuous trigger . . . to occurrences of continuous or progressively deteriorating injury such as injury caused by exposure to asbestos[:] if specified harm is caused by an included occurrence and results, at least in part, within the policy period, it perdures to all points of time at which some such harm results thereafter."[31]

The alleged exposure took place in California, and Esters was a California resident who sued in California, so one might expect California law would apply. Esters' doctor testified she was exposed to asbestos while washing her mother's clothes as a 9 year old girl, and was injured within minutes after first inhaling the fibers, and the disease continued to progress over many years through diagnosis. Under continuous trigger, Travelers' policies covered Esters' claim.

The other trigger is "manifestation trigger," under which coverage is triggered "when the damage ... manifests itself, ... is discovered or, ... in the exercise of reasonable diligence is discoverable."[32] Rhode Island applies the manifestation trigger, and Travelers argued Esters' mesothelioma didn't manifest until she was diagnosed in 2010, long after Travelers' policies had lapsed.

Travelers argued Rhode Island law applied to Esters' claim because in 1987 Textron had sued Travelers and other insurance carriers in Rhode Island for a declaratory judgment of coverage under various policies (including the Travelers policies at issue) for multiple occurrences of property damage and personal injury in many states, including California but not Rhode Island. In that Rhode Island action, Textron had argued duty to defend under all the policies should be determined under Rhode Island law, and in 1991, the Rhode Island court ruled for Textron.

Textron moved for summary judgment on Travelers' cross-complaint for reimbursement, based on Civil Code §1646, requiring a contract to be interpreted in accordance with the law and usage of the place of performance, i.e., California. The trial court denied Textron's motion because by suing in Rhode Island and successfully arguing for the application of that state's law, Textron was estopped to seek application of California law.

After Textron's motion was denied, Travelers moved for summary judgment or adjudication of Textron's claims and cross-claims (including bad faith), and on Travelers' cross-complaint for reimbursement. Travelers argued that by contending in the earlier action that Rhode Island law applied, a contention with which the Rhode Island court agreed, Textron was collaterally and judicially estopped from arguing for application of California law and the continuous trigger. Travelers further argued under Rhode Island's manifestation trigger, there was no occurrence during the policy(ies) period(s).

The court denied Travelers' motion, because it found there were triable issues of fact regarding the necessarily decided element of collateral estoppel. But Travelers took a writ, and the Court of Appeal issued a so-called *Palma* notice,[33] telling the trial court and the parties "that '[i]t appear[ed] to this court' that Textron was collaterally and judicially estopped to 'deny that Rhode Island law applies to the interpretation of the Travelers policies at issue in this case.'"[34] The trial court vacated its prior ruling and granted Travelers' motions, finding the Rhode Island proceeding met the three required elements of collateral estoppel: same parties and policies, same issue, and a final ruling on the merits; and, Textron's successfully taking an inconsistent position in the Rhode Island action judicially estopped it from seeking coverage in Esters' California action.

Textron appealed, and the Court of Appeal reversed, with apologies to the trial judge for causing him to suffer "judicial whiplash."[35]

The Court found neither collateral nor judicial estoppel applied because the "key question [was] whether the identical issue [presented in the California action] was presented and decided between Textron and Travelers in the Rhode Island action."[36] In order to apply collateral estoppel, the Court of Appeal observed, "the factual predicate of the legal issue decided in the prior case must be sufficient to frame the identical legal issue in the current case, even if the current case involves other facts or legal theories that were not specifically raised in the prior case."[37]

Because the specific issue of which trigger rule should apply to the Esters action was not litigated and decided in the Rhode Island action, the identity of issues necessary for collateral estoppel did not exist, even if the "'ultimate issue' or 'disposition' – giving interpretive meaning to the term 'occurrence' in the Travelers policies as applied to personal injury – may be identical."[38]

Travelers argued that the California action presented the

30 *Id.* at p. 740, quoting *Armstrong World Inds. Inc. v. Aetna Cas. & Surety Co.* (1996) 45 Cal.App.4th 1, 39.

31 *Id.* at p. 741, quoting *Aerojet-General Corp. v. Transport Indemnity Co.* (1997) 17 Cal.4th 38, 57.

32 *Id.* at p. 741, quoting *Textron, Inc. v. Aetna Cas. and Sur. Co.* (R.I. 2000) 754 A.2d 742, 746.

33 *See Palma v. U.S. Industrial Fasteners, Inc.* (1984) 36 Cal.3d 171, 178-179.

34 *Textron, supra*, 45 Cal.App.5th at p. 744.

35 *Id.* at p. 745, n. 7.

36 *Id.* at pp. 746-747.

37 *Id.* at p. 747.

38 *Id.* at p. 749.

same choice of law issue as the one in Rhode Island because in both actions Textron sought coverage under the same policy language for incidents of personal injury in California. But the Court noted the Rhode Island case involved 49 carriers, 258 policies, multiple occurrences, and 19 different states. Travelers presented no evidence that the Rhode Island court considered any choice of law issue concerning coverage triggers, nor any consideration of any conflict of laws between Rhode Island or any state.

The Court noted that under the governmental interest analysis, courts are to determine the applicable law based on the interests of the litigants and the states involved, evaluate those interests to see which state's interest would be more impaired if it were not applied, and apply that state's law.

The Court observed that the location of the insured risk is particularly important in determining insurance coverage, because of its intimate bearing on the nature of risk, the parties' expectations, and the state's interest in the determination of issues. Because California is the sole location of the insured risk in Esters, and its interest in applying the continuous trigger rule is compelling – to ensure adequate insurance proceeds – the Court ruled "Textron [was] not collaterally [or judicially] estopped to seek a ruling that California's continuous trigger rule applies."[39]

California Plaintiff Seeking to Enforce Judgment Against Carrier Under Ins. Code §11580 Bound by Policy's Forum Selection Clause of Australia

Lewis v. Liberty Mutual Ins. Co.[40] was another choice of law case, but it involved contractual choice of law in the insurance policy of a defendant who declared bankruptcy, leaving the plaintiff to enforce its $45 million judgment against the carrier under Ins. Code §11580.

Nicolette Lewis and members of her family were severely burned when an outdoor firebowl without a flame arrester exploded on June 8, 2014. They sued the manufacturer and its Australian corporate parent. The manufacturer tendered the Lewises' claims, but Liberty Mutual refused to defend or indemnify because a policy issued about April 30, 2014, added an exclusion for products without a flame arrester. The manufacturer declared bankruptcy, and the plaintiffs filed a direct action against Liberty Mutual.

Liberty Mutual moved to dismiss on *forum non conveniens* grounds based on a forum selection clause in the manufacturer's policy designating Australian courts and law. The trial court granted Liberty Mutual's motion, because even though the plaintiffs were not signatories to the policy, they stood in the shoes of the insured tortfeasor, with no greater rights and subject to the terms and limitations of the policy and any defense the carrier could have raised against its insured. The Court of Appeals affirmed.

Though the plaintiffs had no opportunity to negotiate or agree to the terms of the defendant's policy, California courts interpreting Section 11580 have held "a judgment creditor who has prevailed in a lawsuit against an insured party may bring a direct action against the insurer *subject to the terms and limitations of the policy*."[41] And the insurer may raise any defense it could have raised against its insured.

A defendant moving for *forum non conveniens* without a contract bears the burden of demonstrating an adequate alternative forum and the balance of private and public interest factors, but "[w]hen parties agree to a forum-selection clause, they waive the right to challenge the preselected forum as inconvenient or less convenient for themselves or their witnesses, or for their pursuit of the litigation."[42] Unless the plaintiffs could establish that California law prevented the operation of the policy's forum selection clause or that Australia was an inadequate or inconvenient forum, they were bound by it.

The Lewises argued enforcing the clause would violate public policies embodied in Section 11580 and Ins. Code §678.1, subd. (d), which requires insurers to give insureds at least 60 days' notice of material policy changes, or the original policy remains effective for 60 days. The plaintiffs argued Section 678.1 should apply because the insured tortfeasor received notice of the changes to its policy only 72 hours before the prior policy lapsed less than 60 days before the date of the accident.

The Court of Appeals recognized Section 11580 evinced California's public policy to require an insurance policy to allow for an action for recovery when judgment is rendered against an insured, but nothing in the statute suggested the exclusive jurisdiction of California's courts. The Lewises could sue to enforce their claims in Australia. And the Court found no evidence of a strong public policy in Section 678.1 that would preclude enforcement of the forum selection clause.

The Court also found Australia was not an inadequate or inconvenient forum. Despite the plaintiffs' fears that Australian law would require enforcement of the policy in effect on June 8, 2014, with the flame arrester exclusion, the Court observed *forum non conveniens* dismissal may be granted in favor of an alternate forum whose law is less favorable, as long as the law is adequate. Only if the contrac-

39 *Id.* at p. 754.

40 (9th Cir. 2020) 953 F.3d 1160.

41 *Id. at p. 1164*, quoting *W. Heritage Ins. Co. v. Superior Court* (2011) 199 Cal. App.4th 1196, 1205 (emphasis added).

42 *Id.* at p. 1165, quoting *Atl. Marine Constr. Co. v. U.S. Dist. Court for the W. Dist. of Tex.*, 571 U.S. 49, 60 (2013).

tual forum would provide "no remedies whatsoever" can the court decline to enforce the forum selection clause.[43]

Walker Process Claim for Improper Use of a Patent to Monopolize a Market Does Not Trigger Duty to Defend Under Personal Injury Coverage

In *Travelers Prop. & Cas. Co. v. KLA-Tencor Corp.*,[44] the Sixth District Court of Appeal declined to expand personal injury coverage for malicious prosecution to include a *Walker Process* claim – an antitrust cause of action for using a fraudulently procured patent to attempt to monopolize the market, recognized in a U.S. Supreme Court case of the same name.[45] After years of litigation with a competitor over various patents, the insured, KLA-Tencor Corp. ("KLA") was sued on a *Walker Process* claim. KLA sought a defense under the "personal injury" coverage in its commercial general liability policy, arguing the *Walker Process* claim qualified as a claim for malicious prosecution.

The trial court granted summary judgment for Travelers, and the Court of Appeal affirmed. KLA argued that the term "malicious prosecution" is ambiguous because it has previously been construed to cover abuse of process claims, and that the insured would reasonably expect coverage for claims based on proceedings before the Patent and Trademark Office ("PTO"). However, the Court found that a *Walker Process* claim does not necessarily involve legal proceedings because it arises from fraud on the PTO, not any court.[46] Moreover, the mere fact that the parties had been involved in prior patent litigation did not convert the *Walker Process* claim into a species of malicious prosecution.[47] Accordingly, the term "malicious prosecution" was not ambiguous in the context of the *KLA* case.

■ First Party Policies

Fire Insurance Cannot Exclude Loss Based on Tenant's Marijuana Growing Operation Irrespective of Property Owner's Knowledge of Tenant's Conduct

In *Mosley v. Pacific Specialty Ins. Co.,*[48] the Fourth District Court of Appeal clarified the circumstances under which exclusions in a fire insurance policy can be invoked against a property owner based on proscribed conduct by a tenant. Plaintiffs James and Maria Mosley rented out a home, which was insured by a homeowners policy issued by Pacific Specialty. The tenant used the house for a marijuana growing operation. To support the operation, the tenant rerouted the electrical system, leading to a fire which damaged the home.

Pacific Specialty denied the claim based on a provision excluding any loss associated with "the growing of plants" or the "manufacture, production, operation or processing of . . . plant materials."[49] After the Mosleys sued, the trial court granted summary judgment for Pacific Specialty. The Court of Appeal reversed.

The Court agreed with the Mosleys' argument that if the exclusion barred coverage, then the policy failed to provide the minimum fire coverage mandated by Insurance Code section 2070. That code section requires fire policies in California to provide coverage that is "substantially equivalent" to the form provided in Section 2071. Section 2071 does not include a plant exclusion, but it does provide that an insurer "shall not be liable for loss occurring . . . while the hazard is increased by any means within the control or knowledge of the insured."[50] Thus, to the extent the Pacific Specialty policy purported to hold the Mosleys responsible for the conduct of their tenant irrespective of their knowledge, the policy subjected the Mosleys to increased liability in violation of Section 2071.

The Court of Appeal explained that "an insured increases a hazard 'within its control' *only if* the insured is aware of the hazard or reasonably could have discovered it through exercising ordinary care or diligence."[51] Since it was undisputed that the Mosleys did not know about the marijuana growing operation, and there was no evidence as to whether they could have discovered it by exercising ordinary diligence, there were disputed factual issues, making summary judgment improper.

Vacancy Exclusion Includes Period Prior to Policy Inception

In *St. Mary & St. John Coptic Orthodox Church v. SBC Ins. Services, Inc.*,[52] the insured ("St. Mary") was a Coptic church. The Pope of the Coptic Church (who resides in Egypt) asked that St. Mary purchase a home to be used as his papal residence in the western United States, and for visiting bishops. St. Mary purchased a vacant home and its insurance broker ("SBC") added the residence to St. Mary's existing commercial policy with Philadelphia Indemnity Insurance Company ("Philadelphia").

Fifty-seven days after policy inception, the insured reported a water damage claim. Philadelphia denied the claim based on vacancy exclusion, which provided: "If the

43 *Id.* at p. 1168.
44 (2020) 45 Cal.App.5th 156 ("*KLA*").
45 *Walker, Inc. v. Food Machinery* (1965) 382 U.S. 172.
46 *KLA, supra*, 45 Cal.App.5th at p. 165.
47 *Id.* at p. 167
48 (2020) 49 Cal.App.5th 417.
49 *Id.* at p. 420.
50 *Id.* at p. 425, quoting Civil Code §2071.
51 *Id.* at p. 429 (emphasis in original).
52 (2020) 57 Cal.App.5th 817.

building where loss occurs has been vacant for more than 60 consecutive days before that loss, we will not pay for any loss caused by . . . water damage."[53] However, Philadelphia agreed to loan St. Mary the cost of repair ($461,759) in exchange for an assignment of the broker negligence claim against SBC, to be repaid only from proceeds realized on the claim.

The trial court granted summary judgment to SBC, finding negligence but no damage because the loss should have been covered. The First District Court of Appeal reversed, finding no coverage and therefore liability on the part of SBC. The Court found that the 60-day vacancy exclusion extended to the period prior to policy inception, and that the house was vacant prior to purchase.

SBC argued that, even if the 60-day period extended back prior to policy inception, the home was not actually vacant, either before or after the purchase. Under the policy, "buildings are vacant when they do not contain enough business personal property to conduct customary operations."[54] Because the papal residence was unfurnished except for a single chair, some appliances, window treatments, a plant and toilet paper, the Court found there was insufficient personal property to conduct operations. The Court also rejected as absurd SBC's argument that, prior to the purchase, the residence's operations were that of a home for sale, and therefore it was not really vacant prior to the close of escrow.

Finally, the Court rejected SBC's attack on the loan receipts agreement as a "legal subterfuge." While such agreements have been found to be invalid where an indemnitor's liability was absolute, they have been upheld where the insurer's liability was contingent or undetermined. Given the legitimacy of Philadelphia's invocation of the vacancy exclusion, the loan receipt agreement was not a legal sham seeking to shift responsibility for payment of an undisputed obligation under the policy.

■ Bad Faith

Genuine Dispute on Efficient Proximate Cause of Damage to Structure Bars Bad Faith Claim

In *501 East 51st Street, Long Beach-10 LLC v. Kookmin Best Insurance Co. Ltd.*,[55] an underground water main burst below an apartment complex, and its owner made a claim for damages in the form of movement of and cracks in the building. After initially opining there might be covered and uncovered causes, the carrier denied the claim. The insured sued for bad faith. The carrier moved for summary adjudication of the bad faith claim based on the genuine dispute doctrine, arguing it had relied on expert opinions that the damage to the building was caused by long-term settlement and earth movement, which was not covered under the plaintiff's policy. The trial court granted the carrier's motion, and the Court of Appeal affirmed.

The Court of Appeal analyzed in considerable detail the investigation and opinions of the two sides' experts. Shortly after the insured tendered the claim, the insured's geotechnical expert concluded in a report sent to the carrier that "existing building distress was substantially contributed to by the water main break," while noting "[s]ome of the distress may have pre-existed and be due to longterm soil influences as well as inadequate original design and/or construction," and recommending "[f]urther investigation including soil sampling and testing can be performed to determine the site soil conditions."[56] The insured's expert recommended repairs and remediation costing $258,900.77.

The carrier's experts also observed "at least some settlement and movement of the building [that] occurred prior to the water supply line break," but opined that "[e]xisting settlement-related conditions were likely exacerbated as a result of the water released due to the supply line break."[57]

In a letter to the carrier, its coverage counsel noted experts retained by both the insured and the insurer agreed ongoing general settlement of the building pre-existed the claimed loss. While coverage counsel said there were "a number of candidates for the 'efficient proximate cause' of loss," he also acknowledged "both experts concur that the water leak set in motion forces that seriously exacerbated the preexisting condition of the property and likely caused new damage."[58] Counsel recommended experts "reasonably segregate" uncovered damage due to settlement and cracking from covered damage due to the pipe break, and the carrier should examine water usage records from the insured location to verify the leak was a sudden occurrence and not a chronic condition.

After further investigation, the carrier's experts concluded the claimed damage was caused by long-term differential soil movement, and not the pipe that burst on December 31, 2015 – even though the "January [2016] bill reflected water use that was 9,500 gallons higher than previous months."[59] The carrier denied plaintiff's claim after "concluding the efficient proximate cause of the foundation damage was long-term differential soil movement which cause of loss is

53 *Id.* at p. 821.
54 *Ibid.*
55 (2020) 47 Cal.App.5th 924 ("*Kookmin*").
56 *Id.* at p. 928.
57 *Id.* at p. 929.
58 *Id.* at p. 930.
59 *Id.* at p. 931.

explicitly excluded by the terms of the policy."[60]

Even though the carrier's decision was based on efficient proximate cause, the Court of Appeal did not discuss that doctrine, and the carrier had not sought summary judgment on that basis either. Both the Court and the carrier may have recognized there was evidence from which one might reach opposite conclusions about which cause the plaintiff's loss should have been attributed to. "[W]here there is a concurrence of different causes," the Supreme Court stated almost 60 years ago, "the efficient cause – the one that sets others in motion – is the cause to which the loss should be attributed, though the other causes may follow it, and operate more immediately in producing the disaster."[61]

After noting a carrier is liable for a loss caused by multiple occurrences, some covered and some not, "only if the 'efficient proximate cause' or the 'predominate' cause was a covered risk," the Court focused on the genuine dispute doctrine. "Where there is a *genuine issue* as to the insurer's liability under the policy for the claim asserted by the insured," the Court recited, "there can be no bad faith liability imposed on the insurer for advancing its side of that dispute."[62] Reliance on an expert opinion supports application of the doctrine as long as there is no evidence that the insurer selected its experts dishonestly or failed to conduct a thorough investigation, or that the experts were unreasonable. In this case, the Court noted the carrier presented evidence of a genuine dispute that the efficient proximate cause of the claimed damage was an excluded occurrence. "[N]one of plaintiff's evidence," the Court of Appeal concluded, "raised a triable issue that this was not a genuine coverage dispute."[63]

Summary Judgment Reversed on Bad Faith Claim Based on Denial of Supplemental Claim For Smoke Damage Due to Wildfire

Fadeeff v. State Farm Gen'l Ins. Co.[64] was another genuine dispute case, but this time the Court of Appeal reversed the trial court, holding that there were triable issues of fact whether the insurer's reliance on the opinions of its experts was reasonable.

Plaintiffs made a claim for smoke damage to their home due to the 2015 Valley Fire in Lake County. State Farm accepted the claim and paid for smoke and soot mitigation and cleaning, power washing the exterior. The independent adjustor's report described the home as "well maintained with no apparent deferred maintenance" and said "[a]ll damage is related to smoke and soot."[65]

A few months later, the insureds hired a public adjustor and submitted supplemental claims. State Farm sent a different adjustor, not licensed in California or in any building trade, who inspected and found no smoke damage. State Farm also hired inspectors of the insureds' home and their HVAC system, but without complying with its own operations guide.

State Farm denied the supplemental claims. The insureds sued for bad faith. State Farm moved for summary judgment on genuine dispute grounds, arguing it had reasonably relied on its experts' opinions. The court granted the motion for summary judgment, and the insureds appealed. The Court of Appeal reversed.

The Court of Appeal observed that an insurer that has denied or delayed paying policy benefits due to a genuine dispute over coverage or the amount of benefits owed "is not liable in bad faith even though it might be liable for breach of contract."[66] The Court noted application of the genuine dispute rule has expanded from cases involving disputes over policy interpretation, to factual disputes as well.

The carrier is still obligated to investigate, process, and evaluate the insured's claim thoroughly and fairly. "A *genuine* dispute exists only where the insurer's position is maintained in good faith and on reasonable grounds."[67]

"[D]enial of a claim on a basis unfounded in the facts known to the insurer, or contradicted by those facts, may be deemed unreasonable. A trier of fact may find that an insurer acted unreasonably if the insurer ignores evidence available to it which supports the claim. The insurer may not just focus on those facts which justify denial of the claim."[68]

The Court of Appeal found that State Farm had not demonstrated the insurance bad faith claim failed as a matter of law. The plaintiffs argued, and the Court of Appeal agreed, that State Farm denied some of their supplemental claims without reliance on any expert and based simply on the conclusions of the adjustor, which was insufficient to establish a good faith dispute. A primary example was the claim of the insured that the power washing left the home's exterior paint chipped in many places, a loss that should have been covered under state claims handling regulations.[69] State Farm denied the claim based on the conclusion of its adjustor, not a retained expert, that the damage to the exterior paint "was

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60 *Id.* at p. 933.

61 *Sabella v. Wisler* (1963) 59 Cal.2d 21, 31-32; *see, also*, Cal. Ins. Code §530.

62 *Kookmin, supra*, 47 Cal.App.5th at p. 937.

63 *Id.* at p. 938.

64 (2020) 50 Cal.App.5th 94 ("*Fadeef*").

65 *Id.* at p. 98.

66 *Id.* at p. 101, citing *Wilson v. 21st Century Ins. Co.* (2007) 42 Cal.4th 713, 723 ("*Wilson*").

67 *Id.* at p. 102.

68 *Id.* at p. 101, n. 4.

69 Cal. Code Regs. Tit. 10, §2695.9(a)(1) ("consequential physical damage incurred in making the repair or replacement not otherwise excluded by the policy will be included in the loss").

due to wear, tear and deterioration."[70]

The Court of Appeal also noted an apparent conflict between that adjustor's conclusion and the report of State Farm's first adjustor, before the insureds submitted the supplemental claim, that the home was "well maintained with no deferred maintenance." "Was there preexisting wear and tear," the Court of Appeal asked, "or was there damage to a well-maintained home by power washing after a wildfire? To ask the question shows that State Farm has not established that it is 'undisputed or indisputable that the basis for the insurer's denial of benefits was reasonable.'"[71]

Apart from its holding and legal analysis of the issues, the opinion contained a couple of other items of note to insurance litigators. First, the Court cited authority for a proposition that might surprise and alarm anyone drafting an appellate brief: An appellate court may "decline to consider this argument because it is raised only in a footnote."[72]

Secondly, in reversing the trial court's summary adjudication of the punitive damages claim, the Court noted State Farm had argued the plaintiffs answered "no" to questions about whether they ever got a feeling from their interactions with State Farm that they wished to harm or hurt the plaintiffs in any way, or whether State Farm personnel had ever refused to respond to calls, questions, or correspondence. Although the Court dismissed such testimony as not "conclusively answer[ing] the question whether State Farm intentionally misrepresented or concealed a material fact, or acted with knowing disregard of the rights of others,"[73] attorneys representing bad faith plaintiffs should be on their guard for such questions.

Summary Judgment on Genuine Dispute Grounds Reversed for Carrier's Failure to Prove Medical Necessity Supporting Denial of Coverage for Treatment

Ghazarian v. Magellan Health, Inc.[74] presented another genuine dispute case, in which the Court of Appeal again reversed a summary judgment after finding the carrier, Blue Shield, had not established its denial of treatment for an autistic child was based on a fair and thorough investigation and reached reasonably and in good faith.

The plaintiffs were the parents of A.G., who was receiving applied behavior analysis (ABA) therapy, covered by insurance under statute requiring health insurance policies to provide all medically necessary ABA therapy.[75]

Blue Shield had covered A.G. for 157 hours of ABA therapy each month, but after he turned 7, the carrier denied the request for 157 hours on grounds that only 81 hours a month were medically necessary. A.G.'s parents requested an independent medical review (IMR) through the Department of Managed Health Care, at which two of the three independent physician reviewers disagreed with Blue Shield's denial, and the Department ordered Blue Shield to reverse the denial and authorize the care.

The plaintiffs sued for bad faith, intentional interference with contract, and violations of Business & Professions Code §17200 (the "UCL claim"). They alleged the insurer had adopted unfair medical necessity guidelines that categorically reduced the amount of ABA therapy autistic children receive once they turn 7 years old, regardless of medical need.

Blue Shield moved for summary judgment, arguing that since one of the reviewers had agreed with its denial, Blue Shield acted reasonably as a matter of law. The trial court granted the motion. The Court of Appeal reversed.

While the Court acknowledged the agreement of one of the reviewers created a superficial appearance of reasonableness, it found questions of fact about the medical necessity standards that "appear to arbitrarily reduce ABA therapy for children once they turn seven . . . If defendants used unfair criteria to evaluate plaintiffs' claim, they did not fairly evaluate it and may be liable for bad faith."[76]

The Court's analysis of the bad faith claims focused on whether Blue Shield's standards of medical necessity were consistent with community medical standards. A standard of medical necessity that is "significantly at variance with the medical standards of the community . . . frustrate[s] the justified expectations of the insured, [and] is inconsistent with the liberal construction of policy language required by the duty of good faith. … [G]ood faith demands a construction of medical necessity consistent with community medical standards that will minimize the patient's uncertainty of coverage in accepting his physician's recommended treatment."[77]

The plaintiffs pointed to standards published by the Behavior Analyst Certification Board (BACB), "which state, '[ABA] treatment should be based on the clinical *needs of the individual and not constrained by age*. … ABA is effective across the life span. Research has not established an age limit beyond which ABA is ineffective."[78] The Court treated BACB's guidelines, though not binding on Blue Shield, as evidence of the general standard of medical necessity for

70 *Fadeef, supra*, 50 Cal.App.5th at p. 105.
71 *Ibid.*, citing *Wilson, supra*, 42 Cal.4th at p. 724.
72 *Id.* at p. 106, citing *Sabi v. Sterling* (2010) 183 Cal.App.4th 916, 947.
73 *Id.* at p. 109.
74 (2020) 53 Cal.App.5th 1717 ("*Ghazarian*").
75 Health & Safety Code §1374.73, subds. (a)(1), (c)(1).
76 *Ghazarian, supra*, 53 Cal.App.5th at p. 178.
77 *Id.* at p. 184.
78 *Id.* at p. 185 (emphasis in original).

ABA therapy. Because Blue Shield's summary judgment motion focused on the one reviewer that agreed with its decision, "Blue Shield provide[d] no explanation or evidence in support of the reasonableness of the medical necessity guidelines at issue."[79] The Court found, "[b]ased on the record, triable issues of fact exist as to the reasonableness of Blue Shield's medical necessity standards for comprehensive ABA therapy and whether plaintiffs' claim was unfairly denied based on those standards."[80]

Just showing a reasonable dispute about the ultimate decision was not enough to support summary judgment; Blue Shield must also present undisputed facts showing the medical necessity guidelines used to arrive at the ultimate decision were consistent with community medical standards. The existence of a genuine dispute over coverage or the claim amount is immaterial if the carrier cannot show it fairly evaluated the claim and reached its decision reasonably and in good faith. "A health insurer is not absolved of bad faith liability if it bumbles into a facially reasonable medical decision using patently unfair medical necessity criteria. Even a stopped clock is right twice a day."[81]

Comparing Blue Shield to a bumbling stopped clock conveyed some of the Court's apparent skepticism about Blue Shield's position. And the Court discussed other issues of fact as to whether Blue Shield fairly evaluated plaintiffs' claim.

For example, Blue Shield's stated reason for reducing A.G.'s hours of ABA therapy was that he had made significant progress under ABA therapy, so the additional hours were not medically necessary. But the reviewer who agreed with Blue Shield found the exact opposite: A.G. had made limited improvements that suggested he had minimal response to the therapy.

The Court also discussed "evidence Blue Shield has engaged in a pattern of denying medically necessary ABA treatment," and referred to a declaration by the mother of another autistic child the plaintiffs filed with their opposition papers.[82] (The plaintiffs' separate statement may not have referred to that declaration, because the Court exercised its discretion to consider evidence outside the separate statement, noting "that '[t]he separate statement is not designed to pervert the truth, but merely to expedite and clarify the germane facts.'")[83]

Finally, the Court noted issues of fact regarding whether Blue Shield had pressured the Center for Autism Related Disorders (CARD), which provided A.G.'s ABA therapy, to adopt Blue Shield's "unreasonable criteria," from which the Court took a "reasonable inference that [defendants] threatened to terminate the provider agreement unless CARD adopted [defendant]'s restrictive medical necessity guidelines."[84]

Having reversed summary judgment on the plaintiffs' bad faith claim, the Court also reversed the summary judgment on the UCL claim, noting "bad faith insurance practices may qualify as any of the three statutory forms of unfair competition."[85] The Court held the attorney fees the plaintiffs incurred in navigating the IMR process conferred private standing – although the Court noted punitive damages are not recoverable on a UCL claim.

Anti-SLAPP Motion May Not Be Used to Attack Bad Faith Claim Based on Underlying Claims Handling and Settlement Negotiations

In *Trilogy Plumbing, Inc. v. Navigators Special Ins. Co.,*[86] the plaintiff ("Trilogy") filed a complaint for bad faith against Defendant Navigators Specialty Insurance Company ("Navigators") arising out of its handling of the defense of multiple construction defect cases. Trilogy alleged that Navigators retained conflicted counsel, failed to pay amounts owed, and misled Trilogy regarding its obligations under the policies. Trilogy also alleged that Navigators urged or compelled defense counsel to accept settlements in cases where Trilogy had little or no liability and refused to hire independent counsel when the insured protested.

Navigators filed an anti-SLAPP motion targeting the allegations regarding settlement negotiations and communications regarding control of Trilogy's defense, such as conflict of interest issues. Navigators argued that the specific allegations it sought to strike involved a "written or oral statement or writing made in connection with an issue under consideration or review by a legislative, executive, or judicial body, or any other official proceeding authorized by law" protected by the anti-SLAPP statute.[87]

The trial court denied the anti-SLAPP motion, and the Fourth District Court of Appeal affirmed, holding that "conduct is not automatically protected merely because it is related to pending litigation; the conduct must arise from the litigation."[88] The Court reasoned that "the allegations of the amended complaint that were the object of the anti-SLAPP motion do not refer to any oral or written statements or communicative conduct by anyone, whether in relation to the lawsuits in which Trilogy had been named

79 *Ibid.*
80 *Ibid.*
81 *Id. at p. 187.*
82 *Ghazarian, supra*, 53 Cal.App.5th at p. 189.
83 *Id.* at p. 183, quoting *King v. United Parcel Service, Inc.* (2007) 152 Cal.App.4th 426, 438.
84 *Id.* at pp. 189-190.
85 *Id.* at p. 192, quoting *Zhang v. Superior Court* (2013) 57 Cal.4th 364, 380.
86 (2020) 50 Cal.App.5th 920 ("*Trilogy*").
87 Code of Civil Procedure §425.16 (e)(2).
88 *Trilogy, supra*, 50 Cal.App.5th at p. 931.

a defendant, or in the context of settlement discussions. Instead, the anti-SLAPP motion sought to strike allegations pertaining to Navigators' conduct generally in mishandling the claims process."[89] The Court emphasized the fact that Plaintiff was seeking relief from the insurance company, not any counsel. In reaching its decision, the Trilogy court relied heavily on another recent anti-SLAPP case decided by the First District Court of Appeal, *Miller v. Zurich American Ins. Co*.[90] *Miller*, and now *Trilogy*, make clear that mere references to settlement and other potentially protected activity as part of the context for a bad faith claim are insufficient to trigger the protections of the anti-SLAPP statute.

■ Broker Negligence

Insurance Broker Who Holds Himself Out as an Expert in a Specialized Field of Insurance Owes a Heightened Duty to Advise Insured as to Available Insurance and Limitations of Coverage

It has long been established under California law that an insurance agent assumes only those duties found in any agency relationship and does not have a duty to advise the insured on specific insurance matters. However, in *Murray v. UPS Capital Ins. Agency, Inc.,*[91] the Fourth District Court of Appeal clarified that an insurance broker who holds himself out as having special expertise is held to a higher standard, and in fact has a "heightened duty" to present and explain insurance options to his customers. Moreover, evidence that the broker specializes in a particular field creates a reasonable inference of such expertise.

In *Murray*, the plaintiff, David Murray, purchased used computer equipment worth approximately $40,000 and was shipping it via the United Parcel Service ("UPS") from California to Texas. UPS advertised that its liability was limited but directed Murray to UPS Capital Insurance Agency, a wholly owned subsidiary of UPS, to purchase transit insurance. UPS Capital brokered a "Marine Certificate of Insurance" issued by Tokio Marine, which Murray believed fully insured his shipment in the event of any loss or damage by UPS.

The Certificate contained a "Free From Particular Average" ("FPA") provision stating:

> Warranted free from Particular Average unless the vessel or craft be stranded, sunk or burnt, but notwithstanding this warranty Underwriters are to pay any loss or damage to the interest insured which may reasonably be attributed to fire, collision or contact of the vessel and/or conveyance with any external substance (ice included) other than water, or to discharge of cargo at port of distress; and also to pay the insured value of any merchandise and/or goods jettisoned and/or washed or lost overboard, and the risks of theft of or non-delivery of an entire shipping package.

When the equipment was damaged by UPS in transit, Murray filed an insurance claim. The claim was denied on the ground that the policy covered only catastrophic losses such as the entire destruction of the vehicle in which the shipment was carried by UPS.

Murray then sued UPS Capital for breach of contract and negligence. Murray argued that UPS Capital had held itself out as an expert in inland marine insurance, and owed a duty to fully explain the Certificate's FPA provision and a duty to disclose that other products were available to cover in transit loss. The trial court granted summary judgment for UPS Capital because insurance brokers ordinarily owe only a limited duty of care to procure the insurance requested by the insured, and Murray had not proffered evidence that UPS Capital held itself out as an expert in a particular field. Murray appealed only as to the cause of action for negligence.

The Court of Appeal reversed. The Court declined to institute a per se rule imposing a heightened duty of care for all specialized agents and brokers, but did conclude that "public policy supports the creation of a reasonable inference of expertise when there is evidence the agent specializes in a particular field of insurance."[92] The Court further clarified that, "In this case, the undisputed evidence of UPS Capital's Specialization, in addition to Murray's other evidence, created a triable issue of material fact that if found true in Murray's favor would show UPS Capital assumed a special duty to advise Murray about the limited coverage available to ship his used goods with UPS."[93]

The Court found Murray satisfied his burden by, among other things, presenting evidence that UPS Capital only offered one type of policy to one-time shippers, UPS Capital acted as agent for only Tokio Marine America Insurance Company and offered only Tokio's inland marine coverage, UPS Capital was a subsidiary of UPS, and the crucial provision in the policy was "impossible to decipher."[94] Accordingly, there was a triable issue of fact "as to whether UPS Capital was holding itself out as having expertise in

89 *Id.* at p. 932.

90 (2019) 41 Cal.App.5th 247 ("*Miller*").

91 (2020) 54 Cal.App.5th 628.

92 *Id.* at p. 639.

93 *Ibid.*

94 *Id.* at p. 650.

a specialized area of insurance, and therefore, assumed a heightened duty of care."[95]

95 *Id.* at p. 651.