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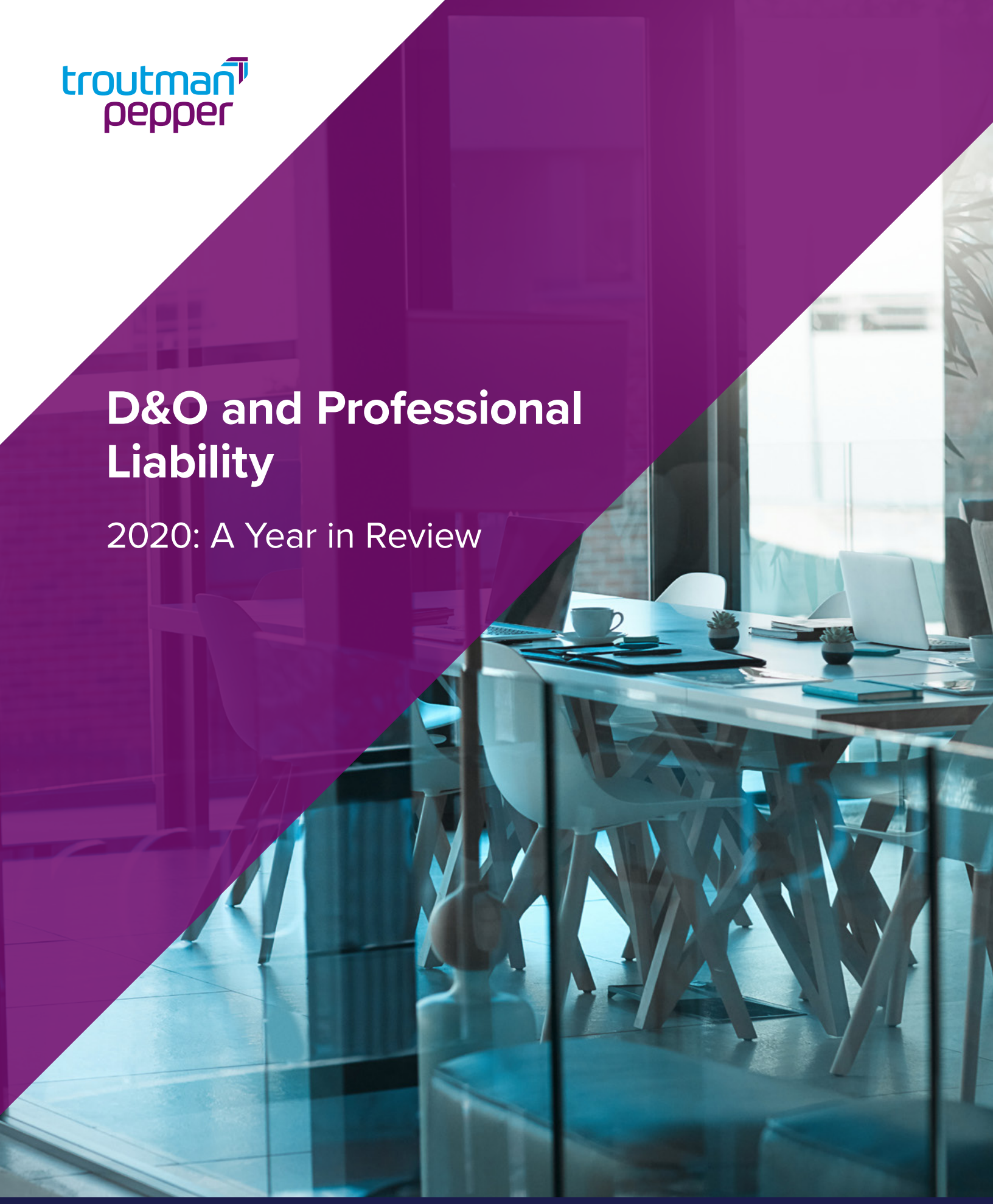
D&O and Professional Liability

2020: A Year in Review



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2020: 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 field, and hope you find the following selection of cases to be informative and helpful. (Please note the cases are organized within each topic alphabetically by the state law applied).

In this issue

I. Notice

AHSL Enters. v. Greenwich Ins. Co., No. B292484, 2020 Cal. App. Unpub. LEXIS 1279, 2020 WL 897259 (Cal. Ct. App. Feb. 25, 2020) (applying California law)

Under California law, the California Court of Appeal affirmed a lower court order that sustained an insurer's demurrer on grounds that the insured had failed to plead the timely reporting of a claim. The case concerned the application of a notice provision in a Claims-Made Employment Practices Liability Policy requiring, as a condition precedent to coverage, that written notice of any claim first made during the policy period be provided to an entity specified on the policy's declaration page "as soon as practicable (but in no event later than sixty (60) days after the expiration of the Policy Period …)." The trial court held that Charges of Discrimination filed with the Department of Fair Employment and Housing (DFEH Charge) were Claims, as that term was defined under the policy. Because the policy provided claims-made coverage, the insured was required to report the DFEH Charge to the program administrator identified in the declarations "as soon as practicable" but no later than 60 days after the expiration of the policy period. Even though the insured reported the DFEH Charge to its insurance broker within the policy period, the trial court held that such notice did not satisfy the reporting requirements of the policy, which required notice to the insurer's program administrator. The insured's failure to provide timely

notice of the DFEH Charge precluded coverage for both the DFEH Charge and the subsequent civil complaint filed against the insured since the trial court also held that the insured's subsequent tender of the civil complaint to the program administrator, after the end of the policy period, was untimely. The trial court also held that the insurer was not required to show prejudice to decline coverage, as California's notice-prejudice rule did not apply to the claims-made policy.

Hanover Ins. Co. v. R.W. Dunteman Co., 446 F. Supp. 3d 336 (N.D. Ill. 2020) (applying Illinois law)

Under Illinois law, the U.S. District Court for the Northern District of Illinois concluded that an insurer need not provide coverage if the insured did not timely report an underlying lawsuit. The insurer issued two consecutive claims-made and reported directors, officers, and entity liability policies with identical provisions. In relevant part, the policies required claims to be reported "as soon as practicable . . . but in no event no later than[] [90] days after the effective date of expiration or termination[.]" The insured was initially sued during the earlier policy period but did not seek coverage for the lawsuit until after a second amended complaint was filed and 90 days had passed from the expiration of the policy period (*i.e.*, during the successive policy period). On cross-motions for judgment on the pleadings, the court strictly construed the policies' reporting requirements and ruled in the insurer's favor, rejecting the insured's argument that "as soon as practicable" meant "within a reasonable time . . . depending on the facts and circumstances of each case." The court noted that courts have repeatedly stressed the differences between occurrence policies and claims-made policies, especially in the context of notice requirements, and that courts strictly construe notice requirements in claims-made policies and view notice requirements as valid conditions precedent. The court also determined that the original and amended complaints filed in the underlying lawsuit were part of a single claim and not separate claims, though the amended complaint had added insured defendants and theories of liability. Because the filing of the original complaint triggered the notice requirement under the earlier policy period, and the insureds had failed to timely notify the insurer of the claim, the insurer was not required to provide coverage. An appeal is pending.

Hartford Fire Ins. Co. v. iNetworks Servs. LLC, No. 18-CV-07693, 2020 U.S. Dist. LEXIS 53473, 2020 WL 1491139 (N.D. Ill. Mar. 27, 2020) (applying Illinois law)

Under Illinois law, the U.S. District Court for the Northern District of Illinois concluded that an insured technology company's failure to provide timely notice precluded coverage. The court considered a Claims-Made Technology Liability Policy, which required the insured to use its "best efforts" to report claims "in writing as soon as practicable." A separate notice condition in the policy required the insured to provide written notice "as soon as practicable of a glitch or circumstance that may result in a claim" and if the insured became aware of a "glitch" during the policy period, it was to provide written notice to the insurer within the policy period. Further, the condition required the insured to provide immediate notice of a claim. The insured and its client exchanged emails about an incident and a potential settlement. The client eventually filed a lawsuit against the insured, but the insured did not report the lawsuit for six months. In the insurer's declaratory judgment action against the insured, the parties agreed that the compromise of the insured's server constituted a "glitch," the emails exchanged between the insured and its client constituted a claim, both the "glitch" and the claim occurred during the policy period, and the insurer did not receive notice of the underlying lawsuit or the "glitch" until after the policy expired. Noting that notice requirements in claims-made policies are strictly construed and viewed as valid conditions precedent, the court concluded that because the insured failed to report the claim "as soon as practicable," the insurer had no duty to defend or indemnify. The court also concluded that the insured breached the notice condition by failing to provide timely notice of the claim and the preceding server compromise, which constituted both a "glitch" and a "circumstance."

Sherman v. Mo. Prof's Mut.-Physicians Prof'l Indem. Ass'n, 599 S.W.3d 207 (Mo. Ct. App. 2020) (applying Missouri law)

Under Missouri law, the Missouri Court of Appeals held that an insured's failure to comply with timely reporting requirements prejudiced the insurer, thereby relieving the insurer of its obligation to indemnify the insured. A Medical Professional Liability Policy expressly provided that timely reporting of every claim or suit was a condition precedent to coverage. The insured was initially sued in the underlying action, but the claim was dismissed. The claim against the insured was later reasserted, but the insurer did not learn of the insured's settlement agreement with the claimant or the subsequent consent judgment until after it was entered. The court noted that one of the factors considered in determining if an insured provided notice within a reasonable time period is whether the insurer was prejudiced by the delay. The court further noted that the burden of demonstrating prejudice is placed on the insurer and that the presence or absence of prejudice is typically a question of fact for the fact-finder. However, because the evidence on the notice issue was not disputed in the case, the court decided, as a matter of law, that the insured's failure to provide timely notice had prejudiced the insurer, and thus, the insurer was not responsible for the consent judgment.

Hunt Constr. Grp., Inc. v. Berkley Assurance Co., No. 19-CV-8775 (JPO), 2020 U.S. Dist. LEXIS 223877, 2020 WL 7046842 (S.D.N.Y. Nov. 30, 2020) (applying New York law)

Under New York law, the U.S. District Court for the Southern District of New York concluded that, where an insurer denied coverage seven months after the claim was submitted, it could not assert a late notice coverage defense. Two consecutive claims-made and reported professional liability policies afforded coverage for a "Professional Claim." The insured's notice of the lawsuit included an earlier grievance letter not previously reported to the insurer. The insurer initially reserved rights and agreed to defend, but it later denied on the grounds that the grievance letter was a "Professional Claim" that should have been reported during the earlier policy period. While the court agreed that the letter constituted a "Professional Claim," it determined that the insurer had waived the late notice defense because the insurer had constructive knowledge of the earlier claim against the insured and did not immediately raise the defense.

Evanston Ins. Co. v. OPF Enters. L.L.C., 826 F. App'x 327 (5th Cir. 2020) (applying Texas law)

Under Texas law, the U.S. Court of Appeals for the Fifth Circuit held that an insured provided sufficient notice to trigger coverage by reporting a potential claim to its broker. A Claims-Made Professional Liability Policy included a "Discovery Clause" that provided coverage for certain claims made against the insured after the expiration of the policy period if the insured provided written notice of the potential for such claims during the policy period. The clause stated that the insured "may provide written notice as stated in Item 11," which listed an email address, physical address, and fax number, where notice could be sent. The insured provided written notice of a potential claim to its insurance agent, who then notified an insurance broker with authority to complete certain tasks on the insurer's behalf. The broker, however, did not report the potential claim to the insurer. The court concluded that the policy language gave the insured the option, but did not require the insured to provide notice in the manner specified by Item 11. It further concluded that the broker was the insurer's agent under a producer agreement for purposes of receiving notice, and as such, the notice to the broker constituted sufficient notice to the insurer.

Landmark Am. Ins. Co. v. Lonergan Law Firm, P.L.L.C., 809 F. App'x 239 (5th Cir. 2020) (applying Texas law)

Under Texas law, the U.S. Court of Appeals for the Fifth Circuit held that absent a showing of prejudice, an insured's failure to comply with notice conditions does not relieve an insurer of its coverage obligations. The court considered a claims-made and reported Professional Liability

Policy containing a "Notice of Claim" provision obligating policyholders to "immediately send copies" of "demands, notices, summonses or legal papers" to its claims department. The insured, an attorney, was sued for malpractice by clients who had sought counsel in connection with a real estate deal. The insured did not report the underlying lawsuit to the insurer's claim department but did provide a summary of the lawsuit through a renewal application submitted to the insurer's underwriting department. The insurer sought a declaration that it owed no duty to defend the insured because, among other things, the insured did not timely report the claim and the renewal application was insufficient to satisfy the reporting requirement. The court disagreed and concluded that the insured had "reported" (*i.e.*, provided information of) the claim to the insurer as required by the policy. The court further determined that by its express terms, the policy's direction of notice to the claims department could not be considered a material condition. As such, the insurer could only be relieved of its coverage obligations upon a showing that it was prejudiced by breach of the condition.

Vela Wood PC v. Associated Indus. Ins. Co., No. 3:19-CV-1140-N, 2020 U.S. Dist. LEXIS 165193, 2020 WL 5440496 (N.D. Tex. Sept. 10, 2020) (applying Texas law)

Under Texas law, the U.S. District Court for the Northern District of Texas determined that an insured's untimely notice barred coverage under a claims-made and reported Professional Liability Policy for a lawsuit asserting claims of breach of fiduciary duty, fraud, and negligence. The insured reported the lawsuit to its retail broker, who did not provide notice to the insurer. After the complaint, the insured reported the lawsuit to the insurer, which denied coverage on grounds of untimely notice. On cross-motions for summary judgment filed in the subsequent declaratory relief action, the court ruled in the insurer's favor, rejecting the insured's arguments that the initial complaint did not constitute a "claim," the insured's report to the broker satisfied the policy's notice requirement, and the issuance of a renewal policy had triggered the automatic extended reporting period on the prior policy at issue such that the claim was timely reported. In relevant part, the court concluded that there was no evidence the insured's broker had the authority to accept notice of claims on behalf of the insurer.

Rich v. First Mercury Ins. Co., No. 2:19-CV-00290, 2020 U.S. Dist. LEXIS 155871, 2020 WL 5079168 (S.D. W. Va. Aug. 27, 2020) (applying West Virginia law)

Under West Virginia law, the U.S. District Court for the Southern District of West Virginia concluded that an insured's nearly three-year delay in notifying its insurer of counterclaims asserted against the insured in an underlying lawsuit was unreasonable and thus, the insurer did not breach the policy by denying coverage. The court considered a Claims-Made Professional Liability Policy issued to an attorney and his law firm. In arriving at its conclusion, the court noted that the notice provision constituted a condition precedent to coverage. As the court had already found that the insured's delay was unreasonable, the court held that the insurer need not show actual prejudice.

II. Related Claims

Landmark Am. Ins. Co. v. Shurwest LLC, No. CV-19-04743-PHX-SRB, 2020 U.S. Dist. LEXIS 167774, 2020 WL 5434550 (D. Ariz. July 23, 2020) (applying Arizona law)

Under Arizona law, the U.S. District Court for the District of Arizona held that multiple claims did not share a causal connection and therefore did not trigger a "related claim provision." The insured's Professional Liability Policy provided that all "Claims arising out of a single negligent act, error or omission, or a series of related negligent acts, errors or omissions by one or more insureds shall be treated as a single Claim for all purposes of this policy." The court found 11 lawsuits "'aris[ing] from a common scheme': to market and promote [financial] products" were not related claims under the policy. The court reasoned that because there were "multiple causative acts" alleged in the various lawsuits, the suits constituted multiple claims even though they alleged wrongdoing by the same insured.

D.R. Horton L.A. Holding Co. v. Certain Underwriters at Lloyd's, No. G057467, 2020 Cal. App. Unpub. LEXIS 8422, 2020 WL 7417409 (Cal. Ct. App. Dec. 18, 2020) (applying California law)

Under California law, the California Court of Appeal, in an unpublished decision, held that a claim was "related" to a claim under an earlier policy because the two claims were logically related. The insured engineering firm was issued Claims-Made Professional Liability Insurance Policies and contracted in 2001 with a construction firm for residential construction. In 2003, neighboring homeowners sued the builder and the insured for damages arising from slope movement allegedly caused by grading activities. In 2007, homeowners in the newly constructed project notified the builder of claims for damages arising from slope movement. Because the claim was deemed related to the 2003 claim, the 2003 carrier tendered its remaining limits to the insured. After the plaintiff in the 2007 suit obtained a judgment and sought to collect from the 2007 policy, the court held that the 2007 claim was related to the 2003 claim because the alleged wrongful acts that formed the basis for the two claims arose from a single project performed by the insured for a single client.

Northrop Grumman Corp. v. Axis Reinsurance Co., 809 F. App'x 80 (3d Cir. 2020) (applying California and Virginia law)

Applying both California and Virginia law, the U.S. Court of Appeals for the Third Circuit held that a 2016 class action was related to a 2006 action and deemed first made at the time of the earlier action. The insured purchased insurance policies specifically designed to cover ERISA claims. The insured was sued for certain wrongful conduct in 2006. Discovery in the 2006 action revealed additional wrongful conduct, which resulted in a separate action filed in 2016. The Third Circuit held that both Virginia and California law apply the same definition of the term "related," which encompasses both causal and logical connections. The Third Circuit held that the two actions were related because each major allegation of wrongdoing in the second action correlated to an allegation of wrongdoing in the first action, that the parties in each action overlapped substantially, and that a "common, continuing breach bridges the temporal gap between the actions."

Alexbay LLC v. QBE Ins. Corp., No. 3:18-CV-00423 (VAB), 2020 U.S. Dist. LEXIS 166856, 2020 WL 5501233 (D. Conn. Sept. 11, 2020) (applying Connecticut law)

Under Connecticut law, the U.S. District Court for the District of Connecticut held that the underlying lawsuits at issue contained a "common nexus of facts, circumstances, or Wrongful Acts" and that the "Related Claims" provision therefore applied and barred coverage because the earliest lawsuit was filed before the inception of the earliest relevant policy. The Directors & Officer and Entity Liability, Employment Liability, and Fiduciary Liability Policy issued to the insured covered the period March 31, 2016 to March 31, 2017 and included a provision that the policy "applies only to claims first made against the Insureds during the policy period." The policy also provided that related claims "shall be deemed a single Claim first made during the policy period in which the earliest of such Related Claims was either first made or deemed to have been first made" and defined "related claim" as "all Claims based upon, arising out of or resulting from the same or related, or having a common nexus of, facts, circumstances, or Wrongful Acts." In 2014, a law firm sued the insured, alleging that the insured had engaged in wrongful financial transactions to evade a judgment entered against it. In 2016, the insured was sued by a shareholder alleging that these same transactions had been wrongful. The court found that the 2016 lawsuit and the 2014 lawsuit both shared the "common nexus" required for the "Related Claims" exclusion to apply. The case is currently on appeal.

Hanover Ins. Co. v. R.W. Dunteman Co., 446 F. Supp. 3d 336 (N.D. Ill. 2020) (applying Illinois law)

Under Illinois law, the U.S. District Court for the Northern District of Illinois held that where an original complaint had not timely been reported to an insurer, a second amended complaint that was related to the original complaint was not covered

because it was not timely reported. The insurer issued two consecutive and otherwise identical directors, officers, and entity liability insurance policies to the insureds for the periods of March 31, 2017 to March 31, 2018 and March 31, 2018 to March 31, 2019. The policies defined "Related Claims" to mean "all Claims based upon, arising from or in any way related to the same facts, circumstances, situations, transactions, results, damages or events or the same series of facts, circumstances, situations, transactions, results, damages, or events." The policies also provided that "all Related Claims will be considered a single Claim made in the Policy Period . . . in which the earliest of such Related Claims was first made or first deemed to have been made. . . ." On August 28, 2017, the underlying plaintiffs filed a complaint in state court against the insureds, alleging that the insureds wrongfully decreased the value of a shareholder's stock following her death. On July 16, 2018, the plaintiffs filed a second amended complaint adding new defendants and new allegations about specific misconduct, including causes of action for minority shareholder oppression under Illinois law, breach of fiduciary duty, fraud, conspiracy to defraud, and breach of fiduciary duty. Following notice of the second amended complaint, the insurer denied coverage because the lawsuit had not been reported within 90 days of the expiration of the 2017 policy. The court agreed with the insurer that the original underlying complaint was a claim, that the second amended complaint was not a separate claim, and that even if it were a separate claim it would still be treated as a related claim because of the expansive language of the provisions. The court characterized the underlying case as "[the insureds'] alleged shortchanging of [the shareholder] and her estate," and found that a common set of facts, circumstances, and events existed sufficient to make the second amended complaint a related claim. The case is currently on appeal.

Nat'l Collegiate Athletic Ass'n v. Ace Am. Ins., 151 N.E.3d 754 (Ind. Ct. App. 2020) (applying Indiana law)

Under Indiana law, the Court of Appeals held that antitrust allegations in a 2014 class action were related to antitrust allegations brought in 2006 because the plaintiffs alleged the same anticompetitive behavior in both. The court considered directors and officers policies issued to the NCAA. The NCAA had faced an action in 2006 relating to caps placed on scholarship amounts for student athletes. In 2014, the NCAA faced another class action, which again alleged anticompetitive behavior restricting the compensation of players. The policy issued during the second suit provided that the policy "shall pay on behalf of the [NCAA] Loss arising from a Claim first made against the [NCAA] during the Policy Period . . . reported to the Insurer . . . for any actual or alleged Wrongful Act of the [NCAA]." The policy provided that Claims alleging Related Wrongful Acts would be deemed first made at the time the earliest Claim was made and defined "Related Wrongful Act" to mean Wrongful Acts that "are the same, related or continuous, or Wrongful Acts which arise from a common nucleus of facts." The Court of Appeals affirmed a lower court's holding that the two suits were "related" and deemed first made in the earlier policy period. The court held that the Related Wrongful Act provision was not ambiguous or overbroad, and that the two actions were related because both alleged that the same NCAA bylaw constituted a violation of the Sherman Antitrust Act. In addition, the second action cited to the first action in its complaint.

La. Health Serv. & Indem. Co. v. Ill. Union Ins. Co., No. 18-278-SDD-EWD, 2020 U.S. Dist. LEXIS 234783, 2020 WL 7338558 (M.D. La. Dec. 14, 2020) (applying Louisiana law)

Under Louisiana law, the U.S. District Court for the Middle District of Louisiana held that two claims, both alleging that a health care provider threatened out-of-network doctors to affiliate with in-network facilities, were "related claims" under the "exceedingly broad" definition of "related claims" in the policy. The insurer issued a number of Managed Care Organization Errors and Omissions Liability Policies, including policies for the years May 25, 2007 to January 1, 2009 and the year April 1, 2016 to April 1, 2017. Both relevant polices provided that "[a]ll Related Claims, whenever made, shall be deemed to be a single Claim and shall be deemed

to have been first made [on the] date on which the earliest Claim within such Related Claim was received . . . ." Both policies also define "Related Claims" as "all Claims for all Wrongful Acts that have as a common nexus any fact, circumstance, situation, event, transaction, cause or series of related facts, circumstances, situations, events, transactions or causes." The first claim was a 2010 lawsuit alleging that the insured wrongfully avoided paying the hospital what it should have received as payment for services. Subsequently, in 2016, another facility sued for damages alleging similar wrongdoing. Rejecting the insured's argument that claims against a health care insurance company will often be based on avoidance for payment of services, the court found that the claims were related because both complaints alleged that the insured "aimed at reducing [reimbursements/payments] to out-of-network providers" and alleged the insured had carried out that practice by "threaten[ing] doctors who practice at out-of-network facilities . . . ."

Argonaut Ins. Co. v. Town of Greenburgh, No. 19-CV-9100 (KMK), 2020 U.S. Dist. LEXIS 174909, 2020 WL 5659469 (S.D.N.Y. Sept. 23, 2020) (applying New York law)

Under New York law, the U.S. District Court for the Southern District of New York, held that a claim was related to earlier-filed claims because they both alleged similar conduct by the municipality insured. The court considered a Public Officers Liability Policy that provided coverage for claims first made against the insured during the policy period. The policy provided that all claims deriving from any related wrongful act will be deemed to have been made at "the time the first of such 'claims' is made." In 2007, a developer appealed a zoning decision to the municipality and then filed suit in federal court. Several subsequent suits ensued, with the developer alleging a continuous effort to block the development. The court found that the actions all were deemed first made in 2007 because each claim "relies on the allegation that Defendants have continued to block and delay . . . development on the Property since 2007." The court rejected the town's characterization of the effort to stall development as "discrete events" and stated that relation back "turns on the factual allegations supporting such claims, not the actual facts or precise legal theory."

Berkley Assurance Co. v. Hunt Constr. Group, Inc., No. 19-CV-2879 (JMF), 2020 U.S. Dist. LEXIS 100175, 2020 WL 3000399 (S.D.N.Y. June 4, 2020) (applying New York law)

Under New York law, the U.S. District Court for the Southern District of New York held that there is no coverage available for a claim when that claim is related to an earlier claim that was not timely reported under the earlier policy. The court considered a claims-made and reported Professional Liability Policy issued to a construction management firm. The policy provided that "Claims . . . arising out of one or more acts, errors, omissions, incidents, events . . . or a series thereof, that are related (either causally or logically), will be considered a single Claim," and the Claim is covered "only [by] a Policy providing coverage for the earliest such Claim." The insured first sought coverage for a lawsuit filed in November 2016 but not reported to the insurer until July 20, 2017, five days after the end of the policy period. The second claim, which arose out of the underlying conduct alleged in the earlier lawsuit, was reported several months later. The court granted the insurer's motion for summary judgment, holding that the first claim was barred because the insured did not report it timely, and the second claim was not covered because it was deemed to have been made and reported at the same time as the first claim, which was outside of the first policy's reporting period.

Vito v. RSUI Indem. Co., 435 F. Supp. 3d 660 (E.D. Pa. 2020) (applying Pennsylvania law)

Under Pennsylvania law, the U.S. District Court for the Middle District of Pennsylvania held that a "related acts" provision did not bar coverage for a shareholder lawsuit, where the allegations were unrelated to an earlier derivative action against the company. The court considered a Directors

and Officers Liability Policy, which was limited to claims first made during the policy period. The policy's "related acts" provision provided that all "Claims based on, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving the same or related facts, circumstances, situations, transactions or events, or the same or related series of facts, circumstances, situations, transactions or events, shall be deemed to be a single Claim for all purposes under this policy . . . and shall be deemed first made when the earliest of such Claims is first made . . . ." In April 2017, a shareholder sent the insured a demand to inspect records, which were provided in October 2017. In June 2018, after the shareholder sued the insured, the insurer denied coverage for the suit, arguing that the shareholder's demand letter and suit related back to a separate demand letter sent in 2015 and a derivative action filed in 2016. The court found "significant differences" between the 2016 derivative action and the 2017 shareholder action because only one out of ten counts in the 2017 action related to conduct also at issue in the 2016 action. Therefore, the court found the two claims to be unrelated.

Nat'l Union Fire Ins. Co. v. Zillow, Inc., 802 F. App'x 265 (9th Cir. 2020) (applying Washington law)

Under Washington law, the U.S. Court of Appeals for the Ninth Circuit held that a demand letter and a lawsuit alleging the same wrongful act were not a "single claim," where the policy at issue did not include a related claims provision. The insurer issued a Professional Liability Policy to the insured, which provided coverage "solely with respect to Claims first made against an insured during the Policy Period . . . and reported to the insurer." The district court entered judgment on the pleadings to the insurer on the basis that the lawsuit, which was reported during the policy period, was "based on the same wrongful conduct" as a demand letter sent to the insured prior to the policy period. On appeal, the Ninth Circuit reversed, rejecting the insurer's argument that the use of the phrase "Claims first made" implicitly requires that the demand letter and the lawsuit be treated collectively as a single Claim. The court reasoned that "[h]ad [the insurer] wanted factually similar Claims to be integrated under the Policy's coverage provision, it could have easily drafted the Policy to include such a requirement." The court remanded the case to the district court to determine whether extrinsic evidence could resolve the ambiguity.

Allied World Surplus Lines Ins. Co. v. Day Surgery Ltd. Liab. Co., 451 F. Supp. 3d 577 (S.D. W. Va. 2020) (applying West Virginia law)

Under West Virginia law, the U.S. District Court for the Southern District of West Virginia held that multiple claims of sexual abuse by a doctor on anesthetized patients were related claims and subject to a single limit of liability under a sexual misconduct endorsement. The insurer issued a Professional Liability and General Commercial Insurance Policy to the insured with a limit of liability of $1 million per claim. The policy provided that related claims "shall be deemed to be a single Claim" and defined related claims as "all Claims based on, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving the same or related facts, circumstances, situations, transactions or events or the same or related series of facts, circumstances, situations, transactions or events, whether related logically, causally or in any other way." The court rejected the insured's argument that the definition of related claim was circular or overly broad, such that any two incidents could be considered "related." The court found that the claims were related because they all involved the doctor's alleged pattern of sexually abusing female patients while under anesthesia for gastroenterology procedures. Because they were related, the $1 million-per-claim limit of liability applied, rather than the aggregate limit.

III. Prior Knowledge, Known Loss, and Rescission

Landmark Am. Ins. Co. v. Shurwest LLC, No. CV-19-04743-PHX-SRB, 2020 U.S. Dist. LEXIS 167774, 2020 WL 5434550 (D. Ariz. July 23, 2020) (applying Arizona law)

Under Arizona law, the U.S. District Court for the District of Arizona granted an insured's motion for partial summary judgment, finding that a prior knowledge exclusion did not apply to bar coverage for several lawsuits against the insured arising from an allegedly rogue employee's actions in marketing a financial product. The prior knowledge exclusion in the Professional Liability Policy at issue precluded coverage for "circumstance[s] giving rise to a Claim that [the insured] had knowledge of prior to the effective date of this policy." An employee of the insured allegedly marketed an unauthorized premium funding product in conjunction with the insured's life insurance offerings. The company that offered the premium funding product was allegedly engaged in a fraudulent scheme that caused it to cease making payments to investors, which ultimately resulted in a number of lawsuits against the premium funding company, the insured, the insured's employee, and others. The insurer declined coverage for the lawsuits, taking the position that the prior knowledge exclusion was implicated by the insured's knowledge prior to policy inception in May 2018 of (1) the premium funding company's collapse and instability prior to that collapse, (2) the use of the premium funding company's funds to pay premiums on certain life insurance policies sold by the insured, and (3) the conduct of the insured's rogue employee in trying to promote the premium funding product to other employees. After undertaking a detailed analysis, the court found that the facts cited by the insurer did not establish that the insured had knowledge sufficient to trigger the prior knowledge exclusion because none of the information of which the insured was aware prior to policy inception actually implicated the insured.

Am. Alt. Ins. Corp. v. Warner, No. 19-cv-04628-KAW, 2020 U.S. Dist. LEXIS 196649, 2020 WL 6204924 (N.D. Cal. Oct. 22, 2020) (applying California law)

Under California law, the U.S. District Court for the Northern District of California denied the insurer's motion for summary judgment on rescission, finding that there were issues of fact with respect to whether the insured made a material misrepresentation on its application. The application for the lawyer's Professional Liability Policy at issue asked the insured whether it was aware of "any legal work or incidents that might be expected to lead to a claim or suit" against it. The insured lawyer, after advising his client of potential statute of limitations defenses to a malpractice action against the client's former attorney, filed a malpractice action on behalf of the client in June 2016. In February 2017, the malpractice action was dismissed based on the statute of limitations defense that the insured previously raised, and the insured advised the client of the client's right to appeal. In April 2017, the insured completed his renewal application and answered "no" to the question of whether he was aware of "any legal work or incidents that might be expected to lead to a claim or suit." The insurer issued the subject policy in May 2017. In January 2018, the insured received a demand letter from an attorney representing the insured's former clients seeking damages for legal malpractice based on an alleged failure to timely file the initial malpractice action. The insured was ultimately named in a lawsuit based on the allegations. The insurer denied coverage for the lawsuit and sought to rescind the policy based on the insured's failure to disclose the dismissal of the initial malpractice action. The court held that there was a triable issue of fact as to whether the insured made a misrepresentation under the circumstances presented because, under the circumstances, a reasonable person in the insured's position could have concluded that no claim would be made against it. The court also held, however, that the fact that the insurer would have increased the policy's premium had the insured disclosed the dismissed malpractice action was sufficient to establish materiality as a matter of law.

Wesco Insurance Company v. Tauler Smith LLP, No. CV 19-08171 PA (SKx), 2020 U.S. Dist. LEXIS 201228, 2020 WL 6162800 (C.D. Cal. Jan. 6, 2020) (applying California law)

Under California law, the U.S. District Court for the Central District of California denied the insured's motion to dismiss an insurer's declaratory relief action seeking rescission. The lawyer's Professional Liability Policy at issue contained a condition stating that "the misrepresentation of any material matter by the Insured or the Insured's authorized agent/broker, which if known by the [insurer] would have led to the refusal by the [insurer] to make this contract or provide coverage for a claim hereunder, will render this policy null and void and relieve the [insurer] from all liability herein." The insurer alleged that the insured failed to disclose its receipt of a claim letter arising out of an alleged scheme to perpetrate a fraud by sending baseless demand letters. The insured allegedly received the claim letter in August 2018 but failed to disclose its existence on its November 2018 application for the subject policy. The insurer alleged that, had the insured disclosed the existence of the claim letter, the insurer would not have issued the subject policy on the same terms. The court rejected the insured's argument that it did not reasonably expect the claim letter to result in a claim against it, because it was not initially named in a lawsuit filed by the law firm that sent the claim letter.

Wallingford Grp. v. Arch Ins. Co., No. 3:18-CV-00946 (AVC), 2020 U.S. Dist. LEXIS 141246, 2020 WL 4464629 (D. Conn. May 11, 2020) (applying Connecticut law)

Under Connecticut law, the U.S. District Court for the District of Connecticut denied cross-motions for summary judgment, finding that issues of fact existed as to whether the insured could reasonably have expected a claim to arise from its receipt of a notice of enforcement investigation from the Army Corps of Engineers ("ACOE") issued nearly two years prior to policy inception. The prior knowledge exclusion in the architects and engineers professional liability policy at issue provided that no coverage was available for amounts "arising out of any fact or circumstance known to [the insured] prior to the commencement of this Policy if such fact or circumstance could reasonably have been foreseen to give rise to a claim against [the insured]." In April 2014, the ACOE sent an Enforcement Letter advising the insured that, among other things, the ACOE was investigating the lack of a wetland disturbance permit for a project the insured was working on, noting that violations of the Clean Water Act are punishable by civil and/or criminal penalties. The insured received no further communications from the ACOE. In April 2016, the insured's client sent a demand letter to the insured seeking $330,000 for additional costs incurred in connection with wetland work and resolving the ACOE's investigation. The demand letter asserted that the insured had advised its client that no permit was required. The insurer denied coverage for both the demand letter and the subsequent lawsuit on the basis that the insured's receipt of the Enforcement Letter triggered the prior knowledge exclusion. Applying a two-part subjective-objective test, the court initially found that the insured had subjective knowledge of the relevant facts underpinning the prior knowledge defense (*i.e.*, the existence of the Enforcement Letter and the fact that he had specifically advised his client that no permit was required for the specific design the insured created). However, the court also found that there were issues of fact that precluded summary judgment on the issue of whether the facts of which the insured had knowledge "could reasonably have been expected to give rise to a claim." Based on that reasoning, the court denied the parties' cross-motions for summary judgment.

Rochester Drug Co-Operative, Inc. v. Hiscox Ins. Co., No. 6:20-CV-06025 EAW, 2020 U.S. Dist. LEXIS 102324, 2020 WL 3100848 (W.D.N.Y. 2020) (applying New York law)

Under New York law, the U.S. District Court for the Western District of New York denied the insurer's motion to dismiss and granted the insured's motion for a preliminary injunction requiring the insurer to advance defense costs, finding that the insurer had not established that a prior knowledge exclusion applied to bar coverage. The Management Liability Policy at issue contained a prior knowledge

exclusion within the application, providing that "[i]t is agreed that if any such known claim, prior action or potential exposure exists, then, unless the resulting insurance policy expressly provides otherwise, such policy shall not provide coverage for any loss in connection with such known claim, prior action or potential exposure." The term "known claim" was defined as "any pending or prior…inquiry or investigation" that "any person or entity proposed for coverage know[s] of or ha[s] information about." The insured, a pharmaceutical distributor, was named in 31 separate actions in New York in connection with alleged unlawful distribution of opioids from 2018 to 2020. The insured also was previously involved in two civil investigations brought by the Department of Justice commencing in July 2015 and February 2017, respectively, that also involved the alleged unlawful distribution of opioids. The insurer argued that the prior knowledge exclusion applied because the prior investigations regarding alleged unlawful distribution of opioids constituted "known claims" and that loss arising from lawsuits filed against the insured was loss "in connection with" those prior investigations. The court rejected the insurer's argument, finding that the recent lawsuits also included negligence and nuisance claims that were not necessarily the subject of the prior investigations and that might not be "in connection with" the prior investigations.

Weeks & Irvine LLC v. Associated Indus. Ins. Cos., 433 F. Supp. 3d 791 (D.S.C. 2020) (applying South Carolina law)

Under South Carolina law, the U.S. District Court for the District of South Carolina granted the insurer's motion for summary judgment where the insured had prior knowledge of the wrongful act giving rise to a subsequent claim. The insuring agreement in the lawyer's Professional Liability Policy at issue provided that coverage was potentially available only where "the Insured has no knowledge of such Wrongful Act prior to the inception date of this Policy." The insured learned in August 2016 that, due to the insured's alleged recording error, its client's mortgage was in fourth position rather than first position. The insured believed the error had been rectified through a subordination agreement between its client and the other mortgage holders, and argued that it accordingly did not believe that a claim would be made against it when it submitted a renewal application to the insurer in September 2016. After the subordination agreement "fell through" in November 2016, the insured's former client pursued a claim against the insured. The insurer denied coverage based on language in the renewal application that precluded coverage for claims arising out of any misrepresentation in the application and based on the insured's knowledge of the alleged wrongful act prior to the policy period. The court found that issues of fact precluded summary judgment on the application-based defense, because that defense required a subjective belief that a claim would result, and the court held that the facts did not establish such a belief. However, the court held that the prior knowledge provision in the insuring agreement did not require subjective belief of a claim and required only knowledge of the relevant Wrongful Act. Because the insured had such knowledge, the court held that coverage was barred.

Allied World Spec. Ins. Co. v. McCathern, P.L.L.C., 802 F. App'x 128 (5th Cir. 2020) (applying Texas law)

Under Texas law, the U.S. Court of Appeals for the Fifth Circuit affirmed the district court's grant of summary judgment in favor of the insured, finding that the insurer had a duty to defend the insured because the prior knowledge provision did not apply to all allegations in the underlying complaint. The prior knowledge provision in the lawyer's Professional Liability Policy at issue precluded coverage if the insured "had any basis (1) to believe that any Insured had breached a professional duty; or (2) to foresee that any such Wrongful Act or Related Act or Omission might reasonably be expected to be the basis of a Claim against any Insured[.]" The insured was sued by a former client for malpractice based on, among other things, its alleged failure to timely accept a *Stowers* demand in May 2009, which allegedly resulted in the client being liable for a judgment in excess of its policy limits. The client's malpractice action also alleged that the insured failed to "work the file," failed to properly research factual and legal issues, and failed to properly monitor the file. The insured tendered

the former client's malpractice action to the insurer, which agreed to defend subject to a reservation of rights. The insurer then filed a declaratory relief action seeking a declaration that the policy's prior knowledge condition precluded coverage. The insurer argued that, prior to the policy's inception in June 2009, the insured was aware that it had failed to timely reject the *Stowers* demand in May 2009. The Fifth Circuit held that the insurer could not rely on the prior knowledge condition to deny a duty to defend because the former client's other malpractice allegations, while vague, were not alleged to have occurred prior to policy inception.

Vistelar LLC v. Cincinnati Specialty Underwriters Ins. Co., 942 N.W.2d 496 (Wis. Ct. App. 2020) (applying Wisconsin law)

Under Wisconsin law, the Court of Appeals of Wisconsin affirmed the trial court's grant of summary judgment in favor of the insurer, finding that a "known loss" provision applied to preclude coverage for a trademark infringement action filed against the insured. The Errors and Omissions Policy at issue precluded coverage for injuries that the insured knew "had occurred or had begun to occur, in whole or in part" prior to the policy period, and provided that the insured would be deemed to have knowledge when an "'authorized representative' . . . becomes aware, or reasonably should have become aware, of a condition from which injury is substantially certain to occur." In October 2013, the insured received and responded to a cease and desist letter from the licensor of certain intellectual property that demanded that the insured cease utilizing that intellectual property. In August 2016, the insurer issued the subject policy to the insured. In July 2017, the licensor filed suit against the insured seeking damages for alleged trademark infringement based on the insured's alleged use of the licensor's trademark through 2017. The insurer declined to defend the insured against the licensor's lawsuit based on the policy's "known loss" condition because the insured was aware of the licensor's alleged injuries prior to the inception of the policy issued in August 2016 based on the insured's receipt of, and response to, the cease and desist letter. Both the trial court and appellate court agreed with the insurer that the insured's alleged conduct in continuing to use the licensor's trademark after receiving the cease and desist letter in October 2013 implicated the "known loss" condition because the insured knew or should have known that the licensor's injury was substantially certain to occur.

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

Pfizer, Inc. v. U.S. Specialty Ins. Co., No. N18C-01-310 PRW CCLD, 2020 Del. Super. LEXIS 2759, 2020 WL 5088075 (Del. Super. Ct. Sept. 1, 2020) (applying Delaware law)

Under Delaware law, the Superior Court of Delaware found that a lawsuit filed against the insured did not implicate a prior notice exclusion because it was not "identical" to an earlier matter. The insurer issued an excess Directors' and Officers' Insurance Policy to the insured that excluded coverage for loss "directly or indirectly[] based on, attributable to, arising out of, resulting from, or in any matter relating to wrongful acts or any facts, circumstances or situations of which notice of claim or occurrence which could give rise to a claim has been given prior to the effective date of this policy under any other policy or policies" or losses "alleging, arising out of, based upon, or attributable to the facts alleged or to the same or related Wrongful Acts alleged or contained in any Claim which has been reported, or in any circumstances of which notice has been given, under any policy of which this policy is a renewal or replacement . . . ." The court held that to apply a prior notice exclusion, the insurer must show that the underlying action is "fundamentally identical" to the earlier suits. Because the underlying action alleged concealment of cardiovascular health risks associated with the insured's anti-inflammatory drug as opposed to the alleged concealment of gastrointestinal risks in the earlier action, the court granted summary judgment to the insured. This case is currently on appeal.

U.S. Specialty Ins. Co. v. Vill. of Melrose Park, 455 F. Supp. 3d 681 (N.D. Ill. 2020) (applying Illinois law)

Under Illinois law, the U.S. District Court for the Northern District of Illinois determined that an insurer did not have a duty to defend or indemnify the insured in an underlying lawsuit based on a "prior and pending" litigation exclusion. The insurer issued an Employment Practices Liability Policy that excluded coverage for "[a]ny 'claim' deriving in whole or in part, from any fact, series of facts or circumstances, or matters asserted or alleged: a. Which were known to any insured; or b. [Which] [w]ere the subject of any prior or pending, legal action or litigation, administrative or regulatory proceeding, 'claim', 'suit', demand, arbitration, decree or judgment against any insured prior to the beginning of the Policy Period listed in the Declarations." The plaintiff in the underlying lawsuit filed a discrimination charge with the EEOC against the insured in 2017, alleging the insured retaliated against him for opposing unlawful or discriminatory practices while employed by the insured. In 2018, the plaintiff then filed the underlying lawsuit based on the same protected activity raised in his EEOC charge. The court concluded that two provisions of the exclusion barred coverage because (1) the insured knew of the facts (at least in part) surrounding the underlying lawsuit before the policy's effective date and (2) because the EEOC charge constituted an "administrative or regulatory proceeding."

City of Grosse Pointe v. U.S. Specialty Ins. Co., 472 F. Supp. 3d 392 (E.D. Mich. 2020) (applying Michigan law)

Under Michigan law, the U.S. District Court for the Eastern District of Michigan found that the prior and pending exclusion at issue did not preclude coverage for claims alleged in the underlying litigation because the claims were not based on the same activity as was alleged in a prior lawsuit. The insured sued its insurer alleging that its Employment Practices Liability Policy should respond to an underlying employment discrimination suit against the insured. The employment practices liability coverage excluded claims for "'damages,' claims or 'suits' alleging, based upon, arising out of, attributable to, directly or indirectly resulting from, in consequence of, or in any way involving . . . [a]ny claim deriving in whole or in part, from any fact, series of facts or circumstances, or matters asserted or alleged in any prior or pending legal action or litigation, administrative or regulatory proceeding, claim, 'suit,' demand, arbitration, decree or judgment against any insured prior to the beginning of the Policy Period listed in the Declarations." The underlying action involved a lawsuit filed in 2018 by a city employee who alleged the city retaliated and discriminated against her on the basis of her sex in violation of Title VII and Michigan state law. She asserted that the city passed her over for a promotion and filled the position with a male sergeant in January 2018 and that she was denied accommodations despite accommodations received by a male officer. The city employee also had filed a prior EEOC charge, which also led to a 2011 lawsuit under Title VII and state law. The 2011 lawsuit asserted several instances of the city's disparate treatment between 2010 and 2011, including that the city denied the employee a promotion based on her sex and retaliated against her. The court held that the exclusion did not apply to the sex discrimination claims in the 2018 suit, because such claims were based on alleged acts of discrimination that occurred in July 2017 and January 2018.

Tile Shop Holdings, Inc. v. Allied World Nat'l Assurance Co., 981 F.3d 655 (8th Cir. 2020) (applying Minnesota law)

Under Minnesota law, the Eighth Circuit affirmed the district court's summary judgment in favor of the excess insurer based on a prior acts exclusion. In preparation for offering public stock and securities for a new entity, the insured purchased primary and excess directors and officers insurance policies, where both policies contained prior acts exclusion clauses. The prior acts exclusion for the primary policy excluded coverage for "any Claim made against an Insured alleging any Wrongful Act occurring prior to August 20, 2012 . . . Loss arising out of the same or related Wrongful Act shall be deemed to arise from the first such same or related Wrongful Act." The excess policy followed form, but the excess insurer argued that its

policy "amended by adding" a broader exclusion, declining coverage for "*any* Loss in connection with *any* claim alleging, arising out of, based upon, or attributable to *any* wrongful act(s) committed, attempted, or allegedly committed or attempted *prior to* August 20, 2012 . . . ." The court determined that the excess policy followed form to the primary policy, but "supplement[ed]," rather than replaced, the primary policy's prior acts exclusion. Thus, the excess insurer was not liable for any losses from prior acts excluded by its own policy or those excluded by the primary policy. Applying its reading of the policy to the facts at hand, the court held that there was no coverage for the insured's alleged wrongful acts based on the relation back clause in the primary policy's prior acts exclusion. The court found that the insured and its executives repeatedly omitted required information regarding related-party transactions from their disclosures to the SEC while preparing to offer public securities in June and July 2012, prior to the August 20, 2012 exclusion date, and continued to do so into 2013. The Eighth Circuit concluded that the alleged wrongful acts occurred prior to August 20, 2012, or were the "same" as or "related" to pre-August 20, 2012 acts. The court further found that the insured's alleged wrongful acts "started well before August 20," and were all excludable under the relation-back clause of the prior acts exclusion.

Vito v. RSUI Indem. Co., 435 F. Supp. 3d 660 (E.D. Pa. 2020) (applying Pennsylvania law)

Under Pennsylvania law, the court denied the insurer's motion for judgment on the pleadings and held that the insurer had a duty to defend the insureds in an underlying shareholder derivative action because the action included claims based on allegations not related to a prior demand letter or prior action. The insurer argued that the related acts provision and prior acts exclusion in a Directors and Officers Liability Insurance Policy precluded coverage for the underlying shareholder action. Although the bulk of the court's analysis focused on the related acts provision, the court also briefly addressed the prior acts exclusion. The insurer argued that a shareholder action filed in 2018 arose from wrongful acts occurring before the policy's exclusion date in 2013. The insureds asserted that the core of the underlying complaint related to a 2017 election and the insureds' subsequent refusal to seat a minority shareholder as a director. The insureds conceded that a single count of the underlying complaint depended solely on facts occurring before the exclusion date, but that the "overwhelming focus" of the complaint was the 2017 board election. The court agreed with the insureds and found that even though the director seat in question had been vacant for a number of years, the key fact was that the underlying plaintiff claimed he was deprived of the seat due to the insureds' wrongful acts no earlier than 2017. The court found that three of the counts in the underlying complaint arguably arose from acts occurring before the exclusion date. However, the remaining nine counts were "based entirely on events surrounding the 2017 and 2019 elections." Further, the court found that the pre-exclusion date acts were not a necessary "but for" cause of the election claims in the underlying litigation. On this basis, the court held that the underlying action was not based on conduct occurring prior to the exclusion date and the insurer therefore had a duty to defend the insureds. The court also held that there was a duty to indemnify for any of the covered counts, should the underlying plaintiff prevail.

V. Dishonesty and Personal Profit

Sharp v. Evanston Ins. Co., 817 F. App'x 317 (9th Cir. 2020) (applying California law)

Under California law, the U.S. Court of Appeals for the Ninth Circuit affirmed the district court's holding that a dishonesty exclusion did not bar coverage under a Professional Liability Insurance Policy. The Ninth Circuit reasoned that the insured's actions may have been negligent rather than the intentional or willful conduct necessary to implicate the exclusion.

Am. Claims Mgmt., Inc. v. Allied World Surplus Lines Ins. Co., No. 18-CV-925 JLS (MDD), 2020 U.S. Dist. LEXIS 161594, 2020 WL 5257795 (S.D. Cal. Sept. 3, 2020) (applying California law)

Under California law, the U.S. District Court for the Southern District of California held that a dishonest act exclusion barred coverage under a Professional Liability Policy. The insured, a third-party insurance administrator, mishandled a claim and was found liable in an arbitration proceeding. The insurer argued that the dishonest act exclusion barred coverage because the insured's actions constituted a "dishonest . . . act." The court held that the exclusion applied because the arbitration panel's findings established dishonest acts and omissions. An appeal to the Ninth Circuit is pending.

Wi2Wi, Inc. v. Twin City Fire Ins. Co., No. 19-CV-06995-BLF, 2020 U.S. Dist. LEXIS 153784, 2020 WL 4913489 (N.D. Cal. May 5, 2020) (applying California law)

Under California law, the U.S. District Court for the Northern District of California held that an insurer stated a valid counterclaim for breach of contract seeking recoupment of defense costs under a Directors and Officers Liability Policy, denying a motion to dismiss the claim. The policy contained a personal profit exclusion, which provided: "The Insurer shall not pay Loss . . . of an Insured, based upon, arising from, or in any way related to the gaining of any personal profit, remuneration or advantage to which such Insured is not legally entitled if a judgment or other final adjudication establishes that such a gain did occur." The movant argued that the exclusion did not apply, in part, because the insured's directors, not the insured, had been adjudicated to have "gained a personal profit and advantage to which they were not entitled." The court rejected this argument, holding the policy, specifically the personal profit exclusion, was reasonably susceptible to the insurer's interpretation, which precluded coverage for claims related to those directors' personal profits.

Rochester Drug Co-Operative, Inc. v. Hiscox Ins. Co., 466 F. Supp. 3d 337 (W.D.N.Y. 2020) (applying New York Law)

Under New York law, the U.S. District Court for the Western District of New York held that a consent to settlement provision in a Private Company Management Liability Insurance Policy did not preclude coverage as a matter of law, denying the insurer's motion to dismiss. The insured was sued in a number of actions, both state and federal, related to the unlawful distribution of opioids, and entered into a deferred prosecution agreement and civil settlement with the U.S. Attorney for the Southern District of New York. The insurer advised the insured that their admissions in the federal matter precluded coverage for the state actions based on the illegal conduct exclusion, and the insured sued the insurer. In its motion to dismiss, the insurer argued that the consent to settlement provision barred coverage for the insured's defense costs for the state court litigation because the admissions formed the basis of liability in that case. The court held that the consent provision did not, as a matter of law, preclude coverage because the admissions were not in an agreement with the plaintiffs in the state court litigation, were as to different claims, and because the damages sought by the plaintiffs in the state action were entirely separate from the payments the insureds had agreed to in the federal stipulation. The court denied the insurer's motion to dismiss because there were "sufficiently serious questions going to the merits" of the applicability of the consent provision. An appeal was filed on July 10, 2020.

Gemini Ins. Co. v. Meyer Jabara Hotels LLC, 2020 PA Super. 84, 231 A.3d 839 (2020) (applying Pennsylvania law)

Under Pennsylvania law, the Superior Court of Pennsylvania affirmed the trial court's order granting an insurer's motion for summary judgment based on a Professional Liability Policy's personal profit and criminal acts exclusions. The insured argued that the exclusionary language required that an employee have engaged in professional services but that the employees' alleged theft meant that they were not acting in a professional capacity.

The court, however, disagreed, and held that the employees were performing professional work when they committed their alleged crime such that the exclusion applied to bar coverage.

For Senior Help LLC v. Westchester Fire Ins. Co., 451 F. Supp. 3d 837 (M.D. Tenn. 2020) (applying Tennessee law)

Under Tennessee law, the U.S. District Court for the Middle District of Tennessee denied an insurer's motion for summary judgment and held that a fraud exclusion did not apply to damages awarded against the insured on a breach of contract claim. The insurer issued a Miscellaneous Professional Liability Policy to the insured that barred coverage for fraudulent acts. After an arbitration, the insured was subject to an award based both on breach of contract and fraud claims. The court concluded that the arbitrator made no specific findings that the conduct giving rise to the breach of contract claim was based on fraudulent conduct. The court further noted that the damages for the breach of contract claim were awarded separately than damages for the fraud claims. Accordingly, the court concluded that, under Tennessee's concurrent cause doctrine, the breach of contract damages "were caused in substantial part" by the failure to perform contractual services, and therefore the fraud exclusion did not apply.

VI. Restitution, Disgorgement, and Damages

AXIS Reinsurance Co. v. Northrop Grumman Corp., 975 F.3d 840 (9th Cir. 2020) (applying California law)

Under California law, in a case of first impression in the Ninth Circuit, the court rejected an excess carrier's "improper erosion" theory and rebuffed that carrier's challenge to lower level carriers' coverage decisions. At issue were lawsuits regarding the insured's administration of employee savings and pension plans under an employee benefits plan fiduciary liability tower of insurance. The insured settled the first lawsuit, which it tendered to its primary and first-layer excess insurers. Both insurers agreed to pay the settlement, exhausting the primary coverage, and substantially eroding the first-layer excess coverage. The insured then settled the second lawsuit and submitted a claim to its first- and second-layer excess insurer. The first-layer excess insurer again agreed to pay for the settlement of the second lawsuit, which exhausted its remaining limits. The second-layer excess insurer also agreed to pay, but it notified the insured that it intended to seek reimbursement on the grounds that the first settlement constituted uncovered disgorgement, and thus had improperly eroded the underlying limits. The second-layer excess insurer subsequently filed a declaratory judgment against the insured, and the district court entered summary judgment in the insurer's favor. On appeal, the Ninth Circuit reversed. The court reasoned that "excess insurers generally may not avoid or reduce their own liability by contesting payments made at prior levels of insurance, unless there is an indication that the payments were motivated by fraud or bad faith." And while the court found that insurers could "contract around this general rule by including specific language in their policies reserving a right to challenge prior payments," here the second-layer excess insurer had not done so. The court declined to address whether the original settlement violated California's public policy against paying insurance benefits to compensate an insured for disgorgement.

Atl. Specialty Ins. Co. v. City of Carbondale, No. 19-cv-556-SMY, 2020 U.S. Dist. LEXIS 137330, 2020 WL 4436307 (S.D. Ill., Aug. 3, 2020) (applying Illinois law)

Under Illinois law, the U.S. District Court for the Southern District of Illinois held that an Errors and Omissions Policy did not provide coverage for a municipality when the insured had been sued for return of an administrative fee. The underlying suit alleged that administrative fees charged in connection with impounded vehicles were unconstitutional. The court held that the return of such fees, as requested in the underlying action, constituted "disgorgement," which was specifically carved out from the policy's definition of "damages."

Allied World Assurance Co. (US) v. Benecard Servs., No. 17-12252 (MAS) (TJB), 2020 U.S. Dist. LEXIS 94810, 2020 WL 2840058 (D.N.J. May 31, 2020) (applying New Jersey law)

Under New Jersey law, the U.S. District Court for the District of New Jersey rejected the insurer's argument that the definition of "loss" excluded liabilities arising out of breach of contract, but nonetheless barred coverage based on violation of a consent provision. The definition of "loss" in a Managed Care Organization Errors and Omissions Liability Policy excluded "fees, amounts, benefits[,] or coverage owed under any contract with any party including providers of health care services, health care plan or trust, insurance or workers' compensation policy or plan or program of self-insurance." The underlying claimant was a Medicare plan sponsor who sued the insured for breach of contract and fraudulent misrepresentations related to certain services in connection with these plans. The insurer argued that the definition of "loss" precluded coverage for any amounts arising from its contract with the claimant. The court concluded that the definition of "loss" did not address damages or liabilities arising out of breach of contract; that a limited definition of "loss" would render the exclusion for expenses or liabilities arising under an indemnity agreement superfluous; and that "amounts … owed under any contract" in the definition was limited to damages for actual breach of contract and not consequential or other damages arising from such breach.

ALPS Prop. & Cas. Ins. Co. v. Murphy, 473 F. Supp. 3d 585 (N.D. W. Va. 2020) (applying West Virginia law)

Under West Virginia law, the U.S. District Court for the Northern District of West Virginia held that a lawyer's Professional Liability Policy did not provide coverage for a claim that an insured had lost its client's funds. The insured's client had been obligated to make a settlement payment to a bank, but the insured received fraudulent wire instructions such that the money was lost. The insured requested coverage for the lost money but the court found that this money did not constitute covered "damages." In this regard, the court held that the lost money would constitute both uncovered restitution and the "loss of use" of funds, which was carved-out from the policy's definition of "damages."

VII. Insured Capacity

Wesco Ins. Co. v. Repasky, No. 19-81734-CIV-ALTMAN, 2020 U.S. Dist. LEXIS 103478, 2020 WL 3129145 (S.D. Fla. June 12, 2020) (applying Michigan law)

Under Michigan law, the U.S. District Court for the Southern District of Florida held that a Professional Liability Policy did not cover an underlying claim brought by a former client of the insured, where the conduct at issue was undertaken in an uninsured capacity for a law firm that was not identified in the application and was not named as an insured in the policy. In granting judgment for the insurer, the court noted that the policy only provided coverage for claims "arising out of an act or omission in the performance of legal services by the Insured or by any person for whom the Insured is legally liable." The policy defined "legal services," in relevant part, as "services performed by an Insured for others as a lawyer . . . only if such services are performed for a fee that inures to the benefit of the Named Insured." Because the law firm sued in the underlying action was not identified as the Named Insured, the court determined that the fee earned from the services at issue in the underlying action would not inure to the Named Insured's benefit. The court further held that even if the underlying action fell within the grant of coverage, the policy's uninsured capacity exclusion (excluding coverage for "any claim based on or arising out of an Insured's capacity as . . . a former, existing, or prospective officer, director, shareholder, partner or manager of a business enterprise . . . unless such enterprise or organization is named in the Declarations") would bar coverage because the insured attorney was sued in his capacity as a partner in a firm not identified in the declarations.

VIII. Insured v. Insured Exclusion

Westchester Fire Ins. Co. v. Schorsch, 129 N.Y.S.3d 67 (2020) (applying New York law)

Under New York law, the Supreme Court, Appellate Division, found that the bankruptcy exception to the insured v. insured exclusion in a Directors and Officers Liability Policy restored insurance coverage to an insured for a lawsuit brought by a creditor trustee against the insured debtor's directors and officers for breach of fiduciary duty. While the trustee's suit was brought on behalf of the bankrupt insured, the insured v. insured exclusion had a bankruptcy trustee exception that restored coverage for claims brought by a bankruptcy trustee or examiner of the Company or any assignee of any such trustee or examiner, or any receiver, conservator, rehabilitator, or liquidator or "comparable authority of the Company" on behalf of the insured. The court found that the creditor trustee was a "comparable authority" because of its similar nature to a bankruptcy trustee, and that the plain language of the bankruptcy exception restored coverage for bankruptcy-related constituents, such as the bankruptcy trustees and comparable authorities.

IX. Coverage for Contractual Liability

Office Depot, Inc. v. AIG Specialty Ins. Co., 829 F. App'x 263 (9th Cir. 2020) (applying California law)

Under California law, the U.S. Court of Appeals for the Ninth Circuit affirmed that the contract exclusion in a Professional Liability Policy precluded coverage for a California False Claims Act lawsuit. The contract exclusion precluded coverage of any claim "alleging, arising out of or resulting, directly or indirectly, from any liability or obligation under any contract or agreement or out of any breach of contract." This exclusion did not apply to liabilities or obligations "an insured would have in the absence of such contract or agreement." In the underlying action, the insured allegedly overcharged California government entities under certain contracts. The Ninth Circuit concluded that the underlying action was premised directly or indirectly on the insured's contractual obligations, and therefore, coverage was precluded by the contract exclusion.

Am. Claims Mgmt. v. Allied World Surplus Lines Ins. Co., No. 18-CV-925 JLS (MDD), 2020 U.S. Dist. LEXIS 161594, 2020 WL 5257795 (S.D. Cal. Sep. 3, 2020) (applying California law)

Under California law, the U.S. District Court for the Southern District of California concluded that coverage for extracontractual claims against the insured, a third-party insurance claims administrator, was not precluded by the contract exclusion in a Professional Liability Insurance Policy. The contract exclusion precluded coverage "for any actual or alleged liability under any express contract or agreement, unless such liability would have attached in the absence of such contract or agreement." The insured was a third-party administrator for another carrier who failed to resolve a claim within policy limits. That carrier commenced arbitration against the insured for mishandling the claim, seeking extracontractual damages, and the insured sought coverage under its Professional Liability Policy. The court determined that the contract exclusion did not preclude coverage based on the exception within the exclusion for liability that would have attached even absent the contract and the fact that the claim involved extracontractual liability.

Domokos v. Scottsdale Ins. Co., No. 20-cv-00336-SVK, 2020 U.S. Dist. LEXIS 125648, 2020 WL 4016811 (N.D. Cal. July 16, 2020) (applying California law)

Under California law, the U.S. District Court for the Northern District of California held that the breach of contract exclusion in a Directors and Officers Liability Policy applied only to "Loss of the Company," and not to losses of the directors and officers. Because the underlying action was asserted against the directors and officers only, the exclusion did not apply. The court further held that, even if the exclusion did apply to the director and officers, the exclusion would not preclude coverage

in any event because the underlying action alleged tort claims for concealment, deceit, and negligent misrepresentation, but not claims for breach of contract. Although the insurer argued that the insured's liability to the underlying plaintiff would not have existed without an agreement, the court explained that the fraud-related claims did not rely on the existence of a contract, and under California law, the court would focus on the facts alleged, rather than the theories of recovery.

Stem, Inc. v. Scottsdale Ins. Co., No. 20-cv-02950-CRB, 2020 U.S. Dist. LEXIS 127486, 2020 WL 4051706 (N.D. Cal. July 20, 2020) (applying California law)

Under California law, the U.S. District Court for the Northern District of California denied a directors and officers liability insurer's motion to dismiss a coverage action filed by an insured technology company. The insured was sued for breach of fiduciary duty, conspiracy, and unjust enrichment for failing to allow the underlying plaintiffs to participate in financing opportunities, which diluted the plaintiffs' equity interests. The insurer argued that the contractual liability exclusion precluded coverage for the lawsuit because the underlying plaintiffs were seeking shares owed to them under a prior settlement agreement. The court found that the breach of contract exclusion did not apply because there was no assertion that the insured failed to perform its contractual obligation to issue the shares it was required to under the settlement. Rather, the underlying plaintiffs alleged that the insured's breach of fiduciary duty lowered the value of what was issued under the settlement contract. The court accordingly denied the insurer's motion to dismiss.

Russell v. Liberty Ins. Underwriters, 950 F.3d 997 (8th Cir. 2020) (applying Kansas law)

Under Kansas law, the U.S. Court of Appeals for the Eighth Circuit held that the contract exclusion in the insured sheet metal company's Directors and Officers Liability and Fiduciary Liability Policy barred coverage for a lawsuit by the decedent shareholder's estate for the insured company's failure to buy out the decedent's shares with the proceeds of a Life Insurance Policy purchased for that purpose. The policy excluded indemnity or defense costs from coverage "[b]ased upon, arising out of, or attributable to any actual or alleged liability under or breach of any contract or agreement." The three individuals who owned the insured company agreed to purchase life insurance policies on each shareholder so the company could use the proceeds to purchase the shareholder's stock from the shareholder's personal representative at death. After the death of one of the shareholders, the proceeds were deposited in the insured company's bank account, but the shares were never purchased. The decedent's wife sued for conversion and breach of fiduciary duty. Because the lawsuit was premised on a breach of contract, no coverage was available for the claim.

Glob. Holdings v. Navigators Mgmt. Co., No. 3:19-cv-00077-GFVT-EBA, 2020 U.S. Dist. LEXIS 100728, 2020 WL 3065914 (E.D. Ky. June 9, 2020) (applying Kentucky law)

Under Kentucky law, the U.S. District Court for the Eastern District of Kentucky granted the insurer's motion for summary judgment on the ground that the contractual liability exclusion precluded coverage in a Directors and Officers Liability Policy. An underlying class action lawsuit was filed against the insured alleging, among other things, that the insured aggressively solicited individuals to sign membership contracts, misrepresented the terms and duration of the contracts, overcharged member accounts, avoided cancellations, and provided inaccurate information regarding cancellations. The court rejected the insured's argument that the policy's severability provision prevented enforcement of the exclusion, both because the underlying lawsuit was brought against the company itself and because even though the alleged wrongful acts were carried out by rank-and-file employees, the actions were alleged to be evidence of the insured's companywide policies and practices. The court found that the exclusion unambiguously excludes all of the causes of action because they either "expressly note the relevance" of the contractual liability of the insureds or, when they do not, relate to misrepresentation of the quality of the services to be received under the membership contracts. The case is under appeal.

Emp'rs Mut. Cas. Co. v. Brant Lake Sanitary Dist., 446 F. Supp. 3d 557 (D.S.D. 2020) (applying South Dakota law)

Under South Dakota law, the U.S. District Court for the District of South Dakota held that the contractual liability exclusion in the Linebacker Public Officials and Employment Practices Liability Policy unambiguously precluded recovery for consequential damages (including lost profits) arising out of a public entity's breach of contract. The policy provided that it did not apply to liability for "failure, refusal, or inability of the insured to enter into, renew or perform any contract or agreement." The underlying plaintiff had sued the insured for breach of contract relating to the insured's agreement with a contractor to build a wastewater system, which included a requirement that the contractor obtain a performance bond. The jury in the underlying matter found in favor of the contractor and awarded damages for retainage, other payments under the contract, and lost profits. The insured argued that the exclusion precludes coverage for the direct damages, such as the retained money and other costs, but not the consequential damages, such as lost profits. The court rejected this argument because the policy broadly defines damages as "those amounts that the insured becomes legally obligated to pay" and does not distinguish consequential from direct damages. The insured argued that the lost profits damages are based on a finding of breach of the duty of good faith and fair dealing, and that the policy is ambiguous because it does not explicitly exclude coverage for breach of the implied covenant of good faith. The court also rejected this argument because the implied covenant is a part of any contract under South Dakota law, and the exclusion precludes coverage for failure or refusal to "perform any contract or agreement," which includes failure to perform the contract because of a breach of the covenant of good faith.

Martin Res. Mgmt. Corp. v. Fed. Ins. Corp., No. 6:20-cv-00083, 2020 U.S. Dist. LEXIS 140858, 2020 WL 4550395 (E.D. Tex. Aug. 6, 2020) (applying Texas law)

Under Texas law, the U.S. District Court for the Eastern District of Texas granted the insurer's motion to dismiss where an insured sought coverage under an Executive Protection Portfolio Policy for sums it paid to defend and indemnify the trustee for the insured company's stock option plan pursuant to an indemnification agreement between the parties. The court held that because the sums were paid pursuant to an indemnification agreement, the obligation was contractual and therefore did not involve any "wrongful acts," as the policy required. An appeal to the Fifth Circuit is pending.

X. Professional Services

Associated Indus. Ins. Co. v. Bloom, No. CV 19-10409 PSG (AGRx), 2020 U.S. Dist. LEXIS 188301, 2020 WL 5802949 (C.D. Cal. Jul. 29, 2020) (applying California law)

Under California law, the U.S. District Court for the Central District of California held that the insurer owed the insured lawyer a duty to defend a claim arising out of "reputation management" services provided by the insured. The insured's Lawyers Professional Liability Policy provided coverage for "any actual or alleged negligent act, error, or omission committed or attempted in the rendering or failing to render Professional Services," and "Professional Services" was defined as services "provided by an Insured to others as a lawyer . . . ." The court found that the insurer did not carry its burden on summary judgment that the insured was not acting "as a lawyer" and that there was no potential for coverage. The insurer argued that the insured was allegedly retained as a "fixer," not an attorney, and the "reputation management" services provided could be performed by nonlawyers. The court found that allegations that the insured provided a legal memorandum to her client arguably containing legal advice and investigated the underlying plaintiff's allegations against her client arguably "arise out of the special risks inherent

in the practice of the profession." The court also found that even where work for a client may involve nonlegal "reputation management" services, "the training and regulation that make the practice of law a profession . . . include professional obligations that go beyond duties of competence associated with dispensing legal advice or advocating for clients in dispute resolution," and "include nonlegal services governed by an attorney's professional obligations."

RLI Ins. Co. v. Acclaim Resource Partners LLC, 2020 IL App (4th) 190757-U (2020) (applying Illinois law)

Under Illinois law, the Appellate Court of Illinois, in an unpublished opinion, held that the insurer did not owe a duty to defend the insured against allegations that it failed to remit the proper amount of subrogation settlement checks. The insured's Target Professionals Liability Policy provided coverage for "any actual or alleged error, omission or negligent act, committed solely in the rendering of or failure to render Professional Services by an Insured." The definition of "Professional Services" included adjuster services, which included "investigating and evaluating claims" and "negotiating settlement of claims including property values, damages and depreciation." The underlying complaint alleged that the plaintiff referred subrogation matters to the insured pursuant to a subrogation services agreement. After the insured performed the subrogation services for the plaintiff, it allegedly "endorsed, cashed, and deposited" the subrogation settlement checks, "and each time they did so they shorted [the plaintiff] in such remittance of its money." The insurer argued that the underlying complaint involved only a fee dispute, not adjuster services falling within the definition of professional services covered by the policy. The appellate court agreed, finding that the factual allegations were unrelated to investigating claims or negotiating the settlement of claims that would support a claim of professional negligence. Rather, the alleged facts pertained to the handling and remittance of fees that took place after investigating or negotiating the settlement of claims.

IberiaBank Corp. v. Ill. Union Ins. Co., 953 F.3d 339 (5th. Cir. 2020) (applying Louisiana law)

Under Louisiana law, the U.S. Court of Appeals for the Fifth Circuit affirmed the district court's granting of the insurer's motion to dismiss on the duty to defend. The Professional Liability Policies at issue covered wrongful acts in the rendering or failure to render "Professional Services," which was defined as "services performed by or on behalf of [the insured] for a policyholder or third party client of [insured]. The Professional Services must be performed pursuant to a written contract with such policyholder or client for consideration inuring to the benefit of [the insured]." The underlying complaint alleged that the insured bank violated the False Claims Act by failing to comply with the Department of Housing and Urban Development's ("HUD") underwriting requirements while participating in HUD's Direct Endorsement Lender Program. These alleged violations caused the Federal Housing Administration to pay insurance claims that it would not have paid if the insured had conducted appropriate underwriting due diligence. The court found that the government was not the insured's client under the Direct Endorsement Lender Program, nor did it provide "professional services" to the government in its role as a lender under the program. The court reasoned that the definition of "Professional Services" required the insured's service be rendered to a "policyholder or client for consideration" and that the certifications the insured provided to HUD were not "for consideration." Moreover, the alleged wrongful acts were not the provision of professional services in issuing mortgage loans to borrowers, but in certifying the borrowers' creditworthiness to HUD.

Atlantic Healthcare LLC v. Argonaut Ins. Co., No. 19-14420-CIV-ROSENBERG/MAYNARD, 2020 U.S. Dist. LEXIS 192241, 2020 WL 6393114 (S.D. Fla. Oct. 15, 2020) (applying Maryland law)

Under Maryland law, the U.S. District Court for the Southern District of Florida held that a professional services exclusion did not relieve the insurer of its duty to defend. The insured was in the business

of managing nursing homes, and its Directors and Officers Liability Policy contained a professional services exclusion providing that the insurer will not pay for losses arising out of the "rendering or failure to render professional services." "Professional services" was defined in relevant part as any health care, medical care, or treatment provided to others, or any other professional services, including but not limited to medical, surgical, dental, psychiatric, mental health, chiropractic, osteopathic, nursing, or other professional health care. The estate of a nursing home resident sued the insured alleging breach of fiduciary and statutory duties owed to the decedent, arguing that the facility was run to maximize profit at the expense of patient care, and included allegations that the facility was inadequately staffed. The court found that while some allegations concerned "professional services," such as intentional operation of the facility with insufficient nursing staff and the failure to meet the complex medical needs of high acuity patients, other allegations did not. The court found that "most" of the allegations in the complaint pertained to business decisions made in handling the facility's affairs, including improper structuring of the business entity, paying higher than market rates to maximize profits at residents' expense, diverting funds through problematic intracompany transfers and fees, and exploiting a vulnerable adult by taking her assets and property and using them for the insured's own benefit instead of for her care. The court also rejected the insurer's argument that "or any other professional services" should be read to include nonmedical professional services, as a reading of the policy as a whole showed that "professional services" was intended to mean health care-related professional services.

***Benecard Servs., Inc. v. Allied World Specialty Ins. Co.*, No. 15-8593 (MAS) (TJB), 2020 U.S. Dist. LEXIS 94749, 2020 WL 2842570 (D.N.J. May 31, 2020) (applying New Jersey law)**

Under New Jersey law, the U.S. District Court for the District of New Jersey held that a professional services exclusion barred coverage for a suit alleging improper claims management of a Medicare Part D insurance plan. The insured purchased a Private Company Management Liability Package Policy that included directors and officers coverage. The policy contained an "Insurance Company E&O Exclusion" barring coverage for professional services including, but not limited to, "the underwriting of insurance policies or reinsurance contracts; the handling and adjusting of claims arising under an insurance policy or reinsurance contract; risk management services; safety inspection and loss control services; premium financing services; insurance consulting; and any advice provided by any Insured with respect to these services." The policy also contained a "Professional Services" exclusion barring coverage for claims "alleging, arising out of, based upon or attributable to or in any way relating to the rendering or failure to render any professional services[.]" The complaint alleged that the insured was contracted to manage and process enrollment, information requests, claims administration, and coverage determinations of the plaintiff's plans, and that it breached the contract by failing in these duties and made fraudulent misrepresentations to conceal the nature and extent of its failures. The court granted the insurer's motion for summary judgment that it did not owe a duty to defend, finding that the Professional Services exclusion barred coverage. It rejected the insured's argument that the narrower Insurance Company E&O Exclusion created ambiguity and should negate the broad Professional Services exclusion. The court found that while overlapping, the Professional Services exclusion was aimed at professional services broadly, in contrast with insurance related services, and therefore still applied to bar coverage.

***TrialCard, Inc. v. Travelers Cas. & Sur. Co. of Am.*, No. 5:19-CV-368-BO, 2020 U.S. Dist. LEXIS 57060, 2020 WL 1609483 (E.D.N.C. Apr. 1, 2020) (applying North Carolina law)**

Under North Carolina law, the U.S. District Court for the Eastern District of North Carolina found that the insurer had no duty to defend the insured in connection with a Telephone Consumer Protection Act suit. The insured's Directors and Officers Liability Policy contained an errors and omissions exclusion that barred coverage for wrongful acts in the

rendering of professional services for others by the insured. The insured was hired by a pharmaceutical company to design, produce, and implement a launch campaign for a generic drug, which included sending a fax advertisement to pharmacies. A Telephone Consumer Protection Act suit was initiated against the pharmaceutical company concerning the unsolicited fax advertisements, and the company tendered the matter to the insured. The insured was not named as a defendant but was a released party under the settlement agreement. The court granted the insurer's motion for summary judgment regarding the duty to defend, finding that not only was the insuring agreement not triggered because the insured was never named as a defendant, but also that the professional services exclusion would bar coverage. The court stated that to the extent that the insured was implicated by the underlying complaint, it was for the professional services it provided to the pharmaceutical company in designing and marketing the launch campaign, not merely the sending of a fax.

Hemphill v. Landmark Ins. Co., No. 19-5260, 2020 U.S. Dist. LEXIS 120447, 2020 WL 3871295 (E.D. Pa. Jul. 9, 2020) (applying Pennsylvania law)

Under Pennsylvania law, the U.S. District Court for the Eastern District of Pennsylvania granted the insurer's motion to dismiss a declaratory judgment action regarding the duty to defend the insured employee placement agency. The Miscellaneous Professional Liability Policy defined "professional services" as those "solely in the performance of providing a permanent and/or temporary employee placement services and/or visa application process services for others for a fee." The insured was sued by a former employee that alleged he was the subject of human trafficking and wage and hour violations, including being forced to work beyond his job responsibility, housed in unsanitary conditions, and threatened with repercussions if he did not acquiesce to the conditions. The insurer declined to defend the insured on the grounds that the alleged wrongful conduct occurred after the plaintiff's employment placement and during his employment, thereby falling outside of the definition of "professional services." The court agreed with the insurer and dismissed the insured's complaint, finding that no cause of action arose out of a negligent act, error, or omission in providing placement services to the plaintiff; rather, the complaint focused on purportedly intentional conduct after the plaintiff was placed. The court also rejected the insured's claim that the plaintiff's allegations supported an unpled claim for negligent misrepresentation because the plaintiff did not allege that he relied upon a representation concerning his housing conditions. An appeal was filed on July 29, 2020.

Gemini Ins. Co. v. Meyer Jabara Hotels LLC, 231 A.3d 839 (Pa. Super. Ct. 2020) (applying Pennsylvania law)

Under Pennsylvania law, the Superior Court of Pennsylvania affirmed the trial court's grant of summary judgment in favor of the insurer, finding that it did not owe the insured hotel management company a duty to defend. The Professional Liability Policy defined "professional services" as "those services you perform for others pursuant to a signed and valid management contract, including financial management and accounting services, human resources management services, food and beverage management services, marketing services, operation management services, communications, information and technology management services." Two employees of the hotel management company allegedly created a company to submit invoices to a hotel the insured managed, even though the company provided no services to the hotel and otherwise instructed third-party vendors to inflate invoices in exchange for kickbacks. After the two employees pleaded guilty to criminal charges, the hotel sued the insured for repayment of damages caused by the scheme. While the court ultimately held that the policy's criminal acts exclusion barred coverage, it did find that the employees' conduct constituted "professional services." The court stated that the wrongful conduct from which the underlying claim arose was committed while the employees were performing their management responsibilities, such as hiring vendors and approving payments, at the hotel. The court reasoned that an argument that the allegedly fraudulent criminal conduct was not

"professional services" would forego the need for the criminal acts exclusion since under such an interpretation, all criminal conduct could be deemed outside the realm of "professional services."

Rich v. First Mercury Ins. Co., No. 2:19-cv-00290, 2020 U.S. Dist. LEXIS 155871, 2020 WL 5079168 (S.D. W. Va. Aug. 27, 2020) (applying West Virginia law)

Under West Virginia law, the U.S. District Court for the Southern District of West Virginia granted the insurer's motion for summary judgment, finding that it did not owe the insured lawyer a duty to defend in connection with a compensation dispute. The Lawyers Professional Liability Policy's insuring agreement provided that "[c]overage shall apply to any such CLAIMS arising out of the conduct of the INSURED'S profession as a Lawyer[.]" The insured attorney filed a declaratory judgment action against a retained expert concerning the compensation owed to that expert for work provided in prior litigation. The expert witness filed a counterclaim against the insured for *quantum meruit*, unjust enrichment, and other claims regarding the fees. In response to this counterclaim, the insured filed third-party complaints against three law firms that served as co-counsel in the prior litigation, each of whom filed a counterclaim against the insured. The court ultimately ruled that the insurer did not owe a duty to defend against the counterclaims because of the insured's unreasonable delay in notice. However, it rejected the insurer's argument that the counterclaims were a business dispute and did not "arise out of" the conduct of the insured's profession as a lawyer. The court found that the counterclaims arose out of conduct as a lawyer because the expert and third-party law firms' claims alleged a contractual relationship with the attorney that arose from his representation of clients and the professional legal services that he provided. The court held that the counterclaims "certainly flow from and have their origins in [the insured's] conduct as an attorney and the services he provided as an attorney over the course of the [prior litigation]."

XI. Independent Counsel

Citizens Ins. Co. of Am. v. Chief Digital Advisors, 20-CV-1075-MMA, 2020 U.S. Dist. LEXIS 220528, 2020 WL 6889174 (S.D. Cal. Nov. 24, 2020) (applying California law)

Under California law, the U.S. District Court for the Southern District of California held that the insured adequately alleged a cause of action for breach of contract related to the insurer's alleged failure to provide independent counsel under a Businessowners Liability Insurance Coverage Policy. The court stated that under California Civil Code Section 2860 and related case law, a conflict of interest entitling the insured to independent counsel may arise when the insurer reserves its rights with respect to a coverage issue that depends on the insured's conduct. Thus, the insured adequately alleged that an actual conflict existed by alleging that the insurer's reservation of rights under a knowing violation of rights exclusion in the policy overlapped with the liability issues in the underlying case. Specifically, both the exclusion and the underlying liability case required examination of the insured's intentional conduct.

L.A. Terminals, Inc. v. United Nat'l Ins. Co., No. 8:19CV00286-ODW, 2020 U.S. Dist. LEXIS 180268, 2020 WL 5820981 (C.D. Cal. Sept. 30, 2020) (applying California law)

Under California law, the U.S. District Court for the Central District of California held that the insured's complaint stated a plausible claim for independent counsel under California law so as to withstand a motion to dismiss in connection with underlying environmental contamination lawsuits. The insureds were covered by four comprehensive general liability policies. Three of the policies also provided coverage to an additional insured that filed the first underlying contamination lawsuit against the insureds. The insureds later filed a separate action against the additional insured arising out of the same contamination, which also involved counterclaims and third-party claims. The insurer

provided a defense to the insureds and additional insureds in both actions. The court determined that the insureds' allegations that the insurer insured both sides of the litigation alleged a conflict of interest requiring independent counsel. The court also accepted as true, for purposes of the motion to dismiss, that the insurer failed to properly segregate liability adjusters for the claim, thereby adding to the conflict of interest.

Travelers Indem. Co. v. Newlin, No. 20cv765-GPC, 2020 U.S. Dist. LEXIS 204302, 2020 WL 6434851 (S.D. Cal. Nov. 2, 2020) (applying California law)

Under California law, the U.S. District Court for the Southern District of California granted the insurer's motion to dismiss an additional insured's claims for breach of contract regarding the insurer's alleged failure to provide independent counsel under a Commercial General Liability Policy. The court explained that under California law a conflict of interest requiring independent counsel exists where the insurer reserves rights on a given issue and the outcome of that coverage issue can be controlled by the insurer's retained counsel. The court accepted as true certain allegations of an alleged conflict of interest based on the insurer's reservation of rights, but dismissed the complaint because it did not allege that the outcome of the coverage issues could be controlled by the insurer's retained counsel or that the reservation of rights were related to the issues in the underlying case. In addition, the court rejected the additional insured's argument that it was entitled to independent counsel because the insured under the policy was also a party to the underlying case and, therefore, the insurer was on both sides of the dispute. This argument was rejected because the additional insured failed to allege that a conflict of interest requiring independent counsel exists where the insurer insures both the plaintiff and defendant.

Joseph T. Ryerson & Son, Inc. v. Travelers Indem. Co. of Am., 2020 IL App (1st) 182491 (applying Illinois law)

Under Illinois law, the Appellate Court of Illinois affirmed the insurer's summary judgment defeating the insured's claim that it was entitled to independent counsel at the insurer's expense under Illinois law. The policy at issue stated that the insurer had "the right and duty to defend" any suit seeking damages. The court noted that the insurer's interest in creating favorable precedent on appeal that would be useful in other cases involving its insureds did not justify independent counsel when the insurer provided defense counsel and there were no other indications that counsel provided a less than vigorous defense. Further, the fact that an excess judgment was likely in the underlying action did not justify independent counsel when the insurer advised the insured of the potential case value and the insured's excess insurer was timely notified of the claim.

Builders Concrete Servs. LLC v. Westfield Nat'l Ins. Co., No. 19 C 7792, 2020 U.S. Dist. LEXIS 167145, 2020 WL 5518474 (N.D. Ill. Sept. 14, 2020) (applying Illinois law)

Under Illinois law, the U.S. District Court for the Northern District of Illinois granted the insurer's summary judgment motion, holding that independent counsel was not owed under a Commercial General Liability Policy in connection with an underlying claim alleging faulty construction work and damaged products. The court explained the general rule under Illinois law that the insured may retain independent counsel at the insurer's expense if there is an actual conflict of interest. Pursuant to Seventh Circuit precedent, however, an actual conflict of interest exists when the underlying complaint contains two mutually exclusive theories of liability — one which the policy covers and one which the policy excludes. The court granted the insurer's motion because it determined that some of the underlying claims asserted against the insured would be potentially covered by the policy at issue such that defense counsel could not conduct the defense in a way that entirely eliminated the insurer's liability even if counsel could minimize the insurer's exposure.

Consolidated Chassis Mgmt. LLC v. Northland Ins. Co., 1-19CV05287, 2020 U.S. Dist. LEXIS 197520, 2020 WL 6262377 (N.D. Ill. Oct. 23, 2020) (applying Illinois law)

Under Illinois law, the U.S. District Court for the Northern District of Illinois granted the insurer's motion for judgment on the pleadings on the grounds that the insureds failed to plead that they were entitled to independent counsel. The insureds had been named as defendants in an underlying automobile personal injury case and asserted crossclaims for contribution against two other insureds that were also defendants in the underlying case. The court rejected the insureds' argument that their crossclaim against the other insureds created a conflict of interest, because the crossclaim did not create an opportunity for the insurer to steer the case into a noncovered claim and relieve itself from paying a judgment. No matter which insured was at fault for the accident, the insurer was obligated to provide coverage up to its policy limit. The court also held that the plaintiff's demand for damages exceeding the policy limits did not create a conflict of interest, where the insureds did not allege that the insurer failed to notify them of a possible excess judgment or that the insurer was gambling with their money.

Great Am. Ins. Co. v. Houlihan Lawrence, Inc., 449 F. Supp. 3d 354 (S.D.N.Y. 2020) (applying New York law)

Under New York law, the U.S. District Court for the Southern District of New York granted the insured's motion for judgment on the pleadings, holding the insured was entitled to independent counsel of its choosing under a Real Estate Professional Liability Policy. The insured was a defendant in an underlying class action pending in New York state court alleging that it breached its fiduciary duties by representing both sellers and buyers in residential real estate transactions and failing to disclose the dual agency. The insurer reserved its rights under a policy exclusion providing that the policy did not apply to claims arising out of dishonesty, intentionally wrongful, or fraudulent conduct. The court held that the insurer's reservation of rights created a conflict of interest entitling the insured to independent counsel with reasonable costs to be paid by the insurer because, while the claims in the underlying action involved allegations of intentional conduct, they could have also resulted in a finding of liability based on the insured's negligent conduct.

Hall CA-NV LLC v. Old Republic Nat'l Title Ins. Co., 440 F. Supp. 3d 596 (N.D. Tex. 2020) (applying Texas law)

Under Texas law, the U.S. District Court for the Northern District of Texas granted the insurer's summary judgment motion with respect to the insured's claim for independent counsel under title insurance policies issued in California and Nevada in connection with a dispute involving a loan to renovate a hotel and casino straddling the California and Nevada state lines. The court, noting California and Nevada law, dismissed the insured's claim without deciding whether an actual conflict existed because the insured failed to meet its burden of producing evidence that it suffered any damages attributable to the insurer's alleged failure to provide independent counsel.

XII. Advancement of Defense Costs

U.S. TelePacific Corp. v. U.S. Specialty Ins. Co., 815 F. App'x. 155 (9th Cir. 2020) (applying California law)

Under California law, the U.S. Court of Appeals for the Ninth Circuit, in an unpublished opinion, held that the carrier's obligation to advance defense costs under the terms of the policy at issue extended only to actually covered claims. The insured tendered two wage-and-hour class action lawsuits, which were later consolidated, to its insurer under a nonduty to defend Directors and Officers Liability Policy. The insurer denied coverage and refused to advance defense costs, because the policy excluded coverage for claims made in connection with alleged violations of the Fair Labor Standards Act or similar laws. The insured brought suit to establish that the insurer was obligated to advance defense costs for any potentially covered claim. The district court rejected this argument

based on the policy's unambiguous condition that the insurer must advance defense costs for claims "for which [the] Policy provides coverage" and granted the insurer's motion for judgment on the pleadings. The Ninth Circuit affirmed that trial court's decision and noted that the insured's reliance on caselaw interpreting an insurer's duty to defend was inapposite in this context.

Westchester Fire Ins. Co. v. Schorsch, 186 A.D.3d 132 (N.Y. App. Div. 2020) (applying New York law)

Under New York law, the Supreme Court of New York, Appellate Division held that an excess insurer was obligated to advance defense costs to insureds until the final disposition of the underlying matter, due to factual disputes precluding summary judgment on numerous coverage issues and the appellate court's finding that a bankruptcy exception to the insured versus insured exception applied to preserve coverage. The insured entity under a Directors and Officers Liability Policy filed for Chapter 11 protection pursuant to a restructuring support agreement, which created a Creditor Trust to prosecute the debtor's litigation assets for the benefit of its unsecured creditors. The Creditor Trust then sued the debtor's former directors and officers for breach of fiduciary duty. The insureds tendered the claim to its insurers for coverage. An excess insurer denied coverage and filed a declaratory judgment action. The trial court granted summary judgment for the insureds, holding that the bankruptcy exception to the primary policy's insured versus insured exclusion allowed coverage. The Appellate Division agreed with the trial court's interpretation of the policy's bankruptcy exception. Nonetheless, because the court found that the application of certain coverage defenses may not be known until the conclusion of the underlying case, the appellate court held that summary judgment should not be granted to the insured. Instead, the appellate court ruled that the insurer must advance defense costs until such time as the viability of the remaining coverage defenses could be determined.

Rochester Drug Co-Operative, Inc. v. Hiscox Ins. Co., No. 6:20-CV-06025, 2020 U.S. Dist. LEXIS 102324, 2020 WL 3100848 (W.D.N.Y. June 11, 2020) (applying New York law)

Under New York law, the U.S. District Court for the Western District of New York ordered an insurer to provide defense coverage for an insured drug distribution cooperative, which had been sued in numerous actions for its alleged involvement in the unlawful distribution of opioids. After the initiation and settlement of at least one of these lawsuits, the insured purchased a Private Company Management Liability Policy from the insurer. The policy contained exclusions for illegal conduct and prior knowledge, as well as a provision requiring the insurer's consent to any settlement. The insured tendered several of the opioid-related claims to the insurer for coverage. The insurer ultimately denied coverage because, among other things, the insured had admitted to certain wrongdoing in related criminal proceedings. The insured sued the insurer for declaratory relief regarding coverage and for an order restraining the insurer from not advancing defense costs. The district court granted the temporary restraining order, finding that the insurer's failure to advance defense costs under the circumstances established irreparable harm to the insured. The court further found that the insured had raised serious questions regarding the applicability of the asserted exclusions. As a result, the court held that the insured was entitled to a preliminary injunction requiring the insurer to pay defense costs subject to the insured posting a bond of $500,000. The insurer has noticed an appeal of the court's decision.

XIII. Allocation

Tapestry on Cent. Condo. Ass'n. v. Liberty Ins. Underwriters, Inc., No. CV-18-04857-PHX-JJT, 2020 U.S. Dist. LEXIS 143623, 2020 WL 4607248 (D. Ariz. Aug. 11. 2020) (applying Arizona law)

Relying on Arizona law and case law from other jurisdictions, the U.S. District Court for the District of Arizona found that "when the insurer has breached its duty to defend, the insurer — rather than the insured — has the burden of demonstrating allocability." The insured sued its insurer for breach of contract for the insurer's refusal to defend the insured in an underlying action. The policy contained what the court found to be an "uncommon provision that mandates a defense notwithstanding no possibility for indemnification." The court held that the insured was required to produce "documentary evidence of the costs and fees expended" defending the underlying action "and the reasonableness of the same." However, "because it was [the insurer's] breach that forced [the insured] to defend the entire underlying action, thereby giving rise to the later need for this action, [the insurer] bears the burden of demonstrating that apportionment of those fees is possible." The court held that "the insurer's burden of persuasion as to whether those fees can be allocated and how they should be allocated is that of a preponderance of the evidence."

Rockhill Ins. Co. v. CFI-Global Fisheries Mgmt., No. 1:16-cv-02760-RM-MJW, 2020 U.S. Dist. LEXIS 35209, 2020 WL 996882 (D. Colo. Mar. 2, 2020) (applying Colorado law)

Under Colorado law, the U.S. District Court for the District of Colorado held that an insurer's failure to obtain allocation of an arbitration award resulted in coverage for the full award. The insurer agreed to defend the insured in an underlying arbitration under a reservation of rights, but then brought a declaratory relief action against the insured, seeking a declaration it had no duty to defend or indemnify the insured in the arbitration. The underlying arbitration panel issued an award against the insured. The court in the declaratory relief action then found that, because the insurer "controlled" the insured's defense, the insurer "had a corresponding duty to ensure that the damages were allocated between those that were covered under [the] policy and those that were not." Therefore, because the insurer "failed to request an allocated award," "the damages awarded are presumed to be covered under [the insured's] policy."

Arch Ins. Co. v. Murdock, No. N16C-01-104 EMD CCLD, 2020 Del. Super. LEXIS 156 (Jan 17, 2020) (applying Delaware law)

Construing excess directors and officers liability policies under Delaware law, the Superior Court of Delaware held that the "larger settlement rule" applied in situations where "(i) the settlement resolves, at least in part, insured claims; (ii) the parties cannot agree as to the allocation of covered and uncovered claims; and (iii) the allocation provision does not provide for a specific allocation method (*e.g.*, pro rata or alike)." As explained by the court, the larger settlement rule states "allocation is appropriate only if, and only to the extent that, the defense or settlement costs of the litigation were, by virtue of the wrongful acts of the uninsured parties, higher than they would have been had only the insured parties been defended or settled." The primary policy's allocation provision did not specify an allocation method, but required the insured and insurer to use "best efforts" and take into account "relative legal and factual financial exposures." Therefore, the court found the "best efforts" language supported the economic rationale behind the larger settlement rule, which is to protect the insured's economic expectations, and held in favor of the insured.

Nat'l Union Fire Ins. Co. v. Fund for Animals, Inc., No. 99, 2019 Md. App. LEXIS 1111, 2019 WL 7369221 (App. Dec. 30, 2019) (applying Maryland law)

The Court of Special Appeals of Maryland, in an unreported opinion, held that an insurer could not allocate a single settlement involving two underlying lawsuits between covered and noncovered claims.

The Not-For-Profit Individual and Organization Insurance Policy defined "Loss" as including amounts paid in settlement of a "Claim" if the insured is "financially liable" to pay the claim. One of the underlying lawsuits was covered, but the other was not covered. The court reasoned that the potentially recoverable damages in both underlying lawsuits were the same and stemmed from the same misconduct. Therefore, the court ruled that as a matter of law, allocation of the settlement payment was not required between the covered and the noncovered claims. However, the court did allow the insurer to offset its liability by amounts that the insured had received from other insurers.

XIV. Recoupment of Defense Costs and Settlement Payments

Wi2Wi, Inc. v. Twin City Fire Ins. Co., No. 19-CV-06995-BLF, 2020 U.S. Dist. LEXIS 153784, 2020 WL 4913489 (N.D. Cal. May 5, 2020) (applying California law)

Under California law, the U.S. District Court for the Northern District of California held that an insurer stated a valid counterclaim for breach of contract seeking recoupment of defense costs under a Directors and Officers Liability Policy, denying a motion to dismiss the claim. The policy contained a personal profit exclusion, which provided: "The Insurer shall not pay Loss . . . of an Insured, based upon, arising from, or in any way related to the gaining of any personal profit, remuneration or advantage to which such Insured is not legally entitled if a judgment or other final adjudication establishes that such a gain did occur." The movant argued that the exclusion did not apply, in part, because the insured's directors, not the insured, had been adjudicated to have "gained a personal profit and advantage to which they were not entitled." The court rejected this argument, holding the policy, specifically the personal profit exclusion, was reasonably susceptible to the insurer's interpretation, which precluded coverage for claims related to those directors' personal profits.

Evanston Ins. Co. v. Aminokit Labs., Inc., 804 F. App'x 982, 983 (10th Cir. 2020) (applying Colorado law)

Under Colorado law, the U.S. Court of Appeals for the Tenth Circuit affirmed the District of Colorado's ruling that the insurer was entitled to reimbursement of a settlement payment where the insured made fraudulent misrepresentations and omissions in the policy application. The case involved a Professional Liability Policy issued to an outpatient rehabilitation center. Prior to settlement, the insurer informed the insured that it was reserving rights to seek reimbursement of defense and settlement payments. The insured subsequently requested that the insurer fund a settlement, which the insurer agreed to do, subject to its right to seek recoupment. Before funding the settlement, the insurer also filed a declaratory judgment action seeking a declaration of no coverage based on material misrepresentations in the policy. The district court held that the insurer was entitled to reimbursement of the settlement payment as damages for fraud and unjust enrichment, and the Tenth Circuit affirmed that ruling.

Certain Underwriters at Lloyd's London Subscribing to Policy No., PGIARK01449-05 v. Advance Transit Co., 132 N.Y.S.3d 621 (N.Y. App. Div. 2020) (applying New York law)

Under New York law, the New York Supreme Court, Appellate Division affirmed the lower court ruling that the insurer was entitled to reimbursement of defense costs where there was no coverage under the policy and the insurer reserved its rights to seek reimbursement.

Hanover Ins. Co. v. Blue Ridge Prop. Mgmt. LLC, No. 1:18CV1018, 2020 U.S. Dist. LEXIS 177325, 2020 WL 5764369 (M.D.N.C. Sept. 28, 2020) (applying North Carolina law)

Under North Carolina law, the U.S. District Court for the Middle District of North Carolina held — as an issue of first impression — that an insurer is

not entitled to reimbursement of defense costs already expended regardless of whether it had a duty to defend. The case involved a Professional Liability Policy issued to a property management company. The court acknowledged that there was a circuit split and that the majority rule allows for the reimbursement of defense costs if there is no duty to defend. However, the court followed Fourth Circuit precedent interpreting Maryland law and holding that there is no right to reimbursement regardless of whether there is a duty to defend.

XV. Consent

Zurich Am. Ins. Co. v. Fluor Corp., No. 4:16CV00429 ERW, 2020 U.S. Dist. LEXIS 173070, 2020 WL 5642315 (E.D. Mo. Sept. 21, 2020) (applying Missouri law)

Under Missouri law, the U.S. District Court for the Eastern District of Missouri denied the insured and insurer's cross-motions for summary judgment on a bad faith failure to settle claim. The insurer argued that it could not be liable for bad faith failure to settle where it did not prevent its insureds from settling, arguing that its role was narrowly limited to contributing funds to the settlements negotiated by the insureds for the portion potentially covered by its policies. The insured argued that because the insurer had the contractual right to settle under its policy, its actions based on that right determine bad faith failure to settle issues. The court denied the insured's motion for summary judgment, finding that there was a question of fact as to whether the insurer or insured actually controlled defense and settlement negotiations. The court likewise denied the insurer's motion, holding that there was a question of fact as to whether the insurer exercised control of litigation and settlement negotiations, including facts relating to the insurer's assertion that settlement could not be reached without its authorization and participation.

Allied World Assurance Co. (US), Inc. v. Benecard Servs., Inc., No. 17-12252 (MAS) (TJB), 2020 U.S. Dist. LEXIS 94810, 2020 WL 2840058 (D.N.J. May 31, 2020) (applying New Jersey law)

Under New Jersey law, the U.S. District Court for the District of New Jersey denied the insured's motion for summary judgment and granted the insurer's cross-motion for summary judgment, finding that, because the insured never obtained written consent from the insurer when it entered into a settlement agreement, the insured was not entitled to indemnity coverage. The Errors and Omissions Policy included a consent clause stating that no defense costs or settlement offer may be made without the insurer's prior written consent, and that no coverage is available for any defense expense or settlement offer made without that consent. The court rejected the insured's argument that it did not have an obligation to seek consent because it had exhausted the limits by the time of settlement. To the contrary, the undisputed evidence "merely showed" that the insured "anticipated its defense costs" to exceed the limits, not that those costs actually did exhaust the limits. The court further held that the insurer did not need to show prejudice to invoke the consent clause, because the New Jersey precedent requiring prejudice applied only to occurrence policies. The court denied the insured's argument that the insurer was equitably estopped from invoking the consent clause by failing to remind the insured of the clause after the insured notified the insurer of settlement talks. The court found that the insured had failed to identify any conduct upon which it relied in believing that it had satisfied the consent clause. An appeal was filed on July 2, 2020.

Rochester Drug Co-Operative, Inc. v. Hiscox Ins. Co., 466 F. Supp. 3d 337 (W.D.N.Y. 2020) (applying New York law)

Under New York law, the U.S. District Court for the Western District of New York held that a consent to settlement provision in a Private Company Management Liability Insurance Policy did not preclude coverage as a matter of law, denying the insurer's motion to dismiss. The insured was sued in a number of actions, both state and federal, related

to the unlawful distribution of opioids, and entered into a deferred prosecution agreement and civil settlement with the U.S. Attorney for the Southern District of New York. The insurer advised the insured that their admissions in the federal matter precluded coverage for the state actions based on the illegal conduct exclusion, and the insured sued the insurer. In its motion to dismiss, the insurer argued that the consent to settlement provision barred coverage for the insured's defense costs for the state court litigation, because the admissions formed the basis of liability in that case. The court held that the consent provision did not, as a matter of law, preclude coverage, because the admissions were not in an agreement with the plaintiffs in the state court litigation, were as to different claims, and because the damages sought by the plaintiffs in the state action were entirely separate from the payments the insureds had agreed to in the federal stipulation. The court denied the insurer's motion to dismiss because there were "sufficiently serious questions going to the merits" of the applicability of the consent provision. An appeal was filed on July 10, 2020.

Hiland Partners Holdings LLC v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA, 475 P.3d 869, *reh'g denied* (Okla. Civ. App. 2020) (applying Oklahoma law)

Under Oklahoma law, the Oklahoma Court of Civil Appeals held, in part, that an insurer that violates the duty of good faith and fair dealing is estopped from raising an insured's violation of a voluntary payments clause, reversing the trial court's grant of summary judgment in favor of the insurer. After settling an underlying personal injury dispute, the insured, who held a Commercial Umbrella Liability Policy with the insurer, sued the insurer for breach of insurance contract and bad faith. The insurer filed a motion for summary judgment arguing that the undisputed facts showed that the insured had violated a no voluntary payments clause. The court analogized this provision to notice, consent-to-settle, and cooperation clauses, because all ensure that the insurer has an opportunity to protect its interests. Acknowledging that Oklahoma had not addressed whether a showing of prejudice is required before an insurer is relieved of its obligation to indemnify, the court concluded that an insurer would be required to make such a showing. The court further held that an insurer that breaches the duty of good faith and fair dealing may not enforce the voluntary payments or settlement clause, and found that there was a disputed question of fact as to whether the insurer did violate the duty of good faith and fair dealing.

Ryan Law Firm LLP v. New York Marine & Gen. Ins. Co., No. 1:19-CV-629-RP, 2020 U.S. Dist. LEXIS 125904, 2020 WL 4043754 (W.D. Tex. July 16, 2020), *report and recommendation adopted sub nom. Ryan Law Firm LLC v. New York Marine & Gen. Ins. Co.*, No. 1:19-CV-629-RP, 2020 U.S. Dist. LEXIS 205615, 2020 WL 6379231 (W.D. Tex. Sept. 9, 2020) (applying Texas law)

Under Texas Law, the U.S. District Court for the Western District of Texas denied the insurer's motion for summary judgment because the insurer failed to show as a matter of law that it was prejudiced by the insured's breach of the notice-of-consent provision. The insurer issued a Professional Liability Policy to its insured, a Texas law firm that was retained by an Indiana corporation to submit claims on the corporation's behalf relating to the Deepwater Horizon incident. The corporation alleged that the insured failed to timely file five claim forms for economic damages, resulting in the claims being time-barred. The insurer disputed that the settlement demand from the corporation accurately reflected the insured's exposure under any damage model or theory of recovery. The insurer therefore refused to consent to settlement. The insured proceeded to accept the demand, and sued the insurer. The insurer moved for summary judgment, arguing that it had no obligation to indemnify for a settlement to which it did not consent. The court held that, in order to avoid liability under the policy, an insurer must show that the insured's breach of a consent-to-settlement provision prejudiced the insurer, and that an insurer's argument that it could have achieved a better result had it been involved in settlement negotiations is a question of fact.

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