May 2020

# 2020 Quarterly Review – First Quarter

News and Developments in Executive Liability and Insurance

## In this Issue



## From the Editors

Welcome to the Quarterly Review for the First Quarter 2020. One of the more important developments in corporate governance occurred with the Delaware Supreme Court's recent decision in *Salzberg v. Sciabacucchi*, 2020 Del. LEXIS 100 (Del. 2020). Delaware incorporated companies can proscribe in their corporate charter a requirement that shareholder lawsuits brought under the Securities Act of 1933 be commenced in federal court. We summarize that important case in this issue. We also address an ERISA case decided by the United States Supreme Court regarding the statute of limitations for breach of fiduciary duty cases. We also review cases interpreting the claim definition in Directors & Officers liability insurance policies and decisions on allocation and notice issues. Our cyber corner looks at the implication of the COVID-19 pandemic on the cyber insurance landscape.

The FSG Legal & Claims team is available to discuss any of these issues at your convenience. We hope that this finds you well in this unusual time and we hope that you enjoy this issue of the Quarterly Review.


**Jacqueline A. Waters, Esq.**
Managing Director & Practice Leader

**Robbyn S. Reichman, Esq.**
Managing Director & Practice Leader


AON
Empower Results®

# General News

### Accounting Securities Class Actions Filings Reach Record Levels While Settlements Decline

Cornerstone Research released its 2019 Review and Analysis - Accounting Class Action Filings and Settlements. The number of securities class actions with accounting-related allegations filed reached record levels in 2019. Even with the increase in the number of filings however, the total value of the accounting related settlements declined. Additionally, the median settlement value of accounting related cases rose in 2019 compared to 2018.

In 2019, there were 169 securities class action suits with accounting-related allegations filed, up from 143 in 2018 – representing an 18% increase. Even though the number of filings increased, the number of accounting-related settlements declined from 41 (in 2018) to 32 (in 2019). This seems to follow the trend of a three-year lag between accounting filing and settlement and likely reflects the historic low number of filings between 2016-2018.

The total settlement value decline was due to the lack of mega settlements (those above $100 million). There were no settlements exceeding $500 million and only two that exceeded $100 million. The median settlement for accounting cases increased to $10.5 million in 2019 up from $9.7 million in 2018. *Cornerstone Research – 2019 Review and Analysis – Accounting Class Actions Filings and Settlements 2019 Review Report*

In 2019, there were 169 securities class action suits with accounting-related allegations filed, up from 143 in 2018 – representing an 18% increase.

### The DOL Issues Final Rule Regarding Joint Employer Status

The United States Department of Labor (DOL) recently announced its final rule interpreting joint employer status under the Fair Labor Standards Act (FLSA). The DOL's guidance for employers, which had not been meaningfully revised in more than 60 years, provides a four-factor balancing test for determining who is a "joint employer." The four factors are whether a company, directly or indirectly, (i) hires or fires the employee, (ii) supervises and controls the employee's work schedule or conditions of employment to a substantial degree, (iii) determines the employee's rate and method of payment, and (iv) maintains the employee's records. No single factor is dispositive, and the appropriate weight given each factor will vary depending on the circumstances. The DOL explained that satisfying the "maintenance of the employee's employment records" factor alone does not demonstrate joint employer status. The DOL further explained while the four-factor test should determine joint employer status in most cases, additional factors may be relevant "but only if they are indicia of whether the potential employer exercises significant control over the terms and conditions of the employee's work." Of note, an employee's economic dependence on a potential employer is not a relevant factor.

The DOL's guidance for employers, which had not been meaningfully revised in more than 60 years, provides a four-factor balancing test for determining who is a "joint employer."

# Cases Of Interest

## At the Supreme Court

### ERISA's 3-Year Statute of Limitations for Breaches of Fiduciary Duty Requires Actual, Not Constructive, Knowledge

In a highly anticipated ruling, the United States Supreme Court held that ERISA's 3-year statute of limitations for breach of fiduciary duty claims requires actual – not constructive – knowledge.

The Employee Retirement Income Security Act of 1974 (ERISA) establishes three separate time periods within which claimants can maintain an action for breach of fiduciary duty against plan fiduciaries – namely:

1. 3 years – triggered from the date when the plaintiff obtains "actual knowledge" of the alleged breach;
2. 6 years – in the absence of "actual knowledge", triggered from the date of the last action constituting the alleged breach (or, in the case of an omission, from the date when the fiduciary could have cured the same); or
3. In the event of fraud or concealment – triggered 6 years from the date of discovery of the alleged breach.

An employee of the insured corporation from 2010 to 2012 participated in two separate company-sponsored retirement plans. In October 2015 he sued the insured's investment policy committee for breach of fiduciary duty alleging that the committee overinvested in alternative assets that charged high fees, including hedge funds and private equity. The employee's suit was filed more than 3 years but less than 6 years after the committee informed him of its decision to invest in these alternative assets.

The committee argued that the employee's claim was time-barred by ERISA's 3-year statute of limitations, maintaining that the employee had actual knowledge of the committee's investment decisions through his receipt of various disclosures and other materials including: (a) a November 2011 email advising that information regarding plan disclosures was available via a website; (b) a 2012 summary plan description describing


plan investments and referring participants to fund fact sheets; and (c) other plan disclosures made in 2012. Further, the committee provided evidence at the trial court level that the employee visited the benefits website site frequently. The employee, however, maintained that he did not recall reviewing the disclosures themselves, and that he was 'unaware' while working at the insured that his retirement plan accounts were invested in hedge funds or private equity. Instead, he "recalled reviewing only account statements sent to him by mail, which directed him to the benefits website and noted that his plans were invested in 'short-term/other' assets but did not specify which."

In *Intel Corp. Investment Policy Comm. v. Sulyma*, the Supreme Court ruled unanimously in favor of the employee, holding that "[t]he question here is whether a plaintiff necessarily has 'actual knowledge' of the information contained in disclosures that he receives but does not read or cannot recall reading. We hold that he does not ..." In an opinion authored by Justice Alito, the Court noted that while "[i]n everyday speech, 'actual knowledge' might seem redundant... the law will sometimes impute knowledge – often called 'constructive' knowledge – to a person who fails to learn something that a reasonably diligent person would have learned." Yet, the use of "actual" as a modifier is critical, and "signals that the plaintiff's knowledge must be more than 'potential, possible, virtual, conceivable, hypothetical, or nominal'." Therefore, Justice Alito concluded:

> [ERISA] §1113(2) requires more than evidence of disclosure alone. That all relevant information was disclosed to the plaintiff is no doubt *relevant* in judging whether he gained knowledge of that information . . . To meet §1113(2)'s 'actual knowledge' requirement, however, the

plaintiff must in fact have become aware of that information. (emphasis in original)

Fortunately for plan sponsors, Justice Alito also commented that the Supreme Court's opinion does not prevent the establishment of actual knowledge throughout the litigation process such as via deposition testimony or even "through 'inference from circumstantial evidence'." For example, Justice Alito noted that the following would be relevant: (a) evidence that plan disclosures were made; (b) electronic records showing that the plaintiff viewed those disclosures; and (c) evidence that implies that the plaintiff acted in response thereto. For this reason, the opinion "also does not preclude defendants from contending that evidence of 'willful blindness' supports a finding of 'actual knowledge'." *Intel Corp. Inv. Policy Comm. v. Sulyma*, 2020 U.S. LEXIS 1367 (2020).

## Corporate Governance

### Delaware Supreme Court Decision Alters IPO Litigation Landscape

Delaware incorporated companies now can avail themselves of the "flexibility and wide discretion" that the Delaware General Corporation Law ("DGCL") allows by proscribing, in their corporate charters, a requirement that shareholder suits under the Securities Act of 1933 ("Securities Act") must be commenced in a federal forum. The ruling has profound implications on a Delaware corporation's ability to direct where its shareholders can bring litigation arising out of the company's public registration filings.

On March 18, 2020, the Supreme Court of the State of Delaware held that corporate charter provisions requiring claims under the Securities Act to be litigated in federal court are facially valid. The court reviewed the underlying December 2018 decision from the Delaware Chancery Court that held federal forum selection provisions were invalid and unenforceable. Forum selection provisions were a proposed solution to *Cyan, Inc. v. Beaver Cty. Emples. Ret. Fund*, 138 S. Ct. 1061 (2018), in which the United States Supreme Court held that shareholders could file Securities Act claims in both federal and state court, thus confirming concurrent state court jurisdiction under the Securities Act.

In *Sciabacucchi*, the Supreme Court of the State of Delaware reversed the trial court, reasoning that federal forum provisions were a valid form of "private ordering." The court scrutinized what the DGCL meant by "internal affairs" and found that the federal forum provisions did not contradict Delaware law, nor the legislative intent of the DGCL. The court also noted that nothing in *Cyan* prohibited a forum selection provision from designating federal court as the venue for Securities Act claims.

In holding that federal forum provisions were facially valid, the court acknowledged that federal forum provisions "involve a type of securities claim related to the management of litigation arising out of the Board's disclosures to current and prospective stockholders in connection with an IPO or secondary offering." The court continued that registration statements were "an important aspect of a corporation's management of its business affairs and of its relationship with its stockholders." Further, the court reasoned that a "bylaw that seeks to regulate the forum in which such 'intra-corporate' litigation can occur is a provision that addresses the 'management of the business' and the 'conduct of the affairs of the corporation,' and is thus, facially valid under Section 102(b)(1)."

In analyzing the distinction between the "internal and external affairs" of a Delaware corporation, the court disagreed with the lower court's conclusion that "everything other than an 'internal affairs' claim was 'external' and therefore not the proper subject of a bylaw or charter provision." Further, the court found federal forum provisions dictating the forum for a Section 11 claim "are neither 'external' nor 'internal affairs' claims.

Additionally, the court determined that federal forum provisions do not "offend federal law and policy, nor do they offend principles of horizontal sovereignty." Moreover, the federal forum provisions aligned with goals of "judicial economy" and avoidance of "duplicative effort." Finally, in recognizing corporate ability to adopt innovative governance provisions, the court averred "that a board's action might involve a new use of plain statutory authority does not make it invalid under our law, and the board of Delaware corporations have the flexibility to respond to changing dynamics in ways that

are authorized by our statutory law." The *Sciabacucchi* decision provides key momentum for Delaware incorporated companies which seek to craft a federal forum provision in its charters and mute the repercussions of *Cyan. Salzberg v. Sciabacucchi*, 2020 Del. LEXIS 100 (Del. 2020).

## Claim

### SEC Formal Order of Investigation Constitutes a Claim

The United States Court of Appeals for the First Circuit determined that a Securities and Exchange ("SEC") investigation of the insured was a claim "first made" when the SEC issued a formal order of investigation. Consequently, two excess insurance policies issued after the formal order were not triggered.

The insured purchased directors and officers Liability ("D&O") insurance for 2012 to 2013 and for 2013 to 2014 on both a primary and excess basis. The primary and excess insurers for the 12-13 policy period, which were also primary and first excess insurers for the 13-14 policy period, paid their limits in defense costs. The excess insurers denied coverage under the 13-14 policy period, stating that the Claim was "first made" during the 12-13 policy period. The trustee for the now bankrupt insured filed suit for coverage but the district court determined that the formal order was a claim "first made" during the 12-13 policy. Consequently, the district court granted the excess insurers' motion for summary judgment.

The First Circuit agreed that the formal order was indeed a claim "first made" during the 12-13 policy period. The applicable policy defined a "Claim" to include "a formal regulatory proceeding (civil, criminal or administrative) against or formal investigation of an Insured." The applicable policy also provided that, "with respect to a formal investigation," a claim shall be "deemed first made" upon "an Insured being identified by name in an order of investigation, subpoena, Wells Notice or target letter . . . as someone against whom a civil, criminal, administrative, or regulatory proceeding may be brought." The court determined that the formal order was a claim and clearly established that a proceeding "may be brought" against the insured. The court noted that the applicable policy only required the possibility that a proceeding could be brought against the insured. The court opined that no reasonable jury could find that the formal order did not signal that a proceeding may be brought against the insured. Similarly, the court determined that the pertinent part of the policy language was unambiguous. *Jalbert v. Zurich Servs. Corp.*, 2020 U.S. App. LEXIS 8500 (1st Cir. 2020).

### Subpoena Not a Claim That Precluded Coverage of Subsequent Lawsuit

The United States District Court for the Southern District of New York held that a creditor's subpoena to the insured title insurance agency was not a claim, such that the creditor's subsequent lawsuit against the insured was not related. The policy defined a claim to include a subpoena "as a non-party to litigation…involving Professional Services provided by such Insured." The court rejected the insurer's interpretation of the definition as applying to any subpoena involving the insured's title services. According to the court, the "plain language" established that a "claim" was more narrowly limited to a subpoena issued in litigation that involved the insured's services. Since the subpoena here was merely issued by a bank's creditor to enforce its property rights against the bank, the later lawsuit was not a related claim and the policy responded.

> The court determined that the formal order was a claim and clearly established that a proceeding "may be brought" against the insured.

The insured did not give notice of the subpoena and in the subsequent policy period, the creditor sued the insured for negligence in submitting documents for certain foreclosed properties at issue. The policy for both policy periods defined a claim as "a written demand by subpoena upon an Insured as a non-party to litigation or arbitration involving Professional Services provided by such Insured." Related claims were defined as claims arising out of one or

more related "wrongful acts." The insurer denied coverage for the lawsuit, contending that the subpoena in the prior policy period was a "claim" per the policy and a "related claim" first made in that period.

In finding for the insured, the court determined that the "claim" definition's phrase "involving Professional Services provided by such Insured" modified the immediately preceding phrase, "litigation or arbitration," not "subpoena." This was "the only reasonable interpretation" and a subpoena simply pertaining to the insured's professional services did not qualify as a claim. Here, no such litigation had been at issue because the subpoena had been served for the purpose of enforcing the assignee's rights as a judgment creditor, "not questioning [the insured's] professional services." Moreover, even if the subpoena and lawsuit were "logically and causally connected," they were not "related claims" as defined by the policy.

> Moreover, even if the subpoena and lawsuit were "logically and causally connected," they were not "related claims" as defined by the policy.

Since related claims were defined as involving related "wrongful acts" and no "wrongful act" was alleged in the subpoena, there was "no nexus of Wrongful Acts" between the lawsuit and subpoena. Further, the court refused to consider the insurer's extrinsic evidence that the "claim" definition was a coverage enhancement, which rendered the subpoena a "claim." This evidence was not "properly considered" because both parties had agreed the "claim" definition was unambiguous. *Protective Specialty Ins. Co. v. Castle Title Ins. Agency, Inc.*, 2020 U.S. Dist. LEXIS 20962 (S.D.N.Y. 2020).

### Declaratory Judgment Complaint is a Claim Alleging a D&O Wrongful Act

A federal district court held that an initial complaint for declaratory judgment was a claim pursuant to the relevant provisions of a Directors and Officers ("D&O") liability policy such that the insured's notice of the second amended complaint was not timely. The original and a first amended complaint were both filed during the same policy period but the insured did not give notice until the second amended complaint was filed in the subsequent policy period. The insurer denied coverage and asserted that the original complaint constituted a "Claim" under the policy such that notice was untimely.

The policy, for the two consecutive periods at issue, defined a claim, in relevant part, as a "[c]ivil proceeding commenced by the service of a complaint or similar proceeding... against an Insured Entity for a Wrongful Act, including any appeal therefrom." Wrongful Act was defined, in relevant part, as "any actual or alleged act, error, omission." The original complaint was filed by the estate of a decedent, alleging that one of the insureds wrongfully reduced her company shares. The insureds countered that the original complaint was not a claim and that they were not required to provide notice until the second amended complaint was filed.

The court concluded that the original complaint alleged wrongful acts by the defendants and that the original complaint was a claim. The insureds argued that the second amended complaint was a separate claim and was not related to the original complaint. The policy deemed claims containing facts and circumstances and related wrongful acts a single wrongful act to have occurred when the first act occurred. The court thus held that the second amended complaint did not contain distinct or additional allegations and instead was part of a single proceeding initiated by the filing of the original complaint. Further, the court did not find persuasive the insureds' position that their notice was timely because they reasonably believed that the original complaint was not a claim. The court reiterated that the original complaint triggered the notice requirement under the prior policy and that "accordingly," there was no coverage. *Hanover Ins. Co. v. R.W. Dunteman Co.*, 2020 U.S. Dist. LEXIS 45737 (N.D. Ill. 2020).

## Notice

### Breach of an Immaterial Notice Condition Does Not Preclude Coverage Without Prejudice

In reversing a district's court ruling, the United States Court of Appeals for the Fifth Circuit held that, under Texas law, an obligation to report a claim under an insurance policy is material but the adherence to other notice requirements is immaterial. Accordingly, an insurer may not deny coverage based on an insured's breach of an immaterial notice condition unless the insurer can show prejudice.

In this matter, a Texas attorney was retained in 2015 by real estate investors for a real estate deal which was revealed to be a fraud. The investors subsequently sued the attorney for malpractice to recoup some of their losses. The malpractice action was filed in July 2015. The attorney had a claims-made and reported professional liability policy for the period of May 2015 to May 2016.

During the pendency of the malpractice suit, the insurer sought a declaration that it had no duty to defend the malpractice suit because the policyholder did not "report" the claim during the policy period. In response, the investors, who had intervened in the coverage action, countered that, as part of the renewal application during the relevant period, the insured attached a "Claim Supplement" detailing the malpractice suit which was provided to underwriting. The insurer argued the "Claim Supplement" to underwriting was insufficient to satisfy the notice requirements.

The Court of Appeals reversed and remanded the lower court's decision for the insurer. The court, reinforcing that policies are to be construed "using ordinary rules of contract interpretation," found that the plain meaning of "reported" should apply. The policyholder argued "reported" by the policyholder means to have provided information. The insurer countered and asserted the "Notice of Claim" provision required the policyholder to "immediately send copies of demands, notices or summonses or legal papers to its claims department." The court held that "while an insured's breach of a material reporting obligation relieves an insurer of its duty to defend and indemnify the insurer, the same is not necessarily true when an insured breaches an immaterial notice condition. Instead, an insurer may be relieved of its duty to defend and indemnify an insured who breaches an immaterial notice condition only when the insurer shows that it was prejudiced by the breach." In reversing the lower court's ruling, the court said the lower court had not reached the question of prejudice to the insured. Also, while the court found that the insured's report during the renewal underwriting process qualified as "reported," it declined to reach the issue of whether there was a breach or prejudice. *Landmark Am. Ins. Co. v. Lonergan Law Firm, P.L.L.C.*, 2020 U.S. App. LEXIS 5190 (5th Cir. 2020).

> The court held that "while an insured's breach of a material reporting obligation relieves an insurer of its duty to defend and indemnify the insurer, the same is not necessarily true when an insured breaches an immaterial notice condition."

### Notice Requirement Enforced Despite Insured's Timely Notice to Broker

The Court of Appeal of California (Second District) found that notice was late under a claims-made employment practices liability policy, holding that the insured's timely notice to its broker was insufficient. This was in part because the broker had not effectively registered as the insured's agent per a California Insurance Code provision. The court was unpersuaded by the fact that the insured had never been given a copy of its policy and that the insurer, in marketing materials, had stated that insureds could notify their brokers or agents of claims.

The insured's broker had sold the insured an employment practices liability policy. The brokerage contract provided that the broker would act as the insured's agent. However, the broker did not file a notice of appointment with the California Insurance Commissioner stating it was the insured's agent, as required by a California Insurance Code provision (Section 1704, subdivision (a)) for that agency to be effective. Further, the insured had never received a copy of the policy, despite repeated requests to the broker.

Within the policy period, the insured received right to sue letters and state agency complaints, which it tendered to the broker no later than two months after receipt. The broker did not forward these to the insurer. Approximately nine months later, after the policy period expired, the employees filed suit. Two months later, the insured tendered the claim directly to the third-party claims service identified in the declarations. The insurer initially accepted the tender subject to a reservation but later denied the claim based on late notice. The policy contained the

standard requirement of notice as soon as practicable, but in no event later than 60 days following the policy period. The broker was not identified in the policy as a proper recipient of notice.

In affirming the lower court's dismissal, the court ruled that the insured's notice to the broker did not fulfill the notice requirement, that the broker had not filed a notice of appointment per the California Insurance Code defeated any claim of agency, and because the broker was also not the insurer's agent, its failure to provide the insured with the policy was not attributable to the insurer. Moreover, the policy specified that the claims service was the party to be notified, regardless of an article on the insurer's website stating an insured should not wait "to contact your agent/broker or insurer" about a claim. The insured did not show that it relied on this article. Additionally, the article had a disclaimer that its information was accurate as of 2017 and for informational purposes only. The court further emphasized that the policy's provision anticipating notice after the policy period expired did not create a prejudice requirement. It concluded that the insured should have given notice at the receipt of the initial right to sue letter and charge. *Ahsl Enters. v. Greenwich Ins. Co.*, 2020 Cal. App. Unpub. LEXIS 1279 (Cal. Ct. App. 2020).

### Notice Prejudice Rule was not Applicable to Claims Made and Reported Policies

The United States Court of Appeals for the Ninth Circuit held that, under California law, an insurer is not required to show prejudice to deny coverage based upon late notice under a claims-made and reported policy. The insured's policy required that claims must be reported "as soon as practicable but in no event later than thirty (30) days after the end of the Policy Period." The policy defined policy period as "the period from the inception date of this Policy to the expiration date of this Policy as set forth in... the Declarations."

The insured did not report the complaint against it because it believed it would resolve the matter within the policy's deductible. The insured reported the matter after its motion to dismiss the underlying lawsuit was denied. The insured contended that California's notice-prejudice rule applies to its D&O policy and sued its insurer. The district court

granted the insurer's motion to dismiss and the insured appealed.

The insured argued that the policy was ambiguous regarding whether a claim may be reported during a renewal period and that such ambiguity should be resolved in the insured's favor. The court disagreed and concluded that the policy was not ambiguous, and the insured was required to report the claim during the policy period but no later than thirty days after the expiration date.

The insured also argued that it was entitled to coverage on equitable grounds. The court again disagreed, advising that equitable relief is only available in unique circumstances and when the insured provided notice of the claim as soon as they became aware of it. Here, the insured "knew of the claim within the policy period and had thirty days after the policy expired to report it yet waited sixteen months to do so." The court determined that equitable relief was not appropriate. Accordingly, the court held that the notice prejudice rule did not apply to the insured's claims made and reported policy, and that the insurer "need not demonstrate substantial prejudice to deny coverage." *EurAuPair Int'l, Inc. v. Ironshore Specialty Ins. Co.*, 2019 U.S. App. LEXIS 36898 (9th Cir. 2019).

## Allocation

### Larger Settlement Rule Applies to Allocation

The Superior Court of Delaware applied the larger settlement rule to allocate between covered and uncovered loss, even though the directors & officers ("D&O") policy contained allocation language that referred to the relative legal exposure method. The larger settlement rule was found "persuasive" over the competing relative legal exposure method because the policy's allocation provision did not prescribe a specific method if the parties could not agree on allocation. Also, the larger settlement rule comported with the rest of the policy, including the insuring agreements' "all loss" language.

As the court explained, the larger settlement rule provides that the insurer can allocate "only if...the defense or settlement costs of the litigation were...higher than they would have been had only the insured parties been defended or settled." By contrast, the relative legal exposure method allows an insurer to limit indemnity to the settlement amounts attributable to covered parties based on their potential liability at the time of settlement.

Here, the insured sought coverage for settlements in shareholder lawsuits as to covered and uncovered defendants. The policy's allocation provision stated that for claims involving "both covered and uncovered matters...the Insureds and Insurer agree to use their best efforts to determine a fair and proper allocation of covered Loss...In making such determination, the parties shall take into account the relative legal and financial exposures of the Insureds in connection with the...settlement of the Claim." The insuring agreements provided that the insurer was to pay "all Loss," in pertinent part, as to the indemnification covered by the policy.

The court agreed with the insureds that the larger settlement rule governed allocation. It was not guided by the policy's allocation provision, which, though unambiguous, was "unhelpful" because it identified no "specific formula" should the parties disagree on allocation. The provision's reference to consideration of the Insureds' relative exposures pertained only to situations where parties made "best efforts" to agree on allocation; it was not the default method if the parties disagreed.

Additionally, the larger settlement rule protected "the economic expectations of the insured" and applied because the settlement, in part, encompassed covered claims; the parties disagreed on allocation; and the policy language did "not provide for a specific allocation method" such as pro rata. Moreover, the rule was "persuasive" in light of reading the policy as a whole, especially given that the policy was to "cover all Loss that the Insured(s) become legally obligated to pay." Thereby, "any type of pro rata or relative exposure analysis seems contrary" to the policy language. Further, the insurer was not "deprived of the economic deal" it bargained for, since it had the right to exercise its subrogation rights and still pursue uncovered defendants. *Arch Ins. Co. v. Murdock*, 2020 Del. Super. LEXIS 156 (Del. Sup. Ct. 2020).

## Defense Costs

### Insured Entitled to Pre-Tender Defense Costs as Insurer Could Not Show Prejudice

The Superior Court of New Jersey held that an insured was entitled to defense costs incurred before its late notice and tender under a commercial general liability (CGL) policy. The court concluded that even though the insurer had been unable to control the insured's defense, it had not shown appreciable prejudice from the insured's late notice or failure to seek the insurer's consent to incur expenses.

The insured retained counsel for a trademark dispute and gave notice to the insurer three months into the litigation. The dispute settled after another month and the insured had incurred approximately $150,000 in defense costs. Under the policy, which required notice of a claim as soon as practicable and the insurer's consent to incur expenses, the insured was entitled to defense costs. Pursuant to these provisions, the insurer paid only the $13,000 in defense costs incurred after notice.

In finding for the insured, the court enforced the prejudice requirement for occurrence-based policies, analyzing "whether substantial rights have been irretrievably lost by virtue of the failure of the insured." Thus, the court examined whether the insurer could meet its burden of showing appreciable prejudice because of the insured's late notice and failure to comply with the expense consent provision. In determining that the insurer failed to meet the burden, it ruled that the insurer's inability to control the litigation, standing alone, did not indicate appreciable prejudice. Further, any contention that the insurer may have negotiated a more favorable settlement if it had control would have been "pure speculation." However, though the court found the insured entitled to pre-tender defense costs, it deferred ruling on damages, including whether the insurer was obligated to pay the full rates of counsel chosen by the insured without its consent. *The Lewis Clinic for Educ. Therapy v. McCarter & English LLP*, No. MER-L-000747-19 (N.J. Sup. Ct. Mercer Cnty. 2020).

## Retroactive Date

### Alleged Wrongful Acts Prior to Retroactive Date Preclude Coverage

The United States District Court for the Northern District of Alabama held that an employment practices liability insurer did not owe coverage to an insured for defense and settlement expenses incurred in an underlying employment discrimination action.

A suit was filed against the insured by an employee alleging that her supervisor discriminated against her based upon her age and sexual affiliation and that she was then terminated on October 25, 2016. The plaintiff initially filed a Charge of Discrimination with the Equal Employment Opportunity Commission ("EEOC") and "the plaintiff indicated under penalty of perjury that October 25, 2016 was the last day on which discrimination took place. She did not identify her charge as a 'continuing action.'"

The insured requested coverage for the discrimination action under the policy's employment practices provision. The insurer declined coverage and stated that "'[t]he date of the alleged wrongful termination was October 25, 2016, with other alleged

disparate treatment prior to that date' such that the 'employment-related practices [] occurred prior to the effective date' of the policy." The employment practices coverage provision of the policy provided that coverage would apply only if "[s]uch 'employment practices' occurred after the Retroactive Date, if any, shown in the Declarations and before the end of the 'policy period.'" The policy provided a retroactive date of January 31, 2017.

The court determined that the alleged wrongful conduct occurred, at the latest, on October 25, 2016. The court added that "under the plain language of the policy, because the final act of discrimination occurred more than three months before the January 31, 2017 retroactive date for the start of coverage, [the insurer] had no obligation to defend or indemnify [the insured] in the underlying action."

The insured argued that the plaintiff's allegations that the insured's "policies, practices, and procedures" continued to violate her rights and that they had "a habit and/or practice" of such conduct and that the court should regard these allegations of ongoing conduct as occurring after the retroactive date. The court, however, was not persuaded. The plaintiff expressly stated that the insured terminated her on October 25, 2016 and her charge, which was incorporated by reference in the complaint, stated that the "latest date" of discrimination occurred on October 25, 2016. Accordingly, the court held that, because the last alleged act of discrimination occurred before the retroactive date, coverage was not triggered and the insurer did not breach their contract by denying the insured's claim. *Elite Refreshment Servs. LLC v. Liberty Mut. Grp., Inc.*, 2020 U.S. Dist. LEXIS 14627 (N.D. Ala. 2020).

## Related Claims

### Claims Made Policy Without Related Claims Provision Ambiguous as to Earlier Pre-Inception Demand

The United States Court of Appeals for the Ninth Circuit found ambiguous a professional liability policy, which lacked an express provision deeming related claims to comprise the same claim. Reversing the decision of the lower court, the Ninth Circuit held that the insured's receipt of a demand letter prior to

the policy period did not necessarily bar coverage for the subsequent lawsuit. This was because the policy had no provision integrating factually related claims. However, the court also found that the policy's operation as a "claims first made" policy suggested that the policy did not intend to cover a claim related to one made before inception. The court thus remanded for review of extrinsic evidence to determine the parties' intent.

The insured had received the claimant's demand letter alleging patent infringement before the policy period at issue. Subsequently, during the policy period, the insured was sued by the claimant on the same factual grounds. The policy defined a claim "as either...a written demand...or a Suit." Importantly, the policy had no provision deeming factually related claims as the same claim and first made upon the issuance of the first related claim. The policy also contained an exclusion for claims arising out of wrongful acts which were also alleged in claims reported under prior policy periods. The lower court found that the demand and suit were a single claim first made before the policy period.

In reversing the lower court's decision, the Ninth Circuit determined that the exclusion and lack of relatedness provision "underscore that factually related Claims are not necessarily integrated" as to coverage. The insurer could have "easily drafted" the relatedness provision if its intent was to integrate factually related claims. Additionally, the exclusion for claims reported before the policy period would be superfluous because if the initial grant of coverage meant to integrate related claims, then such claims would already be excluded. Notably, however, the court declined to affirmatively find that the policy did not integrate related claims. It explained that since the policy was issued as "claims first made," extrinsic evidence was required to resolve the ambiguity regarding related claims. The court remanded to the district court for consideration of such evidence. *Nat'l Union Fire Ins. Co. v. Zillow, Inc.*, 2020 U.S. App. LEXIS 5142 (9th Cir. 2020).

### Multiple Claims Not Related Due to Significant Differences in Parties and Relief Demanded

The Unites States District Court for the Eastern District of Pennsylvania denied an insurer's motion for summary judgment and declared that the insurer had a duty to defend and indemnify the insured in a suit brought against it.

In the underlying case, a minority shareholder sent a books and records demand to the insured in April 2017. In 2018, the same shareholder sued the insureds, claiming that he was deprived of an elected seat on the company's board of directors. The insureds submitted the claims to the company's Directors and Officers Liability insurer.

The insurer denied the claim on the basis that the current demand and suit were related to a 2015 demand letter and a 2016 shareholder derivative action. The denial was also based on the position that the claims arose out of acts occurring before the policy's November 2013 prior acts exclusion date.

The court agreed that while some of the allegations in the 2016 derivative action and the current suit were similar, there were significant differences including the parties and relief sought. Furthermore, many of the acts alleged in the plaintiff's amended complaint occurred after the acts cited in the prior demand letter and derivative action. As such, the court considered them "discrete acts and claims that did not exist prior to the relevant policy periods." Accordingly, the related claims provision did not bar coverage for the majority of plaintiff's claims.

The court also concluded that the factual basis for the claim did not exist before the inception of the policy. While the insured board of directors may have created a board seat that had been vacant since 2015, the seat was not in question until 2017 when the underlying plaintiff launched a bid for the seat and was deprived of that seat at that time. The election to that board seat was the "overwhelming focus" of one of the claims. Therefore, no prior acts were at issue. The court ruled that the insurer must defend and indemnify the insured. *Vito v. RSUI Indem. Co.*, 2020 U.S. Dist. LEXIS 14724 (E.D.Pa. 2020).

## Social Engineering

### Court Denies Insured's Attempt to Avoid Crime Policy's Social Engineering Fraud Sublimit

Applying Mississippi Law, the United States District Court for Northern District of Mississippi held that the insured's loss caused by a business email compromise was limited to the crime policy's Social Engineering Fraud sublimit and rejected the insured's claim that it could recover the far higher limit available under the Computer Transfer Fraud or Funds Transfer Fraud insuring agreements.

The insured purchased its electrodes from a Russian supplier. The insured's CFO received various emails from what appeared to be an employee of the supplier. The emails requested that the insured wire future payments to a new bank account "due to issues [the supplier was] having with [its] account." In response, the CFO then wired two payments totaling over $1 million to the new account. The insured then learned from the true Russian supplier that the supplier had not received payment and the insured had in fact been duped into wiring money to a bank account controlled by fraudsters.

The insured submitted a claim under its crime insurance policy, which had a $1,000,000 limit for Computer Transfer Fraud or Funds Transfer Fraud, but a $100,000 sublimit for Social Engineering Fraud. The insurer took the position that the insured was entitled to coverage only under the Social Engineering Fraud provision and mailed the insured a check for $100,000 but the insured returned the check, filed a declaratory judgment action against the insurer, and sought damages for breach of contract.

The insured did not dispute that the Social Engineering Fraud provision was applicable but instead averred that it was also entitled to coverage under the Computer Transfer Fraud provision and/or the Funds Transfer Fraud provision. The insured claimed that the fraudulent email, which ultimately caused the

CFO to act, was sufficient to trigger the Computer Transfer Fraud and/or Funds Transfer Fraud coverage. The insured contended that it may recover the policy's full limit because the covered peril "was the dominant and efficient cause of [the insured's] loss" and urged the court to apply a "proximate cause" standard.

The court focused on the policy's knowledge or consent requirements and granted the insurers' summary judgment motion. The "Computer Transfer Fraud" provision provided, in relevant part, that "[t]he Insurer will pay for loss . . . resulting directly from Computer Transfer Fraud that causes the transfer, payment, or delivery . . . to a person, place, or account beyond the Insured Entity's control, without the Insured Entity's knowledge or consent." (emphasis added). The policy defined "Computer Transfer Fraud" as "the fraudulent entry of Information into or the fraudulent alteration of any Information

within a Computer System." The court held that the "Computer Transfer Fraud" provision did not apply because the insured consented to the transfer. The court rejected the insured's "proximate cause" argument.

The court also found that the loss was not covered under the "Funds Transfer Fraud" provision, which provided, in relevant part: "[t]he insurer will pay for loss of Money or Securities resulting directly from the transfer of Money to a person, place, or account beyond the Insured Entity's control, by a Financial Institution that relied upon...[an] instruction that purported to be a Transfer Instruction but, in fact, was issued without the Insured Entity's knowledge or consent." The court similarly focused on the provision's language regarding knowledge or consent. In the court's view, the inclusion of the funds transfer fraud provision's "knowledge or consent" requirement again indicated the intended coverage. *Mississippi Silicon Holdings v. Axis Ins. Co.*, 2020 U.S. Dist. LEXIS 29967 (N.D. Miss. 2020).

### Court Finds Direct Loss Under Computer Fraud Coverage Section

The United States District Court for the Eastern District of Virginia found that a truck dealership's social engineering loss was a direct loss under the crime policy's computer fraud coverage. The insured's failure to investigate the wiring instructions in the impersonator's email, the fraudster's sending of legitimate invoices on which the insured owed money, and the insured's affirmative authorization of the wire transfer at issue did not negate the directness of the loss.

The insured truck dealership received an order for two trucks and to fulfill the order, placed its own order with a part supplier. A fraudster purporting to be a representative from the supplier emailed the insured's CEO, attaching two legitimate invoices and wire instructions. The fraudster used an email address that differed slightly from the one used by the genuine representative, who was known to the CEO. The insured did not call anyone at the supplier or otherwise verify the wire instructions before authorizing payment. Forensic analysis found that no active malware or malicious coding was involved. The policy's computer fraud insuring agreement, in pertinent part, covered loss "resulting directly from the use of any computer to fraudulently cause a transfer..."

The interpretation of "the term 'directly' in a contract case" was a matter of first impression under Virginia law. Consulting ordinary dictionary definitions, the court pronounced that "directly" was unambiguous and meant "something that is done in a... proximate manner...without intervening agency from its cause." The court thus found the loss to be directly caused by the use of a computer. A computer was used "in every step" of the payment being made, including the fraudster's creating an email address to mimic and communicate as the supplier and the insured's emails to its bank to effect the transfer. That the fraudster attached legitimate invoices on which the insured owed money was unimportant, since the policy did "not require a fraudulent payment by computer," only the use of a computer to fraudulently cause a transfer. Further, the court rejected the insured's failure to uncover the fraud as a defense, noting that to allow it would be inconsistent with the policy's "framework." The court also noted the lack of precedent holding that "contributory negligence is a defense to a computer fraud claim." Additionally, the six-day timeframe of the transfer was not intervening, since the causal chain of events necessarily required this processing time. *The Cincinnati Insurance Co. v. The Norfolk Truck Center*, 2019 U.S. Dist. LEXIS 220076 (E.D.Va. 2019).

...the court pronounced that "directly" was unambiguous and meant "something that is done in a... proximate manner... without intervening agency from its cause."

## Cyber Coverage

### Cyber Insurance Coverage Found Under Businessowner's Policy

A Maryland federal district court ruled that a ransomware attack involved "direct physical loss of or damage to" software, data, and computer systems under a businessowner's insurance policy. This finding is despite the lack of explicit cyber coverage in the policy.

The insured operated an embroidery and screen-printing business, and stored software and data on its computer server. It suffered a ransomware attack, which prevented the insured from accessing certain files and resulted in a loss of efficiency of the insured's computer systems. Following the attack, the insured sought coverage under its businessowner's policy, which afforded coverage for "direct physical loss of or damage to Covered Property." "Covered Property" was defined to include "[e]lectronic data processing, recording or storage media such as films, tapes, discs, drums or cells" and "[d]ata stored on such media," including software. The insurer denied coverage for the cost of replacing the insured's computer system on the ground that there was no "direct physical loss of or damage to" the system. Instead, the insurer maintained that the insured lost only data, which is an intangible asset, and could still use its computer system to operate its business.

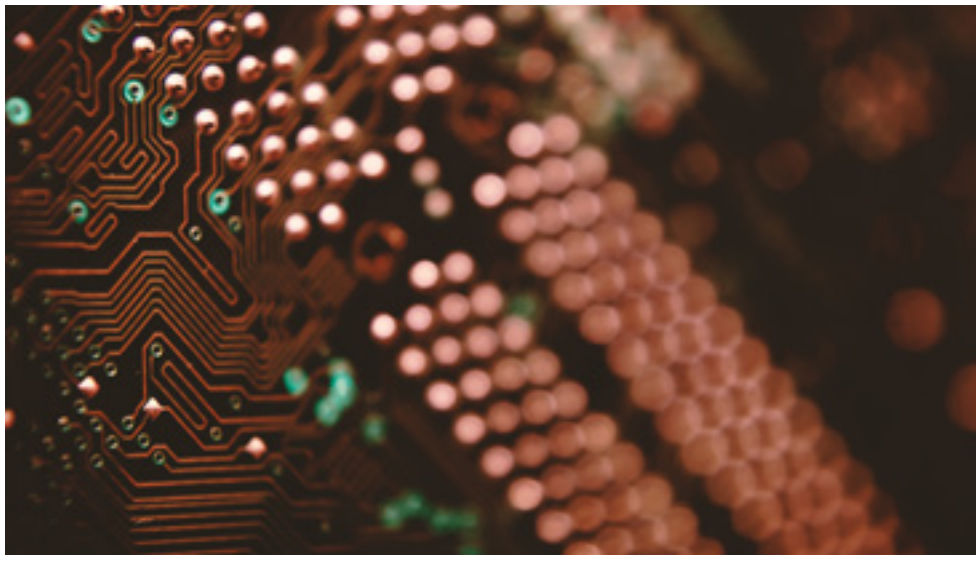
The court decided in favor of the insured. It found that the insured could recover under the policy based on either the loss of data and software, or the loss of functionality of the computer system itself. Initially, the court observed that both "data" and "software" were included in the definition of covered property, suggesting that such property could suffer "direct physical loss or damage" within the meaning of the policy. In addition, the court held that the insured had "demonstrated damage to the computer system itself," and not just to the data and software residing on that system. In so doing, the court rejected the insurer's argument that the system still functioned and that there was not an "utter inability to function." Rather, the court concluded the more persuasive argument and line of cases are those suggesting "that loss of use, loss of reliability, or impaired functionality demonstrate the required damage to a computer system" is what is necessary to satisfy the contract language of "physical loss or damage to" (emphasis added in original). The court continued that "not only did [the insured] sustain a loss of data and software, but [the insured] is left with a slower system, which appears to be harboring a dormant virus, and is unable to access a significant portion of software and stored data." *Nat'l. Ink & Stitch, LLC v. State Auto Prop. & Cas. Ins. Co.*, 2020 U.S. Dist. LEXIS 11411 (D.C. Md. 2020).

### Georgia Supreme Court Allows Suit by Victims of Cyber Breach to Proceed

The Supreme Court of Georgia recently overturned an appellate court's decision to affirm a trial court's decision granting a motion to dismiss in a case involving a cyber breach. The underlying complaint alleged that in June 2016 an anonymous hacker stole personally identifiable information of more than 200,000 patients of an orthopedic clinic. The hacker allegedly demanded ransom, which the clinic refused to pay. The information was then made public on the dark web and posted to a public data-storage website. The clinic notified plaintiffs of the breach in August 2016.

In their class action lawsuit, the plaintiffs alleged that, because their data had been stolen, criminals were able to assume their identities to obtain credit cards, issue fraudulent checks, file tax refund returns, liquidate bank accounts, etc. They had allegedly spent time with credit reporting agencies, and some had experienced fraudulent credit card charges. They sought damages based on costs related to credit monitoring and identity theft protection, attorneys' fees, injunctive relief, and declaratory judgment with respect to the clinic's future data security practices. The clinic filed a motion to dismiss, which was granted on the basis that the plaintiffs had not alleged a cognizable claim under Georgia law. That decision was affirmed on appeal after the appellate court concluded that "plaintiffs were seeking "only to recover for increased risk of harm" and that while the measures the plaintiffs took were prudent, they were "designed to ward off exposure to future, speculative harm."

On further review the Supreme Court of Georgia distinguished the clinic's cited cases, which were issued at a different procedural point in time, not at the motion to dismiss stage. The court reminded the respondents that at the motion to dismiss stage, all factual allegations must be accepted as true – including those allegations that any given class member will ultimately have his or her identity stolen. The court also considered the purpose of a cyber-attack – that the data would be sold by the hacker and/or used to commit identity theft. The court ultimately determined that the allegations raised "more than a mere specter of harm" and were sufficient to survive a motion to dismiss the negligence claims. *Collins v. Athens Orthopedic Clinic, P.A.*, 2019 Ga. LEXIS 848 (Ga. 2019).



# Cyber Corner

### Implications of the COVID-19 Pandemic on the Global Cyber Insurance Landscape

As the COVID-19 pandemic took hold globally, the remote workplace transformed useful technological alternatives such as remote login, video connectivity and conducting business on personal devices into business necessities. The heightened reliance upon technology has escalated the focus on the scope of cyber insurance and professional liability coverages, particularly in a dynamic global insurance market.

Fortunately, many cyber and professional liability insurance policies already contemplate coverage for the risks attendant to the critical technologies relied upon during the pandemic. For example, both stand-alone professional liability policies and cyber policies with a technology errors and omissions insuring agreement insure against the types of third-party liabilities that may arise out of technology services that many businesses may be providing in greater volume during the pandemic.

Similarly, although increased technology reliance brings increased opportunities for hackers and network security incidents, the third- and first-party exposures associated with such incidents are typically covered under most cyber policies. Coverage for ransomware demands, incident response costs, network security liability, privacy liability and regulatory liabilities are readily available, if not standard, in most policies. Likewise, first-party costs may be a part of many robust cyber insurance policies, including income loss and extra expense from network interruption or contingent business interruption, as well as data recovery and restoration costs and income loss from system failure. Renewed focus on adequacy of limits in light of the heightened exposure may also be a common area for discussion with clients.

Although the increased technology-based risks did not necessarily create novel cyber exposures for which risk transfer solutions did not exist, there have been market-driven efforts to introduce new exclusions and wording ostensibly tied to the pandemic. For example, insurers sought to introduce new broadly worded exclusions seeking to exclude "any" losses or claims "arising out of" or "related to" COVID-19. These broad proposed exclusions should be avoided, or at a minimum, negotiated narrowly so that losses and claims intended to be covered are not excluded simply because they are occurring during the pandemic. Similarly, an exclusionary effect can accompany changes to definitions which attempt to narrow what is in-scope as a "professional service", or what constitutes a "computer system." Insureds should work with their broking team to critically analyze the impact of any proposed wording changes given the new necessity of conducting business in a remote work environment.

**Lessons Learned:** As our clients respond to the COVID-19 Pandemic through the implementation of remote business activities, they should carefully assess their augmented business activities and technology business partners to determine whether the associated risks are contemplated by the scope of existing insurance policies. Careful attention should be paid to key policy definitions such as professional services or technology services to determine whether any new or augmented service offerings in the current environment are contemplated. Clients should consult with their broking team in advance of renewal to determine any desired language amendments to meet evolving remote business activities. Finally, considering efforts by the insurance market to introduce new exclusions, Insureds should critically analyze any proposed language to resist efforts to restrict or remove core coverages traditionally offered in cyber and professional liability insurance policies under the guise of overbroad COVID-19 wording.

# SEC Filings, Settlements and Judgments

In February 2020, the SEC announced fraud charges against **SCANA Corp.**, two former executives, and South Carolina Electric & Gas Co. The two executives are CEO Kevin Marsh and EVP Stephen Byrne. The SEC seeks permanent injunction, disgorgement and prejudgment interest, financial penalties, and a director and officer bar against Marsh and Byrne.

In January 2020, the SEC announced that it settled fraud charges against the CEO of **Longfin Corp.**, Venkata S. Meenavalli. The settlement requires Meenavalli to disgorge $159,000 plus prejudgment interest of $9,000, and to pay a $232,000 civil penalty. It also requires Meenavalli to surrender all of his Longfin stock, bars him from acting as an officer or director of a public company and enjoins him from participating in offer or sale of penny stocks. This settlement concludes the SEC's action against Meenavalli, Longfin and other individuals.

In January 2020, the SEC announced that it filed and settled accounting fraud charges against **Hill International** and its former Chief Accounting Officer Ronald Emma. Hill and Emma consented to entry of judgment without admitting or denying the allegations. The judgments impose permanent injunctions and require payment of a $500,000 civil penalty by Hill and a $75,000 civil penalty by Emma. Emma also agreed to a permanent suspension from appearing and practicing before the SEC as an accountant.

In February 2020, the SEC announced a partial consent judgment against Ashik Desai, former executive of **Outcome Health**. Desai consented to entry of a judgment that permanently enjoins him from violating certain provisions of the Securities Act and the Exchange Act and requires payment of a civil penalty that will be determined at a later date.

In March 2020, the SEC announced entry of judgment against Daniel Ustian, the former CEO of **Navistar International Corp**. The judgment orders Ustian to pay a $250,000 penalty and disgorgement of $250,000. The court will determine later whether Ustian will be barred from serving as a director and officer.

# Key Contacts

**Jacqueline A. Waters, Esq.**
Managing Director & Practice Leader
Financial Services Group | Legal & Claims Practice
Commercial Risk Solutions, Aon
312.381.4563
jacqueline.waters@aon.com

**Robbyn S. Reichman, Esq.**
Managing Director & Practice Leader
Financial Services Group | Legal & Claims Practice
Commercial Risk Solutions, Aon
212.441.2309
robbyn.reichman@aon.com

## About Aon

Aon plc (NYSE:AON) is a leading global professional services firm providing a broad range of risk, retirement and health solutions. Our 50,000 colleagues in 120 countries empower results for clients by using proprietary data and analytics to deliver insights that reduce volatility and improve performance.



Empower Results®