INSURANCE LAW

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INTRODUCTION

Normally, we begin our roundup with the latest California Supreme Court pronouncement on insurance law. However, the most important issue in the insurance world in 2021–coverage (or the lack thereof) for COVID-19 business interruption losses–was litigated not in the Supreme Court, but in the state and federal appellate courts. Accordingly, we begin our discussion with two important appellate defeats for policyholders seeking coverage for COVID-19 losses. As for the Supreme Court, the year's only notable insurance decision focused on a narrow issue involving the retroactive effect of new grace period requirements for life insurance policies. Of more significance in insurance circles was the *Pinto* case, which grafted a new element onto bad faith claims based on the failure to accept a reasonable settlement offer. The year's other appellate decisions involved a grab bag of issues, with results generally favoring the insurers.

FIRST PARTY POLICIES

BOTH FEDERAL AND STATE APPELLATE COURTS REJECT COVERAGE FOR COVID-19 BUSINESS INTERRUPTION LOSSES

Following near unanimous rejection of COVID-19 related losses at the trial court level, the first appellate decision to address the issue under California law came from the Ninth Circuit in *Mudpie, Inc. v. Travelers Casualty Ins. Co. of America*.[1] The insured in *Mudpie* operated a children's store in San Francisco which ceased operations following the issuance of a local Shelter in Place Order. Mudpie filed a class action against its insurer, Travelers, after its business interruption claim was denied. Travelers contended both that Mudpie's losses were not the result of "direct physical loss or damage to property" and that coverage was barred by a virus exclusion.[2]

The district court granted Travelers' motion to dismiss, and Mudpie appealed. The Ninth Circuit affirmed on both grounds raised by Travelers. Citing *MRI Healthcare Ctr. Of Glendale, Inc. v. State Farm Gen. Ins. Co.*,[3] the Court found that "for loss to be covered, there must be a 'distinct, demonstrable, physical alteration' of the property."[4] The Court rejected Mudpie's argument that actual damage to the property is not required, only that the property is no longer suitable for its intended purpose. Among other things, the Court pointed out that other provisions in the policy were consistent with requiring physical alteration of property. For example, the

policy provided coverage only during the "period of restoration," which implies physical alterations to the property.[5]

Though not necessary to uphold the decision, the Court further held that the policy's virus exclusion also barred coverage. Under that, Travelers would "not pay for loss or damage caused by or resulting from any virus, bacterium or other microorganism that includes or is capable of inducing physical distress, illness or disease."[6] While Mudpie argued that its losses were caused by the Stay at Home Orders rather than the virus, the Court found that the virus was in fact the efficient proximate cause of the losses. It was the virus that set the other causes in motion, and the virus was not merely a remote cause of the loss.[7] Accordingly, the exclusion applied.

Mudpie was followed in short order by a decision from the Fourth District Court of Appeal in *The Inns By The Sea v. California Mutual Ins. Co.*,[8] which reached similar results. The *Inns* plaintiff operated four lodging facilities in Monterey and San Mateo counties affected by Stay at Home orders. The Court rejected the policyholder's lost business income claim because it did not result from "direct physical loss of or damage to property."

While the plaintiff argued that the physical presence of COVID-19 transformed the property from a safe condition to a dangerous one, the Court found that the insured's business interruption losses were caused by the shut down orders, not any direct physical damage to the property. The court reasoned that, whether or not the plaintiff disinfected its property, it would still be required to suspend its operations in light of the government orders. Nor were the operations suspended due to a direct physical loss, as that term is not synonymous with "loss of use." Coverage under the policy was not triggered solely by "an inability to use the physical premises to generate income, without any other physical impact to the property."

The *Inns* decision considered an additional coverage not at issue in *Mudpie*: civil authority coverage. That coverage applies to loss of business income sustained "by action of civil authority that prohibits access to the described premises due to direct physical loss of or damage to property, other than at the described premises. . . ." However, because the orders were issued in an attempt to prevent the spread of the virus, rather than due to direct physical loss of or damage to any property, the *Inns* Court found that the civil authority coverage was not triggered either.

SUPREME COURT HOLDS THAT NEWLY ENACTED GRACE PERIOD AND NOTICE REQUIREMENTS APPLY TO PREVIOUSLY ISSUED LIFE INSURANCE POLICIES

The lone California Supreme Court insurance case in 2021, *McHugh v. Protective Life Ins. Co.*,[9] addressed important legislative changes to life insurance policies and their retroactive effect. Effective January 1, 2013, the Legislature enacted Insurance Code sections 10113.71 and 10113.72. Section 10113.71 established a 60-day grace period after a missed premium payment and also requires insurers to notify policy owners, as well as persons designated by the policy owners, to receive at least 30 days' notice before terminating a policy due to non-payment. Section 10113.72 requires life insurance policies to grant policy owners the right to designate at least one other person to receive notice of an overdue premium or impending termination of the policy.

William McHugh purchased a $1 million term life insurance policy in 2005 naming his daughter Blakely as the designated beneficiary. McHugh paid the annual premiums through January 2012, but failed to make the payment due on January 9, 2013. Protective Life sent McHugh a letter dated January 29, 2013 warning him that his policy would lapse if payment was not received by February 9, 2013. The policy lapsed, at which point Protective Life sent McHugh a letter on February 18, 2013 notifying him that the policy would expire on March 12, 2013 if the required payment was not made. By this time, McHugh had suffered a serious fall which rendered him disabled.[10]

The grace period and notice provisions of the Protective Life policy did not comply with sections 10113.71 and 10113.72, but the insurer argued that the provisions should not be given retroactive effect. The Court of Appeal agreed with Protective Life, but the Supreme Court reversed. While there is normally a rebuttable presumption that a statute does not operate retroactively,[11] the *McHugh* court found that that presumption did not apply because the case involved an entirely prospective statutory application based on post-enactment conduct, or alternatively, that any retroactive effect would be minimal and did not substantially impair any vested contractual rights.[12]

Having rejected the possible impact of a rebuttable presumption, the Court proceeded to construe the statutory language. While certain elements of the provisions broadly suggested they should apply to all policies, the sections at issue did not conclusively establish this, creating a potential ambiguity.[13] Accordingly, the Court turned to other sources to resolve the ambiguity, including legislative history, which it found favored the interpretation proffered by the policy beneficiary. This included committee statements explaining that the bill would provide consumer safeguards from which "people who have purchased life insurance coverage, especially seniors, would benefit."[14] Accordingly, the Court found that "the Legislature enacted the sections not only to provide protections to people in the future, but also to ensure that existing policy owners don't lose the life insurance coverage that they may have spent years paying for and on which their loved ones depend."[15]

TIMING OF "OCCURRENCE" IS QUESTION OF FACT SUPPORTING REVERSAL OF SUMMARY JUDGMENT WHERE PLAINTIFF ALLEGED "CONTINUOUS AND PROGRESSIVE" DAMAGE BEGINNING DURING POLICY PERIOD

In *Guastello v. AIG Specialty Insurance Co.*,[16] a retaining wall collapsed many years after it was built, and a homeowner sued the subcontractor that built it. The subcontractor defaulted, and the homeowner sued the subcontractor's insurance company under Ins. Code § 11580(b)(2). The insurer moved for summary judgment on the grounds that the damages occurred after its policy expired. The trial court granted the motion, but the Fourth District Court of Appeal reversed. Noting that the policy provided coverage "based on the timing of an 'occurrence,' [so] the determination of when the occurrence took place may be itself a question of fact," the Court of Appeal observed the homeowner alleged "continuous and progressive" damage that "began to occur shortly after the subcontractor built the retaining wall during the coverage period," raising a triable issue of material fact that precluded summary judgment.[17]

The subcontractor, C.W. Poss Inc., had built the retaining walls for a housing development in Dana Point in 2003, and Guastello bought his home in 2006. The retaining wall failed in 2010. When Guastello sued Poss, AIG rejected its insured's tender because the property damage occurred in 2010, after the policy expired in 2004. Poss defaulted and Guastello supported his application for default judgment against the subcontractor with the affidavit of a geotechnical engineer who had testified in the developer's earlier suit against Poss, that the retaining wall collapsed due to defects that were within the subcontractor's scope of work. After getting a default judgment against the insolvent subcontractor, the homeowner sued AIG on three causes of action: in addition to enforcement of the default judgment, he alleged claims for bad faith and declaratory relief, which a third-party beneficiary, particularly a plaintiff under Section 11580, can do.[18]

AIG moved for summary judgment, and the trial court, finding "Guastello 'did not experience property damage until well past the expiration of the policy,'" granted the motion as to all three causes of action.[19] In reversing the trial court, the Court of Appeal first distinguished "claims made" policies, which provide coverage only if the claim is made during the policy period, from "occurrence" policies that cover damages that occur during the policy period even if the claim is made after the policy expired. The Court noted that in addition to measuring the "occurrence" from when the complaining party was damaged rather than when the wrongful act was committed,

"[i]t is also a 'settled rule . . . when continuous or progressively deteriorating damage or injury first manifests itself' the insurer 'remains obligated to indemnify the insured for the entirety of the ensuing damage or injury.'"[20]

The Court reviewed the commercial general liability ("CGL") policies AIG issued to Poss, which contained the typical provisions limiting indemnity against a claim for property damage only if "that damage is caused by an 'occurrence' and the damage–not the 'occurrence'–takes place during the policies' effective dates."[21] AIG's policies further provided that "[w]here '*continuing or progressive*' property damage is at issue, the '"property damage" shall be deemed to be one "occurrence", and shall be deemed to occur only when such . . . "property damage" *first commenced*.'"[22]

Guastello had supported his opposition to summary judgment with the declaration of an expert witness, a civil engineer who averred that the subcontractor had negligently constructed the retaining wall and that negligence began causing damage to its own work and surrounding properties including the one Guastello later bought within months of the wall's substantial completion in 2003. The declarant continued by testifying the damage from that negligence was continuous and progressive and ultimately resulted in the wall's failure in 2010. This meant "the timing of the alleged 'occurrence' (the alleged damage to Guastello's property) within the meaning of Poss' general liability insurance policies is plainly a disputed issue of material fact."[23]

Under the homeowner's latent construction defect theory of liability, supported by competent evidence from his expert witness, there was "a triable issue of material fact as to the timing (or triggering) of AIG's coverage under Poss' insurance policies," on which material fact all three of his causes of action were predicated.[24] "Thus, the trial court erred by granting AIG's motion for summary judgment."[25]

DISMISSAL OF BAD FAITH CLAIM BROUGHT BY DAUGHTER NOT NAMED AS INSURED UNDER PARENTS' FAIR PLAN POLICY AFFIRMED FOR LACK OF STANDING

Brooke Wexler lived with her parents Kimberly and James Talbot in the Talbots' house. After the Woolsey fire in 2018, her parents made claims for smoke damage on their FAIR Plan policy.[26] Wexler and her parents sued FAIR plan for bad faith, FAIR Plan demurred to her complaint on standing grounds, and the trial court sustained the demurrer and dismissed her claims. In *Wexler v. California Fair Plan Assn.*,[27] the Second District Court of Appeal, over the dissent of one of its three panel members, affirmed because "Wexler was not a *signatory*; she was not an *additional insured*; and she was not a *third-party beneficiary*."[28] Lacking any contractual relationship with FAIR Plan, the Court held, Wexler could not sue for bad faith.

Even though the FAIR Plan policy covered personal property of Wexler as a member of the family residing with her parents, the Court interpreted that coverage as "a benefit Wexler's parents enjoy. Her parents' benefit does not make Wexler a party to the contract [of insurance]."[29]

Because the FAIR Plan policy did not identify Wexler as a named insured or loss payee, and further provided, "[t]his policy does not provide coverage to any person or entity not named here,"[30] the Court concluded she was not an additional insured.

Finally, the Court found Wexler was not a third-party beneficiary of the FAIR Plan policy. Applying the three part test set forth by the California Supreme Court in *Goonewardene v. ADP*, LLC,[31] the Court found the language expressly excluding from coverage any unnamed person or entity precluded Wexler from showing a motivating purpose of the contracting parties was to benefit her. And since the Talbots could and did sue, the Court concluded permitting a bad faith action by Wexler was not necessary to effectuate the objectives of the insurance contract.

The Court rejected Wexler's claim that the policy was ambiguous because it covered her possessions in her parents' home but barred coverage for unnamed persons: "These provisions are unambiguous. They afford coverage to the Talbots—and only the Talbots—for the specified contents in their home, including contents owned or used by family members residing there. The no-coverage-for-unnamed-persons clause does not absolve FAIR Plan of its duty to cover this property."[32]

The Court also went to some lengths to dispose of Wexler's argument that her parents had no insurable interest in her personal property at the house. Statute defines "an insurable interest" as "[e]very interest in property, or any relation thereto, or liability in respect thereof, of such a nature that a contemplated peril might directly *damnify* the insured."[33] Rather than explain how damage to Wexler's personal property directly damnified (i.e., "cause loss or damage to")[34] her parents, the Court explored the issue of moral hazard, which, together with gambling, it contended the insurable interest doctrine was meant to eliminate. Because the Talbots were not gambling on the loss of Wexler's personal property when they bought the FAIR Plan policy, nor did that purchase create a moral hazard that would encourage the Talbots to expose her property to excessive risk, the majority believed it was "plain the Talbots had an insurable interest in Wexler's property stored in their house while Wexler lived with them there."[35]

The Court noted the irony of Wexler, as a plaintiff suing an insurer, advancing the insurable interest doctrine that carriers typically use in their defense against policyholders' claims. "The effect of Wexler's attempted expansion, if successful," the Court warned, "would have been to disadvantage policyholders in other disputes."[36]

The dissent conveyed its own warning, for multigenerational households or parents whose adult children live with them: "[I]f you, as the homeowner and a named policyholder, try to protect your family members by paying a premium for a policy that purports to provide coverage for the personal property of resident family members, . . . [and] your family member's personal property is damaged, you will not be able to recover for that damage because you do not have an ownership interest in that property[, and y]our family member will not be able to recover because the insurance company . . . will be able to deny coverage because you did not identify the family member by name."[37]

The dissent rejected the majority's reliance on the disclaimer of coverage for anyone not named in the policy. Instead, it viewed Wexler as "an insured by virtue of fitting into an expressly defined category of those for whose benefit the policy was created:" resident family members with personal property on the premises.[38]

As the dissent saw it, Wexler's parents had no insurable interest in her property, since they suffered no pecuniary loss because of the damage. "In sum," the dissent continued, "FAIR Plan has charged the Talbots a premium for personal property coverage for family members which the Talbots cannot pursue because they lack an insurable interest; it then has argued that the owner of the personal property cannot seek recovery herself."[39]

The dissent would also have found Wexler to be a third party beneficiary of the FAIR Plan policy, so, "although the contract may not have been made to benefit [her] alone, [she] may enforce those promises directly made for [her]," such as the resident family member coverage.[40] The dissent rejected what it described as the majority's "assumptions" about whether benefiting Wexler was a motivating purpose of the Talbots,[41] and concluded that "[g]iven the Talbot's [*sic*] lack of insurable interest in the damaged property, permitting an action by Wexler is the only way to effectuate the contract's objective."[42]

It is not clear whether FAIR Plan would pay a named insured's claim for damage to the personal property of a resident family member. The majority seemed to assume it would, while the dissent plainly anticipated FAIR Plan would deny such a claim due to an

asserted lack of insurable interest. Perhaps another case will answer that question.

TRIABLE ISSUE OF FACT SUPPORTS DENIAL OF CARRIER'S SUMMARY JUDGMENT MOTION ON LAPSED POLICY

In *Antonopoulos v. Mid-Century Insurance Co.*,[43] Mr. and Mrs. Antonopoulos lost their home in a fire on October 9, 2017, and submitted a claim to their insurance company, Mid-Century, only to have it denied because the insurer had canceled the policy for nonpayment of premium on October 3, six days before the fire. After they paid the past due premium, Mid-Century reinstated the policy. But Mid-Century continued to deny the claim. The insureds sued for bad faith, and both sides moved for summary judgment. The trial court found undisputed facts showed Mid-Century had waived forfeiture of the policy and reinstatement was retroactive, so it denied the carrier's motion and granted the motion of the insureds. The First District Court of Appeal affirmed the order denying Mid-Century's motion, but reversed the judgment in favor of the insureds, because it found there were triable issues of fact regarding the carrier's intent in reinstating the policy.

When it reinstated the policy, Mid-Century issued a "Home Insurance Policy Reprint" that attached a declaration page showing a policy period that included the date of loss, as well as identifying the same properties and insured and the same coverages as in the lapsed policy. Additionally, Mid-Century "adjusted" the dates of coverage by tacking on nine days (the time between cancellation and payment of the past-due premium) to the policy period, without "expressly acknowledging a lapse in coverage that actually spanned the time when the loss occurred."[44]

Mid-Century argued it could not have covered the fire loss which predated the reinstatement because of the loss-in-progress rule: "when a loss is 'known or apparent' before a policy of insurance is issued, there is no coverage."[45] But the Court pointed out "plaintiffs' loss did not occur before the policy was issued, as the policy was renewed on April 8, 2017, six months before the loss. What occurred post-loss, on October 12, was *reinstatement* of the prior policy."[46]

The Court quoted a respected treatise noting that an insurer may waive forfeiture of policy benefits that might otherwise occur resulting from nonpayment of premium under certain circumstances. "[W]hether an insurer's acceptance of an overdue premium after loss has occurred acts to preserve coverage is ordinarily a question of the insurer's intent in accepting the premium, and whether that intent has been adequately conveyed to the insured."[47] And the Court examined the authority on which Mid-Century heavily relied, to find that it recognized an insurer's "discretion to reinstate the policy without a lapse, despite the accident that occurred when the policy was out of force."[48]

While the Court agreed with the trial court that there were facts that, if proved, would support a conclusion that the carrier had reinstated the policy without lapse, such a conclusion would require a finding as to Mid-Century's intent in accepting the insured's late paid premium, and "the evidence and reasonable inferences raise a triable issue as to whether Mid-Century intended to retroactively reinstate the policy without a lapse. This precludes summary adjudication for Mid-Century—and for plaintiffs."[49] So the Court of Appeal reversed the summary judgment for Mr. and Mrs. Antonopoulos, sending them back to the trial court to prove their bad faith claim against their insurer.

HOME PROTECTION CONTRACTS DO NOT QUALIFY AS INSURANCE

The Second District Court of Appeal found in *Chu v. Old Republic Home Protection Co., Inc.*[50] that home protection contracts do not constitute insurance, and that the breach of such a contract cannot, therefore, support a bad faith claim.

The plaintiffs in *Chu* purchased a "Home Protection Plan" for their condominium, pursuant to which the defendant, Old Republic, agreed to "provide service for covered systems and appliances [within the

condominium] reported as malfunctioning during the term of the [contract.]"[51] After the contractor selected by Old Republic failed to properly repair the HVAC system, plaintiffs sued for breach of contract, bad faith, and other causes of action. The trial court sustained a demurrer to the bad faith claim and the plaintiffs appealed.

Influenced by the legislative history of the statutes enacted to regulate home protection contracts, the Court of Appeal affirmed.[52] While the Legislature had originally considered treating such contracts as a class of insurance pursuant to an existing Attorney General opinion, it ultimately chose not to do so, instead specifying that only certain provisions of the Insurance Code applied to home protection contracts.

However, that was not the end of the analysis. Citing the California Supreme Court's decision in *Cates Construction, Inc. v. Talbot Partners*,[53] which involved surety bonds, the *Chu* Court engaged in an in-depth evaluation of whether, as a matter of policy, home protection contracts should nonetheless be treated like insurance. First, the Court did not find that buyers and sellers of residential property who enter into home protection contracts lack meaningful bargaining power. Second, the Court found that home protection companies "do not undertake the quasi-fiduciary responsibilities of defending homeowners or settling claims against them."[54] Moreover, home protection contracts do not protect against "calamity or catastrophe" in the same way as insurance policies. Finally, the financial requirements that would be imposed on home protection companies if they were treated as insurers would likely drive the majority of them out of business. Since the Court determined that policy considerations did not favor treating home protection contracts as analogous to insurance, it rejected the plaintiffs' attempt to state a claim for bad faith.

THIRD PARTY POLICIES

SUMMARY JUDGMENT FOR CARRIER AFFIRMED FOR DENIAL OF DEFENSE BASED ON INSURANCE CODE SECTION 533.5, REJECTING DUE PROCESS CHALLENGE

In *Adir International, LLC v. Starr Indemnity & Liability Co.*,[55] plaintiff Adir operated the Curacao retail chain in California, Nevada, and Arizona. In 2017, the California Attorney General sued Adir and its CEO for violations of the state's Unfair Competition Law ("UCL") and False Advertising Law ("FAL"), alleging unfair and misleading business tactics targeting the chain's mainly low-income, Spanish-speaking customers. The complaint sought restitution, civil penalties, costs of suit, and other equitable relief. Adir tendered the complaint to its insurer, Starr, which agreed to defend under a reservation of rights. But in March 2019, the Attorney General warned Starr it was violating Ins. Code sec. 533.5 ("Section 533.5"), which prohibits insurance to indemnify (subdivision (a)) or defend (subdivision (b)) in UCL or FAL actions brought by the Attorney General. Starr withdrew its defense and reserved its rights to seek reimbursement of its payments to that date.

Adir sued Starr in state court, and Starr removed the case to federal court, where it moved for summary judgment. The District Court granted Starr's motion, finding that Section 533.5 "clearly and explicitly establishes that there was no potential for coverage and, consequently, no duty to defend in the underlying action," and that "because 'there is no duty to defend, there can be no duty to indemnify.'"[56] The District Court subsequently awarded Starr reimbursement of over $2 million.

On appeal, Adir argued Section 533.5 violated the due process rights of policyholders, under the Fifth and Fourteenth Amendments to the U.S. Constitution, because the statute interferes with their ability to fund and retain the counsel of their choice. The Ninth Circuit acknowledged that "California has stacked the deck against defendants" by invoking the state's power to deny Adir insurance

coverage that Adir paid for, without having yet proved any of the allegations of its complaint.[57] But after reviewing authority that has "generally acknowledged a civil litigant's Fifth Amendment due process right to retain and fund counsel of their choice," [58] and the language and purpose of Section 533.5, the Court concluded Section 533.5 did not violate that right.

Compared to the "much more robust Sixth Amendment right to counsel," the Court said that the Fifth Amendment "due process right to retain counsel in civil cases appears to apply only in extreme scenarios where the government substantially interferes with a party's ability to communicate with his or her lawyer or actively prevents a party who is willing and able to obtain counsel from doing so."[59] The Court declined to "enlarge the limited due process right to retained counsel to include a constitutional right to use insurance proceeds to pay for legal fees."[60]

"At the end of the day," the Court opined, "California's law only makes it harder, though not necessarily impossible, for a civil litigant to retain the counsel of their choice."[61] Ultimately, because Adir had not alleged Section 533.5 prevented it from retaining counsel at all, the Court ruled that Adir's facial challenge to the statute must fail.

COMPLAINT FOR DECLARATORY RELIEF ON RIGHT TO CUMIS COUNSEL PROPERLY RESOLVED AS A MATTER OF LAW

The plaintiff insureds in *Nede Management Inc. v. Aspen American Ins. Co.*[62] sought a declaration that they had been entitled to "*Cumis* counsel"[63] (i.e. independent defense counsel paid for by the insurance company) in connection with an underlying bodily injury claim. In defending a complaint for wrongful death arising out of a fire at property owned by the insureds, Aspen reserved its right not to pay any judgment in excess of the $1 million policy limit and not to pay punitive damages.[64] The insureds contended that these reservations, as well as instances of appointed counsel allegedly failing to properly defend them, gave rise to a right to independent counsel under Civil Code section 2860. Among other things, the plaintiffs accused appointed counsel of "unremitting hostility" because he believed they would be bad witnesses.[65] The trial court sustained a demurrer to the complaint without leave to amend.

On appeal, the Second Appellate District found that the type of reservations issued by Aspen did not give rise to a right to independent counsel under section 2860(b), which specifically provides that no conflict shall be deemed to exist as "to allegations of punitive damages or . . . because an insured is sued for an amount in excess of the insurance policy limits." As to the insureds' assertion that appointed counsel failed to properly defend them, thereby giving rise to a right to independent counsel, the Court noted that "they misunderstand the nature of the right to independent counsel under section 2860."[66] The right arises from conflicts of interest created by counsel's dual representation of the insurer and insured where an issue in the underlying litigation may determine coverage. Mere complaints about how appointed counsel is handling the case do not suffice.

The reason that this case was unique really involved a matter of civil procedure. The *Nede* court noted that the plaintiff's complaint technically was not subject to demurrer, since it adequately pled a case or controversy subject to declaratory relief. However, since the plaintiff was not entitled to *Cumis* counsel as a matter of law based on the facts as pled, the plaintiff was not prejudiced by the sustaining of the demurrer and the court simply modified the judgment to make that declaration.[67] This sparked a concurring opinion which encouraged the resolution of declaratory relief claims on demurrer where such claims can be adjudicated based on the undisputed facts alleged in the complaint.[68]

BAD FAITH

BAD FAITH JUDGMENT REVERSED WHERE SPECIAL VERDICT FAILED TO ASK ABOUT REASONABLENESS OF INSURER'S CONDUCT

The most significant bad faith case of the year was probably *Pinto v. Farmers Insurance Exchange*.[69] The Second District Court of Appeal reversed a $9,935,000 jury verdict based on the carrier's failure to accept a reasonable policy limits settlement demand, even though the trial court had given the standard CACI instruction. The Court in essence created a new element of a bad faith-failure to settle claim: That in failing to accept a reasonable settlement offer, the carrier acted unreasonably.

The facts were messy. Plaintiff Alexander Pinto was paralyzed after a pickup truck he was riding in with three other people flipped and rolled on the way back from a party in Lake Havasu, Arizona. There was evidence that drugs and alcohol were involved. Farmers' insured wasn't the driver, and the license of Dana Orcutt, the person the insured and the Arizona police report identified as the driver, was suspended at the time of the accident because of a DUI.

Pinto's attorney made a demand for the $50,000 policy limits with a 15 day deadline. In addition to the payment, Pinto demanded a declaration that the insured had not been acting in the course and scope of employment when the accident happened, and a copy of any applicable insurance policy. Farmers' adjuster forwarded the offer to its named insured and Orcutt the next day. Farmers had difficulty contacting Orcutt, but a private investigator it hired reached her, and Orcutt told the investigator she was not acting in the course and scope of employment and she had no other insurance. But she never gave a declaration to that effect.

On the 14th day, Farmers tendered the limits "to resolve Pinto's claims 'against any and all insureds under the policy,'" which Pinto's attorney agreed included both Farmers' named insured and Orcutt, presumed to be a permissive driver.[70] Before close of business on the 15th day, Farmers hand delivered to Pinto's lawyer's office a letter accepting his offer and enclosing a check for $50,000, with a form releasing its insured and the permissive driver. Farmers also faxed a declaration from its insured, but none from the permissive driver, though Farmers' counsel had told Pinto's lawyer Orcutt said she had no other insurance.

Pinto rejected the tender because, "Farmers apparently failed to perform even the most perfunctory investigation and consequently has been unable to provide my client with the most basic and critical information set forth in his offer: reasonable proof of Ms. Orcutt's complete policy limits and course and scope status. . . . [M]y client, with his astronomical medical bills and devastating injuries, would be a fool to accept Farmers' $50,000.00 without knowing the exhaustive policy limits *or course and scope[ ] status of Ms. Orcutt*. [¶]. . . . Suit will soon be filed so that my client can discover that information which Farmers failed to provide."[71]

Pinto sued Farmers' named insured and Orcutt, and settled for an assignment of rights against Farmers, "an agreement that . . . the settlement would be treated as the equivalent of a $10 million judgment," and a $65,000 payment (Farmers' policy limits plus those of another policy that covered Orcutt).[72] Pinto then sued Farmers, alleging Farmers' failure to accept his settlement demand was a breach of the duties of good faith and fair dealing it owed to the named insured and Orcutt.

The case went to trial, and Farmers argued Pinto had to prove it acted unreasonably in failing to accept his demand. The trial court rejected that argument, and the case went to the jury on a special verdict form patterned on CACI No. 2334, which lists three elements of a claim for bad faith failure to settle: 1. The insured was sued for a covered claim, 2. The Carrier failed to accept a reasonable settlement demand within policy limits, and 3. A judgment exceeding policy limits was entered against the insured.[73]

The jury found Pinto made a reasonable demand, Farmers failed to accept it, and an excess judgment

was entered against Farmers' named insured and Orcutt. The jury also found Orcutt failed to cooperate with Farmers, despite Farmers' reasonable efforts to obtain her cooperation, and her lack of cooperation prejudiced Farmers. The jury did not make a finding that any of Farmers' conduct was unreasonable, and Farmers argued in post-verdict motions that the findings about Orcutt's conduct established it had not acted unreasonably and couldn't be held liable for bad faith. The trial court rejected Farmers' arguments and entered judgment for $9,935,000.

On appeal, the Court noted no finding or evidence that Farmers acted unreasonably, and framed "[t]he issue [as] whether, in the context of a third party insurance claim, failing to accept a reasonable settlement offer constituted bad faith per se. We conclude it does not."[74]

The Court started from the principle that, as it stated in a heading, "Bad Faith Requires a Finding that the Insurer Acted Unreasonably," quoting authority defining the "critical issue [as] the reasonableness of the insurer's conduct under the facts of the particular case," and concluding liability required evidence establishing "that the failure to settle was unreasonable."[75] Because "[a]n insurer's duty to accept a reasonable settlement offer is not absolute," the Court continued, "failing to accept a reasonable settlement offer does not necessarily constitute bad faith. '[T]he critical issue is . . . the basis for the insurer's decision to reject an offer of settlement.'"[76] "A claim for bad faith based on the wrongful refusal to settle thus requires proof the insurer unreasonably failed to accept an offer."[77]

The Court approached the matter before it as concerning "[t]he correctness of a special verdict . . . subject to de novo review."[78] This turned out to be crucial, as, after deciding "[t]he special verdict here was facially insufficient to support a bad faith judgment because it included no finding that Farmers acted unreasonably in failing to accept Pinto's settlement offer,"[79] the Court addressed the proper remedy.

Because "[t]he jury was neither asked to nor did find that Farmers acted unreasonably or without proper cause in failing to accept Pinto's settlement offer [, and] a cause of action for bad faith requires a finding that the insurer acted unreasonably," the Court concluded that "the absence of such a finding precludes judgment for the plaintiff on that claim."[80] Remanding to the trial court for findings on whether Farmers had acted unreasonably would have been extremely difficult. And there were findings that suggested Farmers' conduct was reasonable–particularly those relating to Orcutt's cooperation. But reversing a $10 million judgment after jury trial is a harsh remedy–even if "[t]he plaintiff 'bear[s] the responsibility for a special verdict submitted to the jury on [his] own case.'"[81]

This is particularly so when the jury instruction drafted by the Judicial Council omits the element on which the Court of Appeal based its reversal. "Although CACI No. 2334 describes three elements necessary for bad faith liability, it lacks a crucial element: Bad faith. To be liable for bad faith, an insurer must not only cause the insured's damages, it must act or fail to act without proper cause, for example by placing its own interests above those of its insured."[82]

The Court of Appeal concluded, however, "the defective verdict was accomplished at Pinto's behest," because he not only "fail[ed] to propose an appropriate verdict, he also vigorously opposed Farmers' attempts to clarify the erroneous verdict."[83] So, the Court decided "[t]he proper remedy is to vacate the judgment and enter a new judgment for Farmers."[84]

Is amendment of CACI No. 2334 imminent?

SUMMARY JUDGMENT FOR CARRIER SUED FOR BAD FAITH REVERSED DUE TO ISSUES OF TRIABLE FACT REGARDING DELAY IN RESPONDING TO SETTLEMENT DEMAND

In *Hedayati v. Interinsurance Exchange of the Automobile Club*,[85] Auto Club's insured, Maurice Vanwyk, ran a red light and struck Maryam Hedayati

in a crosswalk, catastrophically injuring her. The insured driver notified Auto Club immediately and authorized disclosure of his $25,000 policy limits, which he told Auto Club were the only insurance or assets he had. Auto Club initially responded to Ms. Hedayati's lawyer's settlement communications by declining to disclose its insured's policy limits, and even after it provided that information, it gave no written proof. Nor did Auto Club give the lawyer a copy of its insured's written declaration of no assets or of his policy. Although its adjustor immediately recognized Ms. Hedayati's claim would likely exceed policy limits, and its insured requested it move quickly to settle, Auto Club failed to settle within policy limits and Ms. Hedayati got a judgment against Mr. Vanwyk for $26,000,000, with an assignment of his bad faith claim, which she then brought against Auto Club.

Auto Club moved for summary judgment. The trial court granted the motion, "finding that '[d]efendant has shown that it did not commit any acts that would constitute a breach of the covenant of good faith and fair dealing . . . [because] it never rejected any of plaintiff's settlement demands."[86] Ms. Hedayati appealed, and the Fourth District Court of Appeal, viewing the record de novo in the light most favorable to her, "disagreed with the trial court's evaluation of the evidence" as insufficient to persuade a "reasonable trier of fact [to] find a breach of the covenant of good faith and fair dealing" if she could establish the facts at trial.[87] So it reversed.

The Court recited the facts in some detail. The accident happened on October 1, 2012, and Mr. Vanwyk reported it to Auto Club the next day. Auto Club's mobile adjustor drove to Mr. Vanwyk's home to interview him in person. Within days, Auto Club's files showed it had concluded "our $25K limit is gone."[88] Ms. Hedayati's attorney contacted Auto Club about two weeks after the accident, while she was still unconscious and on life support, and he asked for the policy limits, which Auto Club refused to disclose. The adjustor's notes suggested he had phoned Ms. Hedayati's attorney sometime before 8 o'clock on October 19th to make a policy limits offer, but the attorney denied ever receiving the call, and Auto Club's records appeared to contradict that suggestion.

The facts that appeared most salient to the trial court's granting of summary judgment were that on November 20, 2012, the Tuesday before Thanksgiving, Ms. Hedayati's lawyer sent Auto Club a letter offering to settle her claims for the $25,000 policy limits, which an adjustor had disclosed in a letter sent about three weeks before. The settlement offer required "strict adherence to each and every term and condition of this offer," which included that the attorney must receive written acceptance via UPS or Federal Express within 7 days, on or before Monday, November 27, 2012. The settlement offer was delivered the day before Thanksgiving. Auto Club blew the deadline, and first contacted Ms. Hedayati's attorney on November 28th, to ask for an extension of time to respond to the offer, which he refused because it had already expired.

Auto Club argued "that given the Thanksgiving holiday, the week-long time limitation Hedayati set for acceptance of her settlement offer was unreasonable as a matter of law [and] . . . its failure to accept the offer therefore cannot be deemed unreasonable."[89] The trial court embraced that argument, dismissing "plaintiff's self-imposed, arbitrary deadline to a demand defendant received the day before Thanksgiving."[90] Because the trial court found "there was no real reason for the mega-short deadline," it concluded "no reasonable trier of fact could conclude Auto Club's conduct in failing to meet the clear terms of Hedayati's settlement offer and secure a release constituted a breach of its duties to Vanwyk under his liability policy."[91]

The Court of Appeal, however, noted that Ms. Hedayati alleged in her complaint Auto Club had breached its duty to communicate with its insured by failing to convey her settlement offer to him. The appellate court observed whether such a failure was reasonable was a question of fact, which Auto Club did not address with any evidence, such as that the insured was "incommunicado, nonresponsive, or could not be contacted by Auto Club between

November 21 and November 26, 2012, to convey and discuss Hedayati's settlement offer."[92] By failing to address in its motion for summary judgment an issue raised in the complaint, Auto Club had failed to meet its initial burden to show the action had no merit and shift the burden to the plaintiff to oppose summary judgment.

The Court also observed "whether a seven-day demand was reasonable is for the trier of fact to determine; a short time limit attached to a settlement demand may or may not be reasonable under the circumstances of a given case."[93] Reviewing the events that transpired between October 2nd and the date of the offer, the Court observed, "a reasonable trier of fact could find that by November 20th Hedayati's counsel had good reason to draw 'a line in the sand' with his tight settlement conditions."[94]

The opinion may be read as implicitly rebuking the trial court's embrace of the carrier's skepticism about the deadline plaintiff's counsel set. It seems to stand apart from the many cases rejecting attempts to "set up" insurers to "blow the lid off" policies. But the Court really side-stepped that issue with its focus on Auto Club's failure, as alleged in the complaint and unrefuted by Auto Club, to communicate the settlement offer to its insured. Even though the Court, in reviewing summary judgment, "expressed no opinion on the ultimate merits of Hedayati's bad faith claim"—and it even cited *Pinto v. Farmers Ins. Exchange* for the proposition that "[a] facially reasonable [settlement] demand might go unaccepted due to no fault of the insurer, for example if some emergency prevents transmission of the insurer's acceptance"[95]—the carrier's failure to communicate supported the bad faith allegations, and may be the aspect of the opinion most likely to apply in future cases.

SUMMARY JUDGMENT FOR INSURER REVERSED ON BAD FAITH FAILURE TO SETTLE CLAIM WHERE CARRIER FAILED TO RESPOND TO SUBROGEE'S LETTER DEMANDING PAYMENT IN EXCESS OF POLICY LIMITS

In *Planet Bingo LLC v. Burlington Insurance Co.*,[96] an electronic gaming device designed and supplied by Burlington's insured, Planet Bingo, caused a fire in a bingo hall in London, England. The insured notified its carrier in 2009, and after more than two years, Burlington closed its file, even though Planet Bingo alleged it lost business as a result of "getting known as a deadbeat" while Burlington spent years investigating the fire claim without paying it.[97]

In July 2014, three years after Burlington had closed its file, its insured got a letter from counsel for a carrier for the distributor of Planet Bingo's device, saying it had settled with the bingo hall's operator for £1.6 million, and demanding indemnity from Planet Bingo. The letter invited Planet Bingo to enter into "discussions and negotiations or mediation . . . [w]ith the objective of avoiding the costs of litigation."[98] Planet Bingo notified Burlington but it rejected tender because it was not made in a suit filed in the United States or Canada. In a previous appeal, the Court of Appeal held there would be coverage for a suit filed in the appropriate forum, after which, "[l]o and behold, just such a suit was then filed."[99]

Burlington defended that suit and settled it for policy limits of $1,000,000, rendering Planet Bingo's claims for failures to defend and indemnify moot. The insured maintained claims, however, based on Burlington's prelitigation claims handling, i.e., inadequate investigation and failure to settle sooner as a matter of claim avoidance strategy: Planet Bingo alleged Burlington denied coverage on forum grounds in the hope that claimants would sue its insured in the United Kingdom and the carrier could escape coverage.

Burlington moved for summary judgment on multiple grounds, including that it had no prelitigation duty to settle because it had not

received a settlement demand within policy limits. The trial court granted Burlington's motion and entered judgment for the defense. The Fourth District Court of Appeal reversed.

The appellate court acknowledged that a settlement offer within policy limits was never actually on the table. But Planet Bingo presented the testimony of an expert on claims handling establishing that a letter like the one Planet Bingo received in July 2014 "is routine in industry practice and offers a clear invitation to negotiate a settlement for less than that amount," consistent with what the expert called a "very well[-]known industry custom in such subrogation claims of accepting policy limits for a full release o[f] the insured."[100] Planet Bingo claimed Burlington's failure to settle for policy limits before litigation damaged its business reputation and ultimately destroyed its business in the United Kingdom. In reversing the trial court, the Court of Appeal analyzed whether Burlington's failure to pursue the subrogation demand letter's invitation to discuss or negotiate plaintiff's claim could support a bad faith claim for failure to settle.

The Court acknowledged that "the duty of good faith compels acceptance of a settlement offer only if the offer is *within* the insurer's policy limits."[101] But it also noted "a formal settlement offer is *not* an absolute prerequisite to a bad faith action."[102] According to the Court, the authorities established that "the existence of an opportunity to settle within the policy limits can be shown by evidence other than a formal settlement offer."[103] The testimony of Planet Bingo's expert "raised a triable issue of fact as to whether the letter represented an opportunity to settle within the policy limits."[104]

But, the Court observed, "[r]ather than respond to the letter, less than a month later, Burlington denied coverage, [despite the existence of] at least a potential for coverage."[105] By denying coverage instead of responding to the subrogation demand letter under such circumstances, Burlington "could be liable for bad-faith claims handling, including failure to settle."[106]

ORDER DENYING INSURER'S MOTION TO COMPEL ARBITRATION OF UNDERINSURED/UNINSURED MOTORIST CLAIM REVERSED DESPITE BAD FAITH CLAIM

In *McIsaac v. Foremost Ins. Co.*,[107] Brett McIsaac had motorcycle insurance with Foremost. The Foremost policy included an uninsured/underinsured motorist ("UIM") endorsement with a clause based on Insurance Code § 11580.2, subd. (f) ("Section 11580.2"), requiring arbitration if the insured and the carrier did not agree whether the insured "is legally entitled to recover damages under this coverage or . . . as to the amount of damages."[108]

McIsaac had an accident with an underinsured driver at the end of September 2018, and he filed a claim under the policy's UIM coverage the next month. In March 2019, the carrier made a settlement offer, and McIsaac served an arbitration demand in April 2019. The carrier's lawyer responded with a letter suggesting the parties do basic discovery before going through the time and expense of selecting an arbitrator to see if they could settle the claim, and defendant sent McIsaac written discovery and noticed his deposition. McIsaac never responded to the discovery or appeared at deposition, and in October 2019, he sued Foremost for "(1) breach of contract, (2) unjust enrichment, (3) breach of the covenant of good faith and fair dealing, and (4) bad faith."[109]

The carrier filed a petition to compel arbitration and stay the action. The trial court denied the petition, observing that "arbitration 'applies only to disputes over whether the insured is entitled to recover and, if so, the amount of recovery,'" and citing to authority that the arbitration provision of Section 11580.2 does not apply to bad faith claims.[110] The carrier appealed the order,[111] and the First District Court of Appeal reversed.

The Court noted the mandatory nature of Code of Civ. Proc. § 1281.2, absent waiver, grounds for rescission, or the involvement of a third party and the possibility of conflicting rulings. The Court also cited case law putting on the party opposing

arbitration the "burden to demonstrate that [the] arbitration clause *cannot* be interpreted to require arbitration of the dispute."[112]

While the Court acknowledged an insurer's contractual right to arbitrate the value of a UIM claim does not prevent the insured from suing for bad faith, it pointed out Foremost sought to arbitrate not McIsaac's bad faith claim, but only the amount of UIM damages, and an order staying the litigation until arbitration concluded. "[P]laintiff is free to litigate his bad faith claim after the arbitration takes place."[113]

INSURER V. INSURER

ENTITLEMENT TO EQUITABLE SUBROGATION DOES NOT TRANSFORM LEGAL CLAIMS AGAINST THIRD PARTIES INTO EQUITABLE CLAIMS

In *Berg v. Pulte Home Corp.*,[114] the Third District Court of Appeal analyzed the question of whether an entitlement to equitable subrogation, as opposed to the underlying action itself, determines the right to a jury trial. Pulte Home Corp. ("Pulte"), a general contractor, was sued by homeowners for allegedly violating building standards, breach of contract, and breach of express warranty. St. Paul Mercury Insurance Company ("St. Paul") defended Pulte as an additional insured under a general liability policy.

Pulte had an agreement with its subcontractors whereby they each agreed to "indemnify and defend Pulte against all liability and claims, judgments, suits or demands for damages to persons or property arising out of, resulting from, or relating to that subcontractor's performance of the work under the Agreement and any Contractor Project Agreement."[115] It was undisputed in *Berg* that there were alleged damages that resulted from or related to each of the subcontractors' work for Pulte.

St. Paul thereafter sought reimbursement for the defense of St. Paul from three of these subcontractors through equitable subrogation. This claim rested on the assertion that the subcontractors were in breach of their contract with Pulte. The trial court found that St. Paul had proven all elements of its equitable subrogation claim. Damages were awarded and determined by a jury trial in a second phase.

St. Paul appealed, arguing that there is no right to a jury trial in an equitable subrogation case because it is a claim in equity. This argument relied on a conclusion reached by the Fourth District Court of Appeal in *Pulte Home Corp. v. CBR Electric, Inc.*,[116] that no jury trial right exists in such an equitable subrogation action. However, the *Berg* court reasoned that, "an insurer's entitlement to equitable subrogation does not transform its insured's legal claims against third parties into equitable ones."[117] Therefore, it disagreed with the conclusion reached in *CBR Electric*.

The *Berg* Court reasoned that equitable subrogation consists of two phases: entitlement and enforcement. The first phase (entitlement) asks whether the insurer is entitled to equitable subrogation, and the *Berg* court concluded such an inquiry is appropriately performed by a trial court sitting as a court of equity. In the second phase (enforcement), where the question is whether the insurer prevails against the third parties, the Court reasoned that the right to a jury trial was dependent on the nature of the underlying claim. If the underlying claim is legal, then a jury trial is appropriate. Since St. Paul's claim in *Berg* was based on breach of contract—a legal claim—the Court affirmed the decision to grant a jury trial.

INSURER CLAIMING IT HAD NO DUTY TO DEFEND ENTITLED TO SUE OTHER INSURERS FOR EQUITABLE CONTRIBUTION AND EQUITABLE INDEMNITY TO RECOVER DEFENSE COSTS

Travelers Indemnity Co. ("Travelers") defended a general contractor ("TFM") in a construction defect lawsuit pursuant to a policy issued to one of the subcontractors, Calvac Paving ("Calvac"). In *Travelers Indemnity Co. v. Navigators Specialty Ins. Co.*,[118] seeking declaratory relief, equitable contribution and equitable indemnity, Travelers sued Navigators, which had issued a general liability policy to another

subcontractor, and Mt. Hawley Insurance Company ("Mt. Hawley"), which had insured the general contractor. Travelers subsequently determined that, because TFM and Calvac had entered into a backdated subcontractor agreement, it had no duty to defend TFM, and amended its complaint to seek total reimbursement from Navigators and Mt. Hawley.

The trial court sustained demurrers to Travelers' complaint without leave to amend, finding that (1) the declaratory relief cause of action failed because the underlying action was concluded; (2) the equitable indemnity cause of action failed because defense costs are not the proper subject of such a claim; and (3) the equitable contribution claim failed because Travelers alleged it had no duty to defend, and therefore failed to plead it had the same liability and risk as the defendants.[119] The Fourth District Court of Appeal reversed as to both the equitable contribution and equitable indemnity claims.

With respect to equitable contribution, the Court found that the complaint, on its face, contained allegations sufficient to state a claim. All that is required is an allegation that "several insurers are obligated to indemnify or defend the same loss or claim, and one insurer has paid more than its share of the loss or defended the action without any participation by others."[120] Travelers' allegation that it had defended TFM based on a good faith belief it had a duty to do so sufficed. Nor did Travelers' allegation that it in actuality owed no duty to defend disqualify it from seeking equitable contribution. Whether it had a duty to defend was a "*legal allegation* that was to be resolved in the course of the litigation, not a factual allegation that should be treated as true for the purpose of a demurrer."[121]

As to equitable indemnity, the Court rejected the argument that the concept did not apply because Travelers and Mt. Hawley were not joint tortfeasors. In the context of disputes between insurance carriers, equitable indemnity "applies in cases in which one party pays a debt *for which another is primarily liable* and which in equity and good conscience should have been paid by the latter party."[122] Accordingly, case law holds that an insurer with no coverage obligation of its own may settle a claim against its insured and seek equitable indemnity from other insurers. The Court also rejected the argument that equitable indemnity between insurers does not apply to defense costs, reasoning that equitable indemnity is available to an insurer who "has paid an *obligation* which was entirely the responsibility of a co-insurer."[123] The duty to pay defense costs is as much an obligation of an insurance carrier as the duty to pay the cost of a settlement or judgment.

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1. (9th Cir. 2021) 15 F.4th 885 ("*Mudpie*").
2. *Id.* at p. 888.
3. (2010) 187 Cal.App.4th 766.
4. *Mudpie*, *supra*, 15 F.4th at p. 891.
5. *Id.* at p. 892.
6. *Id.* at p. 893.
7. *Id.* at p. 894.
8. (2021) 71 Cal.App.5th 688 ("*Inns*").
9. (2021) 12 Cal.5th 213 ("*McHugh*").
10. *Id.* at p. 221.
11. *Myers v. Philip Morris Companies, Inc.* (2002) 28 Cal.4th 828.
12. *McHugh*, *supra*, 12 Cal.5th at p. 228.
13. *Id.* at p. 240.
14. *Id.* at p. 241.
15. *Id.* at p. 246.
16. (2021) 61 Cal.App.5th 97.
17. *Id.* at p. 100.

18. *Id*. p. 106, fn. 3, citing *Hand v. Farmers Ins. Exchange* (1994) 23 Cal.App.4th 1847, 1856-1857.

19. *Id*. at p. 101.

20. *Id*. at p. 103, quoting *Montrose Chemical Corp. v. Admiral Ins. Co*. (1995) 10 Cal.4th 645, 686-687.

21. *Id*.

22. *Ibid*. (Italics added by Court of Appeal.)

23. *Id*. at p. 105.

24. *Id*. at p. 106.

25. *Id*.

26. The California FAIR Plan Association was created by statute (Insurance Code §§ 10091 et seq.) to meet the needs of California homeowners unable to find insurance in the traditional marketplace.

27. (2021) 63 Cal.App.5th 55 ("*Wexler*").

28. *Id*. at p. 63.

29. *Id*.

30. *Id*. at p. 60.

31. (2019) 6 Cal.5th 817, 830.

32. *Wexler*, *supra*, 63 Cal.App.5th at p. 66.

33. *Id*. at p. 72, quoting Ins. Code § 281 (Italics added by Court of Appeal).

34. *Id*., quoting Random House Dictionary of the English Language (2d ed. Unabridged 1987) p. 504.

35. *Id*. at p. 74.

36. *Id*. at p. 75.

37. *Id*. at p. 76 (Stratton, J., dissenting).

38. *Wexler*, *supra*, 63 Cal.App.5th at p. 78.

39. *Id*. at p. 79.

40. *Id*. at p. 80.

41. *Id*.

42. *Id*. at p. 81.

43. (2021) 63 Cal.App.5th 580.

44. *Id*. at p. 590.

45. *Id*. at p. 594, quoting *Montrose Chem. Corp. v. Admiral Ins. Co*. (1995) 10 Cal.4th 645, 690; *see also*, Ins. Code §§ 22, 250.

46. *Id*. at p. 598.

47. *Id*. at p. 595, quoting 5 Couch on Insurance (3d ed. 2020) § 78:48.

48. *Antonopoulos*, *supra*, 63 Cal.App.5th at p. 97, citing *Monteleone v. Allstate Ins. Co*. (1996) 51 Cal.App.4th 509, 517.

49. *Id*. at p. 599.

50. (2021) 60 Cal.App.5th 346 ("*Chu*").

51. *Id*. at p. 349.

52. Insurance Code § 12740 *et seq*.

53. (1999) 21 Cal.4th 28.

54. *Chu*, *supra*, 60 Cal.App.5th at p. 355.

55. (9th Cir. 2021) 994 F.3d 1032.

56. *Id*. at p. 1037.

57. *Id*. at p. 1038.

58. *Id*. at p. 1039.

59. *Id*. at pp. 1039-1040.

60. *Adir International*, *supra*, 994 F.3d at p. 1040.

61. *Id*. at p. 1041.

62. (2021) 68 Cal.App.5th 1121 (*Nede*).

63. *See San Diego Federal Credit Union v. Cumis Ins. Society, Inc*. (1984) 162 Cal.App.3d 358, codified and clarified by the Legislature in Civil Code Section 2860.

64. *Nede*, *supra*, 68 Cal.App.5th at 1127.

65. *Id*. at p. 1135.

66. *Id*. at p. 1134.

67. *Id*. at p. 1131.

68. *Id*. at p. 1137 (Wiley, J., concurring).

69. (2021) 61 Cal.App.5th 676 ("*Pinto*").

70. *Id*. at pp. 684-685.

71. *Id*. at p. 685 (italics in original).

72. *Id*. at p. 686.

73. *See* CACI No. 2334.

74. *Pinto*, *supra*, 61 Cal.App.5th at p. 687.

75. *Id.*

76. *Id.* at p. 688, quoting *Walbrook Ins. Co. v. Liberty Mutual Ins. Co.* (1992) 5 Cal.App.4th 1445, 1460.

77. *Id.*

78. *Id.* at p. 689.

79. *Pinto*, *supra*, 61 Cal.App.5th at p. 689.

80. *Id.* at p. 692.

81. *Id.* at p. 693.

82. *Id.* at p. 692.

83. *Id.* at p. 694.

84. *Pinto*, *supra*, 61 Cal.App.5th at 694.

85. (2021) 67 Cal.App.5th 833 ("*Hedayati*").

86. *Id.* at p. 842.

87. *Id.* at p. 837.

88. *Id.* at p. 838.

89. *Id.* at pp. 846-847.

90. *Id.* at p. 842.

91. *Hedayati*, *supra*, 67 Cal.App.5th at p. 842.

92. *Id.* at p. at 846.

93. *Id.* at p. 848, citing *Graciano v. Mercury General Corp.* (2014) 231 Cal.App.4th 414, 442.

94. *Id.* at p. at 847.

95. *Id.* at p. 848, quoting *Pinto v. Farmers Ins. Exchange* (2021) 61 Cal.App.5th 676, 688.

96. (2021) 62 Cal.App.5th 44.

97. *Id.* at p. 50.

98. *Id.* at pp. 50-51.

99. *Id.* at p. 47.

100. *Id.* at p. 51.

101. *Planet Bingo*, *supra*, 62 Cal.App.5th at p. 55 (quoting *Walbrook Ins. Co. v. Liberty Mutual Ins. Co.* (1992) 5 Cal. App.4th 1445, 1457.)

102. *Id.* at p. 56 (quoting *Boicourt v. Amex Assurance Co.* (2000) 78 Cal.App.4th 1390, 1399.)

103. *Id.*

104. *Id.* at p. 57.

105. *Id.*

106. *Ibid.*

107. (2021) 64 Cal.App.5th 418

108. *Id.* at p. 420.

109. *Id.* at p. 421.

110. *Id.* at p. 421-422.

111. Code of Civ. Proc. § 1294, subd. (a).

112. *Hedayati*, *supra*, 64 Cal.App.5th at p. 422, quoting *Buckhorn v. St. Jude Heritage Medical Group* (2004) 121 Cal.App.4th 1401, 1406.

113. *Id.* at p. 423.

114. (2021) 7 Cal. App.5th 277 ("*Berg*")

115. *Id.* at p. 283.

116. (2020) 50 Cal. App. 5th 216.

117. *Berg*, *supra*, 7 Cal.App.5th at p. 293.

118. (2021) 70 Cal.App.5th 341 ("*Travelers*").

119. *Id.* at pp. 351-352.

120. *Id.* at p. 358, quoting *Fireman's Fund Ins. Co. v. Maryland Casualty Co.* (1998) 65 Cal.App.4th 1279, 1293.

121. *Id.* at p. 359 (emphasis in original).

122. *Id.* at p. 363 (emphasis in original).

123. *Id.* at p. 365 (emphasis in original), quoting *Travelers Indemnity Co. v. Hudson Ins. Co.* (E.D.Cal. 2020) 442 F.Supp.3d 1259, 1269.