2020 Year In Review

News and Developments in Executive Liability and Insurance

Volume 17

AON

Contents

From the Editors

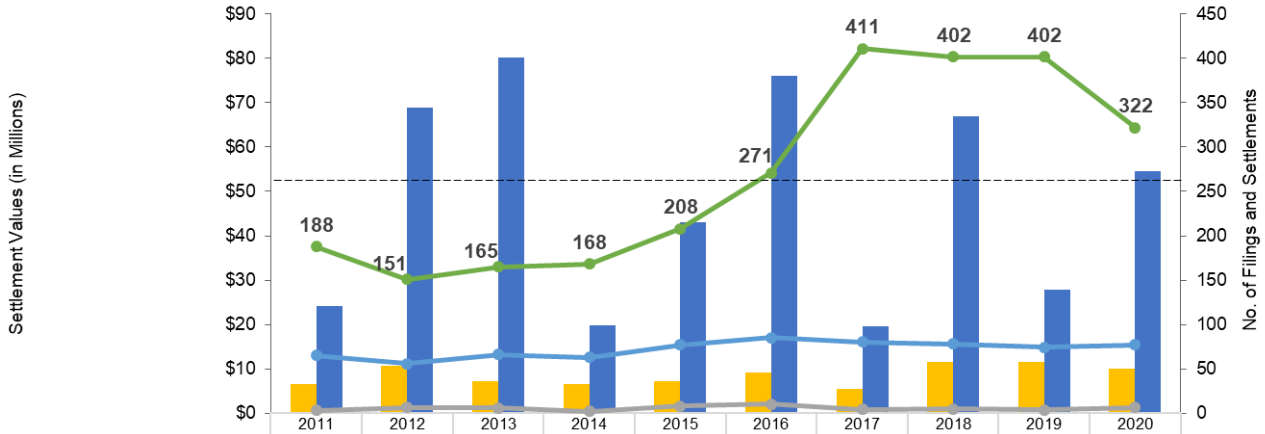
Aon's Financial Services Group is once again pleased to present our annual Year in Review, seventeenth edition. Its contents include case summaries of decisions involving management liability, professional liability, cyber and general insurance topics, and court opinions on securities cases and issues of corporate governance.

2020 was, of course, a year like no other. From the pandemic, to the decrease in traditional securities litigation, to significant corporate governance decisions, to the rise of the SPAC.

The federal securities class action filing numbers dropped from 402 in 2019 to 322 in 2020. Speculation as to the reason includes COVID-19 related issues such as a significant decrease in traditional merger and acquisition activity to the lack of access to the courts. However, while the median settlement decreased slightly, the average settlement amount doubled, largely due to several settlements over $100 million.

COVID-19 had some repercussions on management liability claims. A number were filed, although not to the levels expected. Ransomware took

Securities Class Actions Filings v. Securities Class Action Settlements
2011-2020



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Median Settlement*	$6.6	$10.6	$7.2	$6.6	$7.1	$9.2	$5.5	$11.6	$11.6	$10.1
Average Settlement*	$24.1	$69.0	$80.3	$19.9	$43.0	$76.1	$19.5	$66.9	$27.8	$54.5
No. of SCA Filings (Federal)	188	151	165	168	208	271	411	402	402	322
No. of SCA Settlements	65	56	66	63	77	85	80	78	74	77
Mega Settlements (>$100M)	3	6	6	2	8	10	4	5	4	6

2011 - 2019 Federal SCA Filing Avg. (263)
** Settlement dollars are adjusted for inflation; 2020 dollar equivalent figures are used.*
Filing Data – Stanford Law School Securities Class Action Clearinghouse;
Settlement Data – Cornerstone Research – Securities Class Action Settlements (2020 Review and Analysis)

off and became the most prevalent type of cyber claim. 2020 could be called the year of the SPAC, the special purpose acquisition company, the offerings of which skyrocketed. There were 248 in 2020, representing over 50% of all IPOs, while in 2019 there were only 59 SPAC offerings, and that was a record. This has piqued the interest of regulators and the litigation risk has increased.

On the corporate governance front, we saw other developments and concerns take shape, in the area of board diversity for example, and larger issues of overall diversity and equity. The courts upheld the federal forum provisions in company charters requiring that '33 Act claims be filed in federal court. And, the new administration in place has heightened expectations of a more active SEC and enforcement environment.

The 2020 Year in Review addresses these developments as well as highlights court decisions on insurance coverage issues such as the definition of claim, related claims, notice issues and interpretation of social engineering fraud policy provisions.

We hope that you enjoy the 2020 Year in Review and find it useful. We look forward to advising on the trends that develop in 2021.

Thank you, as always, for your interest and support.

Best Regards,

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News & Developments

First Quarter

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*

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.

Second Quarter

The SEC Cracks Down on COVID-19 Related Fraud

The SEC actively monitors markets for fraud and misconduct as part of its overarching mission. That role may increase in the face of COVID-19 pandemic. In April, the agency filed its first COVID-19 related enforcement action against Praxsyn Corporation and its CEO over false statements made regarding highly sought after N95 masks. During the investigation, the SEC suspended trading in Praxsyn's stock.

In the case of Praxsyn, it is alleged that the company said in a release that it was negotiating the sale of millions of N95 masks. At the end of February 2020, Praxsyn stated that it was evaluating multiple orders and could guarentee delivery of millions of masks. About a week latter, the company issued a statement regarding a direct pipeline from manufacturers and suppliers to buyers, and that the company was accepting orders for a minimum of 100,000 masks. Following inquiries by the SEC, the company latter issued a statement revealing the truth that it never had any mistake available to sell. The SEC complaint was filed days later and charged the company and the CEO with violations of the antifraud provisions of the federal securities laws.

Besides its normal enforcement activities, the agency has also been actively publishing good corporate hygiene guidelines and protocol for companies during the pandemic, as well as updating materials on their website about investor education, "pump- and dump schemes," and other types of market manipulations that may grow in numbers in this current environment. The agency is reminding investors that "fraudsters often seek to use national crises and periods of uncertainity to lure inverstors into scams. They may play off investors' hopes and fears, as well as their charity and kindness, and may try to exploit confusion or rumors in the marketplace." In this environment, we might expect to see an increase of SEC related inquiries, trading suspensions, and enforcement actions.

Third Quarter

California State Court Upholds Federal Forum Provision

On September 1, 2020, the California Superior Court (Judge Maria Weiner) upheld the federal forum provision ("FFP") in the charter of Delaware company Restoration Robotics, Inc. *Wong v. Restoration Robotics, Inc.* 2020 Cal. Super. LEXIS 227 (Cal. Sup. Ct. 2020). (*See* Cases of Interest.) The FFP mandated that stockholder claims under Section 11 of Securities Act of 1933 be heard exclusively in federal court. The Delaware Supreme Court's ruling in *Salzburg v. Sciabacucchi*, 2020 Del. LEXIS 10 (Del. 2020) preceded Judge Weiner's decision in *Restoration Robotics* and supports exclusivity of federal courts to hear Section 11 cases.

For Delaware companies headquartered in California, *Restoration Robotics* confirms the appropriateness of determining federal jurisdiction prior to the outset of litigation in Section 11 cases.

In 2018, the U.S. Supreme Court held that a Section 11 case may be heard in either state or federal court. *Cyan, Inc. v. Beaver County Employees Retirement Fund*, 2018 U.S. LEXIS 1912 (2018). To address, in advance, the challenges faced by responding to securities class actions in concurrent jurisdictions, many companies elected to use an FFP to mandate federal court as the appropriate forum for such cases. The protections afforded in federal court,

particularly related to limitations on discovery until after the motion to dismiss phase, are important to public companies and their boards. Additionally, the risk of inconsistent outcomes, inefficiencies of litigating in multiple forums, and increased costs are all addressed favorably via an enforceable FFP.

There are some limitations to the ruling in *Restoration Robotics*. First, it is a California trial court decision so should be viewed as persuasive rather than precedential. Second, as with *Salzburg*, facial validity of the FFP is confirmed for the Company. Other defendants, including underwriter and venture capital defendants, do not benefit from a Company's FFP. Finally, additional challenges should be expected from plaintiffs' firms against removal or dismissal attempts in order to sustain favorable jurisdiction. Nonetheless, *Restoration Robotics* will be cited as persuasive authority by companies currently responding to state court Section 11 cases.

Financial Services Firm Becomes the First to be Charged with Violating the NYDFS Cybersecurity Regulation

The New York State Department of Financial Services (NYDFS) has, for the first time, charged a financial services institution with violations of the Department's Cybersecurity Regulation. This regulation requires banks, insurance companies, and other NYDFS-regulated financial services firms to establish and maintain a cyber-security program designed to protect consumers and ensure the safety and soundness of the financial services industry.

The charges in this matter stem from the unauthorized access of a title insurance provider's computer systems, which allegedly exposed tens of millions of documents that contained consumers' sensitive personal information, including bank accounts and statements, mortgage and tax records, Social Security numbers, wire transaction receipts, and drivers' license images. The unauthorized access lasted for more than four years. The NYDFS found that the firm not only mishandled its customers' data, but also willfully failed to remediate the vulnerability, even though it was discovered six months prior to when the unauthorized access became publicized. The charges alleged that when the vulnerability was first discovered the firm "failed to conduct a reasonable investigation into the scope and cause of the exposure thereby grossly underestimating the seriousness of the vulnerability." The firm also allegedly failed to follow the recommendations of its internal cybersecurity team to conduct further investigation into the vulnerability.

The insurer was charged with violating six provisions of the Cybersecurity Regulation, including failure to perform an adequate risk assessment; failure to maintain proper access controls; failure to provide adequate security training for cyber-security employees; and failure to encrypt certain nonpublic information. The NYDFS alleged that each instance of non-public information encompassed within the charges constituted a separate violation carrying up to $1,000 in penalties per violation. The charged company strongly disagreed with the NYDFS' charges, explaining that its "investigation into the incident, conducted with an outside forensics firm, identified a very limited number of consumers whose non-public personal information likely was accessed without authorization and otherwise found no evidence of misuse of any non-public personal information. None of these identified consumers were New York residents."

Loss of Unencrypted Device Results in $1 Million Fine

An employee of a healthcare provider had his work laptop stolen from his unattended vehicle. The laptop contained data that should have been, but was not, protected by encryption. In addition, officials determined that emails were cached on the laptop hard drive. This would allow a thief access to any personal patient and medical information that was on the laptop.

The healthcare provider filed a breach report, which resulted in an investigation by the Office of Civil Rights (OCR) at the U.S. Dept. of Health and Human Services. The investigators found: systemic non-compliance with data privacy and security requirements; a lack of device and media controls; and failure to maintain business associate agreements with the proper parties. As a result, the OCR levied a $1 million dollar fine and required implementation of a corrective action plan with two years oversight. *Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS) and Lifespan Health System Affiliated Covered Entity (Lifespan ACE).*

Fourth Quarter

SEC Settles First Action against a Public Company for Misleading Covid-19 Disclosures

On December 4, 2020 the Securities and Exchange Commission ("SEC") issued a press release announcing it had reached a settlement with The Cheesecake Factory ("Company") stemming from charges the Company had made misleading disclosures about the impact of the COVID-19 pandemic on its business operations and its financial condition.

In reference to the administrative proceeding, the SEC reports "the action is the SEC's first charging a public company for misleading investors about the financial effects of the pandemic." The SEC notes the Company reported its "restaurants were 'operating sustainably' during the COVID-19 pandemic," but did not disclose in its March 23 and April 3, 2020 filings that "the company was losing approximately $6 million in cash per week and that it projected that it had only 16 weeks of cash remaining." However, the Company did disclose this information to equity investors and lenders while the company sought additional liquidity.

The SEC further reports the Company also did not disclose it "had already informed its landlords that it would not pay rent in April due to the impacts that COVID-19 inflicted on its business" and other negative factors. SEC Chairman Jay Clayton said that "[d]uring the pandemic, many public companies have discharged their disclosure obligations in a commendable manner, working proactively to keep investors informed of the current and anticipated material impacts of COVID-19 on their operations and financial condition," and that "[a]s our local and national response to the pandemic evolves, it is important that issuers continue their proactive, principles-based approach to disclosure, tailoring these

disclosures to the firm and industry-specific effects of the pandemic on their business and operations." Chairman Clayton went on to provide that "[i]t is also important that issuers who make materially false or misleading statements regarding the pandemic's impact on their business and operations be held accountable."

Coinciding with the issuance of the press release, the SEC released its lengthy Cease-and-Desist Order, which the Company consented to and which confirmed the Company had submitted an Offer of Settlement which the SEC accepted. The administrative proceeding was brought pursuant to Section 21C of the Securities Exchange Act of 1934 ("Exchange Act") against the Company. The Order notes the SEC determined the 8K disclosures were inadequate and "[a]s a result of the conduct described... [the Company] violated Section 13(a) of the Exchange Act and Rules 13a-11 and 12b-20 thereunder, which collectively require every issuer of a security registered pursuant to Section 12 of the Exchange Act to file with the Commission accurate current reports on Form 8-K that contain material information necessary to make the required statements made in the reports not misleading." Stephanie Avakian, Director of the Diversion of Enforcement, reports that "The Enforcement Division, including the Coronavirus Steering Committee, will continue to scrutinize COVID-related disclosures to ensure that investors receive accurate, timely information, while also giving appropriate credit for prompt and substantial cooperation in investigations."

Rare Securities Class Action Trial in Australia Results in First-Ever Defense Verdict

A rare bench trial in a securities class action lawsuit resulted in a dismissal of the plaintiff's action and an award of costs to the defendant. The Australian legal system, unlike the legal system in the United States, does not allow for jury trials in such cases. Justice Jacqueline Gleeson of the Federal Court of Australia determined that the defendant insured did not violate the "continuous disclosure" requirements pertaining to provision of financial guidance by companies traded on the Australian Stock Exchange.

The plaintiff filed a securities class action against the insured in October 2015 on behalf of investors who purchased shares between August 14, 2013 and November 20, 2013. The plaintiff's complaint alleged that the insured and its directors and officers had violated their continuous disclosure obligations under the Australian Corporations Act 2001 and Australian Stock Exchange listing rules. The plaintiff also alleged that the insured's directors and officers violated Australian statutory provisions prohibiting deceptive and misleading conduct.

On August 14, 2013 the insured issued its FY 14 earnings guidance, stating that it expected to deliver "increased earnings" in FY 14 compared to FY 13. This guidance was based, in part, on its internal FY 14 budget approved by the board of directors. The FY 14 budget was the subject of a "bottom-up build" from individual business units and layers of "top-down review" by senior management and the board of directors. The insured reaffirmed its FY 14 earnings guidance on October 9, 2013. Six weeks later, it issued revised earnings guidance. Following that announcement, the insured's share price declined 26%.

The plaintiff's allegations centered around the contentions that the insured (1) did not have a reasonable basis for issuing its FY 14 earnings guidance; and (2) failed to correct its guidance after the insured became aware, on or from August 14, 2013, that its earnings would likely fall materially short of consensus expectations by market analysts. These allegations resulted in an alleged breach of the insured's continuous disclosure obligations via misleading or deceptive conduct.

The judge determined that the insured, through its board of directors, had provided expectations for FY 14 earnings via a reasonable disclosure process and that its audit & risk committee was very careful in the language and representations provided within its earnings guidance. In addition, the judge found that at no stage did any director or officer of the insured know or believe that FY 14 earnings would fall materially short of the consensus expected range. Consequently, the plaintiff failed to demonstrate that the insured contravened any of the statutory rules (including continuous disclosure requirements) against misleading and deceptive conduct by making, repeating and maintaining its FY 14 guidance representations. *Crowley v. Worley Ltd,* [2020] FCA 1522.

SEC Awards Record Breaking $114 Million Whistle-Blower Award

On October 22, 2020, the Securities and Exchange Commission (SEC) announced it made an $114 million award to an individual whistle-blower who reported wrongdoing and provided "substantial assistance" in the SEC's enforcement action. $52 million was awarded in connection with the SEC's case and $62 million was awarded out of anther agency's related case. The SEC also called the whistle-blower's action extraordinary, noting that the whistleblower had repeatedly reported their concerns to the affected company before reporting it to the agencies.

The $144 million award eclipsed the recent record of a $50 million whistleblower award to one individual, set in June of 2020. Whistleblowers may be eligible for an award when they voluntarily provide the SEC with original, timely, and credible information that leads to a successful enforcement action. Whistleblower awards can range from 10 to 30 percent of the money collected when the monetary sanctions exceed $1 million. *Securities and Exchange Commission Press Release* -October 22, 2020.

The Irish Data Protection Commission Fines a U.S. Tech Company for the First Time

In December 2020, the Irish Data Protection Commission fined a U.S. technology company under the General Data Protection Regulations ("GDPR") for the first time. The company was fined £450,000, approximately $545,000, for failing to timely report a data breach that occurred in December 2018. Under GDPR, a breach must be reported within 72 hours after discovery. The tech company reported the breach almost two weeks after discovery, saying reporting was delayed by the staffing fluctuations due to Christmas holidays.

Privacy advocates hope this decision moves the process of applying GDPR because there is "a long line of cases involving big tech companies in Ireland." The award gives some indication of regulators' application of the guidelines as well. Fines can be assessed in

an amount up to 2% of the violator's global annual revenue, which in this case could have resulted in a fine up to $60 million based on the violator's 2018 revenue. In determining the amount, the regulators said the violation occurred out of negligence and was not intentional or systematic. While the fine may be modest, it still represents a significant step in the growing European Union regulation of companies outside the European Union for privacy violations. Corporate liability exposures for privacy-related issues will likely continue to grow.

Cases of Interest

Part I: Supreme Court Cases

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).

Title VII Protections Extend to Sexual Orientation and Transgender Status

On June 15, 2020, the U.S. Supreme Court issued a landmark ruling in *Bostock v. Clayton Cty,* protecting the rights of LGBTQ workers. The decision confirms that Title VII of the Civil Rights Act of 1964, which makes it illegal for employers to discriminate on the basis of sex, also covers sexual orientation and transgender status.

The Court, using principles of statutory construction, looked at the plain language and ordinary meaning of the term "sex." In 1964, when the statute was written, "sex" referred to the biological distinctions between males and females and the meaning of "because of" required but-for causation. The Court further makes clear that sex does not need to be the only factor considered, solely one factor that caused alleged unequal treatment.

Thus, if an employer intentionally relies, even only in part, on an employee's sex when deciding to terminate them, a violation of Title VII has occurred. While it is likely that Congress did not think to expressly list sexual orientation and transgender status in its listing of traits an individual can experience discrimination as a result of, discrimination based on these two categories necessarily entails discrimination based on sex. This is so because, using the facts of this case, an employer who fires a person for being homosexual or transgender, fires them for traits or actions it would not have questioned in members of a different sex. Further, the absence of sexual orientation and transgender status does not cause an ambiguity because the statute is applied in a situation not expressly anticipated by Congress. In fact, the Court notes that it was possible drafters foresaw this

potential application. Debates over the Equal Rights Amendment, which was passed less than a decade after Title VII and bears similar language, pointed out that its text might also protect homosexuals from discrimination. *Bostock v. Clayton City,* 2020 U.S. LEXIS 3252 (2020)

In the Absence of Financial Loss, Participants in a Defined Benefit Plan Do Not Have Standing to Sue Under ERISA

In a decision with potentially sweeping ramifications for defined benefit pension plans, a divided U.S. Supreme Court has held that plan participants who have not suffered financial loss do not have standing to bring claims under Employee Retirement Income Security Act of 1974 (ERISA).

Plaintiffs James Thole and Sherry Smith are retirees and vested participants in the U.S. Bank defined benefit pension plan pursuant to which they are entitled to receive a specific sum each month for the rest of their lives. At no time did either Thole or Smith fail to receive their full monthly benefit. Nevertheless, they sued U.S. Bank and various plan fiduciaries alleging that the defendants violated ERISA's duties of loyalty and prudence by improperly managing plan assets (including investing in proprietary funds in which U.S. Bank was purportedly paid excessive fees), thus causing significant losses to plan assets that ultimately led to the plan being underfunded. U.S. Bank subsequently made additional contributions to the defined benefit plan to ensure that it comported with ERISA's funding requirements. The district court dismissed the plaintiffs' complaint for lack of standing to sue, and that decision was affirmed by the 8th Circuit.

The Supreme Court ruled 5-4 in favor of the defendants. Writing for the majority, Justice Kavanaugh noted that a key factor is that the plaintiffs participate in a defined benefit plan with fixed monthly payments that remain constant regardless of the value of the plan, in contrast with a defined contribution plan (such as a 401(k) plan) in which the benefits to be received are directly related to the financial performance of the plan.

Justice Kavanaugh further reasoned:

> If Thole and Smith were to lose this lawsuit, they would still receive the exact same monthly benefits that they are already slated to receive, not a penny less. If Thole and Smith were to win this lawsuit, they would still receive the exact same monthly benefits that they are already slated to receive, not a penny more. The plaintiffs therefore have no concrete stake in this lawsuit.

Plaintiffs posited various theories in favor of standing, including their position that if plan participants are not permitted to sue for alleged ERISA breaches the conduct of plan fiduciaries would be left unchecked. The majority was unpersuaded by these arguments, with Justice Kavanaugh commenting that "fiduciaries who manage defined-benefit plans face a regulatory phalanx" including monitoring and enforcement by the Department of Labor and the Pension Benefit Guaranty Corporation, as well as by the employer, its shareholders, and other plan fiduciaries.

In response, Justice Sotomayor issued a lengthy and strongly worded dissent, stating that plan participants have standing "because a breach of fiduciary duty is a cognizable injury, regardless of whether that breach caused financial harm or increased the risk of nonpayment". For example, Justice Sotomayor noted that ERISA permits claims seeking injunctive relief including the removal of plan fiduciaries, as plaintiffs sought in their underlying claim. Thus, in characterizing the majority's decision, Justice Sotomayor commented:

> Indeed, the Court determines that pensioners may not bring a federal lawsuit to stop or cure retirement-plan mismanagement until their pensions are on the verge of default. This conclusion conflicts with common sense and longstanding precedent.

Thole v. U.S. Bank, 2020 U.S. LEXIS 3030 (2020).

Part II: Coverage

Claim Definition

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 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.

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).

Complaint Naming Doe Defendants Not Considered a Claim

The United States District Court for the Eastern District of North Carolina held that a Telephone Consumer Protection Act complaint naming John Doe defendants did not qualify as a "claim" against the insured under the insured's Directors and Officers Liability Insurance policy. This was so even though the insured was the party responsible for sending the faxed advertisements at issue. That the insured was expressly named as a released party in the settlement of the lawsuit was unpersuasive. Further, the subpoena for documents served on the insured was not a claim and the exclusions for professional services and contractual liability also applied.

The insured had been hired by a pharmaceutical company to market its drug and sent faxed advertisements. The pharmaceutical company was sued in a putative class action in connection with these unsolicited faxes. The suit did not name the insured as a defendant but named "John Does" to stand in for unknown parties involved in sending the faxes. The insured also received a demand for indemnification from the pharmaceutical company and a subpoena for discovery. Subsequently, the

insured contributed to the settlement and was expressly released under the settlement agreement as a third-party beneficiary. The insurer had denied coverage for the entirety of the matter.

On a motion to dismiss under North Carolina law, the court agreed that the complaint did not qualify as a "claim." This was defined, in part, as a "civil proceeding commenced by service of a complaint…against an Insured for a Wrongful Act." The court ruled that a suit against a Doe defendant is not a claim "initiated against a specific party until the complaint is amended to identify the Doe defendant." Moreover, the insured did not allege that it was served with the complaint, as required by the policy's "claim" definition. As for the subpoena served on the insured company, it was not a "claim" because only a subpoena served upon an insured person in connection with an administrative or regulatory proceeding qualified. Further, the pharmaceutical company's demand for indemnification was "expressly barred" by the policy's contractual liability exclusion. As for the insured's mediation participation, the court found that this did not signify a claim and that the insured had not sought the insurer's consent to contribute to the settlement. Finally, the court determined that the policy's professional services exclusion also precluded coverage, construing the insured's liability in issuing the faxes as part of its professional marketing services. Accordingly, the court dismissed the insured's declaratory judgment action. *Trialcard Inc. v. Travelers Cas. & Sur. Co. of Am.*, 2020 U.S. Dist. LEXIS 57060 (E.D.N.C. 2020).

No Coverage for Claims First Made Before Policy Period

The United States District Court for the District of Puerto Rico determined there was no coverage for a claim made prior to the inception of the policy period. In the underlying case, the insured received a written monetary demand to settle an employee's workplace discrimination claims. The insured acknowledged receipt. The plaintiff subsequently filed an administrative charge and complaint. The insured submitted the matter to its insurer six months into policy period and a year after receipt of the settlement demand and administrative charge The insurer reserved its rights to deny the claim and did subsequently deny the claim. The insured sued, alleging the insurer did not properly raise lack of coverage. The court sided with the insurer, first finding that the complaint, which was filed a month before the insured's notice, was related to the demand letter received in the prior policy year of the claims made policy.

Under Puerto Rican law, an agreement is clear when there can only be one interpretation. The court said that the policy was unambiguous in that interrelated acts would be deemed one claim made on the date the earliest claim is made, whether before or during the policy period. The court deemed the claim was made at the receipt of the demand letter. The court also found that the insured did not notice the matter as soon as practicable during or no later than 60 days after the policy period. Therefore, the court said that because the insurer reserved rights on notice in the coverage letter, it did give the insured proper notice that there was no coverage for the claim. *Galarza-Cruz v. Grupo HIMA San Pablo, Inc.*, 2020 U.S. Dist. Lexis 94546 (D.P.R. 2020).

Attorney's Email Demanding Payment of Overdue Legal Fees is Not a Claim

The United States District Court for the Northern District of California held that an attorney's request for payment of overdue legal fees does not constitute a claim under the insureds' directors and officers liability insurance policy. The attorney filed suit against the insureds for deceit and negligent misrepresentation arising out of alleged statements regarding their financial ability to pay the attorney's invoices. The insureds tendered their claim to their insurer which denied coverage based upon a prior and interrelated wrongful acts exclusion and a determination that the claims were first made prior to the inception of the policy.

The insureds subsequently filed suit. The insurer argued that the insureds were not entitled to coverage because the underlying action was a claim first made before the policy became effective; the underlying action arose out of alleged wrongful acts that occurred prior to the effective date of the policy; and the suit failed to allege loss or wrongful acts as defined by the policy because seeking payment of a debt is uninsurable. The insureds argued that the attorney's email demand for payment of overdue fees was not a claim under the policy because it was a request for payment of overdue invoices and not a written demand for damages. Claim was defined in the policy as "a written demand against any Insured for monetary damages or non-monetary or injunctive relief."

The court concluded that the attorney email "does not indicate a threat of legal action or demand damages from Plaintiffs, as opposed to requesting payment of moneys owed under a contract between [the attorney] and [the insureds]." The court added that " [c]ertainly, not every vendor request for payment under a contract amounts to an insurance claim that must be reported to a company's insurer. [The insurer] failed to demonstrate at this stage of the case that the . . . email upon which its argument relies constitutes a 'Claim' within the meaning of the Policy."

Additionally, the court refused to find that the alleged wrongful acts were interrelated with acts before the policy incepted, concluding instead that the underlying lawsuit was also based on statements and conduct occurring in the policy period. The court further disagreed that the action was premised only on the alleged failure to pay one's bills, which is uninsurable as a matter of law. The court determined that the underlying suit is a tort claim for concealment, deceit and negligent misrepresentation and not a claim for breach of contract. Finally, the court held that the insureds sufficiently alleged facts to support their bad faith claim. *Domokos v. Scottsdale Ins. Co.,* 2020 U.S. Dist. LEXIS 125648 (N.D. Cal. 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).

SEC Wells Notices and Enforcement Action Considered a Single Claim with Previous SEC Formal Investigation and Shareholder Lawsuits

The Texas Court of Appeals determined that a Directors and Officers Liability Insurance policy did not cover Securities and Exchange Commission ("SEC") Wells notices or an enforcement action because they involved the same series of related facts as the SEC formal investigation, a class action, and a derivative lawsuit commenced before the policy period.

The insured is a technology company that developed touchscreen technologies for phones, tablets and other electronic devices. In 2013, shareholders filed a class action ("Class Action") alleging fraud concerning statements about the readiness to ship and financial impact of one of the insured's technology products. In 2013, the SEC issued a formal order of private investigation and served subpoenas on the company and its directors and officers ("SEC Formal Order of Investigation") asserting that the company and its directors and officers made false statements about the viability and revenue potential of the product and failed to maintain adequate accounting controls. In 2014, shareholders filed a derivative lawsuit ("Derivative Lawsuit") alleging that the directors and officers made false statements concerning the production schedule and revenue potential of the product.

In June 2015, the SEC sent Wells notices ("Wells Notices") stating that it had "made a preliminarily determination to recommend that the Commission file an enforcement action." In March 2016, the SEC filed an enforcement action ("Enforcement Action") alleging the company and its officers made materially misleading statements about the company's touch screen technologies and repeatedly violated accounting standards.

The insurance policy at issue was for the period April 1, 2015 - April 1, 2016 ("15-16 policy"). The insureds sought coverage for the Wells Notices and the SEC Enforcement Action under the 15-16 policy. The trial court ruled that coverage was properly denied under the 15-16 policy and granted the insurer summary judgment.

On appeal, the court of appeals observed that the Class Action, the Derivative Lawsuit, the SEC Formal Order of Investigation, Wells Notice and the SEC Enforcement Action were all individual "Claims". However, the policy contained an "Interrelated Claims" provision, which provided that "[a]ll Claims arising from the same Interrelated Wrongful Acts shall be deemed to constitute a single Claim ...." The court noted that the Interrelated Claims provision was not an exclusion and that the insured had the burden to prove that the Claims at issue were not interrelated and thus first made during the 15-16 policy. The policy's broad definition of Interrelated Wrongful Acts stated in pertinent part as "[a]ny Wrongful Act, Company Wrongful Act... based on, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving any of the same or related facts, series of related facts, circumstances, situations, transactions or events." The court determined that the Wells Notices and the SEC Enforcement Action were Claims that arose from the same "Interrelated Wrongful Acts" as the prior Class Action, Derivative Lawsuit and SEC Formal Order of Investigation *i.e.*, the same series of related facts, namely: the insured's statements and representations regarding its technology; the product's potential revenue; and accounting irregularities. Therefore, the court concluded that based upon the facts and the policy's "Interrelated Claims" provision and broad definition of "Interrelated Wrongful Acts", the Wells Notices and the SEC Enforcement Action constituted a single Claim with the Class Action, SEC Formal Investigation and Derivative Lawsuit and were "first made" before the 15-16 policy. Accordingly, the court affirmed the decision of the trial court and dismissed the insured's suit. *UniPixel, Inc. v. XL Specialty Ins. Co.,* Case No. 14-18-00828-CV (Tex. App. Mar. 31, 2020).

Related Claim Not Covered in Subsequent Policy Period

The United States District Court for the Southern District of New York found no coverage for an indemnification demand that was related to a lawsuit commenced before a renewed policy period. The court did not find estoppel or waiver by the professional liability insurer, even though it had initially accepted coverage and had known, while doing so, that the demand related to the lawsuit filed before the policy period.

The insured was hired by a stadium owner to manage construction. The insured brought on a roofing subcontractor. During the prior policy period, the insured and subcontractor sued each other, both alleging breach and abandonment of contract related to the project. The subcontractor included the stadium owner in its counterclaim. The insured did not identify this litigation in its renewal application. Five days into the successive policy period, the insured gave notice of the counterclaim, which had been filed four months before the renewal date. The insurer denied only under the contractual liability exclusion, though reserving the right to raise other policy provisions.

Later in the renewed policy period, the stadium owner sent the insured a written demand for contractual indemnification in connection with the subcontractor's counterclaim against the parties. The insured gave timely notice of this demand and the insurer initially accepted a defense under a reservation. While the insurer received unredacted invoices from defense counsel (whom the insured retained independently), it never provided reimbursement and denied the claim four months after its initial acceptance.

On summary judgment, the court found for the insurer, holding that the indemnification demand was a related claim first made before the renewed policy period. The policy, under both periods, deemed claims "arising out of one or more acts, errors, omissions, ...events... that are related (either causally or logically)" to be a single claim. There was "no dispute" that the indemnification demand was related to the prior litigation. Accordingly, the demand was considered a claim made before the second policy period and for which the insured had not given timely notice under the first policy period.

Notably, the court did not take issue with the insurer's prior acceptance of coverage for the demand. It found no prejudice to the insured arising from the insurer's receipt of privileged defense invoices. It commented that "if sharing privileged invoices were per se prejudicial, every insurer who initially paid for defense costs would be estopped from later raising a defense to coverage." Further, even if the insured had believed that the insurer would fund its defense as to the stadium owner's demand, there was no prejudice because the stadium owner had not filed any claims against the insured. And the insured's belief that the insurer's coverage for the demand would extend to the counterclaim litigation was "unreasonable." This ruling was in conjunction with the court's other finding of no coverage under the first policy period due to the insured's late notice of the counterclaim. *Berkley Assur. Co. v. Hunt Constr. Group*, 2020 U.S. Dist. LEXIS 100175 (S.D.N.Y. 2020).

Qui Tam Pre-Dated the Policy Period and Related Subpoena was Not a Claim

The United States District Court for the Western District of Kentucky ruled in favor of an insurer on multiple coverage issues pertaining to a *qui tam* suit and related subpoena. The insured behavioral health provider purchased a Directors and Officers Liability policy incepting on January 1, 2017. On July 25, 2016 a *qui tam* lawsuit was filed under seal, alleging that the insured violated the False Claims Act. A year later, on July 25, 2017, the Office of the Inspector General issued a subpoena in conjunction with the *qui tam* investigation. The insured noticed the subpoena to its D&O insurer, which denied coverage on the basis that the subpoena was not a Claim and did not allege a Wrongful Act. The *qui tam* suit was unsealed in January 2019 and noticed to the insurer. It, too, was denied, on the basis that it was not a Claim first made during the policy period because the sealed complaint was filed before the policy's inception. The insured then filed a coverage action.

The court first analyzed whether the policy's coverage for "a civil, criminal, administrative or regulatory investigation of an Individual Insured... once such Individual Insured is identified in writing...as a person against whom a proceeding...may be commenced" applied. The insured argued that the coverage was triggered because the subpoena was part of an investigation of employees and executives, even though neither the subpoena nor any other document identified any Individual Insured in writing. The court disagreed, however, on the basis that the subpoena did not identify

any Individual Insured and held that the subject section of coverage was inapplicable.

The court also analyzed whether there was coverage for the subpoena under Coverage C, which provided coverage for the Company. It ultimately determined coverage was barred by the exclusion for Loss in connection with any Claim "seeking fines or penalties or non-monetary relief against the Company; provided, however, that this exclusion shall not apply to any Securities Claim." The insured argued that, because the definition of Loss provided defense costs for certain fines and penalties and the "costs and expenses of complying with any injunctive relief or other form of non-monetary relief," the exclusion should not apply. The court found this argument meritless. It also disagreed with the insured's argument that the exclusion made coverage illusory because there were other scenarios where the insurer would have been obligated to provide coverage – for example, Securities Claims.

With respect to the *qui tam* matter, the Court recognized that the lawsuit was filed on July 25, 2016. Because the policy provided claims-made coverage, there was no coverage for the suit because it was filed roughly six months before the policy incepted in January 2017. *Springstone v. Hiscox Ins. Co.,* 2020 U.S. Dist. LEXIS 139654 (W.D.Ky. 2020).

Loss Definition

"Bump-Up" Exclusion Applies to Claim for Inadequate Consideration

The Superior Court of the State of California (San Mateo County) held that a "bump-exclusion" in a directors and officers policy barred indemnity of a class action settlement against the directors. The court rejected the insured's position that the exclusion should be limited to claims against an acquiring company, not against an insured who was acquired for allegedly inadequate consideration.

Shareholders of the acquired pharmaceutical company filed a class action lawsuit, alleging that its board had breached fiduciary duties by failing to maximize value and agreeing to an unacceptably low sale price. The suit was settled and after the primary insurer paid its limit in defense costs and indemnity, $26 million of the settlement amount remained to be funded. The excess insurers, however, denied coverage based on a "bump-up" exclusion within the definition of "loss", which provided that as to a claim alleging inadequacy of an acquisition price, loss "shall not include any amount of any judgment or settlement representing the amount by which such price or consideration is effectively increased."

The court considered evidence and testimony about the language at issue in renewal negotiations. This included communication during a prior policy period in which the primary insurer had rejected an edit that sought to limit the exclusion to claims of inadequate consideration paid by an acquirer. The court also considered industry and expert testimony that it found to support the insurers' interpretation.

Ultimately, the court concluded that insurers "did not want to have insurance proceeds be a means of funding the purchase of assets by a corporation" and that finding coverage would have that unintended effect, since the insured was now wholly owned by its acquirer. Enforcing what it found was the "usual meaning" in the exclusionary language, the court held that the lawsuit had been a claim alleging inadequate consideration such that the resulting loss was not covered. *Onyx Pharmaceuticals Inc. v. Old Republic Insurance Co.,* Case No. CIV 538248 (Cal. Super. Ct., San Mateo Cty. Oct. 1, 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 th 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).

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).

Insured's Delayed Notice of Server Outage Results in Tech E&O Denial

Applying Illinois law, the U.S. District Court for the Northern District of Illinois has held that a technology company's alleged negligence was not covered under its technology liability policy because the insured violated the policy's reporting conditions by not reporting a claim for over two years.

The insured provides data storage to its clients. The insured's server containing one client's data was infected by a virus that destroyed all of the client's data ("Server Compromise"). The insured learned of the Server Compromise soon after it happened and exchanged emails with its client about the Server Compromise, and unsuccessfully attempted to reach a settlement. Almost two years later, the client sued the insured over the Server Compromise, alleging one count of negligence.

The policy's provisions identified that it was a claims-made policy and required notice of a claim as soon as practicable. Additionally, it required notice of "a glitch or circumstance that may result in a claim" as soon as practicable.

The insured first provided notice of the claim six months after its client filed suit and nearly two and a half years after it learned of the Server Compromise. The insurer filed a declaratory judgment action, arguing that it had no duty to defend or indemnify the insured because the insured breached the policy's notice conditions. The insured asserted that the policy is "not a pure claims-made policy but is a hybrid of both an

occurrence policy and a claim-made policy" and that the insured reported the lawsuit and glitch within a reasonable time, so its claim should be covered.

The court rejected that argument and granted the insurer summary judgment on the ground that the policy was a claims-made policy and courts strictly construe notice requirements in claims-made policies and view notice requirements as valid conditions precedent. The court further noted that Illinois courts have interpreted the phrase "as soon as practicable" to mean "within a reasonable time." Although the court acknowledged that it must take into account the insured's justification for any delay, and under some circumstances, lengthy delays may be reasonable, it found no justification in the record for the insured's delay. It further noted that the insurer may well have been prejudiced by the reporting delay but did not consider an absence of prejudice to dispositively cure late notice. *Hartford Fire Ins. Co. v. iNetworks Servs., LLC*, 2020 U.S. Dist. LEXIS 53473 (N.D. Ill. 2020).

Late Notice Not Grounds for Denial Where Insurer Fails to Raise Defense for Seven Months

The Southern District of New York rejected an insurer's attempt to deny coverage on late notice grounds because the insurer waived its late notice coverage defense by waiting seven months to deny coverage.

An insured was sued for professional negligence during its 2018 policy period ("2018 Policy"). The 2018 Policy was written on a claims-made basis. Additionally, the insured had received a grievance letter regarding arguably similar alleged acts and omissions in a prior policy period ("2016 Policy"). The grievance letter was also submitted to the insurer at the time notice was given of the lawsuit. The 2018 Policy required that notice of a claim be provided in writing "as soon as reasonably possible, which must be during the Policy Period." Additionally, the 2018 Policy provided that multiple claims "arising out of one or more acts, errors, omissions, incidents, events . . . or a series thereof, that are related (either causally or logically), will be considered a single Claim."

Initially, the insurer agreed to defend the lawsuit, although it reserved all rights in doing so, including "the right to deny coverage" pending further investigation. Seven months later, the insurer reversed course, denying coverage on the basis that the "Professional Claim" was first made during the 2016 Policy period.

After litigation ensued, the court sided with the insurer on one issue, and with the insured on a second, dispositive issue. First, the court ruled that the lawsuit was a "Professional Claim" first made when the insured received the grievance letter demanding corrective action – during the 2016 Policy. The court rejected the insured's argument that the subsequent lawsuit constituted a separate "Professional Claim" from the grievance letter under the policy's related-claims provision because the lawsuit alleged additional conduct subsequent to the date of the grievance letter.

However, despite concluding that the insured failed to timely notice the claim, the court nevertheless found in favor of the insured. The court determined that the insurer waived its right to deny the claim based on a late notice defense because it waited seven months after having constructive notice of the late notice defense before issuing a denial. The court stated, "... [the insurer] did not directly state it was considering a late-notice defense, and the boilerplate language [in its reservation of rights letter] was insufficient to lead [the insured] to think otherwise." *Hunt Constr. Grp., Inc. v. Berkley Assur. Co.,* 2020 U.S. Dist. LEXIS 223877 (S.D.N.Y. Nov. 30, 2020).

Professional Services

Alleged Misappropriation of Client Funds Triggers E&O Policy

The insured's officers were sued by the company's bankruptcy trustee for allegedly mishandling client funds. The company's insurer declined to defend the trustee's claims and did not participate in the mediation or settlement between the parties. The chapter 11 bankruptcy trustee then filed suit against the insurer to cover the unpaid balance of the settlement amount, also alleging bad faith.

The court determined that the insurer was obligated to indemnify the insured for the settlement because the officers' underlying conduct—mishandling of fiduciary funds—was negligent, rather than willful, and thus triggered the policy's "professional services" insuring agreement. After determining that the professional services insuring agreement was triggered, the court rejected certain defenses cited by the insurer, including in part a fraud and dishonesty exclusion, as well as California Insurance Code Section 533 - all of which were premised on a finding of intentional or willful conduct.

The court also affirmed the district court's summary judgment for the insurer on the bad faith claim. The court held that California's "genuine issue" rule permits summary judgment for an insurer on a claim for bad faith "when it is undisputed or indisputable that the basis for the insurer's denial of benefits was reasonable—for example, where even under the plaintiff's version of the facts there is a genuine issue as to the insurer's liability under California law." Further, the court found that the insurer was given little advance notice of the mediation date and was not presented with a formal settlement offer until months after the settlement had already taken place. *Sharp v. Evanston Ins. Co.*, 2020 U.S. App. LEXIS 16232 (9th Cir. 2020).

Fidelity

Fraudulent Commission Scheme Leads to Insurable Loss

An insured hotel operator suffered a significant loss due to an employee's fraudulent scheme diverting commissions to fictitious travel agencies. In the ordinary course of its business, the hotel operator paid commissions to third-party travel agencies in exchange for bookings at its hotels. An employee of the hotel operator engaged in a scheme to siphon off these commission payments. The fraudster either diverted commissions legitimately owed to third-party agencies or collected commissions on direct bookings that were not legitimately owed on behalf of fictitious travel agencies that he created. Upon discovering the scheme, the hotel operator submitted a claim under its crime protection insurance policy. The insurer denied the majority of the claimed amount and the hotel operator filed suit, accusing the insurer of wrongfully denying coverage and engaging in bad faith.

The insurer advanced the position that the hotel operator did not suffer "loss" under the policy because the majority of the claim was "bookkeeping loss" not insured by the policy. Further, the insurer argued that a loss connected to those commissions could occur only upon payments to or demands by the legitimate travel agencies. The hotel operator, in opposition, countered that it suffered loss from a diversion of its funds and that the loss occurred immediately upon disbursement of the commission payments that the employee diverted.

The court agreed with the hotel operator and, applying Ohio law, held that the hotel suffered a direct loss upon actual disbursement of the hotel's funds caused by the employee's fraud. The court stated, "[the hotel operator's] complaint demonstrates 'loss' under the Policy because it alleges that it disbursed the funds comprising its claim to [the employee] as a result of his fraudulent scheme."

The court also addressed the insurer's argument that the policy's limitations clause barred the hotel operator's suit. The policy's limitations clause stated that legal action against the insurer was prohibited unless brought within two years of the date the loss was discovered. The hotel operator averred in its proof of loss that it discovered the loss in June 2017 but filed suit more than two years later in February 2020. The hotel operator, however, contended that it could not reasonably be expected to file a lawsuit prior to the determination of its claim by the insurer while also complying with its duty to cooperate with the insurer's investigation. The hotel operator asserted that the insurer waived its ability to enforce the limitations provision because the insurer indicated during its investigation that the loss would be covered under the policy. The court again agreed with the hotel operator and denied the insurer's motion because the hotel operator's allegations sufficiently raised a question as to whether the insurer suggested that the claim would be covered, causing the hotel operator to delay filing suit. In reaching its decision, the court held that "[the insurer] ultimately may demonstrate that [the hotel operator's] waiver arguments fall short, but the Court is not convinced that it should dismiss them at the pleading stage." *M&C Holdings Del., P'ship v. Great Am. Ins. Co.,* 2020 U.S. Dist. LEXIS 134651 (S.D. Ohio 2020).

Computer Fraud

Ransomware Attack not Covered under the Computer Fraud Provision

An appellate court held that a ransomware attack was not computer fraud under the terms of the commercial crime and fidelity coverage part of a multi-peril commercial insurance policy.

The insured's employees discovered that the company was the victim of a ransomware attack when the employees were unable to access the servers and most workstations. The hacker demanded a ransom to be paid in Bitcoin and, after receipt, returned the passwords enabling the insured to restore its computer system.

The insured submitted a claim under the computer fraud provision in the commercial crime and fidelity section of its policy. The insurer denied the claim, in part, because the insured did not purchase the computer virus and hacking coverage that was available. In addition, the insurer "concluded that [the insured's] losses did not result directly from the use of a computer to fraudulently cause a transfer of [the insured's] funds." The insurer also noted the exclusion in the policy for losses resulting from a computer virus or hacking.

The policy defined computer fraud as "loss of or damages to 'money,' 'securities' and 'other property' resulting directly from the use of any computer to fraudulently cause a transfer of that property from inside the 'premises' or 'banking premises': [t]o a person (other than a 'messenger') outside those 'premises'; or [t]o a place outside those 'premises'." The insured argued that the terms "fraud" and "fraudulently" were not defined in the policy and, therefore, they should be given their plain and ordinary meaning which includes an "unconscionable dealing." The insured argued that the hacker's ransomware attack was "deceptive and unconscionable."

While the insurer agreed that the hacker's attack was illegal, it disagreed that it was a computer fraud, as defined by the policy. The court concluded that:

> the hijacker did not use a computer to fraudulently cause [the insured] to purchase Bitcoin to pay as ransom. The hijacker did not pervert the truth or engage in deception in order to induce [the insured] to purchase Bitcoin. Although the hijacker's actions were illegal, there was no deception involved in the hijacker's demands for ransom in exchange for restoring [the insured's] access to its computers.

Accordingly, the court held that "the ransomware attack is not covered under the policy's computer fraud provision." *G&G Oil Co. of Ind. v. Cont'l Western Ins. Co.*, 2020 Ind. App. LEXIS 126 (Ind. Ct. App. 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).

Part III: Exclusions

Contract Exclusion

Contract Exclusion Applies to Fitness Club Membership Practices

The United States District Court for the Eastern District of Kentucky found an insurer had no duty to defend or indemnify a fitness operator given the applicability of the "contractual liability" exclusion.

A class action lawsuit was commenced against the operator of fitness clubs across several states including Ohio. The club operator was sued in Ohio by club members and potential members alleging that the operator aggressively solicited them to sign contracts that allegedly misrepresented both the terms and duration of the contracts. It was also alleged that the operator overcharged members, avoided cancellations, and provided inaccurate information on the cancellation process. A class action was filed alleging violations of the Ohio Consumer Sales Practice Act, the Ohio Prepaid Entertainment Contract Act, the Ohio Deceptive Trade Practices Act, unjust enrichment, conversation and breach of contract. The operator tendered the lawsuit to its insurer, which denied coverage solely based on an exclusion for "contractual liability."

The court undertook a detailed comparison of the policy's terms to the allegations in all of the causes of action within the underlying complaint and based such analysis on Kentucky law – the state where the policy was issued. Two chief arguments were made by the insureds. First, the insureds argued that the severability clause restricted the scope of the contractual liability exclusion only if the alleged conduct was committed by the company's high-ranking officers and thus, even though the company was named, the claims

also implicated lower level employees. The court rejected this argument outright indicating that the severability provision was inapplicable to the current claim and called the argument 'unworkable' as none of the officers were named in the complaint.

The second argument advanced by the insureds was that the breach of contract exclusion with its broad preamble ("based upon, arising out of, relating to, directly or indirectly resulting from or in consequence of, or in any way involving any liability under any contract.....") did not apply to the insureds' extracontractual claims. The court reviewed each cause of action indicating that the "breadth of the exclusionary language is key." The court found that the allegations underlying all of the seven claims in the complaint were "by the unambiguous terms of the exclusion, sufficiently related to liability arising under contracts. At the very least, each of the claims "indirectly result[ed] from" or in some way involved liability that arose under the membership contracts..." Thus, based upon the its analysis of the breadth of the exclusion and the allegations, the court upheld the denial of coverage in its summary judgment decision. *Global Holdings v. Navigators Mgmt. Co.*, 2020 U.S. Dist. LEXIS 100728 (E.D. Ky. 2020).

Ninth Circuit Upholds Contract Exclusion for False Claims Act Suit

The United States Court of Appeals for the Ninth Circuit upheld a lower court's ruling that an insurer was not obligated to defend or indemnify a claim arising out of the California False Claims Act ("CFCA"). In upholding the lower court's ruling, the appellate court agreed that the action did not fall within the scope of coverage and that coverage was further precluded by the contract exclusion.

The coverage lawsuit arose out of a separate underlying lawsuit filed by a *qui tam* "relator", a former employee of the insured office supplier, and contained one cause of action for violation of the CFCA. The real parties in interest were over one-thousand government entities, which included over sixty school districts and regional agencies that were allegedly overcharged by the insured.

The insured tendered the matter to its insurer which declined coverage. After settling the *qui tam* suit for a substantial sum, the insured instituted an action to recover a portion of the settlement amount from its insurer. In analyzing coverage, the lower court found that a threshold question under the subject policy was whether the insured's wrongful acts first occurred during the relevant policy periods. The insuring agreement provided "[w]e shall pay on your behalf those amounts, in excess of the applicable Retention, you. . . are legally obligated to pay, including liability assumed under contract, as damages resulting from any claim made against you. . . for your wrongful acts; provided that such wrongful act(s) first occur during the policy period, regardless of when such claim is made or a suit is filed." Upon a finding the wrongful acts preceded the relevant policies, the court concluded the policy was not triggered.

The lower court opinion further examined the breadth of the contract exclusion, which precluded coverage for any claim "alleging, arising out of or resulting, directly or indirectly, from any liability or obligation under any contract or agreement or out of any breach of contract" and concluded that this language is "crucial because the additional breadth of the provision excludes claims that are not strictly contractual." On appeal, the appellate court similarly focused on the breadth of the contract exclusion citing that the "arising out of" language requires "only a minimal causal connection or incidental relationship" and that the provision "also exclude[s] coverage of tort claims which could not exist without the relevant underlying contracts." In upholding the lower court decision, the appellate court further noted the insured's own words recognized that "[t]he heart of this suit is the contention that [the insured] overcharged California government entities under the terms of particular contracts." *Office Depot, Inc. v. AIG Specialty Ins. Co.*, 2020 U.S. App. LEXIS 35675 (9th Cir., 2020).

ERISA Exclusion

ERISA Exclusion in Errors and Omissions Policies Precludes Coverage for Lawsuit Filed by the Department of Labor

A federal district court held that the ERISA exclusion in two professional liability insurance policies excluded coverage for a lawsuit filed by the United States Department of Labor. The insureds provided independent, third party services to an employee stock ownership programs (ESOP). The president and chief executive officer of the company executed a stock purchase agreement on behalf of the ESOP. The insureds relied on a flawed valuation opinion, thereby significantly overvaluing the stock, causing significant loss to the ESOP. Subsequently, the Department of Labor (DOL) filed suit against the insureds alleging violations of the Employment Retirement Income Security Act of 1974 (ERISA).

The insurer, which issued two consecutive professional liability policies, sought to disclaim coverage for the DOL action. The professional liability policies contained an exclusion providing that coverage was not available for any "[v]iolation of or failure to comply with the Employee Retirement Income Security Act of 1974 (ERISA) or similar provisions of any Federal, State or local statutory law or common law." The insureds argued that the exclusion was ambiguous and should be limited to employee benefit claims, otherwise the coverage would be rendered illusory. In response, the insurer argued that the exclusion was not ambiguous, that the exclusion is not limited to any subset of ERISA claims, and that there are many other non-ERISA "professional services" claims that would be covered under the policies.

The court agreed with the insurer. The court concluded that the ERISA exclusion was not ambiguous and, therefore, the DOL's allegations of ERISA violations were excluded from coverage. The court further concluded that the exclusion was not limited to employee benefit claims, as the insureds attempted to advocate for. Finally, the court agreed that there was not a conflict between the ERISA exclusion and the definition of "professional services." The insurer provided examples of claims that would be covered outside the scope of the exclusion.

Accordingly, "the court [found] that the policies [were] not illusory, as they would provide coverage on non-ERISA professional services claims" and the insurer was not obligated to defend or indemnify the insureds due to the ERISA exclusion in the policies. *Gemini Ins. Co. v. Potts*, 2020 U.S. Dist. LEXIS 124027 (S.D. Ohio 2020).

Insured v. Insured Exclusion

Claims Raised by a Creditor Trust are an Exception to the "Insured Versus Insured" Exclusion

The Supreme Court, Appellate Division, First Department, of New York concluded that a Directors and Officers ("D&O") liability insurance policy covered claims brought by a creditor trust because the "insured versus insured" exclusion contained a bankruptcy exception. The court determined that a creditor trust is similar to a bankruptcy trustee or other bankruptcy-related or "comparable authority" listed within the bankruptcy exception to the exclusion.

The insured is a wholesale broker-dealer and investment bank that was decimated by a financial scandal in 2014 and subsequently negotiated a restructuring support agreement ("RSA") with its unsecured creditors. In 2016, the insured filed for Chapter 11 bankruptcy in the Bankruptcy Court of Delaware, pursuant to the RSA. The RSA provided for the creation of a creditor trust that was permitted to pursue all claims without the approval of the bankruptcy court. In 2017, the creditor trust sued numerous parties, including former directors and officers of the insured, alleging that they had breached their fiduciary duties to the insured. The defendants sought coverage and indemnification under the insured's D&O policy. The insurer, which had issued an excess D&O policy on a follow-form basis to the primary D&O policy, issued a denial of coverage letter and sought a declaration that it had no coverage obligations because of the insured versus insured exclusion. The insurer contended that coverage was barred because the creditor trust suit was a claim brought on behalf of the insured against its directors and officers, and that the bankruptcy exception to the exclusion did not apply. The New York County Supreme Court granted the insured's motion for partial summary judgment on its claim alleging breach of the insurance contact. The insurer appealed.

The appellate court concluded that the D&O policy's exception to the insured versus insured exclusion for "the Bankruptcy Trustee or comparable authority" applied to the creditor trust. The court also held that the pertinent clauses of the exclusion and the bankruptcy exception, when read together, were unambiguous. Significantly, the court also determined that the claims were not prosecuted by the debtor corporation, but by the creditor trust, which is a separate entity. Lastly, the court found that it could "perceive no valid rationale for excluding D&O claims from D&O coverage when asserted by a litigation trust where coverage would otherwise exist for identical claims asserted by a Chapter 11 trustee, liquidator or creditors' committee." By including the undefined and open-ended phrase "comparable authority" within the D&O policy's bankruptcy exclusion, the policy contained a broadly applicable exception to the exclusion with no clear limiting principles.

Interestingly, while the appellate court agreed with the lower court to the extent it had determined that the insured versus insured exclusion did not bar coverage with respect to the creditor trust action, the appellate court found that the lower court should not have granted partial summary judgment to the insured on its claim for breach of contract. The appellate court determined that material factual disputes remained as to the potential application of other coverage defenses, inclusive of whether the sole remedy in the creditor trust claim is disgorgement of ill-gotten gains, which would not be insurable. *Westchester Fire Ins. Co. v. Schorsch,* 2020 N.Y. App. Div. LEXIS 4713 (N.Y. App. 2020).

Managed Care Exclusion

Alleged Misstatements Considered Errors or Omissions Such That Managed Care Exclusion Applies

The United States District Court of New Jersey held that a managed care exclusion applied to an underlying lawsuit involving the insured's management of a client's Medicare prescription drug plan. The exclusion was for actual or alleged acts, errors, or omissions in performing managed care services. The court ruled that the insured's alleged misstatements in relation to its managed care services qualified as actual or alleged acts pursuant to the exclusion.

The underlying lawsuit alleged that the insured failed to perform its contract to manage the client's Medicare drug plans and made false representations and material omissions to avoid termination of the contract. The insured submitted this matter for coverage to both its errors and omissions and directors and officers liability insurers.

The D&O insurer denied coverage based upon the managed care exclusion, which precludes coverage for any claim "based upon, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving any actual or alleged act, error or omission in the performance of, or failure to perform, Managed Care Activities. . .." Managed Care Activities were defined to include services, including marketing, selling and enrollment in the administration or management of prescription drug plans.

The insured argued that the exclusion should not preclude coverage because "it applies only to 'any actual or alleged, error, act, [or] omission,' not misstatements or misleading statements, which are separately addressed in the Policy's Fraud Exclusion." The insured also argued that the fraud exclusion does not apply because it only applies to a deliberately fraudulent act established by a final adjudication." The insurer countered that, although the managed care exclusion and fraud exclusion may overlap, they address different risks. The insurer further argued that "the Managed Care Exclusion concerns claims arising out of Managed Care Activities – which could include deliberate dishonesty as well."

The court compared the two exclusions and determined that the insured engaged in managed care activities, which barred coverage for the contract claims against the insured. The court then considered whether the managed care exclusion applied to the other allegations of fraudulent misrepresentation or omission and fraudulent

concealment. The court agreed with the insurer that "misstatements and misrepresentations are 'acts' and that the Managed Care Exclusion applies to [] claims for fraudulent misrepresentation or omission and fraudulent concealment." The court held that "the Managed Care Exclusion not only applies to claims 'arising out of' Managed Care Activities . . . but also any claim 'directly or indirectly resulting from, in consequence of, or in any way involving' Managed Care Activities." *Benecard Servs., Inc. v. Allied World Specialty Ins. Co.*, 2020 U.S. Dist. LEXIS 94749 (D.N.J. 2020).

Prior Acts Exclusion

Prior-Acts Exclusion Precludes Coverage for Shareholder Lawsuits

The United States Court of Appeals for the Eighth Circuit affirmed that a policy's prior-acts exclusion precluded coverage for shareholder lawsuits arising from the insured's failure to disclose related-party transactions in Securities and Exchange Commission ("SEC") filings. The court determined that the shareholder lawsuits alleged wrongful acts that took place prior to the policy's retroactive date or alleged acts that were the same or related to wrongful acts that occurred before that date.

As part of the "going public" process, the insured filed several documents with the SEC, including a registration statement in June 2012, several amendments in July 2012, and a prospectus in early August 2012. The filings did not mention certain related-party transactions - *i.e.*, millions of dollars in supplies from Chinese export companies owned and operated by the brother-in-law of the insured's founder. After the insured went public, the related-party transactions were revealed, and shareholder class-action and derivative lawsuits followed against the insured.

The lawsuits were settled and the insured pursued coverage under its directors and officers policies. The insured's losses exceeded the primary policy limits and the excess insurer denied coverage based upon the prior-acts exclusion, maintaining that the shareholder lawsuits were based on the same or related wrongful acts – the failure to disclose the related-party transactions in the SEC filings - which occurred before the policy's August 20, 2012 retroactive date. The district court granted summary judgment to the excess insurer based upon the prior-acts exclusion.

On appeal, the court unanimously affirmed the district court's ruling that the losses were nonrecoverable by virtue of the prior-acts exclusion. Initially, the court stated the primary policy contained a prior-acts exclusion with a relation-back clause - it treated certain wrongful acts occurring after the policy's retroactive date as if they happened earlier. The court rejected the insured's concept that the excess policy prior-acts exclusion replaced the primary policy's prior-acts exclusion leaving the excess policy without a relation-back clause. The court stated the excess policy's plain language makes clear that the excess policy prior-acts exclusion supplemented, not replaced the primary policy prior-acts exclusion. The court noted that the excess policy follow-form clause incorporates "all terms ... and limitations," "except as therein stated" of the primary policy and there was nothing in the excess policy that suggested, nor stated, that its prior-acts exclusion replaced the primary policy's prior-acts exclusion. The court further noted that the excess policy endorsement adding the prior-acts exclusion made clear that it "amend[s]" the policy "by adding" the second prior acts exclusion, contrasted with another endorsement from the same excess policy with instruction to "delete[]" a clause "and replace[ ] [it] with the following." Therefore the court concluded that the only reasonable reading is that the excess policy prior-acts exclusion was an addition, not a replacement.

The court therefore applied the primary policy's prior-acts exclusion, which included the relation-back clause. The court determined that the shareholder lawsuits all alleged wrongful acts by the insured that were the "same" or "related to" its failure to disclose the related-party transactions to the SEC which occurred before the policy's retroactive date and thus barred from coverage. *Tile Shop Holdings, Inc. v. Allied World Nat'l Assur. Co.,* 2020 U.S. App. LEXIS 38023 (8th Cir., 2020).

Prior & Pending Litigation Exclusion

Prior and Pending Exclusion Does Not Preclude Coverage for Claim Deriving from Actions Filed Before Policy Period

The United States District Court for the Eastern District of Michigan concluded that an employment practices liability ("EPL") insurer has a duty to defend a lawsuit that was derived in part from facts or circumstances that were the subject of an EEOC claim and a retaliation lawsuit that were each filed prior to the policy period.

The insurer issued an EPL policy for the period October 1, 2016 to October 1, 2017. This policy was subsequently renewed for the period October 1, 2017 to October 1, 2020. In March 2018, the claimant, a public safety officer for the insured city, filed an EEOC charge against the city. In the 2018 EEOC charge, she referred to an EEOC charge and suit she previously initiated in 2011. In her 2011 Complaint she alleged that she was denied a promotion based on her sex and in retaliation for having filed the 2011 EEOC charge. The parties to that lawsuit reached a settlement in 2015. In May 2018, the claimant received her right to sue letter for the 2018 EEOC charge and filed a second lawsuit in June 2018. The suit also alleged retaliation and sex discrimination.

The insurer denied coverage for the 2018 action, based upon the policies' prior and pending exclusion. It contended that the "employment practices wrongful acts" alleged in the 2018 action were related to those alleged in the 2011 action and that the acts occurred prior to the inception of the policies.

The court, applying Michigan law, concluded that the defendant insurer was under an obligation to defend (if the underlying complaint alleges facts constituting a cause of action within policy coverage) even if other facts constituting causes of action not covered by the policy are also alleged. The court explained that the prior and pending exclusion did not preclude coverage because the underlying facts pertaining to two counts of gender discrimination in the 2018 action were not "based on the same activity" raised in the 2011 action. The court concluded this under the principles that it must narrowly construe

exclusions and any doubts as to coverage must be resolved in favor of coverage. *City of Grosse Pointe v. U.S. Specialty Ins. Co.,* 2020 U.S. Dist. LEXIS 122292 (E.D. Mich. 2020).

Theft Exclusion

Theft Exclusion Defeats E&O Coverage for Insured Duped in Email Impersonation

The United States District Court for the District of New Jersey ruled that an exclusion for claims arising out of theft or misappropriation of funds applied against an insured seeking errors and omissions ("E&O") coverage. The insured was a title agent who had mistakenly transferred a mortgage lender's loan proceeds to an imposter. The insured's E&O policy afforded no coverage for the lender's resulting claim against the insured, since the exclusion unambiguously applied to a third party's theft.

The insured had transferred the loan proceeds to an imposter impersonating the mortgage lender who was involved in a real estate transaction. The imposter sent the insured wire instructions from an email address similar to the lender's address. The mortgage lender and its insurer made a claim against the insured for the funds and the insured sought coverage under its E&O policy.

The insurer denied coverage based on the policy's exclusion for any claim "based on or arising out of...the commingling, improper use, theft, stealing, conversion, embezzlement or misappropriation of funds or accounts." Additionally, the insurer reserved rights under an exclusion for criminal acts, which had an exception for non-participating insureds and was not applicable until final adjudication.

The court granted summary judgment to the insurer, finding that the theft exclusion "directly addresses the factual scenario here." The insured had argued that it was unclear if terms such as "theft" and "stealing" applied only to first party conduct, such that this supposed ambiguity should be construed in favor of the insured. Unpersuaded, the court held that the exclusion was "clear as written" and that it was the insured's interpretation "that would introduce confusion." Further, that the exclusion for criminal acts had an exception for uninvolved insureds did not undermine the force of the theft exclusion, which did not have such an exception. In fact, the criminal acts exception reinforced that if the insurer had "intended" for a similar exception to apply to the theft exclusion, the insurer would have "expressly" made the addition. *Authentic Title Servs. v. Greenwich Ins. Co.*, 2020 U.S. Dist. LEXIS 215018 (D.N.J. 2020).

Part IV: General Insurance Provisions

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).

Delaware Court Finds in Favor of Insured on Allocation in Return of Fees Case

The Superior Court of Delaware granted partial summary judgment in favor of an insured on a claim involving breach of contract, misrepresentation, and unfair trade practices claims.

The insured financial services company was sued pursuant to terms of a services agreement that it entered into with a client. The suit alleged: breach of contract; intentional and/or negligent misrepresentation regarding the insured's ability to implement the subject software; negligent and/or intentional misrepresentation of the insured's implementation progression; and violations of the Connecticut Unfair Trade Practices Act

("CUTPA"). The intentional misrepresentation claims were dismissed, as was the CUTPA claim to the extent it did not rely on negligent misrepresentation. The court eventually granted summary judgment in favor of the insured on breach of contract.

The insured and its client settled the claim and the insured sought coverage under its Professional Services, Technology and Media Liability policy. The insurer had agreed to cover defense expenses but refused to cover the settlement payment on grounds that the policy did not cover "the return, reduction or restitution of fees, commissions, royalties, expenses or costs for Professional Services of Technology Services performed or to be performed by the Insured." The insured argued that the damages sought by its customer did not constitute the precluded "Return of Fees" and that no portion of the settlement was attributable to the CUTPA claims. The latter argument was made in order to avoid an exclusion for damages arising out of "any actual or alleged false, deceptive or unfair business practices or any violation of consumer protection laws." The court distinguished between compensatory damages and restitution, stating that "the principal distinction between compensatory damages and restitution is that the compensatory damages respond to the plaintiff's loss, restitution to the defendant's gain." While return of fees and costs were excluded, negligence-based damages were covered. The court held that the insurer breached the Policy by failing to indemnify any portion of the settlement that concerned covered damages. The court opined that "allocation, if any, to non-indemnifiable parts of the Settlement would be minor given the insureds remaining claims prior to trial." *SS&C Techs. Holdings v. Endurance Assur. Corp.*, 2020 Del. Super. LEXIS 2856 (Del. Sup., 2020).

Attachment of Excess

Payment of Less Than Full Limits by Underlying Insurer Will Not Excuse Excess Insurer's Payment Obligation

The Delaware Superior Court has ruled that an excess directors and officers policy attaches although the underlying policy did not pay its full limits. In addition, prior notice clauses in the policy were not a bar to coverage.

The insured, a major pharmaceutical company, had in place a D&O program for the period of April 16, 2004 to April 16, 2005. Prior to the inception of this program, the insured, as successor in interest to another pharmaceutical company, had given notice in 2003 of a securities suit where investors alleged they were misled about the adverse gastrointestinal effects of a popular anti-inflammatory drug. Subsequently, during the 2004-2005 policy period, investors sued alleging they were misled about the *cardiovascular* health risks associated with the same anti-inflammatory drug and others. Following a series of procedural activities, a lower excess insurer reached a settlement with the insured for less than its full limits.

The remaining higher excess carrier disputed the exhaustion of the policy as the relevant provision indicates the excess policy "shall attach only after all Underlying Insurance has been exhausted by actual payment of claims or losses thereunder." The court found that "a settlement in which an insurer makes a payment and the insured agrees that the payment fully satisfies the policy accomplishes just such an exhaustion through actual payment." The court cited its observance to the "Stargatt Rule" that excess policies attach irrespective of "whether the insured collected the full amount of the primary policies, so long as [the excess insurer] was only called upon to pay such portion of the loss as was more than the limits of those policies."

The insurer attempted to invoke contrary precedent decisions from other jurisdictions; however, the judge noted that Delaware courts have specifically rejected California's "Qualcomm Rule" "where underlying policy settlements below limits bar attachment above when the excess policy requires 'exhaust[ion] by actual payment of a covered loss.'" The court reinforced that "Delaware consistently follows the Stargatt Rule, construing a settlement in satisfaction of a policy as an exhaustion of that policy at least in the absence of an explicit provision to the contrary." However, even if contrary language were included in the policy, the court surmised that Delaware would embrace the Stargatt rule. Finally, the court rejected the insurer's position that coverage was barred by the prior notice exclusions. The court did not find that the actions were "fundamentally identical," since they related to different misleading statements about gastrointestinal versus cardiovascular side effects. *Pfizer Inc. v. United States Specialty Ins. Co.*, 2020 Del. Super. LEXIS 2759 (Del. Super. 2020).

Ninth Circuit Rejects Excess Insurer's "Improper Erosion" Argument

The United States Court of Appeals for the Ninth Circuit, applying California law, disallowed an excess insurer's challenge of the payment decisions of underlying insurers, absent a showing of fraud or bad faith, or a policy provision expressly granting the insurer such rights.

The insured, a defense technology company, carried a multilayered program of fiduciary liability insurance, each having a $15 million limit of liability. The insured faced two lawsuits. The first suit was commenced by the Department of Labor (DOL) for alleged ERISA violations. The insured settled the DOL suit, and the primary insurer determined that the DOL settlement was covered under its policy, contributing its entire $15 million limit toward the settlement. Similarly, the first excess insurer determined the settlement was within the scope of coverage and issued a payment to the insured which did not exhaust its policy.

Subsequently, the company settled a separate second suit involving similar allegations for nearly $17 million. The first-layer excess insurer concluded that the settlement was covered, and it paid the remainder of its limit. The second-layer excess insurer agreed to pay the remaining portion of the settlement, but in turn filed a coverage action against the company seeking reimbursement on the theory of "improper erosion." Specifically, the second-layer excess insurer argued that the payments made by the underlying carriers toward the DOL settlement were for not covered loss pursuant to the policy terms, and therefore prematurely triggered its excess policy. The district court granted summary judgment in favor of the second-layer excess insurer.

On appeal, the Ninth Circuit recognized the dearth of case law on the "improper erosion" theory of recovery, and the court rejected the insurer's position. The court found favor in the limited decisions that held that "excess insurers generally may not avoid or reduce their own liability by contesting payments made at prior levels of insurance, unless there is an indication that the payments were motivated by fraud or bad faith." The court reasoned that, if excess insurers were able to contest the soundness of underlying insurers' payment decisions, as the district court suggested, it would "undermine the confidence of both insurers and insurers in the dependability of settlements" and eliminate a fundamental incentive for having insurance in the first place.

The court moreover recognized that the second-layer excess insurer failed to allege fraud or bad faith, and further highlighted that there were no policy terms entitling the second-layer excess insurer to challenge decisions made by insurers below it on the tower. The court concluded by stating that "no reasonable insured [] would understand that it might have to justify its underlying insurers' payment decisions as a prerequisite to obtaining excess coverage..." *Axis Reinsurance Co. v. Northrop Grumman Corp.*, 2020 U.S. App. LEXIS 29046 (9th Cir. 2020).

Bad Faith

No Bad Faith Where Insurer Denied Coverage on Unsettled Question of Law and Ambiguous Policy Language

The United States District Court for the Southern District of Iowa refused to find that an insurer that denied coverage for a fiduciary claim acted in bad faith. The insurer had a "reasonable basis" for its denial pursuant to Iowa bad faith law, particularly since the coverage question was one of first impression. Notably, the court ruled that ambiguous policy language, while construed substantively for the insured, also meant that the existence of coverage was "fairly debatable."

The insured sought coverage for a lawsuit alleging ERISA violations. The insurer denied because the insured, prior to the policy period, had received a letter from the United States Department of Labor announcing that it would conduct an on-site examination at the insured's offices. The insurer asserted that the letter qualified as a fiduciary claim as defined by the policy, such that it was not a claim first made under the policy. The insured filed a coverage action, including for bad faith denial of coverage.

The court granted partial summary judgment for the insured finding that the letter was not a claim. However, it found no bad faith denial of coverage under Iowa's corresponding standard, which requires the insured to prove that the insurer: 1) "had no reasonable basis" to deny and 2) "knew or had reason to know that its denial...was without reasonable basis." In turn, an insurer has such a reasonable basis to deny if the insured's claim is "fairly debatable either on a matter of fact or law," or "open to dispute on any logical basis." Because the insured's claim turned on an unsettled question of Iowa law (whether the Department of Labor letter qualified as a claim), coverage was "fairly debatable." Moreover, the insurer's reliance on supportive precedent from other jurisdictions, as well as its reliance on policy language and dictionary definitions, was reasonable. Additionally, that the policy language was ambiguous inherently meant that coverage was "fairly debatable" per the bad faith standard. *Telligen, Inc. v. Atl. Specialty Ins. Co.,* 2020 U.S. Dist. LEXIS 110591 (S.D. Iowa 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).

Excess Insurer Required to Advance Defense Costs Given Coverage Dispute

The United States District Court for the District of Kansas ruled that an excess errors and omissions (E&O) insurer must advance defense costs while coverage under a primary D&O policy remained contested. The excess E&O policy, including its "other insurance" clause, did not indicate that the excess insurer "intended to restrict or limit coverage while the actual existence of concurrent coverage was litigated."

The insured sought coverage from its primary E&O and directors and officers (D&O) policies, issued by the same insurer, for underlying antitrust litigation. The primary insurer accepted coverage under the E&O and denied coverage under the D&O policy. After the primary E&O limits were exhausted by reimbursement of defense costs, a different insurer who had issued the excess E&O policy

argued that its policy was not triggered until all primary insurance, including the primary D&O policy, was exhausted. The excess E&O policy provided that it would apply once "underlying insurance" was exhausted by actual payment. The schedule of underlying insurance did not include the primary D&O policy. Also, the excess E&O policy's other insurance provision (following the primary E&O form), stated that it was excess and would not contribute with any other insurance, "whether collectible or not."

After denying the insured and primary E&O insurer's motion to dismiss, the court held that the excess insurer must advance defense costs while coverage under the primary D&O policy was pending adjudication. Providing the insured "the coverage it paid for must take priority over disputes among insurers." It was "manifestly unfair to leave the insured without coverage," and the court reinforced that "other insurance" clause disputes are to be "resolved between insurers after the insured has received coverage." *Bedivere Ins. Co. v. Blue Cross & Blue Shield of Kan.*, 2020 U.S. Dist. LEXIS 180223 (D. Kan. 2020).

Pre-Judgment Interest

Court Orders Insurer to Pay Pre-Judgment Interest after Arbitration Ruling

A federal court ruled that an insurer must pay interest accumulated before and after an arbitration, insured.

An insurance coverage matter was the subject of an arbitration. When the insured prevailed in the arbitration, it asked the tribunal to award it interest on the judgment. The arbitration panel said that it did not have the authority to do so, but that the insured could make the request of the court. The court agreed and awarded the insured both pre and post judgment interest.

The Insurer argued that the policy's ADR language limited the insured's recovery to the policy limits. Because the arbitrators had awarded the full policy limit to the insured, there was nothing left to pay. The court said it did not read the ADR in same manner and interpreted it "with the reasonable expectations of a business person." Finding the insurer had the use and value of money that rightfully belonged to insured, the court awarded interest for the requested time-frame. *ExxonMobil Oil Corp. v. TIG Ins. Co.,* 2020 U.S. Dist. LEXIS 87407 (S.D.N.Y. 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).

Part V: Securities and Corporate Governance

Appraisal

Challenged Appraisal Rights Decision Yields Shareholders Lower Value Per Share

In a significant development involving stock appraisal rights, the Delaware Supreme Court affirmed that the fair value of the acquired company's stock price was less than the sale price.

An appraisal action was commenced in 2015 by stockholders who dissented from an acquisition agreement that they viewed as unfair. The dissenting stockholders refused to accept the sale price of $59.21 per share, and petitioned for appraisal by asking the Delaware court to consider a better (and hopefully higher) price for the shares. Various stockholders offered competing valuation methods and related expert testimony. However, the Court of Chancery ultimately determined that the acquiree's fair value was equal to its unaffected market price of $48.31—that is, the market price on the last day the acquiree's stock traded without being affected by news of the merger negotiations, which leaked about a week before the deal was announced.

In July 2020, on appeal, the Delaware Supreme Court confirmed that the fair price of the shares should in fact be $48.31, which was approximately $10.90 less than the shareholders would have received had they not

challenged the agreement and filed the appraisal rights action. The higher court explained that Delaware courts must follow the appraisal statute's "directive to consider 'all relevant factors.'" Additionally, the court recognized that the efficient capital markets hypothesis (that the market quickly assimilated all publicly available information into the stock price) and reiterated that market-based indicators of value still have substantial probative value when making such a decision. *Fir Tree Value Master Fund, LP v. Jarden Corp.*, 2020 Del. LEXIS 237 (Del. 2020).

Texas Court of Appeals Affirms Judgment in Favor of Insurer on Appraisal Rights Submission

The insured announced a merger in February 2014 wherein the purchaser would buy outstanding common stock from the insured. Before the merger vote, dissenting shareholders of the insured filed litigation, alleging breaches of fiduciary duties and moving to enjoin the merger. On May 23, 2014, the court denied the motion. On May 29, 2014, a majority of the insured's shareholders approved the merger and the merger was executed. At that time, the directors & officers liability insurance policies were put into run-off. Three groups of dissenting shareholders pursued an appraisal litigation to obtain a fair price for their shares.

Settlement discussions began in December 2014 and on July 29, 2015, the appraisal action settled without the insurers' consent. Later, the insured demanded coverage from the insurers for the settlement of the appraisal action. The excess policies' run-off endorsements extended coverage for 72 months, but one policy limited the run-off coverage to "any actual or alleged Wrongful Act fully occurring prior to May 29, 2014..." and the other policy excluded claims "based upon, arising from or in any way related to any Wrongful Act fully occurring prior to May 29, 2014." The excess insurers denied coverage based on the run-off coverage limitations.

The insured sued for breach of contract and unfair settlement practices. The excess insurers filed motions for summary judgment, which were granted, and the insured's claims were dismissed with prejudice on the basis that the policy wording excluded coverage because the merger was not executed during the policy period.

On appeal, the court disagreed with the insured's perspective that the loss stemmed from wrongful acts that occurred during the policy period. In so holding, the court looked to the appraisal rights section of Delaware Code and related cases to address whether there had been a wrongful act. It noted that the scope of an appraisal rights action is "limited, with the only litigable issues being the determination of the value of petitioner's shares on the date of the merger." It alsonoted that the merger must be consummated for a petitioner to have standing to bring an appraisal rights suit. The merger was completed on May 29, 2014, which was the earliest the dissenting shareholders could commence an appraisal action.

The court also noted that the appraisal action statute does not require a wrongful act. Second, because the execution of the merger (not the merger process) confers appraisal litigation rights, there was no coverage because the execution of the merger did not occur until after the policy lapsed, and the run-off endorsement did not provide coverage for wrongful acts after that date. Accordingly, the court rejected the insured's argument that the merger process, dating back to February 2014, was a series of ongoing wrongful acts occurring during the policy period. *Zale Corp. v. Berkley Ins. Co.*, 2020 Tex. App. LEXIS 6029 (Tex. App. 2020).

Corporate Governance/Forum Selection Clause

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).

Federal Forum Selection Provision for 1933 Act Claims Ruled Enforceable Under California Law

The California Superior Court ruled that under California law, a forum selection provision in a Delaware corporation's registration statement requiring that certain securities litigation be commenced solely in a federal court was enforceable. Plaintiffs commenced a putative class action in California state court against a robotics company, a Delaware corporation with its principal place of business in California, and its officers and directors asserting claims arising under the Securities Act of 1933. Notably, contained within the company's Amended and Restated Certification of Incorporation was an exclusive forum selection clause designating the United States federal district courts ("Federal Forum Provision" or "FFP") as the exclusive forum for all litigation asserting claims arising under the Securities Act of 1933. The defendants moved to dismiss the plaintiffs' action commenced in California state court based upon the FFP. The motion to dismiss was denied but the court granted the defendants' motion for reconsideration.

On reconsideration, the court determined that the issue was whether the FFP was legal and enforceable under California law and/or under federal law. The court determined that the most closely analogous law for this matter was that relating to forum selection clauses. The court noted found that the FFP was a mandatory forum limitation clause restricting all Securities Act claims to federal court, without restriction on venue. Further, the FFP was subject to shareholder approval and was effective before commencement of the plaintiffs' litigation. Consequently, the burden of proof shifted to the plaintiffs to show that the "FFP was unenforceable, unconscionable, unjust or unreasonable."

The court found that plaintiffs failed to meet the burden, dismissing the action. There was no disruption of plaintiffs' substantive rights provided by the Securities Act of 1933, only the procedural aspect of the state versus federal forum. Likewise, there was no loss of procedural due process because plaintiffs can "present their federal law claims to a federal court, in a state or province of a state close to their residence." Moreover, there is greater power in federal court to obtain personal jurisdiction over persons and entities, and to subpoena witnesses to trial. So too, the court ruled that the "FFP was not illegal under California law and does not violate any California statute or public policy." Similarly, the plaintiffs had "no federal law actually ruling that forum selection clauses are unconstitutional under or illegal under federal law." *Wong v. Restoration Robotics, Inc.,* 2020 Cal. Super. LEXIS 227 (Cal. Sup. Ct. 2020).

Another California State Court Holds a Federal Forum Provision Valid

After the Supreme Court held in *Cyan, Inc. v. Beaver County Employees Retirement Fund*, that an action brought under the Securities Act of 1933 (the "Securities Act") was not removable to federal court, many companies added federal forum provisions to their charters, requiring that any Securities Act claim must be filed in federal court. Following in the footsteps of another trial level California court, the California Superior Court for San Francisco County has upheld the validity of a federal forum provision in a defendant's charter. Notably, the court was the first to dismiss the Securities Act claims against all defendants, including the underwriters of the defendant-issuer's initial public offering ("IPO"), even though the underwriters were not parties to the corporate charter.

The defendant-issuer is a rideshare company incorporated in Delaware and headquartered in California. Some of the company's shareholders filed a complaint in California state court, alleging the company violated the Securities Act. The defendant-issuer's charter contained a federal forum provision. The rideshare company moved to dismiss on the ground that its charter's federal forum provision required the claims to be brought in federal court.

Applying California law, the court granted the defendant-issuer's motion to dismiss, noting that the plaintiffs were on notice of, and presumptively agreed to, the terms of the rideshare company's charter by buying the stock. The court found that the plaintiffs offered no evidence that the federal forum provision was unexpected or unreasonable. The court further decided that the federal forum provision was not unconscionable because plaintiffs could still litigate Securities Act claims and accomplish substantial justice, in federal court. Thus, the court found that the federal forum provision was enforceable. The court further held that because the federal forum provision broadly applies to "any complaint asserting a cause of action arising out of the Securities Act...," the entire complaint must proceed in federal court, including plaintiffs' claims against the non-signatory underwriter defendants. *In Re Uber Technologies, Inc. Securities Litigation,* No. CGC-19-579544, Order on Motion to Dismiss (Cal. Super. Ct. November 16, 2020).

California State Court Upholds Third Federal Forum Provision Case

A third company has had a Federal Forum Provision ("FFP") persuade a state court that a challenge under Section 11 of the Securities Act of 1933 should be adjudicated exclusively in federal court.

Following decisions in Delaware and California state courts, the San Mateo County Superior Court ruled that the exclusive FFP in the company's bylaws mandated dismissal of the state court action. The company persuaded the San Mateo Superior Court to follow both Delaware and California state courts in reaching this conclusion. *Salzberg v. Sciabucchi,* 227 A.3d 102 (Del. 2020) (upholding facial validity of a federal forum provision); *Wong v. Restoration Robotics, Inc.,* San Mateo Superior Court

Master File No. 18CIV02609 (Sept. 1, 2020) (determining that the FFP mandated federal adjudication of Section 11 challenges). The order in the instant case references both *Salzberg and Wong*, indicating that the outcome for the company would be the same whether Delaware or California state court's laws were applied.

Plaintiffs' ability to waive the right to have a case heard in state court was an important consideration. As with other companies that reacted to the U.S. Supreme Court's decision in *Cyan*, which upheld concurrent state and federal jurisdiction for Section 11 cases, the company specifically amended its bylaws to afford notice to potential claimants that federal court would be the exclusive jurisdiction for resolution of disputes. *In Re: Dropbox, Inc.,* 19-CIV-05217, Order Granting Defendants' Motion to Dismiss Based Upon Forum Non Conveniens (San Mateo Superior Court, Dec. 4, 2020).

Demand Futility

Derivative Action Dismissed after Demand Futility Analyzed on a Director-by-Director Basis

The Delaware Chancery Court held that a derivative action alleging that directors breached their fiduciary duties must be dismissed because a pre-suit demand was not made on the board and such demand would not have been futile. The court found that the complaint failed to plead facts suggesting that a majority of the directors acted in bad faith and could not exercise independent and disinterested judgment regarding the demand.

The derivative suit was filed against the directors of a corporation that provides a social networking platform and concerned the proposed reclassification of common stock. The plaintiff, however, did not make a pre-suit demand. The issue before the court was whether demand was excused because a majority of the directors were incapable of making an impartial decision, thus rendering a demand futile.

The Delaware Court has established two tests for determining whether directors can exercise independent and disinterested judgment. First, the court "must decide whether, under particularized facts alleged, a reasonable doubt is created that: (1) the directors are disinterested and independent and (2) the challenged transaction was otherwise the product of a valid exercise of business judgment." The court established the second test after being confronted with a board of directors who had not participated in the challenged decision.

The court refocused "the inquiry on the decision regarding the litigation demand, rather than the decision being challenged." Because the board in the second case did not make the decision being challenged, the court inquired "whether the board that would be addressing the demand can impartially consider its merits without being influenced by improper considerations."

In the present case, the board has nine members, six of whom served on the board when it approved the reclassification of stock. The court decided to apply elements of both tests "when evaluating whether particular directors face a substantial likelihood of liability as a result of having participated in the decision to approve the Reclassification." The court further evaluated impartiality on a director-by-director basis, asking for each director, (i) whether the director received a material personal benefit from the alleged misconduct that is the subject of the litigation demand, (ii) whether the director would face a substantial likelihood of liability on any of the claims that are the subject of the litigation demand, and (iii) whether the director lacks independence from someone who received a material personal benefit from the alleged misconduct that is the subject of the litigation demand or who would face a substantial likelihood of liability on any of the claims that are the subject of the litigation demand."

After the court analyzed demand futility on a director-by-director basis, it held that "[a] majority of the Demand Board is disinterested, independent, and capable of considering a demand." Thus, the case was dismissed. *UFCW & Participating Food Indus. Empls Tri-State Pension Fund v. Zuckerberg*, 2020 Del. Ch. LEXIS 319 (Del. Ch. 2020).

Breach of Fiduciary Duty

Breach of the Duty of Oversight Case Survives Motion to Dismiss

A Delaware court, for the third time in less than a year, held that a plaintiff's *Caremark* claim can survive a motion to dismiss. The duty of oversight ruling reinforces the view that "directors and officers who neglect their oversight responsibilities may be personally liable for resulting harm to the company and its stockholders."

The plaintiff filed a shareholder derivative suit seeking damages from the directors and officers of a Delaware corporation (the "Company"), including the CEO and three successive CFOs, for pervasive oversight issues that often manifested in the form of inaccurate financial reporting and a lack of transparency regarding related-party transactions. Beginning in 2010, the Company persistently struggled with its financial reporting and internal controls, including disclosure of related-party transactions. Despite the Company's resolve to fix such errors, the plaintiff pled facts supporting an inference that the Company's audit committee only met sporadically, devoted inadequate time to its work, and consciously turned a blind eye to the continued deficiencies.

The defendants moved to dismiss the plaintiff's claims for failure to establish demand futility, and for failure to state a claim on which relief can be granted. The court denied the defendants' motion. The court found that the complaint adequately alleged demand futility by asserting that the majority of the board could not disinterestedly consider whether to file suit regarding bad faith oversight failures because there were sufficient facts to infer that those failures of oversight exposed the directors to the substantial likelihood of personal liability. The court also held that those same facts were sufficient to defeat the defendants' contention that the plaintiff failed to state a claim for relief – for the "mere existence of an audit committee and the hiring of an auditor does not provide universal protection against a *Caremark* claim."

Interestingly, the court also rejected the defendants' argument that they cannot be subject to liability because their conduct did not cause the Company to lose income or value. The court, in rejecting this argument, stated that defendants' alleged breach of the duty of oversight could include the expense

of restating the company's financial statements; the reputational harm from the apparent lack of discipline and controls, and the cost of defending against lawsuits. *Hughes v. Xiaoming Hu, 2020* Del. Ch. LEXIS 162 (Del. Ch. 2020).

Merger

Pandemic does not relieve Seller of Obligation to Operate in the Ordinary Course

The Delaware Chancery Court held that a buyer was entitled to walk away from a merger agreement to acquire luxury hotels due to the seller's failure to continue to operate in the ordinary course. The court further held that the pandemic did not cause a material adverse effect on the seller's business under the terms of the Sale and Purchase Agreement.

On the closing date, the buyer asserted that the seller's representations and warranties were inaccurate and, therefore, the buyer did not have an obligation to close. The seller filed suit seeking specific performance of the contract. The buyer alleged that the business of the seller suffered a material adverse effect due to the Covid-19 pandemic, which adversely affected the hotel industry. The seller closed two of its hotels, reduced operations and laid off thousands of employees. The seller argued that the effects of the pandemic fell within an exception to the definition for effects resulting from "natural disasters and calamities" and, therefore, the business did not suffer a material adverse effect as defined in the agreement. For purposes of analysis, the court assumed that the seller "suffered an effect due to the COVID-19 pandemic that was sufficiently material and adverse to satisfy the requirements of Delaware case law. Based on that assumption, the burden rested with Seller to prove that the effect fell within at least one exception." The court concluded that the "COVID-19 pandemic fits within the plain meaning of the term 'calamity.' Millions have endured economic disruptions, become sick, or died from the pandemic" and further concluded that "[t] he plain language of the term 'calamities' therefore controls" and rejected the buyer's argument on that basis.

The court did find that the actions taken by the seller in responding to the pandemic violated ordinary course covenants in the agreement. The relevant provision of the ordinary course covenant required that the seller continue to operate in the ordinary course "consistent with past practice." The buyer argued that "the radical changes that management implemented to respond to the COVID-19 pandemic obviously deviated from how the Hotels normally operated and therefore fell outside the ordinary course of business." The seller responded that "management must be afforded the flexibility to address changing circumstances and unforeseen events, including engaging in 'ordinary responses to extraordinary events.'" The seller further argued that their actions were in the ordinary course during a pandemic. The court's decision turned on the specific buyer friendly language in the agreement. The ordinary course covenant "required the Seller to maintain the normal and ordinary routine of the business." The court found that the evidence demonstrated that the seller "departed from the normal and customary routine of its business as established by past practice." The court also found that the seller failed to fulfill the title insurance condition of the agreement pertaining to prior false judgments and deeds which also relieved the buyer of their obligation to close. The court held that "[t]he Covenant Compliance Condition and the Title Insurance Condition were not satisfied on the closing date, which relieved Buyer of its obligation to close." *AB Stable VIII LLC v. Maps Hotels & Resorts One LLC,* 2020 Del. Ch. LEXIS 353 (Del. Ch. 2020).

Scienter

Second Circuit Raises the Burden of Pleading Corporate Scienter

The Second Circuit Court of Appeals ("Second Circuit") affirmed the dismissal of a class action filed under the Securities Exchange Act of 1934 ("Exchange Act") against two corporations ("Corporate Defendants") agreeing that the plaintiff's proposed amended complaint failed to raise a strong inference of collective corporate scienter.

The Corporate Defendants manufactured and sold the "MicroCool Breathable High Performance Surgical Gown" designed to protect health care workers treating patients with highly infectious diseases. Plaintiff filed a class action against the Corporate Defendants and several of their senior officers alleging that they intentionally misled shareholders about the high quality of the surgical gown product, notwithstanding that it failed several quality-control tests. The district court dismissed the complaint in its entirety because plaintiff failed to adequately allege scienter as to the senior officer defendants and, because plaintiff sought to impute their scienter to the companies.

Plaintiff moved to set aside the dismissal and file a new proposed amended complaint, based on new testimony of three of the Corporate Defendants' high-ranking employees in a California consumer fraud trial concerning the same surgical gown product. The employees testified that they had prepared documents for senior executives of one of the Corporate Defendants that explained manufacturing problems and consequential product compliance failures that were "presented to senior management."

Nevertheless, the district court ruled that the amended complaint still failed to allege scienter adequately against any defendant and denied plaintiff's motion to file a new amended complaint as futile. Plaintiff appealed and on appeal abandoned the claims against the senior officer defendants and argued that the proposed amended complaint raises a strong inference of scienter (*i.e.*, fraudulent intent) against the Corporate Defendants.

On appeal, the Second Circuit unanimously affirmed the district court's ruling agreeing that plaintiff's proposed amended complaint did not adequately allege scienter against the Corporate Defendants. Initially, the court stated that to adequately plead scienter a complaint must state with particularity facts giving rise to a strong inference that the defendant acted with "the intent to deceive, manipulate or defraud." The court further stated that, "[w]here a defendant is a corporation, this requires pleading facts that give rise to a strong inference that someone whose intent could be imputed to the corporation acted with the requisite scienter." Here the court stated that the testimony from the California consumer fraud trial was insufficient to demonstrate

that any individual whose knowledge could be imputed to the Corporate Defendants acted with scienter. Although the employees testified that they had prepared documents explaining manufacturing and compliance failures and presented those documents "to senior executives," the court stated that this testimony was not "sufficiently particularized to raise a strong inference of scienter against any individual, much less one whose knowledge may be imputed to the Corporate Defendants." The court explained that there was "no connective tissue" between the testifying employees' knowledge and the Corporate Defendants' alleged misstatements. The court also rejected the argument that the surgical gown product "was of such core importance" to the Corporate Defendants that their senior executives must have known of the alleged falsity of the representations at issue. The court remarked that plaintiff's bare assertion that the surgical gown was a "key product" for the Corporate Defendants without more was "plainly insufficient" to raise a strong inference of corporate scienter. *Jackson v. Abernathy*, 2020 U.S. App. LEXIS 16754 (2d Cir. 2020).

Securities Litigation Stay

State Securities Act Lawsuit Remains Stayed Notwithstanding Differences with Federal Lawsuit

A New York state court denied a motion to vacate the stay of a state-court class action alleging Securities Act violations ("State Action") in favor of a parallel first-filed federal court action ("Federal Action"). In support of the motion to vacate the stay, the plaintiffs argued that the Federal Action does not share a complete identity of parties and claims with the State Action. Specifically, the plaintiffs maintained that "the Federal Action asserts a 1933 Act claim based on different alleged misstatements in the registration statement that is at issue in both actions, and this action names four defendants that are not named in the Federal Action."

The court declined to grant the plaintiffs' motion to vacate the stay "because the plaintiffs have failed to show that the legal strategy by the lead counsel in the Federal Action... would prejudice the interests of the purported class." Importantly, the court stated that "contrary to plaintiff's claim, the Supreme Court's decision in *Cyan Inc. v. Beaver County Employees Retirement Fund, et al.,* 138 S.Ct. 1061 (2018), did not overrule the body of New York law that holds that a stay or dismissal of a subsequently filed action is appropriate even though the second action "assert[s] different legal theories" when both cases arise "out of the same transaction" and seek "to recover for the same alleged harm based on the same underlying events"" as is the case here. The court acknowledged that the plaintiffs asserted the claim that the "alleged nondisclosure of design problems and subsidy reductions in the registration statement are potentially actionable." The court also was "mindful that the Federal Action is a consolidation of four federal class actions, two of which were filed in the Northern District of California and two of which were filed in the Eastern District of New York." On that note, the court reiterated its previous opinion that "[I]t would manifestly be a waste of judicial resources to have duplicative claims pending in two different courts," especially when the judge in the Federal Action ruled that the plaintiffs in the consolidated Federal Action adequately represent the class. Accordingly, the Court refused to vacate the State Action stay issued in favor of the Federal Action. *In re NIO Inc. Securities Litigation*, Index No. 653422/19 (N.Y. Sup. Ct. Aug. 21, 2020).

Securities Class Actions – State Court

New York State Appellate Court Reverses Denial of Motion to Dismiss in Securities Suit

The Supreme Court, Appellate Division, First Department, of New York reversed a lower court's denial of the defendant's motion to dismiss a securities suit brought under the Securities Act of 1933.

The defendant is a Chinese social media and e-commerce company that completed an initial public offering in the United States in April, 2019. In September 2019, an investor filed a securities class action lawsuit in New York state court against the company, its directors and officers, and its underwriters, alleging that the initial public offering documents failed to disclose that the company had shuttered a large percentage of its online locations prior to the offering. The defendants filed a motion to dismiss, which was denied in an April 2020 order from the New York County Supreme Court.

In a very brief ruling on December 3, 2020, the New York Supreme Court reversed the lower court's decision and directed the lower court to enter judgment dismissing the complaint. The Appellate Division noted that the company had adequately disclosed that it was transitioning to a different model for its online sales and that the motion to dismiss consequently should have been granted. *Jianming Lyu v. Ruhnn Holdings Ltd.,* 2020 N.Y. App. Div. LEXIS 7480 (N.Y. App. 2020).

Part VI: Other Cases of Interest

Biometric Information Privacy Act

Federal Jurisdiction is Appropriate for BIPA Violations

The United States Court of Appeals for the Seventh Circuit has weighed in on the appropriate venue for alleged violations of the Illinois Biometric Information Privacy Act ("BIPA"). Most federal district courts in Illinois have remanded BIPA cases to state court for further adjudication. However, the Seventh Circuit held that collection of biometric information without prior consent constituted an "injury in fact," and therefore Article III standing was appropriate.

The underlying case involved a plaintiff who used a workplace cafeteria with vending machines that did not accept cash. The defendant, the vending machine operator, created user accounts with employees' fingerprints, which were scanned for vending machine purchases. The plaintiff filed a class action for BIPA violations in Illinois state court, noting that the defendant had not secured informed consent for the collection and/or storage of biometric information. The defendant removed the matter to federal court, which was opposed by plaintiff on the ground that a BIPA violation did not constitute a concrete injury. Stated differently, federal jurisdiction should not be available, according to the plaintiff,

because the procedural violations of BIPA were not true injuries for purposes of federal subject matter jurisdiction.

The case turned on an interesting dynamic, as the defendant had to assert the sufficiency of the plaintiff's injury in fact in order to sustain federal jurisdiction. In contrast, the plaintiff downplayed the type of injury in order to have the matter heard in state court, typically viewed as a more favorable venue.

The Seventh Circuit, in effect, joins the Ninth Circuit in conferring federal jurisdiction for alleged biometric injuries. The Second Circuit has ruled that such cases must be adjudicated in state court. There is no indication, yet, that the United States Supreme Court would be willing to address the split. *Bryant v. Compass Grp. USA, Inc.*, 2020 U.S. App. LEXIS 14256 (7th Cir. 2020).

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

First Quarter

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.

Second Quarter

Capital One Ruling Raises Questions as to Whether Forensic Reports Are Discoverable in Post-Breach Litigation

On June 25, 2020, the Eastern District of Virginia affirmed a U.S. Magistrate Judge's ruling that Capital One Financial Corp. ("Capital One") was required to produce in discovery a forensic report prepared by Mandiant in connection with Capital One's 2019 data breach. According to the court, the report was not protected work product because the bank would have commissioned it as part of its ordinary business response and independent of any future litigation.

In ordering that Capital One turn over the report to plaintiffs, the Court rejected Capital One's argument that the report is protected from disclosure under the work product doctrine. Although the ruling raised questions as to whether such post-breach forensic reports could be immune from disclosure if performed by the same vendor that performs work prior to the incident, the fact-intensive ruling in the Capital One matter does not allow for such broad conclusions to be reached. In fact, many of the disclosed facts that the Court relied upon in ordering production of the report will not be present in many other situations or, in some cases, can be avoided altogether.

Capital One had retained Mandiant to perform services since 2015 under a Statement of Work ("SOW") that included breach response services and the SOW was periodically renewed, including in January 2019. The January 2019 SOW provided that Mandiant would perform incident response services, if needed. In March 2019 Capital One suffered a data breach, and subsequently a tri-partite agreement was entered into between Mandiant, Capital One and Capital One's outside counsel, whereby Mandiant agreed to perform many of the same services expressly described in the January 2019 pre-breach SOW. Mandiant was to provide services including "computer security incident response" and "incident remediation" at counsel's direction. After the report was sent to counsel and the bank's legal department, it was subsequently circulated to various regulators and an accounting firm. Further, the bank had anticipated using the report as part of a Sarbanes Oxley Act disclosure and had expressly provided it to an employee for a "business need."

Plaintiffs, in a lawsuit filed in connection with the breach, sought to obtain a September 2019 report that Mandiant prepared, however Capital One objected contending that the report was protected by the work product doctrine since Mandiant had produced the report pursuant to the tri-partite agreement with Capital One's outside counsel in the breach litigation.

The Court, noting the fact-intensive nature of the work product analysis, as well as the narrow interpretation of privilege generally, ultimately held that the Mandiant forensic report was not entitled to work product protection since it would have been prepared in largely the same form regardless of the litigation. Because of the sensitive nature of the issues, the opinions of the Magistrate Judge and District Court do not quote or cite the Mandiant findings, and many of the key facts are either summarized or presented in redacted form. Nevertheless, it appears the Court based its ultimate decision on a few key conclusions.

First, the Court noted that the January 2019 SOW between Capital One and Mandiant provided that Mandiant would perform data breach-related services well before, and not in anticipation of, the data breach litigation. In fact, that SOW was deemed by Capital One as "business critical" and not tied to any legal action or legal purpose. Second, and perhaps most critically, the Court found that the post-breach tri-party letter agreement included the same, and seemingly nearly identical, scope of work as the non-privileged January 2019 SOW agreed upon prior to the data breach. These similarities and lack of differentiation appear to have severely undercut Capital One's contention that because the work Mandiant performed post-breach was done at the direction of counsel, it was entitled to work product doctrine protection. The Court was clear that simply having outside counsel direct the work, without more, will not bestow work product protection to a document. Third, the Court concluded that the Mandiant report was not specifically directed at litigation given the fact that Capital One distributed the report four different regulators, its accountant, as well as to numerous employees and the Board of Directors. Capital One is likely to appeal the District Court affirmation of the Magistrate Judge's decision to the United States Court of Appeals. *In re Capital One Consumer Data Sec. Breach Litig.*, 2020 U.S. Dist. LEXIS 91736 (E.D.Va. 2020).

Lessons Learned: Although the Capital One rulings may generate client questions as to whether the engagement of a service provider for both proactive and incident response work may jeopardize applicable privileges, the circumstances of Capital One are rather unique and not inherent to a single-vendor suite of solutions. Indeed, many of the key factors central to the Capital One ruling, such as the widespread disclosure of the Mandiant Report to regulators and the company accountant, as well as the nearly identical characteristics of the pre-breach "business critical" SOW and post-breach litigation tripartite agreements, will either not be present in many situations and can be strategically avoided rather easily. Finally, it is important to also recognize the Capital One ruling is a decision by one Federal Court – likely to be appealed – that is not binding throughout the courts of the United States and not the "law of the land.' Different courts, in fact, have reached contrary conclusions in similar situations.

Third Quarter

The Heightened Threat of Ransomware and Impact on the Insurance Markets

Among the myriad challenges facing businesses across the globe in 2020 is the heightened risk of ransomware attacks, which have increased in both frequency and severity while simultaneously becoming more sophisticated and targeted. Consequently, in response to the surge in ransomware attacks and cyber extortion claims, the global insurance market has reacted through shifts in appetite, firming pricing and additional underwriting scrutiny relative to insureds' ransomware resilience and response protocols.

The threat of a ransomware attack has elevated to a top concern for many entities and information security professionals, and with good reason as these attacks can paralyze networks and business operations immediately and for extended periods of time. Whether through targeted phishing campaigns or other methods of network infiltrations, ransomware attackers obtain unauthorized access to networks and subsequently encrypt or lock down files essential to operations.

Once the target's files have been locked down, the threat actor will demand a ransom payment in exchange for the digital keys to unencrypt or release the files. Cybercriminals have further increased the pressure on their victims on whether to pay the ransom through methods such as the destruction of data backups and stealing data prior to encryption while threatening release publicly or on the dark web.

In addition to the evolving sophistication of the attacks, there are simply more of these attacks occurring and with higher demand amounts. According to a report from Bitdefender, there has been an increase in reported ransomware attacks in excess of 700% between 2019 through the first half of 2020. Likewise, the amounts being demanded in such attacks is sharply on the rise with percentage increase estimates ranging broadly, however the consistent conclusion is that the demands are rapidly escalating, and it is increasingly typical to see seven-figure demands to unencrypt data.

Many, if not most, cyber insurance policies offer coverage for these ransomware attacks. Cyber extortion coverage was historically not a driving force of purchase in the early days of cyber insurance policies and often was purchased with sublimits. However, as cyber insurance offerings have matured and broadened, full limits coverage for cyber extortion has become a relatively standard part of most offerings while simultaneously becoming a paramount coverage consideration for many insureds even before the current spike in ransomware activity. The markets have nevertheless signaled concerns over the spike in ransomware activity.

Lessons Learned: In response to increased attacks and escalating claims and demand amounts, cyber insurance markets have, unsurprisingly, signaled a renewed focus on managing their cyber extortion exposures. Some insurers have announced an increased focus on their underwriting of ransomware exposure, including the introduction of supplemental ransomware submissions intended to illuminate the insured's resilience and cyber security controls, as well as the insureds protocols and vendor relationships designed to respond to a ransomware attack. Other markets are focusing on limiting appetite and risk selection, with a few even exiting the cyber insurance market. Finally, although many factors contribute to firming rates in the cyber insurance markets, ransomware is often cited as a factor in rate increases, particularly in the middle market. Aon will continue to monitor any changes or shifts in the cyber insurance markets' approach to insuring the ransomware risk, including advising clients as they navigate the heightened focus on ransomware from underwriters.

Class Action Filings

Class Action Filings

Source: Stanford Law School, Securities Class Action Clearinghouse

Filling Name	Filling Date	District Court
500.com Limited	1-13-2020	New York
Aarons, Inc.	2-28-2020	Georgia
Acacia Research Corporation	1-13-2020	Delaware
ACM Research, Inc.	12-21-2020	California
Adesto Technologies Corporation	3-20-2020	Delaware
AgroFresh Solutions, Inc.	7-14-2020	Delaware
Aimmune Therapeutics, Inc.	9-21-2020	California
Airbus SE : American Depositary Shares	8-6-2020	New Jersey
AK Steel Holding Corporation	1-17-2020	Delaware
Akazoo S.A.	4-24-2020	New York
Akcea Therapeutics, Inc.	9-23-2020	Delaware
Alibaba Group Holding Limited	11-13-2020	New York
Align Technology, Inc.	3-2-2020	California
Allakos Inc.	3-10-2020	California
Alpha and Omega Semiconductor Limited	3-19-2020	New York
Alteryx, Inc.	8-19-2020	California
American Electric Power Company, Inc.	8-20-2020	Ohio
Amyris, Inc.	7-28-2020	Delaware
Anadarko Petroleum Corporation	2-19-2020	Texas
Anaplan Inc.	8-24-2020	California
Anaptysbio, Inc.	3-25-2020	California
Anixter International Inc.	2-25-2020	Delaware
AquaVenture Holdings Limited	2-4-2020	Delaware
Arqule Inc.	1-2-2020	Delaware
Aurora Cannabis Inc.	10-2-2020	New Jersey
Baidu, Inc.	4-21-2020	California
Baidu, Inc.	8-19-2020	New York
Bayer Aktiengesellschaft : American Depositary Shares	7-15-2020	California
Bayerische Motoren Werke Aktiengesellschaft : American Depositary Shares	10-27-2020	New Jersey
Becton, Dickinson and Company	2-27-2020	New Jersey
Bed Bath & Beyond Inc.	4-14-2020	New Jersey
Benefytt Technologies, Inc.	7-28-2020	Delaware
Berry Corporation	11-20-2020	Texas
Beyond Meat, Inc.	1-30-2020	California
Bibox Group Holdings Limited	4-3-2020	New York
Binance	4-3-2020	New York
Biogen Inc.	11-13-2020	California
BioMarin Pharmaceutical Inc.	9-25-2020	California

Class Action Filings

Blink Charging Company	8-24-2020	Florida
Block.One	4-3-2020	New York
Boston Scientific Corporation	12-4-2020	New York
BProtocol Foundation	4-3-2020	New York
Braskem S.A. : American Depositary Shares	8-25-2020	New Jersey
Brookdale Senior Living, Inc.	6-25-2020	Tennessee
Business First Bancshares, Inc.	3-27-2020	Delaware
Cabot Oil & Gas Corporation	8-13-2020	Texas
Canaan, Inc. : American Depositary Shares	3-4-2020	Oregon
Cardone Capital, LLC : Cardone Equity Fund V, LLC and Cardone Equity Fund VI, LLC	9-16-2020	California
Care.com, Inc.	1-21-2020	Delaware
Carnival Corporation	5-27-2020	Florida
Casper Sleep Inc.	6-19-2020	New York
CD Projekt S.A. : American Depositary Shares	12-24-2020	California
Celsion Corporation	10-29-2020	New Jersey
CenterState Bank Corporation	3-19-2020	Delaware
Central European Media Enterprises Ltd.	1-21-2020	Delaware
Changyou.com Limited : American Depositary Shares	12-8-2020	New York
Cheetah Mobile, Inc : American Depositary Shares	6-25-2020	California
Chembio Diagnostics, Inc.	6-18-2020	New York
Chembio Diagnostics, Inc.	7-1-2020	New York
Chembio Diagnostics, Inc.	8-17-2020	New York
China XD Plastics Company Limited	7-6-2020	New York
Churchill Capital Corp III	8-11-2020	New York
Cincinnati Bell Inc.	3-23-020	Delaware
Cincinnati Bell Inc.	2-20-2020	New York
Citigroup Inc.	10-30-2020	New York
Civic Technologies, Inc.	4-3-2020	New York
CNX Midstream Partners LP	9-2-2020	Delaware
Co-Diagnostics, Inc.	6-15-2020	Utah
Colony Capital, Inc.	5-26-2020	California
Colony Credit Real Estate, Inc.	9-10-2020	California
Comtech Telecommunications Corp.	5-6-2020	New York
Conn's Inc.	5-15-2020	Texas
Coty Inc.	9-4-2020	New York
CPI Aerostructures, Inc.	2-24-2020	New York
Craft Brew Alliance, Inc.	1-29-2020	Delaware
Credit Acceptance Corporation	10-2-2020	Michigan
Cronos Group Inc.	3-11-2020	New York

Crown Castle International Corp.	2-27-2020	New Jersey
CSS Industries, Inc.	2-10-2020	Delaware
CVR Refining, LP	4-6-2020	New York
CytomX Therapeutics, Inc.	5-21-2020	California
Delphi Technologies PLC	3-18-2020	Delaware
Dermira, Inc	1-27-2020	Delaware
Deutsche Bank Aktiengesellschaft	7-15-2020	New Jersey
Dime Community Bancshares, Inc.	9-23-2020	Delaware
Diplomat Pharmacy, Inc.	1-16-2020	Delaware
DouYu International Holdings Limited : American Depositary Shares	3-24-2020	California
E*Trade Financial Corporation	4-23-2020	Delaware
Eastman Kodak Company	8-13-2020	New Jersey
eHealth, Inc.	4-8-2020	California
E-House (China) Holdings Limited : American Depositary Shares	4-9-2020	New York
Elanco Animal Health Incorporated	5-20-2020	Indiana
Endo International plc	6-19-2020	New Jersey
Energy Recovery, Inc.	7-21-2020	New York
Enphase Energy, Inc.	6-17-2020	California
EQM Midstream Partners, LP	4-2-2020	Delaware
Evolus, Inc.	10-16-2020	New York
Exela Technologies Inc	3-23-2020	Texas
Fairmount Santrol Holdings Inc.	12-10-2020	Ohio
Fastly, Inc.	8-27-2020	California
Fennec Pharmaceuticals Inc.	9-3-2020	North Carolina
FGL Holdings	4-9-2020	Delaware
Fifth Third Bancorp	4-7-2020	Illinois
Finjan Holdings, Inc.	6-29-2020	California
First American Financial Corp.	10-25-2020	California
FirstEnergy Corp.	7-28-2020	Ohio
Fluidigm Corporation	9-21-2020	California
Forescout Technologies, Inc.	3-17-2020	Delaware
Forescout Technologies, Inc.	1-2-2020	California
Forescout Technologies, Inc.	6-10-2020	California
Forescout Technologies, Inc.	7-31-2020	New York
Fortress Biotech, Inc.	11-27-2020	New York
Forty Seven, Inc.	3-17-2020	Delaware
Foundation Building Materials, Inc.	12-14-2020	California
Front Yard Residential Corporation	3-18-2020	Delaware
Funko, Inc.	3-10-2020	California
GAIN Capital Holdings, Inc.	4-17-2020	Delaware

Gardner Denver Holdings, Inc.	1-30-2020	Delaware
Garrett Motion Inc.	9-25-2020	New York
Garrison Capital Inc.	9-24-2020	Delaware
Genius Brands International, Inc.	8-18-2020	California
Geron Corporation	1-23-2020	California
Gilat Satellite Networks Ltd.	3-6-2020	Delaware
GlobalSCAPE, Inc.	8-4-2020	Delaware
GoHealth, Inc.	9-21-2020	Illinois
GOL Linhas Areas Inteligentes S.A.	9-11-2020	New York
Golar LNG Limited	9-24-2020	New York
Golden Star Resources Ltd.	4-1-2020	California
GoodRx Holdings, Inc.	12-18-2020	California
Gossamer Bio, Inc.	4-3-020	California
Grand Canyon Education, Inc.	5-12-2020	Delaware
Groupon, Inc.	4-28-2020	Illinois
GSX Techedu Inc. : American Depositary Shares	4-17-2020	New Jersey
Guidewire Software, Inc.	7-24-2020	California
Gulfport Energy Corporation	3-17-2020	New York
Hallmark Financial Services Inc.	5-5-2020	Texas
Hamilton Beach Brands Holding Company	5-22-2020	New York
Hanmi Financial Corporation	3-26-2020	California
Harborside, Inc.	9-8-2020	Oregon
HDFC Bank Limited : American Depositary Shares	9-3-2020	New York
HDR Global Trading Limited	4-3-2020	New York
Hebron Technology Co., Ltd.	6-9-2020	New York
Hexcel Corporation	3-5-2020	New York
HF Foods Group Inc.	3-29-2020	California
HP Inc.	2-19-2020	California
HP Inc.	11-5-2020	California
iAnthus Capital Holdings, Inc.	4-15-2020	New York
IBERIABANK Corporation	1-8-2020	Delaware
Ideanomics, Inc.	6-28-2020	New York
Immunomedics, Inc.	9-29-2020	Delaware
Innate Pharma S.A. : American Depositary Shares	10-23-2020	California
InnerWorkings, Inc.	8-25-2020	Delaware
Inovio Pharmaceuticals, Inc.	3-12-2020	Pennsylvania
Insperity, Inc.	7-21-2020	New York
Instructure, Inc.	1-13-2020	Delaware

Intel Corporation	7-28-2020	California
Intercept Pharmaceuticals, Inc.	11-5-2020	New York
Interface, Inc.	11-12-2020	New York
iQIYI, Inc. : American Depositary Shares	4-16-2020	New York
J2 Global, Inc.	7-8-2020	California
Jeld-Wen Holding, Inc.	2-19-2020	Virginia
Jernigan Capital, Inc.	8-27-2020	Delaware
JOYY Inc.	11-20-2020	California
JPMorgan Chase & Co.	10-24-2020	New York
Jumei International Holding Limited : American Depositary Shares	4-21-2020	California
K12, Inc.	11-19-2020	Virginia
Kandi Technologies Group, Inc.	6-10-2020	California
Kandi Technologies Group, Inc.	12-11-2020	New York
KayDex Pte. Ltd.	4-3-2020	New York
Kemet Corporation	1-7-2020	Delaware
Kingold Jewelry, Inc.	6-30-2020	New York
Kirkland Lake Gold Ltd.	6-29-2020	New York
KLX Energy Services Holdings, Inc.	6-9-2020	Delaware
KuCoin	4-3-2020	New York
Las Vegas Sands Corp.	10-22-2020	Nevada
Legg Mason, Inc.	4-1-2020	Delaware
Lexinfintech Holdings, Ltd.	9-9-2020	Oregon
Liberty Oilfield Services,	Inc.4-3-2020	Colorado
Livongo Health, Inc.	9-10-2020	Delaware
LogicBio Therapeutics, Inc.	3-18-2020	Massachusetts
LogMeIn, Inc.	1-24-2020	Delaware
Loop Industries, Inc.	10-13-2020	New York
Luckin Coffee Inc. : American Depositary Shares	2-13-2020	New York
Majesco	8-20-2020	Delaware
Maxim Integrated Products, Inc.	8-24-2020	Delaware
McDermott International, Inc.	7-17-2020	Texas
Mei Pharma, Inc.	8-10-2020	California
Mesa Air Group Incorporated	4-1-2020	Arizona
Mesoblast Limited : American Depositary Shares	10-8-2020	New York
MGP Ingredients, Inc.	2-28-2020	Kansas
Minerva Neurosciences, Inc.	12-8-2020	Massachusetts
Mobile Mini, Inc.	4-21-2020	Delaware
Mohawk Industries, Inc.	1-3-2020	Georgia
Momenta Pharmaceuticals, Inc.	9-8-2020	New York
Montage Resources Corporation	9-30-2020	Delaware

MutualFirst Financial, Inc.	1-3-2020	Delaware
Mylan N.V.	6-26-2020	Pennsylvania
Mylan N.V.	4-13-2020	Delaware
Nano-X Imaging Ltd.	9-16-2020	New York
National General Holdings Corp.	8-13-2020	Delaware
Neon Therapeutics, Inc.	4-7-2020	New York
Neonode Inc.	9-2-2020	Delaware
Neovasc Inc.	11-5-2020	New York
NextCure, Inc.	9-21-2020	New York
Nikola Corporation	9-15-2020	Arizona
NMC Health Plc : American Depositary Shares	3-10-2020	California
Noble Energy, Inc.	8-18-2020	Delaware
Northern Dynasty Minerals Ltd.	12-4-2020	New York
Norwegian Cruise Lines	3-12-2020	Florida
Odonate Therapeutics, Inc.	9-16-2020	California
On Deck Capital, Inc.	9-1-2020	Delaware
OneSpan Inc.	8-20-2020	Illinois
Opera Limited : American Depositary Shares	1-24-2020	New York
Opus Bank	4-21-2020	Delaware
Otelco Inc.	9-1-2020	Delaware
Paysign, Inc.	3-19--020	Nevada
Peabody Energy Corporation	9-28-2020	New York
Pfenex Inc.	9-4-2020	Delaware
PharmaCielo Ltd.	3-6-2020	California
Phoenix Tree Holdings Limited : American Depositary Shares	4-24-2020	New York
Pilgrim's Pride Corporation	7-6-2020	Colorado
Pintec Technology Holdings Limited : American Depositary Shares	9-29-2020	New York
Pinterest, Inc.	11-23-2020	California
PlayAGS, Inc.	6-25-2020	Nevada
Pope Resources	3-26-2020	Delaware
Portland General Electric Company	9-3-2020	Oregon
Portola Pharmaceuticals, Inc.	1-16-2020	California
Portola Pharmaceuticals, Inc.	5-28-2020	Delaware
Precigen, Inc.	10-5-2020	California
Primo Water Corporation	2-3-2020	Delaware
Principia Biopharma Inc.	9-1-2020	Delaware
ProAssurance Corporation	6-16-2020	Alabama
Progenity, Inc.	8-28-2020	California
ProShares Ultra Bloomberg Crude Oil	7-28-2020	New York

Proteostasis Therapeutics, Inc.	10-14-2020	New York
Qiagen N.V.	5-29-2020	Delaware
Qiwi plc : American Depositary Shares	12-11-2020	New York
Quantstamp, Inc.	4-3-2020	New York
Qudian Inc. : American Depositary Shares	1-22-2020	New York
Qutoutiao Inc. : American Depositary Shares	8-20-2020	New York
Raytheon Technologies Corporation	10-30-2020	Arizona
RealtyShares, Inc. : Debt Securities	1-17-2020	Massachusetts
Reata Pharmaceuticals, Inc.	10-15-2020	Texas
Restaurant Brands International Inc.	12-21-2020	New York
resTORbio, Inc.	6-26-2020	Delaware
Rexahn Pharmaceuticals, Inc.	8-3-2020	Delaware
Ribbon Communications Inc.	1-16-2020	Delaware
Robinhood Financial LLC	12-23-2020	California
Rosetta Stone Inc.	9-24-2020	Delaware
Royal Caribbean Cruises LTD	10-7-2020	Florida
RTI Surgical Holdings, Inc.	3-23-2020	Illinois
Ryder System, Inc.	5-20-2020	Florida
Sasol Limited : American Depositary Shares	2-5-2020	New York
SB One Bancorp	6-15-2020	Delaware
SCWorx Corp.	4-29-2020	New York
Seacoast Commerce Banc Holdings	9-28-2020	Delaware
Semiconductor Manufacturing International Corporation : American Depositary Shares	12-10-2020	California
ServiceMaster Global Holdings, Inc.	4-10-2020	Tennessee
Silver Lake Group, L.L.C. : Intelsat S.A.	4-7-2020	California
Six Flags Entertainment Corporation	2-12-2020	Texas
Sky Solar Holdings, Ltd. : American Depositary Shares	7-17-2020	New York
Sona Nanotech Inc.	12-17-2020	California
SORL Auto Parts, Inc.	2-3-2020	Delaware
Sorrento Therapeutics, Inc.	5-26-2020	California
Southwest Airlines Co	2-19-2020	Texas
Spirit AeroSystems Holdings, Inc.	2-10-2020	Oklahoma
Splunk Inc.	12-4-2020	California
Spring Bank Pharmaceuticals, Inc.	9-8-2020	Delaware
Staar Surgical Company	8-19-2020	California
Status Research & Development GmbH	4-3-2020	New York
Stein Mart, Inc.	3-10-2020	New York
Stemline Therapeutics, Inc.	5-20-2020	Delaware

Sterling Bancorp, Inc.	2-26-2020	Michigan
Sunworks, Inc.	10-22-2020	California
Synthorx, Inc.	1-3-2020	Delaware
Tactile Systems Technology, Inc.	9-29-2020	Minnesota
Tallgrass Energy, LP	1-31-2020	Delaware
Taubman Centers, Inc.	5-21-2020	Delaware
TD Ameritrade Holding Corporation	3-18-2020	Delaware
Telaria, Inc.	2-13-2020	Delaware
TerraForm Power, Inc.	7-9-2020	Delaware
Tetraphase Pharmaceuticals, Inc.	6-17-2020	Delaware
Tetraphase Pharmaceuticals, Inc.	4-9-2020	Delaware
Tetraphase Pharmaceuticals, Inc.	7-16-2020	Delaware
Teva Pharmaceutical Industries Limited : American Depositary Shares	9-23-2020	Pennsylvania
The GEO Group, Inc.	7-7-2020	Florida
The Habit Restaurants, Inc.	2-11-2020	Delaware
The Kraft Heinz Company	3-25-2020	Indiana
The Meet Group, Inc.	4-7-2020	Delaware
The Republic of Ecuador	7-29-2020	New York
Tiffany & Co.	1-3-2020	Delaware
Tilray, Inc.	3-6-2020	New York
Tivity Health, Inc.	2-25-2020	Tennessee
TiVo Corporation	3-3-2020	Delaware
Triterras, Inc.	12-21-2020	New York
Tron Foundation	4-3-2020	New York
Tufin Software Technologies Ltd.	4-6-2020	California
Tufin Software Technologies Ltd.	7-21-2020	New York
Tupperware Brands Corporation	2-25-2020	Florida
Turquoise Hill Resources Ltd.	10-14-2020	New York
Uber Technologies, Inc.	12-5-2020	California
Ultra Petroleum Corp.	9-1-2020	Colorado
United States Oil Fund, LP	6-19-2020	New York
Varian Medical Systems, Inc.	9-3-2020	Delaware
Vaxart, Inc.	8-24-2020	California
Velocity Financial, Inc.	7-29-2020	California
Verrica Pharmaceuticals Inc.	7-14-2020	Pennsylvania
Vivint Solar, Inc.	8-24-2020	Delaware
VMware, Inc.	3-31-2020	California
Wells Fargo & Company	6-11-2020	New York
Wells Fargo & Company	6-4-2020	California
Wells Fargo & Company	10-30-2020	California

Westpac Banking Corporation : American Depositary Shares	1-30-2020	Oregon
Willis Towers Watson Public Limited Company	5-14-2020	Delaware
Wins Finance Holdings Inc.	7-24-2020	California
Wirecard AG	7-7-2020	Pennsylvania
World Wrestling Entertainment, Inc.	3-6-2020	New York
WPX Energy, Inc.	2-17-2020	Delaware
Wrap Technologies, Inc.	9-23-2020	California
Wright Medical Group N.V.	1-15-2020	Delaware
XP Inc.	3-21-2020	New York
YayYo, Inc.	9-9-2020	California
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