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2024 D&O and Professional Liability Year in Review

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Introduction

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.

I.

Notice

***AIG Specialty Ins. Co. v. Agee*, No. CV 22-5410, 2024 U.S. Dist. LEXIS 13995, 2024 WL 303196 (E.D. La. Jan. 26, 2024)**

Under Louisiana law, the U.S. District Court for the Eastern District of Louisiana found that the subject claim was both first made and first reported within the same policy period, and thus was within the policy's insuring grant (but ultimately excluded from coverage by the policy's breach of contract exclusions). The insurer issued directors, officers, and private company liability and employment practices liability policies to the insured, a laboratory testing company, for consecutive policy periods from March 31, 2015 to March 31, 2017; March 31, 2017 to March 31, 2018; and March 31, 2018 to March 31, 2020. The policies required that a claim be both first made and first reported by the insured to the insurer within the policy period or within ninety days after the policy period concluded. The underlying dispute was between the insured and former employees whom it had terminated on April 3, 2015, without cause and who subsequently demanded unpaid compensation through correspondence throughout April 2015. On May 6, 2017, the insured's former employees brought an action in federal court against the employer for unpaid employee compensation, which was dismissed without prejudice. On October 17, 2017, the insured's former employees brought another action against the insured in state court, resulting in a judgment against the insured, which the court deemed "a Loss" under both the directors and officers and employment practices liability sections of the policies. The insurer argued that the claim arose on April 18, 2015, upon correspondence from one of the former employees demanding monetary relief and that the insured was therefore required to report the claim before June 30, 2017, to trigger coverage under the policy period from March 31, 2015 to March 31, 2017. The court found, contrary to the insurer's argument, that the April 18, 2015, demand did not constitute a claim, because the insured intended to pay the demand and did not interpret it as a claim that would require reporting to the insurer. A claim only arose when the requests for unpaid

compensation could not be satisfied and "a claim was formally made in the form of a lawsuit" initially filed on May 6, 2017, and thus coverage for the judgment against the insured arising out of the underlying litigation fell within the policy period from March 2017 to March 2018. The case is currently on appeal to the U.S. Court of Appeals for the Fifth Circuit.

Stormo v. State Nat'l Ins. Co., 116 F.4th 39 (1st Cir. 2024)

Under Massachusetts law, the U.S. Court of Appeals for the First Circuit held that the insurer was not required to prove prejudice from the insured's failure to provide "prompt written notice," and further that the insured's one-year delay in providing notice to the insurer precluded coverage. The insurer issued a claims-made professional liability policy to the insured, who assigned his rights under the policy to the plaintiff in the coverage action. The policy contained a condition titled, "Insured's Duties Precedent to Coverage," which provided, in relevant part, that "[i]f a Claim is made against any Insured, the Insured must give prompt written notice to [the insurer]." At the trial-court level, the U.S. District Court for the District of Massachusetts held in favor of the insurer, finding that the insured's one-year delay in providing written notice to the insurer failed to satisfy the policy's notice condition, and further that the insurer did not have to demonstrate prejudice from the late notice. On appeal, the insured relied on certain Massachusetts statutes, including those relating to motor-vehicle policies, to argue that the insurer had to demonstrate prejudice from the late notice. The court, however, disagreed, noting that "this notice-prejudice rule does not occupy the field." Specifically, the court held that, under Massachusetts law, the notice-prejudice rule does not apply to claims-made policies and that "Massachusetts case law is most easily read as limiting the prejudice requirement to occurrence-based policies." Accordingly, the court affirmed the district court's judgment in favor of the insurer.

Atos Syntel Inc. v. Ironshore Indem. Inc., No. 21-cv-1576 (JGK), 2024 U.S. Dist. LEXIS 167920, 2024 WL 4227709 (S.D.N.Y. Sept. 17, 2024)

Under Michigan law, the U.S. District Court for the Southern District of New York held that an excess insurer was entitled to summary judgment due to the insured's late notice of the underlying lawsuit, which came over three years after the policy period expired. The insurer issued an excess claims-made errors and omissions policy to the insured, a technology and professional services provider, for the policy period running from October 8, 2014, to October 8, 2015. The excess insurer's policy provided that "'[a]s a condition precedent to their rights under this policy, the Insureds' … 'shall give to the Insurer' … 'as soon as practicable written notice in accordance with the terms, conditions, definitions, exclusions, and limitations of the' [primary] Policy." The primary policy, in turn, provided that "[t]he Insured, as a condition precedent to the obligations of the Insurer[,] shall give written notice of any Claim … to the Insurer as soon as reasonably practicable after any Executive Officer learns of such Claim … but in no event later than ninety (90) days after termination or expiration of the Policy Period or any subsequent renewal Policy Period in an uninterrupted series of renewals, or prior to the expiration of the Extended Reporting Period." Finally, the notice provision of the primary policy was amended by endorsement to provide that "[f]ailure to give any notice required to be given by this Policy within the time prescribed herein shall not invalidate coverage of any claim, unless the failure to provide timely notice has prejudiced [the insurer] or unless the notice is provided after the expiration of the policy period, any renewal policy period and any extended reporting period." On February 23, 2015, a counterclaimant in a lawsuit brought by the insured asserted claims against the insured. On October 5, 2016, the insured provided notice to the primary insurer (which had continued to renew the policy through October 2017). While the primary insurer defended the insured pursuant to a reservation of rights, notice was not provided to the excess insurer until May 3, 2019. The excess insurer denied coverage on May 16, 2019, on several bases, including late notice. Noting that "[t]he notice requirement in the [excess insurer's] Policy 'could not be clearer[,]'" the court found that the insured's failure to provide notice to the excess insurer during the policy period or within 90 days of its expiration (January 6, 2016) vitiated its claim for coverage, "whether [the excess insurer] was prejudiced by the late notice[ ] or not." The excess insurer was not required to demonstrate prejudice due to the late notice because "Michigan law does not 'impose a prejudice requirement on contractual provisions requiring notice within a specified time[.]'"

***Bridges v. Maxum Indem. Co.*, No. 24-10139, 2024 U.S. Dist. LEXIS 201275, 2024 WL 4682691 (E.D. Mich. Nov. 5, 2024)**

Under Michigan law, the U.S. District Court for the Eastern District of Michigan held that the insured's notice of a potential claim during the policy's extended reporting period did not bring the resulting claim within the scope of coverage and granted the insurer's motion to dismiss. The insurer issued a claims-made professional responsibility policy to the insured for the policy period of May 2, 2018, to May 2, 2019. The insured purchased an optional, extended reporting period of two years, which was in effect "from June 2, 2019, until June 2, 2021." The policy provided, in relevant part: "This is a 'claims-made and reported' policy which provides professional liability coverage for those claims that occur subsequent to the retroactive date stated in the declarations and which are first made against you and reported to us while this policy is in force. No coverage exists for claims first made against you and reported to us after the end of the policy period unless, and to the extent, an extended reporting period applies." The policy also provided that, "[i]f during the 'Policy Period' the 'Insured' shall become aware of any 'Wrongful Act' that may reasonably be expected to be the basis of a 'Claim' against the 'Insured' and if the 'Insured' shall during the 'Policy Period' give written notice to the Company of such 'Wrongful Act' and the reason for anticipating a 'Claim' … then any such 'Claim' that may subsequently be made against the 'Insured' arising out of such 'Wrongful Act' shall be deemed for the purposes of this insurance to have been made during the 'Policy Period'." The insured notified the insurer of a potential claim on April 20, 2020, during the extended reporting period, but the claim against the insured (a professional negligence lawsuit) was made on February 18, 2022, after both the policy period and extended reporting period expired. The court held for the insurer, finding that "because Plaintiff's February 18, 2022 claim was made after the expiration of the policy period and extended reporting period, no coverage is afforded under the [insurer's] policy." Further, the insured's reporting of a potential claim during the extended reporting period was insufficient to bring the February 2022 claim within the policy period; potential claims could only be reported during the "'policy period' (not the 'extended reporting period') for coverage to apply to a subsequent actual claim."

***350 E. Houston St., LLC v. Travelers Indem. Co. of Am.*, No. 650450/2018, 2024 NY Slip Op 33729(U) (Sup. Ct. Oct. 10, 2024)**

Under New York law, a New York trial court found that the insured's failure to obtain the insurer's consent prior to undertaking remedial activities prejudiced the insurer for purposes of a late notice defense. While analyzed under a commercial umbrella policy rather than a professional liability policy, the court's analysis is instructive in analyzing what constitutes prejudice, when prejudice is required to prevail on a late notice defense. An owner of a 10-story residential building development qualified as an additional insured under a commercial umbrella policy issued to an excavation subcontractor. The policy included a consent provision providing 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." While the underlying incident that caused damage to an adjacent building occurred in March 2017, the insurer was not provided notice until 11 months later in February 2018, when it was provided with a copy of the summons and complaint that was ultimately filed against the owner. The court agreed with the insurer that there was no coverage for the underlying matter because the insured's 11-month delay in providing notice did not satisfy the policy's "as soon as practicable" reporting requirement and that the insured's late notice had prejudiced the insurer pursuant to N.Y. Ins. Law Section 3420. The court granted the insurer's motion for summary judgment, finding that the insurer was prejudiced by the late notice, because the owner "made payments regarding the stabilization, repair, and remediation work without [the insurer's] consent and prior to affording [the insurer] the opportunity to investigate the claim to adequately defend the claim."

***Virmani v. Pro. Sec. Ins. Co.*, 897 S.E.2d 44 (N.C. Ct. App. 2024)**

Under North Carolina law, the Court of Appeals of North Carolina concluded that the insurer was not required to reimburse the insured for regulatory defense fees incurred in connection with a medical board investigation. The insurer issued a claims-made medical professional liability insurance policy to the insured, an OB/GYN, for a policy period ending in November 2019. The policy "protect[ed]

the [insured] 'from claims first made and incidents first reported . . . during the policy period and arising out of your professional activities during the protected period, provided that you comply with the conditions and notification provisions specified in this policy[.]'" The North Carolina Medical Board informed the insured that he was under investigation on July 26, 2019, and the insured retained counsel. The insured did not, however, notify the insurer until after the policy period ended. Due to the insured's failure to report the claim within the policy period, the court found that the insurer's denial of coverage was proper. In so finding, the court wrote that "[a]llowing [the insured's] late-reported claim to be covered under the policy would improperly transform the policy into an 'occurrence policy,' an insurance policy which indemnifies the [insured] for any loss from an event that occurs within the policy period, regardless of when the claim is made."

***Westport Ins. Corp. v. McGogney*, No. 5:22-cv-02431-JMG, 2024 U.S. Dist. LEXIS 135096, 2024 WL 3606351 (E.D. Pa. July 31, 2024)**

Under Pennsylvania law, the U.S. District Court for the Eastern District of Pennsylvania concluded that the insurer was entitled to declaratory relief that it had no duty to defend or indemnify its insured because the insured did not report the claim within the required policy period. The insurer issued two claims-made-and-reported lawyers professional liability insurance policies to its insured, a law firm, for two consecutive one-year policy periods: the first running from July 11, 2009, to July 11, 2010; the second from July 11, 2010, to July 11, 2011. The policies' declarations pages provided, "in bold letters[,]" the following: "NOTICE: This is a Claims-Made and Reported POLICY. Except as may be otherwise provided herein, this coverage is limited to liability for only those CLAIMS which are first made against the NAMED INSURED and reported to the Company while the POLICY is in force." The policies' "reporting and notice" section further provided, in relevant part, that "[a]s a condition precedent to coverage under this COVERAGE UNIT, if a CLAIM is made against any INSURED, or if any INSURED becomes aware of any CLAIM, the INSURED(S) shall, as soon as practicable, but no later than sixty (60) days after the termination of the POLICY PERIOD, provide written notice to the Company." The underlying claimant filed a legal malpractice lawsuit against the insured on April 2, 2010, the insured was served with the writ of summons on May 11, 2010, and entered his appearance on June 25, 2010. The next day, the underlying claimant filed a complaint alleging, among other things, professional negligence. On October 6, 2010, the insured sent a letter to the insurer, but the letter was not received until June 16, 2011. The insurer denied coverage on July 6, 2011, because the claim was not made and reported to the insurer within the required period. The court determined that the insurer was entitled to default judgment on its claim for declaratory relief because the claim at issue was "first made" (via service of the writ of summons) on May 11, 2010, during the 2009-2010 policy period, but notice was not provided until — at the earliest — October 6, 2010, which was three months after the policy period ended. Noting that, "[w]ith respect to a 'claims made' policy, under Pennsylvania law an insured which fails to give notice to the insurance company in the same policy period as that in which the claim was made against the insured forfeits coverage[,]" the court held that the insured was not entitled to coverage.

***Marshall v. ISMIE Mut. Ins. Co.*, No. 2:24-cv-00223-DCN, 2024 U.S. Dist. LEXIS 187229, 2024 WL 4495355 (D.S.C. Oct. 15, 2024)**

Under South Carolina law, the U.S. District Court for the District of South Carolina held that there was a genuine issue of material fact as to whether the claim against the insured, which was filed after the policy period expired, could be deemed to have arisen during the policy period based on an earlier notice of potential claim given to the insurer during the policy period. The insurer issued a claims-made-and-reported lawyers professional liability policy to its insured, a lawyer, for the policy period of July 10, 2022, to July 10, 2023. The policy "generally provide[d] coverage when 'the Insured becomes legally obligated to pay as a result of a Claim first made against the Insured and reported in writing to the Insurer during … the Policy Period." The policy, however, also included a "Notice of Potential Claims" section providing that "[i] f during the Policy Period, [the insured] becomes aware of any facts or circumstances that may reasonably be expected to give rise to a Claim, and written notice is given to [the insurer] as soon as practicable but in no event later than the last day of the Policy Period … then any Claim or coverage under this policy arising out of

such specific facts or circumstances that is subsequently made against [the insured] and reported to [the insurer] shall be deemed first made during the Policy Period as of the date of such notice." The insured argued that he "first became aware of facts and circumstances that could reasonably be expected to give rise to a claim once the South Carolina Supreme Court dismissed [the underlying malpractice claimant]'s petition for a writ of certiorari [in the underlying litigation] on April 5, 2023." Further, the insured argued, and the insurer did not dispute, that the insured provided the insurer with written notice of the potential claim in either April or May 2023. The underlying malpractice claimant filed a lawsuit against the insured on September 25, 2023, after the policy period expired. The insurer argued that the insured was aware of the facts giving rise to a potential claim before the policy period began, such that the notice of potential claim section would not be able to deem the malpractice claim "first made" during the policy period. The court, after viewing the evidence put forth by both parties, determined that there was "a genuine issue of material fact as to whether [the underlying malpractice claimant]'s claim against [the insured] can be deemed to have arisen during the Policy Period, and the court denies [the insurer]'s motion for judgment on the pleadings accordingly."

W. Va. Mut. Ins. Co. v. Matulis, --- S.E.2d ----, 2024 W. Va. App. LEXIS 383, 2024 WL 5086822 (W. Va. Inter. Ct. App., Dec. 12, 2024)

Under West Virginia law, the West Virginia Intermediate Court of Appeals held that the trial court erred by holding that the insurer failed to demonstrate "sufficient prejudice" to preclude coverage based on the insured's failure to provide timely notice of administrative proceedings. The insurer issued a medical professional liability insurance policy to its insured, a medical services provider. The court's opinion did not specify whether the policy was written on a claims-made, claims-made-and-reported, or occurrence basis. Several former patients of the insured sued the insured, alleging that one of its physicians sexually assaulted them during medical procedures. The trial court did not make any findings regarding the reasonableness of the insureds' delay in providing notice to the insurer. Because, under West Virginia law, the insured's delay in providing notice must be "reasonable" for the burden to shift to the insurer to show prejudice, the West Virginia Intermediate Court of Appeals concluded that the trial court erred by requiring the insurer to demonstrate prejudice without first making findings regarding the reasonableness of the insured's delay.

Giant Eagle, Inc. v. Am. Guar. & Liab. Ins. Co., No. 2:19-cv-00904-RJC, No. 2:22-cv-00468-RJC, 2024 U.S. Dist. LEXIS 57452, 2024 WL 1346650 (W.D. Pa. Mar. 29, 2024)

Under federal law governing discovery disputes, the U.S. District Court for the Western District of Pennsylvania held that an excess insurer's assertion of a late-notice defense made discovery into communications between the excess insurer and its reinsurers appropriate. While the policy at issue was an occurrence-based commercial umbrella liability policy issued to a grocery store company, rather than a professional liability policy, the case is instructive as to issues relating to proving up a late notice defense. The excess insurer moved for a protective order to prevent the insured from obtaining discovery regarding reinsurance information, which the excess insurer argued was irrelevant and confidential. For its part, the insured argued that reinsurance information was "relevant to [the excess insurer]'s late-notice defense and recission counterclaim[.]" The court sided with the insured, noting that "discovery into reinsurance may be appropriate where a party raises an affirmative defense involving notice or a counterclaim for recission based upon misrepresentation." The court reasoned that the "[insured's] purpose for seeking the reinsurance information is simple; they wish to determine whether or not timely notice was given to the reinsurers by the insurer[ ]. If such notice was given, it is evidence that the insurers had timely notice, and would moot the lack of notice defense[ ] ... ."

II.

Related Claims

***Oxnard Manor LP v. Hallmark Specialty Ins. Co.*, 709 F. Supp. 3d 971 (C.D. Cal. 2023)**

Under California law, the U.S. District Court for the Central District of California held that two lawsuits filed against an insured skilled nursing facility operator were not related within the meaning of a professional liability policy's related claims provision. Prior to the policy period, the insured was sued by a resident in an action alleging widespread understaffing of facilities in a manner that risked harm and inadequate medical care for residents. During the policy period, the heirs of a deceased resident brought suit against the insured, alleging that the death of the resident arising from a fall was caused, in part, by the lack of adequate staffing at the facility. The insurer denied coverage, arguing that, by operation of the policy's related claims provision, the second lawsuit related back to the pre-inception lawsuit because each arose from allegations of understaffing and thus arose from logically or causally related common facts and events. The court disagreed and emphasized that the policy language required that there be a "single" act or omission connecting any "related" claims. Although the insurer argued that the understaffing of the facility where the resident died was the common act connecting the claims, the court rejected the notion that the language could be stretched that broadly. The court thus held that the circumstances underlying the two lawsuits were too attenuated to be related, where the decision to understaff facilities years prior to the incident was the sole common connection.

***Alexion Pharms., Inc. v. Endurance Assurance Corp.*, No. N22C-10-340 PRW CCLD, 2024 Del. Super. LEXIS 103, 2024 WL 639388 (Del. Super. Ct. Feb. 15, 2024), reversed by *In Re Alexion Pharmaceuticals, Inc. Insurance Appeals*, 2025 Del. LEXIS 52 (Del. Feb. 4, 2025)**

Under Delaware law, the Delaware Superior Court found that a Securities and Exchange Commission (SEC) investigation and its settlement were not related to a

subsequent securities class action lawsuit. The insured, a drug manufacturer, sought coverage for the securities class action under a tower of directors and officers liability insurance in place from 2015 to 2017. The 2015 to 2017 insurers argued that coverage fell within the 2014 to 2015 tower, because the securities class action related back to the SEC investigation and settlement, and thus was deemed first made at the time of the SEC's order of investigation, which was prior to the inception of the 2015 to 2017 tower. Emphasizing that Delaware law requires a "meaningful linkage" for multiple claims to be considered "related," the superior court found that the only common circumstance connecting the claims was the company's sale of one particular prescription drug in Brazil. In reversing the superior court's decision, the Delaware Supreme Court applied the same "meaningful linkage" standard but came to a different conclusion. The supreme court found that, as a threshold matter, the superior court erred in comparing the securities class action to the earlier SEC subpoena, rather than to the notice of circumstances that the insured provided to the insurers when it reported the SEC subpoena. The notice of circumstances detailed broader categories of possible conduct that could give rise to different types of claims, including the wrongdoing alleged by the securities class action plaintiffs, which overlapped in numerous respects with what the insured disclosed in the notice of circumstances. Thus, the securities class action fell within the 2014-2015 policy period, and not the 2015-2017 policy period.

***Immunomedics, Inc. v. Hudson Ins. Co.*, No. N23C-08-179 PRW CCLD, 2024 Del. Super. LEXIS 275, 2024 WL 1235407 (Del. Super. Ct. Mar. 18, 2024)**

Under Delaware law, the Delaware Superior Court held that lawsuits brought against a drug manufacturer were not related within the meaning of the manufacturer's directors and officers liability policy. In 2017, the insured was sued in connection with alleged breaches of fiduciary duty and mismanagement by the board of directors leading up to the company's annual meeting, at which it was set to launch a cutting-edge drug to be used for breast cancer treatment. In 2018, the insured was sued in a securities class action alleging misconduct by a reconstituted board of directors in managing the consequences of a data breach, which held up the U.S. Food and Drug Administration (FDA) approval of the same drug. The insured sought coverage for the 2018 claim, and the insurer denied coverage under a specific litigation exclusion that barred coverage for claims related to "the Securities Claim filed on June 9, 2016." The court emphasized that Delaware law requires there to be a "meaningful linkage" for claims to be considered related under a directors and officers liability policy. Looking to the factors set forth by the Delaware Supreme Court in *First Solar, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 274 A.3d 1006, 1013 (Del. 2022), the court found that the actions were not related because they involved (1) different directors and officers, (2) different time periods, (3) different theories of liability, (4) different evidence, and (5) different damages.

***Arch Ins. Co. v. PCH Mgmt. Alpha, LLC*, No. 1-23-0738, 2024 Ill. App. Unpub. LEXIS 2381, 2024 WL 5039931 (Ill. App. Ct. Dec. 9, 2024)**

Under Illinois Law, the Appellate Court of Illinois found that coverage was barred under a directors and officers liability policy because the claim tendered for coverage by the insured related back to an earlier lawsuit arising out of related wrongful acts. In the underlying case, the insured was sued in connection with alleged fraudulent medical billing practices. The insured sought coverage under a directors and officers liability policy issued with a September 2017 to September 2018 policy period. The policy provided, however, that all claims arising from interrelated wrongful acts would be deemed a single claim first made at the time of the first such claim. In June 2017, prior to the policy period, the insured was sued in connection with a fraudulent medical billing scheme instituted after the insured took control of operations at the plaintiff hospital system. Then, during the policy period, the insured was sued by a different health system alleging a similar pattern of fraudulent billing practices after taking control of a financially distressed care system. The trial court found that the claims were factually interrelated and that the subsequent claim related back to the first claim prior to the policy period. The appellate court affirmed, reasoning that the two claims "clearly share[d] a common nexus of facts, circumstances, and events" that the insured "engaged in the same fraudulent billing scheme with both hospitals for its own financial benefit."

***Certain Underwriters at Lloyd's, London v. Auto. Acceptance Corp., Inc.*, No. 23-2030-DDC, 2024 U.S. Dist. LEXIS 134302, 2024 WL 3580594 (D. Kan. July 30, 2024)**

Under Kansas law, the U.S. District Court for the District of Kansas found that coverage was barred for a class action lawsuit that was filed prior to the inception of three successive professional liability policies. Prior to the first policy period, the insured was sued in Missouri state court in a class action proceeding alleging unlawful debt collection practices. The insured did not disclose the existence of the class action during the underwriting process and first provided notice to the insurers after the class was certified. The insurers denied coverage and sought a declaratory judgment that the policy did not provide coverage for the class action, which predated the first policy issued to the insured. In response, the insured argued that the claims involving subsequent conduct during the policy period of the 2022 policy were separate claims that were first made upon class certification. The court disagreed and explained that, pursuant to the policy's related claims provision, all claims brought within the class action arose from interrelated wrongful acts and thus related back to the filing of the complaint prior to the policy period of the first policy issued to the insured. The court emphasized that the claims asserted by the class members necessarily must arise from a common nexus of fact because certification would have otherwise been improper. Thus, "even if the class members had asserted separate claims — and to be clear, they didn't — those claims arise out of interrelated wrongful acts because they all share a common nexus."

***Dexon Computer, Inc. v. Travelers Prop. Cas. Co. of Am.*, 101 F.4th 969 (8th Cir. 2024)**

Under Minnesota law, the U.S. Court of Appeals for the Eighth Circuit held that a trademark infringement action against a reseller of computer products did not relate back to an earlier infringement suit raising similar allegations. The insured sought coverage for the subsequent lawsuit under a professional liability policy, which included a retroactive date of May 18, 2019, and a related wrongful acts provision that deemed all interrelated wrongful acts to be first made at the time of the first such wrongful act. Although the complaint alleged wrongful acts occurring during the policy period of the professional liability policy at issue, it also alleged a variety of wrongful conduct prior to the retroactive date which had been previously alleged in the earlier infringement suit. The district court, underscoring the broad nature of the duty to defend under Minnesota law, held that the insurer did owe defense coverage to the insured because if even one wrongful act during the policy period was unrelated to the pre-inception wrongful conduct, the duty to defend was triggered. The Eighth Circuit affirmed, reasoning that the "alleged acts of infringement occurred at different times, involved different customers who were sold different products sourced from different suppliers" and thus were not necessarily causally or logically related.

***Those Certain Underwriters at Lloyd's, London v. U-Drive Acceptance Corp., Inc.*, No. 4:23-CV-99-JMB, 2024 U.S. Dist. LEXIS 102624, 2024 WL 2891467 (E.D. Mo. June 10, 2024)**

Under Missouri law, the U.S. District Court for the Eastern District of Missouri held that a retroactive date exclusion applied to bar coverage for a consumer class action alleging unlawful enforcement and collection practices. The insured sought coverage under a management liability policy that excluded any claims involving wrongful acts committed prior to January 29, 2020. In the underlying action, the insured brought suit to enforce the terms of an auto loan that it issued, and the consumer responded with a class action complaint alleging widespread unlawful collection practices by the insured dating back to the issuance of her loan in 2017. In seeking coverage, the insured argued that, although the class representative's claim involved wrongful acts dating back to 2017, it was possible that other class members would have claims alleging wrongful conduct solely after January 29, 2020. The court, looking to the policy's related wrongful acts provision, rejected that argument and explained that any such claims involving later wrongful conduct would still arise from interrelated wrongful acts and thus relate back to the date of the first wrongful act in 2017. The court reasoned that, by definition, the class action "requires common questions of law and fact" and that any subsequent claims would necessarily involve a common nexus of law and fact and thus arise from a series of interrelated wrongful acts.

III.

Prior Knowledge, Known Loss, and Rescission

***Berkley Assurance Co. v. Springdale Pub. Sch.*, No. 5:23-CV-05042, 2024 U.S. Dist. LEXIS 27871, 2024 WL 666500 (W.D. Ark. Feb. 17, 2024)**

Under Arkansas law, the U.S. District Court for the Western District of Arkansas held that the prior knowledge exclusion precluded the insurer's duty to defend a sexual abuse lawsuit in which the insured school district knew or should have known of the allegations against its assistant principal. The prior knowledge exclusion of the School Board Legal Liability and Employee Practices Liability Policy, stated that the insurer shall not make payment for a loss or defend any claims "[a]rising from any circumstance(s) or incident(s) which might reasonably be expected to give rise to a CLAIM hereunder, which is either known or reasonably should have been known to the INSURED prior to the Inception of this policy and not disclosed to the Company prior to inception." In the underlying lawsuit, a former student alleged that the school's assistant principal groomed, stalked, and sexually assaulted her over a three-year period. The complaint alleged that the abuser's misconduct had been reported to the school's leadership by multiple students and teachers over the years, and the school's principal had displayed "deliberate indifference" to the actual notice that had been provided to him of the sexual misconduct. The insurer denied coverage for the lawsuit based on the policy's prior knowledge exclusion and filed a declaratory judgment action seeking a declaration that it owed no coverage for the lawsuit. The court found that there was "near universal" knowledge of the sexual misconduct scandal within the school district, which led to the abuser's arrest and conviction for sexual assault.

***Evans & Lewis, LLC v. Nat'l Liab. & Fire Ins. Co.*, No. DBD-CV-23-6046736-S, 2024 Conn. Super. LEXIS 1523, 2024 WL 3579684 (Sup. Ct. Conn. July 22, 2024)**

Under Connecticut law, the Superior Court of Connecticut for the Judicial District of Danbury held that

an insured attorney's failure to disclose a professional grievance complaint in its policy application, even though the grievance was dismissed without punishment to the insured attorney, triggered the prior-knowledge exclusion and precluded coverage for a civil suit arising from the same facts. In its application for the professional liability policy, the insured law firm answered "no" to a question asking whether the firm or any attorney had been involved in a suit arising out of the failure to render legal services or if they were aware of any act, error, omission, or incident "reasonably expected to result in a claim or suit." The insureds provided similar responses in a warranty letter two months later. A few months prior to the initial application, a client of the insureds filed a grievance complaint against one partner claiming the insured attorney was negligent in his representation of her foreclosure/bankruptcy. During the policy period, the client also filed a professional malpractice civil suit for which the insureds sought coverage, which was denied. The court applied Connecticut's two-part, subjective-objective test to determine whether a prior knowledge exclusion applies to a claim. In granting judgment in favor of the insurer, the court held that the insured had actual knowledge of the act or omissions, the subjective inquiry, and that a reasonable person in the insured's position would expect those facts to be the basis of a claim, an objective inquiry. The insured argued that the fact that the grievance complaint was dismissed showed a reasonable person would not necessarily have reported it, since the grievance lacked merit, but the court rejected that argument, holding that it "is the fact that the complaint existed at all at the time the application was submitted that is critical," not the merits of the grievance complaint. The court also relied on unrebutted evidence from the insurer's underwriting manager that the insurer "would have either issued an exclusion to the policy for such a claim or substantially increased the premium quoted" had the grievance been disclosed.

***Accent Consulting Grp., Inc. v. Great Am. Assurance Co.*, No. 1:22-cv-01767-JMS-CSW, 2024 U.S. Dist. LEXIS 89990, 2024 WL. 2272126 (S.D. Ind. May 20, 2024)**

Under Indiana law, the U.S. District Court for the Southern District of Indiana held that the insured appraiser made a material misrepresentation in the renewal application for her Real Estate Professional Errors & Omissions policy by failing to disclose a consumer complaint asserted against her. The consumer complaint was filed with the Office of the Indiana Attorney General (AG) and alleged that the insured appraiser conducted an inaccurate appraisal, causing the owners to lose a sale, and that the appraiser did not act in good faith or with appropriate professionalism. The insured also responded to a request for documents from the AG's office. In her application for renewal six months later, the insured denied being aware of any "[c]omplaint, disciplinary action, investigation or license suspension/revocation by any regulatory authority." The AG's office subsequently filed a complaint against the insured before the Real Estate Appraiser Licensure and Certification Board, which the insured tendered to the insurer. The insurer denied on the basis that the claim had been received during the prior policy period and not timely reported. During litigation that arose from the denial, the insurer counter-complained for rescission on the basis of misrepresentation in the policy application. The court held that the insured was entitled to rescind the policy because Indiana law allows rescission even for innocent misrepresentations and the misrepresentation here was material because it "led directly" to the tendered complaint.

***Minnesota Lawyers Mut. Ins. Co. v. Rasmussen, Nelson & Wonio, PLC*, No. 23-1668, 2024 Iowa App. LEXIS 716, 2024 WL 4369947 (Ct. App. Iowa Oct. 2, 2024)**

Under Iowa law, the Court of Appeals for Iowa held that a verbal disclaimer by a potential claimant did not absolve an insured attorney from disclosing a potential claim on its policy renewal application, and entitled the insurer to rescind the policy when that potential claim was realized. The insured law firm purchased professional liability insurance from the insurer. In 2019, the insured firm represented individuals in the purchase and financing of real property. The clients alleged that the insured failed to timely renew a financing statement resulting in the clients' loss of their status as first-priority secured creditors and a loss of net proceeds on the transaction. In March 2021, the insureds alleged that one of the clients told them verbally that he "would not make a claim against them," although there was no writing reflecting this. In August 2021, the insured submitted a renewal application without

mentioning the financing statement issue. In April 2022, the clients' new counsel informed the insured that they should notify their professional liability insurer. The insured denied coverage. The district court granted summary judgment in favor of the insurer and the court of appeals affirmed. In affirming, the court of appeal explained that whether the insured was "aware of any INCIDENT which could reasonably result in a claim being made" referred to whether there was an act or omissions that could support a claim — not the insured's subjective belief as to whether the claim would be asserted.

***CMGK, LLC v. Certain Underwriters at Lloyd's, London*, No. A-1836-22, 2024 N.J. Super. Unpub. LEXIS 1188, 2024 WL 2966570 (N.J. Super. Ct. App. Div. June 13, 2024)**

Under New Jersey law, the Superior Court of New Jersey, Appellate Division, held that there was no coverage for a lawsuit alleging sexual misconduct because the insured had prior knowledge of the sexual act in question. The claims-made professional liability policy included a Sexual Acts Liability Endorsement with a prior-knowledge exclusion that stated: "[P]rior to the effective date of this policy, the Insured had no knowledge of such Sexual Act or any fact, circumstance, situation or incident involving such Sexual Act which may result in a Claim under this policy[.]" (emphasis in original). A victim was sexually assaulted by a masseuse during her massage at the insured facility prior to the effective date of the policy. Shortly afterward, the victim reported the incident to the facility's general manager, and an incident report was filed. Before the policy's effective date, the victim filed a police report, but the police did not press charges against the insured. The victim later filed a lawsuit against the insured, and the insured sought coverage under the policy's Sexual Liability Endorsement. The insurer denied coverage under the endorsement's prior-knowledge exclusion. The trial court granted summary judgment based on the prior-knowledge exclusion, and the appellate court affirmed. The court explained that the insured's argument that it did not believe the victim would file a lawsuit did not render the exclusion inapplicable, because an objective standard applied to the exclusion. Further, the court reasoned that the exclusion would be rendered meaningless if its application depended on the insured's subjective belief as to whether a claim would be filed.

***Meshinsky & Assocs., LLC v. Cont'l Ins. Co.*, No.22-04350 (RK) (JTQ), 2024 U.S. Dist. LEXIS 140969, 2024 WL 3717451 (D.N.J. Aug. 8, 2024)**

Under New Jersey law, the U.S. District Court for the District of New Jersey held that a prior knowledge exclusion precluded coverage because the demands in an underlying lawsuit were known to the insured before the policy took effect. The claims-made professional liability policy incepted on March 1, 2021, and included a prior knowledge exclusion stating that the insurer will pay sums that the insured is legally obligated to pay by reason of an act or omission in the performance of professional services, provided that "prior to the effective date of this Policy, none of you had a basis to believe that any such act or omission, or interrelated act or omission, might reasonably be expected to be the basis of a claim." The insured accounting firm was a party to a contract with a charter school in which the insured served as the independent trustee of the school. The insured received a letter in February 2020 notifying them of a judgment obtained against the school, more correspondence was exchanged in March 2020 related to the judgment, and the New Jersey Government Records Counsel issued two interim orders to "all parties" in 2020 related to the insured's managing member's failure to comply with records requests in the February 2020 letter. In February 2021, the insured submitted a renewal application for insurance, and on June 17, 2021, the insured's managing member was served with a summons and complaint that included a demand for records from the insured. The insured notified the insurer of the underlying lawsuit on August 10, 2021, and the insurer subsequently denied coverage, in part, due to misrepresentation on the renewal application regarding the insured's knowledge of potential claims. The court held that the proper standard under which to analyze the construction of an insurance policy's prior knowledge exclusion in New Jersey is set forth as a two-part test as follows: (1) the test first asks whether the insured had knowledge of the relevant suit, act, error, or omission; and (2) the test next asks whether the suit, act, error, or omission might reasonably be expected to result in a claim or suit. The court found that the insured had subjective awareness that a dispute existed and that it would objectively be expected to result in further disputes.

***Huntington Nat'l Bank v. AIG Specialty Ins. Co.*, No. 2:20-CV-00256, 2024 U.S. Dist. LEXIS 113542, 2024 WL 3226117 (S.D. Ohio June 27, 2024)**

Under Ohio law, the U.S. District Court for the Southern District of Ohio, Eastern Division (on remand from the Sixth Circuit) held that there was coverage under the policy at issue in this fraudulent transaction case, and the insurer could not avoid coverage based on any false statements or representations in the insured's application for insurance. However, the court also found that a genuine issue of material fact existed regarding the insured's prior knowledge, so summary judgment was denied as to that issue. This case involved a bankers professional liability (BPL) policy, and the relevant prior knowledge exclusion was contained in the text of the application. It had two parts as follows: (1) "Does any *prospective insured* have knowledge or information of any act, error or omission which might reasonably be expected to give rise to a claim under the proposed policy?" (emphasis added); and (2) "It is agreed that if such knowledge or information exists, any claim or action arising therefrom is excluded from this proposed coverage." The underlying action involved an alleged fraudulent transaction between the insured and a purported computer-services business. The insured became suspicious of the computer-services business, and it investigated it for fraud. The FBI eventually raided the computer-services business' office, and both it and the insured went bankrupt. A trustee was appointed to represent both companies in bankruptcy proceedings, and the trustee and the insured reached a settlement of $32 million. The insured provided notice of the claim under its policy and asked the insurer for repayment, which the insurer denied. The insured then initiated a coverage action against the insurer alleging breach of contract and bad faith. The court analyzed several application-based defenses on remand, one of which was that the prior knowledge exclusion precluded coverage. The insurer pointed to evidence that the insured was aware of impending claims regarding the computer-services business based on billing records and correspondence from the insured's counsel. The key issue that the court examined was whether the insured's counsel's knowledge of the impending claims constituted knowledge held by an "insured" for purposes of the policy. Ultimately, the court held that the insurer demonstrated that a genuine dispute of material fact as to whether "any Insured" had sufficient knowledge to trigger the prior knowledge exclusion, and the insured's summary judgment motion as to this exclusion was denied.

IV.

Prior Acts, Prior Notice, and Prior and Pending Litigation

***MRFranchise, Inc. v. Stratford Ins. Co.*, Case No. 22-CV-572-LM, 2024 U.S. Dist. LEXIS 213500, 2024 WL 4651195 (D.N.H. Nov. 1, 2024)**

Under California law, the U.S. District Court for the District of New Hampshire held that the insurer had a duty to defend and indemnify the insured under a directors and officers liability policy, rejecting the insurer's reliance on several policy exclusions, including a prior notice exclusion. The insureds sought coverage for claims brought against them in an arbitration proceeding. The claims included allegations of breach of contract, tortious conduct, and a statutory violation under the California Franchise Investment Law. The court found that there was a genuine dispute of material fact as to whether the insured knew of a potential claim before the policy's inception. The court noted that the relationship between the insured franchisor and the franchisees had deteriorated significantly before the policy's inception, leading to a notice of default and discussions about a buy-back arrangement. The franchisees had also threatened to seek damages for breach of the franchise agreement if the buy-back did not proceed. Additionally, the franchisees' counter-complaint alleged that they had communicated their grievances to the insured franchisor before the policy's inception. Given the alleged timing and nature of the disputes, the court concluded that a reasonable jury could find that the insured franchisor knew of acts or omissions that could give rise to a claim before the policy's inception.

***Henrich v. XL Specialty Ins. Co. (In re Insys Therapeutics, Inc.)*, Case Nos. 19-11292 (JTD), 23-50484 (JTD), 2024 Bankr. LEXIS 1261 (Bankr. D. Del. May 29, 2024)**

Under Delaware law, the U.S. Bankruptcy Court for the District of Delaware held that the prior and pending litigation exclusion precluded coverage for a shareholder derivative suit. The case involved a claims-made directors and officers liability policy, which excluded coverage for claims involving any fact, circumstance,

situation, transaction, event, or wrongful act underlying or alleged in any prior and/or pending litigation brought prior to May 2, 2013. The dispute centered on whether the prior and pending litigation exclusion precluded coverage for a shareholder derivative suit filed in 2016, which challenged the same allegedly fraudulent schemes as a qui tam suit filed in 2012. The insurer argued that the shareholder derivative suit arose out of the same facts as the *qui tam* suit, which was filed before May 2, 2013. The court concluded that the prior and pending litigation exclusion precluded coverage for the shareholder derivative suit because it shared significant factual overlap with the *qui tam* suit, which was filed before the May 2, 2013, cutoff date.

***Origis USA LLC v. Great Am. Ins. Co.*, Case No. N23C-07-102 SKR CCLD, 2024 Del. Super. LEXIS 383, 2024 WL 2078226 (Del. Super. Ct. May 9, 2024)**

Under Delaware law, the Delaware Superior Court held that the insurer had no duty to defend or indemnify the insured under two towers of directors and officers liability policies due to the policies' prior acts exclusions. The insured sought coverage for underlying litigation alleging fraud and misrepresentation in the sale of company shares. The policies contained prior acts exclusions, which precluded coverage for claims arising out of wrongful acts that first occurred before November 18, 2021. The court found that the underlying litigation centered on alleged wrongful acts that occurred before the prior acts exclusion date. The insured argued that allegations that it failed to provide information necessary for the investors to investigate their claims, which occurred after the prior acts exclusion date, should be considered new wrongful acts. The court rejected the argument that these ancillary allegations qualified as new wrongful acts and instead concluded that the allegations were merely incidental to the primary claims, which were based on conduct occurring before the prior acts exclusion date. The court further concluded that even if the conduct after the prior acts exclusion date was considered a separate claim, it arose out of the earlier alleged misconduct and was therefore still excluded by the prior acts exclusions.

***Smith v. Travelers Cas. & Sur. Co. of Am.*, Case No. 18-80189-CIV, 2018 U.S. Dist. LEXIS 100711, 2018 WL 4208340 (S.D. Fla. June 13, 2018)**

Under Florida law, the U.S. District Court for the Southern District of Florida held that the prior acts exclusion in the directors and officers liability policies precluded coverage for litigation costs incurred by the insured. The case involved two claims-made directors and officers liability policies with prior acts and prior litigation exclusions. The prior acts exclusion barred coverage for claims arising from wrongful acts occurring before August 18, 2015. The prior litigation exclusion barred coverage for claims related to litigation pending at the policy's inception. The insured homeowner's association allegedly failed to follow procedures required by Florida's Marketable Record Title Act, causing its governing documents to lapse in 2009. The insured continued to operate under the expired documents until it filed for bankruptcy in 2014. An adversary proceeding was initiated against the insured in the bankruptcy proceeding alleging damages based on the lapsed of the homeowner's association documents. The court found that the prior acts exclusion applied because the alleged misconduct dated back to 2009 and was not distinct from acts occurring after August 18, 2015.

***Arch Ins. Co. v. PCH Mgmt. Alpha, LLC*, Case No. 0:24-CV-60962-GAYLES/AUGUSTIN-BIRCH, 2024 Ill. App. Unpub. LEXIS 2381, 2024 WL 5039931 (Ill. App Ct. Dec. 9, 2024)**

Under Illinois law, the Appellate Court of Illinois, First District, held that the insurer had no duty to defend or indemnify the insured because the prior and pending litigation exclusion barred coverage. The insurer issued a claims-made directors and officers liability insurance policy to the insured for the period of September 11, 2017, to September 11, 2018. In June 2017, a lawsuit was filed against the insured alleging fraudulent billing schemes. In 2018, another lawsuit was filed against the insured based on similar allegations of fraudulent billing. The circuit court held that second lawsuit was excluded under the policy's prior and pending litigation exclusion because it arose from wrongful acts that were the subject of the first lawsuit. The appellate court affirmed.

***Endurance Am. Ins. Co. v. Under Armour, Inc.*, Case No. CV RDB-22-2481, 2024 U.S. Dist. LEXIS 68716, 2024 WL 1640565 (D. Md. Apr. 15, 2024)**

Under Maryland law, the U.S. District Court for the District of Maryland held that a prior notice exclusion of a directors and officers liability policy did not apply. The insured sought coverage for government investigations, a consolidated securities class action, and derivative matters. The insurers argued that these matters constituted a single claim first made under an earlier policy period (2016-2017) and were therefore not covered under the subject 2017-2018 policies. The court found that the government investigations and the claims arising therefrom constituted a separate claim first made during the 2017-2018 policy period. The court held that the prior notice exclusion did not apply because the allegations in the government investigations were distinct from the allegations in the earlier securities class action and derivative demands.

***Xerox Corp. v. Travelers Cas. & Sur. Co. of Am.*, 225 A.D.3d 510, (2024)**

Under New York law, the New York Supreme Court held that the directors and officers liability policies' prior acts exclusion did not bar coverage. The insured sought coverage for losses arising from the defense and settlement of several related lawsuits under two separate insurance towers each containing prior acts exclusions precluding coverage for claims arising from wrongful acts committed before January 1, 2017. In March 2017, the insured began discussions with another company regarding a potential acquisition. Two shareholders opposed the purchase and filed lawsuits alleging breach of fiduciary duty by the board. The lawsuits claimed that the board undervalued the company and failed to follow an open bidding process. The court found that the prior acts exclusion did not apply, because the acts giving rise to liability occurred after January 1, 2017, specifically the negotiation and approval of the purchase transaction and the denial of a request to waive the deadline for director nominations.

v.

Dishonesty and Personal Profit Exclusions

***Hanover Ins. Co. v. Ross*, No. 23-CV-80829, 2024 U.S. Dist. LEXIS 105258, 2024 WL 2976762 (S.D. Fla. June 13, 2024)**

Under Florida law, the U.S. District Court for the Southern District of Florida held that the misappropriation exclusion applied to preclude the duty to defend or indemnify in one lawsuit alleging conversion of funds, but the insurer had a duty to defend the insured in a separate lawsuit alleging defamation, tortious interference with a business relationship, and fraud based on communications made to other parties about the alleged conversion. The insurer issued a Lawyers Advantage Professional Liability policy to the insured. The policy excluded "Claim(s) or Supplemental Coverage Matter(s) based upon, arising out of, or in any way relating to, directly or indirectly: … i. Misappropriation. Any actual or alleged conversion, commingling, misappropriation, or improper use of funds, monies or property; or any inability or failure to safeguard or pay or collect any funds, notes, drafts, or other negotiable instruments, deposited in or payable from, any Insured's or former Insured's account, including an attorney trust account, or any resulting deficiency, overdraft or default…" The first lawsuit involved the insured's failure to return an escrow deposit and the transfer of money to an unauthorized party. The parties agreed that the first lawsuit arose out of the failure to safeguard the funds in the account. Therefore, the court found that the Misappropriation Exclusion applied. However, the second lawsuit, regarding defamation and tortious interference with a business relationship, was found to be a wrongful act that did not fall under any exclusion set forth in the policy.

VI.

Restitution, Disgorgement, and Damages

***Beazley Ins. Co., Inc. v. Foster Poultry Farms*, No. 1:21-CV-01806-LHR-SKO, 2024 U.S. Dist. LEXIS 151122, 2024 WL 3904994 (E.D. Cal. Aug. 22, 2024)**

Under California law, the U.S. District Court for the Eastern District of California held that the unjust enrichment claims asserted against the insured in the underlying antitrust litigation fell within the antitrust exclusion. The insured maintained primary and excess directors and officers liability policies. Both policies contained an antitrust exclusion, which excluded claims for "any actual or alleged violation of any law, whether statutory, regulatory or common law, respecting any of the following activities: antitrust, business competition, unfair trade practices or tortious interference in another's business or contractual relationships." The underlying lawsuits alleged that the insured, a chicken producer, illegally conspired to fix prices and sought damages for, among other things, unjust enrichment. Both the primary and excess insurers denied coverage for the alleged price fixing, however, the primary insurer agreed to contribute to the insured's defense costs for the unjust enrichment claims. The excess insurer filed a declaratory judgment action seeking a declaration that it had no obligation to contribute to the insured's defense costs for the unjust enrichment claims. The insurer argued that the unjust enrichment claims were barred under the antitrust exclusion. The court agreed, reasoning that the unjust enrichment claims were entirely derivative of the price fixing allegations, *i.e.*, entirely dependent on, and therefore the antitrust exclusion precluded coverage. The case is currently on appeal to the U.S. Court of Appeals for the Ninth Circuit.

***Jasper v. Chubb Nat'l Ins. Co.*, No. H050804, 2024 Cal. App. Unpub. LEXIS 7136, 2024 WL 4759411 (Cal. Ct. App. Nov. 12, 2024), review filed (Dec. 23, 2024)**

Under California law, the Court of Appeals for the State of California held that the defense costs the insured advanced on its director's behalf were not restitutionary damages excluded from the policy's "loss" definition. The insurer issued a "follow form" excess policy an underlying primary directors and officers liability policy. The policy defined "loss" as "damages, judgments, … settlements and Defense Costs for which [[a director] is] legally obligated to pay" but not "any amount that represents or is substantially equivalent to disgorgement or restitutionary or rescissionary damages, … [or] … matters which may be deemed uninsurable under the law pursuant to which this Policy shall be construed." The insured was contractually obligated to indemnify its directors in any action brought against them in their capacity as a corporate officer unless the director was found to have engaged in fraud. After a director was found to have engaged in fraud in an underlying action, the insured sought reimbursement of the defense costs it advanced on the director's behalf. The insurer denied coverage for the claim, arguing that the damages were "restitutionary in nature." The court rejected this argument, explaining that "not everything that can be labeled 'restitution' is necessarily uninsurable" and that restitutionary damages are limited to "traditional claims in equity to retrieve monies wrongfully obtained", which does not include the claim for reimbursement of the advanced defense costs. The court further explained that the director did not wrongfully acquire the advances, nor did he obtain a windfall in keeping defense costs to which he was not entitled. Accordingly, the court held that the claim for reimbursement of defense costs advanced on behalf of the director were insurable.

***Ghio v. Liberty Ins. Underwriters, Inc.*, No. X07-CV-19-6104759-S, 2024 Conn. Super. LEXIS 1784, 2024 WL 3949196 (Conn. Super. Ct. Aug. 23, 2024)**

Under Connecticut law, the Superior Court of Connecticut held that damages that are restitutionary in nature, as well as those that are derivative thereof, are not insurable. The insured was issued a directors, officers, and company liability insurance policy. The policy's definition of "loss" provided that: "[l]oss means the amount which the Insureds become legally obligated to pay On account of Claims made against them for Wrongful Acts for which coverage applies, including but not limited to … judgments …. Loss does not include … (4) matters uninsurable under the law pursuant to which the Policy is construed." The policy also contained a Personal Benefit Exclusion, which stated that the insurer "shall not be liable under any Insuring Clause in this Coverage Part for Loss on account of any Claim made against any Insured: … 7. based upon, arising from, or in any way related to any Insureds gaining any personal profit, remuneration or advantage to which they are not legally entitled, if a final adjudication establishes that such Insureds gains such personal profit, renumeration or advantage." After a judgment was entered against the insured in the underlying suit, for which the insurer denied coverage citing the aforementioned policy conditions, the insured's assignees filed suit against the insurer. The insurer maintained its denial, arguing that the damages claimed were restitutionary in nature. In the absence of appellate authority on whether restitution is insurable under Connecticut law, the court surveyed the law of other jurisdictions which have held that restitution is uninsurable as a matter of public policy. Adopting the reasoning of its sister courts — *e.g.*, "ill gotten gains should not be insurable," "insurable damages do not include costs incurring money that has been wrongfully acquired," "acts prohibited by law are not insurable" — the court held that restitution, and damages derived thereof, are not insurable as a matter of public policy under Connecticut law.

VII.

Insured Capacity

***Scottsdale Ins. Co. v. Bozorgi*, 2023 U.S. Dist. LEXIS 234190, 2023 WL 9420512 (Dec. 20, 2023)**

Under California law, the U.S. District Court for the Central District of California held that an underlying pleading identifying a former officer as a CEO sufficiently alleged that a former officer was sued in his capacity as a director and officer to survive a motion to dismiss. The Business Management Indemnity Policy included a Directors and Officers Liability Coverage Section. A former officer was sued by a third-party for alleged "Wrongful Acts." Under the policy, a Wrongful Act includes, in pertinent part, "any actual or alleged error omission, misleading statement, misstatement, neglect, breach of duty or act committed or attempted by … any of the Directors and Officers, while acting in their capacity." In the coverage action, the insurer moved to dismiss the former officer's counterclaim for breach of contract on the grounds that the third-party complaint against the former officer did not allege wrongful acts in his capacity as an insured director or officer, but rather in his capacity as a shareholder. The court determined that the third-party complaint had alleged that the former officer was a CEO of the insured and that allegation was incorporated throughout the third-party complaint. As such, the court found that it was not clear from the face of the pleading in the third-party complaint that the former officer was being sued solely in his capacity as a shareholder. Thus, the court held that the former officer had plausibly alleged a claim for breach of contract against the insurer.

***Sec. Nat'l Ins. Co. v. Hendrik Uiterwyk, P.A.*, 725 F. Supp. 3d 1308 (M.D. Fla. 2024)**

Under Florida law, the U.S. District Court for the Middle District of Florida held, on a motion for summary judgment, that coverage was barred for claims arising from the conduct of an insured acting in their capacity as a director or officer of a business enterprise other than the named insured. The insurer issued a professional liability policy to a law firm. The policy contained an

exclusion that barred coverage for "any Damages or Claims Expenses incurred with respect to any Claim … based upon or arising out of any actual or alleged activities of an Insured as, or an Insured acting in, the capacity as an officer, director, partner, trustee or employee of a pension, welfare, profit sharing, mutual or investment trust or fund, charitable organization, corporation or business enterprise, other than [the law firm]" (emphasis in original). The insurer sought a declaration that it had no duty to defend or indemnify several attorneys and a law group for claims arising out of alleged violations of a joint venture agreement between the partners of the insured law firm and another law firm. The joint venture agreement established a separate firm and a fee-sharing agreement between the parties to the agreement for referrals of pre-litigation and litigation matters. The court determined that there was no genuine dispute of material fact that the joint venture was a separate business enterprise than the insured law firm. Thus, the court held that the alleged breaches of the joint venture agreement were unambiguously barred by the exclusion because they were based on activities in the insured's capacity as a partner of a separate business enterprise.

***Mist Pharm., LLC v. Berkley Ins. Co.*, 318 A.3d 744 (N.J. Super. Ct. App. Div. 2024)**

Under New Jersey law, the New Jersey Superior Court held that a dual capacity exclusion barred coverage. The directors and officers liability policy excluded coverage for Insured Persons acting as a director, officer, trustee, employee, member, or governor of any entity other than the Insured Entity. The chairman and majority shareholder of the Insured Entity was an Insured under the Policy. The chairman was also a director of a related company. The Insured Entity was sued, with the plaintiff shareholder alleging that the chairman used the Insured Entity as an intermediary in transactions between the related company and the Insured Entity to defraud the plaintiff. The court held that the dual capacity exclusion barred coverage because the chairman was acting in both his capacity as a director of the related company and as a majority shareholder of the Insured Entity. The court adopted a "but for" analysis, stating that the loss claimed by plaintiff and the Insured Entity could not have occurred but for the chairman's conduct in his capacity as a director of the related company.

VIII.

Insured v. Insured Exclusion

***Divinia Water, Inc. v. Clear Blue Specialty Ins. Co.*, No. 4:23-mc-00095-AKB, 2024 U.S. Dist. LEXIS 46586, 2024 WL 1131291 (D. Idaho Mar. 15, 2024)**

Under Idaho law, the District Court for the District of Idaho held that two individuals were considered "insureds" and thus triggered the insured versus insured exclusion of the directors and officers liability policy. The two individuals were erroneously believed by the insured to be properly elected to the insured's board of directors in 2017. For years after the faulty election, the two individuals acted and were given authority as board members. In 2020, the two individuals were removed from the board of directors and proceeded to file lawsuits against the insured. The insurer denied coverage for these lawsuits citing the insured versus insured exclusion. The district court affirmed the bankruptcy court's decision to apply the insured versus insured exclusion on the basis that the board of directors had cured the defective election *ab initio* by believing that the two individuals were board members and acting in accordance therewith. Moreover, the district court determined that the board of directors had the authority to ratify the election, and thus, the insured versus insured exclusion applied to exclude coverage.

***Walker Cnty. Hosp. Corp. v. Brown (In re Walker Cnty. Hosp. Corp.)*, No: 19-36300, 2024 Bankr. LEXIS 2440, 2024 WL 4394508 (Bankr. S.D. Tex. Oct. 3, 2024)**

Under Texas law, the Bankruptcy Court for the Southern District of Texas held that the bankruptcy exception to an insured versus insured exclusion applied because the insured company acting as debtor-in-possession was sufficiently similar in capacity to a bankruptcy trustee. Analyzing a directors and officers liability policy, the court assessed whether a bankruptcy exception to the insured versus insured exclusion providing coverage where a claim was brought by "a bankruptcy or insolvency trustee … or similar official" applied when the insured claimant was a debtor-in-possession. The insurer denied

coverage for a claim against an individual insured by the insured company acting as debtor-in-possession for purposes of bankruptcy proceedings. On a motion for judgment on the pleadings, the district court reasoned that Texas case law and the bankruptcy code both held that a debtor-in-possession has the same rights as a trustee. As a result, the court determined that a debtor-in-possession qualifies as a "similar official" for purposes of the bankruptcy exception. Additionally, the court noted that the intent of insured versus insured exclusions is to prevent collusive claims and actions arising from internal squabbles, a concern not present in this case. Accordingly, the court determined that the insurer wrongfully denied coverage.

***R. Dennis Kennedy, et al., v. U.S. Liab. Ins. Co.*, No. 4:24-CV-02139, 2024 U.S. Dist. LEXIS 215852, 2024 WL 4905984 (S.D. Tex. Nov. 27, 2024)**

Under Texas law, the U.S. District Court for the Southern District of Texas held that an insured versus insured exclusion barred coverage where the parties were insureds and the insured executives failed to carry their burden to establish that the derivative action exception to the exclusion applied. The insurer issued a Non-Profit Management Liability Policy to its insured. The policy contained an insured versus insured exclusion. which precluded coverage for claims brought by one insured against another. After the insured nonprofit discharged several executives, the executives filed a state court suit against the insured nonprofit seeking unpaid wages, among other causes of action, while the nonprofit filed a federal lawsuit against the executives alleging breach of fiduciary duty and other causes of action. The executives sought coverage for their defense in the federal lawsuit. The insurer denied coverage based on the insured versus insured exclusion and the executives filed suit. The court granted summary judgment in favor of the insurer finding that it was undisputed that the nonprofit and the executives were insured under the policy. Based on this undisputed fact, the court explained "the burden shifted to the Executives to demonstrate that one of the four exceptions to the exclusion applies." The executives argued that an exception for claims by former executives could apply, but the court found that "this exception is expressly limited to claims that do not involve alleged wrongful acts committed by Executives during their tenure." Because the underlying lawsuit alleged wrongful acts during the executives' tenure, the court held that the exception did not apply.

IX.

Coverage For Contractual Liability

***AIG Specialty Ins. Co. v. Agee*, No. 22-54102024 U.S. Dist. LEXIS 13995, 2024 WL 303196 (E.D. La. Jan. 26, 2024)**

Under Louisiana law, the U.S. District Court for the Eastern District of Louisiana held that a breach of contract exclusion in a directors and officers liability policy precluded coverage for a monetary judgement in favor of former employees of the insured. Two employees of the insured laboratory company sued the insured after being terminated in 2017. The court found in favor of the employees and awarded them monetary damages. Soon after, the insurer sought a declaratory judgment that there was no coverage under the policy. In analyzing whether coverage was owed, the court determined that the employees' employment agreements created a contractual liability, and the underlying monetary award arose from those contracts. As such, the court held that the exclusion which barred coverage for loss in connection with a claim for "any actual or alleged contractual liability of the Company under any express contract or agreement" excluded coverage under the policy. The court also held that an exception to the exclusion for "liability which would have attached in the absence of such express contract or agreement" did not apply.

***Zarrelli v. Hiscox Ins. Co., Inc.*, 2024 Md. App. LEXIS 589, 2024 WL 3635576 (Md. App. Ct. Aug. 2, 2024)**

Under Maryland law, the Appellate Court of Maryland held that the contractual liability exclusion in a professional liability policy precluded coverage for a lawsuit alleging breach of contract, even though the allegations in the underlying lawsuit related to the contract at issue were allegedly false. The insured technology company entered into an agreement with a vendor to supply copper tubing for a project. When the insured failed to pay for the order the vendor sued the insured, its principal, and a related specialist based on a mistaken belief about the specialist's role. The

insurer denied coverage for the lawsuit under the policy's contractual liability exclusion, which barred claims "based upon or arising out of any actual or alleged liability of others assumed by the insured under any contract or agreement unless such liability would have attached in the absence of such contract or agreement." The specialist sued the insurer, and the trial court granted summary judgment to the insurer. The specialist appealed, arguing that his role constituted professional services under the policy, and was therefore covered. The appellate court affirmed the trial court's judgment for the insurer. The appellate court determined that the vendor's lawsuit alleged a contract with the insured for copper tubing and claimed the specialist had a duty to pay the vendor from funds held in trust. Consequently, the court concluded the claims against the specialist stemmed from a contractual obligation, despite any erroneous assumptions about the specialist's role.

Paraco Gas Corp. v. Ironshore Indem., Inc., 2024 U.S. App. LEXIS 14628, 2024 WL 3024658 (2d Cir. June 17, 2024)

Under New York law, the Second Circuit Court of Appeals held that the contractual liability exclusion in a directors and officers liability policy barred coverage for a cause of action seeking declaratory relief. Shareholders sued the insured corporation's officers alleging a share transfer violation of two shareholder agreements. The insurer denied coverage based on the contractual liability exclusion, which precluded coverage for any claim against an insured "alleging, arising out of, based upon or attributable to any actual or alleged contractual liability or obligation of the Company or an Insured Person under any contract … ." The district court agreed with the insurer. On appeal, the Second Circuit noted the insured conceded the exclusion applied to nine of the 10 counts. The Second Circuit applied a but-for test as to the remaining count and held that, "Count IV not only alleges the existence of facts showing that [the insureds] violated the terms of the Class A Shareholder Agreement, but the claim relies on that agreement for its theory of harm — demonstrating that the claim could not exist but for [the officer's] alleged violation of the agreement's right of first refusal and stock transfer provisions." The Second Circuit further explained, "while Count IV is not a breach of contract claim per se" it "has a causal relationship to [the insureds'] contractual obligations arising out of the Class A Shareholder Agreement."

x.

Professional Services

PROFESSIONAL SERVICES INSURING AGREEMENTS

***James River Ins. Co. v. Sheehe & Assocs., P.A.*, 716 F. Supp. 3d 1285 (M.D. Fla. 2024)**

Under Florida law, the U.S. District Court for the Middle District of Florida held that an insurer had no duty to defend claims against an insured law firm for allegedly engaging in fraudulent billing practices. The insured purchased a lawyer's professional liability policy, which provided coverage for a covered "Claim" defined as "a written demand for monetary damages arising out of or resulting from the performing or failure to perform 'Professional Services.'" The policy defined "Professional Services" to include, in relevant part, those services performed by the insured for others as a lawyer. The insurance company that had engaged the insured law firm as panel counsel asserted claims against the insured law firm for engaging in fraudulent billing practices, including collection of excess fees. The court concluded that the billing practices did not constitute "professional services" as defined by the policy because, in the context of legal practices, they are not services provided to or performed on behalf of the insurance company. The billing practices also did not require the skill, training, and regulation involved with substantive law practice. Thus, the court decided that the insurer had no duty to defend the insured law firm.

***Solem v. ALPS Prop. & Cas. Ins. Co.*, No. 1:22-cv-212, 2024 U.S. Dist. LEXIS 16343, 2024 WL 342327 (D.N.D. Jan. 30, 2024)**

Under North Dakota law, the U.S. District Court for the District of North Dakota held that claims alleging wrongful disbursement of funds from the insured law firm's trust account fell within the policy's insuring agreement but were otherwise precluded by the policy's exclusions. The insurer issued a legal professional liability policy to an insured law firm, which also listed the individual attorney as an insured. "Professional Services" was defined to include services rendered as a "an

attorney" or as "trustee or other fiduciary." The complaint alleged that the insured law firm sustained a financial loss as a result of the insured attorney wiring funds from the insured law firm's trust account, which turned out to be a fraudulent scheme perpetrated by an unknown individual. Citing the North Dakota Rules of Professional Conduct requiring "attorneys to hold property of others with the care required of a professional fiduciary," the court held that the management of client funds by the insured law firm in its trust account qualified as "professional services."

PROFESSIONAL SERVICES EXCLUSIONS

***MRFranchise, Inc. v. Stratford Ins. Co.*, No. 22-CV-572-LM, 2024 U.S. Dist. LEXIS 213500, 2024 WL 4651195 (D.N.H. Nov. 1, 2024)**

Under California law, the U.S. District Court for the District of New Hampshire held that a professional services exclusion did not bar coverage for an underlying arbitration pertaining to an insured's alleged breach of its disclosure requirements under a state franchise investment law. The insurer issued a directors and officers liability insurance policy to the insured, a franchisor for a restaurant chain in California. The policy contained a professional services exclusion barring coverage for "any Claim arising out of, based upon or in consequence of, resulting from or in any way involving any Insured's performance or failure to perform professional services for others." However, the policy did not define "professional services." The insured eventually initiated an arbitration against its franchisees for breach of a franchise agreement, following the franchisees' failure to complete necessary training to operate the restaurant. The franchisees filed a counter-complaint against the insured, alleging that the franchisor violated the California Franchise Investment Law in multiple ways, including by failing to disclose prior fraud cases against the insured's founder. The insurer denied coverage for the counter-complaint on several grounds, including the professional services exclusion. Following the insured's suit against the insurer, the insurer argued that the professional services exclusion applied because the insured agreed to perform professional services for the franchisees by providing the franchisees with training and resources to run the franchise. The court rejected the insurer's argument, finding that the professional services exclusion did not bar coverage for the counter-complaint because the allegations did not pertain to the insured's failure to provide training and resources to the franchisees.

***Prac. Fusion, Inc. v. Freedom Specialty Ins. Co.*, No. A167130, 2024 Cal. App. Unpub. LEXIS 3822, 2024 WL 3078283 (Cal. Ct. App. June 21, 2024)**

Under California law, the California Court of Appeal for the First District held that coverage was barred under the policies' professional services exclusions for claims arising out of the insured's assistance in the design and coding of allegedly misleading health care alerts. The insurers issued directors and officers liability policies to the insured, a company that developed and licensed electronic health record software for health care providers. The policies contained two professional services exclusions, the first of which applied only to "[l]oss in connection with any Claim made against [the insured company] … arising out of … the rendering of, or actual or alleged failure to render, any professional services." The second professional services exclusion broadly applied to all insureds, including the insured company and the individual insureds under the policy. The insured subsequently was investigated by and entered into a settlement with the U.S. Department of Justice pertaining to claims that the insured violated the federal Anti-Kickback Statute by taking money from pharmaceutical manufacturers in exchange for the insured deploying "Clinical Decision Support alerts" that did not reflect accepted medical standards. When the insured sought coverage for the settlement under its directors and officers liability policies, the insurers denied coverage pursuant to the professional services exclusions. The insured sued the insurers for breach of contract, and the trial court concluded that the claims concerning the Clinical Decision Support alerts arose from the insured's provision of professional services to the pharmaceutical companies, thereby barring coverage under the policies. On appeal, the insured argued that it did not provide professional services but rather merely sold advertising space on its software platform and, in the alternative, that the coding was performed only for the insured itself and not the pharmaceutical companies. The court rejected the insured's arguments and affirmed the trial court's decision, citing the insured's contracts with the pharmaceutical companies which referenced the insured's obligations to assist with the design and coding of the Clinical Decision Support alerts. The court further reasoned that the

coding was unequivocally a service completed for the pharmaceutical companies because the pharmaceutical companies had the express right to review and approve the Clinical Decision Support alerts.

Allied Design Consultants, Inc. v. Pekin Ins. Co., 2024 IL App (4th) 230738-U

Under Illinois law, the Appellate Court of Illinois for the Fourth District concluded that certain professional services exclusions barred coverage for claims arising out of a faulty Health/Life Safety Survey conducted by the insured. The insurer issued a businessowners liability insurance policy and a commercial umbrella liability policy to the insured, an architecture design firm, with both policies containing professional services exclusions. The businessowners liability policy excluded bodily injury "due to rendering and failure to render any professional service" including "preparing, approving, or failing to prepare or approve … surveys." The commercial umbrella liability policy's professional services exclusion included a list of excluded professions, such as "[a]rchitects, engineers, surveyors, or draftsmen." The insured entered into an agreement to provide certain architecture services for a middle school, which included conducting a Health/Life Safety Survey and generating a report with the results of that survey. Following a carbon monoxide leak in the school building, 23 personal injury lawsuits were filed against the insured. The insurer denied that it owed the insured a duty to defend the underlying lawsuits, citing to the policies' professional services exclusions. After the insured filed a declaratory judgment action against the insurer, the trial court entered judgment in favor of the insurer, finding the allegations of the underlying lawsuits fell under the professional services exclusion of both policies. On appeal, the insured argued that the trial court failed to examine each allegation separately to determine application of the professional services exclusions and that the allegations pertaining to the insured's failure to warn were not excluded under the policies. In affirming the trial court's decision, the court noted that the underlying lawsuits were "devoid of allegations" that were "incidental to or independent from" the insured's provision of professional services, including the allegations related to the insured's failure to warn.

TCF Enterprises, Inc. v. Rames, Inc., 544 P.3d 206 (Mont. 2024)

Under Montana law, the Supreme Court of Montana held that a professional services exclusion in a commercial general liability policy did not bar coverage for a lawsuit pertaining to a general contractor's allegedly negligent furnishing of labor, materials, tools, and equipment. The insurer issued a commercial general liability policy to the insured, which worked as a subcontractor on multiple residential building projects for the same general contractor. The policy contained a professional services exclusion, which applied to both the insured and additional insureds under the policy, and barred coverage for "'bodily injury' or 'property damage' arising out of the rendering or failure to render any 'professional services.'" The policy further defined "professional services" as "any service requiring specialized skill or training." The general contractor was subsequently sued by the developer of one of the projects following issues with foundation settlement, and the general contractor tendered the suit to the insurer, seeking defense and indemnity as an additional insured under the policy. The insurer denied coverage for the underlying lawsuit, reasoning that the general contractor was never properly added as an additional insured and that the professional services exclusion applied. The general contractor subsequently sued the insurance agent that was tasked with procuring additional insured coverage for the general contractor. The insurance agent argued that it was unreasonable for the general contractor to rely on any representation that the general contractor was an additional insured under the policy, reasoning that the policy excluded coverage under the professional services exclusion in any event. In finding that the insurance agent had a duty to procure the additional insured coverage, the trial court also reasoned that the professional services exclusion would not have barred coverage for the additional insured. On appeal, the court affirmed the decision, finding that the general contractor's furnishing of labor, materials, tools, and equipment did not qualify as "professional services" because such tasks did not require the general contractor to have "specialized skill or training."

***García-Navarro v. Hogar LA Bella Unión, Inc.*, 717 F. Supp. 3d 193 (D.P.R. 2024), appeal dismissed, Nos. 24-1315, 24-1323, 24-1366, 2024 U.S. App. LEXIS 26542, 2024 WL 4524556 (1st Cir. Jul. 2, 2024)**

Under Puerto Rico law, the U.S. District Court for the District of Puerto Rico held that the professional services exclusion of a commercial general liability policy barred coverage for claims alleging negligent miscommunications and recordkeeping by an insured assisted living facility. The insurer issued a commercial general liability policy to the insured which included a professional services exclusion specifically precluding coverage for "'bodily injury' due to rendering of or failing to render any professional services." The policy did not define the term "professional services." The underlying complaint alleged that a resident at the insured facility died because the insured mistakenly informed a doctor that the resident could not receive a blood transfusion due to her religious beliefs. The complaint further alleged that an investigation by the relevant authority revealed that the insured was in violation of multiple regulations, including failure to maintain proper medical records. Adopting the Supreme Court of Puerto Rico's definition of "professional services" since the policy did not define the term, the court held that the professional services exclusion applied because failure to maintain proper records and miscommunication were an intricate part of professional services rendered by the insured.

XI.

Independent Counsel

***Travelers Prop. Cas. Ins. Co. v. Chipotle Mexican Grill, Inc.*, No. 8:23-cv-01479-MCS-KES, --- F.Supp.3d ----, 2024 WL 4003316 (C.D. Cal. Aug. 13, 2024)**

Under California law, the U.S. District Court for the Central District of California held that that a property owner that was as an additional insured under a commercial general liability policy issued to a general contractor hired by the property owner was entitled to independent counsel to defend it against a series of underlying lawsuits. The owner's additional insured status did not extend to the owner's own negligence and thus created a situation in which the insurer could steer the defense of the lawsuits in such a way as to compromise coverage for the owner.

The owner retained the contractor to build a new restaurant. The contractor was required to add the owner as an additional insured under its commercial general liability policy. However, the owner's additional insured status extended only to damages caused by the acts or omissions of the contractor or its subcontractors. During construction, a fire broke out, causing damage to multiple adjacent properties. These property owners brought six separate lawsuits against both the owner and the contractor. The owner tendered its defense against the lawsuits to the insurer. In the insurer's letters accepting the owner's tenders, the insurer explicitly accepted the owner's defense subject to a reservation of rights stating it would not cover damages or liability unrelated to the work of the contractor (its named insured). The owner rejected the defense counsel appointed by the insurer, and when the insurer refused to provide independent counsel, retained its own counsel and handled its own defense against the underlying lawsuits. The insurer then brought a declaratory judgment action seeking declarations that it had the right to control the owner's defense, that the owner was not entitled to independent counsel, and that the owner's refusal to accept the appointed defense counsel was a breach of the policy that obviated any additional insured coverage for the owner. The court

denied the insurer's motion for summary judgment on the basis that the owner was in fact entitled to independent counsel (although not for any reason actually argued by the owner in its papers). Specifically, the court found a conflict of interest on the part of the insurer in defending both the owner and the contractor because the owner's status as an additional insured did not extend to its own independent acts or omissions. Therefore, the court held that the insurer had an incentive to defend the cases in a manner that might disqualify the owner as an additional insured, allowing the insurer to withdraw from or seek recompense for its defense, by, for example, avoiding pursuing a defense that involved joint and several liability among alleged tortfeasors, including the contractor.

Tribune Publ'g Co., LLC v. ACE Am. Ins. Co., No. 22 C 7327, 2024 U.S. Dist. LEXIS 28892, 2024 WL 689992 (N.D. Ill. Feb. 20, 2024)

Under Illinois law, the U.S. District Court for the Northern District of Illinois held that there was a conflict between the insurer and the insured that entitled the insured to be defended by independent counsel against underlying lawsuits arising out of a workplace shooting. The insurer issued the insured both a commercial general liability policy and a workers compensation/employers liability policy. The court found that the insurer had an incentive to steer coverage toward commercial general liability because that coverage had a significant deductible. There was a question in the underlying cases as to whether the claimants should be deemed employees of the local newspaper for which they worked, or the named insured, which was the parent company of the local newspaper. If the underlying claimants were deemed to be employees of the named insured, coverage for the named insured against the underlying lawsuits would fall under the workers compensation/employers' liability policy, but if the underlying claimants were deemed employees of the local newspaper, coverage for the named insured against the underlying lawsuits would fall under the commercial general liability policy. The commercial general liability policy was subject to a $1 million deductible, which the insured was required to satisfy before the insurer became obligated to pay for the insured's defense, whereas the workers compensation/employers liability policy did not have a deductible, such that the insurer would immediately be responsible for providing for the insured's defense.

The court recognized that this created a conflict between the insured and the insurer because the insurer would be incentivized to steer coverage towards the commercial general liability policy, which was "the precise opposite of the [insured's] interest." Because the court determined that the insured was entitled to independent counsel, it rejected the insurer's arguments that the insured breached the voluntary payments and cooperation clauses of the policies by initially retaining its own defense counsel before tendering the claim to the insurer. However, because the insurer did repeatedly object to the rates charged by the insured's selected defense counsel, the court also held that as to the damages to which the insured would be entitled for its unreimbursed defenses costs, the insurer retained the ability to argue that counsel's rates were not "reasonable," noting that the insurer's "duty to defend is limited to reasonable defense expenses."

Travelers Indem. Co. v. Axis Ins. Co., No. 1:23-cv-01442 (JLR), 2024 U.S. Dist. LEXIS 55361, 2024 WL 1313890 (S.D.N.Y. March 27, 2024)

Under New York law, the U.S. District Court for the Southern District of New York held that a commercial general liability insurer had no obligation to provide separate independent defense counsel for two different defendants it had agreed to defend against an underlying lawsuit.

The insurer accepted a tender from another insurer (the "tendering insurer") to defend the tendering insurer's insureds against a lawsuit brought by a workman who sustained personal injuries on a construction project. The insurer agreed to defend the two insured defendants without a reservation of rights and assigned the same defense counsel to represent both defendants. One of the defendants then retained separate counsel to bring a contractual indemnification crossclaim against the other defendant. The tendering insurer then claimed that this created a conflict of interest requiring the insurer to provide both defendants with separate defense counsel. The insurer refused, and the tendering insurer then brought a declaratory judgment action. The insurer filed a motion to dismiss the declaratory judgment action under Fed R. Civ. Pro. 12(b)(6) for failure to state a claim. The court granted the motion. In so doing, the court held that New York law requires an insurer to provide independent

counsel for an insured only when "the defense attorney's duty to the insured would require that he defeat liability on any ground and his duty to the insurer would require that he defeat liability only upon grounds which would render the insurer liable." The court held that in this case, the insurer and the insureds retained the common interest of defeating the underlying plaintiff's claim and the insurer had no interest in the outcome of the indemnification crossclaim between the two defendants, such that this crossclaim did not give rise to a conflict as between the insurer and the insureds. The court held that the insured itself was solely responsible for paying the costs associated with the crossclaim and that the two insureds could continue to be defended by the same law firm.

XII.

Advancement of Defense Costs

***Ferrellgas Partners L.P. v. Zurich Am. Ins. Co.*, 319 A.3d 849 (Del. June 10, 2024)**

Under Delaware law, the Supreme Court of Delaware held that, based on the specific policy language at issue, an insurer is only obligated to advance defense costs if the claims in the underlying action arise out of wrongful acts that took place entirely before the run-off date in the applicable policy. The insurer issued a management and company liability policy to the insured. The policy contained a run-off coverage period, which provided that the insurer had a duty to advance defense costs for claims made during the run-off coverage period. The policy also contained a run-off exclusion precluding coverage for losses occurring because of claims for wrongful acts that take place in whole or in part after the run-off period incepts. The insured sought advancement of defense costs for a claim made during the run-off coverage period. The insurer denied coverage because the wrongful acts giving rise to the claim occurred, at least partially, during the run-off coverage period. The court found the policy language unambiguously excluded coverage for claims that take place either partially or completely after the run-off date.

XIII. Allocation

***Berkley Nat'l Ins. Co. v. XTO Energy, Inc.*, No. 1:18-cv-195, 2024 U.S. Dist. LEXIS 166651, 2024 WL 4198354 (D.N.D. Sept. 16, 2024)**

Under Minnesota law (in the absence of controlling North Dakota law), the U.S. District Court for the District of North Dakota found that, although an insured generally has the burden of proving allocation of damages between covered and noncovered claims, the burden of proving allocation shifted to the commercial general liability insurer when the insurer denied coverage and did not participate in mediation. Multiple insurers issued commercial general liability primary and umbrella policies to an oil and gas contractor and an oil well owner. Following a fire and explosion at an oil well operated by the contractor, two lawsuits were filed in the District of North Dakota by the injured parties. All defendants and some insurers participated in a mediation, resulting in a multimillion-dollar settlement far exceeding the total limits available under the policies. A second-layer umbrella insurer for the oil well owner maintained the position that the contractor was not an additional insured under the policy, and thus claims arising from the negligence of the contractor would be excluded under the policy and that the settlement value should be allocated between covered and uncovered claims. The district court disagreed. The court found that the insurer "denied coverage, abandoned the insured, and refused to participate in a mediation which resulted in a settlement involving multiple plaintiffs and defendants" and should not be permitted "to profit from its failure to satisfy its minimal duty of requesting allocation" at mediation. An appeal has been filed and is currently pending.

***Roldan v. Lewis*, No. 20-CV-03580 (HG) (MMH), 2024 U.S. Dist. LEXIS 181208, 2024 WL 4389281 (E.D.N.Y. Oct. 3, 2024)**

Under New York law, the U.S. District Court for the Eastern District of New York rejected the "time on the risk" method of allocating defense costs amongst all

insureds and held that all insurers must share defense costs equally. The court had previously granted partial summary judgment finding that two insurers had obligations to defend their insured under municipal liability policies which stretched over five consecutive policy periods. The court rejected the "time on the risk" method proposed by one insurer, who provided coverage during a single policy period and sought a declaratory judgment that it should only bear one-fifth of the defense costs. The court found that any and all insurers whose policy periods were triggered by the underlying claim had a duty to defend against the entire action in full, and that any allocation sought would be shared evenly between insurers who had a duty to defend. The court modified its prior declaratory judgement, requiring both insurers to share the costs of defense evenly, regardless of the number of policies or respective available limits.

Allied World Surplus Lines Ins. Co. v. Richard Goettle, Inc., No. 1:17-cv-670, 2024 U.S. Dist. LEXIS 147640, 2024 WL 3872947 (S.D. Ohio Aug. 19, 2024)

Under Ohio law, the U.S. District Court for the Southern District of Ohio, Western Division, held that insurers denying coverage maintain the right to demand that settlements be allocated between covered and uncovered claims. An insurer held a claims-made Constructors Professional Liability and Protective Policy for their engineering and construction business. The policy was later amended to include a pollution endorsement. Prior to the issuance of the endorsement, the insured had knowledge of an alleged design failure in a retaining wall which would later fail and trigger a claim under the policy. The insurer filed a declaratory judgment, in which the court ruled that the insurer had a duty to defend but declined to rule on the issue of indemnity. The underlying plaintiffs and the insured settled the matter without consulting the insurer, and the insured sought indemnification for the entire settlement value. In its analysis of the issue of allocation between covered and uncovered claims, the court found that even when an insurer denies a defense for claims that are covered, the insured "cannot foist liability for uncovered claims on [the insurer] by claiming that [the insurer] flouted its duty to defend […] and that this failure bars [the insurer] from challenging its coverage obligations now." The court found that, although the improperly denying insurer had surrendered its ability to contest the value of the covered claims, it did not adopt liability for otherwise uncovered claims.

Zurn Indus., LLC v. Allstate Ins. Co., No. 1:18-cv-299-SPB, 2024 U.S. Dist. LEXIS 177578, 2024 WL 4350271 (W.D. Pa. Sept. 30, 2024)

Under Pennsylvania law, the U.S. District Court for the Western District of Pennsylvania found that an insured was not estopped from arguing an "all sums" position for defense allocation even after making a blanket tender to all insurers and maintaining a consistent pro-rata position for its commercial liability and umbrella policies for claims occurring on disputed policy periods. Pennsylvania utilizes the "multiple trigger" theory of liability, made famous by asbestos exposure cases, where "every insurer which was on the risk at any time during the development of a claimant's [related harm] has an obligation to indemnify [and defend] the insured." Generally, this means that an insured can seek the total value or "all sums" of the defense from any insurer whose policy is trigged by the claim. In this case, the insured had already had prior established cost-sharing arrangements among its multiple insurers which allowed the liability and defense costs accrued for any claims on overlapping policy periods to be shared "as broadly as possible" amongst insurers, allowing them to share in pro-rata costs. However, after a dispute with two of its four insurers, the insured elected to tender its defense in an "all sums" manner, which the remaining insurers opposed. The court found that, despite the insured having a "decades-long" course of conduct accepting a pro-rata share of defense costs, the insured was not estopped from changing its tender regarding defense costs and may select any or all insurers whose policy could be triggered by the underlying claim.

XIV.

Recoupment of Defense Costs and Settlement Payments

***Nautilus Ins. Co. v. Acacia Mobile Home Park LLC*, No. 23-CV-2072 JLS (SBC), 2024 U.S. Dist. LEXIS 203402, 2024 WL 4713903 (S.D. Cal. Nov. 7, 2024)**

Under California law, the U.S. District Court for the Southern District of California held that a commercial general liability insurer was entitled to recoupment of defense costs where it expressly reserved the right to recoupment. The insured was a mobile home park owner who was sued by several residents claiming, *inter alia*, that it failed to provide adequate maintenance and living conditions in the mobile home park. The insured tendered the lawsuits to its commercial general liability insurer for coverage. The insurer accepted the defense subject to a full reservation of rights, including the right to reimbursement of defense costs expended in connection with uncovered claims. The insurer then filed a declaratory judgment action seeking a declaration that it had no duty to defend the insured and that it was entitled to recoup the defense costs it had paid. The insurer moved for summary judgment. After finding that the policy's habitability exclusion precluded coverage, the district court found that the insurer had properly reserved its rights to recoupment under the California Supreme Court's ruling in *Blue Ridge Ins. Co. v. Jacobsen*, 25 Cal. 4th 489, 498 (2001) based on an express reservation of the right to seek reimbursement via an email to the insured in which the insurer reserved the right to deny coverage for damages sought that fell within the habitability exclusion. The district court found that by accepting the insurer's defense under these circumstances, the insured was deemed to have accepted the insurer's right to reimbursement. Accordingly, the district court granted the insurer's motion for summary judgment, holding that the insurer was entitled to recoup the defense costs it incurred in connection with the underlying lawsuits.

***Navigators Specialty Ins. Co. v. Svo Bldg. One, LLC*, No. 22-cv-07102-AMO, 2024 U.S. Dist. LEXIS 105458, 2024 WL 2983081 (N.D. Cal. June 13, 2024)**

Under California law, the U.S. District Court for the Northern District of California held that a commercial general liability insurer was entitled to seek recoupment of defense costs for uncovered claims where the underlying lawsuit alleged both covered and uncovered claims. The insured tendered to its commercial general liability insurer a lawsuit alleging claims for breach of contract, misappropriation of trade secrets, patent infringement, intentional interference with contractual relations, defamation, fraud, negligent misrepresentation, and civil conspiracy. The insurer agreed to defend the underlying lawsuit pursuant to a reservation of rights. After the dismissal of the defamation cause of action, the insurer advised the insured that it intended to withdraw its defense because there was no longer coverage. The insured objected and the insurer agreed to continue to defend the underlying lawsuit under a reservation of rights. The parties ultimately settled the underlying lawsuit. The insurer then brought a declaratory judgment action seeking a declaration that it was entitled to reimbursement for defense and indemnity costs it incurred in connection with the uncovered claims in the underlying lawsuit. In response, the insured filed a motion to dismiss the declaratory action. First, the district court found that under California law, when a cause of action includes mixed claims (*i.e.*, claims that are potentially covered and claims that are not) an insurer must defend the action in its entirety, but if it reserves the right to later seek reimbursement of defense costs, it may seek reimbursement as to the claims that are not covered. The insured argued that the insurer's complaint for declaratory judgment was deficient in that it did not specifically state that it was only seeking reimbursement of costs incurred for uncovered claims. However, the district court found that the complaint did allege that the insurer was not seeking reimbursement for defending claims that were potentially covered. Further, the insured argued that the insurer's complaint for declaratory judgment was also deficient because it purportedly sought to recover fees and costs it did not incur (*i.e.*, amounts that were incurred by another insurer who agreed to split the defense on a 50/50 basis). However, the district court found that the insurer specifically stated that it was only seeking to recover those amounts it incurred in defense of the insured under the policy between the insurer and the insured. Accordingly, the district court held that the insured did not meet its burden and declined to dismiss the insurer's claims for reimbursement.

***Mt. Hawley Ins. Co. v. Plymouth Plaza, LLC*, No. 22-62333-CIV-DAMIAN/AUGUSTIN-BIRCH, 2024 U.S. Dist. LEXIS 186003, 2024 WL 4471073 (S.D. Fla. Oct. 11, 2024)**

Under Florida law, the U.S. District Court for the Southern District of Florida held that a commercial general liability insurer's cause of action for reimbursement of defense costs could survive an insured's motion to dismiss because there was no Florida precedent precluding an insurer from seeking reimbursement of defense costs. However, the district court upheld the magistrate judge's ruling that Florida law precludes an insurer from seeking reimbursement of indemnity payments from its policy holder after settling a claim without a nonwaiver agreement. The insured was the owner of a commercial property who was sued by the family of a construction worker who died when a staircase collapsed on him in the parking garage attached to the property. The insured tendered the lawsuit to its commercial general liability insurer. The insurer accepted the defense under a reservation of rights, including the right to seek reimbursement of defense and indemnity costs. The insurer relied on a policy provision providing that "if [the insurer] defends any action but later determines that [the insurer] has no duty to defend, [the insurer] will have the right to reimbursement from that insured for all defense costs and expenses, including attorney's fees, [the insurer] has incurred." The insurer ultimately paid its policy limits to settle the underlying lawsuit and filed a declaratory judgment action seeking reimbursement of the settlement payment and the defense costs it had incurred. In response, the insured filed a motion to dismiss the declaratory judgment action, including the insurer's cause of action for reimbursement. Initially, the magistrate judge issued a ruling recommending that the insurer's counts for reimbursement of defense and indemnity costs be dismissed. In ruling on the insurer's motion for reconsideration, the district court upheld the magistrate judge's ruling with respect to the dismissal of

the insurer's claim for reimbursement of the settlement payment finding that it was not permitted under Florida law absent a nonwaiver agreement. However, the district court did not adopt the magistrate judge's recommendation with respect to the insurer's claim for reimbursement of defense costs. First, the district court noted that the parties failed to cite any case law specifying whether an insurer is entitled to recoup its defense costs from its insured in such a scenario. Next, the district court found that at the motion to dismiss stage, the court was required to accept the insurer's allegations as true and resolve all plausible inferences in the insurer's favor. Accordingly, the district court held that since the insured failed to cite any law demonstrating that the insurer's claim for reimbursement was impermissible under Florida law, the insured did not meet its burden at the motion to dismiss stage. Accordingly, the district court denied the insured's motion to dismiss the insurer's claim for reimbursement of defense costs.

***Berkley Natl. Ins. Co. v. Atlantic-Newport Realty LLC*, 93 F.4th 543 (1st Cir. 2024)**

Under Massachusetts law, the U.S. Court of Appeals for the First Circuit held that a commercial general liability insurer had no right to recoup defense costs, or amounts the insurer pays in settlement, even if the insurer reserves rights prior to payment and obtains a ruling, after the fact, that no defense or indemnity was owed. The insureds owned a company cafeteria and were sued by a food service worker who suffered a foot infection after being exposed to bacteria during a sewage backup. The insureds sought coverage for the lawsuit under a commercial general liability policy. The insurer agreed to defend the lawsuit subject to a full reservation of rights. The insurer filed a simultaneous declaratory judgment action seeking a ruling that no defense was owed. The insurer ultimately settled the underlying case and subsequently amended its declaratory judgment complaint requesting restitution of the amounts it had paid in settlement. The court noted the three circumstances under which Massachusetts law allowed an insurer to seek reimbursement from an insured: 1) when the insured agreed to the insurer's right to seek reimbursement; 2) when the insured gave specific authority to the insurer to reach a particular settlement which the insured itself agreed to pay; or 3) when the insurer told the insured of a "reasonable settlement offer," and gave the insured "an opportunity to accept the offer or assume its own defense," and the insured refused. Here, the court found that the insurer had not followed the precise steps noted above, particularly that it had not advised the insured, at mediation, that the insurer believed the plaintiff's settlement offer was reasonable and, therefore, it did not give the insured an opportunity to accept the offer or assume its own defense. By failing to go through these procedural steps, the court held that the insurer lost its right to seek recoupment of the settlement payment. With respect to the recoupment of defense costs, the court found that, in Massachusetts, this right is limited to situations where the insurer expressly reserves the right to seek reimbursement. Here, the court found that the insurer's reservation fell short of an express reservation because it did not specifically address a right to seek a recoupment of defense costs once those costs were paid.

***Great Am. Fid. Ins. Co. v. Stout Risius Ross, Inc.*, No. 23-1167/1195, 2024 US App. LEXIS 8576, 2024 WL 1511983 (6th Cir. Apr. 8, 2024)**

Under Michigan law, the U.S. Court of Appeals for the Sixth Circuit held that an insurer was entitled to recoup amounts paid in defense after the underlying complaint was amended to remove the only covered claims, even though the policy contained no express recoupment provision. The insured was a financial advisor and valuation expert who submitted to his professional liability insurer underlying lawsuits against him alleging violations of ERISA and securities laws. The insurer agreed to defend the claims but reserved its right to seek a judicial declaration of its rights under the policy and to seek reimbursement of amounts the insurer paid if it was subsequently determined that the insurer had no duty to defend or indemnify the insured. The insurer relied on an exclusion in the policy that precluded coverage for loss arising from actual or alleged violations of ERISA or of securities laws. The underlying plaintiffs later amended their complaints, asserting only federal securities law claims, and no common law claims. In a simultaneous declaratory judgment action it filed against the insured, the insurer moved for summary judgment seeking reimbursement for amounts paid in defense of the underlying lawsuits, bifurcating its recoupment claim between the fees incurred before the amended complaints, and the fees incurred

thereafter. In a unanimous three-judge panel, the Sixth Circuit affirmed the district court's judgment, holding that while the insurer was not entitled to reimbursement of defense fees paid prior to the amended complaints, it was entitled to reimbursement of amounts paid thereafter, even though the policy had no express reimbursement provision. The court reasoned that the insurer had the right to seek reimbursement under an "implied-in-fact" contract theory, whereby the insured was found to have manifested his assent to the insurer's right to reimbursement by accepting the defense subject to the insurer's timely reservation.

Twin City Fire Ins. Co. v. Axis Ins. Co., No. 22-00769-BAH, 2024 U.S. Dist. LEXIS 139937, 2024 WL 3691891 (Dist. Md. Aug. 7, 2024)

Under New York law, the U.S. District Court for the District of Maryland held that an excess general liability insurer was entitled to recoupment of defense costs it paid as a result of a primary insurer's wrongful refusal to defend the insured. The insured in the underlying action was a property management company that was sued by its residents following a carbon monoxide leak. The insured tendered the lawsuit to its commercial general liability insurer who refused to provide a defense. As a result, the excess insurer provided a defense to the insured subject to a reservation of rights. The excess insurer then filed a declaratory judgment action against the primary insurer seeking a declaration that the primary insurer breached its duty to defend the underlying lawsuit and that it was entitled to recoupment of defense costs under the theory of implied indemnification. First, the district court ruled that the primary insurer did in fact breach its duty to defend. Next, the district court found that under New York law, an excess insurer who is forced to assume an insured's defense as a result of a primary insurer's wrongful refusal is entitled to recover the defense expenses the excess insurer incurred. Further, the district court found that New York courts have described claims for payment between co-insurers that are not proportional or ratable, and are based on coverage for the same insured, as arising under the theory of recovery of implied indemnification. Accordingly, the district court held that the excess insurer was entitled to reimbursement of defense costs from the date the insured tendered the lawsuit to the primary insurer until the date when the primary insurer met its policy limits.

Associated Indus. Ins. Co. v. 101 Lehigh, LLC, No. 23-cv-03736, 2024 U.S. Dist. LEXIS 66218, 2024 WL 1585924 (E.D. Pa. Apr. 11, 2024)

Under Pennsylvania law, the U.S. District Court for the Eastern District of Pennsylvania held that a commercial general liability insurer was entitled to recoupment of defense costs where the policy contained a provision expressly including reimbursement language. The insured gas station was sued by the family of a victim who was shot and killed on the premises. The insured tendered the lawsuit for coverage to its commercial general liability insurer. In response, the insurer accepted the defense under a reservation of rights and filed a declaratory judgment action seeking a declaration that it had no duty to defend or indemnify the insured and was entitled to reimbursement of defense costs already paid. The insurer relied on the policy's firearms exclusion and the assault and battery exclusion. After determining that both exclusions applied to bar coverage, the district court turned to whether the insurer was entitled to recoupment of defense costs. First, the district court noted that in Pennsylvania an insurer typically cannot recoup defense costs solely by sending a reservation of rights letter. Rather, the policy must have a provision that expressly allows for recoupment of defense costs. Here, the district court found that the policy included a provision that expressly allowed for the reimbursement of defense costs if it was later determined that no coverage existed. Specifically, the policy provided that if the insurer initially defends an insured or pays 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, [the insurer] has the right to reimbursement for the defense costs [the insurer] has incurred." However, the policy only provided a right of reimbursement for those costs incurred after the insurer issued a reservation of rights letter notifying the insured that it is reserving its right to seek reimbursement of defense costs. Because there was no coverage under the policy, and because the insurer sent a timely reservation of rights letter to the insured reserving its right to recoupment as provided in the policy, the district court held that the insurer was entitled to recoup the defense costs it had expended after it had issued its reservation of rights letter.

xv. Consent

***APR Constr., Inc. v. Colony Ins. Co.*, No. D081146, 2024 Cal. App. Unpub. LEXIS 4492, 2024 WL 3464427 (Cal. App. July 19, 2024)**

Under California law, the California Court of Appeal for the Fourth District ruled that an insured under a commercial general liability policy could not prevail on a claim for breach of contract or breach of the implied covenant of good faith and fair dealing on grounds that the insured suffered damages from a global settlement agreed to by its insurers when, in fact, the insured consented to the settlement. In the underlying lawsuit, several insurers agreed to a global settlement, which required dismissal of the insured's cross-claims. Although the insured initially opposed the global settlement, the insured eventually consented and withdrew its opposition during the underlying plaintiff's motion to enforce the settlement agreement. Thereafter, the insured initiated a lawsuit against one of its insurers for breach of contract and breach of the implied covenant of good faith and fair dealing, claiming, among other things, that the insurer caused damage to the insured by dismissing its cross-claims without obtaining its consent. Contrary to the insured's assertions, the court found that the record demonstrated that the insured consented to the settlement, as evidenced by the fact that the insured withdrew its opposition to enforce the settlement, and counsel for the insured repeatedly represented to the trial court that the parties agreed to settle the underlying matter. As such, the insured could not prevail on a claim for breach of contract or breach of the implied covenant of good faith and fair dealing based on damages allegedly suffered from dismissal of its cross-claims.

***Aearo Techs. LLC v. ACE Am. Ins. Co.*, No. N23C-06-255-SKR CCLD, 2024 Del. Super. LEXIS 519, 2024 WL 3495121 (Del. Super. July 16, 2024)**

Under Delaware law, the Delaware Superior Court held that an insured under a commercial general liability policy who failed to obtain an insurer's consent prior to incurring or paying defense costs was required to

establish lack of prejudice to the insurer to recover the defense costs. The insureds designed and developed earplugs for first responders, military personnel, and others. The insureds were issued a number of multitier policies, some of which contained provisions requiring the insurer's consent prior to incurring or payment of defense costs. For example, one of the policies 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" and another policy provided that "[s]hould any 'claim' or 'suit' to which this policy applies appear likely to exceed the Retained Limit, no loss expenses or legal expenses shall be incurred on behalf of us without our prior consent." Hundreds of thousands of product liability lawsuits were filed against the insured companies, along with the noninsured company that acquired them, alleging hearing related injuries associated with the use of the earplugs. The insured companies and acquiring company brought suit against the insurers, seeking coverage for the defense costs paid, along with the settlement that was reached in connection with the underlying lawsuits. The court denied the insureds' motion for partial summary judgment concerning defense costs, finding, among other things, that the insureds failed to point to any evidence that indicated that they expressly sought consent for incurring or payment of any defense costs. The court explained that, where an insured breaches a consent provision, the insured can avoid forfeiture "only if [it] can prove by competent evidence a lack of prejudice to the insurer." The court concluded that "[f]actual questions remain that are not suitable to resolve on a motion for summary judgment regarding any prejudicial effect from [the] alleged failure to obtain the Insurers' consent for defense costs incurred or paid."

Ill. Cas. Co. v. B&S of Fort Wayne Inc., 235 N.E.3d 827 (Ind. 2024)

Under Indiana law, the Indiana Supreme Court ruled that an insured under a business owners liability policy could freely assign its post-loss claim to an injured claimant, even if the policy contains a consent-to-assignment clause, because Indiana law generally permits insureds to assign claims after a loss occurs. Without the insurer's consent, and as part of an underlying settlement, the insured nightclubs assigned their rights under the policies to several injured claimant models. In the ensuing coverage litigation, a dispute arose as to whether the insured nightclubs validly assigned these claims, and the Indiana Supreme Court found in favor of the insured nightclubs on this issue. As noted by the Indiana Supreme Court, while consent-to-assignment clauses are generally enforceable as "boilerplate" clauses in insurance contracts, courts also widely recognize an exception for assignments made after a loss has occurred. Per the court's ruling, Indiana law embraces this exception because, "once a loss occurs, an assignment of the [insured]'s rights regarding that loss in no way materially increases the risk to the insurer." The court also reasoned that once a loss occurs, "the indemnity policy is no longer an executory contract of insurance," but instead "a vested claim against the insurer and can be freely assigned."

Cincinnati Specialty Underwriters Ins. Co. v. Superior Tactical Response Agency, LLC, No. 1:22-cv-02353-JPH-MG, 2024 U.S. Dist. LEXIS 165075, 2024 WL 4189361 (S.D. Ind. Sep. 13, 2024)

Under Indiana law, the U.S. District Court for the Southern District of Indiana held that an insured did not violate a commercial general liability policy's consent-to-settle and consent-to-assignment provisions after assigning its rights to an injured claimant because Indiana law allows an insured to freely assign a claim after an "identifiable loss." The policy provided that the insured would not "admit to any liability, consent to any judgment, or settle any claim or 'suit' without [the insurer's] written consent," and contained a consent-to-assignment provision. The court held that the insured did not violate either of these provisions by assigning its rights under the policy to a third-party claimant, thereby settling the underlying claim. The court pointed to Indiana Supreme Court precedent holding that an insured may freely assign its claim after an "identifiable loss" without the consent of the insurer, at which point the insured has a "vested claim against the insurer." In such cases, the loss "must be fixed, not speculative," which requires that the loss be "identifiable with some precision" and be "reported to the insurer." Given that the loss, a death, already occurred and the insurer did not risk having to defend the insured in multiple lawsuits, the court found the existence of an identifiable loss, as the risk remained largely the same regardless of who held the policy rights. Lastly, the court rejected the insurer's contention that a

mere assignment of the policy rights violated the consent-to-settle provision, noting that the insurer did not identify any obligations that it assumed through the insured's assignment.

Mist Pharms., LLC v. Berkley Ins. Co., 479 N.J. Super. 126 (N.J. Super. Ct. App. Div. 2024)

Under New Jersey law, the Superior Court of New Jersey, Appellate Division, found that an insurer's refusal to consent to a settlement requested by the insured was not unreasonable where coverage for the underlying matter was excluded from coverage. A pharmaceuticals company was issued a directors and officers liability policy that contained an insurer consent to settle provision, which required the insured to obtain the insurer's consent to enter into settlements. A number of lawsuits were initiated against the insured in connection with various agreements concerning the distribution rights for certain drugs. During settlement negotiations, the insured requested the insurer's consent to globally settle the underlying lawsuits. The insurer withheld its consent, stating that it had not been provided with sufficient information to evaluate the insured's exposure and liability and reserved all rights in connection with a capacity exclusion. A global settlement of $12 million to resolve all of the underlying actions was subsequently entered into and approved by the court, with 25% of the liability (or $3 million) assigned to the insured, an amount in excess of the policy's $2 million limit of liability. The court explained that, under New Jersey law, "where a policy has a consent to settle provision, an insurer has a duty to not unreasonably withhold [its] consent to settle" and if it "breaches this duty, it is liable for indemnification in the amount of the settlement." The appellate court found that the underlying court erred by refusing to consider the applicability of the capacity exclusion when assessing whether the insurer was reasonable in withholding consent. While the appellate court recognized that the insurer's decision was reasonable under the facts, it also found that the capacity exclusion applied. In this regard, the appellate court explained that "there is no coverage under the … policy" and so "[i]t follows that the [insurer's] refusal to consent to a settlement by [the insured] was not unreasonable."

Modell v. Argonaut Ins. Co., No. 1:23-cv-01488 (JLR), 2024 U.S. Dist. LEXIS 22476, 2024 WL 495135 (S.D.N.Y. Feb. 8, 2024)

Under New York law, a federal district court held that an insured had no right under a consent to settle provision to veto a settlement entered into on behalf of a co-insured. A company that operated a retail sporting-goods chain was issued a policy that included a directors and officers liability coverage part which provided that "[n]otwithstanding the Insurer's right and duty to defend any Claim under this Coverage Section, the Insureds shall have the option to … consent to a settlement, which consent shall not be unreasonably withheld." After the insured company filed for Chapter 11 bankruptcy, the liquidation trustee brought an adversary lawsuit against a number of the company's former directors and officers, including its former CEO and former CFO. A settlement was entered into between the liquidation trustee and the former CFO, which required the insurer to pay $2.8 million of the policy's $5 million limit. The former CEO brought suit against the insurer and the former CFO, arguing that the insurer could not fund the settlement because it failed to obtain the former CEO's consent in connection with the settlement. In granting the insurer's motion to dismiss, the court rejected the argument, explaining that "[t]he clear meaning of the [consent-to-settle] provision is that each Insured has the right to consent to a settlement on its own behalf; it does not mean that other Insureds have the right to block settlements with respect to other Insureds."

S.T.A. Parking Corp. v. Fed. Ins. Co., 213 N.Y.S.3d 919 (N.Y. Sup. Ct. 2024)

Under New York law, the Supreme Court of New York found that an excess general liability insurer had a potentially valid coverage defense under the policy's consent-to-settle provision where the insured assigned its rights under the policy and did not contest the damages sought by the underlying plaintiff. The insured, a parking garage operator, sought indemnification from its excess insurer for a multimillion-dollar property-damage judgment. The excess policy contained a consent-to-settle clause that barred the insured from assuming legal obligations or reaching settlements without the consent of its insurer.

In the underlying dispute, the insured entered into an assignment agreement with the underlying plaintiff and chose not to contest the amount of — arguably inflated — damages sought by the underlying plaintiff. After the insured moved for summary judgment in the ensuing coverage dispute, the excess insurer sought, among other things, to amend its answer by adding a counterclaim that the insured forfeited coverage by violating the excess policy's consent-to-settle provision. The trial court allowed the excess insurer to add its counterclaim, finding "at least some merit" to the argument that the combination of the assignment agreement and the insured's decision not to contest damages required the insurer's consent for coverage purposes.

Enchante Accessories, Inc. v. Navigators Ins. Co., 2024 NY Slip Op 04516, 218 N.Y.S.3d 313 (N.Y. App. Div. 2024)

Under New York law, the Supreme Court of New York, Appellate Division, held that an insured could not recover pre-tender defense costs in light of a commercial general liability policy's voluntary payments provision. The policy contained a voluntary payments provision providing in relevant part that "[o]ther than first aid or emergency cleanup costs, no insured shall, except at its own cost, … voluntarily make a payment, assume any obligation, or incur any expense for damages [or] loss" without the insurer's prior consent." Although the insurer agreed to defend counterclaims against the insured, the insurer refused to reimburse any defense costs prior to the date of tender. The insured thereafter filed suit seeking reimbursement of its pre-tender defense costs. Disagreeing with the insured, the court found that the policy's voluntary payments provision required "the insurer's consent where the insured voluntarily makes payments, assumes any obligation, or incurs any expense for damage." Accordingly, based on the plain language of the voluntary payments provision, the insured could not recover pre-tender defense costs.

Hawkins v. Ace Am. Ins. Co., No. 85400-3-I, 2024 Wash. App. LEXIS 2170, 2024 WL 4588799 (Wash. App. Oct. 28, 2024)

Under Washington Law, the Washington Court of Appeals held that a nondefending general liability insurer was not bound by a reasonableness determination in an underlying settlement without receiving notice and having the opportunity to be heard in that proceeding. In the underlying matter, the insurer refused to defend its insured under a liability policy in a work-related car accident, which the insured subsequently settled with the injured claimant for $1.5 million. The injured claimant then filed suit against the insurer for breach of contract, violation of Washington's Insurance Fair Conduct Act (IFCA), and failure to act in good faith. The trial court ruled in favor of the injured claimant for $5,443,200. Ultimately, the court of appeals upheld the trial court's judgment in favor of the injured claimant, except for the trial court's imputation of the reasonableness determination in the underlying lawsuit. According to the court of appeals, while consent to settle need not be obtained from a nondefending insurer, and the nondefending insurer is barred from relitigating the merits of that settlement, the settlement amount is binding on the insurer only "subject to the insurer being given notice of the settlement and the opportunity to be heard on the issue of reasonableness." As such, the court of appeals remanded on the issue of damages, noting that "the existence and extent of [the insurer's] coverage obligation and any damages proximately caused by [the insurer's] breaches remain to be determined."

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