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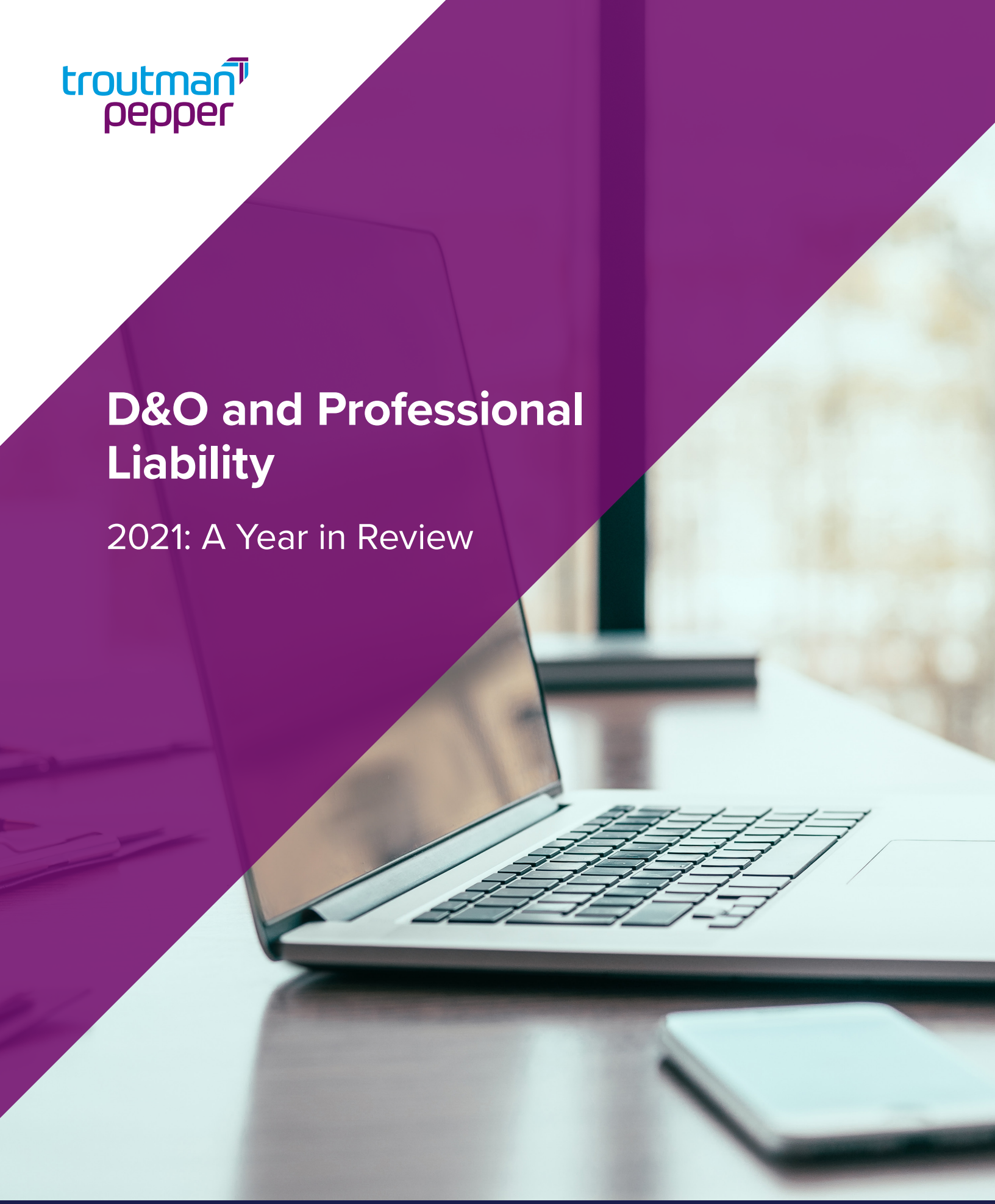
# D&O and Professional Liability

## 2021: A Year in Review



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# D&O and Professional Liability

## 2021: A Year in Review

The past year once again saw a breadth of court decisions addressing a wide variety of directors and officers and professional liability insurance coverage issues. At various levels, state and federal courts across the country issued notable decisions in this arena. We focused on topics we believe will continue to be important in the directors and officers and professional liability insurance fields, and hope you find the following selection of cases to be informative and helpful. (Please note: Cases are organized within each topic alphabetically by the state law applied).

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## I. Notice

### *Supima v. Phila. Indem. Ins. Co.*, No. CV-20-00617-PHX-SPL, 2021 U.S. Dist. LEXIS 112964, 2021 WL 2454052 (D. Ariz. June 16, 2021)

Under Arizona law, the U.S. District Court for the District of Arizona held that an insurer had no obligation to pay defense costs for an underlying arbitration proceeding because the insured had failed to timely report the arbitration to the insurer. At issue were two claims-made directors and officers liability policies, one with a coverage period of October 6, 2012 to July 1, 2013, and another with a coverage period of July 1, 2016 to July 1, 2017. The insured reported the arbitration to the insurer during the 2016-17 coverage period, when a third party commenced arbitration. The insurer disclaimed coverage on the basis that the arbitration should have been reported during the 2012-13 coverage period when the insured received a letter advising that a third party wanted to arbitrate a dispute pursuant to a licensing agreement. The court granted summary judgment for the insurer, finding that, although the insured may have erroneously believed the letter was not a "claim," Arizona law recognizes that arbitration proceedings begin at the demand stage, and therefore, the arbitration should have been reported to the insurer during the 2012-13 coverage period. The court further rejected the insured's argument that the insurer needed to demonstrate prejudice caused by the late notice.

### *Northrop Grumman Innovation Sys. v. Zurich Am. Ins. Co.*, No. N18C-09-210, 2021 Del. Super. LEXIS 92, 2021 WL 347015 (Feb. 2, 2021)

Under Delaware law, the Superior Court of Delaware denied three insurers' summary judgment motions based on late notice, holding that the insurers must demonstrate prejudice to deny coverage based on late notice. The insurers disclaimed coverage for a class-action lawsuit under claims-made primary and excess directors and officers liability policies, arguing that a 438-day delay in providing notice precluded coverage. The insurers moved for summary judgment, arguing that Virginia law permitted the denial based on late notice. However, the court denied the insurers' motion, first finding that Delaware law applied and then holding that, under Delaware law, insurers are required to demonstrate prejudice resulting from late notice, and the insurers' late notice defense could not be resolved on summary judgment.

### *Zurich Am. Ins. Co. v. UIP Cos.*, No. 19-cv-1818 (APM), 2021 U.S. Dist. LEXIS 28115, 2021 WL 602901 (D.D.C. Feb. 16, 2021)

Under District of Columbia law, the U.S. District Court for the District of Columbia found that an insured failed to provide timely notice of a claim, granting an insurer's motion for summary judgment. The court considered two consecutive claims-made management liability policies. The policies, in relevant part, required claims to be reported "as soon as practicable," but in no event later than 90 days after the expiration of the policy. Three related lawsuits were filed against the insured during the later policy period, but the insured did not seek coverage for the lawsuits until over six months after the last lawsuit was filed. The insurer denied coverage on two grounds. First, the insured had not reported the claim "as soon as practicable" after its officers learned of such lawsuits. Second, an email containing a "settlement demand" that preceded the lawsuits constituted a "claim" first made during the earlier policy period, and the claim was therefore reported outside the time allowed by the policy. On the insurer's motion for summary judgment, the court found that the settlement demand constituted a "claim" as defined in the earlier policy, and notice was therefore untimely. The court also found that, regardless of whether the earlier email constituted a "claim," the insured had not reported the lawsuits "as soon as practicable," holding that the insured's months-long delay was unreasonable based on the circumstances of the case. The court noted that the District of Columbia does not require an insurer to demonstrate actual prejudice before denying coverage based on an insured's failure to comply with a contractual notice provision. An appeal is pending.

### *Jeffery v. Med. Protective Co.*, No. 3:19-cv-00023-GFVT-EBA, 2021 U.S. Dist. LEXIS 15295, 2021 WL 280060 (E.D. Ky. Jan. 27, 2021)

Under Kentucky law, the U.S. District Court for the Eastern District of Kentucky concluded that a claimant had plausibly informed the insurer of a "potential claim" under the policy, denying an insurer's motion for judgment on the pleadings. The insurer issued a claims-made professional liability policy to a dentist. The insurer denied coverage for a lawsuit against the dentist on the basis that neither a "claim" nor a "potential claim," as defined in the policy, had been reported to the insurer during the requisite time period. After obtaining a judgment against the insured dentist, the claimant sued the insurer for coverage under the policy. The court denied the insurer's motion for judgment on the pleadings, finding that, although a letter and phone call to the insurer from the claimant's attorney did not constitute a "claim," these communications could plausibly have informed the insurer of a "potential claim." The court further, in dicta, agreed with an earlier Western District of Kentucky case holding that the notice-prejudice rule is inapplicable in claims-made insurance policies.

### *Darwin Nat'l Assurance Co. v. Ky. State Univ.*, No. 2019-CA-1811-MR, 2021 Ky. App. LEXIS 31, 2021 WL 1045716 (Mar. 19, 2021)

Under Kentucky law, the Court of Appeals of Kentucky found that the notice-prejudice rule did not apply to a claims-made-and-reported insurance

policy, reversing the lower court's decision to grant summary judgment for an insured. The insured asserted it was entitled to coverage pursuant to a claims-made-and-reported professional liability policy despite reporting the claim three days late. The policy provided, in relevant part: "[I]n no event shall such notice of any Claim be provided to the Insurer later than ninety (90) days after the end of the Policy Period … ." The court found this reporting requirement to be unambiguous, and therefore, the insured had not given timely notice by reporting a claim 93 days after the expiration of the policy. The court rejected the insured's argument that Kentucky Supreme Court precedent required the insurer to show substantial prejudice to deny coverage for a late reported claim, holding, as a matter of first impression, that the notice-prejudice rule did not apply to claims-made-and-reported policies.

### *Shaut v. Nat'l Cas. Co.*, 2021-Ohio-2522, 176 N.E.3d 1122 (Ct. App.) (applying Massachusetts Law)

Applying Massachusetts law, the Ohio Court of Appeals concluded that a claims-made policy's notice requirement was a condition precedent to coverage. The claims-made directors and officers policy contained a notice provision stating that an insured must give written notice of any claim "as soon as practicable, but in no event later than sixty days after the end of the 2015-2016 Policy Period." The insured did not provide notice of the underlying lawsuit until more than 60 days after the end of the 2015-2016 policy period. The insured argued that a material dispute of fact existed regarding whether the insurer could raise a defense of late notice. However, because the insured failed to raise the issue with the lower court, the insured "waived his claim that [the insurer's] defense was improper." The court, in dicta, also explained that even if the insured did not waive the issue on appeal, the trial court did not err in finding there was no material dispute of fact because "a claim must be reported to the insurer within the policy's reporting period as a condition precedent to coverage under a claims-made policy such as the policies at issue in this case." Because such notice provisions are "strictly enforced in Massachusetts," the court affirmed summary judgment for the insurer.

### *Hanover Ins. Grp. v. Aspen Am. Ins. Co.*, No. CV 20-56-BLG-DWM, 2021 U.S. Dist. LEXIS 161032, 2021 WL 3769324 (D. Mont. Aug. 25, 2021)

Under Montana law, the U.S. District Court for the District of Montana held that the notice-prejudice rule does not apply to claims-made policies. The court considered the notice requirements in a claims-made lawyers professional liability policy and its extended reporting period endorsement. The insurer filed a declaratory judgment action, seeking a declaration that it owed no coverage obligations to the insured law firm and the insured former partner in connection with an underlying malpractice suit. The underlying plaintiff argued that although Montana had not expressly addressed the issue, it would likely apply the notice-prejudice rule to claims-made policies. Rejecting this argument, the court stated that "to date, the Montana Supreme Court has only applied the notice-prejudice rule in the context of occurrence policies." Based on recent trends in Montana caselaw, the court predicted that the Montana Supreme Court would not apply the notice-prejudice rule to claims-made policies. Ultimately, the court granted the insurer's motion for declaratory judgment on the basis that no coverage was available where the insured provided notice of the claim over a year after the policy expired and prior to the effective date of the extended reporting period endorsement. An appeal is pending.

### *Hunt Constr. Grp. v. Berkley Assurance Co.*, No. 19-CV-8775 (JPO), 2021 U.S. Dist. LEXIS 183350, 2021 WL 4392520 (S.D.N.Y. Sept. 24, 2021)

Under New York law, the U.S. District Court for the Southern District of New York concluded that, as a matter of law, insurers cannot waive a late-notice defense under a claims-made-and reported policy. On a motion for reconsideration, the court considered two claims-made-and-reported professional liability policies that required the insurer to defend and indemnify the insured general contractor if a claim is first made and reported in writing during the policy period. Three years after the insured was hired as a general contractor for a large construction project, its client sent it a

"notice of claims" letter, alleging that the insured had mismanaged the project. Almost two years later, the client sued the insured, and the insured promptly notified the insurer of the lawsuit. Although the insurer agreed to defend, it reserved all rights "pending further investigation." Seven months later, the insurer denied coverage, explaining that the initial "notice of claims" letter was a claim, and notice of the lawsuit was therefore untimely. On the court's original review, it concluded that the insurer's late-reporting defense was an example of the insured breaching a policy condition and thus susceptible to waiver. On the insurer's motion for reconsideration, however, the court acknowledged several previously overlooked New York opinions that explained an insurer could never waive an argument for noncoverage based on late notice because waiver may not operate to create coverage where none previously existed. Based on the unique nature of a claims-made-and-reported policy, an insurer's late-reporting defense cannot be subject to waiver. Accordingly, the court granted the insurer's motion for reconsideration and upon reconsideration, granted the insurer's motion for summary judgment.

### *Am. Guar. & Liab. Ins. Co. v. Law Offices of Richard C. Weisberg*, 524 F. Supp. 3d 430 (E.D. Pa. 2021)

Under Pennsylvania law, the U.S. District Court for the Eastern District of Pennsylvania determined that the notice-prejudice rule does not extend to a prompt notice provision in a claims-made policy. The claims-made lawyers professional liability insurance policy required claims to be "both first made and reported to the Company during the Policy Period or any Extended Reporting Period." In addition, the policy also required the insured to "immediately provide Notice to the Company of any Claim made against an Insured," as well as "immediately forward to the Company every demand, notice, summons, or other process received … ." The insured became embroiled in a series of lawsuits with his mother and brother following his father's death. These lawsuits included disputes over the administration of a testamentary trust, a partnership agreement, and an oral agreement related to certain real property. The insured waited between eight and nine months before notifying the insurer of the testamentary trust lawsuit. After a thorough choice of law analysis, the court analyzed whether Pennsylvania law required an insurer to demonstrate prejudice when a claims-made policy contains a notice provision like the one at issue here. Agreeing with the insurer, the court concluded that the insured failed to comply with the policy's requirement that notice of a claim be provided "immediately" as a precondition to coverage. The court equated the phrases "immediate" and "as soon as practicable," stating that they both require notice to be given within a reasonable time under the circumstances.

### *Alps Prop. & Cas. Ins. Co. v. Unsworth LaPlante PLLC*, 526 F. Supp. 3d 23 (D. Vt. 2021)

Under Vermont law, the U.S. District Court for the District of Vermont concluded that insurers can disclaim coverage under claims-made policies based on late notice without proving prejudice. The claims-made-and-reported lawyers professional liability policy contained a notice provision stating "as a condition precedent to the company's obligation to defend or indemnify the insured under this policy, the insured must immediately report any claim to [the insurer] during the policy period." The insured law firm was hired to transfer a mother's title to certain real property to an inter vivos trust controlled by the son. The mother died in July 2016. In October 2017, the son complained to the insured law firm after learning that the firm never transferred title. In September 2019, for the first time, the firm reported the claim to the insurer. In the coverage action, the insured argued that "late report of a claim voids coverage only if the insurer can demonstrate that it suffered prejudice through the delay." Rejecting this argument, the court emphasized that due to the specific nature of claims-made policies, which intend to condition coverage on the insured's reporting the claim within a specified amount of time, the vast majority of courts do not require an insurer to show prejudice under claims-made policies. Thus, although Vermont had not addressed this specific issue, the court relied on the weight of authority to deny the insured's motion to dismiss. Notably, the court also explained that the notice-prejudice rule may still apply to a claims-made policy that lacked a reporting requirement.

## II. Related Claims

### *Supima v. Phila. Indem. Ins. Co.*, No. CV-20-00617-PHX-SPL, 2021 U.S. Dist. LEXIS 112964, 2021 WL 2454052 (D. Ariz. June 16, 2021)

Under Arizona law, the U.S. District Court for the District of Arizona concluded that an insured's failure to report an informal letter demanding arbitration barred coverage of the later initiated arbitration proceeding. The insurer issued claims-made directors and officers liability insurance policies for the 2012-13 and 2016-17 policy periods, with the policies defining a "Claim" as "[a]ny … arbitration proceeding, which subjects an Insured to a binding adjudication of liability for monetary or non-monetary relief for a Wrongful Act." In 2013, the insured received a letter demanding arbitration pursuant to a licensing agreement with another company, with the two companies entering a negotiation period in which the insured allegedly incurred defense costs. In 2016, the company that sent the initial letter to the insured filed an official demand for arbitration before the American Arbitration Association. After receiving prompt notice from the insured of the 2016 arbitration, the insurer denied coverage under the 2012-13 policy given the insured's failure to report the 2013 demand for arbitration. Additionally, the insurer denied coverage under the 2016-17 policy, noting that the 2016 arbitration related to the 2013 demand. In adjudicating the coverage dispute, the court determined that the 2013 demand was a claim under the 2012-13 policy for which the insurer deserved notice, as the demand set out the intent to arbitrate. Additionally, because Arizona law provides that arbitration proceedings begin at the demand stage, the entire arbitration proceeding would be deemed to have begun in 2013, not 2016.

### *First Solar, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA, No.* N20C-10-156 MMJCCLD, 2021 Del. Super. LEXIS 489, 2021 WL 2563023 (June 23, 2021)

Under Delaware law, the Superior Court of Delaware held an insurer was not required to provide coverage for a class action that was "fundamentally identical" to a previous class action, narrowing the standard set forth in *Pfizer Inc. v. Arch Insurance Company*, No. CVN18C01310PRWCCLD, 2019 WL 3306043 (Del. Super. Ct. July 23, 2019) ("*Pfizer*"). A primary insurer issued a directors and officers liability policy to the insured, a solar panel manufacturer, containing a provision that excluded coverage for claims initiated before the policy period. In 2012, some of the insured's shareholders filed a class-action lawsuit against it, alleging violations of federal securities laws. The primary insurer provided coverage for the 2012 suit and paid its limits. In 2014, several of the insured's shareholders opted out of the 2012 action, instead filing a separate action that alleged the directors and officers misrepresented various aspects of the manufacturer's business. The 2014 action settled, but both insurers denied coverage, arguing the 2012 and 2014 actions were related. The insured asserted that the lawsuits involved different plaintiffs, wrongful conduct, causes of action, and time periods. Differentiating the present case from *Pfizer*, the court reasoned that the actions were sufficiently similar. Despite the 2012 and 2014 actions asserting different types of damages, both actions claimed violations under the same fraudulent scheme of misrepresenting stock prices. As a result, the 2012 and 2014 actions were related and the insurer was not required to provide coverage for the 2014 action.

### *Zurich Am. Ins. Co. v. UIP Cos. LLC*, No. 19-CV-1818 (APM), 2021 U.S. Dist. LEXIS 28115, 2021 WL 602901 (D.D.C. Feb. 16, 2021)

Under District of Columbia law, the U.S. District Court for the District of Columbia held an insured's failure to report a settlement offer received in a prior policy period barred coverage for related lawsuits arising in a subsequent policy period. The insurer issued consecutive claims-made directors and officers liability policies in 2017 and 2018, with both policies containing identical "Interrelated Wrongful Acts" provisions. Under the "Interrelated Wrongful Act" provisions, related wrongful acts were treated as one claim, made on the date of the earliest related wrongful act. In 2017, the insured, a limited liability corporation, became engaged in a dispute with a deceased partner's wife over ownership stakes in the LLC. During the 2017 policy period, the wife's

attorney sent an email to the insured demanding compensation for her late husband's equity interest in the LLC. The insured did not report the email to the insurer until the end of the 2018 policy period, after the late partner's wife filed three lawsuits against the insured and its principal officers. The insurer denied coverage for the lawsuits, claiming the email sent by the wife's attorney during the 2017 policy period constituted an unreported related claim. Using the plain language of the policies, the court agreed that the insurer was not obligated to provide coverage because both policies defined a "claim" as "a written demand against any insured for monetary damages or non-monetary or injunctive relief … ." The court rejected the insured's argument that the email sent during the 2017 policy period did not constitute a claim because the attorney never mentioned an intent to seek court-ordered relief. Instead, the court noted that a "claim" under the policy could include a demand for monetary relief, such as compensation for an equity interest, sent without threat of court-ordered relief. An appeal is pending before the U.S. Court of Appeals for the District of Columbia Circuit.

### *Datamaxx Applied Tech., Inc. v. Chubb Custom Ins. Co.*, No. 6:20-cv-291-CEM-DCI, 2021 U.S. Dist. LEXIS 176515, 2021 WL 4166740 (M.D. Fla. Sept. 13, 2021)

Under Florida law, the U.S. District Court for the Middle District of Florida held an insurer had no duty to defend an insured that failed to report related litigation arising prior to the policy period. The insurer issued a claims-made professional liability policy to the insured, a technology company, that contained a related claims provision. In 2013, before the issuance of the policy, a corporation sued the insured over alleged violations of a licensing agreement, though the parties reached a settlement agreement. In 2018, the same corporation involved in the 2013 litigation initiated arbitration against the insured, alleging violations of the previous settlement agreement, as well as violations under the Lanham Act and Florida's unfair competition laws. Although the insured and insurer agreed the 2013 lawsuit was not covered by the policy, the insurer denied coverage for the 2018 lawsuit, claiming the 2018 lawsuit related to the 2013 lawsuit. The insured argued the lawsuits were distinct, as the 2018 lawsuit had an additional defendant and involved a different product. Looking only to the underlying acts at issue, the court found the 2013 and 2018 actions were related because both involved allegations that the insured used patented materials to develop its own product and that the insured failed to pay the corporation pursuant to the licensing agreement. Additionally, each of the products at issue in both proceedings were developed around the same time period. Finally, the court noted that the second litigation asserted breach of the settlement agreement arising out of the first litigation, which weighed heavily in favor of finding the proceedings related.

### *Allied World Specialty Ins. Co. v. SIU Physicians & Surgeons, Inc.*, No. 17-CV-03139, 2021 U.S. Dist. LEXIS 61536, 2021 WL 1220926 (C.D. Ill. Mar. 30, 2021)

Under Illinois law, the U.S. District Court for the Central District of Illinois concluded an insurer had no obligation to provide coverage for claims brought by additional plaintiffs in a lawsuit that the insured initially failed to report. The insured issued identical claims-made-and-reported employment practices liability policies during the 2013, 2014, 2015, and 2016 policy periods, with each policy containing a "Related Claims Provision" advising the insured of its obligation to report related wrongful acts. A former employee of the insured filed a Charge of Discrimination with the Equal Employment Opportunity Commission during the 2013 policy period and a subsequent lawsuit during the 2015 policy period, both alleging gender-based pay discrimination. The insured and insurer agreed the EEOC charge and subsequent lawsuit were related claims and thus were deemed made during the 2013 policy period, with neither warranting coverage given the insured's failure to report. Later, however, the former employee's lawsuit was certified as a collective action under the Equal Pay Act. During the 2016 policy period, the insured notified the insurer of additional plaintiffs joining the action, seeking coverage for the additional plaintiffs' consent forms. The insurer rejected coverage, arguing the consent forms related to the EEOC charge and initial lawsuit. Finding the consent forms were "causally and

logically connected" to the EEOC charge and the initial lawsuit's gender-based pay discrimination allegations, the court recognized the insurer had no obligation to provide coverage. The court further noted that the fact that the individual plaintiffs could pursue their claims individually was irrelevant to whether their claims were related because each of the plaintiffs alleged injuries under the same discriminatory policies.

### *Ric-Man Constr., Inc. v. Pioneer Special Risk Ins. Servs., Inc.*, No. 19-13374, 2021 U.S. Dist. LEXIS 116985, 2021 WL 2579764 (E.D. Mich. June 23, 2021)

Under Michigan law, the U.S. District Court for the Eastern District of Michigan held a crossclaim filed against the insured during the effective policy period related back to a claim made prior to the policy period. The insurer issued a claims-made professional liability policy to the insured, a construction company, that required related professional claims to be treated as a single claim. The insured was sued for breach of contract pertaining to a construction project prior to the inception of the policy. In the same lawsuit, another defendant filed a crossclaim against the insured during the policy period. The court reasoned that the crossclaim incorporated the same allegations raised in the original lawsuit. Additionally, the breaches alleged by the original plaintiff and the co-defendant arose from "a series of related actions or failures to act by the insured." Consequently, the court held that there was no coverage because the original lawsuit and the crossclaim were a single claim and the original lawsuit preceded the policy period.

### *Am. Sw. Mortg. Corp. v. Cont'l Cas. Co*, No. CIV-20-00422-PRW, 2021 U.S. Dist. LEXIS 160790, 2021 WL 3773584 (W.D. Okla. Aug. 25, 2021)

Under Oklahoma law, the U.S. District Court for the Western District of Oklahoma determined yearly audits that made the same clerical error were not interrelated. The insurer issued a professional liability policy to the insured, an auditing company, that contained an interrelated claims provision and a per-claim limit of $1 million. Over the course of three years, the insured failed to report the presence of unsecured loans in their audits of two mortgage funding corporations. The mortgage funding corporations sued the insured for professional negligence during the policy period. Each corporation secured a $1.5 million consent judgment against the insured. Although the insurer agreed the consent judgments fell within the policy's coverage, the insurer argued the judgments were interrelated claims and therefore subject to the single-claim limit of $1 million. The court reasoned that there was no reason to believe the omissions in the earlier audits informed the insured on how to conduct later audits. Instead, the court noted that "each audit is a fresh and focused inquiry uninfluenced by other, earlier audits." As a result, the court reasoned that the claims arising from different audit reports were not interrelated.

### *Turner v. Cincinnati Ins. Co.*, 9 F.4th 300 (5th Cir. 2021) (applying Texas law)

Under Texas law, the U.S. Court of Appeals for the Fifth Circuit held two lawsuits initiated by different plaintiffs in different cities constituted related claims because both lawsuits alleged similar violations by the insured. The insurer issued a claims-made directors and officers liability policy to the insured in 2010, with the policy containing a related claims provision specifying that claims are first made at the time of the earliest related wrongful act. The insured operated trade schools across Texas. In 2010, prior to the inception of the policy, former students at the insured's Dallas County School sued the insured for fraud, unjust enrichment, and various violations of the Texas Deceptive Trade Practices Act. In 2011, former students at the insured's McLennan County School sued the insured with nearly identical claims to the 2010 lawsuit. Although the insurer initially assumed defense of the 2011 lawsuit, the insurer later denied all coverage upon learning of the 2010 lawsuit, claiming the insured failed to report a prior related claim. In 2014, the insured filed for bankruptcy, which stayed both lawsuits and resulted in the insured agreeing to release the insurer from liability arising out of the students' lawsuits; however, in 2018, some of the former students from the 2011 lawsuit successfully petitioned for a relief-from-stay

motion, initiated a new lawsuit in 2019 against the insured, and then filed a direct action against the insurer seeking recovery under the insured's 2010 policy. The insurer argued the plaintiffs' lawsuit in 2019 was not covered, as the first related lawsuit was filed prior to the start of the 2010 policy period. The plaintiffs claimed the 2010 and 2011 lawsuits involved different students and different campuses and thereby could not be deemed related. Affirming the District Court's opinion, the Fifth Circuit held the 2010 and 2011 lawsuits were related claims, with the lawsuits having "virtually identical petitions" with common facts.

## III. Prior Knowledge, Known Loss, and Rescission

### *Med. Protective Co. v. Crafton Chiropractic, Inc.*, No. CV 20-00414-KD-B, 2021 U.S. Dist. LEXIS 210208, 2021 WL 5056436 (S.D. Ala. Nov. 1, 2021)

Applying Alabama law, the U.S. District Court for the Southern District of Alabama held that an insurer could not rescind a policy based on a response to an application question because the insurer must show that its application raised specific questions and the insured answered falsely either by misrepresentation or suppression of the information requested. The insurer issued a health care professional liability policy to the insured chiropractor. In an underlying lawsuit, the family of a deceased patient alleged that the patient was diagnosed with breast cancer and sought alternative cancer treatment from the insured chiropractor, who allegedly advertised a "cancer protocol" that had a "100% success rate in curing cancer." The family sued, alleging various causes of action for misrepresentation and breach of contract as well as wrongful death. The insurer filed a complaint for declaratory relief alleging, among other things, that the insurer was entitled to rescind the policy based on the insured's failure to disclose its alternative cancer treatments. The insured argued it had correctly responded to the question labeled "Other (List Specialty)", which also requested the number of persons providing certain types of specialty services, by listing only the insured chiropractor with the specialty of "chiropractor." The insurer argued that the insured should have included a disclosure of a specialty other than chiropractor because the insured offered a Health Patient Program that provided cancer treatments and was kept "separate and distinct" from the chiropractor practice. The court found that the insurer's argument that the insured offered services that were distinct from chiropractor services was based only on the allegations in the complaint, and was rebutted by, among other things, the insured's sworn declaration. The court held that the insured could not be faulted for failing to list the Health Patient Program on the application because the request was too vague, and that if the insured answers ambiguous questions in good faith, the representations will be construed in the insured's favor.

### *Atain Specialty Ins. Co. v. Lake Lindero Homeowners Ass'n*, No. CV 19-9824 DSF (MRWx), 2020 U.S. Dist. LEXIS 242112, 2020 WL 7416169 (C.D. Cal. Nov. 25, 2020)

Applying California law, the U.S. District Court for the Central District of California ruled that an insurer was entitled to rescind a policy based on misrepresentations in the application relating to an undisclosed complaint against the insured board. The insurer issued a non-profit directors and officers liability policy to the insured homeowner's association ("HOA"). The policy application included the questions, "within the last 5 years, has any inquiry, complaint, notice of hearing, claim or suit been made ... against the organization ... ?" and "is any person proposed for this insurance aware of any fact, circumstance or situation, which may result in a claim against the organization ... ?" In both instances the insured's representative answered "no." The insurer moved for summary judgment on its complaint for declaratory relief on the basis of two facts that it maintained were undisclosed. The first undisclosed fact was a complaint by the state Alcoholic Beverage Control ("ABC") for the unlicensed distribution of alcohol by the contractor that the insured HOA retained to maintain and manage the insured's common areas, parks, and country club. The contractor was aware of the ABC complaint at the time of the application, but the court held that the contractor's knowledge could

not be imputed to the insured HOA because of the severability provisions of the policy, even though the court held that if the HOA itself were aware of the complaint, such knowledge would be imputed to the individual representative completing the application. The second undisclosed fact was a complaint from the local water board that resulted in a payment of $310,000 by the insured HOA. The court determined that it was undisputed that the insured HOA was aware of this fact at the time of the application, and found that in the absence of any evidence to the contrary, it was sufficient evidence of materiality that the insurer's vice president provided a declaration that the policy would not have been issued if the insurer had been aware of the water board complaint.

### *Scottsdale Indem. Co. v. Sun Coast Gen. Ins. Agency, Inc.*, No. 8:19-CV-01947-JLS-DFM, 2020 U.S. Dist. LEXIS 247439, 2020 WL 8569410 (C.D. Cal. Dec. 21, 2020)

Under California law, the U.S. District Court for the Central District of California granted an insurer's motion to rescind its policy and found that the insured's failure to disclose its escalating dispute with a third party was a material misrepresentation. The insurer issued a professional liability policy that was renewed across several years. In its renewal applications, the insured failed to disclose a dispute where a third party alleged that the insured had used an incorrect commission percentage in determining its pay. This dispute escalated over a period of two years. Over the course of the dispute, the third party exercised an automatic termination provision under its agreement with the insured and conducted an audit of the insured's business. During this time, the insured represented in three consecutive annual renewal applications that (1) no agency had terminated a contract with it in the past twelve months, and (2) it was not aware of any claims or potential claims against it. Ultimately, the third party filed suit against the insured, and the insurer moved to rescind the policy. The court recognized that California Insurance Code §§ 331 and 359 entitle an insurer to recission if the insured (1) misstates or conceals a fact in its application for insurance, and (2) the misrepresentation is material. The court concluded that the insured misstated facts in its application by failing to disclose the contract termination or the third party's potential claim. The court accepted the underwriter's certification that this information was material to the issuance of the policy and that, had the information been disclosed, the underwriter would have increased premiums, added endorsements excluding the potential claim, and/or not renewed the account. The court found that the insured failed to raise a triable issue of fact as to materiality and granted the motion to rescind.

### *Kinsale Ins. Co. v. Golden Beginnings, LLC*, No. CV 20-10302-DMG (AFMx), 2021 U.S. Dist. LEXIS 179109, 2021 WL 4205059 (C.D. Cal. Sept. 15, 2021)

Applying California law, the U.S. District Court for the Central District of California granted an insurer's motion for summary judgment, holding that the insured made material misrepresentations in its application, which constituted a breach of warranty and resulted in reformation of the policy. The court also determined that coverage was barred because the claim was a "prior or known claim." The insurer issued a professional and general liability insurance policy to an elder care facility based on an application that asked whether in the preceding two years any resident had fallen and suffered a fracture, been hospitalized, or died as a result of the fall. The application also asked if any applicant was aware of any circumstance that might result in a claim or suit and included an acknowledgement by the applicant that the answers were based on a "reasonable inquiry and/or investigation," and a warranty that the answers were "true and complete." The policy further excluded coverage for prior or known claims based on "any act, omission or circumstance that could reasonably have been foreseen to give rise to a 'claim' prior to the effective date of the 'policy period.'" Prior to applying for the policy, an individual had fallen at the insured elder care home, suffered injuries, was taken to hospice care, and died. Following the inception of the policy, the decedent's family filed suit, and the insurer defended pursuant to a reservation of rights and filed a declaratory relief action. The insured's representative acknowledged that he knew the decedent had fallen, but said that after she died,

the decedent's family had written thank-you notes and brought food to staff to thank them for the care provided. The insured's representative also argued that the broker had filled out the application and did not know why it stated that the insured was not aware of the relevant facts. The court determined that the broker filling out the application provided no defense, and that the insured's representative's subjective belief that the fall would not result in a claim was no defense because foreseeability is an objective question. The court held that the insured's failure to disclose the potential claim was a violation of a condition precedent to coverage and that the policy never attached to the risk.

### *Sycamore Partners Mgmt., L.P. v. Endurance Am. Ins. Co.*, No. N18C-09-211 AML CCLD, 2021 Del. Super. LEXIS 584, 2021 WL 4130631 (Sept. 10, 2021)

Applying Delaware law, the Delaware Superior Court held that an insurer could not void coverage on a theory that the insured misrepresented prior knowledge of a claim when it represented in a warranty letter that it did not have prior knowledge of wrongdoing that could be "reasonably expected" to produce a claim. The court examined several policies issued by multiple insurers, including directors and officers policies and errors and omissions policies, and did not draw distinctions based on differing policy language in its analysis. As a condition to issuing the policies, the insurers required the insured to execute a letter agreement whereby it represented that it lacked knowledge of conduct that could produce a claim. The first paragraph of the Warranty Letter stated that no person for whom the insurance is intended "has any actual knowledge or information of any act, error, [or] omission that is reasonabl[y] expected to give rise to a claim within the scope of the [policies]." The following paragraph contained an agreement that a claim arising from an act of which any insured person has actual knowledge or information is excluded from coverage. The insurers argued that the second paragraph of the letter should be read to preclude coverage whether or not the knowledge of the act is "reasonably expected" to give rise to a claim. However, the court held that the paragraphs must be read together, and the second paragraph only excludes claims if the knowledge of wrongdoing is reasonably expected to give rise to a claim.

### *Freeburg Cmty. Consol. Sch. Dist. No. 70 v. Country Mut. Ins. Co.*, 2021 IL App (5th) 190098

Under Illinois law, the Appellate Court of Illinois granted an insurer's appeal reversing, vacating, and remanding a circuit court decision that had found the common law "known loss" doctrine did not apply in a dispute under a claims-made professional liability insurance policy regarding coverage for a sexual abuse suit. The policy at issue did not contain a known loss or prior knowledge exclusion. Under Illinois law, the common law known loss doctrine "serves to exclude claims that were known, or should have been known, to an insured when purchasing an insurance policy." The insurer argued that the known loss doctrine should apply to preclude coverage for a lawsuit brought by a student against a school district alleging sexual abuse where the school district knew that an employee had sexually abused a number of other students previously. The insurer argued that based on the prior incidents, the school district knew, or should have known, that there was a substantial risk that additional claims associated with the employee's sexual abuse of students would be brought against the district. The circuit court rejected this argument and granted a motion to strike the insurer's known loss doctrine affirmative defense, finding that the insurer wrote the policy with claims-made clauses without reference to the common law known-loss doctrine, and no basis existed for the court "to go beyond the 'four corners' of the policy and add a 'new' provision." The Appellate Court found the circuit court improperly denied an earlier motion to dismiss and therefore vacated the order granting the motion to strike the known-loss affirmative defense.

### *Williams v. Bestcomp, Inc.*, No. 21-106, 2021 La. App. LEXIS 1932, 2021 WL 5913438 (Dec. 15, 2021)

Under Louisiana law, the Court of Appeal of Louisiana denied an insurers' appeal, affirming the trial court's finding that a prior knowledge

exclusion did not apply to bar coverage for a lawsuit against the insured alleging the claimant's workers' compensation medical bills were discounted pursuant to PPO agreements without the benefit of notice as required by Louisiana law, even though the insured had prior knowledge of the discounts. The prior knowledge exclusion in the excess professional liability policies at issue included endorsements that precluded coverage for "[a]ny alleged act, error, omission, or circumstance likely to give rise to a Claim that an Insured had knowledge of prior to the effective date of this policy. This exclusion includes, but is not limited to any prior Claim or possible Claim referenced in the insured's application." The insurer argued that because the insured was aware that it was discounting bills, it had prior knowledge of an act likely to give rise to a claim. Specifically, the insurer argued that the exclusion precludes coverage on a "broad basis for actions or circumstances that may give rise to a claim." The trial court held that the insurer's interpretation of the exclusion put insureds in an "untenable position" of having to disclose actual and perceived acts that may lead to further litigation and "expands upon the purpose of a claims made and reported policy." The Court of Appeal agreed with the trial court and found that the insurers' interpretation was inconsistent with what the insured bargained for and obtained. The Court of Appeal also found that the insured's knowledge of the discounts was not sufficient to establish knowledge of a potential lawsuit alleging a failure to comply with Louisiana notice laws.

### *Alps Prop. & Cas. Ins. Co. v. Keller, Reynolds, Drake, Johnson & Gillespie, P.C.*, 403 Mont. 307, 482 P.3d 638 (2021)

Applying Montana Law, the Montana Supreme Court affirmed the objective-subjective test for a prior-knowledge exclusion and held that there was no coverage when an insured attorney was aware of a default that could form the basis of a malpractice action and did not report it in the attorney's application for a claims-made professional liability policy. An attorney at the insured firm represented a client in two matters, an estate action and a civil suit. In the civil suit, the plaintiffs filed an amended complaint, and the insured attorney failed to file an answer, resulting in a default. The court scheduled a hearing in October 2015 to consider the default, and pursuant to a request from the insured attorney, continued the hearing to November 30, 2015. The insured attorney admitted at the default hearing that he had "not paid the necessary attention to the matter." Also, in November 2015, the firm sought professional liability coverage from the insurer during which time each attorney was required to complete and sign an individual supplement, representing that he or she had no knowledge of any "fact, circumstance, act, error, or omission" that could reasonably be expected to be the basis of a claim. The insured attorney's statement was completed and signed, with no reference to the civil suit, the day after he admitted at the default hearing to have not paid necessary attention. The court held that there was no coverage for two reasons. First, the scope of coverage applies only to claims first made and reported during the policy period, provided that at the effective date of the policy "no Insured knew or reasonably should have known" of the act or error that might be the basis of the claim. Because *an* Insured knew of the claim, the claim itself never came within the grant of coverage for any insured. The court likewise held that the prior-knowledge exclusion precluded coverage because the attorney should have known of the potential claim when the default was entered. Second, the court rejected the insureds' "reasonable expectations" argument, observing that "just as no homeowner would expect to obtain coverage for a house that was already on fire, no reasonable attorney would expect an insurer to cover a malpractice claim that existed prior to the inception of the policy when the malpractice was known to an attorney in the firm."

### *Alps Prop. & Cas. Ins. Co. v. Kalicki Collier, LLP*, 526 F. Supp. 3d 805 (D. Nev. 2021)

Applying Nevada law, the U.S. District Court for the District of Nevada granted summary judgment in favor of the insurer, holding the insurer owed no duty to defend or indemnify the insured-defendants in a malpractice suit brought by the insured's former client. The insurer issued a lawyers professional liability policy to the insured law firm based on an

application in which the insureds responded "no" to a question asking whether they were aware of any errors or omissions that could reasonably be expected to be the basis of a claim against the firm. The application also stated that any claim arising from an error or omission that should have been disclosed would be excluded. The case arose out of the insured lawyer's representation of a client in her capacity as trustee of a trust, who was seeking to recover money that her deceased brother allegedly took from the trust while serving as trustee before his death. The insured law firm began negotiating a settlement in the fall of 2016 for the recovery of the money and assets, but the third party in possession of the money and assets declined, asserting that the statute of repose had run in 2015 — eight months after the insured attorneys were retained. The insured firm filed several other actions in other jurisdictions in an attempt to circumvent the statute of repose but was unsuccessful. During this period, the insureds completed their application for the policy. The court held that even though suit had not been filed, the insureds should reasonably have known that the lapsing of the statute of repose eight months after their retention, or a court's dismissal of the underlying client's claim on the basis of that statute of repose, would be a basis that a malpractice claim might be brought against them. The court found that the lawyer insureds had received multiple undisputed indications that the lapsed statute of repose was a determinative issue for their client's case, and cited Nevada law holding that a missed statute of limitations deadline would put a reasonable attorney on notice of a potential malpractice claim. The court rejected the lawyer insured's argument that the policy only excluded coverage if a legal proceeding was already instituted because, among other reasons, the unreported incident was a "wrongful act" not a "claim." The court employed the "subjective-objective" framework with two steps: first, did the insured have subjective knowledge of the relevant suit, act, error, or omission; and second, should that suit, act, error, or omission have reasonably been expected to result in a claim or suit.

### *Certain Underwriters at Lloyd's of London v. KG Admin. Servs., Inc.*, 855 F. App'x 260 (6th Cir. 2021) (applying Ohio law)

Under Ohio law, the U.S. Court of Appeals for the Sixth Circuit reversed and remanded the district court's grant of an insurer's motion for judgment on the pleadings. The Sixth Circuit concluded that the district court erred in finding that an insured's misstatement of fact in its renewal application was a "warranty statement." In the renewal application, the insured's president stated "[a]fter inquiry I, nor any principal, partner, director, officer or professional employee have any knowledge or information of any act, error, omission, fact, circumstance or contentions of any incident which may give rise to a claim being made against us." However, three lawsuits had been filed against the insured that year. The renewal application form included acknowledgements that the insurer would rely on representations in the application and that the application would be the basis of the contract. The policy incorporated the application, providing that "[a]ll of the information and statements provided to the Underwriters by [the insured] … constitute material representations." After a lawsuit was filed against the insured and the insured sought coverage, the insurer filed an action for rescission. The district court granted judgment on the pleadings based on the representation in the application, and the insured appealed. Under Ohio law, the consequences of a misstatement of fact by an insured depend on whether the statement is a warranty or a representation. If it is a warranty, the misstatement of fact voids the policy *ab initio*. However, if the statement is a representation, the policy is voidable if the representation was fraudulently made and the fact is material to the risk. Ohio courts apply a two-pronged approach to distinguish warranties and representations. First, the representation must plainly appear on the policy and be plainly incorporated into the policy. Second, the policy must plainly warn that a misstatement or misrepresentation renders the policy void from its inception. However, even where the two-prong test would otherwise be satisfied, "expression of personal belief or opinion" as opposed to "statements of fact" cannot constitute a true warranty. The appellate court found that an insured's representation is best understood as an

"expression of personal belief" and, therefore, could not constitute a warranty under Ohio law. On that basis, the court reversed and remanded for further proceedings.

### *Travelers Cas. & Sur. Co. of Am. v. Grimmer Davis Revelli & Ballif, P.C.*, No. 2:19-CV-597-DAK-JCB, 2021 U.S. Dist. LEXIS 218483, 2021 WL 5234373 (D. Utah Nov. 10, 2021)

Under Utah law, the U.S. District Court for the District of Utah held that misrepresentations made by the insured in applying for the policy were material and entitled the insurer to rescind its lawyers professional liability policy. The insured attorney attested in the application that no one at the firm was aware of any facts, circumstances, or losses that could impact coverage under the policy. However, the court found that at the time the insured signed the application, the insured's former client had already "repeatedly threatened substantial claims against the firm and its attorneys, and two courts had already determined that the attorneys' conduct was improper and breached professional obligations." The insured argued that a misrepresentation condition in the policy should govern the issue rather than Utah law on rescission. The court held that the policy was not in existence at the time of the misrepresentation, and the misrepresentation condition in the policy only applies to conduct after the inception date of the policy. The court further held that equitable estoppel barred the insured from claiming that the misrepresentation provision of the policy took precedence over Utah's rescission statute. The court also dismissed as irrelevant the insured's argument that the threatened claims were not meritorious. An appeal to the U.S. Court of Appeals for the Tenth Circuit is pending.

### *James River Ins. Co. v. Inn-One Home, LLC*, No. 18-CV-00100, 2021 U.S. Dist. LEXIS 107230, 2021 WL 2336787 (D. Vt. June 8, 2021)

Applying Vermont law, the U.S. District Court for the District of Vermont held that a prior knowledge condition precluded coverage for a claim that was, in part, related to claims that had been disclosed in a policy application. The insurer issued a professional liability policy to a residential care home that admitted a patient for residential care related to dementia. In September 2015, the patient eloped from the facility, resulting in the patient's daughter threatening to sue a pharmacy for its employee's holding the door that allowed the patient to elope. Later in September 2015, the patient suffered a fall, resulting in a trip to the hospital. In December 2015, a caregiver employed by the insured verbally assaulted and intentionally pushed the patient, causing her to fall and suffer injuries. The application for insurance, which the insured applied for in February 2017, contained a notice stating that "[a]ll known claims and/or incidents that could reasonably result in a claim are specifically excluded from coverage … . Your failure to disclose any claim, or incident that could reasonably result in a claim, may result in the proposed insurance being void and/or subject to rescission." The court applied a two-part test, first asking whether the insured had actual knowledge of a suit, act, error, or omission, and second whether a reasonable professional in the insured's position might expect a claim or suit to result. The insured acknowledged it was aware of the assault, but argued it had no reason to expect a claim would result. The court rejected the argument because the terms of the policy only depend on what the insured knew. The insured also invoked a Vermont statute that the falsity of a statement in an application does not bar the right to recovery unless made with actual intent to deceive or the statement materially affected the acceptance of risk. The court rejected this argument because the insurer did not seek to deny coverage based on the misrepresentations in the application, but instead accepted the application and provided coverage subject to a prior knowledge exclusion. The insured subsequently moved to alter or amend the judgment, arguing that the court must engage in an event-by-event analysis in determining the duty to defend a given suit that includes claims that should have been disclosed. The court rejected this argument, finding that the prior knowledge exclusion precludes coverage for "any claim" that is "based on or directly or indirectly arising out of or resulting from" a professional service rendered prior to the inception of the policy "if any insured knew

or could have reasonably foreseen" that it could give rise to a claim. Further, the court rejected the insured's concurrent causation theory, holding that the policy plainly excludes coverage where a claim essentially derives from the allegedly substandard care provided by the insured to its patient, and the insured knew or should have known that the professional services it had rendered to that patient could give rise to a claim.

### *Med. Mut. Ins. Co. of N. Carolina v. Johnson*, No. 1:19-CV-1601, 2021 U.S. Dist. LEXIS 214739, 2021 WL 5071509 (E.D. Va. Apr. 30, 2021)

Applying Virginia law, the U.S. District Court for the Eastern District of Virginia held that there is a material distinction among provisions that preclude coverage for materially untrue statements in the policy application, provisions that preclude coverage based on what the insured knew, and provisions that preclude coverage based on what the insured knew or should have known. The insurer issued a medical malpractice insurance policy. The insurer initiated a declaratory judgment action, seeking, among other things, a determination that it was not obligated to defend or indemnify its insured based on a prior knowledge provision in the policy that excluded coverage for potential claims the insured knew or "should have known." The court rejected the insurer's argument, reasoning that the provision in question "is not *just* a prior knowledge provision" because it also covers what the insured "should have known." As a result of the "should have known" expansion, the court found there was significant entanglement with the factual disputes in the underlying medical malpractice cases. The court explained it would not risk issuing a ruling that could result in issue preclusion that binds the court in the underlying action.

## IV. Prior Acts, Prior Notice, and Prior and Pending Litigation

### *San Joaquin Cnty Emps. Ret. Ass'n. v. Travelers Cas. & Sur. Co.*, 843 F. App'x 919 (9th Cir. 2021)

Under California law, the U.S. Court of Appeals for the Ninth Circuit reversed the district court's summary judgment in favor of an insurer based on a prior and pending proceeding exclusion. The insurer issued a fiduciary liability insurance policy that excluded coverage for "Loss for any Claim based upon or arising out of any fact, circumstance, situation, event or Wrongful Act underlying or alleged in any prior or pending civil, criminal, administrative or regulatory proceeding against [the insured]." A 1998 lawsuit involved the insured's members claiming that California Supreme Court precedent applied retroactively to include vacation and sick leave pay in calculating retirement benefits. In 2001, the insured settled the 1998 lawsuit and established a supplemental reserve fund to provide retirees with benefits based on the agreement. The plaintiffs in the new underlying litigation claimed that the insured failed to allocate sufficient funds to the supplemental reserves established by the 2001 settlement. The Ninth Circuit found that this claim was not precluded by the policy's prior and pending proceeding exclusion unless it arises out of some "fact, circumstance, situation, event, or Wrongful Act underlying or alleged in the prior proceeding," emphasizing that the underlying litigation concerned only the terms of the 2001 settlement and its implementation. Furthermore, the "fact[s], circumstance[s], situation[s], event[s], or Wrongful Act[s]" that gave rise to the underlying litigation could not have been alleged in the 1998 lawsuit because the supplemental benefits did not exist then. The Ninth Circuit therefore concluded that the district court erred in granting summary judgment to the insurer.

### *Stem, Inc. v. Scottsdale Ins. Co.*, No. 20-cv-02950-CRB, 2021 U.S. Dist. LEXIS 84548, 2021 WL 1736823 (N.D. Cal. May 3, 2021)

Under California law, the U.S. District Court for the Northern District of California granted in part and denied in part an insurer's motion for summary judgement based on a prior or pending litigation exclusion. The insurer issued a business and management indemnity policy that barred coverage for "any prior or pending litigation or administrative or regulatory proceeding … filed or pending on or before the Continuity Date; or any fact, circumstance, situation, transaction or event underlying or alleged in such litigation or administrative or regulatory proceeding[.]" In the underlying lawsuit, the shareholders of the insured asserted claims arising from two transactions: a 2013 Series B financing round and a 2017 loan from a board member to the company. The insurer argued these claims were excluded because the claims related to a 2010 employment dispute that resulted in a claim with the employment development department in California. The court found the prior or pending litigation exclusion barred coverage for the 2013 Series B financing claim based on pages of allegations in the underlying lawsuit detailing specific connections between the 2010 employment dispute and the 2013 Series B financing claim. However, the court found that the exclusion did not bar coverage for the lawsuit involving the 2017 loan claim because there were no facts in support of a connection with the 2010 employment dispute beyond some "general allegations" of a "continuing campaign" of misconduct by the insured. Because the insurer could not point to a specific connection, even a tangential one, between the events surrounding the 2017 loan claim and the 2010 employment claim, the court found the insurer could not establish the absence of a potential for coverage based on the prior and pending litigation exclusion.

### *Northrup Grumman Innovation Sys., Inc. v. Zurich Am. Ins. Co.*, No. N18C-09-210, 2021 Del. Super. LEXIS 92, 2021 WL 347015 (Feb. 2, 2021)

Under Delaware law, the Superior Court of Delaware found that coverage for a lawsuit filed against the insured was not precluded by the policy's prior acts exclusion because the suit was not "fundamentally identical" or "interrelated" to an earlier lawsuit. The insurer issued an excess directors and officers liability policy to the insured and its management that excluded coverage for losses "in connection with any Claim made against [insured and its management] occurring prior to the [retroactive date]." The exclusion further stated that loss "arising out of the same or related Wrongful Act shall be deemed to arise from the first such same or related Wrongful Act." In the underlying lawsuit, shareholders sued the insured and its managers under Section 10(b) of the Securities Exchange Act, alleging that they had intentionally misled shareholders by distributing false post-merger data about the insured's financial health. The insurer argued that the prior acts exclusion barred coverage for the 10(b) claim because it was related to a 14(a) claim occurring before the policy period. The court disagreed, finding that the exclusion applied only where the "wrongful act" is alleged against the insured. Because the 14(a) claim alleged wrongdoing by managers of the prior entities occurring before the merger, coverage for the 10(b) claim was unaffected by the 14(a) claim. Furthermore, differences in timing, type of securities violation, motive, and burdens of proof demonstrated that the claims were not "fundamentally identical," and thus not "related" under Delaware law; therefore, the prior acts exclusion did not apply.

### *Sycamore Partners Mgmt., LP v. Endurance Am. Ins. Co.*, C.A. No. N18C-09-211 AML CCLD, 2021 Del. Super. LEXIS 584, 2021 WL 4130631 (Sept. 10, 2021)

Under Delaware law, the Superior Court of Delaware granted summary judgment in favor of the insured on the insurers' defenses related to the prior notice and prior or pending litigation exclusions. The insureds procured a fiduciary liability insurance

program providing excess directors and officers and errors and omissions coverage. The prior notice exclusion barred coverage for "Loss in connection with any Claim made against an Insured … arising out of [or] resulting from … any fact, circumstance, situation, transaction, event, … or Wrongful Act, which, before [the policy period], was the subject of any notice under any other policy of insurance … ." The exclusion only applied if the former policy "afford[ed] coverage … for such Loss in whole or in part … ." The prior or pending litigation exclusion stated that "[t]he Limits [o]f Liability shall not apply to Claims made against the Insured based upon, arising from, or in consequence of any demand, suit, or other proceeding pending, or order, decree or judgment entered against any Insured prior to [the policies' inception] or the same or substantially the same fact, circumstance, or situation underlying or alleged therein." The insured sued the insurers to recoup part of a settlement reached with respect to claims against the insured for fraudulent transfers, breach of fiduciary duty, and various contract claims and business torts in connection with a series of merger and carve-out transactions leading to a holding company's insolvency. Years earlier, the company's shareholders had brought derivative suits against the company and the insured seeking to enjoin the merger or rescind it after closing, accusing the company's board of breaching its fiduciary duties by accepting inadequate consideration from the insured. The insured provided notice of these suits to its insurer at that time; however, the claims were settled shortly thereafter, and the insured retracted its coverage claim. Among other defenses, the insurers argued that the policies' prior notice and prior or pending litigation exclusions barred coverage for the subsequent claims. The court interpreted the prior notice provision to bar coverage only if two claims originated from the same or similar facts; however, the court found that the later-asserted claims did not originate from the prior shareholder suits just because they shared background facts. It further reasoned that the exclusion did not apply because the insurer did not pay out under the prior policy for the shareholder claims. The court then interpreted the prior and pending litigation exclusion to bar coverage only if the claims arose from the factual circumstances that formed the basis of the prior shareholder suits. In doing so, the court held that, like the prior notice exclusion, the insurers' defense based upon the prior or pending litigation exclusion was defeated by the underlying facts.

### *XF, LLC v. Ace Am. Ins. Co.*, No. 20 C 4756, 2021 U.S. Dist. LEXIS 171506, 2021 WL 4133553 (N.D. Ill. Sept. 10, 2021)

Under Illinois law, the U.S. District Court for the Northern District of Illinois found that a prior acts exclusion in one of the policies at issue did not apply where the insureds sought coverage for two claims under two different policies. The insurer issued two claims-made and reported policies: a private company management liability policy issued to the insured for the period from May 31, 2017 to February 8, 2019 (the "2017 policy"), and a similar policy issued to the successor to the insured for the period from February 8, 2019 to February 8, 2020 (the "2019 policy"). The relevant insuring agreements and definitions for each policy were the same, with two exceptions: the 2017 policy had an "extended reporting period" endorsement, which extended the notice and reporting deadline to February 8, 2025, and the 2019 policy had a prior acts exclusion, which provided that "[t]he insurer shall not be liable for Loss on account of any claim … alleging, based upon, arising out of, or attributable to any Wrongful Act committed, attempted or allegedly committed or attempted in whole or in part, before 02/08/2019." The insurer filed a motion to dismiss, arguing that the prior acts exclusion in the 2019 policy should apply in order to prevent double coverage. Although the court acknowledged that the double coverage danger was "created by the eight-year extended reporting date contained in the 2017 policy[,]" the court found that double coverage was not being sought. The court reasoned that the insureds were asking to be covered by the 2017 policy for an act that occurred and was reported during that policy period, and asking to be covered by the 2019 policy for acts that occurred and were reported during the period that the 2019 policy was in effect. Because the insureds were not demanding that the 2017 policy applied to the 2019 claim, the court rejected the insurer's argument about double coverage and did not apply the prior acts exclusion from the 2019 policy.

### *Atl. Healthcare v. Argonaut Ins. Co.*, No. 2:19-cv-14420, 2021 U.S. Dist. LEXIS 15054, 2021 WL 266281 (S.D. Fla. Jan. 27, 2021) (applying Maryland law)

Applying Maryland law, the U.S. District Court for the Southern District of Florida found that an insurer had a duty to defend because the policy's prior acts exclusion did not apply. The insurer issued a directors and officers liability policy that contained a prior acts exclusion that barred coverage for Loss arising out of "1. any act, omission fact, circumstance, situation, transaction, or event which occurred, or is alleged to have occurred, in whole or in part, prior to December 1, 2012, including any act, omission, fact, circumstance, situation, transaction, and/or event which constitutes a Wrongful Act; or 2, any other act, omission, fact, circumstance, situation, transaction, or event, whenever occurring or allegedly occurring, which together with an act, omission, fact, circumstance, situation, transaction, and/or event described in paragraph 1 above constitute Interrelated Wrongful Acts." The insurer argued the insured's alleged fraud and concealment in the underlying action continued daily until it was discovered, and that the alleged facts from the underlying complaint were logically and casually connected facts that fell within the policy's prior acts exclusion. The court analyzed the underlying complaint and rejected the insurer's characterization that the allegations constituted a daily, ongoing fraudulent scheme that was perpetrated over the course of several years. Construing the duty to defend liberally in the insured's favor, the court concluded that there was a potential for coverage and affirmed the magistrate judge's report and recommendation to grant the insured's summary judgment motion and deny the insurer's amended summary judgment motion.

### *Republic Franklin Ins. Co. v. Ebensburg Ins. Agency*, No. 4:20-CV-01741, 2021 U.S. Dist. LEXIS 103137, 2021 WL 2222729 (M.D. Pa. June 2, 2021)

Under Pennsylvania law, the U.S. District Court for the Middle District of Pennsylvania held that prior notice exclusions did not obviate an insurer's duty to defend its insureds. The insurer issued a professional liability policy that applied only to past wrongful acts where "[t]he insured had no knowledge that such 'wrongful act' was likely to give rise to a 'claim' thereunder," along with an additional insured endorsement that excluded "[a]ny 'claim' for, or arising out of a 'wrongful act' which any insured knew of before the effective date of this endorsement." The plaintiff in the underlying lawsuit asserted claims for negligence, breach of contract, and fraudulent misrepresentation, alleging that the insureds violated a contract between the plaintiff and the insureds when the insured prepared and submitted on behalf of another company an insurance application containing inaccurate information. The insurer sought a declaration that it had no duty to defend or indemnify the insureds in the underlying suit, arguing that the provisions were conditions precedent to the policy's existence. Rejecting that argument, the court found that the prior notice provisions constituted exclusions because, although facially appearing to define claims, they operated to exclude claims of which an insured had prior notice. The court emphasized Pennsylvania's four-corners rule, which requires the insurer to show that the exclusions applied on the face of the underlying complaint, without any extrinsic evidence. The insurer also argued that the claims were precluded because both insureds knew that the first insured had committed a "wrongful act" by submitting the company's application to the plaintiff and thus should have known it was likely to give rise to a claim. Despite finding that the policy exclusion was governed by a mixed subjective knowledge-objective reasonable person standard and the endorsement exclusion was governed by a purely subjective knowledge standard, the court ultimately held that neither exclusion applied because the underlying complaint did not allege facts showing that either insured possessed subjective knowledge that they had committed a wrongful act. The complaint contained neither allegations that the insured supplied or falsified the incorrect information nor even knew it was incorrect, nor any facts showing that the additional insured was aware the application was submitted with false information. The court therefore dismissed the insurer's claims regarding its duty to defend. An appeal to the U.S. Court of Appeals for the Third Circuit is pending.

### *Jeffers Farms, Inc. v. Liberty Ins. Underwriters, Inc.*, No. 20-5475, 2021 U.S. Dist. LEXIS 189466, 2021 WL 4502785 (E.D. Pa. Sept. 30, 2021)

Under Pennsylvania law, the U.S. District Court for the Eastern District of Pennsylvania granted an insurer's motion to dismiss because the "prior acts" exclusion applied where there was no dispute that the alleged acts and omissions at issue in the underlying action began prior to the date at issue. The insurer issued a claims-made directors, officers, and company liability policy. The insurer argued that any losses resulting from the claims made against the insured in the underlying action were excluded from coverage under the policy's prior acts exclusion, which provided, "[t]he insurer shall not be liable under any Insuring Clause in this Coverage Part for Loss on account of any Claim made against any Insured … based upon, arising out of, or attributable to any Wrongful Act taking place in whole or in part prior to 02/18/2016." The court found that the prior acts exclusion applied because the insured did not contest that the alleged acts and omissions at issue began back in 1961. The court further rejected as irrelevant the insured's argument that there was no evidence that the insured committed a Wrongful Act, and the court further found the insured's invocation of the "reasonable expectations" doctrine in the abstract was not enough to overcome the plain language of the policy exclusion. Accordingly, the court found there was no duty to defend and granted the insurer's motion to dismiss the breach of contract claim with leave to amend.

## V. Dishonesty and Personal Profit Exclusions

### *Scottsdale Ins. Co. v. Fineman*, No. 4:20-CV-00368-YGR, 2021 U.S. Dist. LEXIS 22556, 2021 WL 411360 (N.D. Cal. Feb. 5, 2021)

Under California law, the U.S. District Court for the Northern District of California concluded that a conduct exclusion in a directors and officers and company liability policy did not bar coverage for an underlying arbitration because there was no dishonest act upon which application of the exclusion could be based. The exclusion barred coverage for claims "alleging, based upon, arising out of, attributable to, directly or indirectly resulting from, in consequence of, or in any way involving any dishonest, deliberately fraudulent or criminal act of an Insured; provided, however [that] this exclusion … shall not apply unless and until there is a final judgment against such Insured… ." The insured, among various other arguments, asserted that the exclusion did not apply because the arbitrator did not find "intentional, fraudulent, or criminal conduct" attributable to the insured in the underlying arbitration and that the arbitrator's finding of negligent misrepresentation was not predicated on dishonesty under California law, which provides that a defendant may be liable for negligent misrepresentation for false statements made with the honest belief that they are true. Because the arbitrator had found that the insured "honestly believed" the negligent misrepresentation he made, the court determined that the insurer could not show the arbitrator's decision found dishonesty attributable to the insured, and that negligent misrepresentation is not necessarily based on dishonest conduct. Thus, the exclusion did not preclude coverage because no dishonest act was found.

### *RSUI Indem. Co. v. Murdock*, 248 A.3d 887 (Del. 2021)

Under Delaware law, the Delaware Supreme Court held that a personal profit and fraud exclusion in an excess directors and officers liability policy did not bar coverage for the settlement of a securities action arising out of a merger transaction in which the insured was privatized by its director and CEO's acquisition of all stock not already owned by him. The exclusion applied with respect to any Claim "based upon, arising out of or attributable to … any profit, remuneration or financial advantage to which the Insured was not legally entitled; or … any willful violation of any statute or regulation or any deliberately criminal or fraudulent act, error or omission by the Insured; if established by a final and non-appealable adjudication adverse to such Insured in the underlying action." The stockholders of the insured brought the underlying breach of fiduciary

duty action, alleging that the director and CEO, with the help of another executive, manipulated the value of the insured-company's stock and thereby acquired the insured-company at an artificially low price. In its opinion, the underlying court determined that the two executives acted fraudulently and breached their duties of loyalty through a series of intentional, unfair, and fraudulent actions that, among other things, drove down the insured's pre-merger stock price, undermining it as a measure of value. Subsequently, citing the fraud and breach of loyalty findings in the underlying opinion, the stockholders filed a separate federal securities action against the insured-company and the two executives. The insured-company settled the securities action. The excess insurer contended that because the allegations in the federal securities action arose directly out of the findings in the underlying action, the settlement of the federal securities action was "based upon, arising out of or attributable to" the adjudication of fraud and, therefore, the profit/fraud exclusion barred coverage for both the federal securities action and the underlying action. Focusing on coverage for the federal securities action, the Delaware Supreme Court rejected the insurer's argument as contrary to the exclusion's requirement that the fraud adjudication be "in the underlying action," concluding that in the settlement context, "the underlying action" referred to the litigation in connection with which the insureds became legally obligated to pay on account of a claim. The court determined that the fact that some findings in the underlying action might have been implicated in the resolution of the federal securities action had it not been settled was irrelevant to a determination of whether there was an adjudication in the federal securities action. The court further noted that, even if "the underlying action" could be interpreted to include the federal securities action, this would result in an ambiguity to be resolved in the insureds' favor.

## VI. Restitution, Disgorgement, and Damages

### *Sycamore Partners Mgmt., L.P. v. Endurance Am. Ins. Co.*, No. N18C-09-211 AML CCLD, 2021 Del. Super. LEXIS 182, 2021 WL 761639 (Feb. 26, 2021)

Under Delaware law, the Superior Court of Delaware held that settlement funds are not uninsurable losses pursuant to policies' "law most favorable" clauses. The court considered policies that provided coverage excess to directors and officers and errors and omissions policies. The insurers refused to pay a $120 million claim related to the insured's settlement of breach of fiduciary duty claims. The insurers claimed the insured's settlement was uninsurable as a matter of public policy under New York law. Although the policies defined "Loss" to include settlements, judgments, damages, and various litigation fees, the policies excluded from the definition of Loss "amounts which are uninsurable under the law most favorable to … insurability." At issue was whether these policies' "law most favorable" provisions should be interpreted as a choice-of-law clause, allowing the insured to select the state law that applied. The insurers argued that New York law applied because the "law most favorable" provisions did not identify a particular state. The court rejected the insurers' argument, citing to established contracting principles and Delaware's interest in disputes involving insurance coverage for fiduciary mismanagement. The court determined that the policies' "law most favorable" provisions were "unambiguously" clear that the insured had the right to and correctly chose that Delaware law applied. In Delaware, "losses are uninsurable as-against public policy only if the legislature so provides." Here, Delaware had no such statute, thus the loss was "insurable under Delaware law."

### *Astellas US Holding, Inc. v. Starr Indem. & Liab. Co.*, No. 17-cv-08220, 2021 U.S. Dist. LEXIS 195236, 2021 WL 4711503 (N.D. Ill. Sept. 23, 2021)

Under Illinois law, the U.S. District Court for the Eastern District of Illinois held that a settlement payment to the Department of Justice ("DOJ") constituted a covered loss under a directors and officers liability policy. In March 2016, the DOJ issued a subpoena to the insured in connection with an investigation into potential violations of the Anti-Kickback Statute and under the False Claims Act. The DOJ and the insured ultimately entered into a settlement agreement that included a $50 million payment described as "restitution to the United States." The insured demanded coverage for the full amount of the settlement from its directors and officers liability policy. Among other relevant provisions, the primary policy at issue defined "loss" to include "damages, settlements or judgments," but it excluded any matters that "may be deemed uninsurable under applicable law." The insurer argued that the payment constituted a return of the insured's unjust gains, and that well-established Illinois law deemed such losses uninsurable. The court disagreed and held that the settlement payment was insurable. Among other things, the court found that the insurer, not the policyholder, should bear the burden of proof where it seeks to avoid coverage for settlement payments based on the definition of "loss." The court also found that the "restitution" label does not automatically render a settlement payment uninsurable. The case is on appeal to the U.S. Court of Appeals for the Seventh Circuit.

### *J.P. Morgan Sec. Inc. v. Vigilant Ins. Co.*, No. 61, 2021 N.Y. LEXIS 2519, 2021 WL 5492781 (N.Y. Nov. 23, 2021)

Under New York law, the Court of Appeals of New York held that a compensatory settlement payment was not a penalty for which coverage was precluded under the policy at issue. The insurer issued a professional liability policy that defined "loss" to include compensatory and punitive damages but excluded "fines or damages imposed by law." In the 2000s, the insured's successor-in-interest settled claims related to alleged security law violations, agreeing to a "$140 million disgorgement" payment among other agreed payments. At issue was whether this disgorgement payment was a "penalty imposed by law," and thus excluded from the definition of loss under the policy. In holding for the insured, the court found the insurers failed to meet their burden that an exclusion applied to defeat coverage. The court found that the "$140 million payment served a compensatory goal" because it was the estimated third-party gains and investor losses calculated during the settlement negotiations. The court was unpersuaded by the insurer's cite to the Supreme Court's decision in *Kokesh*, which interpreted an SEC-ordered disgorgement payment as a penalty because it was "imposed to vindicate a public, rather than a private wrong." The Court of Appeals of New York explained that the *Kokesh* decision was unrelated to interpreting "penalty" in an insurance contract, thus it did not control the current dispute. Therefore, the court found that the insurer failed to establish that the settlement "unambiguously" fell within the policy exclusion for "penalties imposed by law."

## VII. Insured Capacity

### *TriPacific Capital Advisors, LLC v. Fed. Ins. Co.*, No. SACV 21-919 JVS (JDEx), 2021 U.S. Dist. LEXIS 222497, 2021 WL 5316407 (C.D. Cal. Nov. 15, 2021)

Under California law, the U.S. District Court for the Central District of California held that a directors and officers liability insurer had a duty to defend the president of the named insured against a claim brought in arbitration against the president and a former junior officer. In the coverage action, the president brought a motion for summary judgment that the insurer had a duty to defend him in the arbitration. Among the grounds the insurer raised in opposition to the president's motion was that the claim for breach of fiduciary duty against him was not brought against him in his insured capacity. The insurer cited to several sections of the underlying complaint that referenced an alleged "joint venture" between the president and the claimant. The insurer suggested that the claimant brought the cause of action against the president as a joint venture partner instead of as a director or officer of the

insured because there is no fiduciary duty owed by a supervisor to an employee. The court agreed with the insured that he was potentially acting in his capacity as a director or officer of the insured with respect to the breach of fiduciary duty claim. The court noted that all of the relevant documents were signed by insured in his capacity as president.

### *Spicer v. Nat'l Union Fire Ins. Co. of Pittsburgh*, No. 1:20-cv-3784-GHW, 2021 U.S. Dist. LEXIS 125513, 2021 WL 2809601 (S.D.N.Y. July 3, 2021)

Under New York law, the U.S. District Court for the Southern District of New York held that an insurer had a duty to defend a counterclaim that at least arguably made allegations of wrongful conduct against three insured executives in their capacities as such. The insurer provided directors and officers liability insurance for the benefit of the executives of a company. Three executives covered under the policy also were the principal shareholders of the company's parent corporation. The executives were involved in the sale of the parent company to a third party and later sued the acquirer under the earnout provision in the purchase and sale agreement. The acquirer brought a counterclaim against the executives, alleging that they misrepresented the financial condition of both the parent and subsidiary companies, causing the acquirer to purchase the parent company at an inflated price. The executives made a demand on the insurer to fund their defense. The insurer refused and denied coverage, arguing that the counterclaim did not allege "Wrongful Acts," which required that alleged conduct be taken by the subsidiary's executives or employees "in their respective capacities as such" or involve "claims against such Executive or Employee solely by reason of his or her status as an Executive or Employee of the Company." The insurer also denied coverage pursuant to the policy's "capacity" exclusion, which precluded coverage for losses in connection with claims, "alleging, arising out of, based upon or attributable to any actual or alleged act or omission of an Individual Insured serving in any capacity other than as an Executive or Employee of a Company[.]" In the subsequent coverage action, the executives filed a motion for judgment on the pleadings and the insurer filed a motion to dismiss.

The court granted the executives' motion, holding that because it "cannot conclude with certainty that the Counterclaims fall outside the scope of coverage provided by the Policy," the executives were entitled to a defense from the insurer. Relying on the first prong of the "Wrongful Act" definition, which, unlike the second prong, did not include the word "solely," the court concluded that it "may reasonably be inferred that the plaintiffs acted in their roles as executives of [the subsidiary] in preparing the misleading financial statements of the company that were later provided to [the acquirer]." The court noted that the misrepresentations alleged in the counterclaims related to the subsidiary's business, the misrepresentations were included in the subsidiary's financial statements, and that the misrepresentations were alleged to have been made by the subsidiary.

## VIII. Insured v. Insured Exclusion

### *Tarter v. Navigators Ins. Co.*, No. 21-5129, 2021 U.S. App. LEXIS 32175, 2021 WL 4950375 (6th Cir. Oct. 25, 2021)

Under Kentucky law, the U.S. Court of Appeals for the Sixth Circuit held that an insured v. insured exclusion barred coverage for an underlying litigation despite one of the plaintiffs not being an insured under the policy. The insurer issued a directors and officers liability policy covering various family companies involved in farm equipment manufacturing. The insured v. insured exclusion precluded coverage where a "Claim [is] made against any Insured … by or on behalf of any Insured or any security holder of the Company" unless "the security holder bringing such Claim is acting totally independently of, and without the solicitation, assistance, active participation or intervention of, the Company or any Insured Person." In the underlying action, one of the family businesses and various family members brought an action against another family member, Joshua Tarter. At the time, Mr. Tarter was a part owner of the insured and held management responsibilities there. The insurer denied coverage based on the insured v. insured exclusion. Mr. Tarter then brought suit against the insurer, arguing that because one of the named plaintiffs in the underlying action was not an insured,

the insured v. insured exclusion was inapplicable. The Sixth Circuit disagreed, finding that the insured v. insured exclusion applied despite the presence of a plaintiff who was not an insured.

### *Starr Indem. & Liab. Co. v. Point Ruston LLC*, No. C20-5539RSL, 2021 U.S. Dist. LEXIS 155135, 2021 WL 3630511 (W.D. Wash. Aug. 17, 2021)

Under Washington law, the U.S. District Court for the Western District Court held that an insured v. insured exclusion could not be applied to claims asserted by a member of an insured LLC. Additionally, the court determined that a lawsuit is not brought "on behalf of" an "insured" merely because the person is an officer or "principal" that may benefit from the undertaken action. The insurer issued a claims-made policy containing an insured v. insured exclusion barring coverage for "any Loss in connection with any Claim . . . . brought by or on behalf of any insured . . . ." "Insured" included an "Insured Person" such as an "Executive" defined as a "management committee Member" and "Member of the board of managers." The underlying lawsuit listed numerous insured defendants and alleged mismanagement of a commercial housing development project in which Thomsen Ruston LLC (TRL) and Jess Thomsen, Inc. (JTI) invested. TRL was a member of various LLCs insured under the policy and the president of JTI was also a principal of TRL. The insurer argued that the insured v. insured exclusion applied because TRL was an "Insured" and the underlying action was brought on behalf of TRL's principal. In finding that the insured v. insured exclusion did not bar coverage, the court first reasoned that merely being a member of an insured LLC did not qualify the member as an "Insured Person" under the policy's definitions. Instead, TRL would need to be a member that qualified as an "Executive" in order to be an "Insured Person." On the second argument, the court affirmed that distinct entities such as LLCs and corporations do not "necessarily act 'on behalf of' their principals or officers" and should not be construed as such.

## IX. Coverage For Contractual Liability

### *Fed. Ins. Co. v. Healthcare Info. and Mgmt. Sys. Soc'y, Inc.*, No. 20 C 6797, 2021 U.S. Dist. LEXIS 201161, 2021 WL 4864142 (N.D. Ill. Oct. 19, 2021)

Under Illinois law, the U.S. District Court for the Northern District of Illinois rejected an insurer's broad reading of a contract exclusion and found coverage because it concluded the underlying complaints sought more than just contractual damages. The insured sought coverage under a directors and officers liability policy for the settlement of two underlying lawsuits resulting from the insured's cancellation of a 2020 trade show due to COVID-19. Specifically, the underlying class-action lawsuits sought the return of fees paid by exhibitors scheduled to appear at the insured's trade show. The insurer, in part, argued that coverage was barred by a "Contract Exclusion," which provided that the insurer was not liable for losses "on account of any Claim based upon, arising from, or in consequence of any actual or alleged liability of [the insured] under any written oral contract or agreement," except to the extent that the insured "would have been liable in the absence of such contract or agreement." Holding in favor of the insured, the court reasoned that despite allegations that the insured breached its contract by refusing to refund the exhibitor's fees, the underlying complaints sought more than just contract damages. Rather, the ultimate settlement resolved all claims — not just contract claims. Thus, the court applied the exception to the exclusion because the insured would have still been liable even in the absence of the trade show contracts.

### *Glob. Fitness Holdings, LLC v. Navigators Mgmt. Co., Inc.*, 854 F. App'x 719 (6th Cir. 2021)

Under Kentucky law, the U.S. Court of Appeals for the Sixth Circuit upheld a broad form contractual liability exclusion in a directors and officers liability policy, holding that the exclusion barred coverage for both contract and tort-based causes of action. The insured fitness gym operator sought coverage for a class-action lawsuit in which the insured was

alleged to have misrepresented and concealed material terms of its membership and training contracts, overcharged customer accounts for the services provided under these contracts, and made cancellation of the contracts "as difficult as possible." The insurer denied coverage on the basis of an exclusion that applied to any claim "in any way involving any liability under any contract or agreement," except "to the extent that [the insured] would have been liable in the absence of such contract or agreement." The insured argued that the insurer had misinterpreted the scope of this exclusion and that, even if the exclusion applied, the exception to the exclusion still required the insurer to defend the insured. The Sixth Circuit ultimately upheld the district court's grant of summary judgment to the insurer, reasoning that the underlying litigation "arose out of" the insured's contracts because "every aspect" of that litigation was premised upon the existence of the contracts between the insured and its customers. Further, despite characterizing the exclusion as "staggeringly broad," the nature of the underlying claims — which could not have been brought but for those contracts with the insured — foreclosed any reliance upon the exception to the exclusion for liability in the absence of such contract or agreement.

### *Verto Med. Sols. LLC, v. Allied World Specialty Ins. Co.*, 996 F.3d 912 (8th Cir. 2021)

Under Missouri law, the U.S. Court of Appeals for the Eighth Circuit held that "ambiguous" language in a directors and officers liability policy prevented the insurer from relying upon a contractual liability exclusion to deny coverage for claims brought by investors against the insured company and its CEO. Specifically, the policy had a contractual liability exclusion, identified as exclusion "D," that the insurer would "not cover any Loss in connection with any Claim … based upon, arising from, or in consequence of any actual or alleged liability of any Insured under any express contract or agreement." However, the policy also contained two key endorsements. Endorsement 11 "delet[ed] Exclusion D. in its entirety and replac[ed] it with" a new contractual liability exclusion, also labeled with a "D," while Exclusion 13 purported to delete "Exclusions A., B., C. and D.…in their entirety and replace[]" those exclusions with a list of three new exclusions labeled "A," "B," and "C," none of which directly addressed contractual liability. While the insurer relied on a contractual liability exclusion to deny coverage, the insured argued that the application of the endorsements meant that any contractual liability exclusion was completely stricken from the policy. Reasoning that the policy language was ambiguous as to whether any contractual liability exclusion remained in force, the Eighth Circuit ultimately adopted the insured's interpretation.

## X. Professional Services

### Professional Services Insuring Agreements

### *Kulovitz v. Aspen Specialty Ins. Co.*, No. 1:21-cv-307-ACA, 2021 U.S. Dist. LEXIS 220073, 2021 WL 5300929 (N.D. Ala. Nov. 15, 2021)

Under Alabama law, the U.S. District Court for the Northern District of Alabama held that there was no duty to defend the insured dentist in connection with a claim for malicious prosecution and fraud. The insured's dental liability policy covered amounts an insured is legally obligated to pay as a result of injury or damage that is "caused by a dental incident arising out of the supply of or failure to supply professional services." Under the policy, a "dental incident" meant "any actual or alleged act, error or omission, or a series of actual or alleged acts, errors or omissions, in the supplying of or failure to supply professional services." "Professional Services" was further defined as "those services for which [the insured is] licensed, trained and qualified to perform in [his] profession as a dentist." A patient supplied the insured dentist with a check as security for a monthly payment plan, and after paying down the balance for over a year, the insured altered the check date and attempted to cash it. After the check was returned for insufficient funds, the insured brought charges against the patient. The underlying complaint subsequently brought by the patient against the dentist alleged malicious prosecution, negligence,

and fraud. The insured argued that a defense was owed because the claim "arose out of" his professional services — the original provision of dental treatment. The court disagreed and found that there was no "dental incident" because the allegations of malicious prosecution and fraud were not the result of alleged acts, errors or omissions in supplying or failing to supply dental professional services. In other words, the court found that a defense would be owed only if the alleged injury was caused by an act, error or omission committed by the insured in supplying dental services arising from services in which he was trained to perform as a dentist.

### *Elite Integrated Med., LLC v. Hiscox, Inc.*, No. 1:20-cv-3948-AT, 2021 U.S. Dist. LEXIS 181547, 2021 WL 4269363 (N.D. Ga. Aug. 10, 2021)

Under Georgia law, the U.S. District Court for the Northern District of Georgia held that there was no duty to defend the insured medical practice in connection with a claim for unfair business practices brought by the State of Georgia. The insured's professional liability policy covered claims "alleging a negligent act, error or omission in your professional services[.]" "Professional services" was defined as conduct "[s]olely in the performance of services as a physical medicine clinic including chiropractic, hormone therapy, neurotherapy, medical and non-medical weight loss, allergy testing, durable medical equipment therapy and/or instruction, PRP, and amniotic human tissue injections and naltrexone implants." The State served a "Notice of Contemplated Legal Action" alleging deceptive and unfair business practices related to the insured's marketing, claiming that the insured made several false and/or misleading representations regarding its medical services offerings, including their efficacy and their approval by the FDA. The court agreed with the insurer that no coverage was afforded because the claims did not involve alleged acts or omissions in the insured's "professional services." The court found that the allegations of false advertising did not assert negligent acts in the actual performance of "professional services" such as administering therapies. Rather, the advertising of therapies was "incidental" to the insured's professional services as a medical clinic actually providing injections, implants, therapies, and medical services, and no duty to defend was owed. A notice of appeal was filed on September 8, 2021. (*Note: Troutman Pepper represented the insurer in this action*).

### *Spurling v. Westport Ins. Corp.*, No. 1:21-00053-JDL, 2021 U.S. Dist. LEXIS 229940, 2021 WL 5702161 (D. Me. Dec. 1, 2021)

Under Maine law, the U.S. District Court for the District of Maine held that an insurer owed the insured lawyer a duty to defend in connection with alleged sexual assault and professional misconduct. The lawyer's professional liability policy provided coverage for loss by reason of an alleged Wrongful Act which was defined as "any act, error, omission, circumstance, [Personal Injury] or breach of duty in the rendition of [Professional Services]." To qualify as an insured under the policy, the attorney must have rendered professional services on behalf of the firm. "Professional Services" meant "services rendered to others in the [Insured's] capacity as a lawyer … and arising out of the conduct of an [Insured's] profession as a lawyer." The insurer argued that an alleged sexual assault during an attorney-client meeting did not occur while the lawyer was directly providing professional services, and he therefore did not qualify as an insured. The court rejected this argument, finding that alleged assault during an attorney-client meeting could be found to be a breach of ethical duties and professional responsibilities. The court also found a Wrongful Act, holding that because the insured and claimant entered into an attorney-client relationship and initially met to discuss the rendering of legal services, the insured's subsequent actions would constitute "act[s], circumstance[s], or breach[es] of duty [that occurred] in the rendition of [Professional Services]."

### *Saoud v. Everest Indem. Ins. Co.*, No. 19-12389, 2021 U.S. Dist. LEXIS 140573, 2021 WL 3186736 (E.D. Mich. July 28, 2021)

Under Michigan law, the U.S. District Court for the Eastern District of Michigan found that allegations of providing clients with information about an investment product claimed to be an unregistered security could constitute professional services and warrant a duty to defend. The insured's professional liability policy provided coverage for wrongful acts in rendering "Professional Services," which was defined as "the … attempted sale … of life insurance, accident and health insurance or managed health care organization contracts (that does not require a securities license); (b) the … attempted sale … of disability income insurance … (c) the … attempted sale … of indexed/fixed annuities, … [and] (e) financial planning activities in conjunction with services described in paragraphs (a) through (d) of this definition, whether or not a separate fee is charged[.]" The insured sold insurance-related products, such as life insurance and annuities and was accused of offering to clients an investment product that constituted an unregistered security. The insurer denied coverage for three lawsuits on grounds that the offer of unregistered securities did not constitute "Professional Services." The court disagreed, finding that although the investment product was not insurance or an annuity under subsections (a) – (c), a reasonable jury could conclude that under subsection (e), the offer to clients occurred while the insured was engaged in financial planning activities in conjunction with services described in subsections (a) – (c). The insured offered evidence demonstrating that the insured hosted seminars focused on retirement planning and insurance, and it was only after such seminars that the insured held individual meetings with clients. It was at those meetings where the clients requested alternatives to insurance products, and information about the investment product was provided. The court did not reach a final decision regarding whether a duty to defend was owed, as pursuant to Michigan law, the court required additional briefing regarding whether an exclusion might negate coverage.

### *Aspen Am. Ins. Co. v. Jones*, No. 20-659 (PAM/DTS), 2021 U.S. Dist. LEXIS 13252, 2021 WL 247921 (D. Minn. Jan. 25, 2021)

Under Minnesota law, the U.S. District Court for the District of Minnesota denied a motion for summary judgment brought by a professional liability insurer against an insured dentist who was being sued by a former patient. The dentist's policy provided coverage for any "injury or damage … caused by a dental incident arising out of the supplying of or failure to supply professional services." The insurer began a dental treatment plan for the patient, which involved extractions, implants, and a temporary bridge for which the patient paid in advance. The treatment plan was delayed by 20 months when the dentist lost his practice, declared bankruptcy, and went into treatment for alcohol addiction. During that time, the dentist failed to communicate with his patient and made numerous misrepresentations about his ability to provide dental services. The court found a factual dispute about whether the dentist failed to provide dental services. The court noted that although the services were delayed by 20 months, it was not apparent that the 20-month delay qualified as a failure to provide services within the meaning of the policy. Accordingly, the court denied the motion for summary judgment.

### *Church Mut. Ins. Co. v. Lake Pointe Assisted Living, Inc.*, 517 F. Supp. 3d 467 (E.D.N.C. 2021)

Applying North Carolina law, the U.S. District Court for the Eastern District of North Carolina found that an insurer was obligated to defend an adult care home and its owners in a suit brought by residents of the home for breach of contract, violation of the North Carolina Unfair Trade Practices Act, and negligence. The policy specifically provided coverage for injuries caused by a "professional health care incident." The insurer argued that the policy did not cover injuries caused from ordinary breaches of contract that did not involve the provision of professional services that require specialized skill or knowledge. The district court found that the policy's language had a broader application than normal because it incorporated North Carolina law in its definition of a "professional

health care incident." The court held that a "professional health care incident" encompassed violations of any rights of residents pursuant to the bodies of law that regulate the insured as a residential health care facility. Thus, although the facility's failure to hire staff, provide nutritious meals, or provide promised social activities may not ordinarily fall within coverage under a professional liability policy, there was a possibility for coverage in light of the policy language and North Carolina law.

### *Harriman v. Associated Indus. Ins. Co.*, No. 2:18-cv-2750-DCN, 2021 U.S. Dist. LEXIS 112828, 2021 WL 2457664 (D.S.C. June 16, 2021)

Under South Carolina law, the U.S. District Court for the District of South Carolina held that an insurer owed the insured investment advisor a duty to defend in connection with an alleged "delusional and malicious campaign of economic terrorism." The insured's professional liability policy provided coverage for "any actual or alleged negligent act, error, omission, misstatement, misrepresentation or breach of duty by an Insured … in rendering or in failing to render Professional Services[.]" "Professional Services" was defined generally as "(1) the sale of certain financial products and securities; (2) the administration of certain retirement accounts; (3) the provision of Investment Advisory Services; and (4) professional supervision." The insurer argued that the alleged conduct, disparagement, and defamatory comments did not fit within any of the definitions of Professional Services. The court disagreed, finding that a defense was owed under South Carolina law, which requires that an insurer defend as long as the allegations in the underlying complaint create the possibility of coverage. The underlying complaint alleged that the tortious conduct occurred while the insured was acting in the course and scope of, and in her capacity as, an agent for her employer, and that the insured made defamatory remarks to clients. The court reasoned that so long as the insured was alleged to be acting within the scope of her employment, there was a possibility that she was providing Professional Services.

## Professional Services Exclusions

### *Guaranteed Rate, Inc. v. ACE Am. Ins. Co.*, No. N20C-04-268 MMJ CCLD, 2021 Del. Super. LEXIS 552, 2021 WL 3662269 (Aug. 18, 2021)

Applying Delaware law, the Delaware Superior Court found that a professional services exclusion did not bar coverage for a Civil Investigative Demand ("CID") issued by the U.S. Attorney's Office. The insured's private company management liability policy contained an exclusion barring loss "on account of any Claim … alleging, based upon, arising out of, or attributable to any Insured's rendering or failure to render professional services." "Professional services" was not defined in the policy. The insured received a CID issued pursuant to the False Claims Act. The government investigation concerned allegations that the insured originated and underwrote federally insured mortgage loans that failed to meet applicable quality-control requirements. The court found that the professional services exclusion did not apply, in part because "professional services" was not defined, and therefore warranted narrow application. Relying on comparable case law, the court found that the insured's alleged failure to meet certain standards was owed most directly to the federal government, not to the mortgage borrowers, and the insured was in the business of underwriting and issuing loans to borrowers. Compliance with applicable quality-control standards was therefore not a Professional Service provided directly to borrower clients, such that coverage would be excluded by the professional services exclusion. The court further noted that the broad application advocated by the insurer could be interpreted so that almost any aspect of an insured's business would be related to rendering professional services and could conceivably preclude coverage for all claims made under the policy.

### *Fed. Ins. Co. v. Healthcare Info. & Mgmt. Sys. Soc'y, Inc.*, No. 20 C 6797, 2021 U.S. Dist. LEXIS 201161, 2021 WL 4864142 (N.D. Ill. Oct. 19, 2021)

Under Illinois law, the U.S. District Court for the Northern District of Illinois held that a professional services exclusion did not relieve the insurer of a duty to defend lawsuits resulting from a cancelled trade conference. The policy's directors and officers entity liability section contained a "professional services exclusion" that barred coverage for "any Claim based upon, arising from, or in consequence of any actual or alleged error, misstatement, misleading statement, act, omission, neglect, or breach of any duty … in connection with the rendering of, or actual or alleged failure to render, any Professional Services (as defined in paragraph 2 of this endorsement)[.]" The court did not analyze or apply the policy definition of professional services, but instead applied Illinois courts' interpretation of professional services in an insurance exclusion as "any business activity conducted by the insured which involves specialized knowledge, labor, or skill, and is predominantly mental or intellectual as opposed to physical or manual in nature." The underlying complaints sought damages for breach of contract for failing to return fees paid, as well as damages for costs the plaintiffs incurred preparing for and travelling to the conference. The court stated that the claims were not entirely based on negligent provision of professional services but instead dealt at least in part with reimbursement for damages resulting from the inability to sublet floor space at the conference. The court further found that subleasing floorspace is not necessarily a professional service, and the underlying complaints did not allege that defendant exercised poor professional judgment when cancelling the conference in light of the COVID-19 pandemic. Consequently, the court concluded that the insurer had not carried its burden of establishing that the professional services exclusion applied.

## XI. Independent Counsel

### *Nede Mgmt. Inc. v. Aspen Am. Ins. Co.*, 68 Cal. App. 5th 1121 (2021)

Under California law, the California Court of Appeal held that neither the insurer's reservation of rights with respect to punitive damages and damages beyond the policy limits, nor the alleged failure and refusal of the defense attorney to properly defend the insured, entitled the insured to independent counsel. The insureds brought a declaratory relief action against their liability insurer claiming they were entitled to independent counsel to defend them in the underlying tort action. The court explained that the mere fact that an insurer disputes coverage does not entitle the insured to independent counsel. Nor does the fact that the complaint seeks punitive damages or damages in excess of policy limits. Further, the conflicts of interest contemplated by California Civil Code Section 2860 do not include the insured's "mere dissatisfaction" with the performance of insurer-appointed counsel. The rejection of a policy-limits settlement demand at the start of the tort action, without consulting the insured, was the insurer "simply exercising the right to control the defense." However, the court noted independent counsel would be required if the insurer pursued a settlement in excess of policy limits without the insured's consent.

### *Marentes v. Crusader Ins. Co.*, No. A158769, 2021 Cal. App. Unpub. LEXIS 7760, 2021 WL 5873168 (Dec. 13, 2021)

Under California law, the California Court of Appeal affirmed the trial court's grant of summary judgment for the insurer, finding the insurer did not act in bad faith, including with respect to circumstances surrounding the offering of independent counsel. The insurer issued a $1 million automobile liability policy. After the insured declined an offer of independent counsel and accepted a demand to settle that included payments above policy limits, the insured sued the insurer, primarily arguing the insurer and its counsel had multiple undisclosed conflicts of interest. The court agreed with the

insurer that the insured's declination of independent counsel was informed and therefore binding.

### *Travelers Indem. Co. of Conn. v. Newlin*, No. 20CV765-GPC(DEB), 2021 U.S. Dist. LEXIS 65019, 2021 WL 1238886 (S.D. Cal. Apr. 2, 2021)

Under California law, the U.S. District Court for the Southern District of California found that the insured alleged facts sufficient to support a conflict of interest requiring independent counsel under its commercial general liability policy. The court noted the duty to provide *Cumis* counsel arises out of the attorney's close ties with the insurance company. The attorney, who typically has a longstanding relationship with the insurer and none with the insured, may be forced to make numerous and varied decisions that could help one of his clients concerning insurance coverage and harm the other: "[T]here has been recognition that, in reality, the insurer's attorneys may have closer ties with the insurer and a more compelling interest in protecting the insurer's position, whether or not it coincides with what is best for the insured." The court found two issues raised in the reservation of rights that created a conflict: (1) whether the damages were due to an "occurrence" and (2) whether the Blanket Additional Insured Endorsements applied.

### *Consol. Chassis Mgmt. LLC v. Northland Ins. Co.*, No. 1-19-cv-05287, 2021 U.S. Dist. LEXIS 166903, 2021 WL 3930134 (N.D. Ill. Sept. 2, 2021)

Under Illinois law, the U.S. District Court for the Northern District of Illinois found that a conflict of interest plausibly existed such that the insureds were entitled to independent counsel in the underlying action pursuant to their automobile liability policy. Though the insurer withdrew its reservation of rights to cure any conflict of interest that might have previously existed, there was a separate conflict of interest due to the crossclaims in the underlying suit. The policy covered all defendants in the underlying action. Two of the defendants filed crossclaims against their co-defendants. Under Illinois law, a conflict of interest exists if, comparing the claims in the underlying complaint to the terms of the policy, "the insurer's interests would be furthered by providing a less than vigorous defense to the allegations." Courts in Illinois have recognized at least two types of situations in which a conflict of interest warrants independent counsel: (1) when proof of certain facts in the underlying litigation would shift liability from the insurer to the insured; and (2) when an insurer has a duty to defend two insureds in the same case who have "diametrically opposed" defense strategies. Here, the best interests of the insureds conflicted. Further, even if the insureds had a partially shared interest, Illinois courts have said that shared interests alone do not dispose of a conflict.

### *Amerisure Ins. Co. v. Thermacor Process, Inc.*, No. 4:20-cv-01089-P, 2021 U.S. Dist. LEXIS 51896, 2021 WL 1056435 (N.D. Tex. Mar. 19, 2021)

Under Texas law, the U.S. District Court for the Northern District of Texas denied an insurer's motion to dismiss its insured's declaratory relief action in which it claimed it was entitled to independent counsel. The insurer issued the insured a commercial property policy. In finding a right to independent counsel, the court explained that the insurer did not simply send a reservation-of-rights letter but took the additional step of filing a declaratory judgment action against its insured while the underlying suit was pending. The declaratory judgment action sought a declaration that the insurer had no duty to defend or indemnify and the policy did not cover tear-out costs (the insured was sued for damages arising out of an allegedly defective pipe and its installation). Further, the insured claimed that its insurer attempted to communicate with the plaintiff in the underlying suit in an attempt to include the underlying plaintiff in the coverage lawsuit. These factors created a conflict of interest.

## XII. Advancement of Defense Costs

### *Conn. Mun. Elec. Energy Coop. v. Nat'l Union Fire Ins. Co. of Pittsburgh*, No. 3:19-cv-839, 2021 U.S. Dist. LEXIS 173998, 2021 WL 4170757 (D. Conn. Sept. 14, 2021)

Under Connecticut law, the U.S. District Court for the District of Connecticut held that, where an insurance contract expressly disclaims any duty to defend and allows an insurer to withhold advance defense costs if such costs are not covered under the terms of the policy, the applicable standard for determining whether the insurer must advance defense costs is whether the loss is in fact covered, not whether there is a reasonable potential for coverage. The insurer issued a directors and officers liability policy to the insured, a not-for-profit municipal entity. The policy provided that the insurer "does not assume any duty to defend," but it would advance covered defense costs for a claim. The policy provided that the insurer's consent to payment is required, but it cannot be unreasonably withheld.

The insured received a federal grand jury subpoena and retained defense counsel. Subsequently, the grand jury returned indictments against several of the insured's officers and directors. The insurer declined to advance defense costs related to the subpoenas and the indictments. The insured brought suit for breach of contract and declaratory judgment. The insured argued that the policy language triggered a duty to advance defense costs equivalent to a duty to defend. The Court disagreed, finding the insured's interpretation ignored the policy's plain language disavowing such a duty. As a result, the Court declined to apply a broad "potential for coverage" type standard and instead analyzed whether the policy provided coverage for the claims. (Although the Court initially granted summary judgment in favor of the insurer finding no coverage for the claims, it subsequently granted the insured's motion for reconsideration and found, based on the insurer's admissions at deposition, that the claim was covered.)

### *United Talent Agency, LLC v. Markel Am. Ins. Co.*, No. 2:21-cv-00369, 2021 U.S. Dist. LEXIS 68178, 2021 WL 1257559 (C.D. Cal. Feb. 18, 2021)

The U.S. District Court for the Central District of California, predicting California law, held equitable tolling applies when an insurer's duty to defend is at issue. The insurer issued a management liability policy to the insured that obligated the insurer to pay expenses the insured incurred defending against claims concerning the insured's employees' wrongful acts. During the 2015-16 policy period, the insured and its employees defended against an unspecified number of legal proceedings. The insurer denied coverage for such proceedings on April 16, 2015, the underlying proceedings resolved in late 2018, and the insured brought a coverage action against the insurer on December 18, 2020.

The insurer moved to dismiss based on California's four-year statute of limitations for breach of contract claims and two-year statute of limitations for bad faith claims. However, the court determined that, under California law, the statute of limitations to vindicate the duty to defend is tolled until final judgment in the underlying action(s), making the insured's coverage action timely. The insurer asked the Court to confine the rule to cases where the duty to defend is at issue. However, the Court declined, finding California courts apply the tolling rule broadly and that it would be inequitable to require "an insured to initiate an action for failure to pay defense costs against its insurer while actively defending the underlying suit."

## XIII. Allocation

### *RSUI Indem. Co. v. Murdock*, 248 A.3d 887 (Del. 2021)

Under Delaware law, the Delaware Supreme Court affirmed the lower court's ruling that applied the "larger settlement rule." This case involved a directors and officers liability policy's allocation provision that provided "the Insureds and the Insurer agree to use their best efforts to determine a fair and proper allocation of covered Loss" and "take into account the relative legal and financial exposures of the Insureds." The insurer argued

that the lower court should have allocated the settlements between covered and noncovered loss in accordance with the policy's "relative exposure" language rather than apply the "larger settlement rule," under which "responsibility for any portion of the settlement should be allocated away from the insured party only if the acts of the uninsured party are determined to have increased the settlement." The Court noted its agreement with the lower court's findings that the policy's allocation language was "unhelpful…because it did not establish an allocation methodology to be applied in absence of an agreement between the parties" and that the policy's "more substantive" language required that the policy cover "all Loss that the Insured(s) become legally obligated to pay." The Court further observed that the insurer did not argue that the actions of uninsured entities or individuals increased the amount of the underlying settlements.

### *Legion Partners Asset Mgmt., Ltd. Liab. Co. v. Underwriters at Lloyd's London*, No. N19C-08-305 AML CCLD, 2021 Del. Super. LEXIS 618 (Sept. 30, 2021)

Under Delaware law, the Superior Court of Delaware found that the insured's costs in pursuing affirmative claims against its former employee constituted a covered loss and must be allocated to the insurer. The dispute involved a directors and officers liability policy's allocation provision, which required the parties to use "reasonable best efforts" to allocate covered and uncovered claims. The court found that, under Delaware law, affirmative claims could be "strategically defensive" and "may be reasonable and necessary for a party's defense strategy." The court applied the test outlined by the Northern District of California in *Hewlett-Packard Co. v. Ace Prop. & Cas. Ins. Co.*, 2006 U.S. Dist. LEXIS 109538 (N.D. Cal. 2006), finding that "whether an affirmative claim is 'conducted against liability'" requires the court to look to "the reasonableness and the necessity of the defense strategy to minimize liability, expenses, and a cost-benefit analysis of that strategy." Applying the *Hewlett-Packard* test, the court found that (1) the insured's decision to pursue its affirmative claims "amounted to a reasonable and necessary effort to avoid or at least minimize liability," (2) the insured's incurred expenses were reasonable, and (3) the insured's strategy was "worth the cost because a reasonable insured would have engaged in a similar defense strategy." As such, the court found that the insured's affirmative claims against its former employee were "conducted against liability" and, therefore, were covered under the policy.

### *Calamos Asset Mgmt. v. Travelers Cas. & Sur. Co. of Am.*, No. 18-1510 (MN), 2021 U.S. Dist. LEXIS 203014, 2021 WL 4902450 (D. Del. Oct. 21, 2021)

Under Delaware law, the U.S. District Court for the District of Delaware held that the insured could only seek recovery from an insurer for claims based on the actions of those acting as officers and directors of the defendant company. Under directors and officers policies, the court explained that coverage was available only for "directors and officers of certain companies, but not stockholders." Because the insured individual was sued both as director and officer and as controlling stockholder, the court held that the insured may seek damages at trial "limited to the amounts allocable under the relative exposure rule to the settlement and defense of the portion of the Officer and Director Claim based on acts by [the insured individuals] in their capacity as officers and directors of [the insured]."

### *Tarter v. Navigators Ins. Co.*, No. 21-5129, 2021 U.S. App. LEXIS 32175, 2021 WL 4950375 (6th Cir. Oct. 25, 2021) (applying Kentucky law)

Under Kentucky law, the U.S. Court of Appeals for the Sixth Circuit found that the insurer did not have a duty to defend the insured individual based on the applicability of the insured v. insured exclusion in a directors and officers liability policy. The insurer disputed its duty to defend the insured individual in an underlying lawsuit filed against him by other insured family members in the U.S. District Court for the Eastern District of Kentucky, alleging, in part, embezzlement of trade secrets. The insurer relied on the policy's "insured v. insured" exclusion and the policy's broad definition of "Claim" in arguing that the policy did not cover any civil proceeding seeking

monetary damages brought by an insured against another insured. The insured argued that the "insured v. insured" exclusion was not applicable because the "allocation" provision required the insurer to defend him in the lawsuit. The "allocation" provision provided "[i]f a Claim made against any Insured includes both covered and uncovered matters, or is made against any Insured and others, the Insureds and the Insurer recognize that there must be an allocation between Loss and uninsured damages, settlement amounts and other liabilities in connection with such Claim. The Insureds and the Insurer will use their best efforts to agree upon a fair and proper allocation … ." The Sixth Circuit was persuaded by the Eighth Circuit's decision in *Jerry's Enterprises, Inc. v. U.S. Specialty Insurance Co.*, 845 F.3d 883 (8th Cir. 2017), which analyzed similar facts and policy language and found that the allocation provision did not "restore coverage" for the lawsuit because such a construction would effectively render the "insured v. insured" exclusion meaningless.

## XIV. Recoupment of Defense Costs and Settlement Payments

### *Adir Int'l, LLC v. Starr Indem. & Liab. Co.*, 994 F.3d 1032 (9th Cir. 2021); 2022 U.S. LEXIS 544, 2022 WL 145181 (U.S., Jan. 18, 2022)

Under California law, the U.S. Court of Appeals for the Ninth Circuit affirmed a decision by the U.S. District Court for the Central District of California that confirmed California Insurance Code Section 533.5 precluded an insurer (represented by Troutman Pepper) from defending and indemnifying an insured in an action brought by the California Attorney General under California's Unfair Competition and False Advertising statutes, California Business and Professions Code Sections 17200, et seq. and 17500, et seq. It was further held that the insurer had a right to reimbursement of defense costs for uncovered claims when the insurance contract contained an express right to recoupment.

The directors and officers liability policy provided that, "In the event and to the extent that the Insureds shall not be entitled to payment of such Loss under the terms and conditions of this policy, such payments by the Insurer shall be repaid to the Insurer by the Insureds . . . And the word 'Loss' in turn includes defense costs." The court rejected all of the insured's arguments in response based on the plain language of the policy permitting reimbursement. The court also rejected the insured's estoppel argument because the insured did not explain how it could have reasonably relied on the insurer's conduct to believe there was not a right of reimbursement given the policy's express right to recoupment. Finally, the court rejected the insured's argument that Insurance Code Section 533.5 violated the insured's constitutional rights. The insured petitioned the U.S. Supreme Court for a writ of certiorari, and that request was denied by the Supreme Court on January 18, 2022.

### *Kinsale Ins. Co. v. Golden Beginnings, LLC*, No. CV 20-10302-DMG (AFMx), 2021 U.S. Dist. LEXIS 179109, 2021 WL 4205059 (C.D. Cal. Sept. 15, 2021)

Applying California law, the U.S. District Court for the Central District of California concluded that an insurer was entitled to reimbursement of defense expenses it had advanced when it had no duty to defend and the policy was subject to rescission. The court noted that the insurer advanced fees and costs to defend the insured under a full reservation of rights, including the right to seek reimbursement of any amounts paid by the insurer in connection with the underlying action and declaratory relief. Even though the policy did not provide for a specific right of recoupment, the court concluded that, because the insurer did not have a duty to defend the claims and because the policy was subject to rescission, the insurer could recoup its payments.

### *Starstone Ins. SE v. City of Chi.*, No. 20-cv-2475, 2020 U.S. Dist. LEXIS 252094, 2021 WL 1088313 (N.D. Ill. Mar. 22, 2021)

Under Illinois law, the U.S. District Court for the Northern District of Illinois granted an insurer's motion to dismiss the City of Chicago's counterclaim for violation of Section 155 of the Illinois Insurance Code and held that the insurer did not "unreasonably and vexatiously condition" its payment of a $3,750,000 insurance claim on the

City agreeing to an extracontractual demand of the insurer's right to recoupment.

The lawsuit concerned the insurer's obligations under an excess liability insurance policy. The City informed the insurer that it would pay its retained limit of $15 million for a compensatory damages award against the City and some of its police officers and requested that the insurer pay the additional $3.75 million of the underlying judgment. The insurer agreed to pay that amount, but only if the City agreed to provide the insurer with a right of recoupment. The City refused, arguing that the policy did not expressly allow the insurer to condition payment on such a right. The court ultimately granted the insurer's motion to dismiss the City's bad-faith Illinois Section 155 claim because the Court did not find the insurer's position unreasonable. Specifically, the court reasoned that an "insurer does not act vexatiously or unreasonably where it takes a reasonable legal position on an unsettled issue of law," and recognized that whether insurers may condition indemnification on a right to recoup remains an open legal question.

### *Nautilus Ins. Co. v. Access Med., LLC*, 482 P.3d 683 (Nev. 2021)

Under Nevada law, the Nevada Supreme Court, answering a question certified by the U.S. Court of Appeals for the Ninth Circuit, held that an insurer that defends under a reservation of rights is entitled to reimbursement of defense costs following a ruling that the insurer had no duty to defend. The court considered a policy that required the insurer to defend insureds against any suit seeking damages because of a "personal and advertising injury … arising out of … [o]ral or written publication, in any manner, of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services." The insurer defended its insured under a reservation of rights that included a right to seek reimbursement of defense costs. While the underlying litigation was pending, the insurer obtained a declaration from a Nevada federal district court that it had no duty to defend. Thereafter, the insurer sought reimbursement of defense costs, which the court denied. On appeal, the Ninth Circuit noted the lack of clarity under Nevada law regarding an insurer's right to reimbursement of defense costs following a no-duty-to-defend ruling, and it certified that question to the Nevada Supreme Court. The Nevada Supreme Court answered that an insurer does have a right to reimbursement of defense costs following such a ruling. The court explained that when a court holds that there is no duty to defend, it holds that the claims were never covered by the policy. Moreover, when an insurer reserves its right to seek reimbursement, the reservation is not made pursuant to contract because there is no contract that governs the defense. Rather, the insurer is reserving a right pursuant to the law of restitution, which is allowed.

### *Alps Prop. & Cas. Ins. Co. v. Kalicki Collier, LLP*, 526 F. Supp. 3d 805 (D. Nev. 2021)

Under Nevada law, the U.S. District Court for the District of Nevada granted an insurer's motion for summary judgment and held the insurer was entitled to reimbursement of money it spent defending a noncovered claim. Because the policy provided for an express right to reimbursement and because the court held that the policy did not provide coverage for the underlying action, the court found that the insurer properly could demand reimbursement of its defense payments.

## XV. Consent

### *Apollo Educ. Grp., Inc. v. Nat'l Union Fire Ins. Co.*, 480 P.3d 1225 (Ariz. 2021)

Under Arizona law, the Supreme Court of Arizona held, in response to a certified question from the U.S. Court of Appeals for the Ninth Circuit, that a court should analyze whether it was reasonable for an insurer to withhold consent to a settlement under a policy with no duty to defend from the insurer's perspective rather than relying on the insured's conclusions. The directors and officers liability policy at issue provided that "the Insureds shall not admit or assume any liability, enter into any settlement agreement … or incur any Defense Costs without the prior written consent of the Insurer," that "only those settlements, stipulated judgments and Defense Costs which have been consented to by the Insurer

shall be recoverable as Loss under the terms of this policy," and that "the Insurer's consent shall not be unreasonably withheld … ." The insured settled an underlying class action without the insurer's consent and sued the insurer to recover the settlement amount. After analyzing the consent provisions and finding that they were not ambiguous, the court focused on the fact that the insured controls any litigation in which an insurer does not have a duty to defend. In these circumstances, the insurer should not be required to rely on whether the insured believes the underlying settlement is reasonable but should instead be given the opportunity to make its own independent evaluation. The court further reasoned that the insured often has an interest in settling within policy limits regardless of the merits of the claims. The court further held that the insured's protection against an insurer's refusal to consent to a reasonable settlement is its ability to pursue an action for bad faith failure to settle. In this regard, the court noted that the insurer must, in deciding whether to consent to a settlement, give the matter full and fair consideration in order to fairly value the underlying claims.

### *Jacobs v. Liberty Surplus Ins. Corp.*, No. 3:21-cv-01687-WHO, 2021 U.S. Dist. LEXIS 177689, 2021 WL 4243396 (N.D. Cal. Sept. 17, 2021)

Under California law, the U.S. District Court for the Northern District of California held that an insurer that declined coverage for an underlying action on other grounds could not then rely on the consent provision in its policy. The trustees' professional liability policy at issue provided in relevant part that "[t]he Insured shall not admit or assume liability for any Wrongful Act, or settle any Claim, or incur any expenses, including Claims Expenses, without the written consent of the Company." The insurer denied coverage to the insured trustee for an underlying action in which other beneficiaries of the trust sued the insured trustee for alleged abuse of his position and breach of fiduciary duties. The insured defended and ultimately settled the underlying action, then filed suit against the insurer. The insurer argued that even if there were coverage for the underlying action, the insurer had not consented to the defense or settlement costs incurred and was therefore excused from paying those costs. The court held that established California law precluded the insurer from taking the position that the insured had to comply with the consent provision after the insurer had denied coverage.

### *SavaSeniorCare, LLC v. Starr Indem. & Liab. Co.*, No. 1-18-cv-01991-SDG, 2021 U.S. Dist. LEXIS 184606, 2021 WL 4429088 (N.D. Ga. Sept. 27, 2021)

Under Georgia law, in a case in which Troutman Pepper represented the insurer, the U.S. District Court for the Northern District of Georgia held that an insured was not entitled to coverage for defense costs because it failed to comply with a consent provision. The directors and officers liability policy at issue provided, in relevant part, that "the Insured shall obtain the Insurer's written consent in the selection of defense counsel to represent the Insured as respects any Claim, [and] such consent shall not be unreasonably withheld" and that "the Insured(s) shall not admit or assume any liability, incur any Defense Costs . . . without the prior written consent of the Insurer." Without requesting the insurer's consent, the insured retained several law firms and other vendors to defend it against False Claims Act litigation filed against it by the federal government. Ruling on a motion for summary judgment, the court held that the written consent requirement was enforceable under Georgia law and the insured could not show that it had ever requested or received written consent from the insurer prior to incurring defense costs. The court rejected the insured's argument that the insurer's denial of coverage for the amounts above a sublimit excused the insured from compliance with the consent provision for amounts within the sublimit. The court also rejected the insured's arguments that the insurer provided "constructive consent" by failing to object to the law firms and vendors that the insured retained, as well as the insured's argument that the insurer unreasonably refused consent by not objecting to a list of law firms that the insured sent to the insurer after the insured had already retained those firms. The court held that these latter two arguments regarding the insurer's failure to object "improperly flips the parties' obligations" under the consent provision that required the insured to obtain written consent prior to incurring defense costs.

### *Benecard Servs. v. Allied World Specialty Ins. Co.,* Nos. 20-2359, 20-2360, 2021 U.S. App. LEXIS 26978, 2021 WL 4077047 (3d. Cir. Sept. 8, 2021)

Under New Jersey law, the U.S. Court of Appeals for the Third Circuit affirmed the district court's grant of summary judgment to an insurer, holding that the insurer was entitled to rely on a consent provision to decline coverage for a settlement entered into by the insured without the insurer's consent. The errors and omissions policy at issue provided that "[n]o coverage is available under this Policy for … any settlements or settlement offers made [ ] without the [insurer's] prior written consent." The insurer defended the insured in the underlying litigation but refused to pay for a settlement entered into by the insured without the insurer's consent. The court rejected the insured's argument that it was excused from seeking consent because it anticipated that it would exhaust its policy by payment of defense costs, noting that the policy had not actually been exhausted and that the insured cited no legal support for its argument. The court also rejected the insured's argument that the insurer had to show "appreciable prejudice" to decline coverage based on the consent provision. The court noted that the "appreciable prejudice" standard under New Jersey law applied only to matters involving "unsophisticated consumers" under occurrence policies and not to claims-made policies purchased by sophisticated insureds. Finally, the court rejected the insured's argument that the insurer's failure to "remind" the insured of the consent provision during the insured's settlement negotiations estopped the insurer from relying on the consent provision to decline coverage for the settlement. The court found the insurer had not established that it relied on the insurer's "silence" regarding the consent provision and noted that, if it accepted the insured's argument, it would be "imposing on insurers an obligation to remind their insureds that they must comply with conditions precedent stated plainly in the policy."

### *Sacred Heart Health Servs. v. MMIC Ins., Inc.*, No. 4:20-cv-4149-LLP, 2021 U.S. Dist. LEXIS 226722, 2021 WL 5882990 (D.S.D. Dec. 13, 2021)

Under South Dakota law, the U.S. District Court for the District of South Dakota held in granting in part and denying in part an insurer's motion to dismiss that an insurer that does not breach the duty to defend may rely on a "no voluntary payments" provision to decline coverage for costs incurred without its consent, but may not rely on a "no voluntary payments" provision if it breaches the duty to settle in good faith. The primary and excess healthcare professional liability policies at issue provided in relevant part that the insured shall not voluntarily make any payment or assume any obligation except at its own cost. The insured healthcare providers purchased primary and excess healthcare liability policies from the insurer, one of which had a duty to defend and one of which did not. The insurer defended the underlying medical malpractice actions but ultimately decided not to contribute to a settlement at mediation, which the insureds consummated without the insurer's consent. The insureds then sued the insurer for breach of contract and bad faith to recover on the settlement. In deciding the insurer's motion to dismiss, the court held that an insurer that does not breach the duty to defend or does not have a duty to defend in the first instance may rely on a "no voluntary payments" provision. The court further noted that if an insurer breaches the duty to settle in good faith, the insurer waives its right to rely on a "no voluntary payments" provision.

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