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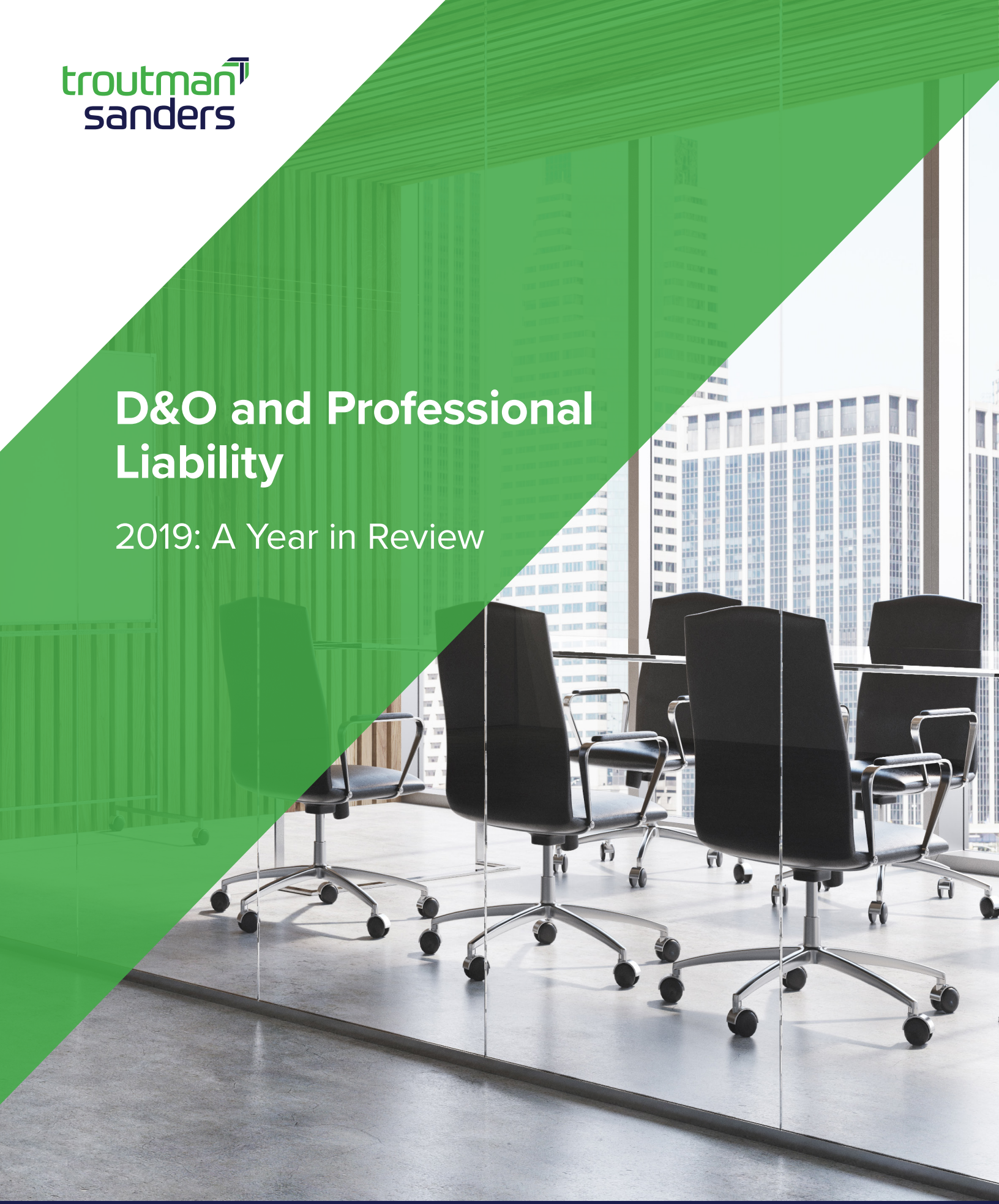
D&O and Professional Liability

2019: A Year in Review



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2019: A Year in Review

2019 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

Pine Bluff Sch. Dist. v. ACE Am. Ins. Co., No. 5:18-cv-00185-KGB, 2019 WL 3074011 (E.D. Ark. July 12, 2019) (applying Arkansas law)

Applying Arkansas law, the court held that the insurer properly denied coverage for a sexual harassment lawsuit filed by a former teacher against the insured school district under claims-made and reported educators legal liability policies because the insured failed to report a prior related charge by the Equal Employment Opportunity Commission (EEOC). The court determined that, under the policies, the teacher's lawsuit involved Interrelated Wrongful Acts, and therefore constituted a single Claim with the prior EEOC charge, which was made in a prior policy period. Therefore, because the insured reported the EEOC charge more than six months after the prior policy's sixty-day reporting grace period, the court granted summary judgment in favor of the insurer.

Euraupair Int'l, Inc. v. Ironshore Specialty Ins. Co., No. 18-55933, 2019 WL 6817593 (9th Cir. Dec. 13, 2019) (applying California law)

Applying California law, the Ninth Circuit held that the insurer was not required to show prejudice to deny coverage under a claims-made and reported policy for a claim that the insured reported sixteen months after the policy expired, where the policy

required a claim to be reported "in no event later than thirty (30) days after the end of the Policy Period." The Ninth Circuit affirmed the district court's dismissal of the insured's coverage action with prejudice.

PAMC, Ltd. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa., No. 18-06001, 2019 WL 666726 (C.D. Cal. Feb. 12, 2019) (applying California law)

Applying California law, the court granted the insurer's motion to dismiss the insured's coverage action because the insured failed to provide timely notice under claims-made and reported directors and officers liability policies. The insured received notice of the claims during the policy period but reported them to the insurer during the subsequent policy period. The court rejected the insured's argument that the policies should be treated as "one contiguous policy" and declined to extend the notice-prejudice rule to claims-made policies.

U.S. HF Cellular Commc'n, LLC v. Scottsdale Ins. Co., 776 F. App'x 275 (6th Cir. May 31, 2019) (applying California law)

Applying California law, the Sixth Circuit held that there was no coverage under consecutive claims-made and reported directors and officers policies due to the insured's failure to provide timely notice of a claim. The insured purchased four policies, three of which had a notice period of sixty days following the end of their respective policy periods. The insured later was sued but did not report the claim to the insurer until over six months after the policy periods ended. The court noted that because the relevant policies were claims-made and reported policies, timely notice was a condition precedent to coverage. Accordingly, the Sixth Circuit affirmed the district court's decision to grant summary judgment in favor of the insurer.

Citizens Ins. Co. of Am. v. Assessment Sys. Corp., No. 18-01762, 2019 WL 4014955 (D. Minn. Aug. 26, 2019) (applying Minnesota law)

The insured's failure to provide timely notice of a claim precluded coverage under a business owners policy. The court determined that the policy's timely notice requirement was a condition precedent to coverage because the policy expressly provided that coverage "only applies" in the event that written notice of the claim is provided "as soon as practicable." The court found that the insured's one-year delay in providing notice was not "as soon as practicable," even though notice was provided during the policy period. The court also found that the insurer was not required to show prejudice to disclaim coverage for the insured's untimely notice. Even if the insurer was required to show prejudice, the court found that the insurer had suffered actual prejudice because it was denied the opportunity to protect its rights of subrogation and other interests during the time that it was unable to participate in the defense of the underlying lawsuit, before notice was provided to it.

JPMorgan Chase Bank, N.A. v. Scottsdale Ins. Co., No. 17-2797 (MAS) (LHG), 2019 WL 959698 (D.N.J. Feb. 27, 2019) (applying New Jersey law)

Applying New Jersey law, the court held that an insured complied with a policy's notice provision requiring written notice of any claim "as soon as practicable, but in no event later than sixty days after the expiration of the Policy Period." The insured provided notice of the underlying lawsuit fifty-one days after the policy was cancelled. The insurer denied coverage, arguing that the "as soon as practicable" language constituted an element independent from the 60-day deadline. The court disagreed and held that the policy's notice provision only required the insured to provide notice within sixty days of the policy's expiration. Accordingly, the court granted summary judgment in favor of the insured.

Certain Underwriters at Lloyds London Subscribing to Policy No. HMPL 18-0164 & HMPL 17-0158 v. KG Admin. Servs., Inc., No. 5:19-cv-1246, 2019 WL 6770061 (N.D. Ohio Dec. 12, 2019) (applying Ohio law)

Applying Ohio law, the court granted the insurer's motion for judgment on the pleadings finding that the insured's failure to provide timely notice precluded coverage under claims-made and reported professional liability policies. The underlying lawsuits were first made in the policy period prior to the policy period during which they were reported. Because the insured failed to provide timely notice of its claims, the court dismissed the coverage action with prejudice.

ISCO Indus., Inc. v. Great Am. Ins. Co., No. C-180636, 2019 WL 6353709 (Ohio Ct. App. Nov. 27, 2019) (applying Ohio law)

Applying Ohio law, the court affirmed the trial court's dismissal of an insured's action challenging an insurer's denial of coverage under a claims-made and reported directors and officers liability insurance policy for untimely notice of a claim. While the policy required that notice of a claim be provided "as soon as practicable" and in no event later than ninety days after the policy period, the insured provided notice of the underlying lawsuit nearly a year and a half after the lawsuit was filed, during the policy period of a renewal policy. The insured contended that the policies provided "continuous coverage" and notice was sufficient so long as it was reported during a renewal policy's policy period. However, the court determined that neither the policy nor the Sixth Circuit law cited by the insured supported this argument. The court further determined that a notice-prejudice rule does not apply to claims-made and reported polices.

ADI Worldlink, LLC. v. RSUI Indem. Co., No. 17-41050, 2019 WL 3521815 (5th Cir. Aug. 2, 2019) (applying Texas law)

Applying Texas law, the Fifth Circuit affirmed summary judgment in favor of insurer, holding that there was no coverage for multiple claims reported under two consecutive claims-made and reported directors and officers policies because the claims all constituted a single, related Claim that was not properly reported during the earlier policy period, and the insured failed to provide timely notice of the first claim.

Landmark Ins. Co. v. Lonergan Law Firm, PLLC, No. 4:17-CV-0278-Y, 2019 WL 2295358 (N.D. Tex. Mar. 8, 2019) (applying Texas law)

Applying Texas law, the court held the insured's claim supplement to a renewal application did not constitute proper notice of the claim under a claims-made and reported lawyer's professional liability policy. The insured's application asked whether the insured or its predecessor firm had been the subject of any claim or suit in the last five years and, if so, required the insured to complete a claim supplement. After the policy was issued, a client filed a lawsuit against the insured, and the insured filed a claim supplement reporting the lawsuit. However, the insured did not seek coverage for the lawsuit until after the policy period and thirty-day grace period for reporting claims. Accordingly, the court held that the insured failed to timely report the claim and was not entitled to coverage.

Stadium Motorcars, LLC v. Fed. Ins. Co., No. CV H-18-1920, 2019 WL 2121111 (S.D. Tex. May 15, 2019) (applying Texas law)

Applying Texas law, the court held that an insurer properly denied coverage under a claims-made and reported employment practices liability policy because the insured failed to provide timely notice of an arbitration. The policy required the insured to give notice "as soon as practicable," but in no event later than ninety days after the end of the policy period, or the extended reporting period, which expired one year after the end of the policy. Because the insured did not notify the insurer of an arbitration until approximately two months after the expiration of the extended reporting period, the court found that they did not provide timely notice. The court further explained that, because the

policy was written on a claims-made and reported basis, the insurer was not required to show that it was prejudiced by the insured's late reporting in order to disclaim coverage. The court granted summary judgment in favor of the insurer.

II. Related Claims

Pine Bluff Sch. Dist. v. ACE Am. Ins. Co., No. 5:18-cv-00185-KGB, 2019 WL 3074011 (E.D. Ark. July 12, 2019) (applying Arkansas law)

In a case involving an Educator Legal Liability policy, the court found that an Equal Employment Opportunity Commission (EEOC) charge and subsequent lawsuit by a teacher against the insured school district alleging retaliation arose from Interrelated Wrongful Acts and therefore constituted a single Claim under the policy. Because the insured failed to timely report the EEOC charge, which was the first of the two claims, the court granted summary judgment in favor of the insurer that there was no coverage for the EEOC charge and related lawsuit.

Gen. Ins. Co. of Am. v. INB Ins. Servs. Corp., No. 18-cv-03372-JST, 2019 WL 1318252 (N.D. Cal. Mar. 22, 2019) (applying California law)

A court found that coverage was only available under a broker's earlier policy, and not his subsequent policy, because the underlying action against him involved a "series of related wrongful acts." An insurance broker was sued by his insured after the insured's property insurer denied coverage for fires that occurred at the insured's properties during both policy periods. The original complaint against the broker, filed during the earlier policy period, alleged that the broker was negligent for representing that the insured's properties were fully sprinklered on the application, which resulted in the property insurer's denial of coverage for the earlier fire. During the next policy period, the insured amended his complaint against the broker, alleging that the broker was also negligent for not revising that representation before the second fire. The broker tendered the lawsuit to its professional liability insurer under both policy periods. The court found that the broker's original representation that the properties were fully sprinklered caused the property insurer's denial of the insured's claims for both fires. In other words, "but for" the broker's original negligence in the application, there would have been nothing for the broker to amend in the application after the earlier fire.

Martin v. QBE Ins. Corp., No. 18-CV-2439 W (BLM), 2019 WL 2009874 (S.D. Cal. May 7, 2019) (applying California law)

Two lawsuits against a real estate agent were deemed related under a Real Estate Services Errors and Omissions Liability Insurance Policy as each suit arose from the insured's dual representation of buyers and sellers in the sale of a multimillion-dollar oceanfront home. The court noted that the lawsuit brought by the buyers and the lawsuit brought by the sellers both involved "the same alleged real estate transaction," were based on the insured's "role as the dual agent," and alleged liability for "negligent misrepresentations based on his alleged failure to make certain disclosures regarding the condition of the Property." The court held that there was no coverage for the lawsuit brought by the sellers as it arose out of the same wrongful acts as the lawsuit brought by the buyers, which was first made prior to the inception of the policy.

Pfizer, Inc. v. Arch Ins. Co., No. CVN18C01310PRWCCLD, 2019 WL 3306043 (Del. Super. Ct. July 23, 2019) (applying Delaware law)

In a case involving excess directors and officers insurance policies, the court held that two class actions alleging securities violations and containing other similarities were not sufficiently related to fall within the Related Wrongful Acts Exclusion, which precluded coverage for Wrongful Acts that relate to a previously reported Claim, or the Specific Litigation Exclusion, which precluded coverage for Loss in connection with a breach of fiduciary duty or related Wrongful Act. The court

determined that, while the class actions similarly alleged securities violations and the same drug, the first action was brought by the insured's stockholders and dealt with false representations and omissions regarding cardiovascular risks associated with the drug, while the second action was brought by a company later acquired by the insured and dealt with false and misleading statements regarding the gastrointestinal health risks of the drug. Therefore, the court granted summary judgment in favor of the insured that the claims were not sufficiently related to preclude coverage under the policies.

Berkshire Hathaway Specialty Ins. Co. v. H.I.G. Cap., LLC, 102 N.Y.S.3d 168 (N.Y. App. Div. 2019) (applying Florida law)

In a case involving professional asset management liability policies issued in 2016, the court found that coverage was excluded under the related claims provision after the insured received two warning notices from the United Kingdom Pensions Regulator in 2014 and 2016. The court also found that the earlier notice constituted prior notice for the purposes of the prior notice exclusion and thus any loss incurred in connection with the later 2016 notice was not covered under the policies.

Nova Se. U., Inc. v. Cont'l Cas. Co., No. 18-CIV-61842-RAR, 2019 U.S. Dist. LEXIS 222124 (S.D. Fla. Dec. 27, 2019) (applying Florida law)

In a case involving a professional liability claim under claims-made and reported architects and engineers liability policies, the court held that three defects relating to the project constituted related claims that must be treated as a single Claim under the policies. The insured had argued that there were three separate and distinct errors relating to the project: (1) a calculation error in the design of the ice tank walls; (2) a failure to consider corrosion issues in the Remedial Design; and (3) a design error in the concrete slab. The court disagreed with the insured, and rejected the insured's contention that such defects, to be sufficiently related, must be logically connected such that "the same or substantially similar transgression (wrongful act) must be repeated in a nearly identical form", which the court stated was inconsistent with the plain language of the policies. The court found that the ice tanks and concrete slab were designed and constructed by the same firm as part of the same project, and observed that "[o]ne would not exist without the other." The court determined that, while the defects may not be causally related, they were logically connected in such a way as to satisfy the policies' related claims provision.

Marcus v. Allied World Ins. Co., 384 F. Supp. 3d 115 (D. Me. Apr. 23, 2019) (applying Maine law)

The Securities Exchange Commission (SEC) sued a lawyer, and several other defendants, for violating federal securities laws. The lawyer sought coverage under his lawyers professional liability policy. The court agreed with the insurer that coverage was unavailable for the SEC suit as it sought disgorgement from the lawyer and therefore did not seek Damages as required by the policy. The lawyer was subsequently sued by two investors alleging that the lawyer assisted in a fraudulent securities scheme that resulted in the misappropriation of the investors' funds. The lawyer tendered the investors' suit to its insurer, and the insurer ultimately denied coverage based on an investment advice exclusion. The court disagreed with the insurer's denial and found that the insurer was obligated to defend the attorney in the investors' suit. The insured argued that since the SEC suit was "related" to the investors' suit, the insurer's duty to defend should also extend to the SEC suit. The court rejected the insured's argument and stated that the related claims provision only impacts "the timeliness of notice, the insurance policy that applies, and the policy limits and deductibles." In other words, the related claims provision did not "broaden[] the insurer's duty to defend by folding in a claim that is otherwise outside policy coverage."

Biochemics, Inc. v. Axis Reins. Co., No. 17-2059, 2019 WL 2223125 (1st Cir. May 23, 2019) (applying Massachusetts law)

A directors and officers liability policy did not provide coverage for the insured pharmaceutical

company because the claim was excluded by the Interrelated Wrongful Acts Provision. While the provision was located under the Limits of Liability section of the policy, the court noted that the provision applied more broadly because the policy also noted that headings and subheadings were not part of the terms and conditions of the policy. The court then determined that certain subpoenas and a subsequent SEC action were sufficiently related to constitute a single Claim under the policy. Because the subpoenas were issued prior to the commencement of the policy period, the Claim was first made before the policy period. The First Circuit affirmed summary judgment in favor of the insurer.

Stadium Motorcars, LLC v. Fed. Ins. Co., No. H-18-1920, 2019 WL 2121111 (S.D. Tex. May 15, 2019) (applying Texas law)

The insurer denied coverage for an arbitration award under an employment practices liability policy based on the insured's failure to give timely notice of the arbitration until after the award was issued. The insured previously provided notice of a lawsuit by a former employee which was voluntarily dismissed. Subsequently, the same employee filed an arbitration against the insured. The insured argued that it had no obligation to provide separate notice of the arbitration as it was "related" to the prior lawsuit by the former employee of the insured. The court disagreed and found that the policy's reporting section required the insured to give notice of "any Claim" as soon as practicable, and did not limit notice to the first of all subsequent "Related Claims." Therefore, because the insured failed to satisfy a condition precedent to coverage under the claims-made and reported policy by untimely tendering its claim, the court granted summary judgment in favor of the insurer that coverage was properly denied for the arbitration.

III. Prior Knowledge / Known Loss / Rescission

Am. Alt. Ins. Corp. v. Warner, No. 19-cv-04628-KAW, 2019 WL 6493945 (N.D. Cal. Dec. 3, 2019) (applying California law)

The district court denied an insured's motion to dismiss an insurer's complaint seeking rescission of a lawyers professional liability policy based on the insured's alleged misrepresentations in its renewal application. Prior to submitting its renewal application, the insured law firm failed to file a malpractice claim against a client's former attorney within the applicable statute of limitations, which resulted in the client's claim being dismissed. On its renewal application, the insured answered "no" to a question regarding any legal work or incidents that might be expected to lead to a claim. The insured also affirmatively represented that it was not aware of any potential claims, disciplinary matters, investigations or circumstances that may give rise to a claim. After the insurer issued the policy, the insured's client filed a lawsuit against the insured alleging legal malpractice based on the missed statute of limitations. The court rejected the insured's arguments that the insurer's complaint should be dismissed because (1) no "claim" was made prior to the insured's statements on its renewal application, (2) the word "might" in the relevant application question was ambiguous, and (3) the insurer had a duty to defend the entire underlying action. Accordingly, the district court denied the insured's motion to dismiss.

Phila. Indem. Ins. Co. v. Stephouse Recovery, Inc., No. CV 18-00564-CJC(DFMx), 2019 WL 4390574 (C.D. Cal. June 13, 2019) (applying California law)

The insurer filed an action seeking, among other things, to rescind a professional liability that it had issued to an insured that operated various facilities, including outpatient treatment centers and sober living residencies. The application for the policy specified that it was for outpatient services only and that if the applicant provides inpatient or residential programs, it must request a

different application. The insured represented that the residential care programs were subcontracted out and provided by treatment facilities that are licensed and insured. After a suit was filed against the insured for events that occurred at one of its sober living homes, the insurer filed a coverage action. The district court determined that, under California law, concealment or misrepresentation of facts entitles an insurer to rescission if the fact at issue was material to the insurer's decision to enter into the contract. The district court further determined that an intent to deceive was not required. However, the district court found that a genuine dispute of material fact remained whether the insured concealed or misrepresented a material fact based on the insured's argument that its representations regarding residential care facilities did not refer to the sober living homes, at which no treatment or care is provided on site. Therefore, the district court denied the summary judgment motion as to the insurer's claim for rescission.

U.S. HF Cellular Commc'ns., LLC v. Scottsdale Ins. Co., 776 F. App'x 275 (6th Cir. May 31, 2019) (applying California law)

Insureds brought an action against an insurer that issued four business and management indemnity policies, seeking declaratory judgment for breach of contract and bad faith after the insurer denied coverage. The Sixth Circuit, applying California law, affirmed the district court's grant of summary judgment in favor of the insurer on the basis of a misrepresentation in the insurance application. The insurance application asked the following question: "Within the last three (3) years, has the Applicant or any person proposed for this insurance in his or her capacity as an employee, officer, or director of the Applicant or another entity been the subject of or involved in any . . . litigation." The persons proposed for the insurance were involved in litigation as directors of another entity at the time the application was submitted. The insureds argued that the prior litigation question in the application was ambiguous due to the phrase "another entity", and therefore, it was proper to answer "no" because the applicant had not been sued in the ongoing litigation yet. The district court concluded that "another entity" referred to "any other entity" and that the insureds had knowledge of the ongoing lawsuit when the application for insurance was submitted. The Sixth Circuit affirmed.

Metro. Dist. Comm'n v. QBE Americas, Inc., No. 3:18-CV-01526 (SRU), 2019 WL 4243223 (D. Conn. Sept. 6, 2019) (applying Connecticut law)

The district court found that, under Connecticut law, coverage was barred by the prior knowledge condition in a public officials and employment practices liability policy. The insured filed a declaratory relief action seeking a determination that it was entitled to coverage in connection with a lawsuit for imposition of surcharges on water customers. The insurer moved to dismiss the action alleging that coverage was barred under several policy exclusions, including a prior knowledge condition, which required that "no Insured had knowledge of any circumstance likely to result in or give rise to a claim nor could have reasonably foreseen that a claim might be made." The court applied a "two-part, subjective-objective test" to determine if the insured had actual knowledge that the surcharges had been held to be illegal and whether a reasonable professional in the insured's position would understand that the surcharges might form the basis of a future claim. The court found that the insurer satisfied both prongs of the test based on the insured's discovery responses and application of Connecticut state law. Ultimately, the court granted the insurer's motion to dismiss.

Berkley Assur. Co. v. Expert Grp. Int'l Inc., 779 F. App'x 604 (11th Cir. 2019) (applying Florida law)

Under a claims-made errors and omissions policy, the insurer sought a judicial declaration that a prior knowledge exclusion barred coverage for a claim that the insured had reported to its prior carriers two days before applying for the first policy issued by the plaintiff insurer. Applying Florida law, the Eleventh Circuit affirmed the decision that under such circumstances, the insured had sufficient prior knowledge for the exclusion to apply. The Eleventh Circuit also clarified that, in the case of multiple policy renewals, the relevant inception date for the

prior knowledge condition in the policy at issue was the inception date of the particular renewal under which the claim was tendered. The Eleventh Circuit found that prior to the renewal at issue, an amended complaint in the underlying litigation that included negligence claims against the insured was sufficient to establish that the insured had prior knowledge that a negligent misrepresentation claim might likely be made. The Eleventh Circuit affirmed summary judgment in the insurer's favor.

Certain Underwriters at Lloyd's London Subscribing to Policy No. HMPL 18-0164 & HMPL 17-0158 v. KG Admin. Servs., Inc., No. 5:19-cv-1246, 2019 WL 6770061 (N.D. Ohio Dec. 12, 2019) (applying Ohio law)

The district court granted an insurer's motion for judgment on the pleadings which sought a declaration that it was entitled to rescind an errors and omissions policy based on the insured's purported misrepresentations in its renewal application. The insured, a third-party administrator for health benefit plans, faced several lawsuits from entities that allegedly retained the insured to administer their self-funded health benefit plans. The three lawsuits at issue were filed before the insured submitted its renewal application. However, the insured failed to report the existence of the three lawsuits on its renewal application and executed a warranty statement attesting that it had no knowledge of any act, error, omission, fact, circumstance or contentions of any incident which may give rise to a claim being made against it. The court agreed with the insurer's argument that it was entitled to rescind the policy based on the insured's false warranties in its renewal application.

Zavodnick, Zavodnick & Lasky, LLC v. Nat'l Liab. & Fire Ins. Co., No. 17-4762, 2019 WL 1003157 (E.D. Pa. Mar. 1, 2019) (applying Pennsylvania law)

The district court granted an insurer's motion for summary judgment, finding that the insurer had a duty to defend or indemnify the insured law firm under a professional liability policy in connection with a malpractice lawsuit filed against the insured by a former client. Prior to submitting a renewal application, the insured settled a personal injury claim where it attempted to obtain, but was not successful in obtaining, a partial waiver of subrogation from the client's workers' compensation carrier. On the renewal application, the insured answered "no" to a question regarding its awareness of any act, error, omission, or incident that might reasonably be expected to result in a claim or suit being made against it. The policy also contained a prior knowledge exclusion, which provided that the insurer had no duty to defend or indemnify the insured against claims where the insured knew or should have known that the same or related wrongful act, legal services, fact, circumstance or adverse outcome might give rise to a claim. After the insurer issued the policy, the insured's client filed a malpractice action. Applying a two-part, subjective-objective test under Pennsylvania law to determine whether the prior knowledge exclusion applied to bar coverage, the court found that the facts that the insured actually knew at the time of policy issuance would have led a reasonable attorney equipped with those facts to know that a claim might be brought against him. Accordingly, the court found that the insurer had no duty to defend or indemnify its insured based on the policy's prior knowledge exclusion.

IV. Prior Acts / Prior Notice / Prior & Pending Litigation

Evanston Ins. Co. v. Winstar Props., No. 2:18-cv-07740-R-KES, 2019 U.S. Dist. LEXIS 189602 (C.D. Cal. Oct. 24, 2019) (applying California law)

The insurer issued a tenant discrimination liability policy that provided coverage for wrongful discrimination so long as "[t]he entirety of the Wrongful Discrimination happens during the Policy Period or on or after the Retroactive Date . . . ." The underlying suit alleged discriminatory rent increases that began before the Retroactive Date of the policy. Therefore, the court held that the "entirety of the wrongful discrimination" did not occur within the policy period and that the underlying suit fell outside the scope of the policy. Accordingly, the court granted summary judgment in favor of the insurer.

Landmark Am. Ins. Co. v. Navigators Ins. Co., 354 F. Supp. 3d 1078 (N.D. Cal. 2018) (applying California law)

The court granted an insurer's motion for judgment on the pleadings because coverage for the claim was precluded by the policy's special circumstances exclusion endorsement and prior acts exclusion. Because the court determined that both exclusions independently precluded coverage for the underlying action, the court did not need to address the insurer's additional argument that the claims asserted against the insured involved the same or related wrongful acts first made prior to its policy period. Therefore, the court granted judgment on the pleadings in favor of the insurer that there was no coverage under its policy.

Ocean Towers Hous. Corp. v. Evanston Ins. Co., 772 F. App'x 459 (9th Cir. 2019) (applying California law)

The Ninth Circuit, applying California law, affirmed a district court's order granting summary judgment in favor of an insurer based on a specific matter exclusion in the directors and officers and organization liability policy, which excluded coverage for any claim arising from any "Specific Matter" or substantially similar fact, circumstance or situation. The Ninth Circuit affirmed the district court's decision that all of the claims asserted against the insureds in the five underlying suits were barred from coverage by this exclusion because it was undisputed that "Specific Matters" in the exclusion included a prior lawsuit between the insured and another entity.

Office Depot, Inc. v. AIG Specialty Ins. Co., No. 2:15-cv-02416-SVW-JPR, 2019 U.S. Dist. LEXIS 167136 (C.D. Cal. June 21, 2019) (applying California law)

The court granted an insurer's summary judgment motion on four independent bases, including a prior acts exclusion, under policies that provided various business and technology related coverages. The policy's prior acts exclusion excluded coverage for any claim alleging, arising out of or resulting, directly or indirectly, from any wrongful act, related wrongful acts or series of continuous or repeated wrongful acts where the first such wrongful acts first occurred prior to the inception of or subsequent to the termination of the policy period. The court determined that the wrongful acts alleged against the insured, such as failing to comply with "best pricing" provisions and fraudulently switching customers to a less favorable price plan, were "related" wrongful acts. Based on the record evidence, including the insured's own prior characterizations of the underlying lawsuit, the court held it was clear the insured's allegedly wrongful acts were related to the first wrongful act that occurred prior to the policy's inception, and therefore, barred coverage under the prior acts exclusion.

Providence Serv. Corp. v. Ill. Union Ins. Co., No. N18C-06-114 MMJ CCLD, 2019 WL 3854261 (Del. Super. Ct. July 9, 2019) (applying Delaware law)

The court found that the professional incidents in the underlying action at issue were not "related" for purposes of the professional liability policy's prior acts or prior notice exclusions. The underlying action alleged that the insured administrator of a county's misdemeanor probation system illegally assessed fees and surcharges against probationers and made improper threats of arrest and probation revocation if the probationers did not pay the assessed amounts. Five years prior, the insured also was sued regarding two specific fees charged by the insured (e.g., a picture fee and a supervisory fee). Despite any similarities, the court distinguished the lawsuits based on the relief sought and the scope of the lawsuit, found ultimately that the differences outweighed the similarities, and concluded the professional incidents in the two actions were not "related" for purposes of the exclusion.

Berkshire Hathaway Specialty Ins. Co. v. H.I.G. Cap., LLC, 102 N.Y.S.3d 168 (N.Y. App. Div. 2019) (applying Florida law)

The court affirmed summary judgment in favor of the insurer based on the related claims and prior notice exclusions under professional asset management liability policies. As to the prior

notice exclusion, the court found that notice of an earlier warning notice issued by the United Kingdom Pensions Regulator alleging wrongful conduct relating to the insured's purchase of a United Kingdom entity, and on which claims were previously paid out, excluded coverage for a later warning notice issued by the regulator that also arose out of the same entity purchase.

Nova Se. U., Inc. v. Cont'l Cas. Co., No. 18-cv-61842-RAR, 2019 U.S. Dist. LEXIS 222124 (S.D. Fla. Dec. 27, 2019) (applying Florida law)

The court granted summary judgment in favor of the insurer, finding that there was no coverage for three alleged defects relating to a project under claims-made and reported architects and engineers liability policies, pursuant to the policies' prior knowledge exclusion and prior notice exclusion. The prior knowledge exclusion, which limited coverage to claims that were not known or reasonably expected by the insured before the inception of the policies barred coverage, because the insured knew or reasonably should have expected that a claim could arise before the policies incepted regarding the negligent design defects. Additionally, the prior notice exclusion precluded coverage because the insured undisputedly reported issues that were the subject of the underlying action prior to the policy's knowledge date.

Arch Ins. Co. v. PCH Healthcare Holdings, LLC, No. 18 C 02691, 2019 WL 3554062 (N.D. Ill. Aug. 5, 2019) (applying Illinois law)

The court granted the insurer's motion for judgment on the pleadings and concluded the insurer was not liable for coverage based on, among other things, a prior acts exclusion. The policy excluded coverage for "claims arising from, based upon, or attributable to the same wrongful act" as claims that were first made before the policy period began, and further excluded coverage for any claim "arising from, based upon, or attributable to any . . . Wrongful Act specified in [a] prior demand, suit or proceeding or any Interrelated Wrongful Acts thereof." The insured argued that the insurer waived its right to deny coverage for the underlying action alleging a health care billing fraud scheme by the insured, based on a prior suit alleging the same type of scheme against the same defendants, because the insurer did not uncover the prior lawsuit in the underwriting process before selling the policy to the insured. The court ruled in favor of the insurer, holding that a contract provision (i.e., the prior acts exclusion) cannot be waived before the contract was in force, and because the insurer reasonably could have assumed that the lawsuit would not be covered under the policy in deciding to issue the policy.

Scout, LLC v. Truck Ins. Exch., 434 P.3d 197 (2019) (applying Idaho law)

The court affirmed summary judgment for the insurer that issued a commercial business policy to an ownership group that bought a restaurant with the intent to rebrand the space and turn it into a pub. The policy's prior publication exclusion precluded coverage for the underlying trademark infringement litigation because the exclusion barred coverage for any advertising injury "arising out of oral or written publication of material whose first publication took place before the beginning of the policy period." The insured argued that while it first used its logo before the policy period began, it was not in business at that time, and therefore, the new logo was not used in connection with the new pub until after coverage began. The court rejected the insured's argument and found that the policy language was unambiguous. Further, the court rejected the insured's further argument that distinct "fresh wrongs" occurring during the policy period were not excluded from coverage, and found that there were no "fresh wrongs" alleged in the underlying complaint.

Emmis Commc'ns Corp. v. Ill. Nat'l Ins. Co., 937 F.3d 836 (7th Cir. 2019) (applying Indiana law)

The Seventh Circuit, applying Indiana law, affirmed a district court's decision that a directors and officers liability policy's "Specific Investigation/ Claim/Litigation/Event or Act Exclusion" did not bar coverage for a shareholder action regarding a stock repurchase by the insured entity based

on prior litigation concerning the entity's attempt to go private. The exclusion precluded coverage for, among other things, all notices of claim or circumstances reported under a prior directors and officers liability policy, which the court determined would exclude only those claims that had been reported under the prior policy as of the policy's effective date, and which was not the circumstance here. The court further found that, while the exclusion also excluded the insured's payments in connection with prior lawsuits, it would not preclude the insured's defense costs in the present underlying lawsuit. Finally, the court determined that, while the exclusion would preclude coverage for claims that share Interrelated Wrongful Acts with a prior lawsuit, such exclusion applied only to the extent the claims shared operative facts—i.e., facts that form the basis of the causes of action asserted in the lawsuit—which the court concluded was not the circumstance.

Tile Shop Holdings, Inc. v. Allied World Nat'l Assur. Co., No. 17-776 ADM/TNL, 2019 WL 2357044 (D. Minn. June 4, 2019) (applying Minnesota law)

The court granted an excess insurer's summary judgment motion 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 exclusions. The excess policy contained a broader exclusion, which declined 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 insured and its executives allegedly repeatedly omitted required information regarding related-party transactions from their disclosures to the SEC while preparing to offer public securities prior to and after the exclusion date. The excess insurer successfully asserted that the omissions made after the exclusion date arose from the same nuclei of wrongful conduct as those that occurred prior to such exclusion date. Therefore, the court found that all claims in the underlying securities and derivative lawsuits were sufficiently related and subject to the policy's prior acts exclusion.

UBS Fin. Servs. v. XL Specialty Ins. Co., 929 F.3d 11 (1st Cir. 2019) (applying Puerto Rico law)

Applying Puerto Rico law, the First Circuit affirmed summary judgment in favor of insurers that issued professional services policies and dismissed the insureds' claims with prejudice. The court found that the specific litigation exclusion, which excluded any claim that in any way involved prior matters, precluded coverage for the insureds' claims relating to two civil actions and two regulatory investigations concerning their dealings with closed-end investment funds because they involved "any fact, circumstance or situation" alleged in an earlier SEC investigation and investors' lawsuit relating to the insureds' handling of closed-end funds. The court found that prior case law addressing a narrower exclusion did not apply.

Ctr. for Excellence in Higher Educ., Inc., v. RSUI Indem. Co., 375 F. Supp. 3d 1217 (D. Utah 2019) (applying Utah law)

In connection with a merger of schools into a corporate entity that purchased a directors and officers liability policy, which contained a prior acts exclusion that excluded coverage for wrongful acts that occurred prior to the merger. The underlying *qui tam* action alleged Medicare fraud by the corporate entity and its director. The court in the coverage action determined that the policy's prior acts exclusion precluded coverage for the director because the allegations against him arose from or are related to wrongful acts that occurred before the policy period.

Starr Indem. & Liab. Co. v. Monavie, Inc., No. 2:14-cv-00395-DN, 2019 WL 1227930 (D. Utah Mar. 5, 2019) (applying Utah law)

Under claims-made and reported liability policies, the court determined that a prior notice exclusion precluded coverage for two class actions alleging false and misleading advertising of the health benefits of the insured's juices. Prior to the inception of the policies, two other similar actions had been brought against the insured regarding

different health claims about its juices. The court determined that such prior actions were sufficiently related to the present class actions under the policies' prior notice exclusion, such that there was no coverage for the present class actions under the policies. Accordingly, the court granted summary judgment in favor of the insurer.

V. Dishonesty & Personal Profit Exclusion

Adir Int'l, LLC v. Starr Indem. & Liab. Co., No. 2:19-cv-04352-R-PLA, 2019 WL 4462613 (C.D. Cal. Sept. 10, 2019) (applying California law)

California Insurance Code section 533.5 prohibited an insurer from defending or indemnifying its insured under a directors and officers liability policy for claims brought by the California Attorney General for alleged violations of the state's Unfair Competition and False Advertising statutes. The insurer did not have a duty to defend or indemnify the insured and was entitled to reimbursement of defense costs paid on behalf of the insured under a directors and officers liability policy. That the insurer had not explicitly reserved its reimbursement right in a reservation of rights letter was of no consequence because the insurer had explicitly reserved its right in the policy itself.

SS&C Techs. Holdings, Inc. v. AIG Specialty Ins. Co., No. 19-cv-7859 JSR, 2019 U.S. Dist. LEXIS 194196 (S.D.N.Y. Nov. 5, 2019) (applying Connecticut law)

The insurer issued a professional liability policy excluding coverage for losses in connection with claims arising out of a "dishonest, fraudulent, criminal or malicious act." A second clause of the exclusion provided the insurer would defend suits alleging such conduct until there was a final judgment, adjudication, or finding of fact against the insured. Acting on instructions from "third-party fraudsters," the insured, a software and services provider, unwittingly transferred funds belonging to a client, who then filed against the insured a lawsuit for which coverage was denied. On a motion to dismiss in a subsequent coverage action, the insurer asserted a plain reading of the first clause of the exclusion applied broadly such that coverage was barred not just for acts committed by the insured, but also to acts by the "third-party fraudsters." Applying Connecticut law, the district court disagreed and concluded the exclusion, when read in its entirety, clearly applied only to acts committed by the insured. The court further reasoned its reading comports with the contracting parties' "most likely intent," as well as the rationale behind such exclusionary provisions.

Desai v. Navigators Ins. Co., 400 F. Supp. 3d 1280 (M.D. Fla. 2019) (applying Florida law)

Applying Florida law, the district court determined an Illegal Advantage Exclusion in a primary directors and officers liability policy precluded coverage under an excess "follow form" policy where an officer of an insolvent insurance company sought coverage for a receiver's demand for repayment of bonus and other compensation deemed void by statute. The exclusion applied to losses "in any way involving the gaining of any profit or advantage" to which an insured was not legally entitled. In granting summary judgment for the excess insurer, the court rejected the insured's arguments that the funds at issue were neither a "profit" nor "advantage" and that the exclusion was inapplicable to claims involving compensation, when read in conjunction with a different exclusion concerning illegal remuneration. The court also concluded that even if the Illegal Advantage Exclusion did not apply, the claim at issue was not "for a wrongful act" within the meaning of the policy and therefore the insurer owed no duty to defend or indemnify.

Imperato v. Navigators Ins. Co., 777 F. App'x 341 (11th Cir. 2019) (applying Florida law)

A directors and officers liability insurance policy covered securities claims for wrongful acts by the insured's directors and officers, including any civil or criminal actions brought by the Securities and Exchange Commission (SEC) for violations

of any securities rules or laws. The policy expressly excluded coverage for claims "brought about or contributed to by . . . the deliberately fraudulent or criminal acts of any insureds" where "it is finally adjudicated that such conduct in fact occurred." In a civil suit by the SEC, an insured director or officer was held liable for engaging in intentionally fraudulent conduct, which constituted "deliberately fraudulent" conduct excluded by the plain language of the policy. Thus, under Florida law, the insurer owed no duty to defend or indemnify the insured for the SEC action. Accordingly, the court affirmed the dismissal of the insured's complaint.

Scottsdale Ins. Co. v. Byrne, 913 F.3d 221 (1st Cir. 2019) (applying Massachusetts law)

The First Circuit, applying Massachusetts law, affirmed a district court's judgment against an insurer awarding damages, including policy limits and interest, for failing to defend an insured real estate investment vehicle against whom default had been entered in an underlying action for negligence and ERISA violations. The underlying allegations were not "clearly excluded" from coverage by the ERISA exclusion or the professional services exclusion in a Business and Management Indemnity policy. Nor did the policy's conduct exclusion excuse the insurer's indemnity obligation such that the insurer should only be liable for defense costs, and not the full policy limits. The conduct exclusion barred coverage with respect to "the gaining of any profit, remuneration or financial advantage" to which the insureds were not legally entitled, provided there was a final judgment against such insureds as to such conduct. The circuit court noted the allegations of "self-dealing" and "improper gain or pecuniary advantage" were only a component of many other allegations in the underlying action, all of which were conclusively established as to the insurer by entry of default against the insured. The circuit court concluded the insurer had failed to meet its burden to prove that all material allegations or any allocable part of the judgment in the underlying action were barred by the conduct exclusion.

Steadfast Ins. Co. v. DBI Servs., LLC, No. N18C-03-291 PRW CCLD, 2019 WL 2613195 (Del. Super. Ct. June 24, 2019) (applying New York law)

A Contractor's Protective Professional Indemnity and Liability Insurance Policy, which insured the business operations of a corporation that provided highway operations and maintenance services to public entities, contained an exclusion precluding coverage, in part, for any dishonest and fraudulent act. The exclusion did not apply to an insured who "did not commit, participate in, or have knowledge of" such conduct. In two separate underlying actions, the insured was accused of intentionally installing counterfeit lane delineator posts along an interstate highway. The insurer declined to defend or indemnify the insured against both underlying actions, and in response, the insured provided facts supporting its position that it had not knowingly installed counterfeit delineators. On cross-motions for summary judgment, the Superior Court of Delaware concluded the exclusion was inapplicable because, under New York law, the insurer had knowledge of facts establishing a reasonable possibility of coverage and therefore had a duty to defend, even if the allegations in the complaint failed to sufficiently allege all requisite facts. The insured's potential liability in the underlying actions could evolve not just from its own dishonest and fraudulent acts, but also from its alleged failure to detect the wrongful acts of other defendants in the actions. The insurer had thus failed to demonstrate the claims in both underlying actions fell "solely and entirely" within the exclusion.

Evanston Ins. Co. v. Certified Steel Stud Ass'n, Inc., et al., 787 F. App'x 879 (6th Cir. 2019) (applying Ohio law)

Under Ohio law, the Sixth Circuit determined that coverage for a manufacturer's judgment against an insured trade association for defamation, commercial disparagement, civil conspiracy, and unfair competition was not barred by the policy's dishonest acts exclusion because liability for the claims did not require a finding of dishonesty. Further, the jury in the underlying action did not find the insured acted with "intent to injure"

when it committed unlawful acts, and thus, Ohio law, prohibiting liability insurers from covering damages caused by intentional acts undertaken with the intent to injure, did not apply.

Okla. Att'ys Mut. Ins. Co. v. Cox, 440 P.3d 75 (Okla. Civ. App. Apr. 5, 2019) (applying Oklahoma law)

A crime/fraud exclusion in a professional liability policy issued to an insured precluded coverage for an underlying action brought against the insured (a disbarred attorney) by a former client for negligence, gross negligence, unjust enrichment, breach of duty by personal representative, deceit/fraud, and unjust enrichment. Applying Oklahoma law, the appellate court affirmed the lower court's grant of summary judgment in favor of the insurer that the exclusion applied, because the former client had failed to present evidence indicating he had sustained damages from the attorney's negligent conduct which were separate from those sustained as a result of the attorney's fraudulent and/or criminal conduct.

VI. Restitution / No Loss

Phila. Indem. Ins. Co. v. Sabal Ins. Grp., Inc., 786 F. App'x 167, 169 (11th Cir. 2019) (applying Florida law)

The Eleventh Circuit affirmed the entry of summary judgment in favor of the insurer in the insurer's action seeking a declaratory judgment that the policy provided no coverage for payments by an insured to settle a felony charge of grand theft. Applying Florida law, the court held that the "restitution of ill-gotten gains" does not qualify as a Loss under an insurance contract, as holding otherwise "would encourage commission of a wrongful act." The Court also found that the payment made to resolve the criminal charges against the insured qualified as restitution of ill-gotten gains, rejecting the insured's argument that the claims against him were unproven and that Florida law favored settlements in lieu of prosecutions. In doing so, the court noted that the amount of the settlement payment was equal to the amount of the insured's charged ill-gotten gains.

Damon Key Leong Kupchak Hastert v. Westport Ins. Corp., No. 19-CV-00099-DKW-KJM, 2019 WL 5088739 (D. Haw. Oct. 10, 2019) (applying Hawaii law)

The insured was defense counsel in an underlying securities fraud class action. During that representation, the insured law firm allegedly defied an asset freeze order by transferring their client's funds to foreign bank accounts. The class action plaintiffs filed a series of applications for show cause orders, seeking an order directing the insured to pay $1.75 million into a trust account as security against any judgment entered against the insured's clients. The insured sought coverage under a professional liability policy, but the insurer denied on the grounds that the actions against the insured were effectively requests for sanction. The policy defined Loss to exclude "civil or criminal fines, penalties, fees or sanctions." The insured argued that the underlying actions did not explicitly seek sanctions. The court disagreed finding that the actions against the insured were necessarily proceedings for sanctions, regardless of how plaintiffs characterized their request for relief, because the underlying proceedings involved a party's intentional violation of a court order. In light of this, the court further concluded that the actions sought damages that were not covered by the policy, and as such, the insurer had no duty to defend.

Allied World Specialty Ins. Co. v. John Sexton Sand & Gravel Corp., No. 1-18-2468, 2019 WL 4466985 (Ill. App. Ct. Sept. 17, 2019) (applying Illinois law)

The insured was alleged to have transferred assets to affiliates with the intent to hinder, delay or defraud a creditor. The underlying complaint sought the return of property or money, as well as damages for the value of the property at the time of the transfers. The directors and officers liability policies defined Loss to include "damages, settlements or judgments" but exclude "amounts deemed uninsurable under applicable law." The insurer argued that, because disgorgement is

uninsurable under Illinois law, the policies did not provide coverage for the claim. The court determined that, since the underlying complaint also sought damages for the value of the property at the time of the transfers, the claimant sought more than disgorgement and the insurer was required to defend the insured.

Marcus v. Allied World Ins. Co., 384 F. Supp. 3d 115 (D. Me. 2019) (applying Maine law)

An insurer did not have a duty to defend an insured lawyer and law firm against a lawsuit brought by the SEC seeking disgorgement of funds obtained in violation of federal securities law. The policy at issue was a professional liability policy that provided a defense against any claim seeking damages. The policy defined "damages" as the monetary portion of any judgment award or settlement, but specifically excluded "criminal or civil fines, taxes, penalties (statutory or otherwise), fees or sanctions." The court found no duty to defend because any amounts the insured would have to pay as a result of the lawsuit would operate as a punitive deterrent against future securities violations, and thus qualified as a criminal or civil penalty expressly precluded from coverage under the policy.

Oceanway Mental Health Agency, Inc. v. Phila. Indem. Ins. Co., No. 2:17-cv-00424-LEW, 2019 U.S. Dist. LEXIS 10542 (D. Me. Jan. 23, 2019) (applying Maine law)

The court granted the insurer's motion for summary judgment and denied the insured's motion on the grounds the insurer did not have a duty to defend or indemnify the insured against administrative proceedings initiated by the Maine Department of Health and Human Services under a professional liability policy. The insureds, mental health services agencies that contracted with the Department of Health to provide mental health services, received notices of violation with respect to billing violations, which culminated in a termination of their provider agreements based on a determination that there existed a credible allegation of fraud. The policy defined Damages to exclude fines, sanctions, and penalties. The court found that the administrative proceedings seeking recoupment of "fines, sanctions, and penalties" based on alleged violations of Medicaid billing standards do not fall within the definition of damages.

VII. Insured Capacity

IDT Corp. v. U.S. Specialty Ins. Co., No. N18C-03-032 PRW CCLD, 2019 Del. Super. LEXIS 55 (Del. Super. Ct. Jan. 31, 2019) (applying Delaware law)

The underlying complaint alleged that the individual defendant engaged in wrongful conduct for the benefit of the insured corporation and himself in his capacity as the Chairman of the insured corporation. The court determined that the underlying action sufficiently alleged that the individual defendant committed wrongful acts within scope of his official capacity for the insured despite the fact that he may have been, at the same time, also a controlling stockholder of a spin off company and breaching his concomitant fiduciary duties there.

Newton Covenant Church, et al. v. Great Am. Ins. Co., No. 18-12628-RGS, 2019 WL 3464705 (D. Mass. July 31, 2019) (applying Massachusetts law)

A majority of the members of an insured church voted to break away from the original church and take control of its property in order to establish a new church. The original church brought suit against the new church and its directors and officers. The new church sought coverage for the action and the resulting settlement under the original church's directors and officers liability policy. The insurer denied coverage on the grounds that the new church was not an Insured under the policy. The court held that the new church was not an Insured under the policy because it was a legal entity distinct from the original church, that the individuals had not been sued for acts taken in their capacity as directors or officers of the original insured church, and that, even if the new church and its members were

Insureds, the Insured versus Insured exclusion barred coverage for the claim against them by the original church.

VIII. Insured v. Insured Exclusion

MJC Supply, LLC v. Scottsdale Ins. Co., No. CV 18-01265 RSWL-SK, 2019 WL 2372279 (C.D. Cal. June 4, 2019) (applying California law)

The insured joint venture was owned by various domestic and foreign entities, who sued each other in federal and state courts. A portion of the claims were tendered to the directors and officers liability insurer. The insurer defended initially but withdrew coverage based on the insured versus insured exclusion. The insured sued the insurer alleging that the insurer wrongfully denied coverage. Denying both sides' cross-motions for summary judgment on the issue of whether the policies' insured versus insured exclusion applied, the court determined that triable issues of fact existed regarding the involvement of the insured entity's directors or officers in the underlying action. Specifically, the court determined that there was an issue as to whether the state action had been filed at the direction of an insured, noting that the insurer "fail[ed] to cite evidence of [the CEO's] actual involvement" in the state action.

Prophet Equity LP v. Twin City Fire Ins. Co., No. 05-17-00927-CV, 2019 WL 3886651 (Tex. Ct. App. Aug. 19, 2019) (applying Texas law)

Under a private equity professional and management liability insurance policy, which provided employment practices liability coverage, the insurer denied coverage based on, among other grounds, the policy's insured versus insured exclusion. The lower court granted the insurer's motion for summary judgment. However, the exclusion contained an exception for any claim that "is brought by one or more of the Insured Persons for Wrongful Employment Practices." The appellate court found that, although an insured versus insured relationship existed, the wrongful employment practices exception precluded the insurer from using the exclusion as a global defense to the Claim. Rather, the exclusion defeated coverage for specific Losses. The appellate court reversed the lower court and granted summary judgment in favor of the insureds holding, in part, that the insured versus insured exception did not globally preclude coverage.

IX. Coverage for Contractual Liability

Cross Check Servs., LLC v. Old Republic Ins. Co., No. 2:15-cv-02113-MCE-EFB, 2019 WL 1429336 (E.D. Cal. Mar. 29, 2019) (applying California law)

The court held that the insurer had no duty to defend or indemnify the insured under a nonprofit organization and management liability policy. The insured refused to pay an invoice to a contractor it had hired, resulting in an arbitration. After issuance of an award in the contractor's favor, the insured's rights under the policy at issue were assigned to the contractor. The policy precluded coverage for losses as a result of claims for obligations under any oral or written contracts or agreements. Because the underlying dispute arose from a contract between the insured and its contractor, the exclusion barred coverage.

Erickson-Hall Constr. Co. v. Scottsdale Ins. Co., 369 F. Supp. 3d 1022 (S.D. Cal. Feb. 20, 2019) (applying California law)

The court held that the insured's mishandling of employee benefits arose from the insured's contractual obligations and fell outside the scope of coverage provided by the Business and Management Indemnity policy and Special Multi-Flex Business Insurance policy at issue. The underlying claims alleged that the insured mishandled the employee benefits promised to its employees, resulting in a lapse of employee benefits. The insurers argued that the insured was not legally responsible for payment of claims arising from an employee benefits injury or wrongful act; rather, the insured's liability arose from its contractual obligation with its employees.

The court agreed with the insurers and held that the insured was obligated to pay the underlying claims because the claims were for a contractual obligation and not the negligent actions of the insured. The claims against the insurers were dismissed.

Office Depot, Inc. v. AIG Specialty Ins. Co., No. 2:15-cv-02416-SVW-JPR, 2019 U.S. Dist. LEXIS 167136 (C.D. Cal. June 21, 2019) (applying California law)

The court held that coverage was barred under the professional liability policies issued to the insured. The underlying action alleged that the insured violated agreements and contracts with hundreds of California public entities through a variety of underhanded pricing practices. The court held that coverage was precluded under the contract exclusion, which "excluded coverage for 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." The court held that the allegations in the complaint would not have existed but for the contracts between the insured and the governmental entities. Ultimately, the court granted the insurer's motions as to the duty to defend and the duty to indemnify.

Suntrust Banks v. Certain Underwriters at Lloyd's of London, No. 2014CV249230, 2019 Ga. Super. LEXIS 363 (Ga. Super. Ct. May 17, 2019) (applying Georgia law)

Applying Georgia law, a Georgia state court found that coverage existed under a professional liability policy for Wrongful Acts for services rendered pursuant to contractual arrangements. The insured sold mortgages and became liable for certain representations and warranties about the origination and underwriting of those mortgage loans. The insurer denied coverage because the insured's liability arose from its contractual liability. The court found that the insuring agreement was sufficiently broad that Wrongful Acts could include certain claims arising from the contracts between the insureds and their customers. The court specifically found that the contractual liability exclusion did not apply because the underlying mortgage disputes did not involve third party "liability assumed" by the insured.

Integrated Tech., Inc. v. Crum & Forster Specialty, 217 A.3d 528 (Vt. 2019) (applying Vermont law)

The court affirmed the trial court's order holding that no coverage was afforded under a professional liability policy for claims that did not arise from the insured's rendering or failure to render professional services. The underlying plaintiff alleged that the insured sought to undermine and replace the underlying plaintiff as a subcontractor through misrepresentations and other bad conduct despite a teaming agreement between the two parties. The court held that the breach of contract claim alleged in the underlying litigation did not arise from the rendering of professional services. The insured broke a promise made to underlying plaintiff, but not in the course of providing professional services. The court also dismissed the insured's argument that any action taken related to its business qualified as professional services, finding that this logic would transform errors and omissions policies into comprehensive liability policies.

Crum & Forster Specialty Ins. Co. v. DVO, Inc., 939 F.3d 852 (7th Cir. 2019) (applying Wisconsin law)

The insured designer and producer of anaerobic digesters was sued for breach of contract based on an alleged design failure. Challenging the insurer's denial of coverage, the insured argued that if the breach of contract exclusion applied, it would effectively render the policy's coverage illusory. While the district court rejected the insured's argument, the Seventh Circuit, applying Wisconsin law, disagreed and held that the language at issue is extremely broad and would preclude coverage for third party claims. The Seventh Circuit reversed the decision of the district court and remanded the case for consideration as to the reasonable expectations of the insured.

X. Professional Services

Kerr v. Gotham Ins. Co., No. 4:18CV00423, 2019 WL 5268625 (E.D. Ark. Oct. 17, 2019) (applying Arkansas law)

The insured, an insurance brokerage that sold and administered health benefit products to small businesses, was sued by the receiver of an insolvent insurance company for conversion, breach of fiduciary duty, and negligence. The insured's CEO was also the president and a minority shareholder of the insolvent insurance company, which provided stop loss coverage and paid excess of loss claims to employers participating in the health benefit plans. The CEO was accused of misappropriating the insurance company funds to make various payments to himself and to cover health care expenses for the insured's employees. The insured's errors and omissions policy defined Professional Services as "Third Party Administrator of employee benefits, placement, administration of stop loss." The court found that the CEO did not qualify as a Covered Person because he was not rendering professional services on behalf of the named insured brokerage. The court found that the CEO's alleged negligence was not related to the performance of professional services on behalf of the insured, but actions in his own self-interest that ignored the company business plan and deliberately abused his position as a corporate officer of the insurance company.

Cominos v. Freedom Specialty Ins. Co., No. 18-cv-02070-BLF, 2019 WL 1779577 (N.D. Cal. Apr. 23, 2019) (applying California law)

The insured attorney was sued in connection with his role in allegedly accepting millions of dollars that his daughter stole and misappropriated from her then-husband. The insured had a Lawyers Professional Liability Policy that covered claims for alleged acts in rendering or failure to render professional services, which included legal and consulting services as an attorney. The insurer denied coverage claiming that the complaint only alleged that the insured accepted the transfer of stolen and/or misappropriated funds due to his relationship with his daughter, not because of any professional services he provided. Though the court agreed that the complaint did not allege that the insured provided any legal services, it found that the insurer owed a duty to defend based on extrinsic evidence of the insured's professional services, including that in light of the daughter's martial disputes, the insured counseled his daughter on a pro bono basis regarding her community property rights, her rights to receive prompt payment of unpaid wages in connection with work for her husband's art business, and the means to protect her money.

Iberiabank Corp. v. Illinois Union Ins. Co., Civ. Action No. 18-1090, 2019 WL 585288 (E.D. La. Feb. 13, 2019) (applying Louisiana law)

The insured bank was sued by a whistleblower in a *qui tam* suit for alleged violations of the false claims act arising from its participation in the Direct Endorsement (DE) mortgage insurance program. The underlying complaint alleged that the insured submitted false and fraudulent records to HUD regarding mortgage loans to secure mortgage insurance from the FHA under the DE program. The insurer denied coverage under a bankers' professional liability policy, arguing that the alleged loss in the underlying matter did not stem from a wrongful act in the rendering or failure to render professional services. Professional services was defined to include "services performed by or on behalf of the [bank] for a policyholder or third party client of the [bank]." The court agreed with the insurer and dismissed the coverage action. The court found that the crux of the false claims act allegations was the insured certifying that it had provided a certain level of underwriting in connection with its participation in the DE program when it actually had not, resulting in the issuance of FHA insurance on ineligible loans. Thus, even though the claim arguably involved allegations regarding the insured's underwriting professional services, the conduct at the heart of the complaint – the insured's false certifications to the government that it had provided an agreed level of underwriting – was not a wrongful act in the rendering or failure to render professional services.

Governo v. Allied World Ins. Co., Civ. No. 17-11672-RGS, 2019 WL 4034810 (D. Mass. Aug. 27, 2019) (applying Massachusetts law)

A counterclaim was filed against the insured attorney by former firm lawyers that left to start their own firm. The subject Lawyers Professional Liability Insurance Policy covered acts, errors and omissions in the performance or failure to perform legal services, which was defined as "those services performed on behalf of the Named Insured for others by an Insured . . . but only where such services were performed in the ordinary course of the Insured's activities as a lawyer." The court found that there was a potential for coverage under the policy and a duty to defend based on the counterclaim allegations that, amongst other claims, the insured provided unfair notice to clients of the departing attorneys and failed to transfer and release client files. The court held that giving notice to clients of an attorney's departure from a firm and transferring a client's file to the attorney's new law firm, if the client wishes, are within the orbit of professional tasks that lawyers perform in the ordinary course of business.

Steadfast Ins. Co. v. DBI Services, LLC, C.A. No. 18C-03-291 PRW CCLD, 2019 WL 2613195 (Del. Super. Ct. 2019) (applying New York law)

The insured, a company providing highway operations and maintenance services to public entities, was sued by two manufacturers whose products combined to create highway lane delineators. The suit alleged that the insured's contract with the Florida Department of Transportation required it to service or replace broken delineators, and in doing so supplied counterfeit delineators that ultimately led to the original manufacturers' products being disqualified from use in Florida highways. The insured had a Contractor's Protective Professional Indemnity and Liability Insurance Policy that provided coverage for negligent acts, errors or omissions in the insured's rendering or failure to render professional services, defined as "those services that [the insured] . . . is qualified to perform for others in [its] capacity as an architect, engineer, landscape architect, inspector, land surveyor or planner, [or] construction manager[.]" Applying New York law, the court found that the underlying complaints alleged that the inspection, planning, and/or construction management activities that brought about the installation of the delineators resulted in the purported violations described therein, and therefore arguably constituted professional services imposing a duty to defend.

Harriman v. Associated Indus. Ins. Co., Inc., No. 2:18-cv-2750-DCN, 2019 WL 1670801 (D.S.C. Apr. 17, 2019) (applying South Carolina law)

The insured investment advisor was sued for allegedly making false and defamatory statements about a medical technology company in her capacity as an investment advisor. The insurer denied coverage for the suit under a professional liability policy, arguing that the underlying complaints did not allege a wrongful act in the performance or failure to perform Professional Services, which was generally defined to include (1) the sale of certain financial products and securities; (2) the administration of certain retirement accounts; (3) the provision of Investment Advisory Services; and (4) professional supervision. In the resulting coverage suit, the court denied the insurer's motion to dismiss, finding that the underlying suits' allegations arguably alleged that the insured was providing Professional Services. The claimant alleged that the insured's tortious conduct occurred while she was acting in her capacity as an agent for the named insured, and thus there was a possibility that she made the allegedly defamatory statements to other clients and was providing Professional Services.

Integrated Techs., Inc. v. Crum & Forster Specialty Ins. Co., 217 A.3d 528 (Vt. 2019) (applying Vermont law)

The insured engineering and project management firm had an errors and omissions policy that provided coverage for wrongful acts in the rendering or failure to render professional services, which was defined to include functions "related to your practice as a consultant, engineer, architect,

surveyor, laboratory, or construction manager." The insured was a sub-subcontractor providing engineering and project management services to a subcontractor, and was alleged to have breached an agreement not to compete with the subcontractor, undermined the subcontractor on a project, and made false statements about the subcontractor. The subcontractor filed an action against the insured, alleging that the insured breached its contract with the subcontractor and tortiously interfered with its business expectancy by undermining the subcontractor's work with the contractor. The insured's professional liability insurer denied coverage for the claim, and the insured sued its insurer. The court affirmed a lower court's order granting summary judgment in favor of the insurer on the grounds that neither the breach of contract claim nor the tortious interference claim arose from the insured's professional services.

Professional Services Exclusions

First One Lending Corp. v. Hartford Cas. Ins. Co., 755 F. App'x 710 (9th Cir. 2019) (applying California law)

The Ninth Circuit Court reversed the district court's order granting summary judgment in favor of the insurer who had issued a general liability policy. The policy contained an exclusion for claims "resulting from the rendering or failure to render financial services." The district court granted summary judgment for the insurer on the grounds that the financial services exclusion precluded coverage for the underlying claim. However, as the Ninth Circuit found that not all claims in the underlying complaint bore a sufficient causal nexus with financial services, such as claims of trademark infringement and unfair competition, the Ninth Circuit Court reversed the district court and remanded for further proceedings.

Scottsdale Ins. Co. v. Byrne, 913 F.3d 221 (1st Cir. 2019) (applying Massachusetts law)

Applying Massachusetts law, the First Circuit Court found that the insurer owed a duty to defend the insured real estate investment vehicle under a business and management indemnity policy. The underlying action alleged that the insured was negligent and violated ERISA through the mismanagement of real estate investments made with the claimants' retirement funds. In particular, the complaint alleged that the insured invested in specific properties that were "lost to foreclosure or written down to a zero value because of tax or mortgages owed," and, generally, that insured "engaged in self-dealing by retaining investment income from the properties for its own use." The policy contained an exclusion for loss on account of a claim involving the rendering or failure to render Professional Services, which was defined to include "services as a real estate broker or agent, . . . real estate developer, real estate consultant [or] property manager. . . . Such services shall include, without limitation, the purchase, sale, rental, leasing or valuation of real property; the arrangement of financing on real property; or any advice proffered by an Insured in connection with any of the foregoing." The court found that while some of the allegations fell within this exclusion, it was not sufficiently clear that all of the insured's alleged misconduct stemmed from Professional Services as a property manager, developer, investor, or otherwise.

Allstate Ins. Co. v. Punturo, 407 F. Supp. 3d 700 (W.D. Mich. Aug. 9, 2019) (applying Michigan law)

The insured, an attorney at the named insured law firm, was sued for defamation and other claims concerning statements he made to the media while representing an individual in a lawsuit against the claimant. The subject Business Owners Policy included a professional services exclusion that barred coverage for personal and advertising injury caused by the rendering or failure to render any professional service, which included legal services. The court found that the professional services exclusion barred coverage because it was not limited to malpractice on behalf of a client, but also encompassed the insured's statement made while acting as an attorney in pending litigation against the claimant. The court also found that coverage was not illusory because other business activities unrelated to providing legal advice or advocacy could potentially be covered.

XI. Independent Counsel

Aspen Am. Ins. Co. v. Ou, No. CV182312DSFGJSX, 2019 WL 1950293 (C.D. Cal. Mar. 14, 2019) (applying California law)

The court granted summary judgment in favor of the insured under a healthcare professional liability insurance policy, holding that the insured was entitled to independent counsel under California Civil Code § 2860(a). In California, an insured has a right to independent counsel when an insurer reserves its rights on a given issue and the outcome of that coverage issue can be controlled by counsel first retained by the insurer for the defense of the claim. The court noted that facts used to show the insured had a reasonable basis for believing an incident might evolve into a claim or suit overlapped with facts that might be used to establish the insured committed medical malpractice. The parties did not dispute that the insurer's coverage defenses turned on what the insured knew regarding the incident or claim and when he knew it. Thus, the court determined there was an actual conflict of interest and that the insured met his burden to show that, as a matter of law, he had a right independent counsel at the insurer's expense.

Mancha Dev. Co., LLC v. Houston Cas. Co. No. SACV19831JVSKESX, 2019 WL 6703541 (C.D. Cal. July 9, 2019) (applying California law)

Under an employment practices liability insurance policy, the insurer moved to dismiss the insureds' coverage action where the insureds asserted they were entitled to select their own defense counsel. In granting the insurer's motion to dismiss in its entirety, the court noted that the policy expressly granted the insurer the right and duty to select and appoint defense counsel and that, under California law, when an insurer has a duty to defend, it also has the right to select defense counsel. The court further determined that the insured was not entitled to independent counsel under California Civil Code § 2860(a) because the insured had conceded that the Wage and Hour Endorsement, under which the underlying action was being defended, provided coverage only for Defense Costs and no other Loss. Thus, regardless of the outcome of the underlying action, there could be no coverage for any judgment entered in the matter and the outcome of the coverage issue could not possibly be controlled by counsel in its defense of the case. Under those circumstances, the court determined there was no conflict of interest, and thus no right on the insured's part to select its own counsel.

Xtreme Prot. Servs., LLC v. Steadfast Ins. Co., No. 1-18-1501, 2019 WL 1976482 (Ill. App. Ct. 2019) (applying Illinois law)

The court affirmed the trial court's grant of summary judgment in favor of the insured, which determined that the insured had the right to select an independent attorney to defend it under a professional liability policy. The insurer argued that independent counsel was not necessary because no conflict existed, as the insurer had expressly waived its right to deny coverage for compensatory damages based on the insured's alleged "intentional, criminal, fraudulent, malicious or dishonest" acts in the underlying action. The court determined that, while the insurer's waiver of its right to deny coverage for compensatory damages may have resolved one type of conflict, its continuing reservation of rights to deny coverage for punitive damages presented another potential conflict. Under Illinois law, the court determined that, where punitive damages form a substantial portion of the potential liability in the underlying action and are disclaimed from coverage under the policy, the insured is left with the greater interest and risk in the litigation and therefore, is entitled to independent counsel paid for by the insurer.

XII. Advancement of Defense Costs

Renovate Am., Inc. v. Lloyd's Syndicate 1458, No. 3:19-cv-01456, 2019 U.S. Dist. LEXIS 212874, (S.D. Cal. Dec. 10, 2019) (applying California law)

An insured tendered two actions to its insurer for

coverage, including defense costs, under a non-duty to defend professional liability policy. When the insurer did not respond within forty days, the insured retained defense counsel and paid for its own defense. The insurer later acknowledged the potential for coverage under the policy but refused to pay the full rates charged by the insured's retained counsel. The insured sued for breach of contract seeking, among other relief, defense costs. The insurer moved to dismiss arguing that the insured's claim was premature because the policy states that defense costs must be paid "prior to final disposition" and the underlying actions were still pending. The court rejected the argument that the insurer was not required to pay defense costs contemporaneously. The court noted that the policy insures for acts for which the insured becomes "legally liable," and an insured becomes legally obligated to pay legal expenses as soon as services are rendered.

UFW v. Hudson Ins. Co., No. 1:18-cv-0134, 2019 U.S. Dist. LEXIS 60257 (E.D. Cal. Apr. 5, 2019) (applying California law)

A former employee brought an action against an insured labor group alleging retaliation for exercising labor rights and various wage and hour violations. The labor group sought coverage under a professional liability policy. The insurer agreed to provide a defense subject to an agreed-upon allocation of costs and a reservation of rights. At trial, the insured was found liable for various wage and hour violations. The insurer subsequently denied coverage and withdrew its defense based on that adjudication, which established that the allegations were not covered under the policy. The insured sued the insurer and argued that the insurer was required to pay all defense costs because the allegations in the complaint presented a possibility of coverage under the policy. The court, in rejecting this argument, held that the policy imposed only a duty to advance defense costs for covered claims; not a duty to defend. Thus, the potentiality standard applicable to duty to defend policies did not apply.

Oceans Healthcare, LLC v. Ill. Union Ins. Co., 379 F. Supp. 3d 554 (E.D. Tex. 2019) (applying Texas law)

An insured sought coverage under a claims-made directors and officers liability policy for the costs of responding to a subpoena issued in connection with a *qui tam* action. The policy obligated the insurer to advance costs "which the Insurer believe[s] to be covered under this Policy until a different allocation is negotiated, arbitrated or judicially determined." The insured argued that the eight corners rule precluded the court from considering the allegations in the *qui tam* complaint in evaluating whether coverage existed for the subpoena. Given an absence of guidance from the Texas Supreme Court, the court declined the insured's invitation to apply the eight corners rule to cases involving a duty to advance defense costs rather than a duty to defend. Instead, the court found that the plain language of the policy permitted the use of extrinsic evidence to resolve the coverage issue. The court granted the insurer's motion for judgment on the pleadings.

XIII. Allocation

Mancha Dev. Co. v. Houston Cas. Co., No. SACV 19-831 JVS (KESx), 2019 U.S. Dist. LEXIS 214545 (C.D. Cal. July 9, 2019) (applying California law)

The court granted an insurer's motion to dismiss the insureds' complaint for failure to state a claim under Federal Rule of Civil Procedure 12(b)(6). The insureds challenged their insurer's allocation on the basis that the employment practices liability insurance policy's allocation provision did not apply to the Wage and Hour Endorsement. The court determined that the policy's Wage and Hour Endorsement was subject to the allocation provision, that the underlying action involved both covered and uncovered loss, and therefore, an allocation was appropriate. Further, under the policy, the insurer need only advance on a current basis those Defense Costs it believed to be covered until a different allocation is negotiated, arbitrated, or judicially determined. The policy further required that if an allocation

is not successfully "negotiated," then it must be "arbitrated." Thus, the court dismissed the complaint to the extent it sought a determination of the propriety of the insurer's allocation determination.

MJC Supply, LLC v. Scottsdale Ins. Co., No. CV 18-01265 RSWL-SK, 2019 WL 2372279 (C.D. Cal. June 4, 2019) (applying California law)

The court found that a triable issue existed as to the issue of allocation and therefore denied the parties' cross-motions for summary judgment on the issue. The policy contained an allocation provision that instructs the parties of what to do in the event that an insured incurs costs that are both covered by the policies (i.e., costs incurred in defending claims) and not covered by the Policies (i.e., costs incurred in prosecuting claims). The insureds argued that their insurer breached its contractual obligations by not paying all costs, charges, and expenses the insureds incurred in connection with the state and federal actions under the business and management indemnity policies. On the other hand, the insurer argued it was only responsible for covering costs incurred in plaintiffs' defense of the claims, not for the costs associated with the prosecution of claims. The court found that neither party produced enough evidence to determine how the allocation was decided, including the specific costs incurred by the insureds and costs withheld by the insurer. Therefore, the court denied the parties' motions.

Horn v. Liberty Ins. Underwriters, Inc., 391 F. Supp. 3d 1157 (S.D. Fla. 2019) (applying Florida law)

The court found that the insureds failed to allocate a settlement between covered and uncovered claims, as required by Florida law, and were therefore precluded from recovery against their insurer. Under Florida law, the party seeking coverage for a settlement has the burden of proving that the settlement is covered under the insurance policy. If a lawsuit contains both covered and non-covered claims and damages, Florida law clearly requires the party seeking recovery to allocate any settlement amount between covered and noncovered claims. The insured's inability to allocate precludes recovery against the insurer. Here, the policy contained an allocation provision that provided that, in the event of covered and non-covered parties (e.g., an insured director and a non-insured third party) or covered Loss (e.g., costs for a shareholder derivative demand) and non-covered loss (e.g., taxes, fines or penalties) in a single Claim, defense costs are recoverable and the Loss shall be allocated based on the relative legal exposure of the parties. The court determined that because the provision did not contractually place the allocation burden on either party in the event of a coverage dispute, it did not modify Florida law. The court also found that the insurer did not waive its allocation defense by failing to raise it as a coverage defense in its initial denial of coverage letters to the insureds, as the insured's burden of allocation is established by the common law and is not a coverage defense.

Allied World Specialty Ins. Co. v. John Sexton Sand & Gravel Corp., No. 1-18-2468, 2019 WL 4466985 (Ill. App. Ct. Sept. 17, 2019) (applying Illinois law)

An insurer who was found to have breached its duty to defend argued that the insured failed to allocate damages among covered and uncovered claims. Under Illinois law, when an insured enters into a settlement agreement that disposes of both covered and noncovered claims, the insurer must indemnify the insured of the entire settlement if the covered claim was the primary focus of the underlying litigation. As it may be impossible to determine the amount of settlement attributable to covered claims versus uncovered claims, requiring an actual allocation between claims would have a chilling effect on settling the underlying case. The court determined that, because the covered action was the center of the settlement, the insurer admitted that the settlement amount associated with the covered action was undeterminable, and the underlying policy did not contain an allocation provision requiring allocation when a settlement includes both covered and noncovered actions, the insured was not required to allocate the settlement amount between the covered action and the uncovered action.

Governo v. Allied World Ins. Co., No. 17-11672-RGS, 2019 WL 4034810 (D. Mass. Aug. 27, 2019) (applying Massachusetts law)

Where the underlying legal invoices did not distinguish between costs associated with uncovered affirmative claims versus the defense of the covered counterclaims, the court placed the burden of allocation under the professional liability policy on the insureds, even though the burden of allocation generally falls upon the insurer. In that case, the insured's counsel was in the unique position of knowing what work (prosecution versus defense) was associated with the invoices, as counsel was involved in performing the work and submitting the invoices.

Brand v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa., 934 F.3d 799 (8th Cir. Aug. 16, 2019) (applying Minnesota law)

The Eighth Circuit affirmed the district court's grant of summary judgment in favor of the directors' and officers' insurer, finding that the insured directors failed to meet their burden of proof that the insurer was liable for all defense costs associated with the underlying litigation. The district court appropriately considered the only issue properly raised before it, which was the insured directors' all-or-nothing claim for entitlement to 100% of defense costs. Only in the summary judgment reply brief did the directors seek alternative allocations. The Eighth Circuit agreed with the district court that the directors failed to carry their burden of showing entitlement to 100% of defense costs. Under Minnesota law, when a liability policy does not include a duty to defend, the burden of proving allocation falls on the insured party.

Prophet Equity LP v. Twin City Fire Ins. Co., No. 05-17-00927-CV, 2019 WL 3886651 (Tex. Ct. App. Aug. 19, 2019) (applying Texas law)

The court found that the trial court erred in granting the insurer's summary judgment motion, in part, because while the insured met its burden to distinguish between covered and uncovered Loss by establishing through summary judgment evidence that it was seeking reimbursement for covered Loss and specifically excluded those items that it did not believe were covered, the burden shifted to the insurer to demonstrate that some or all of the remaining asserted Loss was excluded from coverage but the insurer failed to meet this burden. The insurer only argued that a different allocation was required but failed to raise a fact issue or establish as a matter of law what that other allocation was. The court noted that, although the parties framed the argument in terms of who has the burden to "allocate" between covered and uncovered Loss, the issue is a matter of coverage and exclusions: the insured had to prove the existence of coverage, and then the burden shifted to the insurer to establish any coverage exclusions.

XIV. Recoupment

Adir Int'l, LLC v. Starr Indem. & Liab. Co., No. 2:19-CV-04352-R-PLA, 2019 WL 4462613 (C.D. Cal. Sept. 10, 2019) (applying California law)

Applying California law, the court held that the insurer was entitled to reimbursement of defense costs under a directors and officers liability policy, even though the insurer did not specifically reserve the right to reimbursement because the policy provided that "[i]n the event and to the extent that [the insured] shall not be entitled to payment of [ ] Loss under the terms and conditions of this policy, such payments by [the insurer] shall be repaid to [the insurer] by [the insured]." The court determined that the insurer never had a duty to defend or indemnify the insured in the underlying action, but nevertheless accepted the insured's defense subject to a reservation of rights. Because the insured was not entitled to payment of any defense costs, the court held that the insured is entitled to reimbursement pursuant to the explicit language of the policy.

Evanston Ins. Co. v. Winstar Props., No. 2:18-cv-07740-R-KES, 2019 U.S. Dist. LEXIS 189602 (C.D. Cal. Oct. 24, 2019) (applying California law)

Applying California law, the court held that the insurer was entitled to reimbursement of defense costs under a professional liability policy where there was no coverage under the policy for the claim and where insurer reserved the right to seek reimbursement. To obtain reimbursement of defense costs, an insurer must prove that the defense costs can be allocated solely to claims that are not even potentially covered by the policy, and that the insurer reserved its right to recover the defense costs that it paid but never had an obligation to furnish. The insureds argued that the insurer's reservation of rights letter never actually reached them, and that they did not know about or consent to the reservation of rights. The court held that this was beside the point, as it is the insurer's reservation of rights that is relevant, not the insured's knowledge of the reservation.

Phila. Indem. Ins. Co. v. Stephouse Recovery, Inc., No. CV 18-00564-CJC (DFMx), 2019 U.S. Dist. LEXIS 169235 (C.D. Cal. June 13, 2019) (applying California law)

Applying California law, the court held that the insurer was entitled to reimbursement of a settlement payment under a professional liability policy where there was no coverage for the settlement under the policy and the insurer made the payment subject to an express reservation to challenge coverage and seek reimbursement. An insurer is entitled to reimbursement of reasonable settlement costs paid to settle noncovered claims if the insurer made a timely and express reservation of rights, an express notification to the insureds of the insurer's intent to accept a proposed settlement offer, and an express offer to the insureds that they may assume their own defense when the insurer and insureds disagree whether to accept the proposed settlement.

Evanston Ins. Co. v. Aminokit Labs., Inc., No. 15-CV-02665-RM-NYW, 2019 WL 479204 (D. Colo. Feb. 7, 2019) (applying Colorado law)

Applying Colorado law, the court held that the insurer was entitled to reimbursement of amounts paid to settle a non-covered claim under an unjust enrichment theory where the insurer reserved its right to recoup the settlement payment and the insured nonetheless demanded that the insurer fund the settlement.

Cap. Specialty Ins. Corp. v. Big Sky Diagnostic Imaging, LLC, No. CV 17-54-BLG-SPW-TJC, 2019 U.S. Dist. LEXIS 45234 (D. Mont. Jan. 30, 2019) (applying Montana law)

Applying Montana law, the court held that the insurer was entitled to reimbursement of defense costs under a professional liability policy where it expressly reserved the right to seek reimbursement and there was no coverage for the claim. To recover defense costs, the insurer must timely and explicitly reserve the right to recoup costs and provide the insured with adequate notice of the possible reimbursement. Such a reservation of rights is enforceable where an insurer meets these conditions even absent an express agreement by the insured.

Starr Indem. & Liab. Co. v. MonaVie, Inc., No. 2:14-CV-00395-DN, 2019 WL 1227930 (D. Utah Mar. 15, 2019) (applying Utah law)

Applying Utah law, the court granted summary judgment in the insurer's favor, holding that the insurer was entitled to reimbursement of defense costs under a professional liability policy where the policy provided that "[i]n the event and to the extent that [insured] shall not be entitled to a payment of Defense Costs under the terms and conditions of this policy, such payments by [insurer] shall be repaid to [insurer] by [insured] . . . ." The court held that because there was no coverage for the underlying claims, the insurer was entitled to reimbursement of defense costs

pursuant to the terms of the policy.

Hanover Ins. Co. v. BMOC, Inc., No. 18-CV-325-WMC, 2019 WL 949215 (W.D. Wis. Feb. 27, 2019) (applying Wisconsin law)

Applying Wisconsin law, the court held that the insurer was not entitled to reimbursement of defense costs under a professional liability policy where the policy did not expressly provide a right to reimbursement. The court acknowledged that whether an insurance company can seek reimbursement for defense costs for claims outside the policy coverage is an open question under Wisconsin law, but then concluded that the insurer had an obligation to pay defense costs until the court adjudicated that there was no duty to defend where the policy did not provide a right to reimbursement of uncovered defense costs.

XV. Consent

Apollo Educ. Grp., Inc. v. Nat'l Union Fire Ins. Co., No. 17-17293, 2019 U.S. App. LEXIS 24300 (9th Cir. Aug. 15, 2019) (applying California law)

An insurer issued a non-duty to defend directors and officers liability policy to its insured. Following criminal and enforcement investigations, the insured became the subject of a securities class action. After a year of negotiation, the insured procured a settlement within the policy limit. The insured's counsel believed that the settlement was a "great deal" because the case would have been "enormously expensive" to defend and the potential recovery would likely have exceeded the policy limit. The insurer declined to consent to or fund the settlement. The policy required the insurer's prior consent to settlement, which the insurer could not unreasonably withhold. The district court granted summary judgment for the insurer on the insured's breach of contract claim finding that the insurer had "giv[e]n equal consideration to both the interests of its insured" and its own interests. On appeal, the insured argued that the district court should have considered the objective reasonableness of the settlement. The Ninth Circuit certified to the Supreme Court of Arizona the proper standard for determining whether an insurer unreasonably withheld its consent to settlement under a policy where the insurer has no duty to defend. Oral argument before the state's highest court is currently set in this case for March 24, 2020.

Renovate Am., Inc. v. Lloyd's Syndicate 1458, No. 3:19-cv-01456, 2019 U.S. Dist. LEXIS 212874, (S.D. Cal. Dec. 10, 2019) (applying California law)

An insured tendered two actions to its insurer for coverage, including defense costs, under a non-duty to defend professional liability policy. When the insurer did not respond within 40 days, the insured retained defense counsel and paid for its own defense costs. The insurer later acknowledged the potential for coverage under the policy but refused to pay the full rates charged by the insured's retained counsel. The insured sued for breach of contract seeking, among other relief, the full amount of defense costs. The insurer moved to dismiss based, in relevant part, on the insured's failure to obtain its prior written consent as required by the policy. The court denied the motion and held that the insurer's failure to timely respond to the insured's request for coverage amounted to an unreasonable withholding of consent given the necessity that the insured respond to the complaints in the underlying actions.

Holyoke Mut. Ins. Co. v. Cincinnati Indem. Co., No. 18-cv-01853, 2019 U.S. Dist. LEXIS 88898 (D. Colo. May 28, 2019) (applying Colorado law)

An insurer brought an action for equitable contribution against a co-insurer for amounts paid to their mutual insured to cover losses sustained, including defense costs, in a third-party action for property damage. The insured had tendered the claim to the insurer, but not the co-insurer. The insurer defended and settled the claim on the insured's behalf and only afterwards tendered its defense and indemnity to the co-insurer, who had not previously consented to the insured's defense or settlement. The court found that, in order for the plain meaning of the no-voluntary

payments clause to have meaning, the insured may not voluntarily incur an expense or obligation without first seeking the co-insurer's consent. The court determined that, just as the no-voluntary payments clause barred the insured from recovering defense costs or indemnity from the co-insurer, the clause also barred the insurer from seeking equitable contribution of those costs from its co-insurer.

Arch Ins. Co. v. Murdock, No. N16C-01-104, 2019 Del. Super. LEXIS 227 (Del. Super. Ct. May 7, 2019) (applying Delaware law)

The insurers provided a tower of directors and officers liability coverage to the insured. The primary policy, to which the excess policies followed form, contained a clause requiring the insured to obtain the insurer's prior written consent to any settlement, which consent the insurer could not unreasonably withhold. Following a leveraged buyout, the insured became the subject of multiple shareholder suits. The insured reached settlements with the former shareholders, but the insurers refused to consent to or fund the settlements. Under Delaware law, consent provisions do not provide insurers with an absolute right to veto a reasonable settlement and the breach of such a provision does not preclude coverage absent a showing that the breach caused the insurer to suffer prejudice. The insured's breach of the consent-to-settle clause raises a presumption that the insurer suffered prejudice, which the insured has the burden to rebut. The court found a factual dispute as to whether the insurers unreasonably withheld consent and denied summary judgment.

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