Winning and Losing Strategies Litigating the Duty to Defend

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I. Introduction And Overview Of The Duty To Defend

The duty to defend is an issue that (typically) (1) is decided as a mater of law, (2) involves narrow issues of contract interpretation, (3) can be resolved on a limited record, and (4) can be done on a more limited budget.

From the insured's perspective, when successful, it can provide not only immediate financial relief for the insured but may also generate enough leverage to reach negotiated resolutions. Indeed, sometimes the pending motion (whether brought unilaterally or as a cross-motion) can generate enough impetus to resolve a coverage dispute. From the insurer's perspective, a judicial determination on the duty to defend almost always terminates any prospective coverage obligation of the insurer and reduces or eliminates liability under the applicable policy or policies entirely.

Below, we explore cases decided on summary judgment from across the country that highlight some of the strategic issues that come into consideration in determining how and where to litigate issues regarding an insurer's obligation to defend, advance defense costs, or reimburse the insured for amounts already incurred.

II. Insurer Case Studies:

The following provides a few examples of recent issues we have encountered related to the duty to defend, from the varied perspectives of counsel for both insureds and insurers.

1. Broad Application Of The Intellectual Property And Unfair Business Practices Exclusions

Many commercial general liability policies contain the following, or substantially similar, exclusions:

> **Claim or Suit Alleging Infringement of Intellectual Property**
>
> (1) Any claim or "suit" that alleges "personal and advertising injury" arising out of any actual, alleged, or threatened misappropriation, infringement, or violation of any intellectual property or intellectual property right or law of any description, including but not limited to any of the following:

2. (a) copyright; (b) patent; (c) trademark; (d) trade name; (e) trade secret; (f) trade dress; (g) service mark; (h) slogan; (i) service name; (j) description of origin, source, authorship, authenticity, or quality; (k) other right to or law recognizing an interest in any expression, idea, likeness, name, style of doing business, symbol, or title; or (l) Any other intellectual property right or law.

This exclusion applies to our duty to defend and our duty to pay damages whether such misappropriation, infringement, or violation is committed in your "advertisement" or otherwise.

* * *

Claim or Suit Alleging Violation of Laws Concerning Unfair Competition or Similar Laws

1. Any claim or "suit" that alleges "personal and advertising injury" arising out of any actual, alleged, or threatened violation of any statutes, common law, or other laws or regulations concerning unfair competition, antitrust, restraint of trade, piracy, unfair trade practices, or any similar laws or regulations.

2. Any "personal and advertising injury" alleged in a claim or "suit" that also alleges any actual, alleged, or threatened violation of any statutes, common law, or other laws or regulations concerning unfair competition, antitrust, restraint of trade, piracy, unfair trade practices, or any similar laws or regulations.

This exclusion applies to our duty to defend and our duty to pay damages whether such misappropriation, infringement, or violation is committed in your "advertisement" or otherwise.

* * *

(Hereinafter, respectively, the "IP Exclusion" and the "UC Exclusion").

Recently, courts have applied these exclusions broadly to exclude coverage for entire actions that include excluded allegations, even where they also include other non-intellectual property or unfair competition claims.[1] The following provides a few recent examples.

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[1] *See, e.g., Ventana Medical Systems v. St. Paul Fire & Marine Ins. Co.*, No. CV 09-102-CKJ-CRP, 2010 WL 1752509, *19 (D. Ariz. Jan. 13, 2010), *adopted* 709 F. Supp. 744, 757-758 (D. Ariz. Apr. 29, 2010), *aff'd* 454 Fed. Appx. 596 (9th Cir. 2011) (the court stated that the exclusion is "sweeping" and that "[w]hile this is a potentially harsh exclusion, insurance policies are contracts entered into by parties who have the choice to agree or not agree to the terms of the contract."); *Pinnacle Brokers Ins. Solutions, LLC v. Sentinel Ins. Co., Ltd.*, Case No. 15-cv-02976-JST, 2015 WL 515953, *4 (N.D. Cal. Sept. 2, 2015) (the court found that "the policy language does not require a connection between the alleged intellectual property violation or infringement and another injury or damage alleged in the same suit in order for the intellectual property exclusion to apply."); *TELA Bio, Inc. v. Federal Ins. Co.*, 761 Fed. Appx. 140, 144 (3d Cir. 2019) ("The expansive language … clearly and unambiguously excludes from coverage all allegations within a suit, if that suit contains any allegations of intellectual property rights violations," and thus the exclusion "plainly applies to [the underlying action] which asserts that TELA misappropriated [the underlying plaintiff's] trade secrets and proprietary information." [emphasis in original]); *Sentinel Ins. Co., Ltd. v. Yorktown Industries, Inc.*, Case No. 14-cv-4212, 2017 WL 446044, *3-4 (N.D. Ill. Feb. 2, 2017) (coverage was excluded for the entire underlying action because every claim was predicated on defendant's alleged misappropriation of trade secrets); *Citizens Ins. Co. of America v. Uncommon, LLC*, 812 F. Supp. 2d 905, 910 (N.D. Ill. 2011) (the court stated that the factual

a. The IP Exclusion

This insurance coverage action arose out of an insurer's denial of coverage to an insured manufacturer and distributor of chemical products, for an underlying lawsuit alleging that the insured misappropriated trade secrets under its "personal and advertising injury" coverage. The policies at issue were subject to the IP Exclusion and the UC Exclusion.

The plaintiff in the underlying action was the developer of a proprietary product that is added to a tire's air chamber to reduce tire failures. The plaintiff alleged that the insured induced plaintiff's former employees to share trade secrets that enabled the insured to develop a competing product. The plaintiff filed a lawsuit against the insured and the former employees, asserting causes of action for (1) misappropriation of trade secrets, (2) declaration of rights and injunctive relief – ownership of inventions, (3) breach of contract, (4) breach of duty of loyalty – disclosure and use of non-trade secrets confidential information, (5) tortious interference with the former employees' obligations to plaintiff, (6) tortious interference with current and prospective relationships with customers, and (7) declaratory judgment – shop rights. The fourth cause of action (breach of duty of loyalty) and fifth and sixth causes action (tortious interference) alternatively pled claims under the common law, "[t]o the extent that any of the information described in the First Claim is determined not to constitute a trade secret as defined under the Oregon Uniform Trade Secrets Act."

The insured filed a coverage action in Oregon state court. In that action, the parties filed cross motions for summary judgment. Relevant here, the insurer argued that coverage was barred by the above exclusions, which should be construed broadly in general, but also because all claims at issue necessarily arose out of the insured's alleged misappropriation of confidential materials. The insurer also argued that the IP exclusion applies to any "suit" that alleges intellectual property infringement and is not limited to just specific claims, as set forth in *Ventana Medical Systems v. St. Paul Fire & Marine Ins. Co.*, No. CV 09-102-CKJ-CRP, 2010 WL 1752509, *19 (D. Ariz. Jan. 13, 2010), *adopted* 709 F. Supp. 744, 757-758 (D. Ariz. Apr. 29, 2010), *aff'd* 454 Fed. Appx. 596 (9th Cir. 2011). The court in *Ventana* applied a narrower exclusion because all claims in the action arose out of intellectual property violations. *See id.* at *26-27.

The insured, on the other hand, argued that the insurer did owe a duty to defend, that it had forfeited any right it may have had to select defense counsel or control the defense by declining to provide a defense, and that it was obligated to pay the insured's reasonable attorney fees pursuant to Or. Rev. Stat. § 742.061.[2] The insured's argument was based upon the principle in

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allegations in the underlying action, and not the legal theories, determined whether an intellectual property exclusion applied: "Indeed, there is no other way to faithfully interpret the actual text of the exclusion, which refers not to copyright, patent, trademark, and trade secret claims, but rather to claims '[a]rising out of the infringement of copyright, patent, trademark, trade secret or other intellectual property rights" [emphasis in original]); *Sentinel Ins. Co. v. Beach for Dogs Corp.*, 17 C 1501, 2017 WL 6570079, at *5 (N.D. Ill. Dec. 21, 2017) ("The IP Exclusion is clear, explicit, and resoundingly settled as a matter of law throughout the country as operating to preclude coverage in underlying suits just like that at issue here."); *EP&A Envirotac, Inc. v. Great American E&S Ins. Co.*, No. 5:21-cv-00145, 2021 WL 3779227, *4 (C.D. Cal. July 27, 2021) ("Thus, although the express references to intellectual property infringement are not included in the first or second amended complaint, the second amended complaint still includes allegations regarding the violation of intellectual property rights.").

[2] This section provides an additional tool for Oregon policies. Subject to certain exceptions, it provides that:

Oregon, like other jurisdictions, that courts "interpret the terms of an insurance policy according to what [they] perceive to be the understanding of the ordinary purchaser of insurance[,]" and that they refuse to apply exclusions ordinary purchasers of insurance could reasonably conclude have narrow meanings. *See Hunters Ridge Condominium Association v. Sherwood Crossing, LLC*, 285 Or. App. 416, 422 (2017).

Ultimately, the question of whether the complaint potentially alleged covered damages turned upon whether the alternatively pled claims for breach of the duty of loyalty and tortious interference – which were vague – could create enough of a potential for coverage based upon the fact that the universe of other violations was not entirely clear. Specifically, the insured argued that factual allegations in the complaint that the insured's products were nearly identical to the plaintiff's – which were pled as part of the trade secrets cause of action – were sufficient to create a potential for coverage when read in conjunction with the fourth, fifth, and sixth causes of action, which alleged harm to the extent no trade secrets were misappropriated. The insured separately argued that the unfair business practices exclusion is intended to apply to price-fixing and antitrust violations and therefore did not apply here.

The court held that the insured's "potential for coverage" argument was too speculative to be plausible when evaluated within the context of the complaint. The court noted that there would be no basis for liability absent some type of misappropriation of confidential or proprietary material, and it therefore concluded that all allegations arose out of the alleged misappropriation of trade secrets, and coverage was therefore excluded by the IP Exclusion. The court also concluded that the UC Exclusion was broadly worded enough to include common law trade secret claims – by its use of the phrase "any actual, alleged, or threatened violation of any statutes, common law, or other laws or regulations concerning unfair competition, antitrust, restraint of trade, piracy, unfair trade practices, or any similar laws or regulations – but emphasized that its ruling was based primarily upon the IP Exclusion.

b. <u>The UC Exclusion</u>

This coverage dispute addressed both the IP Exclusion and the UC Exclusion. The insurer denied coverage to a developer, manufacturer, and marketer of dust control and soil stabilization products, for an underlying action filed by a competitor that alleged it engaged in unfair business practices by "palming off and misappropriation," among other reasons.

The plaintiff in the underlying action asserted causes of action against multiple parties, including the insured, for (1) breach of contract, (2) tortious interference with business expectancies, (3) unfair business practices; (4) unjust enrichment, (5) preliminary and permanent injunctive relief, and (6) aiding and abetting. The underlying plaintiff alleged a number of unfair business practices, including the following allegation describing the insured's wrongful conduct:

"if settlement is not made within six months from the date proof of loss is filed with an insurer and an action is brought in any court of this state upon any policy of insurance of any kind or nature, and the plaintiff's recovery exceeds the amount of any tender made by the defendant in such action, a reasonable amount to be fixed by the court as attorney fees shall be taxed as part of the costs of the action and any appeal thereon …."

> [utilizing] false, misleading and confusing internet search and posting tactics/advertising efforts to redirect customers and potential customers to [its] internet materials instead of to [plaintiff's] with reference to [plaintiff's] products and services in order to wrongfully trade upon and profit from [plaintiff's] name, products or services; making wrongful, misleading and factually inaccurate comparisons and connections between [the insured's] and [plaintiff's] products and services in the marketplace regarding safety, performance, equivalency, etc.; false and misleading statements regarding the dishonesty of [plaintiff] and its owners, including statements alleging that [plaintiff] stole its formulas from [the insured's]; false and misleading statements and conduct suggesting that [plaintiff's] ownership have an ongoing professional affiliation with [the insured]; and, false and misleading claims about the origin, manufacturing, safety and ingredients in connection with the [insured's] promotion, sale and application of their products and services.

The insured filed a coverage action in the U.S. District Court, Central District of California. In that action, the parties filed cross motions for summary judgment as to the duty to defend. The insurer argued that the UC Exclusion applied to preclude coverage for two categories of claims: (1) lawsuits that allege personal and advertising injury arising out of the violation of any statutes, common law, or other laws or regulations concerning unfair competition or unfair trade practices, and (2) any other alleged personal and advertising injury in lawsuits that also include allegations for such conduct. In other words, even where there were other non-excluded claims, the broad language used in the UC Exclusion barred coverage for the entire action based solely upon the inclusion of allegations of unfair business practices. *See, e.g., Great American E & S Ins. Co. v. Theos Medical Systems, Inc.*, 357 F. Supp. 3d 953, 971 (N.D. Cal. 2019) ("in situations concerning language similar to the exclusions at issue here, courts have held that non-intellectual property claims need not be related to the intellectual exclusion language provided that the exclusion applied to the entire suit."). The insurer also argued that the IP Exclusion precluded coverage for "suits" that allege personal and advertising injury arising out of any alleged misappropriation or infringement, as in the above matter.

The insured countered that a broad application of the UC Exclusion would violate California's well-settled public policy that insurers must defend "mixed" actions, set forth in *Buss v. Superior Court*, 16 Cal.4th 35, 48-49 (1997), and that an insurer "cannot contract around California law that requires insures to defend the entire action if there is any potentially covered claim," citing *Saarman Constr., Ltd. v. Ironshore Specialty Ins. Co.*, 230 F.Supp.3d 1068, 1080 (2017).

The district court ruled that both the IP Exclusion and the UC Exclusion barred coverage for the underlying action. The court first noted that the language of the IP Exclusion that excludes coverage for any "claim or 'suit'" that alleges intellectual property violations clearly applied. The court further explained that even if it did not, the UC Exclusion applied to bar coverage because, where applicable, there is no obligation to defend the "mixed" action because the UC Exclusion clearly provides that there is no coverage for any action that includes allegations of unfair competition. The court noted that the parties are free to negotiate regarding the scope of coverage if they believe this clear exclusionary language is too harsh.

3. New York Insurance Law Section 3420(d)(2)

New York Insurance Law section 3420(d)(2) presents difficult issues for insurers of New York risks. This section applies to bodily injury claims arising out of accidents within the state of New York and requires an insurer to "give written notice as soon as is reasonably possible of such disclaimer of liability or denial of coverage to the insured and the injured person or any other claimant." *See* N.Y. Ins. Law § 3420(d)(2) (emphasis added). Where Section 3420(d)(2) applies, "[i]f the insurance carrier fails to disclaim coverage in a timely manner, it is precluded from later successfully disclaiming coverage." *NGM Ins. Co. v. Blakely Pumping, Inc.*, 593 F.3d 150, 153 (2d Cir. 2010). Unlike "traditional common-law waiver and estoppel defenses, section 3420(d)(2) creates a heightened standard for disclaimer that 'depends merely on the passage of time rather than on the insurer's manifested intention to release a right as in waiver, or on prejudice to the insured as in estoppel.'" *KeySpan Gas E. Corp. v. Munich Reinsurance Am., Inc.*, 23 N.Y.3d 583, 590 (2014). The legislative goal of Section 3420(d)(2) is "to 'aid injured parties' by encouraging the expeditious resolution of liability claims" through a rule that a late disclaimer of coverage based upon an exclusion results in a waiver of the right to assert that exclusion. *See id*.

The question of whether an insurer has timely disclaimed coverage is measured from the time the insurer first learns of the grounds for disclaiming coverage, and as such, this is a case-specific analysis. *See Crescent Beach Club LLC.*, 468 F. Supp. 3d 515, 537-538 (E.D.N.Y. 2020) (citing *Country-Wide Ins. Co. v. Preferred Trucking Servs. Corp.*, 22 N.Y.3d 571, 575-576 (2014). If the justification for the disclaimer is "readily ascertainable from the face of the complaint in the underlying action" or "all relevant facts supporting ... a disclaimer [are] immediately apparent ... upon ... receipt of notice of the accident," a disclaimer must be made rapidly. *See id*. at 538. A reservation of rights letter does not extend the insurer's time to disclaim coverage. *See Golden Ins. Co. v. Ingrid House, Inc.*, No. 20-CV-1163 (LJL), 2021 WL 1893594, at *5 (S.D.N.Y. May 10, 2021). New York courts have found delays of over a month to be unreasonable. *See id.* at 539-540 (collecting cases). On the other hand, "New York courts have found that a disclaimer of coverage issued within a month after the insurer obtains sufficient facts to form the basis of the disclaimer is, as a matter of law, reasonable." *See Liberty Ins. Underwriters Inc. v. Great American Ins. Co.*, No. 09 CIV 4912 DLC, 2010 WL 3629470, at *9 (S.D.N.Y. Sept. 17, 2010) (collecting cases). A delay is justified where an initial period of investigation is required in order to determine whether an exclusion actually applies. *See Crescent Beach Club LLC*, 468 F. Supp. 3d at 538 (finding that an 18-month delay did not waive the right to rely upon a similar construction exclusion where factual investigation was needed to determine the applicability of the exclusion to the claim).

a. Section 3420(d)(2) Applies Only To Insurance Policies That Are "Issued Or Delivered" In New York

By its terms, Section 3420(d)(2) applies only to liability policies that are "issued or delivered" in New York. Interpreting a different section of Section 3420 that uses the same "issued or delivered" language, however, New York's highest court recently gave a broad construction to this requirement, finding it to mean that "[a] policy is 'issued for delivery' in New York if it covers both insureds and risks located in th[e] state." *See Carlson v. American International Group, Inc.*, 30 N.Y.3d 288, 305-307 (2017). The Court held that an insurer of DHL, headquartered in Florida, was subject to that separate portion of Section 3420 for a wrongful death claim arising out of an auto accident in New York because DHL "had a substantial

business presence and created risks in New York." *See id*. at 306; *see also United States Underwriters Ins. Co. v. Image By J & K, LLC*, 335 F. Supp. 3d 321, 341, fn. 9 (E.D.N.Y. 2018) ("[a] named insured is 'clearly' located in New York if 'it has a substantial business presence and creates risks' in the State."). Because Section 3420(d)(2) uses the same language, the reasoning of *Carlson* may apply to Section 3420(d)(2), as well.

b. <u>The Dilemma Of The Out-Of-State Insurer That Provides Coverage For Risks In New York</u>

A recent matter we handled highlighted the unique difficulties presented by Section 3420(d)(2) when a liability policy issued in another state – in this instance, California – insures risks in New York. This matter involved a coverage dispute between a California-based chain of sports clubs, which obtained commercial general liability insurance at its California headquarters that was broad enough to cover the insured's New York operations. A club member suffered injuries and ultimately died in New York, allegedly due to an exposure to the Legionella bacteria at one of the insured's New York clubs.[3] Mindful of Section 3420(d)(2), the insurer promptly denied coverage under a "Fungi or microbes" exclusion, which excluded coverage for injuries caused by bacteria.

The insured subsequently retained California-based coverage counsel, who argued that California law should apply because the policy was delivered to the insured in California.[4] Counsel threatened to file coverage litigation in California, and argued that because in California "[e]very insurer shall conduct and diligently pursue a thorough, fair and objective investigation and shall not persist in seeking information not reasonably required for or material to the resolution of a claim dispute," *see* Cal. Code Regs. tit. 10, § 2695.7(d), the insurer's immediate denial in order to comply with New York law constituted bad faith. *See Bosetti v. United States Life Ins. Co. in City of New York*, 175 Cal. App. 4th 1208, 1235-36 (2009) ("[A]n insurer cannot reasonably and in good faith deny payments to its insured without fully investigating the grounds for its denial."); *see also Track Mortgage Group, Inc. v. Crusader Ins. Co.*, 98 Cal. App. 4th 857, 870 (2002) (holding that an insurer acted in bad faith by failing to investigate the scope of loss and refusing to discuss scope of loss with policyholder). Counsel further argued that the exclusion did not clearly apply because it defined the excluded "fungi and microbes" to include bacteria whose "injurious source is in or on a building or its contents," and there was a fact

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[3] The above fact pattern comes from a recent matter involving an excess insurer that did not owe any immediate duty to defend, and the injuries alleged were subject to an exclusion. Nonetheless, the matter raised issues that are relevant to this discussion regarding the duty to defend.

[4] Pursuant to California Civil Code section 1646, "[a] contract is to be interpreted according to the law and usage of the place it is to be performed; or, if it does not indicate a place of performance, according to the law and usage of the place where it is made." The place of performance for an insurance policy is the location of the insured risk, which is usually not clear in the context of a multi-state liability policy. *See Frontier Oil Corp. v. RLI Ins. Co.*, 153 Cal. App. 4th 1436, 1459 (2007); *Store Kraft Mfg. v. Wausau Bus. Ins. Co.*, 2014 WL 12561603, at *5 (C.D. Cal. Mar. 24, 2014) (explaining that using the location of an injury to determine the location of the insured risk for a multi-state policy "would eliminate the second prong of the section 1646 test, insofar as virtually every contract would thus indicate a place of performance."). In California, a contract is made in the state in which "the last act necessary to the contract, the acceptance, was performed." *See Ury v. Jewelers Acceptance Corp.*, 227 Cal. App. 2d 11, 16 (1964); *see also Ameron International Corp. v. American Home Assurance Co.*, No. CV 11-1601 CAS AGRX, 2011 WL 2261195, at *5 (C.D. Cal. June 6, 2011) (recognizing the same).

question related to the "source" of the Legionella bacteria here. Accordingly, she demanded that the insurer withdraw its denial of coverage and investigate the claim.

While the insurer was confident that its exclusion applied to bar coverage (which, ultimately, drove the settlement of the claim), this did create some difficult decisions given the inherent tension between Section 3420(d)(2)'s requirement that an insurer disclaim coverage quickly and California's requirement that an insurer fully investigate a claim before denying coverage.

It is certainly possible that a California court would determine that Section 3420(d)(2) does not apply in a California coverage action. California courts typically apply a "governmental interest" test to determine choice of law issues other than contractual interpretation. *See Frontier Oil Corp.*, 153 Cal. App. 4th at 1459-60. This test compares the laws of each state and, if different, determines whether both states have an interest in having their law applied to this case. If the laws are different and each state has such an interest, the court must apply a "comparative impairment" analysis to determine which state's interests would be more impaired if subordinated to the law of the other state. *See Paulsen v. CNF Inc.*, 559 F.3d 1061, 1080 (9th Cir. 2009). Courts evaluate a variety of factors, including the underlying policies for the conflicting laws, and whether one is more progressive; whether either policy can be satisfied by some other means; the commitment of each state to the conflicting laws, including the function and purpose of the laws; and the location of the injury. *See Van Winkle v. Allstate Ins. Co.*, 290 F. Supp. 2d 1158, 1166-67 (C.D. Cal. 2003). California recognizes a "well established" rule that the doctrines of implied waiver and estoppel cannot be used to create coverage for risks that would otherwise be excluded, which conflicts with the goals of Section 3420(d)(2). *See Advanced Network, Inc. v. Peerless Ins. Co.*, 190 Cal. App. 4th 1054, 1066 (2010). Absent any risk of waiver under Section 3420(d)(2), an insurer might provide a defense where it is a close call whether or not an exclusion applies, at least until it is clear that the exclusion will or will not apply under the facts developed in the case.

On the other hand, at least one California court has applied a separate provision of Section 3420 (prohibiting exemplary damages in a direct action against an insurer by a third party), recognizing that New York's statutorily-expressed policy expressed was "stronger than California's permissive stance which has evolved through case law." *See Van Winkle*, 290 F. Supp. 2d at 1168 ("The mere fact that the injury in the underlying suit occurred in California is not sufficient to outweigh the strong New York interests explicitly expressed in New York Insurance Law § 3420."). If the court were to determine that Section 3420(d)(2) did apply, a withdrawal of the denial of coverage might have waived the insurer's ability to rely upon the exclusion, to the extent it was clear enough that it applied from the face of the pleadings.

Ultimately, the claim settled, and the issue did not need to be litigated. However, the above demonstrates the ways in which counsel for an insured can generate leverage based upon the possible application of Section 3420(d)(2).

III. Policyholder Case Studies

1. Venue considerations: The fight over where to fight.

Insurers and insureds often file competing lawsuits in different jurisdictions within a short period of time. Deference may be given to the "first filed" suit and/or a motion to dismiss for *forum non conveniens* may be filed. One recent case, however, explained Delaware's slightly different take on *forum non conveniens* law in *CVR Refining, LP v. XL Specialty Insurance Co.*, N21C-01-260 EMD CCLD, 2021 WL 3523925 (Del. Super. Ct. Aug. 11, 2021). The reason we included this case was that it demonstrated how an early motion for summary judgment on, *inter alia*, the duty to advance defense costs forced the insurers to bring a procedural motion in a forum that almost certainly was more beneficial for the insureds.

Lawsuits were filed against the insureds, and coverage disputes arose over both defense costs and indemnification. At least one of the insurers denied coverage based on Texas law. As the underlying actions approached mediation, the insureds gave the insurers a deadline to respond confirming that they would cover any settlement reached at mediation. Before the deadline expired, the insurers sued in Texas federal court.

Three days later, the insureds sued in the Superior Court of Delaware, and about six weeks later, moved for summary judgment on one of the carrier's duty to advance defense fees and costs.

The insurers then moved to dismiss the Delaware action on the ground of *forum non conveniens*. (It seems clear that insurers had no choice—otherwise, the dispositive motion would go forward in Delaware under Delaware law.)

The trial court denied the motion. Delaware courts generally defer to the venue of the first-filed lawsuit. But if the filings are "contemporaneous," the courts will apply Delaware's *forum non conveniens* factors.

The court first noted that declaratory relief actions filed in anticipation of a lawsuit by the "natural plaintiff" are not entitled to the deference afforded first-filed actions. The court took into consideration additional facts as well, including that the insurers, not the insureds, were the parties engaged in a "race to the courthouse."

The court also rejected the idea that "contemporaneous" is determined merely by a timeline. Instead, Delaware courts may treat cases "files within the same general time frame" as contemporaneous. This approach is expressly to avoid a "race to the courthouse" scenario between insurers and insureds.

Having determined that the suits were contemporaneous, the traditional *forum non conveniens* factors applied[5] *but* the insurers had to prove "overwhelming hardship and inconvenience,"

[5] The traditional factors are (1) the relative ease of access to proof; (2) the availability of compulsory processes for witnesses; (3) the possibility of the view of the premises; (4) whether the controversy is dependent upon the application of Delaware law; (5) the pendency or non-pendency of a similar action or actions in another jurisdiction; and (6) all other practical problems that would make the trial of the case easy, expeditious and inexpensive. *See General Foods Corp. v. Cryo-Maid, Inc.*, 198 A.2d 681, 684 (Del. 1964), *overruled on other grounds by Pepsico, Inc. v. Pepsi-Cola Bottling Co. of Asbury Park*, 261 A.2d 520 (Del. 1969).

which the did not do (and could not have done, according to the court, because all the insurers were licensed, and did business, in Delaware).[6]

2. Leverage considerations: No interlocutory appeals.

One advantage to early motion practice is that it can afford insureds a quick win that insurers cannot undo through immediate review. Such a result was recently illustrated in *Verizon Communications Inc. v. National Union Fire Insurance Company of Pittsburgh, PA*, No. CVN18C08086EMDCCLD, 2021 WL 1016445, at *1 (Del. Super. Ct., Mar. 16, 2021), albeit in the reimbursement context. The takeaway from this case is that certain states view coverage issues are simply contract disputes, which are not compelling enough to warrant interlocutory review. (Note that there was no ongoing defense or advancement obligation in this litigation, which undoubtedly influenced the court's decision.)

In this case, a coverage dispute arose following the spin-off of an asset and that asset's subsequent merger with another entity ("Reverse Morris Trust"). Following a bankruptcy petition by one of the entities involved, the bankruptcy trustee filed suit against the insureds for fraudulent transfer. The insureds notified the carriers, which, in turn, denied coverage even though the policies at issue had been specifically purchased to cover securities risks associated with this transaction. Ultimately, the trustee's lawsuit was settled, but the insureds had incurred $24 million in defense fees and costs in the process.

The insureds filed suit in Delaware and brought a motion for partial summary judgment on the issues of defense fees and costs and indemnification, and the insurers cross-moved to dismiss. The court granted the insureds motion, denied the insureds, and also found that all $24 million in defense fees and costs were reasonable as a matter of law and therefore covered. The insurers subsequently applied to the court for certification of an interlocutory appeal, arguing the court had made a number of errors (never a great position to be in).

The court rejected the application on the ground that its opinion was not of "a nature warranting interlocutory review" because the litigation was just a contract case. "As a general matter, issues of contract interpretation are not worthy of interlocutory appeal," the court held. The court went on to state that the challenged opinion "addresses unambiguous contractual language in an insurance contract applying accepted principles of Delaware law," which "does not necessarily create a 'substantial issue of material importance' out of a mere contract dispute" sufficient to warrant review. Moreover, because there was no indication that reversal of any single issue would end the litigation, there were no efficiencies to be gained through appeal at this time.

Finally, the insurers had not disputed the "reasonableness" of the insureds' attorneys fees and costs, and thus the opinion was not in conflict with other trial court decisions, which might also have warranted review.

3. Prepositions, intransitive verbs and other word forms to fight over.

[6] The court noted that the insurers had not actually addressed the "overwhelming hardship and inconvenience" standard in their briefing.

Our legal battles often turn on the placement of a comma, the use of "an" versus "the," and other minute details in sentence and grammar structures that drive clients, other attorneys, and judges crazy. However, it is these same details that make for targeted legal issues for courts to decide in the context of an insurer's defense obligations, as exemplified by the decisions below.

a. "Because of" v. "for"

In the last 12 months, courts across the country have handed down decisions addressing coverage in the context of opioid-related litigation. These cases have turned, in large part, on the meaning of two words and phrases: "because of" or "for."

The allegations in the cases are similar. Counties and states have sued insured defendants alleging the improper manufacture, distribution, marketing and/or sale of opioids, which, in turn, had led to opioid abuse, addiction, overdose and deaths throughout their jurisdiction. (Courts have noted some differences in the allegations, as explained below.)

The insureds, in turn, have sought coverage under general liability policies contending that the costs incurred by the plaintiff counties, and sought as damages in the litigation, were "because of" or "for" "bodily injury."

The following are simply examples of recent decisions in which courts have reached different outcomes regarding the meaning of these words and phrases, all in the context of summary judgment motions.

Motorist Mut. Ins. Co. v. Quest Pharmaceuticals, Inc., No. 5:19-cv-00187-TBR, 2021 WL 1794754 (W.D. Ky. May 5, 2021)[7] (damages sought were not "because of 'bodily injury'")

The district court granted the insurer's motion for summary judgment holding there was no coverage.

The policy at issued obligated the insurer to pay "damages because of "bodily injury" or "property damage.'" The district court held that, under Kentucky law, "***because of*** 'bodily injury'" was "interchangeable" with "***for*** 'bodily injury.'" (All emphasis added throughout unless otherwise indicated.)

The court rejected the insured's reliance on *Cincinnati Ins. Co. v. H.D. Smith*,[8] in which the Seventh Circuit had held that a policy covering damages "***because of*** 'bodily injury'" was broader than one covering damages "***for*** 'bodily injury.'"

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[7] Quest's appeal from the decision is pending before the Sixth Circuit.

[8] *Cincinnati Insurance Company v. H.D. Smith*, 829 F.3d 771, 774 (7th Cir. 2016) ("West Virginia alleged that its citizens suffered bodily injuries and the state spent money caring for those injuries—money that the state seeks in damages;" suit thus sought damages "because of" "bodily injury" and triggered defense.).

The court also rejected the insured's argument that damages should be covered when they arise "because of 'bodily injury'," noting that the policy does not use the phrase "arising out of."

Finally, the court concluded that the damages sought were not "for" "bodily injury." "[T]he plaintiffs in the Underlying Litigation do not need to provide proof that its citizens or patients experienced any bodily injury. Those allegations merely 'put a human touch' on the claims." Accordingly, the insurer had no duty to defend, much less indemnify, the insured.

Cincinnati Ins. Co. v. Discount Drug Mart, Inc., 183 N.E.3d 538 (Ohio Ct. App. 2021) (damages sought were potentially "because of 'bodily injury'")

The insurer filed an action for declaratory relief against its insured. On cross-motions for summary judgment, the trial court granted the insured's motion, finding the insurer had a duty to defend.[9] (Notably, under Ohio procedural law specific to declaratory judgment actions, the trial court's order was treated as final and was therefore appealable.)

The trial court rejected the insurer's argument that "because of" and "for" were interchangeable. Because at least part of the claimed damages were for services that the counties have arguably had to provide "because of bodily injury," the insurer had a duty to defend.[10] "Therefore, although the counties are expressly seeking economic damages, we find that at least part of those claimed damages are for services that the counties have arguably had to provide "'because of bodily injury.'"

ACE American Insurance Company v. Rite Aid Corp., 270 A.3d 239, 241 (Del. 2022) (damages sought were not "because of 'bodily injury'")

The insured sued in Delaware Superior Court, and moved for summary judgment on the insurers' duty to defend. The trial court granted the motion, and the Supreme Court granted the insurer's application for interlocutory review.

The Delaware Supreme Court reversed and held the insurer had no duty to defend because the county plaintiffs were not seeking damages "because of" "bodily injury" to their citizens.

The Counties' complaints were not alleging personal injury damage claims for or on behalf of individuals who suffered or died from the allegedly abusive prescription dispensing practices. In fact, the Counties expressly disclaim personal injury damages to plead around Ohio statutory law. Accordingly, the Counties made clear that they "do not seek damages for death, physical injury to person, emotional distress, or physical damages to property," their costs "are of a different kind and degree than Ohio citizens at large" and could only be suffered by them (the Counties), and "are not based upon or derivative of the rights of others." The Supreme Court thus concluded that the Counties "disavow personal injury claims" and seek to recover only their

[9] The insured first moved to transfer the case to its home county, but that motion was denied.

[10] *See also Acuity v. Masters Pharm., Inc.*, 1st Dist. Hamilton No. C-190176, 2020-Ohio-3440, 2020 WL 3446652. *Acuity* was accepted for review by the Ohio Supreme Court. *See Acuity v. Masters Pharmaceutical, Inc.*, 159 N.E.3d 277 (Ohio 2020).

own economic damages from Rite Aid's alleged contribution to a "public health crisis" of opioid addiction.

AIU Inc. Co. v. McKesson Corp., No. 20-CV-07469-JSC, 2022 WL 1016575, at *1 (N.D. Cal., Apr. 5, 2022) (damages sought were potentially "because of 'bodily injury'")

On cross-motions for summary judgment on the insurers' duty to defend, the court found that the complaints against McKesson sought damages because of 'bodily injury,'" but that the insurers did not have to defend because the complaints did not allege an "occurrence."

In October and December 2017, respectively, Cuyahoga and Summit Counties of Ohio filed suit against McKesson and other defendants. The suits were consolidated into an opioid multidistrict litigation ("MDL"). The court found that the suits potentially alleged "bodily injury," and also potentially sought damages "because of" or "for" those bodily injuries. (Under the policies, "[d]amages because of Bodily Injury include damages claimed by any person or organization for care, loss of services or death resulting at any time from the Bodily Injury.") The court described the allegations as follows:

> The government plaintiffs allege they bear costs to provide various services to address and mitigate the bodily injury suffered by people in their jurisdictions. The government plaintiffs seek, among other relief, "[a]ctual damages," "[f]orfeiture," "abatement," "recovery of abatement costs," "restitution," "compensatory damages," "disgorgement," and "punitive damages."

Actual damages, restitution, and compensatory damages, among other forms of relief, the court said, could constitute reimbursement of the government plaintiffs' asserted costs of responding to and providing care for the alleged bodily injury. Thus, the requested relief at least potentially falls within the "plain and unambiguous meaning" of "damages for care, loss of services or death resulting at any time from the Bodily Injury."

The court rejected *ACE American Insurance Co. v. Rite Aid Corp.* as unpersuasive based on prior California law holding that government cleanup costs were incurred "because of" "property damage." Thus, the counties' costs to provide services and mitigate "bodily injury" caused by opioids were likewise "because of" "bodily injury."

Moreover, as in *Rite Aid,* the policies cover "damages claimed by any person or organization for care, loss of services or death resulting at any time from the Bodily Injury." The court agreed with the *Rite Aid* dissent, finding that "[n]othing in the policy language limits coverage to claims asserted by the person injured, a person recovering on behalf of the person injured, or an organization that treated the person injured…."

b. <u>"Arising out of"</u>

"Arising out of" is another phrase that is frequently invoked in motions for summary judgment, particularly in the duty to defend context. The following are some examples of recent cases addressing the phrase and its implications on an insurer's duty to defend.

Landry's Inc. v. Insurance Co. of the State of Pa., 4 F.4th 366 (5th Cir. 2021)

This case is illustrative of the breadth a court can give the phrase "arising out of" when used in an insuring agreement.

Landry's operates retail properties like restaurants, hotels, and casinos. Paymentech processes credit card payments to those retail properties. Paymentech discovered some credit card problems with Landry's and began an investigation, which, in turn, uncovered a data breach. The data breach involved an unauthorized program on Landry's processing devices that searched for data from credit cards' magnetic strips—including the cardholder's name, card number, expiration date, and internal verification code—as the information was being routed through the payment-processing systems. The program retrieved personal information from millions of customers' credit cards, some of which was used to make unauthorized charges.
The lawsuit at issue was filed by Paymentech against Landry's, alleging that Landry's had breached the parties' agreement and was also responsible for losses assessed against Paymentech by Visa and Mastercard. The district court granted the insurer's motion for summary judgment.

The Fifth Circuit reversed, however, and held that the insurer had a duty to defend under Coverage B (personal and advertising injury) of the CGL policy. The policy covered "personal and advertising injury," defined as "injury ... arising out of one or more of the following offenses: … (e) Oral or written publication, in any manner, of material that violates a person's right of privacy;…." The question under the policy was whether the potential liability resulting from this data breach arose from "an oral or written publication."

The Fifth Circuit first adopted a broad definition of publication, finding that because the policy covered a "publication, in any manner," it did not matter that a third party was responsible for sharing the information; the analysis focuses on whether anyone "expos[ed] or present[ed] [information] to view."

The court then rejected the insurer's argument that the claim was not covered because it arose from the insured's alleged breach of contract, and not a violation of privacy rights. The court focused on the phrase "arising out of" to hold that the policy "does not simply extend to violation of privacy rights; the Policy instead extends to all injuries that arise out of such violations."

Moreover, the facts alleged in the Paymentech complaint constitute an injury arising from the violation of customers' privacy rights, as those terms are commonly understood. It does not matter that Paymentech's legal theories sound in contract rather than tort.

What is particularly notable about this decision is that the underlying litigation was, in essence, a business dispute. But because the contract claims arose from publication of the credit card holders' personal information, the insurer's duty to defend was triggered.

James River Insurance Company v. Rawlings Sporting Goods Company, Inc., No. CV 19-6658-GW-MAAX) 2021 WL 346418 (C.D. Cal., Jan. 25, 2021)

Rawlings manufactures sports equipment. A class action complaint was filed against it alleging that Rawlings misrepresented the weight of its baseball bats. The allegations were that the actual weight of a Rawlings' bat is often heavier than the sticker weight or the weight implied by the other information on the bat's labeling. The suit stated consumer protection claims against Rawlings, including violations of California's Unfair Competition Law, False Advertising Law and Consumer Legal Remedies Act.

The insurer denied its duty to defend and indemnify under a D&O policy based on an "anti-trust exclusion" which provided:

> This policy shall not cover any Loss in connection with any Claim ***alleging, arising out of, based upon or attributable to*** any violation of any law, whether statutory, regulatory or common, as respects any of the following: anti-trust, business competition, unfair trade practices or tortious interference in another's business or contractual relationships; provided, however, that this exclusion shall apply only to the Company.

The issue was whether the consumer protection claims in the class action were ones "alleging, arising out of, based upon or attributable to any violation of any law ... as respects ... unfair trade practices." The court ruled the exclusion did not apply.

The court gave a narrow construction to the term "unfair trade practices" for the following reasons. Although the state statutes at issue prohibited or referred to unfair acts or unfair trade practices, that alone did not define the phrase. (There were other state statutes not at issue, including antitrust laws, that also used similar language.)

Moreover, "unfair trade practices" was surrounded by other types of business conduct targeted at other businesses, not consumers.

The court acknowledged the breadth of terms like "any" and "arising out of," but ultimately those terms did not help define what "unfair trade practices" meant in the first place.

Additional problems with the exclusion were that it failed to mention the types of consumer-oriented conduct described in the rest of the exclusion, and seems to run counter to the broad promise of coverage for "***any*** actual or alleged breach of duty, neglect, error, misstatement, misleading statement, omission or act" by Rawlings.

IV. Recent Noteworthy Developments

1. *Monroe Guaranty Ins. Co. v. BITCO Gen. Ins. Corp.*

The insurer's duty to defend is a key feature of any liability insurance policy. While most jurisdictions apply some variation of the "eight corners" rule, comparing the allegations within the four corners of a complaint with the terms contained within the four corners of the policy, the application of this rule is not always straightforward. The majority of jurisdictions permit the use of extrinsic evidence as a supplement to the allegations of the complaint, though to differing extents.

The Texas Supreme Court's recent decision in *Monroe Guaranty Ins. Co. v. BITCO Gen. Ins. Corp.*, No. 21-0232, 2022 WL 413940 (Tex. Feb. 11, 2022), potentially adds a wrinkle to duty to defend determinations in Texas. Historically, Texas courts recognized only one exception to the "eight corners" rule – the so-called *Northfield* exception,[11] which permits courts to consider extrinsic evidence bearing solely on coverage facts when the eight-corners analysis is not determinative of whether coverage exists or does not exist due to gaps in the plaintiff's pleading.

In *Monroe Guaranty Ins. Co*., the Court addressed the ultimate question of whether an insurer owed a duty to defend a suit in which the plaintiff alleged that the insured negligently drilled an irrigation well, damaging the plaintiff's land, but also addressed whether Texas law permits consideration of stipulated extrinsic evidence to determine whether the duty to defend exists when the plaintiff's pleading is silent about a potentially dispositive coverage fact. Specifically, the Court addressed two certified questions from the Fifth Circuit:

(1) Whether the *Northfield* exception is permissible under Texas law; and

(2) Whether the date of an occurrence is a type of extrinsic evidence that may be considered when these requirements are satisfied.

The facts of this decision were unremarkable, as the dispute turned upon the timing of a drill bit becoming dislodged and damaging property that implicated one of the insurer litigants' policies. However, the Court's holding was significant. The Court first concluded that the *Northfield* exception is permissible under Texas law provided the extrinsic evidence (1) goes solely to the issue of coverage and does not overlap with the merits of liability, (2) does not contradict facts alleged in the pleading, and (3) conclusively establishes the coverage fact to be proved. *See id*. at *1. The Court next held that stipulated facts can be considered under these circumstances, but it declined to consider the stipulation at issue because it overlapped with the merits of liability. *See id*. In reaching this conclusion, the Court was clear that the "eight corners" rule remains the default in Texas:

> Today, we expressly approve the practice of considering extrinsic evidence in duty-to-defend cases to which *Avalos* does not apply. In doing so, we do not abandon the eight-corners rule. It remains the initial inquiry to be used to determine whether a duty to defend exists, [citation], and it will resolve coverage

[11] The "*Northfield* exception was articulated by the Fifth Circuit in *Northfield Ins. Co. v. Loving Home Care, Inc.*, 363 F.3d 523 (5th Cir. 2004).

> determinations in most cases. But if the underlying petition states a claim that could trigger the duty to defend, and the application of the eight-corners rule, due to a gap in the plaintiff's pleading, is not determinative of whether coverage exists, Texas law permits consideration of extrinsic evidence provided the evidence (1) goes solely to an issue of coverage and does not overlap with the merits of liability, (2) does not contradict facts alleged in the pleading, and (3) conclusively establishes the coverage fact to be proved.

Id. at *6 (citation omitted). Nonetheless, it is likely that this new exception will lead to additional litigation regarding the nature and extent of "gaps in a plaintiff's pleading" that permit the use of extrinsic evidence and the types of evidence that may be used.