INSURANCE LAW

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INTRODUCTION

In 2023, there was a veritable tidal wave of insurance company victories in California courts, with all but two of the cases discussed in this article coming down in favor of the insurance industry. With respect to first party property policies, the courts have continued to narrowly construe the meaning of "direct physical loss." And while policyholders scored a rare victory reaffirming the broad scope of the duty to defend under a third party liability policy, two other cases construed "insured contract" and "no voluntary payment" provisions in ways limiting coverage. Looking ahead, 2024 promises two major decisions from the California Supreme Court on coverage for COVID-19 business interruption claims, and perhaps on whether the contractual one-year statute of limitations in property policies governs Unfair Competition Law claims. Will the pendulum swing back in favor of policyholders? Check back next year.

FIRST PARTY POLICIES

SPECIFIED PERILS HOMEOWNERS POLICY PROVIDES NO COVERAGE FOR LOSS OF EMBRYOS

As discussed below, the question of what constitutes "direct physical loss" under first party property damage policies has bedeviled California courts since the onset of the COVID pandemic. The issue presented itself in a different context in *Wong v. Stillwater Ins. Co.*,[1] in which the First District Court of Appeal found the insureds failed to show that the partial thawing of stored embryos constituted direct physical loss.

Following in vitro fertilization, the Wongs stored three viable embryos cryogenically with Pacific Fertility Center ("PFC"). Several years later, the Wongs received notice that the storage tank suffered from a mechanical failure, leading to partial thawing of the embryos. The Wongs tendered a claim under their homeowners insurance policy, which provided coverage for "direct physical loss" to personal property "anywhere in the world" arising out of 16 specified perils.[2] When the carrier, Stillwater Insurance Company ("Stillwater"), denied coverage, the Wongs filed suit, but the trial court granted summary judgment in favor of Stillwater.

On *de novo* review, the Court of Appeal affirmed the judgment on two separate grounds. First, the Court found that plaintiffs had failed to raise a triable issue of fact as to whether the claimed loss fell within the

policy's insuring clause. Quoting the seminal case of *MRI Healthcare Center of Glendale, Inc. v. State Farm General Ins. Co.*,[3] the *Wong* court noted that "for loss to be covered, there must be a 'distinct, demonstrable, physical alteration' of the property."[4] Yet the Wongs' own IVF doctor conceded that there was "no way to know" whether the embryos had actual physical damage; rather, the doctor testified that as a result of the malfunction, "no responsible physician would use them."[5] This was fatal to the Wongs' claim.

However, the Court found that coverage was barred on a second, independent basis. Because the policy was for "specified perils" only, the insureds also had the threshold burden of proving the loss was caused by a specifically-enumerated peril.[6] The Wongs claimed the loss was caused by an "explosion," one of the 16 enumerated perils. In support, they cited to testimony from an expert's deposition in a separate case pending in federal court against PFC. However, that expert testified that the storage tank failure resulted from an "implosion," not an "explosion," which the *Wong* court noted are opposite concepts.[7] Moreover, the deposition testimony was inadmissible hearsay, and therefore could not be relied upon to oppose summary judgment in any event.[8]

FINAL DETERMINATION OF COVERAGE FOR COVID-19 BUSINESS INTERRUPTION CLAIMS AWAITS TWO CALIFORNIA SUPREME COURT CASES

Coverage for business interruption losses under commercial property insurance policies resulting from the COVID-19 pandemic has predominantly revolved around the question of whether the virus causes physical alteration of the subject property. This stems from two cases decided in 2021: the Ninth Circuit's ruling in *Mudpie, Inc. v. Travelers Cas. Ins. Co. of Am.* that "for loss to be covered, there must be a 'distinct, demonstrable, physical alteration' of the property;"[9] and the Fourth District Court of Appeal opinion in *The Inns By The Sea v. California Mutual Ins. Co.*, rejecting a policyholder's lost business income COVID-19 claims because they did not result from a "direct physical loss of or damage to property."[10]

Since those rulings, most courts in California have rejected the argument that the COVID-19 virus can cause physical damage to property. However, starting with *Marina Pacific Hotel & Suites, LLC v. Fireman's Fund Ins. Co.*,[11] a few have been willing to accept the premise as true at the demurrer stage. Given this divergence of opinion, in early 2023, the California Supreme Court agreed to settle the debate over whether the actual or potential presence of the COVID-19 virus on an insured's premises can constitute "direct physical loss or damage to property" by accepting that certified question from the Ninth Circuit in *Another Planet Entertainment, LLC v. Vigilant Ins. Co.*[12] Meanwhile, during the pendency of the appeal, the Supreme Court has granted review of several other decisions, whose ultimate outcomes will follow from *Another Planet*.[13]

However, even if such cases can get past the pleading stage, the decision by Division One of the Fourth Appellate District in *Best Rest Motel, Inc. v. Sequoia Ins. Co.*[14] provides a preview of the challenges such cases will face on summary judgment. *Best Rest* involved a fairly typical fact pattern, in which the policyholder was a hotel which suffered lost income during the pandemic. Its policy provided coverage for loss of business income "due to the necessary suspension of its operations caused by direct physical loss of or damage to the insured property from a covered cause of loss."[15]

The insurer filed a motion for summary judgment, arguing there was no evidence that the virus damaged any property, or alternatively, that there was no nexus between Best Rest's losses and the presence of COVID-19 at the hotel.[16] While Best Rest submitted an expert declaration opining that COVID-19 does in fact damage property surfaces by making them infectious,[17] the *Best Rest* court could still not find causation between the physical presence of the virus and the insured's economic damages. The *Best Rest* court found that while there was a decline in the insured's hotel business, there

was no evidence that it was *caused* by the physical presence of the virus on the hotel premises itself.[18] Rather, the economic losses suffered by the insured were caused by overall conditions of the global pandemic, i.e., the decline in travel and need for hotels.[19] Accordingly, summary judgment for the insurance company was affirmed.[20]

A second COVID-19 coverage case pending in the California Supreme Court is *John's Grill, Inc. v. The Hartford Financial Services Group, Inc.*[21] In *John's Grill*, the First Appellate District considered a virus coverage endorsement which, unlike most policies found in COVID-19 coverage disputes, included an affirmative grant of coverage for "loss or damage" caused by virus, and a special definition of "loss or damage" that included the cost of structural mitigation work to remove the virus and testing for it once the work was done.[22] However, while the virus endorsement provided the potential for coverage for lost business income caused by the pandemic, the Court found it was rendered illusory by a separate clause which specified the causes of loss that would trigger the virus endorsement. The trigger clause was found to be "indecipherable when applied to viruses" because "none of the listed causes has anything to do with the biological processes that actually cause a virus."[23] Thus, while the insured had a reasonable expectation of coverage pursuant to the virus endorsement, no such coverage was actually provided.

The Supreme Court will therefore address whether such a limiting condition renders a grant of coverage illusory. It will also address whether a conditional grant of coverage for property loss or damage to covered property caused by a virus, including the cost of removal of the virus, is triggered by cleaning surfaces in the covered property that are contaminated by the virus in the absence of physical alteration of the property.

GOVERNMENT ORDERS DO NOT CONSTITUTE A PHYSICAL LOSS

In contrast to cases focused on physical alterations to the subject property, some insureds have attempted to argue that government shutdown orders caused a *functional* loss of the property. In *Starlight Cinemas, Inc. v. Massachusetts Bay Ins. Co.*,[24] the insured movie theater operator alleged that its commercial property policy covered lost business income due to suspension of operations required by government shutdown orders. (It likely framed the issue this way because its policy contained a virus exclusion.) Consistent with prior rulings holding that property must be physically altered in order to trigger coverage, the Second Appellate District, Division Seven, held that "the allegation of temporary loss of use of property resulting from pandemic-related government closure orders—without any physical loss of the property—is not sufficient."[25]

In so ruling, the *Starlight Cinemas* court expressly disagreed with *Coast Restaurant Group, Inc. v. Amguard Ins. Co.*, [26] in which the Fourth Appellate District, Division Three, found that business interruption insurance potentially covered a restaurant's losses resulting from government closure orders. According to the *Coast* court, the restaurant "suffered a covered loss under the policy because the governmental restrictions . . . deprived the appellant of important property rights in the covered property."[27] However, coverage was nonetheless barred by two exclusions: for loss or damage caused directly or indirectly by (1) "the enforcement of any ordinance or law . . . regulating the construction, use or repair of any property" and (2) any virus that "is capable of inducing physical distress, illness or disease."[28] *Starlight Cinemas* properly treats *Coast* as an outlier given the "now-existing wall of precedent" requiring direct physical loss to trigger coverage.[29]

CARRIER NOT OBLIGATED TO CONDUCT INDEPENDENT ANALYSIS OF SUITABILITY OF VARIABLE LIFE INSURANCE POLICIES FOR INSURED

In *Fischl v. Pacific Life Ins. Co.*,[30] Fischl bought variable life insurance policies, which required him to pay annual premiums that would be invested as retirement funds until withdrawn or paid out

as a death benefit, from Pacific Life Insurance Company through a broker, Acosta. The broker had investigated Fischl's financial condition and investment goals and assessed the suitability of Pacific Life's policies for him, consistent with certain "suitability standards" adopted by the insurer. Pacific Life did not independently examine its policies' suitability for Fischl, only whether the policies posed an unacceptable risk to Pacific Life. Fischl lost money on the policies and he sued Acosta.

Fischl settled with Acosta, and released Pacific Life "from all claims that result from any of Acosta's acts or omissions . . . that are negligent . . . or that result from Acosta's . . . violation of, or refusal or failure to comply with: (1) the terms of Pac[ific] Life's Producer's Contract with Acosta; or (2) any federal or state law, rule or regulation . . . except to the extent that Pac[ific] Life . . . caused, contributed to, or compounded such."[31] Fischl did not release Pacific Life from claims "for its direct conduct including, but not limited to, underwriting and marketing of its life insurance policies."[32] Fischl then sued Pacific Life.

Pacific Life moved for summary judgment, arguing Fischl's release of Acosta "bars any liability against Pacific Life based on *Acosta's* negligence in conducting the suitability analysis (which Pacific Life assumed to be negligent for purposes of the motion), and Pacific Life owes no further duty that survives the release."[33] In opposition, Fischl argued that Pacific Life had a duty to do its own analysis of his suitability for the variable life insurance policy, so Fischl's claims against Pacific Life survived his release of Acosta. The trial court granted the summary judgment motion, finding "that Pacific Life had no duty to conduct an independent suitability analysis that survived the release."[34] Division 2 of the Second District Court of Appeal affirmed.

The Court's analysis focused on section 2534.2, subd. (c), of Title 10 of the California Code of Regulations, which "obligates an insurance company to adopt and file 'Standards of Suitability' with the Insurance Commissioner as a prerequisite to 'enter[ing] into the variable life insurance business in this State.'"[35] So, the Court found, the regulation "obligates *someone* to conduct a suitability analysis before a variable life insurance policy may be recommended or issued."[36] But "it is the broker who performs the suitability analysis to determine whether a variable life insurance policy suits *the applicant*, while the insurance company accepts the broker's suitability analysis and instead performs an underwriting analysis to determine whether the policy suits *the insurance company.*"[37]

In the ordinary case, if a broker negligently conducts a suitability analysis, both the broker and the insurance company would be liable to the client, because the broker acted as the company's agent, and the company would have ratified the broker's conduct by adopting the suitability analysis. But Fischl had released the broker, so he could only recover from Pacific Life if the company had a duty to conduct its own, independent suitability analysis. The Court of Appeal, like the trial court before it, found the company had no such duty, principally based on the text of Section 2534.2(c) and canons of statutory construction.

The Court of Appeal accepted, *arguendo*, that Pacific Life had ratified Acosta's suitability analysis by issuing the policies to Fischl and taking his premiums, but because Fischl had released the company for liability for all claims *except* for "its own conduct that 'caused, contributed to, or compounded' Acosta's shortcomings or for 'its direct conduct including . . . underwriting and marketing of its life insurance policies," the Court of Appeal found the release barred Fischl's claims against Pacific Life because the company's actions did not "'cause[ ]' Acosta's defective analysis and also did not 'contribute[ ] to' or 'compound' that analysis," so its conduct fell "completely within the terms of the release."[38]

More than a primer on a relatively narrow set of insurer duties, the opinion is a cautionary tale about the perils of release language.

SUMMARY JUDGMENT FOR DISABILITY INSURER REVERSED, AS STATUTES OF LIMITATION FOR BREACH OF CONTRACT AND BAD FAITH DID NOT START TO RUN UNTIL BENEFIT PAYMENTS STOPPED

In *Bennett v. Ohio National Life Assurance Corp.*,[39] Mark Bennett was a surgeon who held disability insurance policies issued by Ohio National Life Assurance Corp. The policies provided lifetime benefit payments for total disability caused by sickness starting before age 55, and for total disability caused by injury before age 65. If the insured's total disability resulted from sickness starting on or after age 55, benefits would be paid only until the insured turned 65.

In 2006, when he was 53 years old, Bennett was thrown from a horse, injuring his left shoulder and collarbone, causing numbness and tingling in his left hand. He was able to keep working until 2014, when he stopped due to chronic pain. He filed a total disability claim with Ohio National, which approved it. On June 8, 2015, Ohio National sent Bennett a letter stating its determination that his disability was due to sickness rather than injury, so his benefit payments would end on his 65th birthday, September 3, 2018. Between June 2015 and September 2018, Ohio National made Bennett's monthly benefit payments.

"In April 2019, after reviewing previously available information as well as new information submitted by Bennett, Ohio National informed him its determination remained unchanged."[40] In August 2019, Bennett sued Ohio National for breach of contract and breach of the implied covenant of good faith and fair dealing ("bad faith"). Ohio National moved for summary judgment on statute of limitations grounds, arguing Bennett's claims accrued on June 8, 2015, when it denied his disability was due to injury, and was thus barred by the four-year and two-year statutes for breach of contract and Bad Faith, respectively.[41] "Bennett argued the time to sue did not begin to run until September 3, 2018, when he suffered actual damages in the form of losing replacement income and assets essential to his health and welfare."[42]

The trial court granted summary judgment. The First District Court of Appeal, Division 3, reversed.

The Court of Appeal noted "statutes of limitation do not begin to run until a cause of action accrues[,] . . . a cause of action accrues when it is complete with all of its elements[, and] . . . [w]here damages are an element of a cause of action, the claim does not accrue until the damages have been sustained."[43] The Court found "the elements of Bennett's causes of action were not complete until September 3, 2018, when Ohio National ceased making its monthly disability payments," which was less than two years before he sued. So, the Court "conclude[d] Bennett's breach of contract and breach of implied covenant of good faith and fair dealing claims are not barred by the statute of limitations."[44]

OVER DISSENT, UCL CLAIM AGAINST CARRIER HELD TIME-BARRED UNDER POLICY'S ONE YEAR STATUTE OF LIMITATIONS; SUPREME COURT WILL HAVE THE LAST WORD

In *Rosenberg-Wohl v. State Farm Fire and Casualty Co.*,[45] a property owner insured by State Farm filed a putative class action under the Unfair Competition Law[46] after the carrier denied her claim for the cost of repairing an outdoor staircase. Division 2 of the First District of the Court of Appeal affirmed the trial court's ruling sustaining State Farm's demurrer without leave to amend on the ground that the claim was subject to the policy's "Suit Against Us" clause providing "[t]he action must be started within one year after the date of loss or damage,"[47] and was not filed timely.

Rosenberg-Wohl, an attorney, owned a home in San Francisco with a State Farm homeowner's policy. In late 2018 or early 2019, she noticed an exterior staircase had become unsafe. In August 2019, she submitted a claim for past and anticipated costs to replace it. State Farm denied the claim two weeks later. In August 2020, its adjustor left a voice mail message saying State Farm had "reopened" the

claim and she offered to address and possibly resolve any coverage questions. The adjustor spoke with the insured's husband two weeks later, and then sent a letter advising that an investigation found no evidence of covered accidental, direct physical damage to property, and concluding the claim instead concerned uncovered preventive maintenance and safety measures.

On October 22, 2020, Rosenberg-Wohl filed two lawsuits. One alleged breach of contract and bad faith and was removed to federal court and dismissed. The other was this case, "for declaratory relief and violation of the Unfair Competition Law (UCL)[,] . . . filed by plaintiff 'on behalf of herself and those similarly situated.'"[48] Plaintiff filed an amended complaint "stating claim for unfair competition and need for public injunctive relief," to which State Farm demurred because of "another action pending," and because the action was "time-barred."[49]

At the demurrer hearing, the trial court engaged in colloquy with plaintiff's husband (also an attorney) about the nature of the public injunctive relief plaintiff sought, and he acknowledged to the Judge that relief would focus on State Farm's claims handling conduct. The court sustained State Farm's demurrers to the amended complaint with leave to amend. State Farm also demurred to the second amended complaint because "Plaintiff's claim is time-barred under her insurance policy."[50]

The trial court sustained that demurrer without leave to amend, in what the Court of Appeal called "a comprehensive order indeed, eight pages of thoughtful analysis[,] . . . concluding as follows: [¶] [T]he limitation period in the contract applies to all of plaintiff's claims, including her claim for unfair practices, false advertising, and injunctive relief because the essence of the relief sought relates to the denial of her claim."[51] As the trial court 'thoughtfully analyzed' it, the issue was whether the UCL claim was "'on the policy,' meaning that it seeks to recover policy benefits *or is grounded upon a failure to pay policy benefits*."[52] The judge conceded the plaintiff was not claiming policy benefits, but the "claims are nonetheless 'on the policy' because they are 'grounded upon [State Farm's] failure to pay policy benefits.'"[53]

Two out of three Justices of the Court of Appeal agreed with the trial court. They looked "to the nature of the obligation allegedly breached" and concluded "[t]he alleged acts that form the basis of plaintiff's UCL claim occurred during the claims handling process[, and] . . . the gravamen of plaintiff's claim arises out of the contractual relationship. It is within the one-year limitation provision."[54]

The majority discussed seven cases, four from the California courts of appeal and three decisions of federal courts (two unpublished, but "citable"[55]), to arrive at the conclusion that "the crux of plaintiff's claim is grounded upon a failure to pay policy benefits. That claim necessarily arises out of the contractual relationship."[56]

There is an undercurrent of apparent irritation in the majority opinion. For example, a footnote quotes an allegation from the federal case that the plaintiff understood "some portion of the staircase had just settled," followed by the statement that "[w]e cannot help but note that one of the perils excluded by the policy is loss by 'settling.'"[57] The next footnote reports, while discussing plaintiff's counsel's colloquy with the trial judge, that "[a]t oral argument here, Mr. Rosenberg-Wohl could not answer whether any such injunction would be mandatory or prohibitory. And, we hasten to add, at no point along the way has he as much as suggested how the superior court would monitor any such injunction."[58] A later footnote criticizes the plaintiff for stating in her opening brief that State Farm had "expressly" waived the limitation provision, even though "one looks at [the cited evidence] in vain for any allegation of 'in writing.'"[59] And the injunction plaintiff's counsel described "hardly merits injunctive relief. It is good old-fashioned bad faith law, already on the books–law well known to State Farm."[60]

The majority also found that "substantive UCL law, . . . plaintiff's express statements to the contrary notwithstanding, demonstrate [*sic*] that plaintiff is seeking–indeed, *must* be seeking–policy benefits,"

because the law requires a UCL claimant to prove he or she "has lost money or property as a result of the unfair competition."[61] "The standing requirement is intended to preserve standing for those who had 'business dealings with a defendant and had lost money or property as a result of the defendant's unfair business practices.'"[62] "Put bluntly," the Court concluded, "plaintiff must prove 'policy benefits.'"[63]

Finally, the Court concluded State Farm had not "magically"[64] waived the limitation provision by reopening the denied claim, because "[c]onduct by the insurer after the limitation period has run . . . cannot, as a matter of law, amount to a waiver or estoppel."[65]

Justice Miller dissented. She agreed with the majority on the issue of waiver, but concluded the one-year limitation did not apply to the UCL claim. The dissent noted this was a case of first impression in California. Although she recognized "the optics of this case provide a tempting basis to mistake this UCL claim for something that it is not," Justice Miller disagreed with the majority's "conclusion that plaintiff's UCL claim is grounded upon a failure to pay policy benefits, and that what she is seeking to recover in this case is (and '*must* be') policy benefits."[66]

As Justice Miller saw it, the UCL claim was not an action "on" the insurance policy, and was "governed by the UCL's four-year limitations period," not the one-year period under the policy and Section 2071.[67] According to the dissent, "[t]he 'crux' of plaintiff's lawsuit is that State Farm is marketing homeowner's insurance to the public, promising benefits on defined terms, while its claims adjustment process is, by design, so superficial (little to no investigation) and obscure (no communication with insureds about the basis for denials) that it manages to avoid paying out on all but the claims that are obviously covered."[68] The plaintiff sought prospective injunctive relief against State Farm's alleged practices, protecting all its customers, not just her. And she did "not seek damages at all, much less damages recoverable under the policy."[69]

Justice Miller proposed to "refrain from prejudging the legal viability of plaintiff's UCL claim . . . because the issue is complicated and it is by no means clear the claim is not legally viable. '[C]ommon law [insurance] bad faith claims provide a viable basis for a UCL action.'"[70]

To Justice Miller, the UCL claim was:

> "not a claim based on the insurance policy itself and does not even depend on whether plaintiff's stairway repairs ultimately fall within policy coverage. As a policyholder, plaintiff seeks merely to vindicate the consumer public's interest in transparency and fair practices, so that no State Farm insured will have to go to extraordinary lengths just to ascertain and resolve whether coverage exists for a particular loss. This lawsuit is not a disguised attempted [*sic*] to recover (or even litigate) any policy benefits. It seeks only to compel State Farm to reform the way it conducts business with its customers."[71]

The dissent reinforced its analysis by pointing to the UCL's unique scope and purpose, barring compensatory damages and limiting recovery to restitution and injunctive relief, "to prevent further harm to the public at large rather than to redress or prevent injury to a plaintiff."[72]

In the absence of controlling California authority, Justice Miller cited to an opinion of the Connecticut Supreme Court holding an unfair practices claim under that state's statutory counterpart to Business & Prof. Code secs. 17200, et seq., "was *not* an action on an insurance policy and thus not subject to a one-year limitations provision identical to the one at issue here."[73]

In closing, the dissent described the trial court's error in concluding the policy's one year limitations clause governed the UCL claim:

> "This lawsuit seeks nothing but public injunctive relief to reform the way an

> insurance company conducts business with its policyholders, premised not on any contractual rights belonging to any insured under their policy of insurance but on a statutory remedy for 'unfair' business practices under the UCL. It does not seek any remedy intended to vindicate the plaintiff's private, individual rights under her insurance policy. At most, it is an action that *concerns* her insurance policy (and countless others). Regardless of whether there is merit to the claim or State Farm may ultimately prevail on defenses such as lack of statutory standing, it is not a claim 'on' the policy. And thus it is not time-barred."[74]

On October 18, 2023, the Supreme Court granted the plaintiffs' petition for review, on the following limited issue:

> When a plaintiff files an action against the plaintiff's insurer for injunctive relief under the Unfair Competition Law, which limitations period applies, the one-year limitations period authorized by Insurance Code section 2071 or the four-year statute of limitations in Business and Professions Code section 17208?[75]

The Supreme Court denied the request to depublish the opinion, and further instructed that "[p]ending review, the opinion of the Court of Appeal . . . may be cited, not only for its persuasive value, but also for the limited purpose of establishing the existence of a conflict in authority that would in turn allow trial courts to exercise discretion under Auto Equity Sales, Inc. v. Superior Court (1962) 57 Cal.2d 450, 456, 20 Cal.Rptr. 321, 369 P.2d 937, to choose between sides of any such conflict."[76]

Stay tuned.

THIRD PARTY POLICIES

SUMMARY JUDGMENT FOR HOMEOWNERS INSURER REVERSED, BASED ON HOLDING THAT CARRIER OWED DUTY-UNDER TWO THEORIES-TO DEFEND FRIVOLOUS OR GROUNDLESS CLAIMS WHERE IT CONDUCTED MINIMAL INVESTIGATION THAT DID NOT ELIMINATE POTENTIAL FOR COVERAGE

Perhaps this year's friendliest opinion for policyholders was *Dua v. Stillwater Ins. Co.*[77] Dua had a homeowner's insurance policy from Stillwater Insurance Company. She and her boyfriend were sued for emotional distress dog owners allegedly suffered when Dua's boyfriend's dogs attacked dogs belonging to Mr. and Mrs. Peroff. Dua was not present during the alleged attack, which allegedly occurred on a public street not Dua's home, and she did not own the dogs that allegedly attacked. The complaint alleged the dogs lived at Dua's home and she knew they were dangerous but breached a duty of care to take measures to prevent a foreseeable attack. Dua tendered the claim to Stillwater, which denied it based on an "Animal Liability Exclusion endorsement," excluding coverage for bodily injury caused by or related to an animal owned by or in the care, custody, or control of the insured or her family or household member.

Dua settled the Peroffs' case and sued Stillwater for breach of contract and bad faith, alleging Stillwater failed to conduct an adequate investigation of the claims against her and unreasonably and narrowly interpreted the policy. Because it did not reasonably investigate, Dua alleged, Stillwater failed to "discover[ ] the following facts: (1) she was not married to Taylor; (2) Taylor did not live with her nor was he staying with her at the time of the dog attack; (3) the attack did not occur on her premises; and (4) at the time of the dog attack, the dogs were leashed and under the care, custody, and control of Taylor."[78]

Stillwater moved for summary judgment, arguing "that if Dua lacked ownership, care, custody, or control of the dogs, then there is no possibility that Dua could be held liable under the Peroffs' complaint

[and] . . . if Dua did have ownership, care, custody, or control of the dogs, then there would be no coverage under the policy because Exclusion 1 would apply."[79] The trial court granted summary judgment. Division 2 of the Second District Court of Appeal reversed, in both majority and concurring opinions.

The majority opinion pointed out that Stillwater's denial ignored the facts Dua provided that suggested the animal exclusions did not apply because she did not own the dogs and they were not in her care, custody, or control. The Court noted that, because Dua's facts "suggest[ed] a claim potentially covered by the policy, the insurer's duty to defend arises and is not extinguished until the insurer negates all facts suggesting potential coverage. There is no evidence," the majority continued, "that Stillwater took any measures to investigate or otherwise negate the facts suggesting an animal liability exclusion may not apply and there was potential coverage, and therefore it had a duty to defend Dua."[80]

The majority faulted Stillwater for "conflat[ing] the possibility of Dua's liability with Stillwater's duty to defend. Even if Dua cannot be found legally liable under the Peroffs' complaint as pleaded, and is therefore not entitled to indemnity coverage under the policy, Stillwater may still be required to defend her."[81]

The insurance company's argument seems to have distracted the trial court from this simple but important distinction. Stillwater focused on facts that would be required either to defeat or prevail on the claims, rather than facts that could establish the potential for coverage at the time of tender. That perspective allowed Stillwater to evade its duty to defend until the Court of Appeal properly framed the analysis.

The majority found that "Stillwater has not established that there was no conceivable theory to bring the third party complaint within the possibility of coverage, and the facts Dua provided to Stillwater suggested there may be coverage," so it reversed the summary judgment on Dua's cause of action for breach of contract.[82] The majority also reversed on the bad faith claim, because "Dua has introduced facts giving rise to a material dispute of fact as to whether Stillwater unreasonably or improperly failed to defend when it was presented with facts suggesting that the animal liability exclusions did not apply."[83] The majority quoted the California Supreme Court's holdings in *Wilson v. 21*st *Century Ins. Co.*,[84] that "an 'insurer is not entitled to judgment as a matter of law where . . . a jury could conclude that the insurer acted unreasonably' and '[a] trier of fact may find that an insurer acted unreasonably if the insurer ignores evidence.'"[85]

In her concurring opinion, Justice Ashmann-Gerst agreed the trial court erred in granting Stillwater's motion for summary judgment, but she analyzed the issue differently. Her concurrence took another view of erroneously "conflating" the insurer's duty to defend with its insured's exposure to potential liability.

Starting from the rule that "[t]he insurer must defend any claim that would be covered if it were true, even if in fact it is groundless, false, or fraudulent," the concurrence cited authority obligating the insurer "to defend the insured when sued in any action where the facts alleged in the complaint support a recovery for an 'occurrence' covered by the policy, regardless of the fact that the insurer has knowledge that the injury is not in fact covered."[86] The concurring opinion observed that "the insurer may not decline to defend a suit merely because it is devoid of merit, but instead must assert appropriate defenses on the insured's behalf in the underlying action,"[87] as long as the complaint alleges damages that are of the "nature and kind of *risk covered by the policy*."[88]

Even if Dua did not have ownership, care, custody, or control of the dogs, the concurring opinion pointed out, the complaint alleged she knew the dogs were dangerous and she did nothing to prevent the attack. "While this potential theory of liability may be a stretch under the current state of the law [which has explicitly rejected the concept of universal duty], that is not to say there was *no* potential for indemnity."[89]

Because there was a possibility a court could have found Stillwater's insured liable under a novel theory premised on her duty to take steps to prevent foreseeable injury and damage, the underlying "claim would have fallen within the scope of the nature and kind of risk covered by Dua's policy [and would not implicate the animal liability exclusion because it does not arise out of Dua's ownership, custody, control, or care of the dogs]."[90]

Stillwater was obligated to defend its insured against groundless claims, so the concurrence agreed the insurer had failed to negate all facts suggesting potential coverage and was not entitled to summary judgment or summary adjudication of either the breach of contract or bad faith cause of action.

INSURED'S INDEMNITEE HAS NO THIRD PARTY BENEFICIARY RIGHTS UNDER "INSURED CONTRACT" PROVISION OF CGL POLICY

In a case with far reaching implications, particularly for the construction industry, the Third Appellate District found in *LaBarbera v. Security National Ins. Co.*[91] that an insured's contractual indemnitee had no direct right of action against the insurer, even though the policy provided coverage for liability assumed in an "insured contract." LaBarbera hired Knight Construction to remodel his house. Pursuant to the construction contract, Knight agreed to defend and indemnify LaBarbera for claims arising out of the work.[92] A subcontractor was severely injured on the job, and sued both LaBarbera and Knight.

Knight was defended by its insurer, Security National, and LaBarbera was defended under his own policy issued by Certain Underwriters at Lloyds ("Underwriters"). LaBarbera's tender to Security National was initially denied because he was not named as an additional insured. However, LaBarbera (and Underwriters) continued to demand a defense, pointing out that the indemnity clause constituted an "insured contract" under the Security National policy.[93] After LaBarbera and Underwriters paid $465,000 to settle the underlying case and $100,000 in defense costs, they sued Security National for breach of contract and subrogation, among other things.[94]

While the Security National policy contained an exclusion for contractual liability, under the "insured contract exception," liability assumed in an "insured contract," including reasonable attorney's fees, is "deemed to be damages because of bodily injury."[95] As such, any payments for such assumed liability reduce policy limits. However, the Supplementary Payments provision of the policy contains an "indemnitee defense clause," pursuant to which Security National will defend a contractual indemnitee so long as, among other things, no conflict exists, and both the indemnitee and the insured ask to be defended and agree to use the same defense counsel.[96] Such defense costs do not reduce the policy limits.

While the parties agreed that the indemnity provision constituted an insured contract, Security National contended that LaBarbera was not an intended third party beneficiary and therefore lacked standing to sue. The Court of Appeal agreed, upholding summary judgment in favor of Security National. While the Court acknowledged that LaBarbera was an incidental beneficiary of the Security National policy, it found that he was not an intended beneficiary. Rather, the intent and purpose of the indemnitee defense clause was to benefit the insured and insurer, not the indemnitee. Quoting a case from Wisconsin as persuasive authority,[97] the Court reasoned that "it is in the insured's interest to have the insurer pay for the indemnitee's defense without having that payment reduce payments from the insurer for the tort liability the insured has assumed; and it is in the insurer's interest to minimize its obligation with the efficiency of a combined defense where feasible and where agreeable to the insured."[98] The *LaBarbera* court also noted that the insured must also consent to joint defense, thus giving it veto power over whether any benefit is conferred on the indemnitee.[99] Accordingly, LaBarbera was not an intended third party beneficiary and had no standing to sue under the policy. The lesson for contractual indemnitees (such as property owners): require an additional

insured endorsement; the insured contract exception does not guarantee a defense.

CONSENT DECREE TRIGGERS NO VOLUNTARY PAYMENTS PROVISION OF CGL POLICY, BARRING COVERAGE FOR ENVIRONMENTAL CLEAN-UP

In *Santa Clara Valley Water District v. Century Indemnity Co.*,[100] federal authorities notified a municipal water district of environmental claims. The district tendered the claims to its insurance carrier, which denied tender because there was no lawsuit filed, but asked the district to keep it informed. The district negotiated with the authorities and agreed to a consent decree on which a judgment was entered, without the carrier's knowledge or involvement. After the district finished its work under the decree, it tendered a claim to the insurance company for clean-up costs. The insurance company denied the claim because it contended the consent decree violated the policies' No Voluntary Payments clause (NVP) that the insured "shall not, except at [its] own cost, voluntarily make any payment, assume any obligation or incur any expense."[101] The district sued the insurance company for breach of contract and bad faith but the trial court granted the insurance company's motions for summary judgment and summary adjudication. The Sixth District of the Court of Appeal affirmed.

In August 2000, the U.S. Dept. of Interior's Fish & Wildlife Service notified Santa Clara Valley Water District of potential claims for natural resource damages ("NRD"). Fish & Wildlife "advised the District it would file a lawsuit against it and others seeking approximately $40 million if the District refused to sign a tolling agreement and work toward an informal resolution of the NRD claim."[102] The District submitted the claim to Century Indemnity Co., which had issued primary and excess insurance policies. Century initially responded that coverage issues might warrant further investigation and asked the District for further information about the status of its negotiations with Fish & Wildlife and of investigation and remediation at the site. In May 2001, the carrier advised the District that there was no duty to defend because no lawsuit had been filed.

Meanwhile, the District made a tolling agreement with Fish & Wildlife and commenced investigating and negotiating. In May 2002, Century sent a letter to the District, reserving its rights "under the terms, conditions, and provisions of the policies."[103] In about May 2005, without advising Century, the District signed a consent decree obligating it to clean up the damages; in July 2005, Fish & Wildlife filed a lawsuit, and the consent decree; and in November 2005, the court entered judgment on the consent decree. The District first notified Century Indemnity of the lawsuit and the consent decree in 2008, and tendered a claim for $4 million in clean-up costs to date. Century responded by reiterating its reservation of rights, and for the first time "alluding to the NVP provisions in the policies—that '[t]he policies may not provide coverage to the extent that the policyholder voluntarily made or makes any payment, assumed or assumes any obligation, or incurred or incurs any expense without our prior consent, as may be required by the policies.'"[104]

In 2014, when the District completed its work under the consent decree, it wrote to Century, detailing the work and costs, for which Century refused to reimburse the District. The District sued Century for breach of contract and bad faith. Century moved for summary adjudication and then summary judgment, based on the NVP clauses in Century's primary policies and similar provisions of the excess policies that "permitted reimbursement where 'the amount of ultimate net loss becomes certain through trial court judgment or agreement among the Insured, the claimant and [the Insurer]" and "'ultimate net loss' is defined . . . as 'the sum actually paid or payable in cash in the settlement or satisfaction of losses for which the Insured is liable either by adjudication or compromise with the written consent of [the Insurer].'"[105]

The trial court granted Century's motions, finding it had no obligation to indemnify the District under any of the policies, because the District entered into the consent decree voluntarily, and concluding "[The District] could have provided notice to [Century] prior to entering into the consent decree and that would have given [Century] the option to

negotiate or decline to participate. This would have satisfied [the District's] obligations under the NVP provision."[106]

On appeal, the District argued it had not voluntarily agreed to the consent decree, but sought to be reimbursed under the policies for an "ultimate net loss[: the] sum actually paid or payable in cash in the settlement or satisfaction of losses for which the Insured [was] liable . . . by adjudication,"[107] since the court in the underlying action had entered judgment on the consent decree. The Court of Appeal rejected that argument, finding, "[i]t cannot be reasonably concluded that the procedure employed here by [Fish & Wildlife] and the District (i.e., the District's pre-suit execution and later filing of the Consent Decree), involved '[t]he process of judicially deciding a case[, and was] an 'adjudication' in the sense that it was 'submitted to the trial court for its consideration in deciding a substantive matter in that action.'"[108]

"Rather," the Court of Appeal continued, "it was a 'case' in which the outcome was determined consensually by the parties before it was even filed with the court."[109] The Court of Appeal cited authority from the California Supreme Court, quoting the U.S. Supreme Court, that although "consent decrees bear some of the earmarks of judgments entered after litigation[, a]t the same time, because their terms are arrived at through mutual agreement of the parties, consent decrees also closely resemble contracts.' Their 'most fundamental characteristic,' however, is their 'voluntary nature.'"[110]

The source of the court's authority to enter judgment was the consent decree, an "agreement of the parties, rather than the force of the law upon which the complaint was originally based, that creates the obligations embodied in a consent decree."[111] The Court of Appeal concluded the consent decree was a settlement or, in the words of Century's policies, a compromise without the written consent of the insurer.

The District argued the NVP clause was an exclusion that the court must strictly construe against Century.[112] It is not clear how this rule, or its corollary that the language about "ultimate net loss" was an exception to an exclusion to be construed broadly in the District's favor, would have helped the District, since the Court of Appeal found the District had voluntarily assumed the consent decree's obligations rather than having had them imposed by trial court judgment. In any event, the Court of Appeal dismissed that argument, too, characterizing NVP as "a term and condition prohibiting the insured from making a voluntary payment or a voluntary undertaking of liability, rather than an exclusion that removes from coverage certain risks under the policy."[113]

The District also contended that after it gave notice of the claim in August 2000, Century's May 2001 response was an election not to participate in the District's defense, as a result of which, since "Century refused to defend," "it lost any contractual right to control the handling of that claim."[114] But the Court of Appeal held "Century's letter did not constitute a 'refus[al] to defend'" because at that time Century had no duty to defend under the primary policies since "the insured [had not] tender[ed] defense of the third party lawsuit to the insurer," and Century had no duty to indemnify under the excess policies because "there was nothing at the time of the tender to indicate that the primary policies had been or would be exhausted by a money judgment."[115]

The Court of Appeal acknowledged, "[i]t is true that an insurer's wrongful denial of a defense or coverage is a breach of contract, and in such instance, the insured, if it achieves a reasonable settlement of the third-party claim against it may seek reimbursement from the insurer as damages."[116] "But here," the Court observed, "there was no wrongful denial of defense or coverage by Century. And–contrary to the District's argument–Century's notification in its May 31, 2001 letter that its obligations for defense and indemnification under the primary and excess policies had not yet ripened did not constitute an 'elect[ion] not to participate in the defense of the NRD Claim'."[117]

The opinion did not address Century's failure to cite to the NVP clause in the reservation of rights letter it sent reserving rights generally "under the terms, conditions, and provisions of the policies" in May 2002, when it knew the District was negotiating with Fish & Wildlife. By the time the insurance company did assert NVP as a bar to coverage, the District had already made the consent decree. This may be the reason the Court of Appeal took pains in its opinion to distinguish NVP as a condition rather than an exclusion.

Century's reservation under "terms, conditions, and provisions" ended up doing a lot of work for the insurer. For insureds, the opinion is a lesson in communicating with carriers before agreeing to resolve a claim, even if the resolution includes entry of judgment.

MOTOR CARRIER LIABILITY COVERAGE

EXPIRATION OF TRUCKER'S AUTO LIABILITY INSURANCE IS GOVERNED BY POLICY PERIOD, NOT WHETHER THE INSURER HAS SUBMITTED NOTICE OF CANCELLATION TO THE DMV

In its only insurance decision of the year, *Allied Premier Ins. v. United Financial Casualty Co.*,[118] the California Supreme Court decided the rather esoteric question of whether a commercial automobile liability policy continues in full force and effect until the insurer cancels the corresponding certificate of insurance on file with the Department of Motor Vehicles. Such policies are governed by California's Motor Carriers of Property Permit Act ("the MCPPA").[119] The MCPPA requires commercial truckers to submit proof of financial responsibility to secure a DMV permit, typically by obtaining insurance. The insurer in turn must submit a certificate of insurance to the DMV.[120] The certificate of insurance cannot be cancelled without notice to the DMV by the insurer.[121] When the policy lapses or is terminated, the DMV must suspend the carrier's permit unless the motor carrier provides evidence of new insurance coverage.[122]

United Financial Casualty Co. ("United") provided coverage for commercial trucker Jose Porras from May 2, 2013 through April 12, 2015. During that period, the DMV returned United's cancellation notice as an "incomplete filing."[123] Effective April 13, 2015, Porras was insured with Allied Premier Insurance ("Allied"). On September 1, 2015, Porras was involved in a fatal car accident. Allied settled the underlying plaintiff's claim for $1 million, and then sued United for equitable contribution, arguing that the United policy remained in effect because the DMV had rejected its cancellation notice.[124]

Allied relied on a prior Supreme Court decision, *Transamerica Ins. Co. v. Tab Transportation, Inc.*,[125] which was decided under a since-repealed permitting system codified in the Public Utilities Code. However, the *Allied* court distinguished *Transamerica* because the prior statutory scheme specifically prohibited cancellation of an insurance *policy* without notice, whereas the MCPPA only prohibits cancellation of a *certificate of insurance* without notice. While cancellation of a certificate triggers the DMV's obligation to suspend the motor carrier's permit, the MCPPA does not say that the underlying policy remains active beyond the policy period.[126] The *Allied* court thus found that the duration of the policy's coverage is regulated by its terms, not whether a cancellation notice has been properly filed.

TRUCKER'S AUTO LIABILITY POLICY WHICH PROVIDED LESS THAN $750,000 MINIMUM COVERAGE COULD NOT BE REFORMED TO PROVIDE GREATER COVERAGE

In *Infinity Select Ins. Co. v. Superior Court*,[127] a trucker was issued a $50,000 automobile liability policy by Infinity Select Insurance Company ("Infinity Select"). The trucker was sued for wrongful death by plaintiffs following a three-vehicle collision. Plaintiffs demanded $750,000 to settle on the theory that the trucker was required to maintain that amount of coverage. After that demand was rejected, plaintiffs settled with Infinity Select, which paid its policy limits of $50,000. The parties further agreed that plaintiffs' overall damages exceeded $3.5 million,

and that plaintiffs would be assigned the trucker's bad faith claim against Infinity Select for failure to settle within policy limits.[128] This settlement demonstrated remarkable confidence by Infinity Select in the soundness of its position.

The plaintiffs then sued Infinity Select to collect on its "assumed judgment" under Insurance Code section 11580, among other claims. In the first phase of a bifurcated trial, the lower court reformed the Infinity Select policy to provide policy limits of $750,000. Infinity Select filed a petition for writ of mandate, which was granted by the Fifth Appellate District.[129]

The *Infinity* court began its analysis by noting that the MCPPA requires a motor carrier to obtain evidence of financial responsibility. Proof of financial responsibility may take the form of a certificate of insurance, surety bond, or certificate of self-insurance.[130] The motor carrier must provide not less than $750,000 in protection for any one accident.[131]

However, the Court found no basis to reform the Infinity Select policy to increase the policy limits to comply with the statutory minimum. First, the Court reasoned that the MCPPA imposes obligations on motor carriers to obtain insurance, not insurers.[132] While the MCPPA imposes certain requirements on insurers who have filed a certificate of insurance with the DMV, such as notice of cancellation, these obligations do not apply to an insurer that has not filed a certificate such as Infinity Select.[133] Second, a motor carrier "may meet its MCPPA insurance obligations by purchasing more than one policy so long as the aggregate limits of the policies procured total $750,000."[134] Where an insurer like Infinity Select provides coverage less than the statutory minimum, it is up to the insured motor carrier to secure additional insurance in order to comply. Finally, the MCPPA provides other ways to comply with its financial responsibility requirements, and Infinity Select was not obligated to ensure that the insurance requirements were met.[135] Thus, Infinity Select's gamble paid off and it made law helpful to the trucking insurance industry in the process.

INSURER V. INSURER

JUDGMENT FOR CGL INSURER AGAINST WORKERS COMPENSATION CARRIER REVERSED, HOLDING NO RIGHT TO EQUITABLE CONTRIBUTION BECAUSE PARTIES DIDN'T INSURE THE SAME RISK

California Capital Ins. Co. v. Employers Comp. Ins. Co., [136] arose from a suit against La Sirena Grill for injuries a passenger suffered in a car its employee was driving drunk. Although the complaint did not allege it, discovery disclosed the plaintiff was also a La Sirena employee. Whether he was acting in the course and scope of his employment at the time of the accident remained contested when La Sirena's commercial general liability insurer, California Capital Insurance Company, paid $2 million to settle the claim. California Capital then sued La Sirena's worker's compensation ("WC") carrier, Employer's Compensation Insurance Company ("ECIC"), for equitable contribution.

At a bench trial, the judge found the employee's underlying claim was potentially covered under the ECIC policy and awarded California Capital half of its costs of defense, plus $1 million and interest.[137] The trial court denied ECIC's motion to set aside the judgment, despite acknowledging the California Capital and ECIC policies were "mutually exclusive" and ECIC generally had no duty to cover civil suits under its workers compensation policy, concluding "this general rule must give way where its uncritical application would work a hardship."[138] Division 3 of the Fourth District of the Court of Appeal reversed.[139]

"Equitable contribution . . . is a loss sharing procedure by which an insurer that defended and settled a claim against its insured may seek to apportion those costs among coinsurers who refused to settle or defend the claim."[140] An insurer is equitably entitled to contribution for loss payments that exceed its proportionate share only from another insurer that "share[s] the same level of liability on the same risk as to the same insured."[141] The Court of Appeal found California Capital's CGL policy did not cover the same risk as ECIC's WC policy. "California

Capital's CGL policy covers bodily injury claims *unless* the claimant is an employee injured in the course and scope of his employment, whereas ECIC's workers' compensation and employers' liability policy covers bodily injury claims *only if* the claimant is an employee injured in the course and scope of his or her employment."[142] Because the California Capital and ECIC policies did not cover the same risk, California Capital had no equitable right to contribution from ECIC.

ECIC's policy had two parts; Part One covered workers compensation claims and Part Two "covered bodily injury claims by employees arising out of and in the course of their employment . . . if not otherwise covered by workers' compensation."[143] Although "these two kinds of coverage are mutually exclusive," the Court of Appeal quoted the explanation of the California Supreme Court that "they are meant to be read together."[144]

The Court of Appeal, again citing the Supreme Court, described Part Two "as a gap-filler, providing protection to the employer in those situations where the employee has a right to bring a tort action despite the provisions of the workers' compensation statute or the employee is not subject to the workers' compensation law."[145] Part Two coverage is triggered in such "rare situations" as where "the injury was proximately caused by a willful physical assault by the employer[,] . . . aggravated by the employer's fraudulent concealment of its existence[,] . . . proximately caused by a defective product manufactured by the employer[,] . . . or . . . proximately caused by the employer's knowing removal of, or knowing failure to install, a point of operation guard on a power press."[146] No allegations or facts in the underlying lawsuit suggested any of those "rare exceptions to the workers compensation exclusivity doctrine apply here."[147]

California Capital argued Part Two applied because there was a possibility the underlying plaintiff was acting in the course and scope when injured. The Court of Appeal pointed out that if the plaintiff's injury had occurred during the course and scope of his employment, "his exclusive remedy would have been to file a workers' compensation claim, and his civil suit against his employer would have been statutorily barred by the workers' compensation exclusivity doctrine."[148]

Because there was no theory that would bring the plaintiff's claims within ECIC's coverage, ECIC owed no duty to defend or indemnify, and California Capital had no right to equitable contribution from ECIC.

ENDNOTES

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1. (2023) 92 Cal.App.5th 1297 ("*Wong*").
2. *Id.* at p. 1302.
3. (2010) 187 Cal.App.4th 766.
4. *Wong*, *supra*, 92 Cal.App.5th at p. 1317.
5. *Id.* at p. 1307.
6. *Id.* at p. 1319.
7. *Id.* at p. 1320.
8. *Id.* at p. 1324.
9. (9th Cir. 2021) 15 F.4th 885.
10. (2021) 71 Cal.App.5th 688.
11. (2022) 81 Cal.App.5th 96.
12. (9th Cir. 2022) 56 F.4th 730 ("*Another Planet*").
13. *See, e.g.*, *Shusha, Inc. v. Century-National Ins. Co.* (2022) 87 Cal.App.5th 250 (allegation that COVID-19 physically altered premises sufficient to withstand demurrer); *Endeavor Operating Co., LLC v. HDI Global Ins. Co.* (2023) 96 Cal.App.5th 420 (allegation that viral particles were deposited onto or absorbed into the surfaces of policyholder's properties insufficient to withstand demurrer).
14. (2023) 88 Cal.App.5th 696 ("*Best Rest*")
15. *Id.* at pp. 699-200.
16. *Id.* at p. 702.
17. *Ibid.*
18. *Id.* at p. 707.
19. *Ibid.*

20. *Id.* at p. 711.
21. (2022) 86 Cal.App.5th 1195 (review granted) ("*John's Grill*").
22. *Id.* at p. 1215.
23. *Id.* at p. 1221.
24. (2023) 91 Cal.App.5th 24 ("*Starlight Cinemas*").
25. *Id.* at p. 38.
26. (2023) 90 Cal.App.5th 332 ("*Coast*").
27. *Id.* at p. 340.
28. *Id.* at p. 337.
29. *Starlight Cinemas*, *supra*, 91 Cal.App.5th at p. 38.
30. (2023) 94 Cal.App.5th 108.
31. *Id.* at p. 118 (internal quotations omitted).
32. *Ibid.*
33. *Ibid.*
34. *Id.* at pp. 118-119.
35. *Id.* at p. 122.
36. *Ibid.*
37. *Id.* at pp. 122-123.
38. *Id.* at pp. 130-131.
39. (2023) 92 Cal.App.5th 723 ("*Bennett*").
40. *Id.* at p. 727.
41. Code Civ. Proc. §§ 337(a), 339(1).
42. *Bennett*, *supra*, 92 Cal.App.5th at p. 727.
43. *Id.* at pp. 728-729, citing *Fox v. Ethicon Endo-Surgery, Inc.* (2005) 35 Cal.4th 797, 806; *Thomson v. Canyon* (2011) 198 Cal.App.4th 594, 604 (internal quotations omitted).
44. *Id.* at p. 733.
45. (2023) 93 Cal.App.5th 436 ("*Rosenberg-Wohl*").
46. Bus. & Prof. Code § 17200, et seq.
47. This provision is part of the standard form adopted by Ins. Code § 2071 for "insurance policies providing fire insurance on California property."
48. *Rosenberg-Wohl*, *supra*, 93 Cal.App.5th at p. 442.
49. *Ibid.*
50. *Id.* at p. 445-446.
51. *Id.* at p. 446.
52. *Ibid.*
53. *Id.* at p. 447.
54. *Id.* at p. 449.
55. *Id.* at p. 451, fn. 6.
56. *Id.* at p. 452 (citations and internal quotations omitted).
57. *Id.* at p. 441, fn. 2.
58. *Id.* at p. 443, fn. 3.
59. *Id.* at p. 456, fn. 7.
60. *Id.* at p. 452.
61. *Id.* at p. 453, quoting Business & Professions Code § 17204.
62. *Id.* at p. 454, quoting *Kwikset Corp. v. Superior Court* (2011) 51 Cal.4th 310, 321.
63. *Ibid.*
64. *Id.* at p. 456.
65. *Id.* at p. 455.
66. *Id.* at p. 458 (dissenting opinion) (internal quotations and citations omitted).
67. *Id.* at p. 459 (dissenting opinion).
68. *Id.* at p. 460 (dissenting opinion).
69. *Ibid.*
70. *Id.* at p. 461, fn. 9 (dissenting opinion) (quoting *Zhang v. Superior Court* (2013) 57 Cal.4th 364, 381).
71. *Id.* at pp. 460-461 (dissenting opinion).
72. *Id.* at p. 463 (dissenting opinion).
73. *Id.* at p. 464 (dissenting opinion), citing *Lees v. Middlesex Ins. Co.* (1991) 219 Conn. 644; 594 A.2d 952.
74. *Id.* at p. 465 (dissenting opinion).
75. (2023) 536 P.3d 737; 314 Cal.Rptr.3d 192.
76. *Ibid.*
77. (2023) 91 Cal.App.5th 127 ("*Dua*").
78. *Id.* at p. 134.
79. *Ibid.*
80. *Id.* at p. 137.
81. *Id.* at p. 138.
82. *Ibid.*
83. *Id.* at p. 139.
84. (2007) 42 Cal.4th 713 ("*Wilson*").
85. *Dua*, *supra*, 91 Cal.App.5th at p. 139, quoting *Wilson*, *supra*, 42 Cal.4th at p. 721.
86. *Id.* at p. 141 (concurring opinion), citing *Borg v. Transamerica Ins. Co.* (1996) 47 Cal.App.4th 448, 455.
87. *Ibid*, citing *Montrose Chemical Corp. v. Superior Court* (1993) 6 Cal.4th 287, 298.
88. *Ibid*, citing *Westoil Terminals Co., Inc. v. Industrial Indemnity Co.* (2003) 110 Cal.App.4th 139, 153.
89. *Id.* at p. 142, fn. 2 (concurring opinion).

90. *Id.* at p. 143, fn. 3 (concurring opinion).
91. (2023) 86 Cal.App.5th 1329 (“*LaBarbera*”).
92. *Id.* at p. 1333.
93. *Id.* at p. 1336.
94. *Ibid.*
95. *Id.* at p. 1334.
96. *Id.* at pp. 1335-36.
97. *Berg v. Gulf Underwriters Ins. Co.* (2008) 313 Wis.2d 522,
98. *LaBarbera*, *supra*, 86 Cal.App.5th at p. 1343.
99. *Id.* at p. 1344.
100. (2023) 89 Cal.App.5th 1016, 1028 (“*Santa Clara Valley*”).
101. *Id.* at p. 1028.
102. *Id.* at p. 1031.
103. *Id.* at p. 1029.
104. *Id.* at p. 1030.
105. *Id.* at p. 1032.
106. *Id.* at p. 1048, fn. 16.
107. *Id.* at p. 1042.
108. *Id.* at p. 1043.
109. *Ibid.*
110. *Ibid.*, citing *Aerojet-General Corp. v. Transport Indem. Co.* (1997) 17 Cal.4th 38, 66-67, quoting *Firefighters v. Cleveland* (1986) 478 U.S. 501.
111. *Ibid.*
112. *See*, *e.g.*, *Minkler v. Safeco Ins. Co.* (2010) 49 Cal.4th 315, 322; *Miller v. Elite Ins. Co.* (1980) 100 Cal.App.3d 739, 751.
113. *Santa Clara Valley*, 89 Cal.App.5th, *supra*, at p. 1045.
114. *Id.* at p. 1047.
115. *Ibid.*
116. *Id.* at p. 1048, citing *Isaacson v. California Ins. Guarantee Assn.* (1988) 44 Cal3d 775, 791.
117. *Ibid.*
118. (2023) 15 Cal.5th 20 (“*Allied*”).
119. Vehicle Code § 34600 *et seq.*
120. Vehicle Code § 34631.5, subd. (b)(1).
121. Vehicle Code § 34630, subd. (b).
122. Vehicle Code § 34630, subd. (c).
123. *Allied*, *supra*, 15 Cal.5th at p. 26.
124. *Id.* at p. 27.
125. (1995) 12 Cal.4th 387 (“*Transamerica*”).
126. *Allied*, *supra*, 15 Cal.5th at p. 32.
127. (2023) 94 Cal.App.5th 190 (“*Infinity*”).
128. *Id.* at p. 197.
129. *Ibid.*
130. Vehicle Code § 36430, subd. (a).
131. Vehicle Code § 34310.5, subd. (a)(1).
132. *Infinity*, *supra*, 94 Cal.App.5th at p. 206.
133. *Ibid.*
134. *Id.* at p 207.
135. *Id.* at p. 209.
136. (2023) 89 Cal.App.5th 638.
137. *Id.* at p. 643.
138. *Ibid.* (internal quotations omitted).
139. *Id.* at p. 648.
140. *Id.* at p. 644 (distinguishing equitable contribution from equitable contribution and equitable indemnity).
141. *Id.* at p. 645.
142. *Id.* at p. 646.
143. *Id.* at p. 642.
144. *Id.* at p. 646, quoting *Producers Dairy Delivery Co. v. Sentry Ins. Co.* (1986) 41 Cal.3d 903, 916.
145. *Id.* at p. 647, quoting *Producers Dairy*, *supra*, 41 Cal.3d at 916.
146. *Id.* at pp. 646-647, citing Lab. Code §§ 3602, 4558.
147. *Id.* at p. 647.
148. *Id.* at p. 647.