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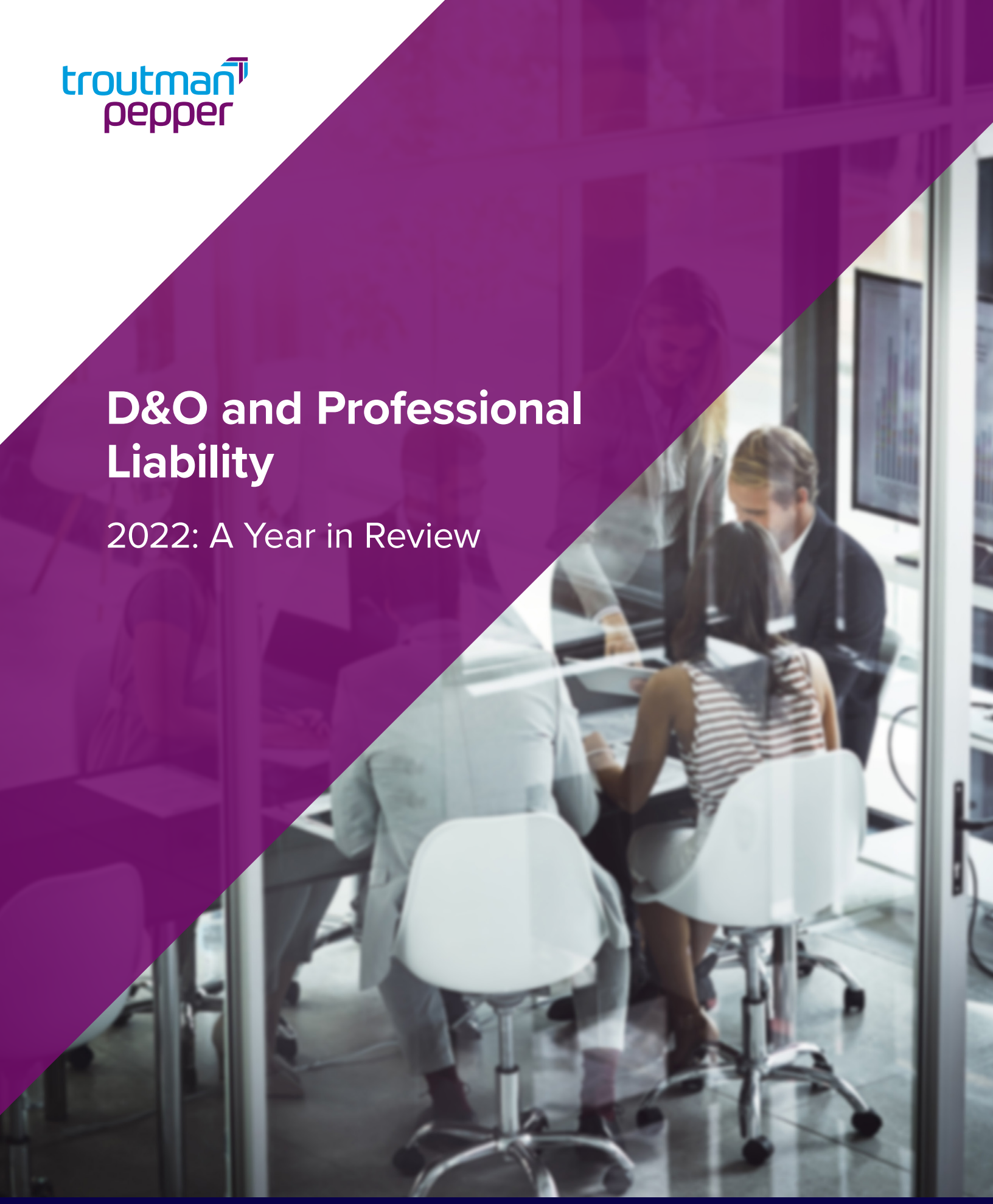
D&O and Professional Liability

2022: A Year in Review



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2022: 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 case selections to be informative and helpful. (Please note: Cases are organized within each topic alphabetically by the state law applied).

In this issue

I. Notice

Heritage Bank of Commerce v. Zurich Am. Ins. Co., No. 21-cv-10086-RS, 2022 WL 3563784, 2022 U.S. Dist. LEXIS 150720 (N.D. Cal. Aug. 17, 2022)

Under California law, the U.S. District Court for the Northern District of California held that correspondence to an underwriter referencing a claim during the renewal process did not satisfy the notice requirement of a claims-made-and-reported policy. The policy provided that "coverage is limited to loss from claims against the policyholder during the policy period … and reported to the underwriter pursuant to subsection III.A.," which required the claim to be made during the policy period or 60 days thereafter. The insured bank sought coverage for losses arising from lawsuits filed by Ponzi scheme victims who sued the bank after the bankrupt client who perpetrated the scheme could not fully compensate the victims for their losses. The insured mentioned these lawsuits in correspondence to its insurer's underwriting department during the 2018-2019 policy period. However, the insurer denied coverage for the claim when it was formally reported, arguing that it did not receive notice of the claims until February 2021. The court agreed with the insurer, reasoning that the bank's correspondence to the underwriter did not satisfy the notice provision because insurers do not have a duty to investigate unless notice is sent as required by the policy language. It further held that notice of a potential claim, which the insured claimed to have done via the communication to the underwriter, does not substitute for notice of an actual claim.

Nat'l Union Fire Ins. Co. of Pittsburgh, PA v. Estate of Calendine, No. 21-CV-01541-NYW-MDB, 2022 U.S. Dist. LEXIS 147427, 2022 WL 3446023 (D. Colo. Aug. 17, 2022)

Under Colorado law, the U.S. District Court for the District of Colorado held the notice-prejudice rule does not apply to claims-made policies. Two insurers issued claims-made professional liability policies to the insured, a dentist. The insured purchased extended reporting period endorsements from both insurers, which covered claims arising out of dental incidents during the policy periods. After both policies expired, the insured faced a series of negligence lawsuits. However, the insured never notified the insurers of the lawsuits, with the insurers instead learning of the claims through the underlying claimants. Although the insured argued the insurers could not deny coverage without a showing of prejudice, the court held the notice-prejudice rule did not apply to claims-made policies.

Georgian Am. Alloys, Inc. v. Axis Ins. Co., No. 21-1947, 2022 U.S. App. LEXIS 24536, 2022 WL 3971584 (3d Cir. Aug. 31, 2022)

Under Delaware law, the U.S. Court of Appeals for the Third Circuit affirmed the district court's ruling that an insurer could deny coverage for late notice of a claim without a showing of prejudice. The insurer issued a claims-made directors and officers liability policy. The insured argued it was unable to report the claim at issue within 90 days of the expiration of the policy period because the insurer's offices were closed due to the COVID-19 pandemic. The court rejected this argument, noting that permitting an extension of the reporting period would require the court to read an amendment into the policy. Accordingly, the court applied the policy language at issue, limited the reporting period to 90 days after the policy's expiration, and did not require the insurer to prove prejudice.

Philadelphia Indem. Ins. Co. v. Lewis Produce Mkt. No 2, No. 21-cv-4037-MFK, 2022 WL 1045640, 2022 U.S. Dist. LEXIS 64688 (N.D. Ill. Apr. 7, 2022)

Under Illinois law, the U.S. District Court for the Northern District of Illinois held that a claim was first made when the insured supermarket received actual, rather than constructive, notice of the claim. The insured was insured under two successive professional liability policies for 2020 and 2021, both of which provided that "[a] claim shall be considered made when an Insured first receives notice of the Claim." On the final day of the 2020 policy's policy period, a claimant sued an uninsured affiliate of the insured alleging violations of the Illinois Biometric Information Privacy Act (BIPA). The insured was subsequently named in the lawsuit but did not receive notice of that suit until a week later, after the inception of the 2021 policy. Notably, unlike the 2020 policy, the 2021 policy barred coverage for BIPA claims. Accordingly, the insurer filed a declaratory judgment action, arguing it had no duty to defend or indemnify the insured under either of the policies because the lawsuit was not a claim "first made" during the 2020 policy and the 2021 policy did not provide coverage for BIPA violations. The court granted judgment on the pleadings to the insurer, reasoning that, under the relevant policy language, the claim was deemed made when the insured first received notice of the lawsuit, it was undisputed that the insured did not receive actual notice of the lawsuit until after the 2020 policy expired, and the 2021 policy did not provide coverage for BIPA claims.

Phila. Indem. Ins. Co. v. Great Plains Annual Conf. of the United Methodist Church, No. 621CV01197HLTKGG, 2022 U.S. Dist. LEXIS 31076, 2022 WL 522962 (D. Kan. Feb. 22, 2022)

Under Kansas law, the U.S. District Court for the District of Kansas held the notice-prejudice rule does not apply to claims-made policies. The insurer issued two consecutive claims-made directors and officers liability policies. The insured received a request for a tolling agreement, which constituted a claim under the policies, during the 2020-2021 policy period.

However, the insured did not report the claim until after the 2020-2021 policy period had expired. Adopting the Tenth Circuit's rationale that the notice-prejudice rule should not apply to claims-made policies, the court held the insurer could deny coverage under the 2020-2021 policy without a showing of prejudice, and there was also no coverage under the 2021-2022 policy because the claim was made during the earlier policy period.

Meadows Constr. Co. LLC v. Westchester Fire Ins. Co., No. 20-P-1272, 100 Mass. App. Ct. 1120, 180 N.E.3d 1032 (2022)

Under Massachusetts law, the Appeals Court of Massachusetts affirmed judgment in favor of an insurer, holding that the notice requirement in a claims-made policy is "of the essence" in determining whether coverage exists, and an insurer need not show it was prejudiced by late notice to deny coverage on the basis of an insured's untimely reporting of a claim. The insured belatedly sought coverage for a wage and hour class action complaint filed after the claims-made policy expired, arguing that notice was nonetheless timely under the policy provision governing the reporting of notices of circumstances, which provided that "[i]f, during the Policy Period … any of the Insureds first becomes aware of facts or circumstances which may reasonably give rise to a future Claim covered under this Policy, and if the insureds, during the Policy Period … give written notice to the insurer as soon as practicable … then any Claim made subsequently arising out of such Wrongful Act shall be deemed … to have been made at the time such written notice was received by the insurer." The insured argued it did not become aware of facts or circumstances that could reasonably give rise to the claims asserted in the class action until it was served with the complaint after the policy period expired; thus, its notice shortly thereafter was timely pursuant to the notice of circumstances provision. The court, however, reasoned that the insured never provided written notice of the circumstances during the policy period and could not find a "safe harbor" in the provision. The court further noted that a prejudice requirement would "defeat the fundamental concept on which claims-made policies are premised."

President & Fellows of Harvard Coll. v. Zurich Am. Ins. Co., No. 21-cv-11530-ADB, 2022 WL 16639238, 2022 U.S. Dist. LEXIS 199326 (D. Mass. Nov. 2, 2022)

Under Massachusetts law, the U.S. District Court for the District of Massachusetts held that an insured university's late-noticed claim was not covered under an excess claims-made-and-reported policy. The court further found that the insurer need not show it was prejudiced by late notice and that it was irrelevant whether the insurer had actual or constructive notice of the claim during the reporting period. The insured university had an excess claims-made-and-reported policy for November 2014 to November 2015, which provided that all claims must be reported in writing to the insurer no later than 90 days after the end of the policy period. During that period, the insured was named in a lawsuit alleging its admissions policy discriminated against Asian American students. The insurer denied coverage because the suit was not reported to the insurer until May 2017. The court granted the insurer's motion for summary judgment, finding that the policy's notice requirement was a condition precedent to coverage and that the university undisputedly reported the lawsuit late. The insured argued that the underlying lawsuit was widely publicized. However, the court held that the result was the same even if the insurer had actual or constructive knowledge of the suit during the policy period because the notice provisions in claims-made-and-reported policies leave no wiggle room to excuse an insured's noncompliance.

Republic Franklin Ins. Co. v. Ficke & Assocs., LLC, No. A-2835-20, 2022 WL 4588097, 2022 N.J. Super. Unpub. LEXIS 1802 (App. Div. Sept. 30, 2022)

Under New Jersey law, the Appellate Division of the New Jersey Superior Court upheld the trial court's ruling granting summary judgment in favor of the insurer on the grounds that the insured failed to give its insurer timely notice of underlying claims. The parties disputed the language of a 2016-2017 claims-made errors and omissions professional negligence policy provision that required the insured to notify the insurer of a claim "as soon as

practicable." The insurer denied coverage for a lawsuit filed in 2016 against its insurance brokerage-insured because the insurer first received notice of the lawsuit via a January 2019 email. The court reasoned that "as soon as practicable" means "within a reasonable time," and the insured's three-year delay, during which time the insured renewed its insurance three times while certifying there were no claims made against it, was untimely.

Gen. Star Indem. Co. v. Guthrie, No. 19-CV-314-JWB, 2022 U.S. Dist. LEXIS 160105, 2022 WL 4088066 (E.D. Okla. Sept. 2, 2022)

Under Oklahoma law, the U.S. District Court for the Eastern District of Oklahoma concluded an insurer must prove it was prejudiced by an insured's late notice of a claim when notice is given within a policy period. The insurer issued a claims-made-and-reported physicians and surgeons professional liability policy to the insured hospital. The policy required the insured to report a claim to the insurer within 10 days after the receipt of the claim. One of the insured hospital's physicians, who was covered under the policy, did not timely report a lawsuit against him for over two weeks. Reasoning that the notice was still given within the policy period, the court held the insurer could not deny coverage without a showing of prejudice.

II. Related Claims

Associated Indus. Ins. Co. v. Slattery, No. 6:22-cv-80-PGB-DAB, 2022 U.S. Dist. LEXIS 218187, 2022 WL 17370510 (M.D. Fla. Sept. 14, 2022)

Applying California law, the U.S. District Court for the Middle District of Florida concluded that three lawsuits brought against the insured by timeshare developers constituted a "single claim" under the policies, subject to a single limit of liability. The insurer issued a professional liability policy to insured law firms, which were sued in three separate lawsuits arising from the insureds' alleged participation in a "timeshare exit scheme," luring in timeshare owners with false and misleading advertising, and then inducing the owners to breach their timeshare contracts. The insurer, which had defended the insureds against the lawsuits, sought a declaration that it had no further duty to defend or indemnify the insureds because the limit of liability was exhausted. The court found the three lawsuits constituted a "single claim" under the policies because each claim arose from the same interrelated wrongful acts—namely, the insureds' participation in the "timeshare exit scheme." The court further found that a "single claim" is subject to a single limit of liability under the policies, and the limit of liability had been exhausted, relieving the insurer of its duty to defend and indemnify.

First Solar, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, 274 A.3d 1006 (Del. 2022)

Under Delaware law, the Supreme Court of Delaware, disagreeing with the lower court's reasoning but affirming its holding, found that a first-filed action was sufficiently related to a later action so as to exclude coverage for the later action under later-issued policies. A primary insurer issued directors and officers liability policies to the insured, a solar panel manufacturer, containing a "Related Claims Exclusion." In 2012, some of the insured's shareholders filed a class-action lawsuit against the insured, alleging that the insured had violated federal securities laws by making false or misleading public disclosures. The primary insurer provided coverage for the 2012 action. In 2015, stockholders who had opted out of the first lawsuit filed a separate class action against the insured, alleging violations of the same federal securities laws as in the first action, violations of Arizona statutes, and other claims for fraud. The insured settled the 2015 action, and its primary and excess insurers denied coverage for the settlement, arguing that the 2012 and 2015 actions were related. On appeal, the insured argued that the lawsuits were not fundamentally identical, challenging the lower court's determination. The Delaware Supreme Court, agreeing with the insurers that the lower court applied the wrong legal standard, first clarified that whether a claim relates back to an earlier claim is decided by the language of the policy, not a generic "fundamentally identical" standard. Pointing out that the "minor differences" between the actions—one action focused on cost-per-watt representations while the other focused on grid parity,

for example—were not meaningful to the relatedness inquiry, the court noted that both actions revolved around the manufacturer's misrepresentations about the cost of solar power. Further noting that "absolute identity" between the two lawsuits is not required, the court held that because the actions involved the same subjects, common facts, circumstances, transactions, events, and decisions, the 2012 and 2015 actions were related, and the insurers were not required to provide coverage for the 2015 action under the 2015 policies.

AmTrust Fin. Servs., Inc. v. Liberty Ins. Underwriters Inc., No. 21-374-JLH, 2022 WL 980299, 2022 U.S. Dist. LEXIS 59828 (D. Del. Mar. 31, 2022)

Under Delaware and New York law, the U.S. District Court for the District of Delaware denied an insurer's motion to dismiss, finding that a first amended complaint plausibly alleged loss that did not fall within the scope of an exclusion for previously noticed claims or pre-claim inquiries. The insurer issued an excess claims-made directors and officers liability policy to the insured, a property and casualty insurance holding company. In 2017, some of the insured's shareholders sued its directors and officers under the Securities Exchange Act, primarily based on certain assertions made about the company's financial condition. The plaintiffs in the underlying action also alleged that the defendant directors and officers knew that the company was improperly accounting for bonuses because of a 2014 public letter questioning the company's accounting practices. In 2017, the SEC also served subpoenas on the insured company. Following a denial of coverage, and in a motion to dismiss the insured's first amended complaint, the insurer argued, in part, that the 2017 matters were excluded from coverage because they arose out of the same circumstances that gave rise to the 2014 letter, which the insured provided to its insurers in 2015 as a "notice of circumstances which may give rise to a Claim." However, the court rejected this argument, finding that the record showed that it was plausible that the 2017 matters and the 2014 letter did not arise out of the same circumstances under the meaning of the policy.

Although the 2014 letter made "broad references to improper accounting and weaknesses in internal controls, and the warranty and bonus accounting issues that gave rise to the 2017 matters fall under that wide umbrella," the court refused to analyze the relevant language at such a "high level of abstraction—*i.e.,* as accounting problems." Because there was no "meaningful linkage" between the accounting issues in the 2014 letter and the accounting issues that gave rise to the 2017 matters, and no evidence that they arose from a single fraudulent scheme, the court rejected the insurer's contention that the case should be dismissed due to the applicable policies' exclusion for previously noticed claims or pre-claim inquiries.

Datamaxx Applied Techs., Inc. v. Brown & Brown, Inc., No. 21-13451, 2022 U.S. App. LEXIS 23561, 2022 WL 3597311 (11th Cir. Aug. 23, 2022)

Under Florida law, the U.S. Court of Appeals for the Eleventh Circuit affirmed the district court's finding that 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. In 2013, before the issuance of the policy, a corporation sued the insured over alleged violations of a licensing agreement, and 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, licensing agreement, and the two agreements' implied covenants of good faith and fair dealing. The insurer denied coverage for the 2018 action. On appeal from the district court's grant of summary judgment for the insurer, the Eleventh Circuit placed significance on the policy's use of the term "correlates," instead of "relates," in its claim-aggregating provisions, finding that "correlates" is narrower than "relates." Nonetheless, the Eleventh Circuit affirmed, finding that the insurer had shown that the 2018 claim "correlates" to the claim made before the onset of policy coverage, barring coverage under the policy.

Stafford v. Stanton, No. 17-cv-262 (SMH), 2022 U.S. Dist. LEXIS 175471, 2022 WL 4491073 (W.D. La. Sept. 27, 2022)

Applying Florida law, the U.S. District Court for the Western District of Louisiana held that an action for negligence and breach of fiduciary duty against an insured attorney for allegedly aiding in a client's fraudulent scheme related back to a prior policy period, barring coverage under the current policy. The court interpreted a "related claims provision" in a professional liability policy, finding that the provision would be triggered by claims that are logically linked by a "sufficient factual nexus." The court found that claims against the insured had a sufficient factual nexus to trigger the related claims provision, where the insured had previously reported a potential claim to his prior insurer because of events that had unfolded at that time, including his client defaulting on several loans; a group of guarantors filing suit over a loan made to his client's business; and the insured being served with a subpoena for documents and communications related to the fraud perpetrated by his client. The insured had sent notice to his prior insurer to notify it of potential claims arising out of his client's fraudulent scheme, and the court concluded that the present action related back to the earlier notice because both claims arose out of the insured's representation of his client and the role the insured played in securing and handling loans made to his client's business. Therefore, the court held there was no coverage available under the professional liability policy, both because the claim was not first made during the applicable policy period and pursuant to the policy's prior knowledge exclusion, entitling the insurer to judgment as a matter of law.

ALPS Prop. & Cas. Ins. Co. v. Edenfield, No. CV 6:21-008 (JRH), 2002 U.S. Dist. LEXIS 161411, 2022 WL 4098516 (S.D. Ga. Sept. 7, 2022)

Under Georgia law, the U.S. District Court for the Southern District of Georgia rejected an insurer's argument that two claims were related under policy language treating "[a]ll Claims that arise out of or in connection with the same Professional Services or Related Professional Services" as a single "Claim." The court held that although the professional liability insurer had no duty to defend its insureds against a legal malpractice claim for failing to timely file a discrimination suit against their client's employer, the malpractice claim was not related to a workers compensation claim for physical injury the client suffered while working for the same employer. The policies defined "Related Professional Services" as "Professional Services that are connected temporally, logically or causally, by any common fact, circumstance, situation, transaction, event, advice or decision including, but not necessarily limited to, work that is part of the same or continuing Professional Services." Applying this definition, the court found the two claims were not connected temporally, logically, or causally. The court reasoned that although both claims occurred in the same calendar month, they did not occur "at the same time" or in a "continuous or connected series." Further the events were not logically or causally connected, as the two claims were independent, albeit involving the same attorney-client relationship. Therefore, the court declined to consider the two claims as involving "Related Professional Services" and denied the insurer's motion for summary judgment on that ground. An appeal is pending with the U.S. Court of Appeals for the Eleventh Circuit.

Hanover Ins. Co. v. R.W. Dunteman Co., 51 F.4th 779 (7th Cir. 2022)

Under Illinois law, the U.S. Court of Appeals for the Seventh Circuit affirmed the district court's grant of an insurer's motion for judgment on the pleadings, finding that broadened allegations in an amended pleading in the underlying action against the insureds were related to and thus treated as part of an original complaint. The insurer issued consecutive directors and officers liability insurance policies for the 2017 and 2018 policy periods. The underlying action involved a conflict among family members over ownership interests in the family's construction business. The estate of one family member sued one business entity in 2017, with the allegations concerning the family member's sons' actions as officers, directors, and shareholders. In an amended complaint filed in 2018, the estate broadened its factual allegations, adding another business entity and the deceased's sons as co-defendants. At that point the insureds—the two

business entities and the deceased's sons—first notified the insurer and sought coverage under the 2018 policy. The insurer denied coverage on the grounds that the claim was first made in 2017 and had not been timely reported during the 2017 policy period. Affirming the district court's determination on cross-motions for judgment on the pleadings, the Seventh Circuit found the original 2017 complaint to be a reportable "Claim" and that the policy's "Related Wrongful Acts" and "Related Claims" provisions treated the amended complaint and original complaint as a single claim reportable when first made in 2017, not 2018. As a result, the insured's notice was untimely, and the court held the insurer correctly denied coverage.

USA Gymnastics v. Liberty Ins. Underwriters, Inc., 27 F.4th 499 (7th Cir. 2022)

Under Indiana law, the U.S. Court of Appeals for the Seventh Circuit held an insurer was required to provide coverage for sexual assault claims despite the FBI conducting certain interviews before the policy period commenced. The insurer issued a claims-made directors and officers liability policy to the insured, an athletics organization, for the 2016 to 2017 policy period. Under the policy, a claim was considered made "only once 'an Insured receive[d] a written demand, complaint, indictment, notice of charges, or order of formal investigation.'" Almost a year before the policy period began, in July 2015, allegations of serious misconduct by one of the insured's employees led to an FBI investigation of the insured, including interviews of the insured's athletes. The insurer argued that the FBI interviews in 2015 constituted a formal investigation, and that, because the other claims related to the insured's employee's misconduct arose from the same wrongful acts that led to the FBI interviews, the claims arose before the policy period and therefore were not covered. The court rejected the insurer's position, holding that the FBI interviews and preliminary investigation did not rise to the level of a formal investigation, meaning that they did not constitute a claim under the policy.

Henry v. Maxum Indem. Co., No. 2:20-02995-WBV-JVM, 2022 U.S. Dist. LEXIS 202969, 2022 WL 16758298 (E.D. La. Nov. 8, 2022)

Under Louisiana law, the U.S. District Court for the Eastern District of Louisiana concluded that two separate actions were related claims even though the court earlier had refused consolidation of the actions on the grounds that they were not sufficiently interconnected to support consolidation. Applying the policy's related claims provision to claims regarding the insured law firm's processing of four oil spill subsidence claims (one made before and three made during the insurer's policy period), the court found the claims to be related under the policy because the cases both involved the same or related facts, circumstances, transactions, or events, namely the insured's solicitation and mishandling of the filing of the plaintiffs' subsidence claims. The plaintiffs in each case alleged that they lost the opportunity to be compensated for their subsidence losses because the insureds accepted over 14,000 subsidence claims right before the deadline for filing claims, despite not having the resources to do so, resulting in the mishandling and ultimate denial of those subsistence claims. The court further found its earlier order denying consolidation of the matters to be irrelevant to the issue of coverage. As such, the court granted summary judgment to the insurer, dismissing the insureds' claims with prejudice.

Fair Isaac Corp. v. Certain Underwriters at Lloyd's, London, No. 21-CV-734 (ECF/JFD), 2022 U.S. Dist. LEXIS 224879, 2022 WL 17670081 (D. Minn. Dec. 14, 2022)

Applying New York law, the U.S. District Court for the District of Minnesota, in a case in which Troutman Pepper represented the insurer, rejected an insured's argument that the insurer's decision to defend the insured in a product disparagement action precluded it from later disclaiming coverage for a subsequent, consolidated class action alleging product disparagement that the insurer deemed to be a "related claim" to the first action. The multimedia and advertising liability policy at issue included a "related claims" provision that treated

multiple claims "arising from the same or a series of related or repeated acts, errors or omissions, or from any continuing acts, errors or omissions" as a single "Claim." The insured argued that because the two lawsuits were deemed a single "Claim" pursuant to the policy's "related claims" provision, the insurer's defense of the first action barred the insurer from denying defense coverage for the subsequent related action. The court rejected that argument, explaining that the purpose of a "related claims" provision is to determine when a "Claim" is first made for purposes of identifying the applicable policy period, limit of liability, and retention. The court concluded, however, that a "related claims" provision does not create coverage for an otherwise non-covered claim merely because the non-covered claim and the covered claim were deemed related under the policy. Rather, each "Claim" must be evaluated independently to determine if there is coverage regardless of whether the "Claims" have been deemed a single, related "Claim."

Lonstein Law Off., P.C. v. Evanston Ins. Co., No. 20-cv-9712 (LJL), 2022 U.S. Dist. LEXIS 19166, 2022 WL 311391 (S.D.N.Y. Feb. 2, 2022)

Under New York law, the U.S. District Court for the Southern District of New York granted the insurer's motion to dismiss because the insurer had no ongoing duty to defend where the four underlying lawsuits constituted "related claims," and the insurer had already paid the $1 million "Each Claim Limit." The lawyers professional liability policy's related claims provision provided that "[m]ore than One Claim arising out of a Single Wrongful Act … shall be considered a single Claim," and that "[a]ll such Claims, whenever made, shall be treated as a single claim." The insurer defended the law firm in each of the four underlying actions until it exhausted the $1 million "Each Claim Limit" in July 2020. The insured argued that each lawsuit alleged distinct wrongful acts such that there should be multiple "Each Claim Limits" available. Rejecting this argument, the court concluded that each of the four lawsuits alleged a single overarching scheme to "defraud small-business owners" throughout an overlapping period, using nearly identical misrepresentations. The court distinguished this case from one where a "law firm was in error on a single [legal] proposition" that affected multiple representations. In that instance, "no one claim of malpractice would rest upon the viability of any other claim of malpractice." Here, however, the claims were "related because, based on the allegations of the complaints, Plaintiffs engaged in a single prearranged course of fraudulent conduct that affected more than one individual, and the viability of the claims in each case rests on the notion that the wrongdoing is not a one-off."

Travelers Cas. & Surety Co. v. Jeld-Wen Holding, Inc., No. 3:21-cv-173-MOC-DCK, 2022 U.S. Dist. LEXIS 210167, 2022 WL 17095207 (W.D.N.C. Nov. 18, 2022)

Under North Carolina law, the U.S. District Court for the Western District of North Carolina granted the insurer's motion for summary judgment, holding that its "preceding claims exclusion" and definition of "Interrelated Wrongful Acts" were unambiguous and applied to preclude coverage for a securities claim filed against the insured. The excess directors and officers liability policy contained an exclusion for "preceding claims," which barred coverage for "any Claim made, or deemed first made, before the Policy Period," including Claims for any "Interrelated Wrongful Acts." The policy defined "Interrelated Wrongful Acts" as "Wrongful Acts that have as a common nexus any fact, circumstance, situation, event, transaction, cause or series of casually connected facts, circumstances, situations, events, transactions or causes." From 2016 to 2019, several customers brought antitrust lawsuits, alleging that the insured engaged in anticompetitive conduct by setting prices and reducing quality in coordination with its only market competitor. In 2020, during the insurer's policy period, the insured and several of its directors and officers were sued in a securities class-action lawsuit relating to misrepresentations about the insured's business success and competitive marketplace for the insured's products. The insurer, as the fourth excess insurer, disputed its obligation to pay pursuant to the policy's "preceding claims" exclusion. The court concluded that the facts created a common nexus that was sufficient to make the antitrust and securities claims interrelated under the policy's broad "Interrelated

Wrongful Acts" definition. The court highlighted the interrelatedness by commenting on: (1) the claims' common scheme of hiding the insured's conspiracy with its competitor to set anti-competitive prices; (2) the common cast of characters—the same officers "who engaged in antitrust violations also misrepresented [the insured's] corporate success" to the shareholders; and (3) the fact that the insured "hid the same illicit conduct from both its customers and its shareholders." Thus, the court held the preceding claims exclusion applied, and both the antitrust and the securities claims fell outside the scope of coverage.

Drawbridge Energy US Ventures, LLC v. Fed. Ins. Co., No. 4:20-CV-03570 (ASH), 2022 U.S. Dist. LEXIS 61686, 2022 WL 991989 (S.D. Tex. Apr. 1, 2022)

Under Texas law, the U.S. District Court for the Southern District of Texas held that an insurer had no duty to defend where the "wrongful act" that gave rise to the underlying lawsuit was first alleged in a letter before the policy period. The directors and officers liability policy's "related claims" provision stated that "[a]ll Related Claims shall be deemed a single Claim made in the Policy Year in which the earliest of such Related Claims was first made" and defined "Related Claims" to mean "all Claims for Wrongful Acts based upon, arising from, or in consequence of the same or related facts, circumstances, situations, transactions or events or the same or related series of facts, circumstances, situations, transactions or events." In May 2018, before the policy period commenced in June 2018, the insured received a letter stating that it would face liability under Australian law for its violations of the Australian Securities Exchange's listing rules. In July 2018, a lawsuit sought to enjoin the insured from investing or disposing of $21 million that was transferred to it as part of an allegedly voidable transaction that was completed in violation of the exchange's listing rules. The insurer denied coverage for the underlying lawsuit because it considered the underlying lawsuit to be a "related claim" made before the policy period, and because the policy's pending or prior proceedings exclusion barred coverage. The insured argued that (1) the May 2018 pre-coverage letter was inadmissible under Texas's eight corners rule, and (2) even if the letter were admissible, it did not constitute a claim under the policy. The court permitted the insurer to base its coverage determination in part on the letter because the letter went solely to the coverage issue of when the claim was first made and did not overlap with the merits of liability, did not contradict facts in the pleadings, and went "to the heart of the pivotal issue [of whether] the claim against the Plaintiffs was first made prior to the inception of the policy." Thus, because the "wrongful act" alleged in the letter led to the underlying lawsuit, the letter and underlying lawsuit were "Related Claims" under the policy, and therefore were a single claim "first made" before the policy period, and the insurer owed no duty to defend.

Smartsheet, Inc. v. Fed. Ins. Co., No. C22-314 MJP, 2022 U.S. Dist. LEXIS 140719, 2022 WL 3160379 (W.D. Wash. Aug. 8, 2022)

Under Washington law, the U.S. District Court for the Western District of Washington held that an arbitration demand by a shareholder was a distinct "claim" that was unrelated to a class-action lawsuit brought in the following policy period. The insurer issued a directors and officers liability policy to a software company for both the 2018 and 2019 policy periods, with both policies providing that "All Related Claims … shall be deemed a single Claim made in the Policy Period in which the earliest of such Related Claims was first made." The underlying claims concerned two groups of lawsuits that were filed against different directors, all alleging that the directors "duped early investors into selling their shares" before the company's IPO in April 2018. The first set of "claims" related to a June 2018 arbitration demand wherein the ex-wife of the insured's founder alleged that the founder induced her to sell her shares to him as part of the divorce settlement at a deceptively low price, and violated a representation in the divorce settlement that the insured was not intending to go public within the next 18 months. The second group of claims included, among other lawsuits, a December 2019 lawsuit alleging that a director of the insured induced a group of shareholders to sell their shares at artificially reduced prices because he "improperly

failed to disclose knowledge relating to a potential future … IPO." The insured moved to dismiss the coverage dispute on the basis that the claims were all related and must be treated as a single claim under the 2018 policy. In relevant part, the court held that the claims were unrelated because they alleged distinct injuries and distinct misrepresentations made by two different individuals during different time periods. Additionally, there was a lack of evidence that the two directors acted in concert as part of a common scheme.

III. Prior Knowledge, Known Loss, and Rescission

Associated Indus. Ins. Co. v. Geragos & Geragos, APC, No. CV 21-1963-DMG (KSx), 2022 WL 601046, 2022 U.S. Dist. LEXIS 36764 (C.D. Cal. Feb. 15, 2022)

Under California law, the U.S. District Court for the Central District of California held an insurer had not breached the implied covenant of good faith and fair dealing when it reserved the right to rescind the policy upon commencing a defense of its insured. The insurer issued a professional liability policy to the insured law firm, with coverage for certain acts made in rendering professional services. A third-party plaintiff sued the insured, asserting various claims based on the insured's alleged involvement in a conspiracy to extort Nike. The insured argued that the insurer's agreement to defend under a reservation of rights that reserved the right to rescind the policy was a breach of the covenant of good faith and fair dealing because it was a "threat to rescind" without legitimate basis. The court held that because the insurer did provide coverage (albeit subject to a reservation of rights), it "cannot have breached the implied covenant" and therefore the insured's bad faith claim failed. The court also reiterated the precept that "[s]ending a reservation of rights letter does not amount to a breach of an insurance policy or bad faith, nor does filing suit for rescission or a declaration of non-coverage while still providing coverage in the interim." Although the insured argued the insurer sued for rescission without valid basis, the court held the insured could seek a remedy for wrongful rescission in a separate lawsuit—a claim for malicious prosecution, "which cannot be brought as a counterclaim in the same underlying lawsuit."

Soni v. Certain Underwriters at Lloyd's, No. CV 20-8667 FMO(ASx), 2022 WL 11044708, 2022 U.S. Dist. LEXIS 169216 (C.D. Cal. Sept. 19, 2022)

Applying California law, the U.S. District Court for the Central District of California held that an attorney made a material misrepresentation in connection with his application for professional liability insurance, which was sufficient to justify recission of the policy. The attorney answered "2" in response to a question regarding prior fee collection actions but did not adequately disclose that one such action was a cross-claim in a suit brought by a former client. The court found that the insurer was not barred from rescinding the policy on the basis of the insurer's failure to investigate what lawsuits the "2" referred to. This conclusion was bolstered by the fact that the attorney responded "No" to a separate application question asking whether the attorney had been a party to any lawsuit or other legal proceeding in the past year. The court granted the insurer's motion for partial summary judgment and concluded it was undisputed that the insured made a material misrepresentation in connection with his application for insurance, which was sufficient to rescind the policy. This case is on appeal to the Ninth Circuit.

Admiral Ins. Co. v. Versailles Med. Spa, LLC, Case No. 3:20-CV-0568 (JCH), 2022 WL 14813533, 2022 U.S. Dist. LEXIS 194719 (D. Conn. Oct. 25, 2022)

Under Connecticut law, the U.S. District Court for the District of Connecticut denied the insurer and the insureds' motions for summary judgment because of outstanding issues of material fact and held that an insurer is not required to produce expert testimony to establish whether facts known to an insured could reasonably be expected to give rise to a claim. The insurer issued a professional liability policy to the insured medical spa and an employee and officer. In an underlying action, a patient sued

the insureds because treatment to remove brown spots from the patient's legs allegedly had resulted in burns. The parties to the coverage lawsuit disputed whether the patient emailed the insureds a month after the treatment complaining about discoloration and burns, but it was undisputed that the patient met with the CEO, also a defendant, to discuss the patient's legs, and the CEO ultimately agreed to waive certain therapy costs thereafter. Six months later, the insured applied to renew its policy, and responded "no" to a question whether any Claims (defined as "a written demand for money or services by any Insureds resulting from a Professional Incident") had been filed against the insured or its employees. Under the Prior Knowledge Exclusion, the policy excluded claims known by the insured before signing the application. The court did not consider whether the meeting with the CEO constituted a "Claim," but held that it was an issue of fact both whether the email was actually sent and whether the email constituted a claim. The court also denied the insureds' motion for summary judgment, holding that an insurer does not need to present expert testimony to prove the objective prong of the subjective-objective test for prior knowledge under Connecticut law. This prong requires that an insurer establish that the facts known to the insured could reasonably be expected to give rise to a claim, which the court held can be determined without the aid of experts.

Infinity Q Capital Mgmt, LLC v. Travelers Cas. & Sur. Co. No. N21C-07-158, 2022 WL 3902803, 2022 Del. Super. LEXIS 363 (Aug. 15, 2022)

Under Delaware law, the Superior Court of Delaware held that a prior knowledge exclusion must be applied using an objective, "reasonable person" standard even where the exclusion does not use the terms "objective" or "reasonable person." The insured's policy contained several coverages, including directors and officers liability coverage and excess coverage. The policy was issued in reliance on a warranty letter and also included its own prior or pending litigation exclusion. The court held that as a matter of contract interpretation, the warranty letter stated there was no coverage if any insured had "any" knowledge of "any" act that "may" give rise to a claim. The court found that the insured's knowledge of, and nondisclosure of, two SEC inquiries and an ongoing SEC matter were sufficient to bar coverage for those matters. The court also rejected the insured's argument that a prior knowledge provision must be interpreted separately with respect to innocent insureds.

Stafford v. Stanton, Case No. 17-262 (SMH), 2022 WL 4491073, 2022 U.S. Dist. LEXIS 175471 (W.D. La. Sept. 27, 2022)

Applying Florida law, the U.S. District Court for the Western District of Louisiana held that an insurer had satisfied the "objective prong" in a "prior knowledge" provision in a professional liability policy issued to an attorney. The insurer issued a claims-made policy with a "Prior Knowledge" provision, which stated: "As of the inception date of the policy, no insured had knowledge of any circumstance likely to result in or give rise to a 'Claim' nor could have reasonably foreseen that a claim might likely be made." In the underlying suit, the plaintiff sued his longtime friend (an attorney), claiming he encouraged the plaintiff to invest $2.5 million in the business ventures of his friend's client. The business ventures, which turned out to be a fraudulent scheme, collapsed. Florida law provides that prior knowledge provisions are triggered under a subjective-objective test, the objective prong requiring that an insured "could have reasonably foreseen" that a wrongful act might be expected to be the basis of a claim, based on the facts subjectively known by the insured. The court granted summary judgment to the insurer, identifying several facts that would lead a reasonable person in the attorney's shoes to foresee that a claim might be made, including the plaintiff's personal counsel questioning the authenticity of signatures on documents relating to the scheme, the insured receiving a copy of another lawsuit arising out of the scheme, the insured receiving a subpoena requesting documents and communications relating to the scheme, and the insured's tender of notice to a different insurer regarding a "potential claim."

ALPS Prop. & Cas. Ins. Co. v. Edenfield, No. CV 621-008 (JRH), 2022 WL 4098516, 2022 U.S. Dist. LEXIS 161411 (S.D. Ga. Sept. 7, 2022)

Under Georgia law, the U.S. District Court for the Southern District of Georgia held that an insured attorney's failure to comply with a statute of limitations constituted a Wrongful Act that could form the basis of a Claim, which therefore should have been disclosed in a claim information supplement required under her professional liability policy. The policy application asked whether the insured had knowledge of any "fact, circumstance, act, error, or omission that could reasonably be expected to be the basis of a claim against any current or former attorney in the firm …" The insured represented a private school teacher in her suit for discrimination and other workplace injury. The teacher was provided right-to-sue letters by the EEOC, and suit was filed in the district court 96 days after the letters were issued. The private school's counsel asserted that the suit was untimely, and the insured responded that she planned to amend the complaint. The teacher also retained the insured on a separate matter for workers compensation benefits against the same school. The insured decided after investigation that she did not have a good faith basis to assert new claims in the discrimination suit, and therefore did not amend the complaint in that action. The suit was dismissed with prejudice for filing outside of the statute of limitations. The court held that the insured's failure to report dismissal of a claim for failure to comply with the statute of limitations was unreasonable as a matter of law. The court held that no reasonable attorney would have failed to understand that missing a statute of limitations might give rise to a claim for legal malpractice.

Goldberg Simpson, LLC v. Evanston Ins. Co., No. 3:21-cv-00002-GFVT, 2022 WL 697978, 2022 U.S. Dist. LEXIS 40577 (E.D. Ky. Mar. 8, 2022)

Under Kentucky law, the U.S. District Court for the Eastern District of Kentucky held that neither party had demonstrated the absence of a genuine issue of material fact on the issue of whether a reasonable person in the insured's position would have concluded that a claim was likely prior to the policy period. The insurer issued a professional liability policy to the insured, a law firm, for the July 2019 to July 2020 policy period. Coverage was contingent upon "no Insured [having] any knowledge of such Wrongful Act or Personal Injury, or any fact, circumstance, situation or incident which would lead a reasonable person in the Insured's position to conclude that a Claim was likely." In January 2019, the insured received a letter from a client, suggesting the possibility of a lawsuit. The insured neither informed the insurer of the potential claim nor mentioned it when it renewed the policy. The insured did, however, create an internal memorandum that summarized actions taken in connection with dealings with that client and named the memorandum "Potential Malpractice Claim." When the client sued the insured in May 2020, the insurer denied coverage based on the prior knowledge provision. The court found that no evidence indicated the insured "had knowledge" that he had committed a "Wrongful Act" because the insured's internal memorandum did not indicate that an act, error, or omission had in fact occurred—rather, it simply "summarized his involvement in the matter" to that point. Ultimately, due to a lack of evidence regarding whether a reasonable person in the insured's position would have thought a claim was likely after receiving the 2019 letter, the court declined to grant summary judgment in favor of either party.

James River Ins. Co. v. Hilton, No. 2:20-cv-00687-CDS-VCF, 2022 WL 2704792, 2022 U.S. Dist. LEXIS 122666 (D. Nev. July 11, 2022)

Applying Nevada law, the U.S. District Court for the District of Nevada concluded that an insurer could rescind a sixth-year renewal policy but found there was a genuine dispute of material fact as to whether the insurer knew of the insureds' misrepresentations by the time the seventh-year renewal policy was issued. The insurer argued that an investigation by the Nevada State Bar should have been disclosed on the application for legal malpractice insurance as "any new or current investigation, disciplinary action or proceeding." The insureds argued that the insurer

had independent knowledge of the investigation based on documents third-party claimants submitted to the insurer with their malpractice complaints. The court looked at the timing of the evidence and found that the insurer did not receive any communications regarding the insured's disciplinary proceedings before it issued the sixth policy, but the insurer had received those communications before it issued the seventh policy. Thus, the insurer could rescind the sixth policy.

Certain Underwriters at Lloyd's v. Good Night Nursing Agency, LLC, Civil Action No. 21-07666 (MAS) (LHG), 2022 WL 1137302, 2022 U.S. Dist. LEXIS 71059 (D.N.J. Apr. 18, 2022)

Applying New Jersey law, U.S. District Court for the District of New Jersey found an insurer adequately demonstrated equitable fraud where a nursing agency applied for retroactive coverage three months after an infant died under the nursing agency's care and failed to disclose the infant's death on the policy application. Shortly after the insurer issued the professional and general liability policy, the insured notified the claims administrator of the infant's death. The insurer filed a declaratory judgment action, seeking to rescind the policy. The insured did not respond to the complaint, and the insurer filed a motion for default judgment. In analyzing the merits, the court noted there were "ample facts set forth in the pleadings to show that the insured knew of the infant's death when completing the application and, more importantly, its exposure for future claims." Accordingly, the court entered a default judgment and issued a declaration finding the policy was void.

J.P. Morgan Sec. Inc. v. Vigilant Ins. Co., 166 N.Y.S.3d 1 (App. Div. 1st Dept. 2022)

Under New York law, the New York Supreme Court, Appellate Division, held an insurer could not rely on a prior knowledge exclusion in its binder to deny coverage. The excess professional liability insurer issued a binder to its insured, a securities broker-dealer, which included a prior knowledge exclusion. In part because there was no evidence that any of the insured's "employee[s] fitting [the] description [of 'officer'] had knowledge, before March 21, 2000, of the deceptive market timing and late trading scheme that [the insured] facilitated and participated in during the period 1999 to 2003," the court found the insurer's reliance on the prior knowledge exclusion unavailing. Additionally, the court held that the insurer could not even assert the exclusion-based defense because the exclusion was only included in the policy binder but not in the policy itself.

N. River Ins. Co. v. Leifer, No. 21-CV-7775 (VC), 2022 WL 1210847, 2022 U.S. Dist. LEXIS 75134 (S.D.N.Y. Apr. 25, 2022)

Under New York law, the U.S. District Court for the Southern District of New York held an insurer had no duty to defend its insured due to the insured's prior knowledge of a possible claim when obtaining coverage. The insurer issued a legal malpractice policy to the insured, a law firm. The insured defended a client in a 2016 lawsuit but "never answered the complaint" and failed to "demonstrate a reasonable excuse for failing to answer or to advance a potentially meritorious defense to the case." Accordingly, the client was subject to a default judgment. The insured did not mention the default judgment or its own failure to avoid a default judgment when it applied for malpractice insurance in 2019. The client sued the insured for malpractice, and the insurer initially agreed to defend but later withdrew its defense because of the insured's prior knowledge of facts reasonably likely to give rise to a claim. Because the insured knew the facts that formed the basis of the malpractice suit, and those facts involved the insured's failure to file an answer—which is prima facie evidence of negligence—the court found that the insured must have known that a claim was possible. Therefore, because the insured "could have foreseen that a claim might arise out of that incident," the court found that the policy's prior knowledge exclusion barred coverage and relieved the insurer of the duty to defend. This decision has been appealed to the Second Circuit.

Union Univ. v. Evanston Ins. Co., No. 1:20-cv-01254-JBD-jay, 2022 WL 507666, 2022 U.S. Dist. LEXIS 29940 (W.D. Tenn. Feb. 19, 2022)

Applying Tennessee law, the U.S. District Court for the Western District of Tennessee held an insurer had not sufficiently demonstrated that the known loss doctrine barred coverage because whether the insured was "aware of" the loss prior to the application was an issue of fact. Although employees of the insured were aware of the loss, the employee responsible for obtaining insurance was not. The insurer issued a professional services liability policy to the insured, a university, for the August 31, 2018 to August 31, 2019 policy period. On January 28, 2018, a patient died due to allegedly improper administration of a drug by one of the insured's student nurses. The director of the insured's nurse anesthesia program received notice of the incident in January 2018, and the insured was also notified of a potential lawsuit in April 2018; however, none of the recipients of these notices informed the insured's vice president of business affairs who was responsible for obtaining insurance. The insurer argued it had no duty to defend the insured because the insured knew of the incident before applying for the 2018-2019 renewal. However, the court found that the insured's knowledge presented an issue of fact.

Drawbridge Energy U.S. Ventures, LLC v. Fed. Ins. Co., No. 4:20-CV-03570 (ASH), 2022 WL 991989, 2022 U.S. Dist. LEXIS 61686 (S.D. Tex. Apr. 1, 2022)

Applying Texas law, the U.S. District Court for the Southern District of Texas held an insurer owed no duty to defend its insured because the insured breached a warranty in the insurance application. The insurer issued a directors and officers liability policy. The application for insurance warranted that "[n]o person or entity proposed for coverage is aware of any fact, circumstance, or situations which he or she has reason to suppose might give rise to any claim that would fall within the scope of the [policy]." The application also provided that the applicant would have to inform the insurer if "any material change" in the answers to the application occurred. The insured answered the application question in the negative on May 7, 2018, but 10 days later received a letter alerting it of its potential liability under Australian law that would fall within the scope of the policy. The court found that the insured's failure to update the insurer and disclose the content of the letter was material because the application stated that the insurer "relied on" the application in issuing the policy. Because the insured failed to disclose its knowledge of the potential claim to the insurer, and such information was material, the court found that the insured's breach of the application's warranty provision relieved the insurer of the duty to defend.

Loya Cas. Ins. Co. v. Certain Underwriters at Lloyd's, London, No. SA-21-CV-00611-JKP, 2022 WL 2329196, 2022 U.S. Dist. LEXIS 113760 (W.D. Tex. June 28, 2022)

Under Texas law, the U.S. District Court for the Western District of Texas held an insurer had pled sufficient facts to state a plausible counterclaim for misrepresentation and application of the known loss doctrine. The insurer issued a one-year professional liability policy to the insured, another insurance company. In 2018, the insured "became aware" that a third party intended to submit a claim for extra-contractual liability based on the insured's alleged bad faith in handling an underlying auto liability bodily injury claim. However, when the insured applied for professional liability insurance in July 2019, the insured answered "no" in response to a question asking whether it had "knowledge or information of any act, error, omission, fact, or circumstance which may give rise to a claim which may fall within the scope of the proposed insurance." The insured reported the bad faith claim in 2020, and the insurer denied coverage. In the coverage action, the insurer counterclaimed, asserting that the bad faith claim was a "known loss" before the policy took effect, and therefore the insured made a material misrepresentation in its application. The insured filed a motion to dismiss, which the court viewed as an attempt to prematurely argue the merits. The court determined that "[a]t this stage of the litigation, [it would] not engage in analysis of the substantive merits of an asserted counterclaim, a choice of law determination,

a determination of any questions of fact, or a party's argument in support of its position," and therefore it would not dismiss the insurer's counterclaim for known loss.

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

AmTrust Fin. Servs., Inc. v. Liberty Ins. Underwriters, Inc., C.A. No. 21-374-JLH, 2022 U.S. Dist. LEXIS 59828, 2022 WL 980299 (D. Del. Mar. 31, 2022)

Under Delaware law, the U.S. District Court for the District of Delaware could not conclude as a matter of law that a prior notice exclusion barred coverage. The insurer issued a second-layer excess directors and officers liability policy, which excluded coverage for "Claims or Pre-Claim Inquiries arising out of any circumstances of which notice has been given under any directors and officers liability insurance policy in force prior" to September 30, 2016. In 2017, various securities and derivative actions were filed against the insured after the insured made changes to its accounting practices that resulted in a restating of its financials (the 2017 actions). The insured sought coverage for expenses related to the 2017 actions, but the insurer rejected the claim based on the policy's prior notice exclusion because the conduct the insured sought coverage for "ar[o]se out of the same circumstances that gave rise to" a 2014 public letter (the 2014 letter) by the insured's investment advisor that questioned the insured's accounting practices. The insurer contended that the 2017 actions' reference to the 2014 letter was indicative that the 2017 actions arose from the same conduct referenced in the 2014 letter. However, the court could not conclude as a matter of law that the policy excluded coverage because of the 2014 letter. The court noted that the 2014 letter did not "initiate[] a chain of events that led to" the underlying actions. Further, the court stated there was no "meaningful linkage between the accounting issues identified in the [2014] Letter and the accounting issues that gave rise to the restatement and the" 2017 actions.

Ashland Hosp. Corp. v. Darwin Select Ins. Co., 2020-SC-0260-DG, 2022 Ky. LEXIS 331, 2022 WL 12198051 (Ky. Oct. 20, 2022)

Under Kentucky law, the Kentucky Supreme Court held that a prior notice exclusion did not bar coverage for a claim related to a government investigation noticed and accepted by a prior insurer. Three insurers issued three separate policies to the insured medical center, including a directors and officers liability policy, a professional liability policy, and an excess liability policy which applied in excess of the professional liability policy. The professional liability policy included a prior notice exclusion that stated that coverage would not apply to any claim "based on, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving … any facts, matters, events, suits or demands notified or reported to, or in accordance with, any policy of insurance or policy or program of self-insurance in effect prior to October 16, 2012." The professional liability insurer and the excess insurer argued that the prior notice exclusion contained in the 2012-2013 policy barred coverage because the insured invoked its directors and officers liability policy with a different insurer in 2011 in connection with a U.S. Department of Justice (DOJ) subpoena it received in July 2011. However, both the professional liability insurer and the excess liability insurer conceded they had knowledge of the 2011 DOJ subpoena during the August 2012 negotiations and renewal of the relevant 2012-2013 policy. Moreover, the professional liability insurer and the excess insurer took the position that the DOJ subpoena did not contain sufficient information to constitute notice of circumstances that might give rise to a claim. In September 2013, the insured was sued for medical malpractice arising out of the DOJ subpoena, which became the subject of the coverage litigation. The court rejected the insurers' arguments that the prior notice exclusion barred coverage, noting that, because the insurers adopted the position that the DOJ subpoena did not constitute adequate notice of circumstance giving rise to a claim due to lacking critical facts, it could not form the basis for invoking the prior notice exclusion in the professional liability policy and excess policy. Additionally, the court found that because the professional liability insurers had notice

of the investigation before issuing their renewal policies, the insurers created an expectation of coverage by failing to inform the insured prior to the inception of the policy that the prior notice exclusion would apply to bar coverage for any claims related to the investigation. Finally, the court also rejected the insurers' argument that the subpoena was an uninsurable known loss. Because it did not constitute notice of circumstances, the court reasoned the subpoena therefore could not be a known liability.

Knox v. Ironshore Indem., Inc., 21-3032, 2022 U.S. App. LEXIS 17160, 2022 WL 2236951 (2d Cir. June 22, 2022)

Under New York law, the Second Circuit affirmed summary judgment in favor of an insurer, finding a policy's prior acts exclusion unambiguously excluded coverage. The insurer issued a directors, officers, and private company liability policy that stated that "the Insurer shall not be liable to make any payment for Loss in connection with any Claim for any Wrongful Act which occurred prior to April 30, 2012. Loss Arising out of the same Wrongful Act or Related Wrongful Acts shall be deemed to arise from the first such Wrongful Act." In 2017, the insured was sued for discriminatory pay practices based on conduct, beginning in 2005, in which the insured gave male employees certain taxable benefits unavailable to female employees. The catalyst for the litigation was the insured's 2015 change in policy that gave female employees a non-taxable discount on clothing. The insurer denied coverage for expenses related to the lawsuit, arguing the inception of the insured's discriminatory practices placed the claim outside of the policy's coverage. The Second Circuit held that the policy "unambiguously exclude[d] coverage" because the insured instituted the discriminatory policy prior to April 30, 2012. Further, the court noted that "[the insured's] introduction of the discount offer to female employees in 2015 d[id] not … transform[] [the insured's] discriminatory policy into something not 'the same [as], related [to] or continuous [with]" the 2005 discriminatory policy. Thus, the court held the implementation of the later discriminatory policy arose "from a common nucleus of facts" as the earlier discriminatory policy. Therefore, the insurer was not required to provide coverage pursuant to the prior acts exclusion.

Green Tree Comty. Health Found. v. Admiral Ins. Co., No. 21-3137 (TJS), 2022 U.S. Dist. LEXIS 143311, 2022 WL 3281873 (E.D. Pa. Aug. 10, 2022)

Under Pennsylvania law, the U.S. District Court for the Eastern District of Pennsylvania granted summary judgment in favor of an insurer, finding a policy's prior acts exclusion applied even though the named insured did not exist until years after the incident giving rise to the claim. The insurer issued tail insurance for professional liability medical malpractice claims. The policy covered "Incurred But Not Reported Claims" that occurred between March 1, 1984, and March 1, 2005, and applied to "only claims that were first made against the insured and reported to [the insurer] after October 1, 2011." In 2019, a mother and her child brought a claim against the insured, stemming from the birth of the child in 2001. The insurer denied coverage because the mother had previously brought the underlying cause of action against several hospitals in 2002. The insurer argued that the 2019 claim fell within the "prior acts exclusion" because the 2002 litigation was reported to another insurer at that time. The insured argued that the 2002 claim could not be a claim under the policy because it did not name the insured and was made before the insured existed. The court rejected the insured's argument, finding that the 2002 claim was made against the insured's "predecessor whose liability [the insured] assumed." Here, the court stated the 2019 lawsuit was "based on the same 'Medical Incident' resulting in bodily injury to the same patient" from the 2002 lawsuit, therefore, "it [wa]s the same 'Loss Event' or claim." Thus, the court held the policy excluded coverage for the 2019 claim because the original cause of action "had both been incurred and reported to another insurer prior to the inception date of the [insurer's] policy."

Homeland Ins. Co. of N.Y. v. Clinical Pathology Labs., Inc., No. 1-20-CV-783-RP, 2022 U.S. Dist. LEXIS 127485, 2022 WL 2820741 (W.D. Tex. July 19, 2022), *clarified by* 2022 U.S. Dist. LEXIS 148466, 2022 WL 3371631 (W.D. Tex. Aug. 16, 2022)

Under Texas law, in a report and recommendation in the U.S. District Court for the Western District of Texas, the magistrate judge recommended to the court that it grant the insureds' summary judgment motion as to the insurer's prior notice exclusion affirmative defense. The insurer issued a medical facilities and providers professional liability, general liability, and employee benefit liability policy, which covered certain claims for wrongful acts and personal injury. The policy included a prior notice exclusion that barred coverage for "any Claim based on, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving any actual or alleged … act, error, omission or Wrongful Act, event, suit or demand which was the subject of any notice given under … any medical professional liability or similar policy of insurance or plan or program of self-insurance, with respect to any Claim otherwise covered under INSURING AGREEMENT (A) …." The insureds moved for summary judgment on the insurer's prior notice exclusion affirmative defense. The insurer argued that the prior notice exclusion barred coverage because the insured's sister lab provided notice of the claims at issue to the sister lab's insurer. However, the insureds argued that the sister lab was not covered by the policy, and the court agreed. Because the sister lab was not a party to the policy with the insurer, the sister lab's notice of bulk claims to its own insurer did not constitute claims "otherwise covered under Insuring Agreement (A)" to trigger the exclusion. The court further reasoned that this outcome was also consistent with the purpose of prior notice exclusions, which are designed to prevent double recovery.

V. Dishonesty and Personal Profit Exclusions

Houston Specialty Ins. Co. v. Fenstersheib, No. 20-60091-CIV-ALTMAN/Hunt, 2022 U.S. Dist. LEXIS 179241, 2022 WL 4880148 (S.D. Fla. Sept. 30, 2022)

Under Florida law, the U.S. District Court for the Southern District of Florida held that a policy's "theft of funds" exclusion precluded coverage for an underlying lawsuit. The insurer issued a claims-made-and-reported professional liability policy to its insured, a personal injury law firm. The policy included an improper use of funds/theft exclusion, which barred coverage for "[a]ny claim arising out of, relating to or involving improper commingling of client funds, conversion of anyone's funds, theft of anyone's funds, the wire transfer of anyone's funds … a counterfeit check or a check bearing anyone's forged or bogus signature." In 2017, the insured discovered one of its employees embezzled millions of dollars from the firm's trust account. Two state court cases were filed against the law firm, one of which asserted nine claims against the insured, including civil theft, conversion, breach of contract, and negligence. The insurer defended both lawsuits in state court under a complete reservation of rights. In a coverage action, the insurer argued "that the Theft of Funds Exclusion applie[d] because 'the underlying complaint specifically alleges that plaintiffs' alleged loss arises out of [the employee's] theft of millions of dollars from [the insured's] trust account.'" The insured argued that "'[o]f the eight counts for monetary relief in the Underlying Complaint, only two allege damages arising out of or related to the [employee] theft[.]" The court rejected the insured's argument, finding that the phrases "arising out of, relating to, or involving" plainly worked to expand the categories of excluded claims. Thus, the court concluded that the insurer had no duty to defend. This case is currently on appeal to the Eleventh Circuit.

USA Gymnastics v. Liberty Ins. Underwriters, Inc., 27 F.4th 499 (7th Cir. 2022)

Under Indiana law, the Seventh Circuit held that a wrongful conduct exclusion applied to 10 instances of sexual abuse, but not to all claims related to that abuse. The insurer issued USA Gymnastics (USAG), the insured, a claims-made directors and officers liability policy, which stated: "This Policy does not apply to any Claim made against any Insured: … based upon, arising from, or in any way related to: … (b) any deliberately dishonest, malicious or fraudulent act or omission or any willful violation of law by any Insured; provided, however, this exclusion shall only apply if it is finally adjudicated that such conduct in fact occurred." The court noted that "Larry Nassar sexually assaulted hundreds of girls and young women over decades during his involvement with [USAG] … As a result of Nassar's abuse, USAG has been sued numerous times and investigated by Congress and federal and state authorities." The court agreed with USAG "that the wrongful conduct exclusion does not apply to most of the Nassar-related claims" because "the resolution of Nassar's state criminal cases informs whether, and how much of, his wrongful conduct has been 'finally adjudicated' for purposes of the wrongful conduct exclusion." Only 10 counts were finally adjudicated. Thus, the court concluded that "[t]he policy's wrongful conduct exclusion applies to only the ten claims for which Nassar was found guilty, and not to the remaining Nassar-related claims, for which [the insurer] must provide insurance coverage."

CUMIS Specialty Ins. Co., Inc. v. Kaufman, 21CV11107 (DLC), 2022 U.S. Dist. LEXIS 176535, 2022 WL 4534459 (S.D.N.Y. Sept. 28, 2022)

Under New York law, the U.S. District Court for the Southern District of New York issued a declaration that an insurer was not required to pay its insured's legal expenses resulting from the appeal of his criminal conviction. The insurer had issued a management and professional liability policy effective from April 30, 2016 to April 30, 2017, which included a dishonest or willful acts exclusion that barred coverage for "'loss' related to any 'claim' based upon … any deliberately dishonest, fraudulent, intentional or willful misconduct or act." The insured was convicted of intentionally and corruptly accepting gratuities in exchange for the provision of favorable loans and advertisement purchases. The court determined that these acts constituted both a "willful or intentional violation of any law," and the "gaining [of] remuneration … [to which the] 'insured' was not legally entitled." Because the insured's defense costs arose out of these acts, they were excluded if the acts were established by a "final adjudication." The insured argued that because he had appealed his case, there had yet to be a final adjudication. The court found that, under New York law, it is "well settled that the imposition of the sentence constitutes the final judgment against the accused," and "the finality of it is not changed by the pendency of the appeal." Accordingly, the insurer was not obligated to pay the insured's defense costs on appeal.

VI. Restitution, Disgorgement, and Damages

G-New, Inc. v. Endurance Am. Ins. Co., No. N21C-10-100 MMJ CCLD, 2022 Del. Super. LEXIS 371, 2022 WL 4128608 (Sept. 12, 2022)

Under Delaware law, the Delaware Superior Court found that an insured's settlement of a class-action lawsuit based on allegations of false advertising did not involve disgorgement or restitution under either Delaware or New York law. The insurer issued a policy to a chocolate manufacturer that included directors and officers liability coverage. The insurer declined to provide coverage for the class-action settlement on the basis of an exclusion for matters uninsurable under New York law; however, the insured argued that Delaware law applied and that restitution is insurable under Delaware law. The court concluded that a choice-of-law analysis was not required because the settlements did not involve disgorgement or restitution. The court based its conclusion on the facts that there had been no order of disgorgement, and the settlement contained no admission of wrongdoing, instead representing the difference in value between a properly advertised product and a falsely advertised product.

SXSW, LLC v. Fed. Ins. Co., No. 1:21-CV-00900-RP, 2022 U.S. Dist. LEXIS 92709, 2022 WL 1648500 (W.D. Tex. May 24, 2022), *report and recommendation adopted,* No. 1:21-CV-900-RP, 2022 U.S. Dist. LEXIS 183423, 2022 WL 4866706 (W.D. Tex. Sept. 29, 2022)

Under Texas law, the U.S. District Court for the Western District of Texas held that a breach of contract claim requesting the return of amounts paid was a covered loss and did not constitute a request for disgorgement or restitution. The insurer issued a policy that included directors and officers and entity liability coverage to a company that hosted festivals. The underlying claimant alleged that the insured committed conversion by failing to return festival credential payments when the festival was cancelled. The insurer denied coverage on the basis that claims for disgorgement and restitution are uninsurable under Texas law. The court found that disgorgement required that funds be retained unlawfully or fraudulently, and the underlying claimant had not alleged that the insured fraudulently or illegally acquired the payments. The court concluded that the request for repayment was a claim for contractual damages and a covered loss under the policy. The court distinguished contractual damages from claims for equitable injunctive relief that would constitute disgorgement or restitution damages "uninsurable under the law."

VII. Insured Capacity

Liberty Ins. Underwriters, Inc. v. Cocrystal Pharma, Inc., No. 119CV02281JDWCJB, 2022 U.S. Dist. LEXIS 91839, 2022 WL 1624363 (D. Del. May 23, 2022)

Under Delaware law, the U.S. District Court for the District of Delaware held that directors and officers under investigation by the SEC for a "pump-and-dump" scheme were not acting in their capacity as insureds under the insured Cocrystal Pharma, Inc.'s (Cocrystal) director's and officer's liability policy because the corporation was not yet in existence at the time of the alleged scheme. Cocrystal was formed following a reverse merger between Biozone Pharmaceuticals, Inc. and Cocrystal Discovery, Inc. The following year, Liberty sold Cocrystal a claims-made policy, providing coverage for claims made during the policy period arising from wrongful acts by Cocrystal's directors and officers. The policy listed only Cocrystal as the insured organization and contained related claims provision to cover all claims arising from the same wrongful acts as a single claim. The following year, the SEC determined that various executives from Biozone who later became directors and officers of Cocrystal were involved in a "pump-and-dump" scheme. After the SEC filed its complaint, various shareholder suits were brought against both Cocrystal, as Biozone's successor, and Cocrystal's directors and officers, alleging violations of the Exchange Act and various state laws. In the declaratory judgment action filed by Liberty, the court granted summary judgment to Liberty, finding that the defendants were not acting in their capacities as directors and officers of Cocrystal at the time of the alleged pump-and-dump scheme, but as officers and directors of its predecessor Biozone. Accordingly, the court held that there was no coverage under Cocrystal's policy as a matter of Delaware law, and Liberty was entitled to recoup defense costs that it had advanced to the defendants under that policy.

Associated Indus. Ins. Co., Inc. v. Wachtel Missry LLP, No. 21 CIV. 3624 (LGS), 2022 U.S. Dist. LEXIS 162454, 2022 WL 4109771 (S.D.N.Y. Sept. 8, 2022)

Under New York law, the U.S. District Court for the Southern District of New York held that a business enterprise exclusion in the defendant law firm's professional services policy barred coverage for a legal malpractice claim brought against the firm and its former partner. The underlying suit was brought by representatives of a former client and his corporation. The client's representatives alleged that the partner took advantage of the client's age and deteriorating health and convinced the client to sell a lucrative real estate property to the partner without advising him of the inherent conflict of interest in such a transaction. Specifically, the partner organized a corporation to purchase the land, prepared the documentation for the sale, and encouraged the client to sign the sales documents despite observing the client's inability to feed himself, wipe his face, or concentrate for

any length of time. The partner also convinced the client to lend him $500,000 via a promissory note. The firm continued to represent the client in the documentation of the loan. The firm's professional services insurer, Associated Industries Insurance Company, Inc. (AIIC), filed suit seeking a declaratory judgment that the policy did not provide coverage for the firm or the partner. The court granted judgment on the pleadings in favor of AIIC after determining that the policy's business enterprise exclusion barred coverage for claims arising out of an insured's activities "acting in, the capacity as . . . an officer, director, partner, trustee or employee of a . . . corporation or business enterprise, other than the Named Insured." The court found that the business enterprise exclusion applied because the claim arose from the partner's capacity as the organizer of his own business. The court further found that the exclusion applied to both the partner and the firm because the exclusion was triggered by "any claim" arising out of activities of "an Insured." Thus, the court held that the firm did not qualify for coverage independent of the partner.

VIII. Insured v. Insured Exclusion

RSUI Indem. Co. v. Lichtenberg, No. 3:20-cv-00218-RLY-MPB, 2022 U.S. Dist. LEXIS 45173, 2022 WL 740756 (S.D. Ind. Feb. 25, 2022)

Under Indiana law, the U.S. District Court for the Southern District of Indiana found that the insured v. insured exclusion applied based on the named plaintiff bringing the underlying suit. The directors and officers liability policy at issue contained an insured v. insured exclusion that barred coverage for any claim against any insured brought by any insured. Here, the underlying action was a leadership dispute between the National Executive Committee (NEC) of the Phi Mu Alpha Sinfonia Fraternity of America (the Fraternity) and the Fraternity's national president and executive director. The national president, Mark Lichtenberg, and executive director, Edward Klint, sought coverage for the suit under the Fraternity's policy, which was issued by RSUI Indemnity Company (RSUI). RSUI denied coverage based on the insured v. insured exclusion, and the court agreed that the policy did not afford coverage. Even though the state courts in the underlying action determined and affirmed that the NEC lacked authority to sue on behalf of the Fraternity, the federal court in the coverage action reasoned that the nature of the claim, rather than the merits, dictated RSUI's duty to defend. Thus, because both the plaintiff and the defendants were insureds, the exclusion barred coverage. Lichtenberg and Klint argued that by the same logic, a total stranger could bring claims under the Fraternity's name and exempt RSUI from any duty, but the court noted that, although true, any attempts would surely be deterred by the inevitable sanctions under the Federal Rules of Civil Procedure.

T.D. Williamson, Inc. v. Fed. Ins. Co., No. 21-5043, 2022 U.S. App. LEXIS 10057, 2022 WL 1112530 (10th Cir. Apr. 14, 2022)

Under Oklahoma law, the U.S. Court of Appeals for the Tenth Circuit concluded that an insured v. insured exclusion applied to underlying derivative suits brought by an individual director against other directors of the insured company. The directors and officers liability policy at issue excluded coverage for claims "brought by an Insured Person in any capacity against an Insured." Richard Williamson, a director and majority shareholder of the insured, TDW, at the time, initiated a direct, and in the alternative, a derivative suit against eight other directors. When requested to provide coverage for the lawsuit, Federal Insurance Company ("Federal") denied coverage based on the insured v. insured exclusion. The district court found that Federal had no duty to defend or indemnify. On appeal, the Tenth Circuit held that the exclusion was not ambiguous and that a separate subsection of the exclusion that carved out coverage for derivative claims made by an entity did not apply here.

Stoneburner v. RSUI Indem. Co., 598 F. Supp. 3d 1292 (D. Utah Apr. 12, 2022)

Under Utah law, the U.S. District Court for the District of Utah held that an insured v. insured precluded coverage for a claim with multiple causes of action brought by both insureds and non insureds. The directors and officers liability policy at issue contained an insured v. insured that barred coverage for any "claim" by an insured against any

other insured. In the underlying action, two insured individuals, Stoneburner and Abdalla, were sued by a number of individuals, some of whom were insureds under the policy language. When the insurer denied any coverage to Stoneburner and Abdalla, the individuals brought suit and the insurer moved for summary judgment. Stoneburner and Abdalla argued that the causes of actions brought by non-insured individuals were an exception to the exclusion. However, the court noted that the plain language of the policy defined "an entire civil proceeding as a single claim." Thus, despite non-insured individuals bringing causes of action, those causes of action were in one singular civil proceeding with other insured individuals. Therefore, the court agreed with the insurer and applied the insured v. insured exclusion.

IX. Coverage For Contractual Liability

Global Travel Int'l, Inc. v. Mount Vernon Fire Ins. Co., No. 6:21-cv-716-GAP-GJK, 2021 WL 6070579, 2021 U.S. Dist. LEXIS 245343 (M.D. Fla. Dec. 21, 2021)

Under Florida law, the U.S. District Court for the Middle District of Florida found that an insurer had no duty to defend an arbitration proceeding based on a contract exclusion in an errors and omissions policy. An insured travel agency purchased a professional errors and omissions policy from Mount Vernon Fire Insurance Co. (Mount Vernon). After an employee embezzled over $1.1 million, the insured was unable to meet its payment obligations to its credit card processing company, QualPay. QualPay, in turn, alleged breach of contract in an arbitration proceeding, and the insured requested a defense from Mount Vernon, which denied coverage pursuant to the contract exclusion. In the ensuing coverage action, Mount Vernon argued it had no duty to defend because the arbitration demand alleged a breach of contract and was thus excluded from coverage. The insured countered that the policy's breach of contract exclusion did not apply to "unintentional breach of a written contract." The court agreed with Mount Vernon, holding that the demand did not contain allegations of unintentional breach sufficient enough to take the demand "outside the scope" of the exclusion. Instead, "the facts alleged in the demand suggest that [the insured] breached the Qualpay contract because it could not afford to pay [the] fees," which "does not amount to an unintentional breach of contract." Although the complaint stated that "[u]pon information and belief, these breaches of contract were not reflections of intentional obstinacy by [the insured]," the court held that "conclusory buzz words unsupported by factual allegations are not sufficient to trigger coverage."

Siplast, Inc. v. Employers Mut. Cas. Co., 23 F.4th 486 (5th Cir. 2022)

Under Texas law, the U.S. Court of Appeals for the Fifth Circuit found that a contractual liability exclusion in a commercial general liability policy did not eliminate the insurer's duty to defend. The underlying complaint arose from the insured's installation of a roof membrane for the New York Archdiocese, for which it offered a guarantee. Within a few years of installation, however, the membrane proved faulty, the insured refused to honor the guarantee, and the Archdiocese brought suit. The company's insurer denied coverage for the suit and both parties moved for summary judgment in the ensuing coverage action. The court found that the insurer had a duty to defend and the contractual liability exclusion did not apply. The applicable clause stated that coverage was excluded for property damage for which the insured "is obligated to pay … damages by reason of the assumption of liability in a contract or agreement …" but does not apply to liability for damages that "that Insured would have in the absence of the contract or agreement." The court held that because it had "already determined that the Underlying Plaintiffs alleged that the [insured] negligently provided a defective roof membrane, causing damage," the insured would be liable even absent the guarantee.

X. Professional Services

Professional Services Insuring Agreements

Medmarc Cas. Ins. Co. v. Yanowitch, No. 1:20-CV-22822-GAYLES/OTAZO-REYES, 2022 U.S. Dist. LEXIS 39880, 2022 WL 673546 (S.D. Fla. Mar. 7, 2022)

Under Florida law, the U.S. District Court for the Southern District of Florida held that an insurer was required to defend its insured attorney against a lawsuit, alleging breach of fiduciary duty. The lawyers professional liability policy at issue extended coverage to claims "involving errors or omissions in services rendered by an Insured as a provider of legal services in a lawyer-client relationship." A claimant sued the insured for breach of fiduciary duty, alleging that the insured induced him to invest several million dollars in a business venture focused on building a supercar and later cancelled its agreement with him, causing the loss of the value of his investment. In a coverage action, the court held that the insurer had to defend the insured because the allegations of the underlying complaint repeatedly alleged that the insured "breached his fiduciary duty to the plaintiff while acting as his attorney." Although the alleged injury stemmed from the breach of fiduciary duty, it occurred while the attorney was rendering services as a provider of legal services in an attorney-client relationship and therefore was "more than enough" to trigger the duty to defend. This case is on appeal to the Eleventh Circuit.

Compulife Software, Inc. v. Rutstein, No. 9:16-CV-80808-RLR, 2022 U.S. Dist. LEXIS 134369, 2022 WL 4594181 (S.D. Fla. Jul. 28, 2022)

Under Florida law, the U.S. District Court for the Southern District of Florida held that an insurer issuing an insurance agents errors and omissions liability policy did not have a duty to defend an insured in connection with a lawsuit alleging various intellectual property violations. The policy covered claims arising from a negligent act, error, or omission in the rendering or failure to render "Professional Services" for others in the conduct of the "Named Certificate Holder's profession as an 'Agent.'" "Professional Services" was defined to include "the sale, solicitation or servicing of: Life Insurance, Accident and Health Insurance, Workers' Compensation Insurance as part of a 24-Hour Accident and Health Insurance Product, Disability Income Insurance or Annuities." The underlying complaint alleged that the insured gained access to the plaintiff's software and data without permission or license, and subsequently used that data on its website in connection with services provided to life insurance agents, including website creation and a life insurance quote engine. The court found that the allegations against the insured—including copyright infringement, unfair competition, theft of trade secrets, and violation of Florida's deceptive trade practice act—did not arise out of the rendering of "Professional Services." The undisputed material facts showed that the insured was not engaged in the "sale, solicitation, or servicing" of insurance products with the relevant insurance agency when the acts giving rise to the claim occurred. Rather, his only involvement was to hold the insurance license and to provide digital marketing and web design services. The court found that the insuring agreement was not triggered because merely putting one's name on an insurance license, without more, is not the "sale, solicitation or servicing" of insurance for others, nor is it engaging in the profession of being an insurance agent.

Elite Integrated Med., LLC v. Hiscox, Inc., No. 21-13151, 2022 U.S. App. LEXIS 14830, 2022 WL 1740098 (11th Cir. May 31, 2022)

Under Georgia law, the U.S. Court of Appeals for the Eleventh Circuit held that an insurer had no duty to defend the insured medical practice under a professional liability policy against a lawsuit arising out of the insured's alleged false representations in communications and advertising. The policy covered claims made against the insured "alleging a negligent act, error, or omission in your professional services performed …." Professional services were defined as "only those services identified as Covered Professional Services," which in turn included conduct "[s]olely in the performance of

services as a physical medicine clinic including chiropractic, hormone therapy, neuropathy, medical and non-medical weight loss, allergy testing, durable medical equipment and/or instruction, PRP, and amniotic human tissue injections and naltrexone implants." The state of Georgia sued the insured for violations of the Fair Business Practices Act, alleging that the insured, "through [its] advertising materials (including [its] websites, social media posts, emails, written marketing materials, and live seminars) made false and misleading representations to consumers about [its] regenerative medicine products and services." The court agreed with the insurer that the policy provided no coverage because none of the state's claims involved an alleged "negligent act, error, or omission" in the performance of professional medical services. Rather, the state's claims focused solely on the insured's conduct related to marketing and advertising, which required no medical training.

Med. Protective Co. v. Kelley, No. 3:20-CV-763-RGJ, 2022 U.S. Dist. LEXIS 171461, 2022 WL 4389556 (W.D. Ky. Sept. 22, 2022)

Under Kentucky law, the U.S. District Court for the Western District of Kentucky held that a drug counselor's alleged sexual abuse, emotional abuse, and sexual assault and battery of a patient did not constitute "professional services," as required to trigger coverage under a professional liability policy. The drug counselor's employer, a drug-treatment center, was insured under the policy for claims arising from rendering or failing to render "professional services," which was defined to include "the rendering of medical, surgical, dental or nursing services to a patient and the provision of medical examinations, opinions, or consultations regarding a person's medical condition within the Insured's practice as a licensed health care provider ...." The counselor and the counselor's patient began a sexual relationship. The counselor alleged that the relationship was consensual, but the patient alleged that the counselor engaged in sexual abuse, emotional abuse, exploitation, sexual assault and battery, sexual harassment, false imprisonment, invasion of privacy, intentional infliction of emotional distress, wanton and reckless conduct, lack of consent, and fraud. The patient also made claims against the clinic and its owner for negligent hiring, training, and supervision, and for failing to protect her from the counselor. The insurer initiated a declaratory judgment action against the counselor and clinic as to its duties to defend and indemnify. The court noted that Kentucky courts have held that the term "professional services" is defined as requiring an exercise of judgment or training. Thus, only acts that require "the use or application of special learning or attainment" could constitute "professional services" under the policy and Kentucky law. The court therefore found that the counselor's actions did not constitute "professional services," holding that the acts at the heart of the patient's complaints were unrelated to the counselor's education or training.

Schulman v. Axis Surplus Ins. Co., No. 21-cv-1252-LKG, 2022 U.S. Dist. LEXIS 79068, 2022 WL 1307102 (D. Md. Apr. 29, 2022)

Under Maryland Law, the U.S. District Court for the District of Maryland held that an insurer had no duty to defend an attorney under professional liability policies because the criminal indictment against the attorney did not involve an error in the commission of professional services. The policies provided coverage for claims for wrongful acts, which were defined as "any actual or alleged ... act, error or omission[,] ... breach of contract for Professional Services[,] ... or ... personal injury ... committed or attempted ... solely in the performance of or failure to perform Professional Services by any Insured." An attorney sought coverage after he was criminally indicted for conspiracy to commit mail, wire, and bank fraud, conspiracy to commit money laundering, and money laundering. The insurer denied coverage, arguing that the indictment did not involve professional services. The court agreed with the insurer and found no duty to defend, holding that the attorney was alleged to have "conspire[d] to recover frozen Somali Government assets—not that [he] made an error or mistake in providing professional legal services," and determined that the indictment did not constitute a wrongful act under the policies' terms.

Aspen Specialty Ins. Co. v. Blankenship, No. 21-cv-10164 (GAD), 2022 U.S. Dist. LEXIS 2486, 2022 WL 43284 (E.D. Mich. Jan. 5, 2022)

Under Michigan law, the U.S. District Court for the Eastern District of Michigan held an insurer had a duty to defend its insured under a professional liability policy for a lawsuit arising out of the insured's delivery of massage therapy services. The policy provided coverage for damages from injuries "arising out of professional services," which was defined as "those services provided within the scope of the insured's certification and licensure as a massage therapist." The underlying plaintiff, after reportedly suffering nerve damage in her legs after receiving the insured's massage therapy services for about a year, sued the insured, alleging that the insured's services caused her injuries. The court, finding that the insured's conduct "plausibly constitute[d] massage therapy," held that the conduct giving rise to the claim involved "professional services." Applying Michigan's statutory definition of massage therapy, which included a "system of structured touch," the court found that the underlying plaintiff's description of the massage treatment demonstrated that the insured employed a system of structured touch. Although the insurer argued that the insured's manipulation of the claimant's skeletal structure and diagnosis of medical conditions took its conduct outside the scope of "massage therapy," the court noted that the insured's performance of either service was a disputed question of fact. Therefore, the court held that the insured's alleged conduct met the statutory definition of massage therapy, and thus, met the requirements of the coverage agreement.

ECB USA, Inc. v. Chubb Ins. Co. of N.J., No. 20-20569-Civ-Scola, 2022 U.S. Dist. LEXIS 33797, 2022 WL 611536 (S.D. Fla. Feb. 25, 2022)

Applying New Jersey law, the U.S. District Court for the Southern District of Florida held that an insurer had no duty to defend its insured against an underlying suit arising from the insured's auditing services because the insured did not perform said services for a financial institution. The insurer issued a professional liability policy to its insured, a limited partnership that provided professional and consulting services. The policy provided coverage for claims related to "management consulting services," which were defined as "services directed toward expertise in banking, finance, accounting, risk and systems analysis, design and implementation, asset recovery and strategy planning for financial institutions." The insured was sued for its alleged wrongdoing in connection with a professional audit on which it assisted. The insurer denied coverage on the grounds that auditing services were not covered under the policy. In the ensuing coverage action, the court found that auditing financial statements constituted "services directed toward expertise in accounting." The court noted that under New Jersey statutory law, auditing financial statements is a "widely recognized" accounting service. However, the court found that because the auditing was not done "for [a] financial institution[]," the insurer had no duty to defend. In this regard the court noted that because the phrase "for financial institutions" followed a series of nouns, it applied to the entire series, so unless the auditing services were done for financial institutions, there was no coverage. This case is on appeal to the Eleventh Circuit.

Schanker & Hochberg, P.C. v. Berkley Assurance Co., 589 F. Supp. 3d 281 (E.D.N.Y. 2022)

Under New York Law, the U.S. District Court for the Eastern District of New York held that an insurer had to defend its insured under a professional liability policy for alleged violations of the New York False Claims Act because the alleged fraudulent conduct was inseparable from the insured's professional services as a law firm. The insurer issued the policy to a law firm, covering "those sums [the insured] bec[ame] legally obligated to pay … because of an act, error or omission arising out of [the insured's] 'legal services' rendered or that should have been rendered." The policy defined legal services as the "usual and customary services of a licensed lawyer in good standing." The underlying action alleged that the insured "knowingly aided and abetted" schemes to defraud New York via tax returns and records of clients, certain filings with the SEC, and records of a client foundation. The insurer denied

coverage, pointing to the allegedly fraudulent nature in which the insured performed the acts that gave rise to the claims. In the coverage action, the court found for the insured law firm because the underlying complaint alleged acts, including supervision of an estate transaction, consultation on SEC reporting, and preparation of tax returns, all of which are "indisputably [the services] that licensed attorneys usually and customarily perform." Although the insurer argued that extending coverage to the allegedly fraudulent acts would signify that fraud and crime are usual and customary services of an attorney in good standing, the court disagreed, noting that, instead, the fraudulent nature of the actions "color the [way] they were performed" and bear "not on whether the actions themselves—*e.g.,* consulting on SEC reporting requirements—constitute legal services."

LePatner & Assocs., LLP v. RSUI Grp., Inc., No. 21-cv-3890 (JSR), 2022 U.S. Dist. LEXIS 44876, 2022 WL 769614 (S.D.N.Y. Mar. 14, 2022)

Under New York Law, the U.S. District Court for the Southern District of New York held that an insurer had no duty to defend an insured's construction management firm under a lawyers professional liability policy because that entity's service did not constitute professional services. The policy provided coverage for claims "arising out of a negligent act, error, [or] omission … in the rendering of or failure to render Professional Services as a Lawyer." The policy defined professional services to mean "only services performed for others by an Insured such as an escrow agent, lawyer, notary public, administrator, conservator, executor, guardian, guardian ad litem, arbitrator, mediator, trustee, and title insurance agent." The insured's policy was for its legal practice, but it also ran a construction management firm out of the same office. In the underlying action, the claimant named both the insured in its capacity as the construction management firm and the law firm. The insurer provided a defense to the insured law firm but denied any coverage or duty as to the insured's construction management firm, noting that the policy limited coverage to claims arising out of the provision of professional services, as defined by the policy. The insured argued that because the underlying complaint referred to both the insured's law firm and construction management firm, the insurer had to defend both of the insured's entities. In the coverage action, the court found that because the construction management services provided by the insured neither involved the special acumen and training of an attorney, nor aligned with the policy's definition of professional services, the insured's construction management firm was not covered under the policy, and the insurer had no duty to defend the construction management firm. The court also analyzed whether the insurer's failure to inform its insured of the insured's right to independent counsel was wrongful. Because the insurer simply denied coverage for non-covered claims against a non-insured entity, the court held that there was no incentive for the appointed defense counsel to only defeat liability on certain grounds, and thus, no conflict. Accordingly, and due to the absence of allegations of resulting harm and the unsettled state of the law, the court declined to find the insurer interfered with the insured's defense by failing to tell the insured it could retain independent counsel. This case is on appeal to the Second Circuit.

Aspen Specialty Ins. Co. v. NCMIC Risk Retention Grp., Inc., No. 20-CV-03439 (JMA) (ARL), 2022 U.S. Dist. LEXIS 204220, 2022 WL 16837069 (E.D.N.Y. Nov. 9, 2022)

Under New York law, the U.S. District Court for the Eastern District of New York held that there was a reasonable possibility that a licensed massage therapist was providing a "professional service," triggering the professional liability insurer's duty to defend under a professional services liability policy. The policy defined "professional services" as "services which are within the scope of practice of a chiropractor in the state or states in which the chiropractor is licensed. Professional Services does not include any services furnished by an insured as a practitioner of any other healing or treating art." The underlying matter involved a suit against a massage therapist and the chiropractic office after the claimant suffered an injury to her shoulder while receiving a massage from the massage therapist on the chiropractic office's premises. The massage therapist's professional liability insurer filed a

declaratory judgment action against the chiropractic office's professional liability insurer, seeking a declaration that the chiropractic office's insurer had a duty to defend the massage therapist in the underlying action. The court held that there was a reasonable possibility that the massage therapy provided constituted a "professional service" under the chiropractic office's policy, observing that the New York State's Office of Professions includes "massage" within the authorized practices of a licensed chiropractor, and that, although massage typically requires licensing, it does not require a license for individuals authorized to practice, among other things, chiropractic medicine. Because massage "may fall within the scope of chiropractic practice," there was a reasonable possibility the massage therapist was providing a professional service under the terms of the policy.

Janette Hendrex & Recessability, Inc. v. Phila. Indem. Ins. Co., No. 4:20-CV-3734 (CAB), 2022 U.S. Dist. LEXIS 99901, 2022 WL 1797042 (S.D. Tex. Jan. 28, 2022)

Under Texas law, the U.S. District Court for the Southern District of Texas held an insurer had no duty to defend its insured, a recreational and aquatic therapy business, under a professional liability policy against underlying claims for breach of contract, tortious interference, and violations of HIPAA. The policy defined a professional incident as an actual or alleged negligent act, error, or omission "in the actual rendering of professional services to others in your capacity as an insured." In the underlying suit, another therapy business with whom the insured had entered into an independent contractor agreement sued the insured, alleging that the insured had solicited the plaintiff's clients and contractors in violation of the parties' agreement. The insurer denied coverage on the ground that the underlying lawsuit did not involve a "professional incident," and in the insured's ensuing coverage action, the insurer moved for summary judgment on the issue of coverage under the policy. The court found in the insurer's favor, noting that none of the allegations in the underlying complaint—improperly soliciting the third party's clients, interfering with the third party's business relationships with clients, and improperly accessing and using protected health information to solicit clients—involved the use of specialized training in recreational therapy, the relevant professional service.

Professional Services Exclusions

United Talent Agency, LLC v. Markel Am. Ins. Co., No. 2:21-cv-00369-MCS-E, 2022 U.S. Dist. LEXIS 14576, 2022 WL 599023 (C.D. Cal. Jan. 26, 2022)

Under California law, the U.S. District Court for the Central District of California held an insurer had no duty to defend its insured under a management liability policy against a lawsuit alleging tortious hiring of employees and clients from a competitor. The policy issued to the insured talent agency contained a professional services exclusion. The exclusion precluded coverage for any loss or claim arising from any actual or alleged errors, acts, omissions, neglect, or breach in connection "with the rendering or failure to render any professional services to others for a fee, commission, or other compensation by any Insured." The insurer denied coverage under the policy's professional services exclusion. In a coverage action, the court noted the broad meaning of "arising from," and that under California law, professional services are those "arising out of a vocation, calling, occupation, or employment involving specialized knowledge, labor, or skill, and the labor or skill involved is predominantly mental or intellectual." The court held that the "[Insured] has no serious argument that the allegations of hiring agents from a [competitor] have no connection with the rendering of professional services … for compensation. The Court cannot imagine, and [the insured] did not provide, any other motive for the alleged acts than for [the insured] to increase its profits." Because the alleged wrongful acts were most likely performed for developing a competitive advantage in the market, the acts did occur in connection with rendering professional services for money, and therefore, the professional services exclusion barred coverage. This case is on appeal to the Ninth Circuit.

Guaranteed Rate, Inc. v. ACE American Insurance Company, No. N20C-04-268 MMJ CCLD, 2022 Del. Super. LEXIS 367, 2022 WL 4088596 (Del. Super. Ct. Aug. 24, 2022)

Applying Delaware law, the superior court found that a professional services exclusion did not bar coverage under a private company management liability policy for a Civil Investigative Demand (CID) issued by the U.S. Attorney's Office. The 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. In motions for judgment on the pleadings and summary judgment, the court found that the professional services exclusion did not apply, in part because "professional services" was not defined, and therefore warranted narrow application. Applying the term to the facts of the underlying matter, the court found that the insured's professional obligations were to mortgage borrowers whereas the CID involved alleged duties owed to the government.

Phila. Indem. Ins. Co. v. Ronin Staffing, LLC, No. 3:20-CV-00374-FDW-DSC, 2022 U.S. Dist. LEXIS 37914, 2022 WL 628518 (W.D.N.C. Mar. 3, 2022)

Under North Carolina law, the U.S. District Court for the Western District of North Carolina held an insurer had no duty to defend its insured due to the applicable policies' professional services exclusion. The insurer issued a businessowners policy and a commercial general liability policy (CGL) to its insured, a pharmacy staffing agency, each of which contained professional services exclusions. Each exclusion broadly excluded coverage for bodily injury due to the rendering or failure to render any professional service, which in turn, included "[m]edical, surgical, dental, x-ray or nursing services treatment, advice or instruction[,] … [s]ervices in the practice of pharmacy; but this exclusion does not apply to an insured whose operations include those of a retail druggist or drugstore." Neither policy defined the term professional services. A third-party plaintiff sued the insured, seeking contribution and indemnification for a different settled lawsuit that alleged malpractice, as well as damages for fraud and negligent misrepresentation and unfair and deceptive trade practices. The insurer sought a declaration that it had no duty to defend the insured, arguing that under both its policies, the professional services exclusion barred the possibility of coverage. First analyzing the coverage issue under the CGL policy's professional services exclusion, the court filled in the meaning of "professional service" with precedent, defining it as a service "arising out of a vocation or occupation invoking specialized knowledge or skills [that] are mental as opposed to manual." Because the injury from the underlying lawsuit arose from one of the insured's employee's improper mixing of chemicals to create a pharmacological substance, the court "disagree[d] with [the] contention that the acts of a pharmacy technician, in compounding and dispensing IV solution, [were] merely manual tasks that [did] not require mental skills." The court applied the same logic to interpret the professional services exclusion in the business owners policy, and therefore found that the exclusion relieved the insurer of its duty to defend the insured under that policy as well. The relevant acts—"compounding and dispensing of a prescribed IV solution—were not routine acts which any unskilled person could perform," so they were instead professional services, excluded from coverage by the policies' professional services exclusions. This case is on appeal to the Fourth Circuit.

XI. Independent Counsel

Scottsdale Indem. Co. v. Latino Coal., No. SACV 21-00989 JVS (JDEx), 2022 U.S. Dist. LEXIS 78717, 2022 WL 2204724 (C.D. Cal. Mar. 16, 2022)

Under California law, the U.S. District Court for the Central District of California held that an insurer was entitled to a default judgment in part because its reservation of rights created no conflict of interest, and, therefore no duty to pay for independent counsel. The insurer issued a business and management indemnity policy to its insured, a business development service. On February 20, 2020, on behalf of the U.S. Department of Justice (DOJ), the U.S. District Court for the Western District of Texas issued subpoenas to testify before a grand jury to the insured. The insured retained its own counsel to respond to the subpoenas and report receipt of the subpoena to its insurer. The insurer agreed to defend the insured in connection with the subpoenas and made multiple requests to the insured to transfer the defense from its earlier-retained counsel to the insurer-assigned counsel, but the insured refused, instead insisting that the insurer either pay for the earlier-retained counsel or agree to pay for both insurer-assigned counsel and its own chosen "independent counsel." The court, in determining that the insurer's motion for default judgment was proper, found that the insurer had no duty to defend or indemnify its insured. The court agreed with the insurer's argument that it had no duty to pay for the insured's independent counsel in connection with the subpoenas because there was no actual conflict of interest. The court concluded that the insurer's reservation of rights letter in which it agreed to provide the insured with a defense against the subpoenas did not create a conflict of interest, and therefore there was no obligation to pay for independent counsel under California Civil Code § 2860.

L.A. Terminals, Inc. v. United Nat'l Ins. Co., No 8:19-cv-00286-ODW (PVCx), 2022 U.S. Dist. LEXIS 109986, 2022 WL 2209362 (C.D. Cal. June 21, 2022)

Applying California law, the U.S. District Court for the Central District of California granted summary judgment to two insureds named as defendants in two environmental contamination lawsuits, holding as a matter of law that their commercial general liability insurer owed the insureds a defense via the insureds' selected independent counsel. The insureds were named as defendants in separate state court and federal court actions. In the state court action, the insureds filed counterclaims against the plaintiff, who was also an additional insured under the policy. The insurer first agreed to defend the plaintiff/additional insured in the state court action under a reservation of rights and later agreed to defend both insureds in both actions under a reservation of rights, reversing a prior coverage denial as to one of the insureds. While the insurer initially had a single claims adjuster handle all claims, it eventually split the file between the defense of the additional insured and the defense of the named insureds. When the insurer agreed to defend the insureds, it offered to appoint defense counsel, but the insureds sought independent counsel which the insurer refused to provide and the insured initiated coverage litigation. The court agreed with the insured that the insurer's agreement to defend direct adversaries created an untenable conflict of interest necessitating independent counsel as a matter of law. The court rejected the insurer's argument that it had cured the conflict by splitting the claim file and appointing separate liability adjusters, noting that the insurer had waited six months to split the file and that even after it did so, sent both adjusters—handling both sides of the claim—the "master claim file" that included an attorney's claim assessment report. The court also agreed with the insureds that the insurer's reservation of rights letter provided a basis for the appointment of independent counsel. The insurer's reservations included the right to "disclaim indemnity and the right to withdraw from defending [insureds] should it be discovered that no 'sudden and accidental' releases did, in fact, occur." The court noted that because the nature of the alleged contamination was at the heart of both underlying lawsuits, by controlling the insureds' defense, the insurer would have the ability to direct a more vigorous defense against a liability theory based on ongoing, deliberate pollution (which was excluded from coverage) versus sudden, unexpected contamination (which was covered). The court found that because the insurer's appointed counsel could

control the outcome of the very issue on which the insurer had reserved its right to withdraw the insureds' defense, the insureds were entitled to be defended by independent counsel.

Call One Inc. v. Berkley Ins. Co., 587 F. Supp. 3d 706 (N.D. Ill. 2022)

Applying Illinois law, the U.S. District Court for the Northern District of Illinois denied an insurer's motion to dismiss its insured's breach of contract and bad faith claims. The insurer issued a directors, officers, and corporate liability policy to its insured, a telecommunications business. The insured had received a subpoena duces tecum served by the Illinois Attorney General pursuant to the Illinois False Claims Act (IFCA). The insurer agreed to cover costs incurred by the insured in responding to the subpoena but denied any coverage related to the underlying IFCA claims. The insured settled these claims and later sued its insurer for breach of contract and bad faith denial of coverage, contending that the insurer had a duty to defend, provide independent counsel, and indemnify the IFCA claims. The insured based its bad faith claim on the contention that the insurer failed to provide independent counsel, and argued that in Illinois, "so long as the plaintiff does more than just recite the elements of the cause of action … the Court may not decide the issue on the pleadings alone." Accordingly, the court denied the insurer's motion to dismiss, finding that it was premature to decide the case on the merits before discovery occurred.

Nautilus Ins. Co. v. Access Medical, LLC, No. 2:15-cv-00321-JAD-BNW, 2022 U.S. Dist. LEXIS 205962, 2022 WL 16922029 (D. Nev. Nov. 10, 2022)

Applying Nevada law, the U.S. District Court for the District of Nevada held that when the insurer was entitled to recoup defense costs spent defending the insured against uncovered claims, those recoupment rights also extended to costs the insurer spent on independent counsel for its insureds. The case arose when a business deal between two erstwhile partners soured. One partner, Switzer, sued his partner, Wood and Wood's separate company, Access Medical, LLC (Access), alleging that Wood and Access improperly interfered with Switzer's business relationships. Access tendered defense of the claim to its general liability insurer, theorizing that Switzer's allegations of interference with prospective economic advantage triggered the insurer's duty to defend because those claims alleged facts supporting a possible defamation claim, which would constitute "personal and advertising injury" under the policy. The insurer agreed to provide a defense under a reservation of rights, but later identified a potential conflict of interest and offered to pay for independent counsel for the insureds. The insurer then filed a declaratory judgment action, seeking declarations that it had no duty to defend the insureds and that it was entitled to recoup the paid defense expenses, including those associated with the insureds' independent counsel. The district court granted complete summary judgment to the insurer, and the insureds appealed to the Ninth Circuit. The Ninth Circuit affirmed the district court's finding that the insurer had no duty to defend but reversed the district court's ruling on the reimbursement claim and remanded it for further proceedings following an interlocutory appeal to the Nevada Supreme Court to clarify an unsettled issue of Nevada law on insurers' recoupment rights. On remand, the insured argued that the insurer was not entitled to recoup defense fees incurred by independent counsel, arguing that under Nevada law, the duty to provide independent counsel is a separate and independent duty from the duty to defend. The court disagreed, finding that, under the controlling precedent from the Nevada Supreme Court, "the duty to provide independent counsel presupposes and is a part of the contractual duty to defend." The court held that because the insurer paid for independent counsel to satisfy the potential duty to defend, which was ultimately found not to exist, the insurer was entitled to reimbursement for its independent-counsel expenditure.

LePatner & Assocs., LLP v. RSUI Grp., Inc., No. 21-cv-3890 (JSR), 2022 U.S. Dist. LEXIS 44876, 2022 WL 769614 (S.D.N.Y. Mar. 14, 2022)

Under New York Law, the U.S. District Court for the Southern District of New York held that an insurer

had no duty to defend an insured's construction management firm under a lawyers professional liability policy because that entity's service did not constitute professional services. The policy provided coverage for claims "arising out of a negligent act, error, [or] omission … in the rendering of or failure to render Professional Services as a Lawyer." The policy defined professional services to mean "only services performed for others by an Insured such as an escrow agent, lawyer, notary public, administrator, conservator, executor, guardian, guardian ad litem, arbitrator, mediator, trustee, and title insurance agent." The insured's policy was for its legal practice, but it also ran a construction management firm out of the same office. In the underlying action, the claimant named both the insured in its capacity as the construction management firm and as the law firm. The insurer provided a defense to the insured law firm but denied any coverage or duty as to the insured's construction management firm, noting that the policy limited coverage to claims arising out of the provision of professional services, as defined by the policy. The insured argued that because the underlying complaint referred to both the insured's law firm and construction management firm, the insurer had to defend both of the insured's entities. In the coverage action, the court found that because the construction management services provided by the insured neither involved the special acumen and training of an attorney, nor aligned with the policy's definition of professional services, the insured's construction management firm was not covered under the policy and the insurer had no duty to defend the construction management firm. The court also analyzed whether the insurer's failure to inform its insured of the insured's right to independent counsel was wrongful. Because the insurer simply denied coverage for non-covered claims against a non-insured entity, the court held that there was no incentive for the appointed defense counsel to only defeat liability on certain grounds, and thus, no conflict. Accordingly, and due to the absence of allegations of resulting harm and the unsettled state of the law, the court declined to find the insurer interfered with the insured's defense by failing to tell the insured it could retain independent counsel. This case is on appeal to the Second Circuit.

XII. Advancement of Defense Costs

CUMIS Specialty Ins. Co. v. Kaufman, No. 21-cv-11107 (DLC), 2022 U.S. Dist. LEXIS 176535, 2022 WL 4534459 (S.D.N.Y. Sept. 28, 2022), *mot. for reconsideration denied* 2022 U.S. Dist. LEXIS 190200, 2022 WL 10640903 (S.D.N.Y. Oct. 18, 2022)

Under New York law, the U.S. District Court for the Southern District of New York held that an insurer was not required to pay the insured's defense expenses incurred in appealing his criminal conviction under a professional liability policy. The policy defined defense costs to encompass reasonable attorneys' fees incurred as a direct result of defending a claim, including any appeals. However, the policy excluded coverage for loss related to any claim based upon intentional misconduct if established in a final adjudication. The insurer paid the expenses of defending the insured in a criminal bribery trial at which the insured was convicted and from which the insured filed an appeal. The insurer disputed that the insured was entitled to coverage for defense expenses for the appeal, but the parties agreed the insurer would advance such expenses and the insured agreed to repay them if they were determined to be excluded from coverage. In the subsequent coverage action, the court agreed with the insurer that a criminal conviction is a "final adjudication" and ordered the insured to reimburse the insurer for the defense expenses advanced for the appeal. The case has been appealed to the U.S. Court of Appeals for the Second Circuit.

XIII. Allocation

Aspen Specialty Ins. Co. v. ProSelect Ins. Co., No. 21-11411 (LJM), 2022 U.S. Dist. LEXIS 162179, 2022 WL 4109623 (E.D. Mich. Sept. 8, 2022)

Under Michigan law, the U.S. District Court for the Eastern District of Michigan refused to enforce an escape clause in an "other insurance" provision of a professional liability policy issued to a massage therapist's employer. In the underlying matter,

an individual sued a massage therapist and the massage therapist's employer. Aspen, the massage therapist's professional liability insurer, filed a declaratory judgment action asking the court to declare that ProSelect, the employer's insurer, had a duty to defend the massage therapist and to provide equitable subrogation to Aspen for incurred and future defense expenses. The court found that the parties' policies' "other insurance" clauses both were "excess" clauses. Although ProSelect's other insurance clause also contained an "escape" provision, the court found that the policies' excess clauses were "virtually the same, so they [could not] be reconciled." The court explained: "[I]f both policies claim to be excess to the other such that they are not responsible for coverage until the other's limit is reached, neither can be excess. So it appears that the escape clause in ProSelect's policy does not come into effect as the Court cannot find that ProSelect's policy is excess over Aspen's." The court concluded that the insurers would be liable for defense costs that were proportionate to the limits of each policy.

Liberty Ins. Underwriters, Inc. v. GuideOne Specialty Mut. Ins. Co., No. 2:20-CV-36-D, 2022 U.S. Dist. LEXIS 151335, 2022 WL 3636949 (E.D.N.C. Aug. 23, 2022)

Under North Carolina law, the U.S. District Court for the Eastern District of North Carolina analyzed the appropriate allocation among a professional liability policy, a general liability policy, and an umbrella policy. In the underlying action, a student athlete sued a university and an athletic trainer, seeking damages from injuries suffered as the result of a fitness assessment and settled the claim for $3 million. In a subsequent coverage action considering allocation, the court declined to find that the policies "appl[ied] to the loss on the same basis" such that they were "mutually repugnant." Instead, the court found that the general liability policy was primary, the professional liability policy was intended to "insure[] a primary/secondary risk[,]" and the umbrella policy was intended to insure "contingent excess liability." Therefore, "[g]iving effect to the language in all three policies requires that the … CGL policy be exhausted as the primary, the [professional liability] policy be exhausted next because there is no other policy that applies to the loss 'on the same basis' (that is pro rata or secondary), and the … umbrella be exhausted" next.

XIV. Recoupment of Defense Costs and Settlement Payments

FCE Benefit Administrators, Inc. v. Indian Harbor Ins. Co., No. 21-CV-00186-CRB, 2022 U.S. Dist. LEXIS 31229, 2022 WL 526158 (N.D. Cal. Feb. 22, 2022)

Under California law, the U.S. District Court for the Northern District of California held that if an insurer mistakenly issues payments in excess of its limits of liability, the insured must pay the excess amounts back to the insurer. The insurer's errors and omissions policy provided a limit of liability of $5 million, but the limit was $3 million with respect to certain claims. After an arbitration judgment against the insured, the insurer began making payments that resulted in its paying more than $3 million. In the subsequent coverage action, the court held that the limit was $3 million and ordered the insured to reimburse the insurer for amounts in excess of $3 million. The court reasoned that "[n]early every authority on mistaken payments supports application of restitution on facts like those here." This case is on appeal to the Ninth Circuit.

Evanston Ins. Co. v. Winstar Properties, Inc., Case No. 18-cv-07740-RGK-KES, 2022 U.S. Dist. LEXIS 77366, 2022 WL 1309843 (C.D. Cal. Apr. 14, 2022)

In a case applying California law where the insurer was represented by Troutman Pepper, the U.S. District Court for the Central District of California held that an insurer adequately reserved its right to reimbursement. The insurer issued a tenant discrimination liability policy to the insured, a management company for a residential apartment building in Los Angeles. Following a bench trial, the district court, applying the mailbox rule, found that the insured had failed to present sufficient credible evidence to rebut the presumption that the insurer, according to its customary mailing practices, had sent a letter properly reserving its right to seek

reimbursement of defense expenses advanced for non-covered claims. The court further held that the insured could not rely on the defenses of waiver or estoppel to avoid repayment.

Liberty Ins. Underwriters, Inc. v. Cocrystal Pharma, Inc., Case No. 1:19-cv-02281-JDW-CJB, 2022 U.S. Dist. LEXIS 91839, 2022 WL 1624363 (D. Del. May 23, 2022)

Under Delaware law, the U.S. District Court for the District of Delaware held that an insured was required to repay defense costs its insurer advanced to it under a directors and officers liability policy based on a recoupment clause in the policy, despite the insurer's failure to reserve the right to recoupment. The underlying matter involved an SEC investigation into the alleged misconduct of one of the insured's predecessor corporation's directors and officers. In a coverage action, the district court found that the investigation into one of the insured's predecessor entities was not covered under the policy. Accordingly, under the policy's undisputed terms, the insured was required to reimburse defense costs advanced to the insured in connection with the investigation even if the insurer did not reserve its right to seek reimbursement in its reservation of rights letter. The case has been appealed to the U.S. Court of Appeals for the Third Circuit.

Mid-Continent Excess & Surplus Ins. Co. v. Experiential Sys., Inc., No. 1:19-CV-02365 (PAB), 2022 U.S. Dist. LEXIS 3908, 2022 WL 80323 (N.D. Ohio Jan. 7, 2022)

Applying Illinois law, the U.S. District Court for the Northern District of Ohio held that an endorsement to a policy explicitly allowing the insured to seek reimbursement of defense costs incurred pursuant to a reservation of rights, after a finding of no coverage, was enforceable. The insurer issued a commercial general liability policy to the insured for its business designing and building "challenge course" equipment such as zip lines and climbing structures. The insured was sued by a student who was injured using equipment designed and installed by the insured at a camp in Ohio. The insured tendered notice of the claim to the insurer, which provided a defense pursuant to a reservation of rights, and subsequently filed a declaratory judgment action alleging that several policy provisions precluded coverage. The insurer also sought reimbursement of defense expenses, pursuant to an Illinois-specific endorsement providing the insurer the "right to reimbursement for the defense costs" if the insurer defends and it is later determined that the claims are not covered. Because the instant policy explicitly provided for reimbursement, and that right was properly reserved, the court found the insurer was entitled to recoup defense costs from the insured.

XV. Consent

Landmark Am. Ins. Co. v. Taisei Constr. Corp., No. CV 16-9169 FMO (PJWx), 2022 U.S. Dist. LEXIS 181042, 2022 WL 17002157 (C.D. Cal. Sept. 30, 2022)

Under California law, the U.S. District Court for the Central District of California found that an insurer could not rely on a no-voluntary payments provision to deny coverage for defense expenses incurred by an insured's replacement counsel where it consented and paid that firm's fees. The insurer issued a number of commercial general liability policies to the insured, which contained no-voluntary payments provisions that provided "[n]o insured will, except at that insured's own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without [the insurer's] consent." An additional insured terminated panel counsel appointed by the insurer. While the insurer advised that it had the right to appoint panel counsel, it ultimately consented to the additional insured's retention of its counsel of choice. In the declaratory judgment action, the insurer relied on the no-voluntary payments provision to argue that it was not obligated to pay for replacement counsel's fees. However, the court found that the additional insured did not violate the no-voluntary payments provision, because the insurer "itself made the payments … and agreed to do so." This case is on appeal to the Ninth Circuit.

McLeod v. Doctors Co., No. S19C-12-003 RHR, 2022 Del. Super. LEXIS 267, 2022 WL 2374018 (Jun. 30, 2022)

Under Delaware law, the superior court denied an insurer's motion for summary judgment, finding that conflicting statements by the insured during the underlying liability case and during the coverage action created a question of fact regarding the extent to which the insurer could rely on a consent-to-settle provision. The insurer issued a physician a professional liability policy that contained a consent-to-settle provision that required the insurer to obtain the insured's consent prior to settling any claim against him. When the underlying claimant issued a limits demand, the insurer did not accept the demand and the insured likewise did not consent to settle, and the claimant later obtained an excess judgment. The insured subsequently assigned his rights under the policy to the claimant, who argued that the insurer's failure to settle within limits constituted bad faith. In denying the insurer's motion for summary judgment, the court found that there were questions of fact that existed regarding the extent to which the insured's action or inaction prevented the insurer from settling. The court noted that, although the insured made statements during the pendency of the underlying case indicating that he would never settle because he was adamant that he was not negligent, his testimony during the coverage action indicated that he would have settled had he been properly advised of the risks of the case.

Guaranteed Rate v. ACE Am. Ins. Co., No. N20C-04-268 MMJ CCLD, 2022 Del. Super. LEXIS 367, 2022 WL 4088596 (Super. Ct. Aug. 24, 2022)

Under Delaware law, the superior court found that an insured had properly attempted to seek consent from its insurer, which denied coverage, giving rise to a presumption of reasonableness for the settlement entered into by the insured. The policy at issue included directors and officers liability coverage and employment practices liability coverage that contained a consent-to-settle provision. The insurer disclaimed coverage for the underlying *qui tam* action brought against the insured under the False Claims Act. Shortly afterwards, the insured settled the *qui tam* action with the government. In an ensuing coverage action, the court explained generally that, "when an insurer wrongfully refuses to defend a claim, 'the insured may enter into a reasonable settlement with the claimant, absent fraud, collusion, or bad faith, and sue the insurer for indemnity … for the amount paid in settlement.'" The court found that the insured had properly attempted to seek the insurer's consent to settle with the government both before and after the insurer denied coverage, giving rise to a presumption of reasonableness for the settlement.

Louisville Galleria, LLC v. Phila. Indem. Ins. Co., 593 F. Supp. 3d 637 (W.D. Ky. 2022)

Under Kentucky law, the U.S. District Court for the Western District of Kentucky found that an insurer waived its right to require its consent to settle an underlying claim where the insurer breached its duty to defend. The insurer issued a security firm a commercial liability policy, which provided that insureds must obtain the insurer's consent prior to settling claims. The insurer denied coverage for an underlying lawsuit that ultimately settled. In a subsequent coverage action, the court found that the insurer waived its ability to rely on the consent provision because it had improperly denied coverage and breached its duty to defend.

Moore v. Cincinnati Cas. Co., No. 5:21-cv-107-BJB, 2022 U.S. Dist. LEXIS 148044, 2022 WL 3570355 (W.D. Ky. Aug. 18, 2022)

Under Kentucky law, the U.S. District Court for the Western District of Kentucky held an insurer did not act in bad faith by failing to accept within-limits settlement demands where the professional liability policy provided that the insurer "will not settle or compromise any claim or 'suit' without the insured's written consent." Although a number of within-limits settlement offers were issued in the underlying wrongful death action, those offers were never accepted, and a judgment was ultimately entered in excess of the policy's limits. The underlying claimant, as a third party, brought suit against the insurer for bad faith settlement practices under the

Kentucky Unfair Claims Settlement Practices Act. The court granted the insurer's motion to dismiss with prejudice, finding that the insurer could not have acted in bad faith because the insured never provided any consent to settle. This case is currently on appeal to the Sixth Circuit.

Landmark Am. Ins. Co. v. Esters, No. 2:20-CV-1263 (TAB), 2022 U.S. Dist. LEXIS 97119, 2022 WL 1720379 (W.D. La. May 3, 2022)

Under Louisiana law, the U.S. District Court for the Western District of Louisiana held that an insurer waived its right to enforce a consent-to-settle provision under its professional liability policy because it had denied coverage. The policy contained a consent-to-settle provision that provided "[t]he insured shall not admit any liability for or settle any Claim or incur any costs, charges, or expenses without the written consent of the [insurer]." Following Hurricane Laura, a number of lawsuits were filed against the insured for failing to bind insurance coverage. The insurer denied coverage, highlighting some allegations that premium thefts by an employee had caused policies not to bind. The insured subsequently settled a number of the underlying claims. In the subsequent coverage action, although the court noted that the consent-to-settle provision was unambiguous, it explained that the condition "does [not] apply when the insurer has denied coverage and defense."

Brooklyn Union Gas Co. v. Century Indem. Co., Case No. 403087/2002, 2022 N.Y. Misc. LEXIS 597 (Sup. Ct. Feb. 4, 2022)

Under New York law, a New York state trial court found that an excess insurer's initiation of a declaratory judgment action constituted a disclaimer, excusing the insured from complying with a consent-to-settle provision. The insurer issued excess insurance policies to a gas utility company, which included consent-to-settle provisions. The decades-old coverage litigation involved the extent of coverage available for vast expenses incurred without the insurer's consent to remediate environmental damage. In interpreting a modified appellate decision reversing the trial court's grant of summary judgment in favor of the insurer on the consent issue, the court explained that the appellate court held that the insurer's commencement of "this action constituted a sufficiently clear disclaimer of its liability on [the insured's] claims as to excuse [the insured] from needing to seek [the insurer's] consent to settle a related remediation claim."

Liberty Mut. Fire Ins. Co. v. Michael Baker Int'l, Inc., No. 2:19-cv-00881-JNP-DAO, 2022 U.S. Dist. LEXIS 90430, 2022 WL 1568923 (D. Utah Feb. 10, 2022) (applying Pennsylvania law)

Applying Pennsylvania law, the U.S. District Court for the District of Utah recognized an insured's argument that it was entitled to replace appointed counsel without the insurer's consent based on the insurer's failure to appoint effective counsel. The insurer issued an engineering firm a commercial general liability policy, which included a no-voluntary payments provision that provided "[n]o insured will, except at that insured's own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without our consent." The insured ultimately retained its own counsel to represent it in connection with an underlying high-exposure personal injury lawsuit, arguing that panel counsel was ineffective and had failed to convey settlement demands to the insured. The insured paid for replacement counsel's fees and sought reimbursement from the insurer. The court recognized the insured's argument that, because the insurer breached its duty to provide effective counsel, it waived the right to rely on the policy's no-voluntary payments provision. However, the court found issues of fact existed that prevented it from ruling on the issue through a motion for summary judgment.

Contacts

Charles A. "Tony" Jones
Partner
Washington D.C.
tony.jones@troutman.com
202.662.2074

Jennifer Mathis
Partner
San Francisco
jennifer.mathis@troutman.com
415.477.5706

EDITORS

Brandon D. Almond
Partner
Washington, D.C.
brandon.almond@troutman.com
202.274.2864

Daniel W. Cohen
Associate
New York
dan.cohen@troutman.com
212.704.6256

CO-EDITOR

Darren W. Dwyer
Associate
Washington, D.C.
darren.dwyer@troutman.com
202.274.2952

Insurance and Reinsurance Group Members

Atlanta
Crighton T. Allen*

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Charles T. Blair
Chelsea Brewer
Margaret J. Burnside*
Madeleine Cane*
Michael T. Carolan
Leslie Davis
Darren W. Dwyer*
Charles A. "Tony" Jones*
Shermineh C. "Shi" Jones*
Thomas J. Kinney
William C. O'Neill
Richard J. Pratt
Jordan M. Rubinstein
Jenna Tyrpak*
Cassidy Webb*

*Contributors