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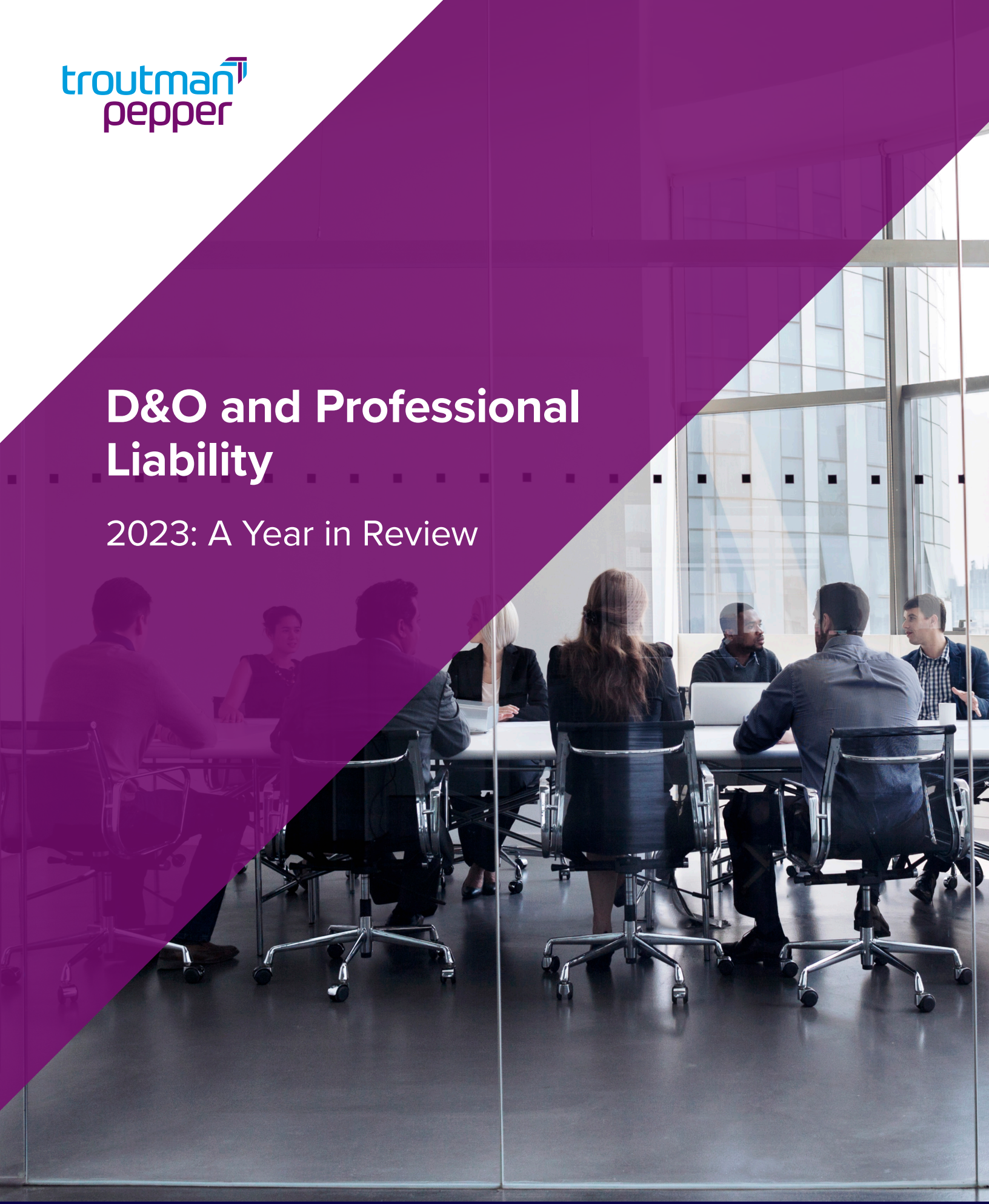
D&O and Professional Liability

2023: A Year in Review



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D&O and Professional Liability

2023: A Year in Review

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

In this issue

I. Notice

Triyar Hosp. Mgmt., LLC v. QBE Specialty Ins. Co., No. 2:21-cv-04474-SSS-SK, 2023 U.S. Dist. LEXIS 38883, 2023 WL *2372049* (C.D. Cal. Jan. 17, 2023)

Under California law, the U.S. District Court for the Central District of California denied an insurer's cross-motion for summary judgment on the issue of late notice. The insurer had issued a directors and officers liability policy for a September 15, 2016 to November 15, 2017 policy period. The policy provided that "[n]otice of any Claim … is considered timely when reported to the Insurer as soon as practicable after the Parent Company's chief executive officer or chief financial officer first becomes aware of such Claim." The policy also provided that the "Insurer shall not assert that notice of a Claim was untimely unless the Insurer is materially prejudiced by the untimely notice; [h]owever, in no event shall any notice be provided later than … 60 days after the [date of] expiration or termination" of the applicable coverage part. A claim was made against the insured during the policy period and judgment subsequently was entered against it. The insured did not provide notice, however, until several years after the judgment. Although the court found that notice was untimely, it nonetheless held that the policy was a claims-made policy rather than a claims-made-and-reported policy, such that California's notice-prejudice rule applied. The court found a genuine question of fact as to whether the insurer was prejudiced by the insured's late notice.

Heritage Bank of Com. V. Zurich Am. Ins. Co., 648 F. Supp. 3d 1125 (N.D. Cal. 2023), *appeal filed*, No. 23-15115 (9th Cir. Jan. 30, 2023)

Under California law, the U.S. District Court for the Northern District of California held that an insured did not meet the policy's notice requirements when it reported circumstances as part of the renewal application. The insurer issued an excess claims-made-and-reported directors and officers policy to the insured for the 2018-2019 policy. During the renewal process for the 2019-2020 policy, the insured included correspondence reflecting notice of a claim to the primary carrier and argued that this communication constituted sufficient notice. The court disagreed, holding that "[the insured] did not comply with the notice requirements in [the] policy." The insured also argued that its communication satisfied the substantial-compliance standard, which California courts apply to conditions precedent, but the court noted that "a party [does not] 'substantially compl[y] with the 'to whom' requirement … when it provides any kind of notice to any kind of agent of [the insurance company] during the policy period'; rather, the Claims Department must have received notice of a claim during the policy period."

Nat'l Union Fire Ins Co. of Pittsburgh, PA v. Estate of Calendine, No. 21-cv-01541-NYW-MDB, 2022 U.S. Dist. LEXIS 220682, 2022 WL 17486796 (D. Colo. Dec. 7, 2022)

Under Colorado law, the U.S. District Court for the District of Colorado held that two insurers had no duty to defend or indemnify their insured due to the insured's failure to comply with the policies' notice provisions. One of the insurers issued a claims-made professional liability insurance policy to the insured, a dentist, and the other insurer issued a claims-made professional liability insurance policy to a dental group, with the insured dentist named as an additional insured. One of the insurers was aware of a claim against the insured through correspondence from a third party, but both insurers argued that coverage was not available because the insured did not provide the notice required by the policy. The insured argued that the notice-prejudice rule applied to the case and, because the insurers could not demonstrate prejudice from the deficient notice, the failure to comply with the policies' notice provisions could not bar recovery under the policies. The court noted that no Colorado precedent expressly stated whether the notice-prejudice rule applied to claims-made policies in this context and "decline[d] to hold that the notice-prejudice rule applie[d] in this case."

Floyd v. Endurance Am. Spec. Ins. Co., No. 3:23cv10244-TKW-ZCB, 2023 U.S. Dist. LEXIS 99632, 2023 WL 3814041 (N.D. Fla. June 5, 2023)

Under Florida law, the U.S. District Court for the Northern District of Florida dismissed an insured's declaratory judgment action against its insurer because the insured provided notice to the insurer after the reporting period in the policy. The insured was issued a $2 million primary professional liability policy and a $25 million claims-made umbrella liability policy for the 2016-2017 policy period. The umbrella policy "explained that 'certain portions of [the] policy are written on a claims made and reported basis,' meaning that 'claims must be first made and reported to [the insurer] in writing during [the] policy period or any extension periods.'" About a week following a national newspaper's March 30, 2017, publication of an article reporting that "complications from knee surgery had put Plaintiff's football career in jeopardy," the insured notified the primary carrier but did not notify the excess insurer prior to the expiration of the 2016-17 policy. Noting that the "essence … of a claims-made policy is notice to the carrier within the policy period," the court agreed with the insurer and found that the notice provided by the insured to the primary insurer could not be considered notice to the excess insurer, or else "the separate notice requirements in the [excess] policy would be rendered meaningless."

Allied World Surplus Lines Ins. Co. v. Southwestern Ill. Health Facilities, Inc., No. 23-cv-02622, 2023 U.S. Dist. LEXIS 178380, 2023 WL 6443937 (S.D. Ill. Oct. 3, 2023)

Under Illinois law, the U.S. District Court for the Southern District of Illinois granted an excess insurer's request for a declaration that it owed no duty to defend based on late notice. The insured hospital had a $10 million claims-made excess policy for the policy period of March 2015 to March 2016. The policy required as a condition precedent to the insurer's payment under the policy that the insured provide the excess insurer "with prompt notice of any claim under any Underlying Insurance, or any circumstance that could give rise to a claim under any Underlying Insurance, involving . . . unexpected deaths[.]" In January 2016, a patient died at the insured's hospital after being treated for sepsis. The insured notified its primary insurer of the medical incident in February 2016 but did not report the medical incident and resulting lawsuit until November 29, 2021. The court agreed that six years of delay was unreasonable as a matter of law, and, thus, the excess insurer had no duty to defend.

Kentucky State University v. Darwin Nat'l Assur. Co., No. 2021-SC-0130-DG, 2023 Ky. LEXIS 165, 2023 WL 6362842 (Ky. Sept. 28, 2023)

Under Kentucky law, the Supreme Court of Kentucky held that the notice-prejudice rule did not apply to a claims-made-and-reported policy's unambiguous provision requiring written notice of a claim no later than 90 days after the policy period expired. The insurer issued an employment practices liability policy to its insured for a July 2014 to July 2015 policy period. The policy provided that the insured "shall, as a condition precedent to the obligations of the Insurer under this Policy, give written notice to the Insurer, at the physical or email address indicated in Item 7. of the Declarations, of a Claim made against an Insured as soon as practicable.... [I]n no event shall such notice of any Claim be provided to the Insurer later than ninety (90) days after the end of the Policy Period...." During the policy period, two professors submitted Notices of Charges of Discrimination related to their employment at the university. On September 2, 2015, the professors brought employment-related claims against the university in Kentucky state court. On October 2, 2015, three days after the extended reporting period expired, the insured notified the insurer of the litigation and the insurer denied coverage. The court reasoned that the notice-prejudice rule should not apply to a claims-made-and-reported policy with unambiguous notice requirements. Therefore, the court held that because the insured failed to comply with the notice requirements, the insurer was entitled to deny coverage for the professors' employment claims.

President and Fellows of Harvard College v. Zurich Amer. Ins. Co., 77 F.4th 33 (1st Cir. 2023) (applying Massachusetts law)

Under Massachusetts law, the U.S. Court of Appeals for the First Circuit affirmed the trial court's order granting an excess insurer's motion for summary judgment, holding that the insured failed to provide the insurer with timely notice of the underlying action. The insurer issued a claims-made excess liability policy to the insured for the policy period of November 2014 to November 2015. The policy required that the insured provide notice no later than the expiration of a reporting period. In November 2014, a group sued Harvard in federal court, claiming that Harvard violated Title VI of the Civil Rights Act of 1964. Although Harvard timely notified the primary carrier of the suit, the insured neglected to notify the excess insurer until May 2017, which was outside the reporting period. The court rejected the insured's notice-prejudice arguments, stating that applying a notice-prejudice rule would impermissibly collapse the "critical distinction ... between occurrence-based and claims-made policies." The court concluded that the insured's failure to provide timely written notice under the excess policy resulted in a forfeiture of coverage.

***Stormo v. State Nat'l Ins. Co.*, No. 19-10034-FDS, 2023 U.S. Dist. LEXIS 149899, 2023 WL 5515823 (D. Mass. Aug. 25, 2023), *appeal filed*, No. 23-1792 (1st Cir. Sept. 26, 2023)**

Under Massachusetts law, the U.S. District Court for the District of Massachusetts held that an insurer was entitled to judgment notwithstanding the verdict because the insured's "notice to the insurer of the malpractice action was too late," and therefore, "the policy d[id] not provide coverage." The insurer had issued a claims-made legal malpractice policy to its insured, who assigned his rights under the policy to the plaintiff. The policy covered claims "made … during the [Policy Period]" and provided that "[i]f a [Claim] is made against any [Insured], the [Insured] must give prompt written notice to the Company," but that "breach of this condition shall not result in a denial of coverage with respect to any [Insured] who had no knowledge of the [Claim]." The insured's conduct had caused a real-estate sale between the plaintiff and a third-party to fail to close and, as a result, the plaintiff sued the insured for malpractice. The insured did not report the malpractice action against him to the insurer for almost 14 months, and the insurer accordingly denied coverage. Although the jury in the coverage action found in favor of the plaintiff, the court entered judgment notwithstanding the verdict. The court noted that the insured had not provided notice promptly, as required by the policy. Thus, because Massachusetts law does not require a showing of prejudice in claims-made policies, the court ruled in favor of the insurer.

***Maple Manor Rehab. Ctr., LLC v. Evanston Ins. Co.*, No. 359147, 2023 Mich. App. LEXIS 3036, 2023 WL 3131930 (Mich. Ct. App. Apr. 27, 2023)**

Under Michigan law, the Court of Appeals of Michigan affirmed a trial court's grant of summary judgment in favor of an insurer on the ground that the insured failed to comply with the policy's notice provision. The insurer issued a claims-made medical professionals liability insurance policy to its insured, a rehabilitation center, for the December 10, 2016 to December 10, 2017 policy period. After a former patient's son filed a wrongful death lawsuit against the insured on July 20, 2017, the insured defended the lawsuit itself and did not notify the insurer until June 7, 2019. The insurer denied coverage based on late notice, arguing that the insured had not provided notice "as soon as practicable" as required by the policy. The court first held that the phrase "as soon as practicable" was unambiguous and then held that a two-year delay in notification was unreasonable. Finally, the court held that the notice-prejudice rule did not apply to claims-made policies.

***Evanston Ins. Co. v. Rodriguez Engineering Laboratories*, No. 1:21-cv-01129-RP, 2023 U.S. Dist. LEXIS 128517, 2023 WL 1788541 (W.D. Tex. Feb. 6, 2023), *report of magistrate adopted*, 2023 WL 4539850 (Feb. 21, 2023)**

Under Texas law, the U.S. District Court for the Western District of Texas granted the insurer's motion for summary judgment, finding that the insured failed to comply with the policy's notice provisions. The insured engineering firm was issued excess professional liability errors and omissions policies for the 2016-2017 and 2017-2018 policy periods. The excess policies contained their own notice and reporting provisions, requiring that "[n]otice to the insurer shall be given at the respective address shown in Item 5 of the Declarations. Any notice to the insurer of Underlying Insurance shall not constitute notice to the Insurer unless also given to the Insurer as provided above." In September 2016, the insured received notice of a claim from a construction firm. The insured requested that its broker provide notice on its behalf. The broker provided notice to the primary carrier but did not provide it to the excess insurer. The excess insurer did not receive notice until February 2020 and denied coverage under the first excess policy for late notice and under the second excess policy for late notice and based on a prior knowledge exclusion. The court found that the insured had failed to comply with the notice provision in the excess policies and rejected the insured's argument that the excess insurer was on constructive notice based on the insurer's relationship with the broker.

II. Related Claims

FCE Benefit Administrators, Inc. v. Indian Harbor Ins. Co., No. 22-15484, 2023 U.S. App. LEXIS 2736, 2023 WL 1501634 (9th Cir. Feb. 3, 2023) (applying California law)

Applying California law, the U.S. Court of Appeals for the Ninth Circuit held that a single $3 million per claim limit applied to multiple claims asserted against the insured in the same arbitration proceeding. The insured's professional liability policy included two limits of liability: (1) a $3 million per claim limit applicable to claims arising from acts or omissions committed before June 6, 2017; and (2) a $5 million per claim limit applicable to claims arising from acts or omissions committed after June 6, 2017. The policy's related claims provision further provided that "[t]wo or more claims arising out of the same or related facts, circumstances, situations, transactions or events, or arising out of the same or related acts or omissions" would be treated as a single claim. In the underlying arbitration proceeding, two companies asserted separate claims against the insured based on its alleged mismanagement of group health plans. The court, looking to the broad language of the policy, held that the claims were related and, because the earliest act in the claims dated back to 2014, that the policy's $3 million per claim limit applied. Moreover, because the insurer contributed amounts exceeding the $3 million per claim limit to effectuate the settlement, the court held that the insurer was entitled to reimbursement from the insured.

Triyar Hosp. Mgmt., LLC v. QBE Specialty Ins. Co., No. 2:21-CV-04474-SSS-SKx, 2023 U.S. Dist. LEXIS 38883, 2023 WL 2372049 (C.D. Cal. Jan. 17, 2023)

Applying California law, the U.S. District Court for the Central District of California determined that a judgment entered against co-owners of an LLC related back to an earlier judgment that was reported in an untimely fashion. The insured LLC was issued a directors and officers liability policy that covered loss the company was required to pay on behalf of its officers, managers, and "functionally equivalent" executives as indemnification. In 2014, the insured brought suit against its contractual partner in connection with the sale and purchase of a hotel. The trial court entered judgment against the insured and, pursuant to the parties' contractual fee-shifting provision, awarded $2.1 million in fees and costs to the other entity in February 2017. The insured failed to pay the February 2017 judgment and did not notify its insurer. Then, in September 2019, the court amended the February 2017 judgment to provide that the insured's co-owners, the Yaris, were personally liable for the judgment as "alter egos" of the company. The insured indemnified the Yaris for the judgment and sought coverage under Side B of the policy. The court, after finding that both the 2017 and 2019 judgments constituted "Claims" within the meaning of the policy, held that the claims were clearly related because the 2019 judgment simply amended the 2017 judgment to add the Yaris as debtors. Accordingly, because the insured failed to provide timely notice of the 2017 judgment, notice of the 2019 judgment was also untimely as both constituted a single claim. Nevertheless, because the court construed the policy as providing pure "claims-made" coverage rather than "claims-made-and-reported" coverage, the insurer was required to demonstrate substantial prejudice from the insured's late notice, an issue that could not be adjudicated based on the cross-motions for summary judgment.

Gilderman v. Argonaut Ins. Co., No. 223-CV-01399-JLS-AGR, 2023 U.S. Dist. LEXIS 153911, 2023 WL 5506019 (C.D. Cal. July 10, 2023)

Applying California law, the U.S. District Court for the Central District of California held that alleged wrongful acts committed by the insured in his capacity as trustee did not relate back to earlier alleged wrongful acts. The insured was issued a professional liability policy that provided claims-made-and-reported coverage. In January 2020, during the policy period, a beneficiary of the trust, MG, filed a petition asserting that the insured had exercised undue influence over the grantor to secure his appointment as trustee and, after his appointment, committed self-dealing transactions. The insurer denied coverage because, among

other reasons, the alleged self-dealing occurred through a series of related wrongful acts that commenced prior to the policy's retroactive date. After the policy period ended, three more actions were filed by individuals involved in the trust that alleged wrongful acts by the insured in his capacity as trustee postdating the retroactive date. The district court denied the insurer's motion for judgment on the pleadings. With respect to the first underlying petition, the court found that the insurer had not demonstrated a series of related wrongful acts that commenced prior to the retroactive date. Characterizing this inquiry as a "fact-intensive" one, the court explained that the insured's actions as trustee predating the retroactive date were not necessarily portrayed as wrongful acts in the petition and instead appeared to constitute background information that was not directly connected to the later self-dealing transactions. Next, with respect to the actions asserted after the policy period, the court found that the insurer could not show that the later-asserted claims did not relate back to the first petition, because they alleged related wrongful acts and therefore may have constituted a single claim first made during the policy period.

Nat'l Ass'n of Television Program Executives, Inc. v. Navigators Ins. Co., No. 2:23-CV-01805-RGK-AS, 2023 U.S. Dist. LEXIS 189141, 2023 WL 6881900 (C.D. Cal. July 11, 2023)

Under California law, the U.S. District Court for the Central District of California held that a letter threatening additional litigation related back to an earlier claim which was not timely reported. The insured company was issued a directors and officers liability policy that required written notice of any claim within 90 days. In February 2022, a hotel with whom the insured company contracted to host two events filed an arbitration demand against the company for canceling the events and breaching a settlement agreement negotiated in connection with the cancellations. Then, in May 2022, the hotel sent the insured a letter which presaged that additional claims would be asserted against the insured's directors and officers in the underlying arbitration for allegedly acting fraudulently and in bad faith. The insured reported the May 2022 letter to its insurer, which denied coverage because the potential claim related back to the February 2022 arbitration demand. The district court agreed and explained that the claims were related because they both arose from the breach of the same agreements and resulted in the same injury to the hotel. Accordingly, the court granted the insurer's motion to dismiss the insured's coverage action because the claims arose from the same transactions and events and were not timely reported.

Nat'l Amusements, Inc. v. Endurance Am. Specialty Ins. Co., No. N22C-06-018 AML CCLD, 2023 Del. Super. LEXIS 211, *2023* WL 3145914 (Del. Super. Ct. Apr. 28, 2023)

Under Delaware law, the Superior Court of Delaware denied several insureds' motion to dismiss their insurers' counterclaims for declaratory relief. The plaintiffs were insured under a tower of directors and officers liability policies. The dispute between the parties arose from the merger of CBS and Viacom in 2019, a transaction that spawned two shareholder lawsuits alleging the consideration paid by CBS to acquire Viacom was improper. The primary and excess insurers denied coverage for the 2019 merger lawsuits, taking the position that those actions arose from interrelated wrongful acts first asserted in several lawsuits against Shari Redstone that occurred before the relevant policy period. In those lawsuits, Redstone was alleged to have manipulated her father to consolidate control over his assets, including CBS and Viacom, by replacing independent directors with her own hand-picked loyalists. The Superior Court, although noting "substantial differences" between the lawsuits, agreed that the insurers' contentions were sufficient to survive the insureds' motion to dismiss. Specifically, the court explained that the record was not fully developed as to the allegations asserted in the 2019 merger lawsuits and the insureds had arguably taken an inconsistent position in the prior lawsuits as to the relatedness of any claims which arose from Redstone's conduct alleged therein. Troutman Pepper represented one of the excess insurers in this case.

PNI Litig. Tr. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa., No. 21-21416-CIV, 2023 U.S. Dist. LEXIS 25672, 2023 WL *2528942* (S.D. Fla. Feb. 14, 2023)

Applying Florida law, the U.S. District Court for the Southern District of Florida held that several claims arising from the same course of conduct were related. The insured company was issued consecutive directors and officers liability policies (as well as excess policies which generally followed form thereto) for the 2016-2017 and 2017-2018 policy periods. In 2016, Wasik, a shareholder, filed a class action lawsuit asserting that the insured's CEO, Mariano, had unjustly enriched himself through self-dealing transactions, which were rubber-stamped by a board that Mariano controlled. The insurers accepted coverage for the Wasik action under the 2016-2017 primary and excess policies. Thereafter, the insured filed for bankruptcy and certain derivative claims asserted in the Wasik action became the property of a trust created pursuant to a reorganization plan. The trust, after securing severance of the derivative claims, asserted a demand for coverage under the 2017-2018 primary and excess policies. The insurer denied coverage, taking the position that the claims asserted by the trust in the severed action were related to the claims still pending in the Wasik action and thus dated back to the 2016-2017 policy period. The district court agreed, rejecting the trust's argument that claims must be "interdependent" to be related. Instead, the court explained that the claims need only be factually or logically connected, a standard that was easily satisfied because the claims all arose from the same course of conduct by Mariano and the board. Although the trust's claims contained additional allegations of wrongful conduct occurring in 2017, those actions simply formed continuations of the same scheme by Mariano to enrich himself with the company's assets. Accordingly, the claims were related, and coverage was only available under the 2016-2017 primary and excess policies.

RLI Ins. Co. v. OutsideIn Architecture, LLC, No. 8:20-CV-2395-CEH-AEP, 2023 U.S. Dist. LEXIS 160568, 2023 WL 5840590 (M.D. Fla. Sept. 11, 2023)

Under Florida law, the U.S. District Court for the Middle District of Florida held that an insurer could not deny coverage on the basis that a wrongful death claim asserted against the insured was related to an earlier claim predating the policy period. The insured's professional liability policy covered negligent acts arising out of the course of the insured's architectural services. The claims at issue arose from a construction project that the insured contracted to oversee as the lead architect. As part of the project, a subcontractor, IG, agreed to assist with site supervision and developing the proper plans and permits. The insured terminated the agreement, and IG sent a demand letter requesting damages. That same day, during demolition operations on the construction project, a worksite employee fell to his death and the employee's estate later asserted a wrongful death claim against the insured. The insurer denied coverage for the claim, contending, among other things, that coverage was barred because the wrongful death claim was related to the earlier IG demand letter and thus predated the policy period. The district court disagreed, finding that the claims lacked a "sufficient factual nexus" to be related, because (according to the court), the claims arose from fundamentally different wrongful acts involving a contractual dispute on the one hand and allegations of negligence in supervising the demolition operations on the other, despite arising from the same construction project.

Lloyd's Syndicate 3624 (Hiscox) v. Clow, No. 19 C 6405, 2023 U.S. Dist. LEXIS 46293, 2023 WL 2572424 (N.D. Ill. Mar. 20, 2023)

Under Illinois law, the U.S. District Court for the Northern District of Illinois found that an insurer did not have a duty to defend its insureds against breach of fiduciary duty and fraud claims. The insurer issued a series of claims-made professional liability policies to the insureds that covered loss arising from certain negligent acts in the insureds'

capacities as trustees. As part of their duties in managing a trust, the insureds sold a parcel of property that allegedly contained contaminants that the insureds failed to disclose. The individual who purchased the property sued the insureds and the insurer denied coverage because the insureds failed to provide timely notice. Thereafter, certain beneficiaries of the trust intervened in the same lawsuit and asserted cross claims against the insureds for allegedly negotiating an impermissible reduction in the purchase price of the same property. The insurer took the position that the cross claims were related to the buyer's original claim and that coverage was therefore barred due to untimely notice. The district court agreed. Looking to the plain language of the policy's related claims provision — which provided that claims were related if they were "based upon, arise out of, or allege … [a] common fact, circumstance, situation, event, service, transaction, cause, or origin"— the court found that the beneficiaries' claims and the buyer's claim were clearly related because they arose from the same transaction: the sale of the property. Accordingly, the beneficiaries' cross claims dated back to the time of the buyer's original claim and the insurer had no duty to defend because the insureds failed to provide timely notice of the claim.

Atl. Specialty Ins. Co. v. Blue Cross & Blue Shield of Kansas, Inc., No. 18-2371-DDC-ADM, 2023 U.S. Dist. LEXIS 51987, 2023 WL 2648223, (D. Kan. Mar. 27, 2023), *appeal filed* (10th Cir.)

Under Kansas law, the U.S. District Court for the District of Kansas held that no coverage was available for claims asserted in a multidistrict litigation proceeding because they were related to earlier claims predating the policy period. The insured company was issued a directors and officers liability policy that covered certain antitrust claims against the company. In 2012, during the policy period, the insured was sued in several class action lawsuits, which were later consolidated into a multi-district litigation (MDL) before the U.S. District Court for the Northern District of Alabama. The lawsuits alleged the insured leveraged its market power to stifle competition, increase health care costs to consumers, and decrease compensation for providers. Years prior, health care providers in Florida brought a class action lawsuit, the Love litigation, against the insured raising similar allegations that the insured wielded its market dominance to deny reimbursements to which participating health care providers were entitled. The court, applying the plain language of the policy, concluded that the MDL action and the Love litigation were based upon, arose out of, directly or indirectly resulted from, or were in consequence of the same or related facts and thus constituted a single claim predating the 2012 policy period. That standard was satisfied because both the MDL action and the Love litigation alleged the insured conspired with related Blue Cross entities to fix prices, divide the relevant markets, refrain from competition, and underpay providers. Accordingly, the claims were related and the insurer properly denied coverage.

Aaron v. Illinois Nat'l Ins. Co., No. 20-1253, 2023 U.S. Dist. LEXIS 94255, 2023 WL 7385804 (E.D. La. Nov. 8, 2023)

Under Louisiana law, the U.S. District Court for the Eastern District of Louisiana found that claims asserted by the Federal Deposit Insurance Corporation (FDIC) as receiver for the insured were not related to prior claims. The insured, a bank, was issued a tower of claims-made directors and officers liability insurance for the 2017 policy period. During the policy period, the FDIC, as receiver for the insured bank, asserted claims against the insured's CEO and board of directors for gross negligence in approving certain loans. The 2017 primary and excess insurers denied coverage because, among other reasons, the FDIC's claims were related to earlier claims asserted against the CEO and director defendants and therefore constituted a single claim predating the policy period. The district court disagreed, reasoning that the policy language — which provided that multiple claims would be considered related if they arose out of, were based upon, or were attributable to the same facts or series of related facts — required at least a "but for" causal relationship. Applying that standard, the court found that there was no causal connection between the prior claims and the FDIC's claims because, among other things, the prior claims either (1) involved entirely separate loan approvals that constituted independent business decisions, or (2)

generally alleged breaches of duty or misconduct that did not identify the approval of specific loans as wrongful acts. Accordingly, the court held that coverage was not precluded by the policies' related claims provisions and granted partial summary judgment in favor of the FDIC on that issue.

Quality Health Plans of New York Inc. v. Ironshore *Specialty Insurance Company*, No. CV 20-3563 (JS)(AYS), 2023 WL 2970089, 2023 U.S. Dist. LEXIS 32453 (E.D.N.Y. Feb. 27, 2023)

Under New York law, the U.S. District Court for the Eastern District of New York, in a case where Troutman Pepper represented the insurer, granted the insurer's motion for judgment on the pleadings because, among other things, a lawsuit was related to another lawsuit made in a prior policy period, and thus was not covered by the policy. The 2019 managed care organization directors and officers policy provided that "[a]ll Claims that constitute Related Claims … shall be deemed to be a single Claim" and defined related claims to mean "all claims for Wrongful Acts based on, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving the same or related facts, circumstances, situations, transactions or events, whether related logically, causally or in any other way…" A third party filed two lawsuits against the insured — one in 2019 and one in 2020. The court found that in light of established New York law, the Related Claims Provision was unambiguous and that the two actions were related. To reach the latter conclusion, the court engaged in a "side-by-side review of the underlying claims," explaining that "the claims all arise out of the allegation that [the insured] failed to pay Northwell for health care rendered to [the insured's] members. The underlying facts alleged in the Northwell Actions are the same, as is the precise amount alleged to be owed to Northwell." The court rejected the insured's arguments that different legal theories and different named parties preclude a finding of relatedness, explaining that "[h]ere, as in other cases applying related claims provisions, the critical question is not the legal theories alleged, but whether the claims arise out of a single or related set of Wrongful Acts. They do."

Pine Mgmt. Inc. v. Colony Ins. Co., 1:22-cv-02407 (MKV), 2023 WL 2575082, 2023 U.S. Dist. LEXIS 46854 (S.D.N.Y. Mar. 20, 2023)

Under New York law, the U.S. District Court for the Southern District of New York granted the insurer's motion for judgment on the pleadings because the underlying lawsuit was related to a claim made before the policy incepted. The insured real estate management and development company sought coverage under a professional liability policy. The policy deemed each wrongful act in a series of related wrongful acts to have occurred on the date of the first such wrongful act. Before the policy period, the insured received a letter advising of claims against it related to the insured's management, alleging breach of contract and breach of fiduciary duties. During the policy period, the insured was sued in a lawsuit alleging, *inter alia*, breach of contract and breach of fiduciary duties. The insurer denied coverage for the lawsuit on the basis that the pre-policy period letter and the lawsuit constituted a single claim made before the policy incepted. To determine whether the claims were related, the court analyzed "whether the underlying claims are based upon, arising from, or in consequence of the same or related facts, circumstances, situations, transactions or events or the same or related series of facts, circumstances, situations, transactions or events." The court, agreeing with the insurer, held that the pre-policy period letter and the lawsuit constituted a single claim because they alleged related conduct.

Am. Sw. Mortg. Corp. v. Cont'l Cas. Co., 84 F.4th 910 (10th Cir. 2023) (applying Oklahoma law)

Under Oklahoma law, the U. S. Court of Appeals for the Tenth Circuit held that claims for negligently prepared annual audit reports constituted interrelated claims because they arose out of interrelated acts and thus were a single claim subject to a single per-claim limit of liability. The professional liability policy provided a $1 million per claim limit of liability and provided that "interrelated claims" were considered one "claim" subject to one per-claim limit of liability. "Interrelated claims"

was defined as "all claims arising out of a single act or omission or arising out of interrelated acts or omissions in the rendering of professional services" and "[i]nterrelated acts or omissions" was defined as "all acts or omissions in the rendering of professional services that are logically or causally connected by any common fact, circumstance, situation, transaction, event, advice or decision." When preparing three subsequent years of annual audit reports of a mortgage company, the insured auditor failed to detect or report the mortgage company's fraud. In reliance on the audit reports, certain lenders loaned money to the mortgage company and ultimately lost millions of dollars. The lenders then sued the insured auditor. In the coverage action, the Tenth Circuit held that the reports were "logically connected by common facts and circumstances relating to the Auditor's negligence." The court found there was a clear logical connection because there was one auditor who performed the same service for the same clients three times while making the same error which perpetuated the same fraud scheme — regardless of the quantity of claimants.

III. Prior Knowledge, Known Loss, and Rescission

***Woodbridge Liquidation Tr. v. Certain Underwriters at Lloyd's of London*, No. B312870, 2023 Cal. App. Unpub. LEXIS 2261, 2023 WL 2998659 (Cal. Ct. App. Apr. 19, 2023)**

Applying California law, the California Court of Appeal affirmed a trial court's decision holding that a group of insurance underwriters that issued or subscribed to a commercial lender placed/real estate owned insurance policy were entitled to rescind the policy based on the insured's failure to disclose that it was an integral part of a billion-dollar Ponzi scheme and misrepresented itself as a legitimate commercial lender. The insured sued the underwriters to pursue a $3.5 million unpaid claim for fire loss at a residence in Maui, HI that was one of the properties covered by the policy. The underwriters moved for summary judgment, arguing that the policy was void *ab initio* due to material misrepresentations and concealments made by the primary named insured in its application for the policy. The trial court agreed and held that rescission was warranted because (1) it was undisputed that, at the time the primary named insured applied for the policy, it and its affiliates, including the other insureds under the policy, were actively engaged in a criminal investment fraud scheme in connection with which the scheme's participants sold innocent investors interests in sham real estate loans; and (2) it was also undisputed that, in the primary insured's application for the policy, it did not disclose that fact and represented that it was a legitimate hard money commercial lending business when it was not. On appeal, the California Court of Appeal affirmed, concluding that the underwriters were entitled to rescind the policy pursuant to sections 331 and 359 of the California Insurance Code. In doing so, the appellate court held that a "misrepresentation or concealment is material if a truthful statement would have affected the insurer's underwriting decision." The court then stated that it "[could not] imagine how an insured's active participation in an ongoing criminal enterprise by selling duped investors interests in sham real estate loans could not directly have affected an insurer's decision to issue it any type of policy, much less one designed to provide coverage for commercial lenders' lending portfolios." The court added that, although "that information might not bear directly on the risk of fire or damage to the properties proposed to be insured," "it would be very relevant to whether the insurer would want to enter a contractual relationship with the insured at all," as "[a]mong other things, an insured's involvement in criminal fraud — even if that fraud did not directly affect the insured risk — bears directly on the risk of the insured submitting a fraudulent insurance claim or not paying its premium or embroiling the insurer in the insured's criminality."

Evanston Ins. Co. v. Footprints Behav. Interventions, Inc., No. SACV 20-682 JVS (KESx), 2023 U.S. Dist. LEXIS 91227, 2023 WL 4317198 (C.D. Cal. May 24, 2023), appeal docketed, No. 23-55706 (9th Cir. Aug. 10, 2023)

Applying California law, the U.S. District Court for the Central District of California granted summary judgment in favor of an insurer, rescinding a Specified Medical Professions insurance policy. The policy provided that "[p]rior to the effective date of this policy the Insured had no knowledge of such act, error or omission or any fact, circumstance, situation or incident which may lead a reasonable person in the Insured's position to conclude that a Claim was likely." In November 2017, the insured terminated an employee following allegations of sexual misconduct. In February 2019, four employees of the insureds testified at the former employee's criminal trial and several months later, the insured submitted an application for the policy. In November 2019, the insured was served with a lawsuit relating to the former employee's conduct, which the insured tendered to the insurer, and in March 2020, the insurer disclaimed coverage. The court ruled in favor of the insurer because the insured had knowledge of a circumstance that may lead a reasonable person in the insured's position to conclude that a claim was likely.

Certain Underwriters at Lloyd's, London v. Anchor Ins. Holdings, No. 8:21-cv-370-TPB-AEP, 2022 U.S. Dist. LEXIS 227925, 2022 WL 17776547 (M.D. Fla. Dec. 19, 2022)

Applying Florida law, the U.S. District Court for the Middle District of Florida held that a professionally liability policy could be rescinded by an insurer. The insurer sued the insured based on misrepresentations made in the application. The application had asked whether there were "any pending claim(s)" against the insured or any director, officer, or employee, and whether the insured or any director, officer, or employee knew "of any act, error or omissions, which could give rise to" a claim or suit," and the insured answered "no" to both questions. Granting summary judgment in favor of the insurer, the court ruled that the record was clear that at the time of the application, the insured had actual knowledge of potential claims against it by investors including a claim for rescission of the investment. This was based, in part, on acknowledgments by directors and officers of the insured that certain investors had demanded their money back and sent a demand letter regarding the same. The court rejected the insured's arguments that the demands were made not to the named insured but to related single-purpose investment entities, finding that no reasonable jury could find that the company's corporate structure made the insured's response to the application questions true. The court further ruled that for the application to be "complete, true, or correct," the claims should have been disclosed even if the potential claims were meritless.

RLI Ins. Co. v. OutsideIn Architecture LLC, No. 8:20-cv-2395-CEH-AEP, 2023 U.S. Dist. LEXIS 160568, 2023 WL 5840590 (M.D. Fla. Sept. 11, 2023)

Applying Florida law, the U.S. District Court for the Middle District of Florida held that misrepresentations in the application barred coverage. The insurer issued a professional liability policy to the insured architect for the March 2020 to March 2021 policy period. The insured sought coverage after being sued for wrongful death in connection with a workplace accident in June 2019. The insurer argued that the insured knew of the death and could have reasonably expected that it would give rise to a claim. The insured argued that it could not have reasonably expected the death would lead to a claim against the insured because it had no contractual or legal duties related to the demolition portion of the project that was being performed at the time and was never contacted regarding the accident. The application asked whether the insured was "aware" of any "act, error, omission or circumstance which may possibly result in a claim being made against them." The court held that the subjective requirement of "may possibly result in a claim" was a "low bar" that required the insured to disclose information relating to the death at the construction site. The court also addressed

the policy's prior knowledge exclusion, but held that it did not bar coverage because the exclusion did not include the term "alleged" and would only apply if there were "actual negligent acts, errors, or omissions."

Call One Inc. v. Berkley Ins. Co., 655 F. Supp. 3d 733 (N.D. Ill. 2023)

Applying Illinois law, the U.S. District Court for the Northern District of Illinois held that each insurance policy is a new contract and that an insurer could not rescind a later policy based on misrepresentations in a prior policy application, but the court ultimately denied the insured's motion to dismiss based on a potential misrepresentation in the relevant application. The insured telecom company sued its insurer for its refusal to pay the insured's defense costs and denial of coverage under its professional liability policy. The insurer counterclaimed for rescission based on misrepresentations in the application. As an initial matter, the court agreed with the insured that because each policy is a new contract, the insurer could not rescind the policy based on misrepresentations in earlier policy applications. Nonetheless, the court found that an omission in an unanswered question could constitute a "misrepresentation." Accordingly, the court ruled that the insurer had sufficiently alleged misrepresentation with actual intent to deceive.

Aspen Am. Ins. Co. v. MF Acquisition Inc., No. 1:21-cv-738, 2023 U.S. Dist. LEXIS 197279, 2023 WL 7162569 (W.D. Mich. Sept. 28, 2023)

Applying Michigan law, the U.S. District Court for the Western District of Michigan rescinded an insured's policy on the basis of misrepresentations in the application. At issue was an errors and omissions policy held by an insurance agency that had placed coverage for a gas station owner. The application asked whether the agency was aware of "any fact, circumstance, or situation that might result in any professional liability claim or suit," to which the insured replied "no." During the policy period, the gas station owner filed suit against its insurance agency for failure to place renewal coverage. The agency tendered to its insurer, which defended the agency subject to a reservation of rights. In a coverage action, the court held that the insured agency knew that the underlying gas station owner wanted to renew its policies but that its renewal was ineffective because it was submitted after the renewal deadline. The court found the record "replete" with evidence that the insured agency's failure to obtain a renewal for the gas station created a litigation risk. The insurer also provided an affidavit saying that the application would have been rejected if the insured agency had answered truthfully. Accordingly, the court allowed the insurer to rescind the policy.

Evanston Ins. Co. v. Desert State Life Mgmt., 56 F.4th 899 (10th Cir. 2022) (applying New Mexico law)

Applying New Mexico law, the U.S. Court of Appeals for the Tenth Circuit upheld a trial court order denying as untimely an insurer's attempt to rescind the insured's professional liability policy. The insured had applied for the policy in October 2016, answering "no" to the question whether the applicant or "any principal, partner, owner, officer, director … Or any person(s) or organization(s) proposed for this insurance [is] aware of any fact, circumstance, situation, incident or allegation of negligence or wrongdoing, which might afford grounds for any claim such as would fall under th[e] proposed insurance?" The insured was sued in mid-2017 in a class action alleging embezzlement by the insured's CEO, and the insurer defended and filed a declaratory relief action seeking rescission and declaratory relief to cease defense of the class action. The circuit court upheld the trial court's ruling that rescission was not permitted because the rescission action was untimely. Interpreting New Mexico law on rescission, which requires "immediate" action, the court highlighted that the insurer was aware of the misrepresentations in the application in March of 2017, but did not attempt to rescind until June of 2018. The court found that the insurer faced few obstacles in rescinding the policy, the information in the insurer's December 2017 reservation of rights letter was sufficient to rescind, and the five-month delay following that reservation of rights letter was sufficient to hold, and "common sense" dictated, that the rescission was too late.

Allied World Assur. Co. (U.S.) Inc. v. Golenbock Eiseman Assor Bell & Peskoe, LLP, No. 653762/2022, 2023 N.Y. Misc. LEXIS 12071, 2023 WL 7106431 (N.Y. Sup. Ct. Oct. 27, 2023)

Applying New York law, a New York state trial court held that a prior knowledge condition in a lawyer's professional liability insurance policy barred coverage for an underlying malpractice lawsuit. The policy at issue included a "No Prior Knowledge" provision that provided coverage only if "prior to August 1, 2019 no Insured had any basis (1) to believe that any Insured had breached a professional duty; or (2) to foresee that any fact, circumstance, situation, transaction, event, or Wrongful Act might reasonably be expected to be the basis of a Claim against any Insured…" In 2018, the insured and a client entered into a tolling agreement regarding possible claims. Four years later, the client sued the insured, alleging that the insured had committed legal malpractice. In a coverage action, the court found the No Prior Knowledge provision was not satisfied based on its application of the two-prong "subjective/objective" knowledge test. The court found that the insured's "subjective knowledge of circumstances relevant to a potential claim" prior to August 1, 2019 could not have "reasonably [been] disputed" in light of the tolling agreement; and then further concluded based on the 2018 tolling agreement that "[a] reasonable attorney" would have inferred that the underlying plaintiff "had a legal malpractice claim [against the insured] in mind" prior to August 1, 2019. Based on the foregoing, the court determined that the "No Prior Knowledge" condition precedent to coverage under the policy was violated and, therefore, the policy did not provide coverage.

SHH Holdings, LLC v. Allied World Specialty Ins. Co., 65 F.4th 830 (6th Cir. 2023) (applying Ohio law)

Applying Ohio law, the U.S. Court of Appeals for the Sixth Circuit held that disclosure requirements in an insurance application were not ambiguous. The insured nursing home facility sued its directors and officers insurer after the insurer declined coverage for an employee retaliation claim. The Sixth Circuit held that the insured had failed to disclose material information on its application. The application included a question asking the insured to "provide full details of all inquiries, investigations, administrative charges, claims, and lawsuits filed within the last three (3) years…" and a question asking the insured to identify whether the insured or "any Subsidiary, any Executive or other entity proposed for coverage kn[ew] of any act, error or omission which could give rise to a claim…" The insured answered "no" to both. The application also contained an "application exclusion" incorporated into the policy that stated that if inquiries, investigations or other actions exist, then coverage for such matters is excluded. The insured completed the application in April 2019, two years after receiving a demand from the U.S. Department of Justice. The parties disputed what types of "administrative charges, claims, and lawsuits" would need to be disclosed. While the insured argued the application was overbroad in what it required to be disclosed, the Sixth Circuit found that such broad language did not make it ambiguous and held that the demand should have been disclosed and therefore coverage for the demand was excluded.

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

Nat'l Amusements, Inc. v. Endurance Am. Specialty Ins. Co., No. N22C-06-018 AML CCLD, 2023 Del. Super. LEXIS 211, 2023 WL 3145914 (Del. Super Ct. Apr. 28, 2023)

Under Delaware law, the Delaware Superior Court granted the insureds' motion to dismiss and to strike as to the insurers' counterclaims and affirmative defenses based on the policies' prior notice exclusions. The insureds were issued a tower of directors and officers liability insurance under which they sought coverage for litigation challenging the fairness of a merger between two companies controlled by the insured. The court determined that the insureds notified their previous directors and officers liability insurance program only after the insurers had denied coverage for the merger pricing litigation under the current directors and officers liability insurance program. Because the notice was

not given before the inception date and because coverage was not accepted as a result of any such pre-inception date notice, the court held that the plain language of the prior notice exclusion did not apply to the facts of the case.

RLI Ins. Co. v. OutsideIn Architecture LLC, No: 8:20-cv-2395-CEH-AEP, 2023 U.S. Dist. LEXIS 160568, 2023 WL 5840590 (M.D. Fla. Sept. 11, 2023)

Under Florida law, the U.S. District Court for the Middle District of Florida held that an insurer could not rely on a prior notice exclusion to bar coverage. The insured's professional liability policy covered negligent acts arising out of the course of the insured's architectural services. The claims at issue arose from a construction project that the insured contracted to oversee as the lead architect. As part of the project, a subcontractor, IG, agreed to assist with site supervision and developing the proper plans and permits. The insured terminated the agreement, and IG sent a demand letter requesting damages. That same day, during demolition operations on the construction project, a worksite employee fell to his death and the employee's estate later asserted a wrongful death claim against the insured. The insurer denied coverage for the claim, contending, among other things, that coverage was barred because the wrongful death claim was related to the earlier IG demand letter and thus predated the policy period. The court rejected the insurer's contention that the policy's prior notice provision barred coverage for the lawsuit, because (according to the court) the lawsuit did not relate back to the June 10, 2019 demand letter. The court reasoned that although the claims arose from the same event and a similar time period, they involved different causes of action, legal duties, damages, and alleged victims.

Bigelow v. Great Am. Ins. Co., Case No. 22-cv-00545-DKW-KJM, 2023 U.S. Dist. LEXIS 70093, 2023 WL 3024089 (D. Haw. Apr. 20, 2023)

Under Hawaii law, the U.S. District Court for the District of Hawaii ruled in favor of an insurer on a motion to dismiss, holding that the insurer had no duty to indemnify because the "prior acts/notice/knowledge" exclusion barred coverage. The insurer issued a claims-made professional services policy for the January 7, 2021 to January 7, 2022 policy period. The policy included a "prior acts/notice/knowledge" exclusion which barred coverage for any claim "based upon or arising out of any actual or alleged breach of duty or negligent act, error, omission that" was committed before the retroactive date of January 7, 2021. The underlying action was filed on April 15, 2021, but nearly all of the alleged acts occurred prior to January 7, 2021. Thus, the court found coverage was barred under the "prior acts/notice/knowledge" exclusion.

Aaron v. Ill. Nat'l Ins. Co., No. 22-9 c/w 22-2070 c/w 20-1253 c/w 22-4518 c/w 19-10341 c/w 20-3189 c/w 23-5056, 2023 U.S. Dist. LEXIS 200444, 2023 WL 7385804 (E.D. La. Nov. 8, 2023)

Under Louisiana law, the U.S. District Court for the Eastern District of Louisiana granted the insured's motion for partial summary judgment and denied the insurers' motion for partial summary judgment with respect to a prior notice exclusion. The insurers issued a tower of directors and officers liability policies to the insured and argued that a notice of circumstances involving the approval of certain loans related to two sets of prior actions, but the court disagreed. First, the court held that the prior notice exclusion did not apply to notices of potential claims. Second, the court held that the notice of circumstances did not relate to a prior action brought by the Georgia insurance commissioner alleging that the insured used straw entities to prop up a client. Third, the court held that the notice of circumstances did not relate to prior shareholder lawsuits.

Nahant Pres. Trust, Inc. v. Mt. Vernon Fire Ins. Co., 78 F.4th 48 (1st Cir. 2023) (applying Massachusetts law)

Under Massachusetts law, the U.S. Court of Appeals for the First Circuit affirmed the district court's order granting the insurer's motion to dismiss based on a prior or pending litigation exclusion. From June 19, 2018 to June 19, 2022, the insured was issued nonprofit management liability insurance through a succession of four continuous annual claims-made policies. The insured was named in a lawsuit during the second policy period but did not notify the insurer until the fourth policy period. The insured argued the prior or pending litigation endorsement's language permitted excluding a claim only if a claim related to an action that was pending at the time of the inception of the earliest policy. The First Circuit rejected the insured's arguments, holding that the endorsement could not be interpreted as an after-the fact mechanism for expanding coverage through a reformation of the entire series of the policies. The court noted that holding otherwise would violate the core purpose of claims-made policies.

Crysknife Cap. v. Liberty Specialty Mkts., Case No. 22 Civ. 7912 (KPF), 2023 U.S. Dist. LEXIS 78524, 2023 WL 3255777 (S.D.N.Y. May 3, 2023)

Under New York law, the U.S. District Court for the Southern District of New York held that a prior litigation exclusion did not bar coverage under a directors, officers, and company liability policy. The exclusion barred coverage for any claim "based upon, arising out of, or attributable to any written demand or proceeding against any Insured which was made or pending on or before the applicable Prior Litigation Date set forth in the Coverage Schedule in Item IV(B) of the Declarations, or the same or substantially the same fact, circumstance or situation underlying or alleged therein[.]" The insurers contended the Prior Litigation Exclusion barred coverage for the operative underlying claim because the claim was "based upon, aris[es] out of, or [is] attributable to" certain demands, which had been made before the June 7, 2018 prior litigation cut-off date. The court, however, rejected this argument, reasoning that although the facts of the prior demands and litigations were relevant to the underlying action, the action concerned breach of an entirely separate guaranty and was premised on more than the demands. Therefore, the court found the prior litigation exclusion did not apply to bar coverage.

Green Tree Cmty. Health Found. v. Admiral Ins. Co., Case No. 22-2602, 2023 U.S. App. LEXIS 22007, 2023 WL 5378814 (3d Cir. Aug. 22, 2023) (applying Pennsylvania law)

Under Pennsylvania law, the U.S. Court of Appeals for the Third Circuit held that a prior acts exclusion barred coverage for claims previously reported to another insurer. In 2011, the insured purchased a hospital's charitable funds and acquired some of the hospital's liabilities and obtained a tail policy that provided coverage for medical malpractice claims that occurred at the hospital between March 1984 and March 2005 so long as the claim was first made against the insured and reported to the insurer. The policy also included a "Prior Acts" exclusion which barred coverage for "any Claim that was reported to any other insurer" before October 1, 2011. In 2019, a mother and her child sued several entities, including the hospital, for birth-related injuries sustained at the hospital in 2001. The insurer sought to bar coverage under the Prior Acts Exclusion because the 2019 lawsuit involved similar claims and allegations to a medical malpractice suit the mother brought against the hospital in 2002, which had been reported to the hospital's insurer at the time. The insured argued that the 2002 suit could not be a "claim" under the policy because the 2002 suit named only the hospital as a defendant and did not name the named insured as the 2002 suit existed before the named insured was formed. The court affirmed the district court's ruling, finding that the insured's argument disregarded the structure of the sale and that the policy was created to insure the insured against medical malpractice suits for what occurred at the hospital between 1984 and 2005.

V. Dishonesty and Personal Profit Exclusions

Parkside/El Centro Homeowners Ass'n v. Travelers Cas. Ins. Co. of Am., No. 3:20-CV-01732-JAH-DDL, 2023 U.S. Dist. LEXIS 54516, 2023 WL 2705834 (S.D. Cal. Mar. 29, 2023)

Under California law, the U.S. District Court for the Southern District of California held that coverage was not barred by a dishonesty exclusion or a personal profit exclusion under a directors and officers policy issued to the insured. The policy provided that "[t]his insurance does not apply to any claim: i. if judgment adverse to your "Directors" or "Officers," in "suit" brought against them, will establish that their affirmative dishonesty or actual intent to deceive or defraud was material to the cause of action so adjudicated." The policy further provided "[t]his insurance does not apply to any claim: g. due to an 'insured' gaining any personal profit or renumeration or advantage to which the 'insured' is not legally entitled." With regard to the dishonesty exclusion, the court held that because the underlying judgment arose from negligent conduct, the insurer could not satisfy the intent requirement of the exclusion. With regard to the personal profit exclusion, the court held that the phrase "due to" within the exclusion was ambiguous and that the underlying action did not establish illegal personal gain.

Primary Color Sys. Corp. v. Hiscox Ins. Co., Inc., 654 F. Supp. 3d 982 (C.D. Cal. 2023)

Under California law, the U.S. District Court for the Central District of California held that an employment liability policy did not provide coverage based upon an underlying finding of fraud. The Employment Practice Liability Coverage Part of the policy excluded coverage for any claim "arising out of, based upon or attributable to the committing of any deliberate criminal or deliberate fraudulent act if any final adjudication establishes that such deliberate criminal or deliberate fraudulent act was committed." In the underlying matter, an arbitrator concluded that the insured had induced an employee to stay at the company by making representations about receiving equity interests, but the insured never intended to give any equity. The court ruled for the insurer, holding that California statutory law, as well as the exclusion, barred coverage for the arbitral award. At the time of this writing, this case is on appeal before the U.S. Court of Appeals for the Ninth Circuit.

VI. Restitution, Disgorgement, and Damages

California State Grange v. Carolina Cas. Ins. Co., No. 22-16169, 2023 U.S. App. LEXIS 30078, 2023 WL 7486748 (9th Cir. Nov. 13, 2023) (applying California law)

Under California law, the U.S. Court of Appeals for the Ninth Circuit affirmed, in relevant part, a district court order dismissing a claim for coverage of certain damages, finding that they constituted restitution not covered by the policy. The management liability policy at issue barred coverage for disgorgement or restitution. In an underlying action to quiet title to real and personal property wrongfully converted by the insured, a judgment was entered against the insured awarding, among other things, damages for conversion of funds in bank accounts. In the coverage action, the court noted that in determining whether a certain remedy is insurable, courts must look beyond the labels of the asserted claims or remedies. While the underlying award for the converted funds was labeled as damages, the awarded amount was substantively restitution, which was not covered under the policy.

Tandem Fund II, L.P. v. Scottsdale Ins. Co., No. 23-CV-02810-VC, 2023 U.S. Dist. LEXIS 144606, 2023 WL 5281451 (N.D. Cal. Aug. 17, 2023)

Under California law, the U.S. District Court for the Northern District of California held that an arbitral award for the return of amounts wrongfully obtained was an award for restitution uninsurable by law. The insurer issued a policy with directors and officer liability coverage to the insured. In an arbitration alleging the insured's intentional misrepresentation to induce a lender to issue a loan, the lender obtained

an award that included, among other things, the amounts that had been loaned to the insured. The lender obtained the insured's rights under the policy, and in subsequent coverage litigation, sought payment of the award. In granting the insurer's motion to dismiss, the court determined that the arbitral award was restitutionary in nature because it ordered the insured's return of amounts to the lender. The arbitral panel's labeling of the award as actual "damages" rather than restitution was irrelevant; what mattered was the nature of the award.

***Dollar Point Ass'n, Inc. v. United States Liab. Ins. Co.*, No. 2:22-CV-0995-KJN, 2023 U.S. Dist. LEXIS 87353, 2023 WL 3570037 (E.D. Cal. May 18, 2023), *appeal dismissed*, No. 23-15898, 2023 U.S. App. LEXIS 33934, 2023 WL 8804574 (9th Cir. Nov. 17, 2023)**

Under California law, the U.S. District Court for the Eastern District of California held that an action to quiet title did not constitute "loss" as defined by the policy. Under a nonprofit professional liability policy, the definition of "loss" included, in part, "damages, settlements, front pay and back pay, pre-judgment and post judgment interest … and punitive or exemplary damages". The underlying action against the insured sought to quiet title or an equitable irrevocable license, which are equitable remedies, and therefore did not seek "loss" as defined by the policy.

***MHM Corr. Servs., Inc. v. Evanston Ins. Co.*, *2023* IL App (1st) 221708-U, *appeal denied sub nom. MHM Corr. Servs., Inc.*, No. 130051, 2023 Ill. LEXIS 901, 2023 WL 8449395 (Ill. Nov. 29, 2023)**

Under Illinois law, the Appellate Court of Illinois held that an insured's contractual agreement to defend its client, and the insured's subsequent payment of defense costs in connection with underlying litigation against that client, were not "damages" for a settlement as defined by the policy. The professional liability policy defined "damages", in part, as "the monetary portion of any judgment, award or settlement." The insured had contracted with a state department of corrections to provide certain services, and as part of the contract, undertook the duty to defend and indemnify. After officials in the department of corrections were sued, the insured paid associated costs to defend the officials and tendered the matter to the insurer, who denied coverage. In subsequent coverage litigation, the insured argued that its agreement to defend the department of corrections constituted a settlement such that the defense costs it had paid were "damages" under the policy. The appellate court rejected that argument noting that the settlement contemplated by the policy unambiguously refers to a payment to a plaintiff or claimant in compensation for a loss that gave rise to the claim in the underlying litigation, made as part of an agreement terminating that litigation.

***Ploen v. AIG Specialty Ins. Co.*, No. 21-CV-2248 (PJS/JFD), 2023 U.S. Dist. LEXIS 161764, 2023 WL 5960244 (D. Minn. Sept. 13, 2023)**

Under Minnesota law, the U.S. District Court for the District of Minnesota held that settlement amounts were not uninsurable disgorgement of ill-gotten gains because the issue had not yet been established by a final adjudication as required by the policy's definition of "loss." Under the directors and officers liability insuring agreement, the policy provided coverage for certain "loss," which carved-out "amounts which may be deemed uninsurable under the law pursuant to which this Policy shall be construed including, without limitation, any disgorgement or payment of ill gotten gains … as established by final adjudication." The insured was sued for fraudulent inducement and negligent misrepresentation. The insured settled and stipulated to entry of judgments against it. On partial summary judgment motions in subsequent coverage litigation, the court held that the underlying settlement was not uninsurable under the definition of "loss". The court rejected the insurer's arguments that a final adjudication was one of multiple ways to establish that the settlement was uninsurable and that the settlements themselves were final adjudications because stipulated judgments had been entered based on the settlement agreement. The court found that the stipulated judgments were not adjudications as contemplated by the policy and noted that the settlement agreements expressly stated they were not intended to be adjudications.

VII. Insured Capacity

Clover Health Invs., Corp. v. Berkley Ins. Co., C.A. No. N22C-06-004 MMJ CCLD, 2023 Del. Super. LEXIS 278, 2023 WL 1978227 (Del. Super. Ct. Feb. 6, 2023)

Under Delaware law, the Delaware Superior Court held that the future officers and directors of Clover Health Investments, Corp. (Clover Health) were insured persons under a directors and officers liability policy that was issued to Social Capital Hedosophia Holdings Corp. III (Social Capital) before its merger with Clover Health. Clover Health sought coverage for its individual directors and officers for various derivative actions. The insurers disclaimed coverage on the basis that the future directors and officers of Clover Health were not acting in their capacity as "Insured Persons," (i.e., directors and officers of Social Capital), and thus not entitled to coverage. Clover Health argued that the directors and officers were the "functional equivalents" of insured persons because they were acting in a position of control and authority. The policy defined "Insured Persons" to include individuals that "shall become duly elected … directors … [or] officers … of the Company or their functional equivalent." The court found that under this language, an "Insured Person" could be someone associated with another entity that is not Social Capital if that person operated in a functionally equivalent role to a director or officer of Social Capital. The court reasoned that because Social Capital was set to become Clover Health at the time of the alleged wrongdoing — and the individual directors and officers allegedly committed the wrongdoing concerning Social Capital's SEC filings while in positions of control as future directors and officers of Clover Health — these individuals were "Insured Persons" under the policy as they were acting in functionally equivalent roles to Social Capital's directors and officers when they committed the alleged wrongdoing.

In re Ford City Condo. Ass'n, 653 B.R. 420 (Bankr. N.D. Ill. 2023)

Under Illinois law, the U.S. Bankruptcy Court for the Northern District of Illinois held that the bankruptcy trustee's adversary proceeding against the insured's former officers and directors was barred from coverage by an "insured v. insured" exclusion. The bankruptcy trustee of the insured's estate issued a demand to the organization's insurer, requesting coverage for alleged breach of fiduciary duty and mismanagement by the insured's former directors and officers. The trustee subsequently brought an adversary proceeding against the insurer, seeking coverage under a community association's directors and officers liability policy. The policy excluded from coverage claims "against the Insured arising out of, directly or indirectly resulting from or in consequence of, or in any way involving… any claim by, at the behest of, or on behalf of the Organization and/or any Individual Insured." The policy also expressly included bankruptcy trustees and debtors-in-possession in its definition of the insured "Organization." Thus, the court determined that the bankruptcy trustee's adversary proceeding was a suit brought by the "Organization" against the individual insureds. The court also explained that the inclusion of bankruptcy trustees and debtors-in-possession in the policy definition of an insured was not unenforceable because their inclusion was not conditioned on the commencement of bankruptcy proceedings. Accordingly, the court granted the insurer's motion to dismiss the bankruptcy trustee's complaint.

Markovitz & Germinaro v. Berkley Ins. Co., No. CV 22-1344, 2023 U.S. Dist. LEXIS 109486, 2023 WL 5098546 (W.D. Pa. June 26, 2023)

Under Pennsylvania law, the U.S. District Court for the Western District Court of Pennsylvania found that a "capacity exclusion" in a Lawyers Professional Liability Insurance Policy did not preclude coverage because it was unclear whether the individuals were acting in their capacity as insureds or as agents of uninsured entities. The insured law firm's policy excluded coverage for services performed by other specified entities. Former clients of the firm brought

an unjust enrichment claim against M&G and the uninsured entities. On a motion to dismiss, the court found that the underlying complaint alleged misconduct by both entities, such that it could not conclusively apply the capacity exclusion to bar coverage for the unjust enrichment claim.

VIII. Insured v. Insured Exclusion

Bigelow v. Great Am. Ins. Co., No. *22*-cv-00545-DKW-KJM, 2023 U.S. Dist. LEXIS 70093, 2023 WL 3024089 (D. Haw. 2023)

Under Hawaii law, the U.S. District Court for the District of Hawaii upheld the enforcement of an insured v. insured exclusion where a former officer was sued by the insured company. The insured company was insured under a claims-made directors and officers liability policy. The policy included an insured v. insured exclusion that stated "the insurer shall not be liable to make any payment for Loss in connection with any Claim made against any Insured:... (6) brought or maintained by or on behalf of any Insured..." The former director asserted that the exclusion did not apply because the underlying action was filed on behalf of the shareholders, but the court noted that the lawsuit was filed and pursued by the insured company, and the shareholders were not named in the complaint nor were they participants in the lawsuit. Therefore, the court granted the insurer's motion for summary judgment.

Avellone v. United States Liab. Ins. Co. (In re Ford City Condo. Ass'n), 653 B.R. 420 (Bankr. N.D. Ill. 2023)

Under Illinois law, the U.S. Bankruptcy Court for the Northern District of Illinois concluded that an insured v. insured exclusion barred coverage for a trustee's claims against the bankrupt insured's former officers and board members because the policy unambiguously included bankruptcy trustees and debtors-in-possession as insureds. The insurer issued a community association directors and officers policy to the insured that included an insured v. insured exclusion, which barred coverage for any claim "against the Insured" that in any way involved "the o and/or any Individual Insured." The policy defined "organization" to include "any person or entity while acting in the capacity of receiver, bankruptcy trustee, or debtor in possession." In July 2022, the plaintiff trustee demanded insurance coverage for his claims of alleged breaches of fiduciary duty and mismanagement by the insured debtor's former officers and board members. In coverage litigation, the insurer moved to dismiss the plaintiff trustee's claims and the bankruptcy court agreed, citing the unambiguous language of the policy.

Gregory v. Navigators Insurance Company, No. 23-17-cv, 2023 WL 8538173 (2d Cir. Dec. 11, 2023)

Under Kentucky law, the U.S. Court of Appeals for the Second Circuit affirmed the lower court's dismissal of a claim on grounds that the policy's insured v. insured exclusion barred coverage for a suit brought by both insured and noninsured entities. At issue in this case was a directors and officers liability policy under which two insureds, both high-level employees at the insured company, sought coverage when they were sued by two other insureds and one noninsured entity for allegedly using their position to defraud multiple entities. When the insureds requested coverage, the insurer refused, citing the insured v. insured exclusion. When the insurer denied coverage, one of the defendant insureds filed a breach of contract action against the insurer in the District Court for the Eastern District of Kentucky and the other defendant insured filed an action against the insurer in the Southern District of New York. As the Second Circuit noted, the Eastern District of Kentucky read the insured v. insured exclusion as applying to the underlying claim. In that case, the insured tried to argue that the allocation provision in the policy required the insurer to cover the portion of the claim by the noninsured entity. However, the Kentucky court dismissed this claim because the policy considered the entire litigation to be a singular claim for which coverage was barred under the insured v. insured exclusion. Given Kentucky's decision in virtually the same case, the Second Circuit court chose to defer to the Kentucky decision by also dismissing the breach of contract claim, citing the insured v. insured exclusion, and refraining from addressing any further arguments.

Bay Club Member's, LLC v. Selective Ins. Co. of Am., No. 21-11791-WGY, 2023 U.S. Dist. LEXIS 201999 (D. Mass. 2023)

Under Massachusetts law, the U.S. District Court for the District of Massachusetts held that an insured v. insured exclusion did not apply to bar coverage. The insured was issued a private company management liability policy with directors and officers liability coverage. The policy included an insured v. insured exclusion that barred coverage for a claim "made by or on behalf of the 'company', or any security holder of the 'company', or any 'insured person'." The exclusion excepted shareholder derivative actions if brought or maintained without the participation of any "insured" or where the claim was brought by a former director or officer who had not served in that capacity for the company for at least three years. The underlying action involved a claimant that had been a former director of the insured (but not for over ten years) suing the insured. The court granted summary judgment to the insured based on the former director exception. The court granted summary judgment to the insurer for another portion of the action in which trustees sued the insured.

IX. Coverage For Contractual Liability

Windermere Oaks Water Supply Corp. v. Allied World Specialty Ins. Co., 67 F.4th 672 (5th Cir. 2023)

Under Texas law, the U.S. Court of Appeals for the Fifth Circuit held that a contractual liability exclusion contained in a public officials and management liability policy did not bar coverage for claims against the insured following the sale of a tract of land to an entity owned by a board member of the insured. Partial owners of the insured corporation sued the insured and various officials, alleging that the sale of a valuable land parcel to a commercial entity owned by a board member of the insured at a significantly reduced price exceeded the powers of the board, caused losses to the insured, and constituted a breach of fiduciary duty. The court found that the breach of fiduciary duty claims against the insured and its board members did not entirely fall within the exclusion, noting that the board could have breached their duties absent any contractual obligation, as they allegedly failed to market the land properly. Despite the exclusion's "arising out of" phrasing, the court deemed the insurer's interpretation excessively broad. The court emphasized that the underlying claims are established by law, not contract, and could exist even in the absence of a contract.

X. Professional Services

Professional Services Insuring Agreements

Arch Specialty Ins. Co. v. Beacon Healthcare Servs., Inc., No. 822-CV-00305 MCS-DFM, 2023 U.S. Dist. LEXIS 9016, 2023 WL 2347396 (C.D. Cal. Jan. 18, 2023)

Under California law, the U.S. District Court for the Central District of California concluded a policy's professional services coverage was triggered. The insurer issued a health care professional liability policy, which provided coverage for damages from a "'medical professional injury' resulting from acts or omissions in providing 'health care professional services' by or for an insured." The policy defined "health care professional services" to include "providing or dispensing food, beverages, medications or medical supplies or appliances." The insured, a psychiatric hospital, was sued for wrongful death and elder abuse and neglect after one of the insured's residents died from choking. The court held that the policy provided coverage, reasoning that the professional services definition explicitly included the providing or dispensing of food to patients.

Integris Ins. Co. v. Tohan, No. HHD CV21-6141816, 2023 Conn. Super. LEXIS 2700, 2023 WL 7544065 (Conn. Super. Ct. Nov. 8, 2023)

Under Connecticut law, the superior court found that claims against an insured fertility doctor for allegedly impregnating two women using his own sperm without their knowledge or consent fell within the policy's coverage. The insured's

medical professional liability policy covered claims for injury arising out of a medical incident, with medical incident defined as "any act or omission in the furnishing of professional services." The policy defined professional services in relevant part as "any professional medical services within the customary scope of the insured's practice specialty or classification as described in the application for insurance and specified in the declarations." The court held that the medical procedure was inextricably intertwined with and inseparable from the alleged intentional conduct and that the professional liability policy therefore must provide coverage. The court rejected the insurer's argument that the production of sperm was the nonprofessional activity at issue.

Everest Nat'l Ins. Co. v. Komarek, No. 22 C 3368, 2023 U.S. Dist. LEXIS 71758, 2023 WL 3074678 (N.D. Ill. Apr. 25, 2023)

Under Illinois law, the U.S. District Court for the Northern District of Illinois held an insurer had no duty to defend or indemnify a registered representative of the insured. The insurer issued two broker-dealer professional liability policies to the insured, which provided coverage for wrongful acts committed by the registered representative, so long as the "Wrongful Act occurs in the rendering of or failure to render Professional Services." The policies' definition of "Professional Services" included services "rendered in connection with an Approved Activity" and "Investment Advisory Services." To qualify as an approved activity or investment advisory service, the registered representative had to receive approval from the insured broker-dealer and offer the product or service through the insured broker-dealer. When one registered representative was sued based on participation in a multimillion-dollar Ponzi scheme, the insurer sought a declaratory judgment that it had no duty to defend. The court agreed with the insurer, reasoning that the particular allegations asserted that the registered representative transferred clients' funds away from the insured's accounts into other fraudulent accounts without the insured's approval.

Mount Vernon Fire Ins. Co. v. Jane Child Care, Inc., No. 22-cv-03816, 2023 U.S. Dist. LEXIS 149093, 2023 WL 5486309 (N.D. Ill. Aug. 24, 2023)

Under Illinois law, the U.S. District Court for the Northern District of Illinois held that an insurer had a duty to defend claims against an insured child-care facility for alleged child abuse and substandard care. The insured purchased a multipart liability policy that included professional liability coverage, which provided coverage for "sums that the insured becomes legally obligated to pay as damages because of liability arising out of any negligent act, error, or omission in rendering or failure to render childcare services. The complaints alleged that the insured and its employees physically, mentally, and emotionally abused children while in the insured's care, custody, and control, and that they were negligent in failing to properly care for the children. The court noted that Illinois courts interpret "professional services" as including "any business activity conducted by the insured which involves specialized knowledge, labor, or skill," and that caring for infants and children requires a specialized level of care. The court also rejected the insurer's argument that deficient care does not involve a professional service, as it would not have included professional liability coverage in the policy if residential child care was not a professional service.

DeWall v. Med. Protective Co., 59 F.4th 364 (8th Cir. 2023) (applying Iowa law)

Under Iowa law, the U.S. Court of Appeals for the Eighth Circuit held that an insurer did not have an unlimited duty to defend a Medicare recoupment claim brought against its insured, which operated multiple health care clinics. The insurer issued professional liability policies to the insured, which covered claims "based on professional services." The policy also included a Medicare endorsement, which limited the insurer's duty to defend certain claims under each policy to $50,000. The insured had entered into an agreement with a third party to manage the third party's health care clinics. In 2020, the third party initiated an arbitration against

the insured seeking recoupment of Medicare repayments. The insured argued the policy obligated the insured to provide unlimited defense costs, as the Medicare repayment claims were "based on" the insured's professional services of providing doctor's orders and diagnoses. The court concluded that the Medicare endorsement applied such that the insurer's duty to defend was limited to $50,000 in defense expenses for such claims.

LePatner & Associates, LLP v. RSUI Group, Inc., No. 22-762, 2023 U.S. App. LEXIS 26820, 2023 WL 6563868 (2d Cir. Oct. 10, 2023) (applying New York law)

Under New York law, the U.S. Court of Appeals for the Second Circuit found that an insurer had no obligation to cover allegations that did not relate to covered professional services. The insured lawyer's professional liability policy provided coverage for claims alleging negligence in the rendering or failure to render professional services as a lawyer. The insured law firm also owned a construction management firm that was not an insured under the policy. The underlying complaint alleged that the plaintiffs, the law firm and the construction management firm entered into an agreement concerning the renovation of a home whereby the law firm would provide legal services and the construction management firm would provide management services. Plaintiffs alleged breach of the construction management firm's obligations. The court found that the policy did not apply because the complaint alleged no claim against the law firm involving its professional services.

Professional Services Exclusions

United Talent Agency, LLC v. Markel Am. Ins. Co., No. 22-55205, 2023 U.S. App. LEXIS 6146, 2023 WL 2523834 (9th Cir. Mar. 15, 2023) (applying California law)

Under California law, the U.S. Court of Appeals for the Ninth Circuit held a professional liability exclusion did not preclude coverage for claims arising out of the insured's alleged theft of clients and employees from a competitor. The insurer issued a management liability policy to its insured, a talent agency, which excluded coverage for loss "in connection with the rendering or failure to render any professional services to others for a fee, commission or other compensation." The insured was sued by a competitor for allegedly stealing clients and agents. The court held that the professional liability exclusion was inapplicable because the allegations of stealing clients and employees did not involve conduct in connection with the rendering of professional services for a fee. While the court recognized that the insured's actions may have been motivated by a desire to increase profits, that motive was insufficient to bring the actions within the scope of the policy's definition of professional services.

ACE American Insurance Company v. Guaranteed Rate, Inc., No. 360, 2022, 2023 Del. LEXIS 307, 2023 WL 5965619 (Del. Sep. 14, 2023)

Applying Delaware law, the Supreme Court of Delaware held that a professional services exclusion did not bar coverage under a management liability policy for alleged False Claims Act violations. The policy contained an exclusion for loss from any claim "alleging, based upon, arising out of, or attributable to any Insured's rendering or failure to render professional services." The insured received a Civil Investigative Demand that asserted that the insured violated the False Claims Act by originating and underwriting federally insured mortgage loans that failed to meet applicable quality-control requirements. The court ruled that the exclusion did not bar coverage because the insured's professional services were mortgage banking, mortgage underwriting, and loan servicing, whereas the allegations involved falsely certifying that loans met FHA and VA insurance requirements. Thus, the alleged misconduct arose out of the false certifications, not professional services the insured provided to borrowers.

Atl. Specialty Ins. Co. v. Blue Cross & Blue Shield of Kansas, Inc., No. 18-2371-DDC-ADM, 2023 U.S. Dist. LEXIS 51987, 2023 WL 2648223 (D. Kan. Mar. 27, 2023)

Under Kansas law, the U.S. District Court for the District of Kansas concluded a professional services exclusion precluded coverage for a multidistrict antitrust litigation. The insurer issued both a directors and officers policy and an errors and omissions policy to the insured, a health care insurance organization. The directors and officers policy contained a professional services exclusion that precluded coverage for any loss arising out of an "error or omission in the performance of, or failure to perform Managed Care Activities." The directors and officers policy defined managed care activities to include "selling or enrolling for health care…compensation plans" and "services or activities performed in the administration or management of health care…plans." Following the filing of many antitrust actions, the insurer denied coverage under the directors and officers policy based on the professional services exclusion, among other exclusions, but agreed to reimburse defense expenses under the errors and omissions policy. The court agreed with the insurer's approach, holding that the professional services exclusion should be interpreted narrowly (but not "especially narrowly"), such that the exclusion unambiguously excluded the claims at issue in the multidistrict class action against the insured.

XI. Independent Counsel

Associated Indus. Ins. Co. v. San Joaquin Hill Transp. Corridor Agency, No. CV 18-1776 PSG (JDEx), 2023 U.S. Dist. LEXIS 21755, 2023 WL 2357292 (C.D. Cal. Feb. 7, 2023)

Under California law, the U.S. District Court for the Central District of California rejected an insurer's attempt to frame the insured's claims for the insurer's alleged failure to promptly and completely pay for the insured's defense as a dispute regarding fees owed to the insured's *Cumis* counsel subject to mandatory arbitration under California's independent counsel statute. The insured tendered an underlying lawsuit to the insurer, and after the insurer failed to respond to the tender for over three months, the insured retained independent counsel to represent it. The insurer eventually agreed to defend the insured subject to a reservation of rights that some or all of the insured's alleged conduct was not covered, and stated that, although the insurer did not believe its coverage position entitled the insured to independent counsel, the insurer would agree to "accommodate" the insured's chosen defense counsel. For the next two years, the insurer allegedly "engaged in unreasonable delays" in paying the insured's defense costs. The insurer eventually filed a declaratory judgment action seeking a declaration of noncoverage, and the insured filed counterclaims alleging the insurer breached the duty to defend and the implied covenant of good faith and fair dealing by failing to promptly and completely pay for the insured's defense. The insurer moved to compel arbitration of the insured's three counterclaims under California Civil Code § 2860 (Section 2860). The court denied the motion, holding the insurer failed to demonstrate Section 2860 applied, because Section 2860 only applies when independent counsel is retained in light of a conflict of interest, and the insurer failed to identify a requisite conflict of interest. The court also noted the "gravamen" of the insured's counterclaims was the insurer's alleged bad faith and breach of contract and not independent counsel's fees themselves, which is what Section 2860 arbitrations are intended to address.

Robert Sonny Wood v. Nautilus Ins. Co., No. 2:17-cv-02393-MMD-VCF, 2023 U.S. Dist. LEXIS 225617, 2023 WL 8777827 (D. Nev. Dec. 18, 2023)

Under Nevada law, the U.S. District Court for the District of Nevada held that an insurer's obligation to pay for "the reasonable costs" of the insured's independent counsel means the insurer is obligated to pay for independent counsel at hourly rates that are "reasonable for similar work in the jurisdiction" and may not cap its payments at the hourly rate the insurer pays its panel defense counsel.

Mid-Continent Cas. Co. v. Harris Cnty. Mun. Utility Dist. No. 400, No. 09-22-00252-CV, 2023 Tex. App. LEXIS 6935, 2023 WL 5621664 (Tex. App.—Beaumont Aug. 31, 2023)

Under Texas law, the Texas Court of Appeals held that a directors and officers liability insurer's reservation of rights did not entitle the insureds to independent counsel to defend them in the underlying lawsuit. The insurer had reserved rights pursuant to the policy's improper profit exclusion, which precluded coverage for "Loss resulting from any Claim… based upon or attributable to any of the Insureds gaining in fact any profit, remuneration, or advantage to which such Insured was not legally entitled." The court held the insurer's reservation under this provision did not create a conflict of interest entitling the insureds to independent counsel because the underlying lawsuit did not allege the insureds received any monetary advantages to which they were not entitled, and thus the development of the facts in the underlying lawsuit would have had no bearing on whether the exclusion applied.

XII. Advancement of Defense Costs

Clear Blue Specialty Ins. Co. v. Ozy Media, Inc., Case No. 5:21-cv-08764, 2023 U.S. Dist. LEXIS 69611, 2023 WL 3046796, (N.D. Cal. Apr. 20, 2023)

Under California law, the U.S. District Court for the Northern District of California held that where insureds challenge the propriety of a unilateral rescission of a policy and the rescission appears facially proper, the insurer has no duty to advance defense costs pursuant to the policy unless and until the rescission is set aside as improper. The insurer issued a directors and officers liability policy to the insureds with a provision that the insurer would advance covered defense costs incurred on a quarterly basis. The insurer subsequently rescinded the policy because of material misrepresentations and omissions in the application and filed a declaratory judgment action to confirm the rescission. The insureds filed a motion for a preliminary injunction requesting a court order directing the insurer to advance defense costs and stay discovery pending the resolution of the underlying proceedings. The insureds argued the insurer's refusal to advance defense costs constituted a breach of its obligations under the policy. The court denied the insureds' motion, reasoning that the question of whether the rescission was proper must be resolved before evaluating whether the insurer has breached any policy obligations. In response to the insureds' argument that such a ruling would raise moral hazard concerns, the court noted that seeking rescission without a valid basis constitutes a breach of the implied covenant of good faith and fair dealing and potentially the commission of an unfair claim settlement practice under California law.

Daileader v. Certain Underwriters at Lloyds London Syndicate 1861, Case No. 23-690-CV, 2023 U.S. App. LEXIS 30374, 2023 WL 7648381 (2d Cir. Nov. 15, 2023) (applying New York law)

Under New York law, the U.S. Court of Appeals for the Second Circuit affirmed the denial of an insured's motion for a mandatory preliminary injunction obligating his insurers to pay defense costs in various underlying proceedings. The insurers issued a tower of directors and officers liability coverage to the insured's company, of which the insured was the sole director. The Second Circuit agreed with the district court that the insured had not established that irreparable harm would result in the absence of an injunction. The district court had reasoned that litigation costs alone — mere financial harm — do not constitute irreparable harm for purposes of a preliminary injunction. An insured seeking an injunction requiring an insurance company to defend the insured must make a specific showing that harm will result from not receiving the defense coverage and demonstrate that this harm cannot be remedied later with compensatory damages. In other words, an insured must show that they cannot pay for a defense or will suffer permanent financial harm, such as bankruptcy.

In re SVB Fin. Group, 650 B.R. 790 (Bankr. S.D.N.Y. 2023)

The U.S. Bankruptcy Court for the Southern District of New York, applying federal law, granted the insured directors' and officers' motion to allow advancement and payment of their defense costs. The insurers issued a program of directors and officers liability insurance to the insured company. The relevant policies included "priority of payments" provisions that granted individual directors and officers priority to the policy proceeds over the insured company. The insureds — both the company and individual directors and officers — were sued in seven class actions arising from the company's failure, as well as various regulatory actions. The individual insureds sought advancement of their defense costs. The company's bankruptcy estate and the insurers refused to advance defense costs without the bankruptcy court's approval. The court explained that in cases where liability insurance policies provide direct coverage to both individual insureds and the debtor company, the policy proceeds are property of the estate if depletion of the proceeds would have an adverse effect on the estate to the extent the policy actually protects the estate's other assets from diminution. In such scenarios, the parties seeking access to the funds must establish cause to modify the bankruptcy stay. The court found, without deciding whether the policy proceeds were property of the estate, cause to lift the stay because the estate would benefit from a rigorous defense of the insureds in the underlying actions, any claims against the estate based on those actions were at that point merely speculative, and the priority of payments provisions established that the individual insureds were entitled to have their claim paid first.

XIII. Allocation

Clover Health Invs. v. Berkley Ins. Co., No. N22C-06-004 MMJ CCLD, 2023 Del. Super. LEXIS 278, 2023 WL 1978227 (Super. Ct. Feb. 6, 2023), cert. denied, 2023 WL 2595733 (Del. Super. Ct. Mar. 9, 2023), and appeal refused sub nom. *Endurance Risk Sols. Assurance Co. v. Clover Health Invs., Corp.*, 295 A.3d 136 (Del. 2023)

Under Delaware law, the Superior Court of Delaware held that an allocation dispute between insurers and their insured was ripe for judicial determination and that the "larger settlement rule" applied, requiring the insurers to advance all defense costs. Multiple insurers issued directors and officers liability insurance coverage. The insured sought coverage in connection with a securities class action, shareholder derivative suits, and an SEC investigation. The insurers denied coverage and the insured filed suit seeking declaratory judgment regarding coverage for defense costs in the underlying action, among other issues. The court found that policy language stating that the insured and insurer "shall use best efforts to allocate" did not mandate that the parties enter into negotiations before the allocation dispute was ripe for judicial determination. Finding the allocation issue ripe, the court analyzed the "Larger Settlement Rule" to determine whether the insurers would be responsible for the entirety of the defense costs in the underlying actions. As the court explained, the Larger Settlement Rule requires that an insurer pay all costs associated with a settlement or defense, without allocation of any costs to the uninsured parties or matters, if: (i) the settlement or defense resolves, at least in part, insured claims; (ii) the parties cannot agree as to allocation of covered and uncovered claims; (iii) the allocation provision does not provide for a specific allocation method; and (iv) the defense or settlement costs were not higher than they would have been had only the insured claims been defended or settled. The insured argued that the insurers were not entitled to allocation, and that even if the allocation provisions in the policies were triggered, the Larger Settlement

Rule should apply because all defendants in the underlying litigation shared the same counsel and benefited from the same defense work. The court found that the policy was ambiguous with respect to allocation, that the primary policy did not provide a specific allocation method, and found that all requirements for the Larger Settlement Rule were satisfied. Accordingly, the court held that the insurers were required to advance all defense costs, subject to their respective retentions and limits. The insurers sought an interlocutory appeal, but their request was denied.

QBE Specialty Ins. Co. v. Uchiyama, No. CV 22-00450 SOM-KJM, 2023 U.S. Dist. LEXIS 184855, 2023 WL 6796159 (D. Haw. Oct. 13, 2023)

Applying Hawaii law, U.S. District Court for the District of Hawaii found that a policy's "advancement" and "priority of payments" provisions did not determine allocation of interpleaded policy funds or priority of distribution. The insurer issued a directors and officers policy that provided coverage to former directors and officers of a company that had entered into bankruptcy proceedings. Multiple parties sought coverage and the insured moved to interplead the policy funds. The insured and uninsured interpleader-defendants sought summary judgment as to the relative priority of their claims in the distribution of the interpleaded policy funds. One insured argued that the policy's "advancement" and "priority of payments" provisions required the insurer to advance defense costs as bills were presented and prioritize defense costs, with the insured being required to repay uncovered defense costs after a final adjudication regarding coverage. The court rejected the insured's arguments, finding that the policy provisions did not conclusively resolve substantive rights to the policy funds. The insured also argued that the Ninth Circuit's decision regarding allocation in *Safeway Stores, Inc. v. National Union Fire Insurance Co.*, 64 F.3d 1282 (9th Cir. 1995) controlled. The court disagreed, finding that *Safeway Stores*, Inc. was distinguishable. The court explained that, unlike the costs incurred through the defense of the named insured and insured directors and officers at issue in *Safeway Stores*, the costs at bar may have arisen through the defense of the insured and his uninsured co-defendants in the underlying litigation. The court ruled that the policy terms did not clearly establish a priority of payments among interpleader-defendants' claims to the interpleaded funds and that the court was required to instead design a *pro rata* distribution based on equitable principles.

Twin City Fire Ins. Co. v. Alcast Co., No. 20-cv-1065-JES-JEH, 2023 U.S. Dist. LEXIS 97868, 2023 WL 3743886, (C.D. Ill. Apr. 27, 2023) appeal dismissed, No. 23-2092, 2023 U.S. Dist. LEXIS 31728, 2023 WL 8252986 (7th Cir. Sept. 18, 2023)

Applying Illinois law, the U.S. District Court for the Central District of Illinois held that defense costs incurred in underlying adversary proceedings initiated by a bankruptcy trustee to benefit the insured and other noninsured management defendants were to be allocated based on the insured's ownership interest in the company. The insurer issued a directors and officers liability policy. The insurer sought a declaratory judgment that it had no obligation to indemnify or defend its insured in an underlying action where the insured was one of 14 defendants. The court found that the insurer had a duty to defend, but that it was only obligated to pay an allocated portion of defense costs because certain defense costs were incurred to benefit noninsureds. The allocation provision provided that costs were to be allocated based on the "relative legal exposure of all parties," but that phrase was not defined by the policy. The court determined that it faced a case of first impression as to how to allocate defense costs when multiple noninsured defendants and an insured defendant are represented by the same counsel. Relying on the Seventh Circuit's decision in *Level 3 Commc'ns, Inc. v. Fed. Ins. Co.*, 168 F.3d 956 (7th Cir. 1999), the court found that the Seventh Circuit's reasoning, while not directly on point, supported the conclusion that it is reasonable to structure the apportionment between parties who have an ownership interest in an entity based on the percentage of that ownership. Accordingly, the court held that the insurer was obligated to pay 39.71% as its allocated share of defense costs that benefited the insured along with other noninsured defendants.

Daileader v. Certain Underwriters at Lloyd's London, No. 22 CIV. 5408 (PGG), 2023 U.S. Dist. LEXIS 69413, 2023 WL 3026597 (S.D.N.Y. Apr. 20, 2023)

Under New York law, the U.S. District Court for the Southern District of New York court held, based on an allocation clause, that the insured was not entitled to coverage for all defense costs. The insurer issued a first-layer excess policy above a directors and officers liability policy. The policy contained a bankruptcy/insolvency exclusion and an allocation clause. The underlying insurance was exhausted, and the excess insurer denied coverage for a trustee's claims against the sole director of the insured based on the bankruptcy/insolvency exclusion. The insured sued seeking coverage for all defense costs incurred in the adversary proceeding initiated by the trustee. The court held that the language of the bankruptcy/insolvency exclusion barred coverage for the entire adversary proceeding. In the alternative, the court held that the insured would not be entitled to coverage for all defense costs based on the policy's allocation clause which provided that the insurer was permitted to advance defense expenses that the insurer believes to be covered under the policy until a different allocation is negotiated, arbitrated, or judicially determined. The court concluded that under the allocation clause, unless every allegation in the trustee's proceedings fell outside the bankruptcy/insolvency exclusion, the insured was only entitled to a partial defense by the insurer at most.

XIV. Recoupment of Defense Costs and Settlement Payments

Gen. Ins. Co. of Am. v. Hall, 657 F. Supp. 3d 1302 (C.D. Cal. 2023)

Under California law, the U.S. District Court for the Central District of California held that the insurer was entitled to recoupment of all fees and costs paid to defend the insured in an underlying action as well as prejudgment interest. The insurer issued a homeowner's insurance policy to the insured. The insurer sought a declaratory judgment against the insured that the insurer did not owe a duty to defend or indemnify the insured in an underlying sexual-assault-related action based on multiple exclusions. The insurer subsequently moved for summary judgment and the court granted the motion, holding that the insurer owed no duty to defend and was entitled to recoupment for all fees and costs incurred on the insured's behalf. Citing *Buss v. Superior Ct.*, 16 Cal. 4th 35 (1997), the court explained that "California law recognizes that an insurer has an implied-in-law right to be reimbursed for defense fees and costs incurred defending claims not covered under an insurance policy." The court held that the insurer was entitled to such recoupment, plus prejudgment interest, because there was no triable issue of fact as to whether the insurer owed the insured a duty to defend in the underlying action.

Century Sur. Co. v. Popelino's Transportation, Inc., No. 521-CV-01987 RGK-RAO, 2023 U.S. Dist. LEXIS 2164, 2023 WL 225630 (C.D. Cal. Jan. 4, 2023), *aff'd*, No. 23-55051, 2023 WL 8469192 (9th Cir. Dec. 7, 2023)

Under California law, the U.S. District Court for the Central District of California held that an insurer was entitled to recoupment of all fees and costs paid to defend the insured in an underlying action. The insurer issued a commercial general liability insurance policy to the insured. The insurer sought rescission of the policy and declaratory judgment that it did not owe a duty to defend or indemnify the insured in an underlying action involving property damage caused by the insured's recycling operations which were never disclosed to the insurer in the policy application. The insurer subsequently moved for summary judgment on its rescission and declaratory judgment claims and the court granted the motion, holding that the policy was rescinded based on misrepresentations in the application and, thus, that the insurer owed no duty to defend or indemnify. The court also held, as a consequence, that the insurer was entitled to recoupment of defense fees incurred on the insured's behalf based on *Buss v. Superior Ct.*, 16 Cal. 4th 35 (1997).

Liberty Ins. Underwriters, Inc. v. Cocrystal Pharma, Inc., No. 22-2242, 2023 U.S. App. LEXIS 7405, 2023 WL 3067498 (3d Cir. Apr. 25, 2023) (applying Delaware law)

Under Delaware law, the U.S. Court of Appeals for the Third Circuit concluded that a case was required to be remanded to the Pennsylvania district court to determine whether the insurer was entitled to seek recoupment of defense costs expended on the insured's behalf in light of the Third Circuit's reversal of the district court's entry of judgment for the insurer on its declaratory judgment claim. The insurer issued a directors and officers liability policy to the insured. The insurer sought declaratory judgment that it did not owe a defense to the insured in connection with a Securities and Exchange Commission (SEC) subpoena and proceeding against the insured. The district court granted judgment for the insurer, and the insured appealed. On appeal, the Third Circuit reversed the district court's judgment for the insurer, finding genuine issues of fact precluding summary judgment. Because the court remanded the case to the district court, it declined to resolve the issue of whether the insurer was entitled to recoupment of its defense costs incurred on the insured's behalf. However, the court recognized that, under Delaware law, the insurer would be entitled to recoupment of defense costs if the claim is ultimately found not to be covered. "If the SEC was investigating [the insured] for a Wrongful Act at the outset," the court explained, "then [the insurer] had a duty to pay defense costs and is not entitled to recoupment," but "[i]If the SEC was not investigating [the insured] for such an act, then [the insurer] may be able to recoup the defense costs paid."

Atain Specialty Ins. Co. v. T. Disney Trucking & Grading, Inc., No. 3:21-CV-01097-CRK, 2023 U.S. Dist. LEXIS 164539, 2023 WL 6038097 (M.D. Fla. Sept. 15, 2023)

Under Florida law, the U.S. District Court for the Middle District of Florida held that an insurer was entitled to recoupment of defense costs incurred on the insured's behalf in an underlying action. The insurer issued commercial general liability insurance policies to the insured. The insurer moved for summary judgment on its declaratory judgment claim that it owed no defense or indemnity to the insured in connection with an underlying construction-related suit against the insured. The court granted judgment to the insurer on its declaratory judgment claim and also on its related claim for recoupment of defense costs. "Insurers may recover attorneys' fees incurred in defending an insured when there is no duty to defend, and when the insurer timely issues a reservation of rights letter," the court explained. The court relied on the fact that the insurer issued two reservation of rights letters, both of which reserved the right to recoup defense costs if the claim was later determined to be uncovered, as well as the insured's failure to contest that reservation. "Because [the insured] accepted [the insurer's] tenders of defense under reservation," the court stated, "[the insured] agreed to reimburse costs in the event that [the insurer] had no duty to defend."

Cont'l Cas. Co. v. Winder Labs., LLC, 73 F.4th 934 (11th Cir. 2023) (applying Georgia law)

Under Georgia law, the U.S. Court of Appeals for the Eleventh Circuit held that "an insurer can[not] recoup defense costs when such a right is provided for in a reservation of rights letter but not the parties' operative insurance contract." The insurer issued commercial general liability and umbrella policies to the insured. While an underlying action remained pending against the insured, the insurer filed a declaratory judgment action and subsequently moved for summary judgment on its claims that it had no duty to defend the insured in the underlying action and, consequently, was entitled to reimbursement for defense costs expended on the insured's behalf. The district court granted the insurer's summary judgment motion, holding that no defense was owed, but denied the insurer's claim for reimbursement of defense costs. On appeal, the Eleventh Circuit Court of Appeals, predicting Georgia law, held that the insurer was not entitled to reimbursement of defense costs where the insurance policy itself provided no such right. "This position comports with the national trend that disfavors recoupment in similar circumstances," the court explained, adding that

"[w]hile insurers can certainly contract for a right to reimbursement, they cannot do so in a subsequent reservation of rights after a reimbursement-less bargain has been struck."

St. Paul Fire & Marine Ins. Co. v. Bodell Constr. Co., 538 P.3d 1049 (Haw. 2023)

Under Hawaii law, the Hawaii Supreme Court held that "an insurer may not recover defense costs for defended claims unless the insurance policy contains an express reimbursement provision." The insurers issued commercial general liability and umbrella policies to the insureds. The insureds, in a related Hawaii federal district court action, moved for summary judgment on the insurers' claims for recoupment of defense costs incurred in defending the insureds in a construction-related underlying action. The Hawaii federal district court certified to the Hawaii Supreme Court the question of whether, and under what circumstances, Hawaii law allows insurers to recoup defense costs. After accepting certification of the question, the Hawaii Supreme Court held that insurers are permitted to recoup defense costs for claims that are later determined to be not covered, but only if the insurance policy provides for such right. "Insurers may reserve contractual rights, not create new ones," the court explained, adding that "[a] reservation of rights letter does not alter policy coverage or remake a contract." The court further explained that "[p]ermitting reimbursement by reservation of rights, absent an insurance policy provision authorizing the right in the first place, is tantamount to allowing the insurer to extract a unilateral amendment to the insurance contract."

John Moriarty & Assocs., Inc. v. Zurich Am. Ins. Co., 207 N.E.3d 542 (Mass. Ct. App. 2023)

Under Massachusetts law, the Appeals Court of Massachusetts held that the insured demonstrated that "an actual controversy exists with respect to the issue whether [the insurer] may reserve the right to recoup defense costs as a matter of law," and therefore remanded the case to the trial court to allow the insured to proceed with its declaratory judgment claim. The insured had sought a declaratory judgment that its insurer owed a defense and indemnity under its commercial general liability policy for an underlying action against the insured. The trial court dismissed the declaratory judgment claim as unripe because the insurer eventually agreed to defend the insured, albeit under a reservation of rights to seek recoupment of defense costs incurred on the insured's behalf. The insured appealed, arguing that the insurer's "baseless reservation of the right to recoup defense costs renders [the insurer's] agreement to defend nothing more than a sham," which constitutes an actual controversy for purposes of allowing a declaratory judgment claim to proceed. The appeals court agreed, explaining that "an actual controversy exists with respect to the issue whether Zurich may reserve the right to recoup defense costs as a matter of law," in part because "the parties' dispute implicates a question of law that is unsettled in Massachusetts — if, and in what circumstances, an insurer may seek to recoup defense costs provided to an insured." The court further explained that, "[g]iven the legal uncertainty regarding the enforceability of [the insurer's] reservation of a right to recoup, [the insured] has demonstrated a real dispute concerning the parties' rights in which they have a definite interest." Ultimately, the court stated that "whether an insurer may seek to recoup costs of a defense undertaken pursuant to a unilateral reservation of rights is an open issue under Massachusetts law" and remanded the case to the trial court.

Bright View Enter. Sols., LLC v. Farm Fam. Cas. Ins. Co., No. 20-CV-7915 (EP) (AME), 2023 U.S. Dist. LEXIS 20764, 2023 WL 1794850 (D.N.J. Feb. 7, 2023)

Under New Jersey law, the U.S. District Court for the District of New Jersey held that commercial general liability insurer was not entitled to reimbursement of defense fees incurred to defend the insured in an underlying action. The insured filed a declaratory judgment and bad faith action against the insurer for failing to settle an underlying bodily injury action within the policy limit. The insurer counterclaimed for a declaratory judgment and recoupment of defense fees incurred on the insured's behalf in the underlying action. The insured moved for summary judgment on all claims against the insurer. The court denied summary judgment on the insured's coverage and bad faith claims, but granted judgment for the insured

and against the insurer on the insurer's counterclaim for recoupment of defense costs, finding no explicit policy-based support for the recoupment claim or any other reason or evidence to support the insurer's claim. "Significantly," the court observed, "the Insurance Contract's terms do not provide for the relief that [the insurer] now seeks; namely, that [the insurer] is entitled to recoup expended defense costs if [the insured] breaches its contractual obligations" such that coverage would be negated. The court further reasoned that the insurer "does not point to any other record evidence that suggests it is entitled to such relief, nor does [the insurer] argue that there are any relevant ambiguities in the insurance contract that could lead to the interpretation that it is entitled to recoup defense costs from [the insured]." The court agreed with the insured that the insurer failed to present "precedential authority for its proposition that it is entitled to recoup defense costs from its insured where, as here, it is not required by the Insurance Contract."

Peleus Ins. Co. v. RCD Restorations Inc., Index No. 65682/2021, 2023 N.Y. Misc. LEXIS 125, 2023 WL 193721 (N.Y. Sup. Ct. Jan. 9, 2023)

Under New York law, the New York Supreme Court held that a commercial general liability insurer was not entitled to recoupment of defense costs expended on the insured's behalf in an underlying action. The insurer sought and obtained a declaratory judgment against the insured, after moving for default judgment, that the insurer did not owe a defense or indemnity for an underlying construction-related bodily injury action against the insured. The court granted judgment for the insurer on the duty to defend, but denied the insurer's request for recoupment because the insurer never reserved the right to seek recoupment. "Although [the insurer] provided [the insured] with coverage in the underlying action/third-party action under a reservation of rights," the court explained, "the letter notifying [the insured] of [the insurer's] coverage position did not reserve the right 'to recoup expenses [the insurer] incurred that are not covered by the polic[y].'" The court further explained that, "[a]bsent a reservation of [the insurer's] right not merely to later deny coverage but also to obtain recoupment, this court sees no basis to permit recoupment now."

Liberty Ins. Underwriters Inc. v. The Plaza Condominium, No. 656871/2017, 2023 N.Y. Misc. LEXIS 1469, 2023 WL 2730472 (N.Y. Sup. Ct. Mar. 31, 2023)

Under New York law, the New York Supreme Court held that a directors and officers liability insurer was entitled to recoupment of defense costs expended on the insured's behalf. The insurer obtained summary judgment on its declaratory judgment claim against the insured that the insurer did not owe a defense to the insured in an underlying action that alleged the insured's residential unit owners were overcharged by the insured for electricity charges. Having established it had no duty to defend, the insurer then moved for summary judgment on its claim for recoupment of defense costs paid on the insured's behalf, and the court granted the motion based on "binding First Department precedent" permitting recoupment when reserved by the insurer in writing to "recoup their defense costs upon a determination of non-coverage." The court also rejected the insured's tardy attempt to argue recoupment was not permitted under a contrary decision from another department.

Mt. Hawley Ins. Co. v. Plymouth Plaza, LLC, No. 0:22-CV-62333, 2023 U.S. Dist. LEXIS 152398, 2023 WL 6973729 (S.D. Fla. Aug. 29, 2023), *report and recommendation adopted*, No. 22-62333-CV, 2023 U.S. Dist. LEXIS 209166, 2023 WL 8111899 (S.D. Fla. Nov. 22, 2023)

Under both New York and Florida law, the U.S. District Court for the Southern District of Florida held that an insurer was not permitted to seek recoupment of defense costs or a settlement payment the insurer paid on the insured's behalf to resolve an underlying action. The insurer issued a commercial general liability policy to the insured. The insured moved to dismiss the parts of the insurer's declaratory judgment complaint concerning the insurer's right to recoupment of defense and settlement costs incurred on the insured's behalf in an underlying bodily injury action. The court granted the insured's motion to dismiss the parts of the insurer's complaint concerning recoupment because the insurer

was unable to cite case law supporting the right to recoupment for defense costs or settlement payments — under either Florida or New York law — "when the insurer settled the underlying action," explaining that "[b]y settling the [underlying] action, [the insurer] declined to defend its position that it was not required to provide a defense in that action," and so the insurer "cannot now recoup the costs of that defense from [the insured]."

Nat'l Liab. & Fire Ins. Co. v. Brimar Transit, Inc., No. 22-2565, 2023 U.S. App. LEXIS 25158, 2023 WL 6172886 (3d Cir. Sept. 22, 2023) (applying Pennsylvania law)

Under Pennsylvania law, the U.S. Court of Appeals for the Third Circuit concluded that a case was required to be remanded to the Pennsylvania district court to determine whether the insurer was entitled to seek recoupment of defense costs expended on the insured's behalf in light of the Third Circuit's holding that the insurer did not have a duty to defend or indemnify the insured in an underlying sexual-assault-related action against the insured. The insurer issued a commercial auto insurance policy to the insured. The insurer moved for summary judgment in the district court on the insurer's declaratory judgment claim that it owed no duty to defend or indemnify the insured for the claims in the underlying action. The district court denied summary judgment and the insurer appealed. On appeal, the Third Circuit reversed the district court, holding that the insurer had no duty to defend the insured, but remanded the question of whether the insurer was entitled to recoupment of defense costs incurred on the insured's behalf, even though the insurer argued that "it ha[d] both equitable and contractual rights to reimbursement of all amounts it has paid while having no duty to do so." Citing the Pennsylvania Supreme Court's decision in *Am. & Foreign Ins. Co. v. Jerry's Sport Ctr., Inc.*, 2 A.3d 526 (Pa. 2010), which held that insurers generally are not entitled to recoupment of defense costs, the Third Circuit explained that, "[g]iven our opinion about [the insurer's] duty to defend, the fact-intensive inquiry required, and the unsettled nature of Pennsylvania law on certain aspects of the issue, the District Court is better positioned on remand to address these issues."

W. Am. Ins. Co. v. Del Ray Properties Inc., No. 3:22-CV-05563-LK, 2023 U.S. Dist. LEXIS 75413, 2023 WL 3172471 (W.D. Wash. May 1, 2023)

Under Washington law, the U.S. District Court for the Western District of Washington held that a commercial general liability insurer was entitled to reimbursement of defense fees incurred to defend the insured in an underlying action. The insurer sought a declaratory judgment that it did not owe a duty to defend or indemnify the insured in an underlying action alleging the insured breached its contract with the claimant and committed other business-related harms. The insurer subsequently moved for summary judgment on its declaratory judgment claims and the court granted the motion, holding that the insurer was entitled to recoupment for all defense fees incurred on the insured's behalf, notwithstanding Washington law which generally forbids such recoupment. "[T]he Court finds that the relevant policy language permits such efforts," the court explained, because the policy explicitly stated that the insurer had "the right to reimbursement for the defense costs we have incurred" if the insurer "initially defend[s] an insured or pay[s] for an insured's defense but later determine[s] that none of the claims, for which [the insurer] provided a defense or defense costs, are covered under this insurance [policy]." The court also allowed recoupment because the insurer reserved the right to recoupment in a letter to the insured explaining the right to pursue such recoupment in the event of noncoverage. Observing that "at least one court in this district has found that when the insurance policy at issue contains language reserving the right to recover defense costs if a court ultimately determines that no duty to defend exists, recoupment is allowed," the court granted the insurer's request for judgment on the issue because the insurer's "ability to recover costs incurred defending in the underlying suit was explicitly bargained for, and is therefore valid under the relevant policy endorsements."

XV. Consent

VIZIO, Inc. v. Arch Ins. Co., No. 22-55755, 2023 U.S. App. LEXIS 28735, 2023 WL 7123784 (9th Cir. Oct. 30, 2023) (interpreting California law)

Under California law, the Ninth Circuit held that an excess insurer's uncommunicated internal decision to disclaim coverage did not amount to a breach that would excuse an insured from obtaining the insurer's consent to an underlying settlement. The insurer issued an excess policy to an electronics manufacturing company which followed form to a primary policy that included language requiring the insured to obtain the insurer's consent before settling any claim. A number of consumer class action lawsuits were filed against the insured. The primary insurer denied coverage. Although the excess insurer was also notified and provided with the primary insurer's denial letter, the insured never provided the excess insurer with any substantive updates regarding the underlying matters. The insured ultimately settled the underlying class action lawsuits without the excess insurer's knowledge or consent. The Ninth Circuit affirmed the lower court's granting of the excess insurer's motion to dismiss with prejudice, finding that the excess insurer had no obligation to reimburse the insured for the settlement due to the insured's failure to obtain consent. The court rejected the insured's argument that the insurer was in breach because it had internally decided to disclaim coverage for the underlying matters. The court explained that "having never been notified of a denial of coverage, [the insured] still had an obligation to obtain [the excess insurer's] consent to any settlement[.]"

Santa Clara Valley Water Dist. v. Century Indem. Co., 89 Cal. App. 5th 1016 (Cal. Ct. App. 2023)

Under California law, a California Appellate Court held that negotiating and entering into a settlement regarding potential environmental cleanup liability did not constitute an extraordinary circumstance that would excuse an insured from complying with a consent provision. The insurer issued the insured water district a number of commercial general liability excess policies which provided that "[t]he [District] shall not, except at [its] own cost, voluntarily make any payment, assume any obligation or incur any expense[.]" The U.S. Department of Interior's Fish and Wildlife Service asserted allegations against the insured regarding mercury contamination of the Guadalupe River watershed. Although the insurer was notified of the allegations and reserved rights, the insured proceeded to negotiate and entered into a settlement and consent decree (and proceeded to make payments and incurred expenses pursuant to that agreement) without the insurer's knowledge or consent. The court affirmed the lower court's granting of the excess insurer's motion for summary adjudication, finding that "[n]o ... economic necessity, insurer breach, involuntariness of the District's actions, or other extraordinary circumstances justified the nonenforcement of the [consent] provisions in the excess policies[.]" In this regard, the court found that potential environmental cleanup liability did not constitute an exigency that would have excused the insured from complying with the consent provisions.

Am. Builders Ins. Co. v. Southern-Owners Ins. Co., 71 F.4th 847 (11th Cir. 2023) (applying Florida law)

Under Florida law, the Eleventh Circuit held that an insurer could not rely on lack of consent to a settlement as a defense where it could not establish "diligence and good faith in attempting to receive consent" and substantial prejudice resulting from the insured's settlement. The defendant insurer issued a commercial general liability policy to a subcontractor, which included language that provided "[n]o insured will, except at the insured's own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without our consent." An employee of the subcontractor was involved in an accident and asserted demands against the project's contractor, among others. The project's contractor was named as an additional insured by an endorsement which also provided that the subcontractor's policy would be primary under the circumstances. The contractor's commercial general liability insurer settled the underlying claim on behalf of the contractor after unsuccessfully attempting to

obtain consent from the subcontractor's insurer. The contractor's insurer succeeded at trial in a subsequent bad faith equitable subrogation lawsuit that it brought against the subcontractor's insurer. The Eleventh Circuit affirmed the underlying court's denial of the subcontractor's insurer's motion for judgment as a matter of law, or in the alternative for a new trial, holding, among other things, that it could not demonstrate that it was prejudiced by the lack of consent and could not demonstrate that it engaged in diligent and good faith attempts to obtain consent. Instead, the Eleventh Circuit found that the subcontractor's insurer "sat back and watched" while the contractor's insurer "did everything when it came to investigating … and deciding whether the insured should make a payment", and concluded that "without good faith, an insurer may not avail itself of an affirmative defense based on an insured's failure to cooperate [by obtaining consent]."

U.S. Sugar Corp. v. Com. & Indus. Ins. Co., No. 22-21737-Civ, 2023 U.S. Dist. LEXIS 58395, 2023 WL 2757027 (S.D. Fla. Apr. 3, 2023)

Under Florida law, the U.S. District Court for the Southern District of Florida held that a consent provision was enforceable with respect to expenses that were incurred before tender. An insurer issued a sugar company a commercial general liability policy that provided that "[n]o Insured will, except at that Insured's own cost, voluntarily make a payment, assume any obligation or incur any expense, other than for first aid, without our consent." The insurer denied coverage for a class action lawsuit that was filed against the insured. The insured successfully defended the underlying lawsuit and subsequently filed suit against the insurer to recover its defense expenses. While the court ruled in favor of the insured, finding that the insurer had breached its defense obligations, a dispute regarding what amounts the insurer was obligated to reimburse the insured ensued. The court granted the insurer's motion for partial summary judgment, concluding that the insurer had no obligation to pay for pre-tender expenses because, among other things, the insured had failed to seek the insurer's consent before incurring such costs.

Faulkner v. Martin, No. 1:19-CV-00054-GNS-HBB, 2023 U.S. Dist. LEXIS 63180, 2023 WL 2898446 (W.D. Ky. Apr. 11, 2023)

Under Kentucky law, the U.S. District Court for the Western District of Kentucky held that a settlement entered into by an insurer without its insured's consent was enforceable where there was no showing that the insurer acted in bad faith in obtaining the settlement. The insurer issued a law enforcement liability policy to a city that included language providing the insurer with the "authority to 'investigate and settle any claim or 'Suit' at [its] discretion" and the "right to settle any 'Claim' without the consent of the 'Member[.]'" The insurer settled the underlying lawsuit and obtained a full release on behalf of the insured police chief and other defendants. However, the police chief objected to the settlement and dismissal of the underlying lawsuit, arguing that the insurer did not have the authority to settle the matter without his consent. The court explained that, under Kentucky law, "[a]n insurer acting in good faith is permitted to act independently, and [is] 'not required to consult the interest of the insured to the exclusion of its own interest,' when deciding whether to settle claims against an insured party." The court rejected the police chief's argument that the insurer acted in bad faith because the insurer allegedly "made a self-serving business decision against his best interests of vindication by trial." The court explained that, even if the insurer's decision to settle was self-serving, it "does not amount to bad faith" because there was no indication that the police chief was prejudiced. The court found it significant that the claims released against the police chief were "without any finding of fault or wrongdoing by him," such that there could be no "impression that he acted wrongfully or illegally." Accordingly, the instant underlying lawsuit was dismissed with prejudice in light of the settlement.

First Am. Title Ins. Co. v. Ace Am. Ins. Co., No. 2:18-cv-01823, 2023 U.S. Dist. LEXIS 175258, 2023 WL 6379723 (D. Nev. Sep. 29, 2023)

Under Nevada law, the U.S. District Court for the District of Nevada held that summary judgment based on an insured's failure to obtain an insurer's consent to a settlement was inappropriate where questions of material fact existed as to whether the insurer acted in good faith in connection with defense and settlement efforts. The insurer issued a title agent company a professional liability policy which provided that "[t]he Insured shall not admit or assume liability or settle or negotiate to settle any Claim or incur Claims Expenses without the prior written consent of the Company[.]" The insurer agreed to defend the insured in connection with underlying litigation involving a construction loan transaction. After the underlying litigation had proceeded for about a decade, the insured advised the insurer that it reached a settlement with the underlying plaintiffs and that "'final settlement documents' would be completed in the coming days[.]" The insurer advised, among other things, that it was not in a position to consent to the settlement, requested a further analysis from the insured, and urged the insured to participate in a mediation. The insured proceeded to finalize the settlement without the insurer's consent. Because the settlement had already been reached without the insurer's knowledge or consent by the time its consent was requested, the court was persuaded that the policy's consent provision had been breached. However, in denying the insurer's motion for summary judgment, the court found that a genuine dispute of material fact existed regarding the enforceability of the consent provision, namely, whether the insurer had acted in good faith with respect to the underlying defense and underlying settlement efforts.

Conduent State Healthcare v. AIG Specialty Ins. Co., No. N18C-12-074 MMJ CCLD, 2023 Del. Super. LEXIS 97, 2023 WL 2256052 (Feb. 14, 2023) (applying New York law)

Under New York law, the Delaware Superior Court held that, because the insurer continued to reiterate its initial denial after receiving information concerning a subsequent amended pleading, the insurer's conduct amounted to a continued repudiation which excused the insured from seeking the insurer's consent to settle. The insurer issued certain policies to a company that was responsible for processing requests by Medicaid providers. The policies required the insured to obtain the insurer's prior written consent to settle. The State of Texas filed a lawsuit against the insured and others under the Texas Medicaid Fraud Prevention Act, among other things, in connection with the processing of Medicaid prior authorizations. In addition to granting the insured's motion for a new trial, the court granted the insured's motion for judgment as a matter of law in connection with the policies' consent provision. The insurer argued that, although it had previously denied coverage, the filing of the third amended petition "reset" the insured's requirement to cooperate and to seek consent because "there was no subsequent denial after that pleading was filed." The court rejected the argument, explaining that "[a]n insurer's 'non-final' coverage determination subject to a reservation of rights is a disclaimer of coverage and repudiation of liability, both of which release the insured from its duties to cooperate and to seek consent." In this regard, the court explained that the insurer was provided with information contained in the third amended petition before the settlement was executed. However, the insurer responded that it had previously "denied coverage based on the information available to it" and advised that "[y]ou have not provided us with any additional information that would change our view." The court found that the insurer's conduct constituted a continued repudiation of coverage, which excused the insured from obtaining the insurer's consent to settle as a matter of law.

Ballard v. Admiral Ins. Co., No. 5994, 2023 S.C. App. LEXIS 68, 2023 WL 4218123 (June 28, 2023)

Under South Carolina law, the South Carolina Appellate Court found that an insurer had the right to enter into settlement negotiations with the underlying claimant over the objections of the insured and found that the policy's hammer clause was unambiguous and enforceable. An attorney's professional liability insurer issued a policy that provided that the insurer had the right to control the underlying defense and that the insured had a duty to cooperate. The policy also contained a hammer clause providing that if "the Named Insured shall refuse to consent to any settlement recommended by the Insurer, which is acceptable to the claimant, and shall elect to contest the Claim … then the Insurer's liability for the Claim shall not exceed the amount for which the Claim could have been settled, including Claims Expense incurred up to the date of such refusal." The policy provided further that "the Insurer's right and duty to defend such Claim shall end upon the date of such refusal." An underlying claim was asserted against the insured, but the insured repeatedly rejected the insurer's plan to engage in settlement negotiations or to initiate mediation with the underlying claimant, as any settlement would purportedly tarnish the insured's reputation. The insured filed a declaratory judgment action and argued that, because the policy provided that "the Insurer shall not settle any Claim without the Named Insured's consent," she had the right to control settlement. The court rejected the argument, finding that the language relied on by the insured could not be read in isolation. The court affirmed the lower court's granting of the insurer's motion for judgment on the pleadings, finding that the insurer had the right to control settlement, that the insured had a duty to cooperate, and that the policy's hammer clause was unambiguous and enforceable and would operate to cap the insurer's liability and terminate its duty to defend if the insured refused to consent.

Knox TL Lot Acquisition, LLC v. First Am. Title Ins. Co., No. 3:21-CV-00374-JRG-DCP, 2023 U.S. Dist. LEXIS 52846, 2023 WL 2669050 (E.D. Tenn. Mar. 28, 2023)

Under Tennessee law, the U.S. District Court for the Eastern District of Tennessee rejected the argument that an insurer waived the policy's consent to settle requirement because it was aware of the underlying mediation and offered to contribute to an underlying settlement. The insurer issued the insured title insurance company policies that provided that the insurer "shall not be liable for loss or damage to the insured for liability voluntarily assumed by the Insured in settling any claim or suit without the prior written consent of [the insurer]." Although the insurer had previously advised the insured of the consent requirement, the insured proceeded to settle the underlying matter without the insurer's consent. The insured brought suit against the insurer for, among other things, refusing to indemnify it in connection with the underlying settlement. The court granted the insurer's motion for summary judgment regarding the enforcement of the consent provision. Although the court acknowledged that an insurer could impliedly waive its reliance on consent provisions, it found that those circumstances were not present, especially given the insurer's numerous references to the consent provision prior to the settlement. The court also rejected the argument that the insurer's knowledge of the underlying mediation was relevant for the waiver analysis, given that the insurer had put the insured on notice of the consent requirement. Further, the court rejected the insured's argument that the insurer's offer to contribute to the underlying settlement — in exchange for a claim release — and fact that the insurer reviewed the underlying settlement agreement after it was entered into were relevant to the waiver analysis.

BPX Prod. Co. v. Certain Underwriters at Lloyd's London, No. 4:22-cv-01058, 2023 U.S. Dist. LEXIS 85, 2023 WL 23233 (S.D. Tex. Jan. 3, 2023)

Under Texas law, the U.S. District Court for the Southern District of Texas rejected the argument that an insurer should be barred from relying on

the consent requirement in the policy's definition of "suit" because it denied coverage for the claim. The insurer issued a commercial general liability policy to an oilfield services company, which provided that it only had a duty to defend "suits," which were defined to include "[a]ny other alternative dispute resolution proceeding in which such damages are claimed and to which the insured submits with our consent." Although the court acknowledged that pre-litigation settlement discussions between the insured and underlying claimant could constitute "any other alternative dispute resolution proceeding," the court found that the insurer did not consent to any such negotiations or mediation attempts. Accordingly, the insurer did not have a duty to defend the insured and the court granted the insurer's motion to dismiss. The court rejected the assignee's argument that because the insurer denied coverage, it could not rely on the consent language. The court explained that "[i]n effect, [the assignee] asks me to read the consent provision out of the CGL Policy" and that under Texas law, "[a]s much as [the assignee] would like me to, I cannot read words out of the CGL Policy." The court also found that the insurer's general reservation of rights sufficiently preserved the right to raise the consent issue, even though it was not specifically addressed in their denial letter. This decision is currently on appeal to the Fifth Circuit.

Ryan Law Firm, LLP v. New York Marine & Gen. Ins. Co., No. 1:19-CV-629-RP, 2023 U.S. Dist. LEXIS 183425, 2023 WL 6702597 (W.D. Tex. Oct. 12, 2023)

Under Texas law, the U.S. District Court for the Western District of Texas ruled that where an insurer demonstrates prejudice, it is relieved from contributing to a settlement entered into without its consent. A law firm was issued a professional liability policy which provided that "the Insured shall not assume any obligations, incur any costs, charges, or expenses or enter into any settlement without the Company's consent." A malpractice lawsuit was brought against the insured that sought, in part, relief from excluded conduct. The insured entered into post-tender negotiations with the underlying claimant and reached a tentative settlement of $2.75 million, believing that it faced significant exposure from the excluded conduct. The insured proceeded to settle without the insurer's consent after the insurer indicated that it would only contribute $300,000, a number which the insurer believed was reasonable to resolve the "covered or potentially covered damages." The court denied the insured's motion for a new trial, finding that there was sufficient evidence to support a finding of prejudice due to the insured's failure to obtain the insurer's consent. The court explained that the insurer was "complete[ly] excuse[d]" from participating in the settlement, rejecting the argument that the insurer should have been compelled "to pay what was reasonable," *e.g.*, the amount that it previously offered to contribute.

Hermanson Co., LLP v. Siriuspoint Specialty Ins. Corp., No. 2:23-cv-00431-JHC, 2023 U.S. Dist. LEXIS 223805, 2023 WL 8701090 (W.D. Wash. Dec. 15, 2023)

Under Washington law, the U.S. District Court for the Western District of Washington held that an insurer was required to show actual and substantial prejudice in order to rely on a consent provision to deny coverage. The insurer issued a professional liability policy to a mechanical contractor, which included coverage for certain contractor's professional redress expenses "provided that… prior to incurring such REDRESS EXPENSE… the Company consents in writing to such expense." The insurer denied the insured's requests for certain redress expenses, given that they were incurred without the insurer's consent prior to tender. The court found that, because the consent provision was not a "core coverage requirement," the insurer must show that it was actually and substantially prejudiced by the failure to obtain consent in order to deny coverage. Given the insurer's failure to make such a showing, the court denied the insurer's motion for summary judgment.

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