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D&O "Capacity Exclusion" May Bar Coverage When Acting Outside the Scope of Insured Status

By Ellis I. Medoway

Directors' and officers' (D&O) policies insure against claims arising from alleged wrongful acts attributed to directors and officers of the insured entity—provided they were principally engaged in that capacity at the time the alleged wrongful conduct was committed. In other words, such coverage is placed in question when the insureds accused of the alleged wrongful conduct were not acting strictly within their insured role.[1] In that circumstance, the D&O insurer will undoubtedly invoke its policy's "capacity exclusion" to bar coverage.

Not many cases have addressed this coverage issue, and only a few appellate courts have rendered rulings on the exclusion. Recently, a New Jersey appeals court, in a case of first impression, applied the exclusion and barred coverage.[2] That decision and other more recent decisions on the D&O policy's capacity exclusion are the subject of this article.

Overview

D&O policies are "claims made" policies. They cover claims brought against the insured during the time the policy is in effect, even if the conduct leading to that potential liability did not occur during the policy period.

These policies offer protection to those who sit on boards of directors, so they are shielded from the significant liability risks associated with their corporate roles. But like all policies, D&O policies contain several exclusionary provisions. One such exclusion is the "capacity exclusion." As long as the insured is acting strictly in his or her capacity as a director or officer on behalf of the company (the insured entity), the insured may be covered. However, if that board member acts outside his or her corporate role, the exclusion may be triggered to bar coverage. Although the capacity exclusion may not be identical in every D&O policy, the language is often very similar. One example of that exclusion is as follows:

> [T]he Insurer shall not be liable to make any payment for Loss in connection with a claim made against any Insured:
> * * *
> G. based upon, arising out of, directly or indirectly resulting from or in consequence of, or in any way involving any Wrongful Act of an Insured Person serving in their capacity as director, officer, trustee, employee, member or governor *of any other entity other than an Insured Entity* or an Outside Entity, or by reason of their status as director, officer, trustee, employee, member or governor of such other entity.[3]

This exclusion eliminates coverage if the insurer can demonstrate that the insured's alleged wrongful act or acts arose from conduct outside his or her capacity as a director or officer of the insured entity. The burden, of course, rests with the insurer to establish this. The insurer thus

must show the insured's wrongful acts arose from conduct in his or her capacity as a director or officer of some entity *other than the insured entity.*

In the four cases to be discussed next, in which insurers invoked the capacity exclusion, only one court found the exclusion did not apply.

Recent Decisions: *Langdale Co. v. National Union Fire Insurance*

In 2015, the Eleventh Circuit Court of Appeals concluded that a family-owned company's D&O policy did not cover claims made against officers and directors of that insured entity based on the policy's capacity exclusion. In *Co. of Pittsburgh, Pennsylvania*,[4] the underlying litigation involved alleged misconduct committed by family members who were serving simultaneously as officers of the family business and as trustees of a family trust that held a substantial amount of the company's stock. The trust beneficiaries sued two company officers in Georgia state court, asserting, among other things, that they breached their fiduciary duty as directors of the company by, essentially, causing the beneficiaries to sell their stock interests to the family-owned business at a price far below fair market value.[5]

After the trust beneficiaries filed suit, the company filed a separate action in Georgia state court against the beneficiaries seeking a declaration that it held clear title to certain company stock. In that second action, the beneficiaries filed a counterclaim asserting, among other things, the company's respondeat superior liability for its directors' and officers' misconduct. These two state court actions were later "consolidated into one action in Georgia state court" (the underlying litigation).[6]

The company notified its insurer, National Union, of the underlying litigation, seeking defense and indemnity for the directors and officers and the family-owned business. National Union denied coverage based on its Capacity Exclusion 4(g). That exclusion barred coverage for any claim "alleging, arising out of, based upon or attributable to" the company directors' or officers' "actual or alleged act[s] or omission[s]" in any capacity other than as a director or officer of the family company.[7] The company then filed suit against National Union in federal court, seeking damages as well as declaratory relief.[8]

The district court granted National Union's motion for summary judgment. The court held the D&O policy's Exclusion 4(g) barred coverage because, "but for" the acts of the insureds in their capacity as "trustees" in breaching their fiduciary duty, there could not have been any claim made against those insureds. Applying Georgia law, the court emphasized that the "genesis" of the underlying litigation and those causes of action arose out of the trustees' alleged wrongful acts, rather than the alleged wrongful conduct of the insureds in their capacity as officers and directors of the family company.[9]

On appeal, the Eleventh Circuit affirmed, finding the D&O policy's capacity exclusion barred coverage. The appeals court rejected the insureds' argument that because the underlying litigation also contained allegations that the directors' and officers' wrongful conduct occurred in their insured capacity contributed to the beneficiaries' alleged loss, that was sufficient to trigger coverage under the company's D&O policy. Applying Georgia's "but for" test based on the

exclusion's "arising out of" language, the court observed: "[T]he causes of action alleged against [the company] could not have existed in the absence of the claims that [the officers and directors] committed wrongful acts in [their] uninsured capacity as trustees."[10] In other words, even though the court recognized the underlying litigation involved "dual-capacity misconduct committed by the same actors," that could not override the capacity exclusion's application.[11]

Recent Decisions: *Goggin*

A similar result followed a few years later in *Goggin v. National Union Fire Insurance Co.*,[12] in which a Delaware trial court concluded that a D&O policy's identical capacity exclusion barred coverage under Delaware law.[13]

In *Goggin*, two directors (Goggin and Goodwin) of a company (U.S. Coal Corporation) sued its insurer, National Union, seeking declaratory relief to determine the scope of coverage available under the company's D&O policy. The company had filed for Chapter 7 bankruptcy. After that filing, the trustee for U.S. Coal sued the two directors, claiming they engaged in self-dealing at the company's expense. The directors tendered the claim to National Union, requesting defense and indemnity coverage, which request was denied based on the same capacity exclusion discussed previously in *Langdale* (i.e., Exclusion 4(g)). Suit followed in Delaware state court with the directors seeking a declaration that the capacity exclusion did not apply and thus National Union had to defend them.[14]

Goggin and Goodwin were both directors of U.S. Coal, as well as investors in that company. In their "uninsured" capacity as investors, they "purportedly attempted to reinvigorate U.S. Coal through debt purchase and other capital restructuring by forming two investment vehicles" (referred to as the ECM Entities).[15] According to the trustee, however, the two directors "breached their fiduciary duties and committed other acts in favor of their own personal interests" at the expense of U.S. Coal.[16] Specifically, the trustee alleged Goggin and Goodwin "schemed to form and use the ECM Entities to control U.S. Coal and defraud its creditors by, among other things, entering various agreements that secured them: benefits of a high return on investment; preferred recovery in the event of U.S. Coal's liquidation; and a loan at a discounted value." This "self-interested dealing . . . [thus] undermined the interest of U.S. Coal and its debtors and creditors."[17]

In moving for judgment on the pleadings[18] and a declaration that National Union had a duty to defend them under the company's D&O policy, the directors argued that the capacity exclusion did not apply because it was designed solely to address "a wholly 'uninsured' activity or duty." The directors further argued the exclusion was not intended to bar coverage unless the alleged misconduct was "taken 'solely' in an insured capacity."[19] Under their interpretive construction, Goggin and Goodwin would be entitled to coverage in their dual capacity as investors and directors of the company because whatever alleged wrongful acts they engaged in, in their capacity as directors, was independent from their alleged misconduct in their uninsured capacity as investors of the company.

The court rejected that interpretation, finding the capacity exclusion's language to be "clear and unambiguous."[20] The court observed the exclusion's "arising out of" language must be construed

broadly under Delaware law, and the court adopted the same "but-for" test applied in *Langdale*.[21] Applying that test, the court concluded National Union's capacity exclusion barred coverage because "but for" Goggin's and Goodwin's alleged misconduct in their roles as "members/managers of [the] ECM Entities," the trustee's claims could not be established.[22]

The *Goggin* court, like the court in *Langdale,* thus ultimately concluded that National Union's capacity exclusion applied to bar coverage even when the insured director or officer was alleged to have breached his fiduciary duty while acting in his insured capacity under the D&O policy. In other words, both courts rejected the argument that the exclusion might not apply when the director or officer was acting in a dual capacity and the alleged wrongful acts included misconduct that was attributed to the director or officer while acting in his insured capacity on behalf of the insured entity. The rationale for applying the exclusion in these dual-capacity circumstances was the court's adoption of the "but for" test to determine whether a claim may be covered under the D&O policy. In short, applying the "but for" test apparently leaves no room for flexibility to consider the independent allegations involving the director's or officer's misconduct in his or her insured capacity.[23]

Recent Decisions: *Abrams*

A contrary result was obtained more recently in *Abrams v. Allied World Assurance Co. (U.S.) Inc.*,[24] in which the court determined that the D&O policy's capacity exclusion did not apply. In *Abrams*, the court concluded the breach of fiduciary duty claims asserted against the insured directors in the "underlying action" arose solely from their alleged misconduct while engaged in their insured capacities as directors of the insured entity; thus, the exclusion was not triggered.[25] In arriving at that conclusion, the district court did not consider the factual backdrop presented to align with a "dual capacity" situation as was presented in *Langdale* and *Goggin*.

Abrams involved five former officers and directors of a California corporation (Altierre) who also held various positions simultaneously at another company, Stratim Capital, LLC. One Altierre officer (Abrams) was the principal of Stratim, another Altierre officer (Such) was a Stratim partner, and the other three Altierre officers held positions at a Stratim-related company.[26] One of Altierre's minor shareholders (Kline Hill) filed the underlying action against the five Altierre officers and directors, claiming they breached their fiduciary duties owed Altierre. That action also asserted similar claims against various Stratim-related companies.

It was alleged that once Abrams took control of Altierre's board of directors, he was able to take certain actions benefiting Stratim to the detriment of Altierre. The defendants' alleged wrongful acts included approving "a secret agreement" with Altierre's main secured creditor, thereby allowing that creditor to foreclose on Altierre's assets, and then flipping those assets to a "Stratim affiliate" on the same day. The stripping of Altierre's assets allegedly left the company's other shareholders with a shell corporation worth nothing.[27]

Abrams and the other four defendants tendered the underlying action to Altierre's insurer, Allied World Insurance Company (U.S.) Inc., which denied coverage based on its D&O policy's "Insured Capacity Exclusion." That exclusion barred coverage for any loss, "alleging, arising out of, based upon or attributable to any actual or alleged act or omission of any Insured Person serving in any capacity other than as an Executive. . . ."[28]

The insureds then sued Allied in federal court, asserting claims for (1) declaratory relief requiring Allied to defend and indemnify them against the underlying action, (2) breach of contract, and (3) bad faith. The insureds moved for partial summary judgment, contending Allied's capacity exclusion was not applicable to the allegations in the underlying action.[29] They argued they should be covered under Allied's D&O policy because the claims brought against them in the underlying action arose from alleged wrongful acts that were taken *solely* in their insured capacities as executives of Altierre. In contrast, Allied argued there should be no coverage because the claims in the underlying action arose "at least in part from the [i]nsureds' acts in their uninsured capacities as agents of Stratim and Stratim-related companies."[30] In essence, Allied was claiming its capacity exclusion applied because the insureds were acting in a dual capacity on behalf of themselves and Stratim-related entities at the expense of Altierre and its minority shareholders. Indeed, the allegations in the underlying action suggested as much, leading the court to observe that the "gist" of the underlying action was that the insureds "took control of and looted Altierre for the benefit of Stratim and Stratim-related companies."[31]

Abrams served in a dual capacity as an Altierre executive and principal of Stratim. Abrams allegedly took control of Altierre's board of directors "'to entrench Stratim's position' in Altierre while taking various actions that were detrimental to Kline Hill and other investors." The underlying action even referred to Abrams as an "agent" of the Stratim companies who executed documents on Stratim's behalf to assist in the foreclosure of Altierre's assets.[32] In evaluating the coverage dispute under California law, the court initially observed that there was "a surprising dearth of cases interpreting capacity exclusions under California insurance law."[33] Indeed, the court noted the parties cited only one such case—*XL Specialty Insurance Co. v. AIG Specialty Insurance Co.*[34]—in which another California district court concluded a D&O policy's capacity exclusion did not apply because the alleged wrongful conduct asserted against the director defendants arose solely from their actions taken in their insured capacities as executives of the insured entity.[35] Although the *Abrams* court recognized that the underlying allegations clearly made this a "closer call" than in *XL Specialty*, ultimately it found the capacity exclusion was not triggered. Agreeing with the reasoning of *XL Specialty*, the court found the exclusion did not apply because the claims asserted against the insureds similarly were for breach of fiduciary duties they owed solely based on their insured capacities as executives of Altierre.[36]

In finding the capacity exclusion did not bar coverage "as a matter of law," the *Abrams* court expressly declined to follow the decisions in *Langdale* and *Goggin* because they were "out-of-state cases" that did not apply California law.[37] The *Abrams* court also rejected those decisions because the courts in *Langdale* and *Goggin* "found that the insureds were acting in dual capacities, which impacted application of the capacity exclusions." However, in *Abrams*, the court concluded the insured directors were not acting in a "dual capacity" because the underlying claims against them focused solely on their alleged misconduct committed in their insured capacities as directors of Altierre.[38]

Because the *Abrams* court concluded the underlying actions did not present a "dual capacity" situation, presumably there was no need to address the "but-for" test adopted in *Langdale* and *Goggin*.[39]

In July 2024, a New Jersey appellate court adopted the "but-for" test in a dual-capacity case and, as in *Langdale* and *Goggin*, concluded the D&O capacity exclusion barred coverage. In *Mist Pharmaceuticals, LLC v. Berkley Insurance Co.*, the court noted the coverage issue before it presented "a matter of first impression" involving "the operation of capacity exclusion language in a directors and officers commercial insurance policy where the insured director/officer is alleged to have engaged in wrongful corporate acts in a dual capacity: first, acting in an official capacity as a director/officer of the insured business; and second, in an official capacity as a director/officer of an uninsured business."[40]

Recent Decisions: *Mist Pharmaceuticals*

Mist Pharmaceuticals presented a rather complex factual record. The underlying action involved Mist being sued by CelestialRX Investments, LLC, in Delaware state court along with several other named parties.[41] These other parties included (a) Joseph Krivulka, (b) Akrimax Pharmaceuticals, LLC, and (c) various other Krivulka family entities. Celestial alleged that Krivulka—who was the chairman of Mist's board of directors and held a majority interest in that company, while simultaneously serving as a director of Akrimax—engaged in self-dealing that defrauded Celestial. Specifically, Celestial alleged that Krivulka improperly inserted various entities he controlled as "middlemen" between Akrimax and other pharmaceutical companies from which Akrimax sought to receive certain drug-related rights. These "middlemen" allegedly received "a cut of the sales or marketing performed by Akrimax." Mist was identified as one of the "middlemen" entities that engaged in this alleged wrongful conduct.[42]

Mist and Krivulka sought coverage from their insurer—Berkley Insurance Co.—for the claims in the underlying action. Mist was covered for wrongful acts under a D&O policy issued by Berkley with a $2 million policy limit. Krivulka also was covered under the Berkley policy, provided no exclusion applied. The policy contained a "capacity exclusion" (Exclusion G) that stated:

> [T]he Insurer shall not be liable to make any payment for loss in connection with a claim made against any Insured:
>
> G. based upon, arising out of, directly or indirectly resulting from or in consequence of, or in any way involving any Wrongful Act of an Insured Person serving in their capacity as director, officer, trustee, employee, member or governor *of any other entity other than an Insured Entity* or an Outside Entity, or by reason of their status as director, officer, trustee, employee, member or governor of such other entity.[43]

Berkley sent Mist a reservation of rights letter reserving its right to deny coverage on several grounds, one of which was that its capacity exclusion might "either bar or limit coverage." When Mist later requested settlement authority for an upcoming mediation with Celestial, Berkley again emphasized the potential for no coverage and expressly reserved its rights based on the policy's capacity exclusion. Berkley further advised that it was no longer obligated to participate in Mist's or Krivulka's defense. As a result, Mist filed a declaratory judgment action in the New

Jersey Superior Court, Law Division, making the following claims: (i) breach of contract; (ii) duty to defend; (iii) duty to indemnify; (iv) bad faith; (v) estoppel for failure to timely deny coverage; and (vi) estoppel for failing to inform Mist of its right to reject a defense.[44]

Eventually, the Delaware court in the underlying action approved a $12 million global settlement, allocating 25 percent liability to Mist. Prior to that Mist, in the course of settlement negotiations, requested that Berkley consent to settlement and also provide indemnification, which requests were denied. Thereafter, Mist and Berkley filed several dispositive motions in the declaratory judgment action.[45] In ruling on those motions, the New Jersey trial court ultimately concluded that Berkley's withholding consent to settle was unreasonable and therefore Mist was entitled to coverage under the New Jersey Supreme Court's decision in *Fireman's Fund Insurance Co. v. Security Insurance Co. of Hartford.*[46] Based on that ruling, the court found it was unnecessary to reach the other coverage issues raised, including Berkley's argument that the capacity exclusion barred coverage. On appeal, Berkley argued its motion for summary judgment should have been granted and that the trial court erred by failing to apply that exclusionary provision.[47]

In reversing the trial court, the appeals court first rejected the lower court's reliance on *Fireman's Fund*. Although the appellate court found a similarity of facts presented in *Fireman's Fund*, the court concluded there were "material distinctions" in *Mist Pharmaceuticals* that required a review and analysis of the capacity exclusion. The appeals court thus observed:

> However, unlike *Fireman's Fund*, Berkley asserted withholding consent to settle was reasonable given the relevant facts—that the global settlement represented the separate interests of multiple entities not insured under the policy, and Berkley reserved its rights under the capacity exclusion repeatedly from its earliest communications with Mist regarding the claim. These are material distinctions that the trial court should have considered, and the court's legal analysis would have been better informed if it had first addressed the application of the policy's capacity exclusion.[48]

Turning to the exclusion, the court pointed out that New Jersey courts "have not analyzed a capacity exclusion paragraph in a commercial D&O policy on facts like this before."[49] Nonetheless, the court noted that the exclusion's language "'arising out of,' which frequently appears in insurance policies, has been interpreted expansively by New Jersey courts in insurance coverage litigation."[50] In the absence of any New Jersey precedent on the capacity exclusion and looking for guidance from outside jurisdictions, the appeals court found the Eleventh Circuit decision in *Langdale* to be persuasive. The New Jersey appeals court thus "adopt[ed] [the] Eleventh Circuit's sound interpretation of the . . . capacity exclusion given the similarity in language, operation and effect between *Langdale's* and Berkley's capacity exclusion."[51]

In further step with *Langdale*, the New Jersey appeals court also adopted the "but for" coverage analysis employed in *Langdale*[52] (as well as in *Goggin*). By employing that test, the court believed that it was not required to "unpack the percentage of Krivulka's conduct attributable to

his role as a director/officer at Akrimax and compare it to the percentage of Krivulka's conduct attributable to his role as a director/officer at Mist."[53] The court's rationale for not having to engage in the more complicated and messy exercise of "unpacking" and allocating what conduct of Krivulka's was covered as an insured director/officer as opposed to an uninsured director/officer was predicated on "[t]he clear language in the policy" and because the "jurisprudence . . . applied to it foster a simpler approach."[54]

In light of the above analysis, the New Jersey appeals court concluded that Krivulka's conduct "constituted a sufficient basis to trigger the capacity exclusion";[55] thus, there was no coverage under Berkley's policy for Krivulka, as well as Mist—which raises a separate question as to why no coverage was available to the insured entity for its own liability. In any event, because the court held that the capacity exclusion barred coverage, it "follow[ed] that Berkley's refusal to consent to a settlement by Mist was not unreasonable."[56]

Conclusion

While there is a dearth of cases that have addressed the D&O capacity exclusion in a dual-capacity setting, the majority of courts that have evaluated that exclusionary language have ruled favorably for insurers when the exclusion is invoked. Whether future courts will continue to follow that trend—employing the "but for" test and refusing to "unpack" what might be covered and not covered when dual-capacity allegations are presented—is yet to be seen. However, what is clear from these decisions is the potential for significant consequences when a director or officer also sits on other boards or is engaged in other businesses or activities and there is some overlap between that director's or officer's actions taken in an insured capacity as opposed to actions he or she might take in an uninsured capacity. These decisions simply highlight why it is important for directors and officers sitting on boards to consider legal consultation so they understand the coverage risks involved and the potential significant exposure they face when their actions might be construed as inconsistent with their fiduciary duties owed the insured entity they serve.

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[1] A similar "capacity" exclusion appearing in a lawyer's professional liability policy has also been applied to bar coverage when the lawyer's alleged wrongful acts are found not to have been performed principally in his professional capacity as an attorney. *See, e.g.*, *Law Offices of Zachary R. Greenhill, P.C. v. Liberty Ins. Underwriters, Inc.*, 147 A.D.3d 418 (N.Y. App. Div. 2017) (applying capacity exclusion under New York law and barring coverage based on pleadings in the underlying action and record evidence that showed lawyer's questionable conduct occurred only in his capacity as president and chief executive officer of a corporate entity, rather than in providing professional services as a lawyer); *Associated Indus. Ins. Co. v. Kleinhendler*, 2023 U.S. App. LEXIS 32327, at *3 (2d Cir. Dec. 23, 2023) (applying New York law where lawyer was alleged to have committed malpractice and concluding lawyer was not

entitled to a defense because his alleged wrongful conduct included actions he took on behalf of his company in connection with the sale of his client's property); *but see Niagara Fire Ins. Co. v. Pepicelli, et al.*, 821 F.2d 216, 220 (3d Cir. 1987) (rejecting exclusion's application under Pennsylvania law because core "claims" at issue involved alleged breach of contract and professional negligence by insureds in rendering services in their principal capacity as lawyers).

[2] *Mist Pharms., LLC v. Berkley Ins. Co.*, 479 N.J. Super. 126 (N.J. Super. Ct. App. Div. 2024). Mist, the policyholder, filed a petition for certification to the New Jersey Supreme Court, which appeal is still pending. (*See* N.J. Supreme Court Docket No. 089689; *see also* N.J. Court Rule 2:12-3). By orders entered on December 2, 2024, the parties were granted additional time for briefing that appeal. Research has not disclosed any state supreme court that has addressed this coverage issue.

[3] Emphasis added. This "Exclusion G" was the subject of analysis in the New Jersey appeals court decision in *Mist Pharmaceuticals*, 479 N.J. Super. at 132, which will be discussed in the next section of this article.

[4] *Langdale Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 609 F. App'x 578 (11th Cir. 2015).

[5] *Langdale*, 609 F. App'x at 579–81. The trust beneficiaries received approximately $27 million for their stock sold to the family company but claimed the true value of that stock was worth more than $150 million.

[6] *Langdale*, 609 F. App'x at 582–83.

[7] *Langdale*, 609 F. App'x at 582–83, 586.

[8] *Langdale*, 609 F. App'x at 583.

[9] *Langdale*, 609 F. App'x at 584.

[10] *Langdale*, 609 F. App'x at 590.

[11] *Langdale*, 609 F. App'x at 592, 596. As the Eleventh Circuit ultimately concluded in its application of the capacity exclusion, the claims against the family company based on the alleged wrongful conduct of the directors and officers in their insured capacity could not be separated "from their alleged misconduct as trustees of the [beneficiaries] Trust." Likewise, the claims against the directors and officers in their insured capacity "could not have existed independent from their alleged misconduct as trustees."

[12] *Goggin v. Nat'l Union Fire Ins. Co.*, C.A. No. N17C-10-083 PRW CCLD, 2018 Del. Super. LEXIS 1533 (Del. Super. Ct. Nov. 30, 2018).

[13] *Goggin*, 2018 Del. Super. LEXIS 1533, at *11 (noting the National Union D&O policy exclusion in *Langdale* was "identical to this one" in *Goggin*).

[14] *Goggin*, 2018 Del. Super. LEXIS 1533, at *1–2.

[15] *Goggin*, 2018 Del. Super. LEXIS 1533, at *3–4.

[16] *Goggin*, 2018 Del. Super. LEXIS 1533, at *4.

[17] *Goggin*, 2018 Del. Super. LEXIS 1533, at *11–12.

[18] *Goggin*, 2018 Del. Super. LEXIS 1533, at *6. Under Delaware law, a party may move for judgment on the pleadings pursuant to Delaware Civil Rule 12(c), which standard of review is almost identical to the standard for a motion to dismiss.

[19] *Goggin*, 2018 Del. Super. LEXIS 1533, at *8.

[20] *Goggin*, 2018 Del. Super. LEXIS 1533, at *10.

[21] *Goggin*, 2018 Del. Super. LEXIS 1533, at *11.

[22] *Goggin*, 2018 Del. Super. LEXIS 1533, at *12 (noting the directors' "alleged ECM-related misconduct . . . [was] the core of the Trustee's Claims").

[23] *Goggin*, 2018 Del. Super. LEXIS 1533, at *11 (Del. Super. Ct. Nov. 30, 2018) (court noting that "[a] claim does not 'arise out of' a circumstance or conduct if, *independent* of that circumstance or conduct, the claim is still valid" (emphasis added)).
In the latter regard, it is also worth noting that the two directors in *Goggin* created the ECM Entities while they were acting as directors of U.S. Coal, with the apparent goal to assist and advance the company's interests. Further, "but for" their role as directors of U.S. Coal, the trustee's claims could not exist. Nonetheless, and despite the independent nature of the trustee's claims against Goggin and Goodwin in their insured capacity as directors, National Union's capacity exclusion was applied to bar coverage; consequently, no defense was provided.

[24] *Abrams v. Allied World Assurance Co. (U.S.) Inc.*, 657 F. Supp. 3d 1280 (N.D. Cal. 2023).

[25] *Abrams*, 657 F. Supp. 3d at 1287 (finding "claims asserted against the Insureds in the [underlying action] are for breach of fiduciary duties owed solely based on their capacities as [the insured company's] executives").

[26] *Abrams*, 657 F. Supp. 3d at 1282.

[27] *Abrams*, 657 F. Supp. 3d at 1283.

[28] *Abrams*, 657 F. Supp. 3d at 1284. Allied also denied coverage based on another exclusion—the "Major Security Holder Claims Exclusion." The court found that exclusion was not "plausible" and was also ambiguous based on California law; accordingly, the exclusion was not applicable and did not bar coverage. *Abrams*, 657 F. Supp. 3d at 1289.

[29] *Abrams*, 657 F. Supp. 3d at 1284.

[30] *Abrams*, 657 F. Supp. 3d at 1286.

[31] *Abrams*, 657 F. Supp. 3d at 1287.

[32] *Abrams*, 657 F. Supp. 3d at 1287.

[33] *Abrams*, 657 F. Supp. 3d at 1286.

[34] *XL Specialty Ins. Co. v. AIG Specialty Ins. Co.*, No. 2:20-cv-06540-VAP-SHKx, 2021 U.S. Dist. LEXIS 143269 (C.D. Cal. July 13, 2021).

[35] *Abrams*, 657 F. Supp. 3d at 1286. Notably, in *XL Specialty*, 2021 U.S. Dist. LEXIS 143269, at *59–60, the court—applying California law and construing AIG's D&O policy's capacity exclusion narrowly—found that, even if the allegations in the underlying matters could be viewed as creating a "dual capacity" situation for the defendant directors, AIG's capacity exclusion still would not apply. The *XL Specialty* court explained that the exclusion's language did "not address when liability arises from actions taken by covered executives in a covered and non-covered capacity" and, thus, that created an ambiguity that had to be resolved in the insureds' favor and "consistent with the insureds' reasonable expectations." *XL Specialty*, 2021 U.S. Dist. LEXIS 143269, at *60.
The *Abrams* court did not see a need to consider this alternative holding by the *XL Specialty* court because it concluded the underlying action's asserted claims for breach of fiduciary duties arose solely from the insureds' capacities as Altierre executives. *Abrams*, 657 F. Supp. 3d at 1287.

[36] *Abrams*, 657 F. Supp. 3d at 1287 (recognizing that the allegations involving the Stratim companies "certainly provided a motive for [the defendant directors'] actions," but emphasizing that the defendant directors were "not sued for breach of any fiduciary duties arising from their roles as Stratim executives").

[37] *Abrams*, 657 F. Supp. 3d at 1287–88.

[38] *Abrams*, 657 F. Supp. 3d at 1288.

[39] As noted above in endnote 35, the *XL Specialty* court reasoned in the alternative that even if a dual-capacity situation was presented, the capacity exclusion was ambiguous and thus coverage should be available to the insured directors. *XL Specialty*, 2021 U.S. Dist. LEXIS 143269, at *60. In discussing the dual-capacity scenario, the *XL Specialty* court did not suggest that a but-for test should be applied as it was in *Langdale* and *Goggin*.

[40] *Mist Pharmaceuticals, LLC v. Berkley Ins. Co.*, 479 N.J. Super. 126, 129 (N.J. Super. Ct. App. Div. 2024).

[41] *CelestialRX Invs., LLC v. Krivulka et al.*, No. 11733-VCG, 2017 Del. Ch. LEXIS 22 (Del. Ch. Jan. 31, 2017). Named defendant Krivulka passed away after the Delaware action was filed, prompting Celestial to file a corporate suit in New Jersey seeking a stay of and distribution of Krivulka's estate. *Mist Pharmaceuticals*, 479 N.J. Super. at 132. The "underlying action" referred to in this article focuses mainly on the Delaware Chancery action.

[42] *Mist Pharmaceuticals*, 479 N.J. Super. at 130–31.

[43] Emphasis added. *Mist Pharmaceuticals*, 479 N.J. Super. at 131–32.

[44] *Mist Pharmaceuticals*, 479 N.J. Super. at 133. Initially, Berkley agreed to contribute 10 percent of the legal fees incurred by Mist and Krivulka in their defense of the underlying action. In other words, it appears that Berkley initially believed its capacity exclusion did not bar all potential coverage, including an allocated amount for the insureds' defense.

[45] *Mist Pharmaceuticals*, 479 N.J. Super. at 135.

[46] *Fireman's Fund Ins. Co. v. Sec. Ins. Co. of Hartford*, 72 N.J. 63 (1976). In *Fireman's Fund*, the New Jersey Supreme Court held that where a policy has a consent to settle provision, the insurer has a duty not to unreasonably withhold consent to settle, and when the insurer breaches that duty, it is liable for indemnification in the amount of the settlement. The court observed that this obligation arises from "considerations of good faith and fair dealing," which "require that the insurer make such an investigation [of the insured's claim] within a reasonable time." *Fireman's Fund*, 72 N.J. at 69–70.

[47] *Mist Pharmaceuticals*, 479 N.J. Super. at 136.

[48] *Mist Pharmaceuticals*, 479 N.J. Super. at 138.

[49] *Mist Pharmaceuticals*, 479 N.J. Super. at 139.

[50] *Mist Pharmaceuticals*, 479 N.J. Super. at 139.

[51] *Mist Pharmaceuticals*, 479 N.J. Super. at 141. The court emphasized that, as in *Langdale*, Celestial's alleged loss stemmed from Krivulka's self-dealing as he "was acting in his capacity as both a director of Akrimax and majority shareholder of Mist," and it was "undisputed that Krivulka acted in a dual capacity." In that regard, the court further noted that the loss in the underlying action "arose from and could not have occurred but for Krivulka's conduct in his capacity as a director of Akrimax." *Mist Pharmaceuticals*, 479 N.J. Super. at 142.

[52] *Mist Pharmaceuticals*, 479 N.J. Super. at 142.

[53] *Mist Pharmaceuticals*, 479 N.J. Super. at 142.

[54] *Mist Pharmaceuticals*, 479 N.J. Super. at 142. Although New Jersey, like all jurisdictions, construes exclusions narrowly and places the burden on the insurer "to bring the case within the policy exclusion," *Mist Pharmaceuticals*, 479 N.J. Super. at 139, the appeals court found there was no need to "unpack" the allegations against Krivulka to determine what conduct might be covered as opposed to the excluded conduct he performed in an uninsured capacity. However, as previously noted in *XL Specialty*, 2021 U.S. Dist. LEXIS 143269, at *60 (C.D. Cal. July 13, 2021), the California district court, construing narrowly a similar D&O capacity exclusion, concluded that even if the factual record suggested the insured director was acting in a dual capacity, the capacity exclusion should not apply because that exclusion did not address when the alleged wrongful conduct arises from actions taken by a covered executive in a covered versus uncovered capacity. Similarly, the capacity exclusion in *Mist Pharmaceuticals* does not address that situation.

[55] *Mist Pharmaceuticals*, 479 N.J. Super. at 142.

[56] *Mist Pharmaceuticals*, 479 N.J. Super. at 142. If the New Jersey Supreme Court agrees to hear Mist's appeal, it will presumably have to determine whether it agrees with the appellate court's treatment of *Fireman's Fund* and, thus, whether Berkley's refusal to consent requires a reversal and reinstatement of the trial court's decision.

Insurance Coverage Litigation

Vol. 34 No. 1

Event Cancellation Insurance: Don't Shake (the Issues) Off

By Latosha M. Ellis and Yosef Y. Itkin

In today's unpredictable world, the need for event cancellation insurance has never been more evident. Whether it is a high-profile concert by a global superstar like Taylor Swift or an international sporting event like the Olympics, the potential for disruption looms large. Terrorism and war, adverse weather events, and pandemics contribute to the growing risks faced by event organizers, artists, and venues.

Despite the sparse case law addressing coverage issues in event cancellation policies, certain issues have been teased out to some degree. Frequently disputed coverage issues include whether certain exclusions apply, including the communicable disease exclusion and war exclusion; what "losses" (e.g., expenses, profits) will be covered; and whether a cause of loss is beyond the policyholder's control.

Become Familiar with Event Cancellation Insurance Issues

Event cancellation insurance is a specialized type of coverage designed to protect against financial losses when an event is canceled, postponed, or relocated[1] due to unforeseen circumstances beyond the policyholder's control.[2] It can cover a wide array of risks depending on the type of policy. Many policies are written on an "all-risk" basis, whereas others are issued on a specified perils basis. Depending on the terms of the policy, the insurance can protect policyholders from unforeseeable circumstances, such as inclement weather, earthquakes, power failures, non-appearances by performers, and terrorism. But a policy issued on a specified perils basis, such as a virtual event cancellation policy, will offer more limited coverage based on specified causes, such as the malfunction of necessary facilities (i.e., equipment vital for the event to proceed virtually) or the non-appearance of a key speaker. Or a policy may specify coverage only where the cause is the direct result of terrorism or loss arising out of adverse weather events such as "Storm, Cyclone, Typhoon, Tempest, Hurricane, Tornado, Flood and Inundation."

But one thing is evident: As global events become more complex and fraught with potential disruptions, the importance for insurance coverage practitioners to be familiar with the legal issues pertaining to this coverage has become increasingly clear.

Increased Threats of Event Disruption Implicate Coverage Issues

There are many circumstances that could affect proceeding with an event. More recently, the world has faced greater obstacles introduced by terrorism and war, adverse weather events, and a pandemic, all causing event disruptions and each potentially implicating exclusions to coverage.

Terrorism and War

Application of the war exclusion. The cancellation of Taylor Swift's concerts in Austria due to terrorist threats highlights the dangers that high-profile events face.[3] Particularly after the attacks on September 11, 2001, event cancellation policies commonly include exclusions for terrorist acts and war-related events.

The war exclusion generally bars coverage for damages caused by war or "warlike" actions. The term "war" "has been defined almost always as the employment of force between governments or entities essentially like governments, at least de facto."[4] Two of the leading cases addressing the war exclusion in an insurance policy are *Pan American World Airways, Inc. v. Aetna Casualty & Surety Co.*, under an aviation all-risk insurance policy, and *Holiday Inns Inc. v. Aetna Insurance Co.*, under an all-risk property policy. In both *Pan Am* and *Holiday Inns*, the courts refused to treat violent actions by Palestinian terrorist organizations targeting civilians as falling within the war exclusion.

Consistent with these prior cases, the Ninth Circuit held a few years ago, in *Universal Cable Products, LLC v. Atlantic Specialty Insurance Co.*, that the war exclusion in a television production insurance policy did not apply after a Hamas rocket attack forced NBC Universal to relocate a show production in Jerusalem during the 2014 Israeli-Palestinian conflict.[5] The war exclusion at issue excluded "undeclared or civil war," "insurrection, rebellion, revolution, [and] usurped power," and "[w]arlike action by a military force."[6] The court recognized that the war exclusion had achieved a specialized meaning ascribed to it when used in the insurance context,[7] and the court found that war "refers to and includes *only* hostilities carried on by entities that constitute governments at least de facto in character."[8] It concluded that Hamas was neither a de jure nor de facto sovereign, so its conduct could not be construed as "war" in the context of the war exclusion.[9] Much like *Pan Am* and *Holiday Inns*, this case demonstrates the need to look at the nature of the conflict and status of the party on each side to assess whether the exclusion could act as a bar to coverage.

In 2023, a New Jersey Superior Court Appellate Division panel examined the war exclusion in a property policy.[10] In *Merck*, the court rejected the insurers' attempts to invoke an exclusion for "hostile or warlike action" to avoid covering losses claimed by Merck & Co. resulting from the 2017 NotPetya malware cyberattack.[11] The malware was delivered to Merck's computers through accounting software developed by a Ukrainian company, spreading to over 40,000 Merck computers.[12] The decision was the first ruling on whether a traditional war exclusion bars coverage for a cyberattack.

The war exclusion at issue in *Merck* specifically excluded the following:

> Loss or damage caused by hostile or warlike action in time of peace or war, including action in hindering, combating, or defending against an actual, impending, or expected attack: (a) by any government or sovereign power (de jure or de facto) or by any authority maintaining or using military, naval, or air forces; (b) or by military, naval, or air forces; (c) or by an agent of such government, power, authority, or forces[.][13]

The court, taking a plain language view of the exclusion, agreed with the trial court that the exclusion would not apply to a cyberattack on a non-military company, even if it came from a government or sovereign.[14] Further, despite the rise in cyberattacks before the policies were issued, the insurers used standard war exclusion language, which Merck had the right to expect applied only to traditional warfare.[15] The court noted that past cases show the exclusion relates to

actions clearly tied to war or military objectives.[16] Based on this, the court concluded that a cyberattack was not the type of act contemplated by the exclusion.[17]

Similar to *Merck*, a case in Illinois state court, *Mondelez International Inc. v. Zurich American Insurance Co.*, involved an insurer's attempt to invoke a "war exclusion" under a property policy as a basis for not paying losses suffered by snack food giant Mondelez International due to the same incident in *Merck*, the 2017 NotPetya attack. The parties ultimately settled after nearly four years of litigation and weeks of trial. The settlement decision reflected and reinforced the court's ruling in *Merck* that the war exclusion did not apply to the cyberattack.

The war exclusion in event cancellation policies. *Pan Am*, *Holiday Inns*, *Universal Studios*, *Merck*, and *Mondelez* provide valuable insight into how courts may interpret an insurer's attempt to invoke the war exclusion in an event cancellation policy. Given recent developments in the law, particularly regarding cyberattacks, insurers have sought to broaden the scope of the exclusion in their policies. As a result, it is crucial for practitioners to stay informed about ongoing litigation concerning the application of the war exclusion.

For example, some event cancellation policies exclude the following:

> a. War, including undeclared or civil war; b. Warlike action by a military force, including action in hindering or defending against an actual or expected attack, by any government, sovereign or other authority using military personnel or other agents; or c. Insurrection, rebellion, revolution, usurped power, or action taken by governmental authority in hindering or defending against any of these.

This exclusion would cover actions nearly identical to those excluded in the television production policy reviewed by the Ninth Circuit in *Universal*, including "undeclared or civil war"; "insurrection, rebellion, revolution, [and] usurped power"; and "[w]arlike action by a military force."

As another example, the war exclusion in other event cancellation policies excludes

> loss or damage directly or indirectly occasioned by, happening through or in consequence of war, invasion, act of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition or destruction of or damage to property by or under the order of any government or public or local authority.

This exclusion bars coverage for war, hostilities, civil war, rebellion, revolution, insurrection, military action, and usurped power. Given the similarities to the war exclusion examined by the Ninth Circuit in *Universal*, it is likely that a court would apply the same reasoning and rule that "war" in event cancellation policies refers only to hostilities conducted by entities that are at least de facto governments as well.

It is likely that a court would find the war exclusions in event cancellation policies inapplicable to a cyberattack. Applying the reasoning from *Merck*, policyholders would have reasonably expected these exclusions to apply to traditional forms of warfare, given their alignment with standard war exclusion language. In addition, both exclusions reference hostile or warlike actions and terms like "military force," which in *Merck* were interpreted as relating to actions clearly connected to war or military objectives. The specific language is crucial, but for war exclusions in event cancellation policies with similar wording, the long-standing rulings in P*an Am*, *Holiday Inns*, and *Merck* should apply.

The terrorism exclusion in event cancellation policies. Recent developments in the law regarding the war exclusion, especially in the context of cyberattacks, have led insurers to expand this exclusion in their policies. At the same time, insurers are also increasingly adding terrorism exclusions. These exclusions may cover "any act of terrorism and/or the threat or fear of terrorism, whether actual or perceived," regardless of other contributing factors. It is crucial to carefully review policy language to understand whether coverage applies only when a terrorist attack occurs or whether it also covers threats of terrorism. In the latter case, it is essential to thoroughly document the threat and ensure it is deemed reasonable to avoid challenges that the threat was a hoax and the event should have proceeded.

Weather-Related Disruptions

Weather events have significantly altered the risk landscape for event organizers, particularly in relation to outdoor events. Over the years, sports and entertainment events have been affected by severe weather, ranging from hurricanes and snowstorms to extreme heat and flooding. Recently, Hurricane Milton in Florida caused the cancellation of preseason professional basketball games and postponed or canceled "countless" college and high school sporting events.[18] The entertainment industry has been affected too. In 2022 and 2023 alone, there were at least 21 music festival cancellations in the United States as a result of extreme weather.[19]

Although event cancellation insurance can offer protection against the risks of weather-induced disruptions, some policies may limit or altogether exclude coverage for "adverse weather." Thus, it is vital for a practitioner to be wary of weather-related issues when advising on procuring event cancellation coverage. An "adverse weather" exclusion may not be problematic for indoor events in a location with historically good weather. But for outdoor events, particularly in locations with devastating seasonal weather, the exclusion can be problematic.

The particular language will also be important. The exclusion may limit only certain types of weather, or it may exclude only weather events that are so extreme that they prevent attendees from reaching the event. Another concern practitioners should be on the lookout for is the duration of the policy. With many events extending beyond the main event itself and including pre- and post-events (pre-game concerts, etc.), it is important to ensure that the policy period covers the timing of such events.

Pandemics

In addition to its devastating health impacts on so many, COVID-19 also led to the cancellation, postponement, or relocation of events. While there were valid reasons for policyholders to seek coverage under their business interruption policies, event cancellation insurance—if they had

it—seemed like a more straightforward path to coverage because it did not require proving physical damage. However, policyholders have faced challenges when attempting to claim coverage under their event cancellation policies.

The Ninth Circuit examined whether event cancellation coverage could apply to COVID-19-related losses in a case involving Metallica.[20] In September 2019, the band purchased a cancellation, abandonment, and non-appearance policy with a communicable disease exclusion.[21] In April 2020, as the band prepared for six shows in Argentina, Brazil, and Chile, the COVID-19 pandemic and related government shutdowns forced them to cancel when crowd and travel restrictions went into effect.[22]

The band filed a lawsuit seeking coverage, but the court granted the insurer's motion for summary judgment. The trial court ruled that the communicable disease exclusion barred coverage because it excluded losses "directly or indirectly arising out of, contributed to by, or resulting from any communicable disease or fear or threat thereof."[23] The policy defined "communicable disease" as "any disease capable of being transmitted from an infected person or species to a susceptible host, either directly or indirectly." The court determined that the exclusion's exceptions did not apply in this case.

Metallica appealed, arguing the trial court wrongly equated "disease" with "virus."[24] The band pointed out that the World Health Organization distinguishes between SARS-CoV-2 (the virus) and COVID-19 (the disease).[25] The Ninth Circuit upheld the trial court's decision, finding that the policy's definition of "communicable disease" encompasses the pathogen causing the disease.[26] The court also ruled that COVID-19 was the proximate cause of Metallica's loss, given that government restrictions were imposed in response to the spread of SARS-CoV-2.[27]

In response to COVID-19, insurers expanded their communicable disease exclusions, but future health crises may not fit these exclusions. In such cases, careful examination of the exclusion's wording will be essential.

What Losses Are Covered?

Covered losses typically include out-of-pocket expenses and lost profits or revenues. Canceling, rescheduling, or relocating an event often incurs significant costs, such as venue rent, non-refundable deposits, production expenses, and contractual obligations to vendors and sponsors. In addition, there may be coverage for lost revenue, including ticket sales, concessions, and other event-related income.

A policyholder can typically choose which losses to insure. Some policies use "ascertained net loss" to determine recovery, which can vary in definition, but in one policy, it is defined as follows:

> (a) Expenses which have been irrevocably expended in connection with the insured Event(s), less any savings the Assured is able to effect to mitigate such loss, and (b) Profit (where insured and stated in the Schedule) which the Assured can satisfactorily prove would have been earned had the insured Event(s) taken place.[28]

Under this definition, loss would typically cover non-mitigated expenses and any insured profit (presuming it was stated in the schedule). Alternatively, a policyholder, such as a nonprofit, may choose not to cover lost profits for an event where no admission fees were charged.

When applying for coverage, a policyholder must carefully consider what constitutes "loss," as defined by the policy. For example, a dispute arose over lost profits under an event cancellation policy purchased for a marching band competition by Defeat The Beat, Inc., which hosted annual band competitions.[29] After light rain turned into a storm with lightning and thunder, the event was interrupted for 35 minutes, causing a 35 percent drop in expected attendance.[30] Defeat The Beat claimed lost profits from attendee income, program sales, T-shirt sales, and CD/DVD sales as part of its damages.[31] Defeat The Beat's event cancellation policy covered ascertained net loss, defined to include profit when specified in the schedule.[32] While the policy's schedule set a limit of $350,000 for indemnity excluding profit, the limit for indemnity including profit was left blank.[33] This omission proved fatal to Defeat The Beat's claim for lost profits, as the policy covered profit only if explicitly stated in the schedule, which it was not.[34]

This case highlights the importance of clearly defining losses in the policy to avoid disputes over coverage. Lost profits are not automatically covered under event cancellation insurance. Policyholders seeking to protect potential earnings from a canceled event should negotiate for explicit lost profits coverage or additional policies addressing this risk.

The Show Must Go On . . . Or Must It?

Event cancellation policies generally do not cover losses caused by expected events or those within the policyholder's control, as these policies are meant to cover unforeseen causes.[35] A couple of decisions provide insight into a key factor in coverage availability: whether the cause of cancellation was beyond the policyholder's control.

In *HDMG Entertainment, LLC v. Certain Underwriters at Lloyd's of London Subscribing to Policy No. L009082*, the court examined whether the cause of an event cancellation was within a policyholder's control. At issue was an event cancellation policy for the Swamp Fox Biker Bash; the insurance application was submitted in February for the event planned in May.[36] The policy applied only if (1) the loss resulted from an unexpected cause beyond the control of the policyholder and any contracted party performing a critical function for the successful fulfillment of the event; and (2) the loss was not the direct or indirect result of any excluded cause.[37]

A communications system was essential for the Bash, and in January the policyholder hired a contractor to install one by March 14.[38] As the deadline approached, the contractor delayed the installation until late April, just 10 days before the event.[39] Ultimately, the contractor stated the system would not be ready until after the Bash, forcing its cancellation.[40] The insurer denied the policyholder's claim and sought to rescind the policy.[41]

In its summary judgment motion, the insurer argued coverage was not triggered because the loss was expected, within the policyholder's control, and caused by a contracted party.[42] It argued that the policyholder knowingly chose a venue without a communications system, was aware of installation needs when applying for insurance, hired the contractor directly, and failed to seek alternatives when delays occurred.[43]

The court denied the insurer's summary judgment motion, citing several factual issues, including whether the policyholder's choice of a venue without a communications system made the loss expected and within its control, and the extent of the policyholder's control over the contractor.[44] This case highlights that determining whether a loss is beyond a policyholder's control is fact-intensive. It also emphasizes the importance of carefully selecting contractors, documenting communications, and understanding potential delays.

In *Information Management Network v. Certain Underwriters at Lloyd's*, a conference planner canceled an October 2001 conference in the Bahamas, with more than 1,000 planned participants, after the September 11 attacks led to corporate travel restrictions and safety concerns, causing participants to withdraw.[45]

Its event cancellation policy covered losses from events that were "necessarily" canceled or postponed.[46] The insurer argued cancellation was not necessary because of the travel restrictions.[47] Because the term "necessarily" was not defined in the policy, the court used a dictionary definition of "necessarily," which included "inevitably"—meaning "impossible to avoid or prevent."[48] Despite more than 200 participant cancellations due to corporate travel restrictions, the court concluded that the event cancellation did not meet the policy's definition. It was "neither inevitable nor impossible to avoid" because there were no government-imposed travel restrictions to the Bahamas and the venue was available. The court therefore found no coverage.[49]

As these cases show, whether a cancellation is due to causes beyond the policyholder's control can be contentious. The definition of "beyond control" can be broad, as in *HDMG Entertainment*, or narrow, as in *Information Management Network*. Logistical challenges may be seen as manageable risks within the policyholder's control and thus not covered. Furthermore, as *HDMG Entertainment* highlights, this determination is fact-specific and depends on the circumstances and the policy language.

Conclusion

Risks like terrorism, war, pandemics, and extreme weather are becoming more prominent. Practitioners must understand the challenges event cancellation policyholders face, including coverage exclusions. Issues such as what losses to insure and whether a loss is beyond the policyholder's control will continue to arise. When addressing the legal issues tied to event cancellation coverage, don't just "shake it off." Instead, ensure that the policyholder is properly protected and advised so that the policyholder can weather the storm when challenges arise—both literally and figuratively.

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[1] *See, e.g.*, *HDMG Entm't, LLC v. Certain Underwriters at Lloyd's of London Subscribing to Policy No. L009082*, 355 F. Supp. 3d 373, 380 (D.S.C. 2018) (quoting event cancellation policy that agreed to indemnify a policyholder for "loss as a direct result of **cancellation**,

abandonment, **curtailment**, **postponement**, or **relocation** of the insured event" (bold in original)).

[2] Most event cancellation policies will have some form of language to this effect. *See, e.g.*, *HDMG Entertainment*, 355 F. Supp. 3d at 380 (quoting event cancellation policy that required that "the loss must be the direct result of an unexpected cause beyond your control"); *Info. Mgmt. Network v. Certain Underwriters at Lloyd's*, 2004 NYLJ LEXIS 4607, at *1 (Sup. Ct. N.Y. Cty. Oct. 15, 2004) (quoting policy that required a "cause beyond the control of the Assured").

[3] Diana Shafter Gliedman, Marshall Galinsky & Fiona Hogan, "Insurance Likely Kept Swift Out Of The Woods After Vienna," *Law360*, Oct. 1, 2024.

[4] *Pan Am. World Airways, Inc. v. Aetna Cas. & Sur. Co.*, 505 F.2d 989, 1012 (2d Cir. 1974); *see also Universal Cable Prods., LLC v. Atl. Specialty Ins. Co.*, 929 F.3d 1143, 1154 (9th Cir. 2019) ("[W]ar refers to and includes *only* hostilities carried on by entities that constitute governments at least de facto in character." (emphasis in original)); *Holiday Inns Inc. v. Aetna Ins. Co.*, 571 F. Supp. 1460, 1503 (S.D.N.Y. 1983) (holding in the insurance context that "war" must be "between sovereign or quasi-sovereign states").

[5] *Universal Cable Products, LLC*, 929 F.3d at 1161.

[6] *Universal Cable Products, LLC*, 929 F.3d at 1149.

[7] *Universal Cable Products, LLC*, 929 F.3d at 1153.

[8] *Universal Cable Products, LLC*, 929 F.3d at 1154.

[9] *Universal Cable Products, LLC*, 929 F.3d at 1159.

[10] *Merck & Co. v. Ace Am. Ins. Co.*, 475 N.J. Super. 420, 425 (App. Div. 2023).

[11] *Merck*, 475 N.J. Super. at 425–26.

[12] *Merck*, 475 N.J. Super. at 428.

[13] *Merck*, 475 N.J. Super. at 427.

[14] *Merck*, 475 N.J. Super. at 438.

[15] *Merck*, 475 N.J. Super. at 430.

[16] *Merck*, 475 N.J. Super. at 445.

[17] *Merck*, 475 N.J. Super. at 426.

[18] "Roof at Tropicana Field badly damaged by Hurricane Milton," *ESPN*, Oct. 9, 2024.

[19] Milad Haghani, "Music festivals are increasingly affected by climate change—is the industry doing enough to mitigate the impact?," *Phys.org*, Mar. 13, 2024.

[20] *Frantic, Inc. v. Certain Underwriters at Lloyd's, London*, No. B326222, 2024 WL 1152376 (Cal. Ct. App. Mar. 18, 2024).

[21] *Frantic*, 2024 WL 1152376, at *1.

[22] *Frantic*, 2024 WL 1152376, at *2.

[23] *Frantic*, 2024 WL 1152376, at *1.

[24] *Frantic*, 2024 WL 1152376, at *3.

[25] *Frantic*, 2024 WL 1152376, at *4.

[26] *Frantic*, 2024 WL 1152376, at *6.

[27] *Frantic*, 2024 WL 1152376, at *9–10.

[28] *Defeat The Beat, Inc. v. Underwriters At Lloyd's London*, 669 S.E.2d 48, 51 (N.C. Ct. App. 2008).

[29] *Defeat The Beat*, 669 S.E.2d at 52.

[30] *Defeat The Beat*, 669 S.E.2d at 51.

[31] *Defeat The Beat*, 669 S.E.2d at 51.

[32] *Defeat The Beat*, 669 S.E.2d at 51.

[33] *Defeat The Beat*, 669 S.E.2d at 51.

[34] *Defeat The Beat*, 669 S.E.2d at 53.

[35] *HDMG Entm't, LLC v. Certain Underwriters at Lloyd's of London Subscribing to Policy No. L009082*, 355 F. Supp. 3d 373, 380 (D.S.C. 2018).

[36] *HDMG Entertainment*, 355 F. Supp. 3d at 376.

[37] *HDMG Entertainment*, 355 F. Supp. 3d at 380.

[38] *HDMG Entertainment*, 355 F. Supp. 3d at 376.

[39] *HDMG Entertainment*, 355 F. Supp. 3d at 376.

[40] *HDMG Entertainment*, 355 F. Supp. 3d at 376.

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[41] *HDMG Entertainment*, 355 F. Supp. 3d at 377.

[42] *HDMG Entertainment*, 355 F. Supp. 3d at 380.

[43] *HDMG Entertainment*, 355 F. Supp. 3d at 380.

[44] *HDMG Entertainment*, 355 F. Supp. 3d at 382.

[45] *Info. Mgmt. Network v. Certain Underwriters at Lloyd's*, 2004 NYLJ LEXIS 4607, at *1–2 (Sup. Ct. N.Y. Cty. Oct. 15, 2004).

[46] *Information Management Network*, 2004 NYLJ LEXIS 4607, at *3.

[47] *Information Management Network*, 2004 NYLJ LEXIS 4607, at *3.

[48] *Information Management Network*, 2004 NYLJ LEXIS 4607, at *6.

[49] *Information Management Network*, 2004 NYLJ LEXIS 4607, at *8.

Insurance Coverage Litigation

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The Risks in Transactional and M&A Insurance and Litigation, Part I: Representations and Warranties Insurance

By Lauren Sandground, Chiara Tondi Resta, Ezra Gollogly, and Will Davis

Over the past decade, there has been a fairly rapid adoption of transactional risk insurance by parties to corporate transactions. They are regularly seeking insurance solutions through representations and warranties insurance (RWI) (or, as it is sometimes referred to outside the U.S., "warranty and indemnity insurance") to minimize potential downside risks they face should any promises the transaction parties made to each other turn out not to be true. Relatedly, with post-transaction shareholder disputes continuing at a solid pace in the U.S., companies are considering if and how their directors' and officers' (D&O) insurance may provide coverage in the event of a post-closing dispute, including disputes over the valuation of a transaction.

Given the rapid adoption of RWI policies and ongoing litigation under D&O policies for post-transaction events, the authors have kept a close eye on how coverage disputes under these two policies have developed. Many of the coverage disputes that have reached public litigation under these policies involve the "bumping up" of share prices and valuation "multipliers." These coverage disputes, plus the mergers and acquisitions (M&A) market generally and policyholder interest in insuring post-transaction events, have each affected how underwriters are "weighing" the risks of the companies and transactions they insure.

This two-part article—the first on RWI and the second on D&O insurance—assesses what's on the horizon for transactional insurance in light of recent developments in underwriting, claims, and coverage disputes.

Overview of M&A Trends and the Value Proposition of RWI

In 2023, M&A activity fell to a 10-year low, reflecting a broad global decline in deal-making activity and a sharp decrease in initial public offering activity. For the deals that did occur, there was an increase in minority transactions and secondary exits (wherein company shares are sold by individual shareholders rather than the company).

Despite last year's decline in M&A activity, RWI has never been more popular. According the *2023 Private Target M&A Deal Points Study* published by the ABA Section of Business Law, from 2016 to 2023, the percentage of private company transaction agreements in the United States that referred to RWI grew from 29 percent to 55 percent.

For companies contemplating a transaction, RWI is often viewed as an integral tool to enable smoother negotiations, reduce friction between buyers and sellers, and safeguard against unforeseen risks that might arise post-transaction. In general, these policies protect against unforeseen liabilities or financial losses that may arise or be discovered post-transaction that result in breaches of representations and warranties. RWI policies are primarily "buyer-side" policies, issued to the buyers to protect against the downside risk of breaches by the seller, but

there are also "seller-side" policies to cover the seller should the buyer later claim a breach. By transferring the risks of a loss due to a breach of representations and warranties from the buyer and seller to the insurer, these policies not only protect against the subject risk but also facilitate deals by enabling buyers and sellers to close transactions with the assurance that a reliable safety net exists to address risks that may materialize later, essentially lowering the transaction costs of M&A deals. Unlike the traditional indemnification provisions in transaction agreements, which would rely on the financial stability of the seller or the liquidity of escrow arrangements that lock up a portion of the purchase price, RWI offers a risk-management tool that has a fundamentally different security and dispute-resolution profile. Such policies also promote deal efficiency by allowing sellers to walk away with less exposure to potential claims, which, in turn, facilitates cleaner exits and quicker settlements. By shifting risks to an insurer, transaction parties can better allocate resources and focus on their core business objectives.

Key RWI Language

RWI typically covers the insured party's (either the buyer's or seller's) loss due to breaches of representations and warranties that are specified in the underlying deal document. Those representations and warranties encompass a range of areas such as financial statements, legal compliance, litigation, taxes, and other material aspects of the business. An RWI policy generally covers a specified period, often mirroring the survival period of the representations and warranties agreed upon in the underlying deal documents. Coverage often includes defense costs and indemnity payments, subject to the policy's terms and conditions. While RWI policy language varies, one example of a common claims-made and reported insuring agreement provides that, subject to the terms and conditions of the policy, the insurer will indemnify, reimburse, or pay on the insured's behalf the covered loss (due to breaches of the underlying agreement) under the policy as reported within the policy term or other specified terms. The terms "loss" and "breach" are often defined terms in RWI policies. "Loss" may be defined to include "any loss, liability, claim, or action arising out of, in connection with, relating to, or resulting from a Breach." "Breach" may be defined to mean "any breach of, or inaccuracy in, the representations and warranties set forth in Articles X and Y of the Acquisition Agreement as of the date of the Acquisition Agreement." RWI policies contain many other terms and conditions, including both standard and bespoke provisions drafted during the underwriting process, as discussed below.

Underwriting Considerations

As with any other form of insurance, the underwriting of an RWI policy is viewed by insurers and underwriters as an exercise in reducing information asymmetry between insurer and insured. From the insurer/underwriting perspective, left unaddressed, "information asymmetry gives rise to problems of adverse selection and moral hazard, problems that cannot be solved by pooling and pricing." As a result, RWI underwriters act with similar goals as underwriters for any other type of insurance policy—to minimize information asymmetry and thereby minimize the potential resulting outcomes of adverse selection and moral hazard. The distinguishing feature of the RWI underwriting process is that the buyer of the target company also suffers from information asymmetry as compared with the seller of the target company, and therefore the underwriter also acquires access to transaction due diligence and is focused on understanding the buyer's due diligence process in underwriting the RWI policy.

The RWI underwriting process can be viewed as consisting of three stages: risk selection, the underwriting call, and policy negotiation. Of these, the initial stage of risk selection is when the underwriters are most concerned about and are most susceptible to information asymmetry as they do not yet have access to the buyer's diligence reports. A typical request for RWI coverage can include a confidential information memorandum detailing the target company's operations, financial statements, and, depending on the stage of the deal timeline, a letter of intent or a draft of the transaction agreement (or both). Using this initial information, the underwriter then chooses whether or not to quote coverage for transactions that fit within the risk appetite of the carrier. The underwriter's quote will include premium pricing, retention thresholds, exclusions limiting the scope of coverage, "heightened concerns" that will be subject to enhanced diligence expectations, and "synthetic" comments to the acquisition agreement. Each of these areas is subject to competitive pressures and can shift dramatically depending on whether RWI is placed during an insured-friendly soft market when M&A deal activity is low, as in 2023, or a carrier-friendly hard market.

Once the insured selects a carrier from among those that quoted coverage, a formal underwriting agreement is entered between the insurer and insured, and the parties begin preparing for the second stage of the process: an underwriting call held between the carrier, the buyer, and the buyer's advisors. The underwriter requests and is typically provided the buyer's diligence reports and access to the seller's virtual data room, which the underwriter reviews in conjunction with the underwriter's legal counsel and accounting advisors. This stage is the meat and potatoes of the underwriting process, when the underwriter can assess the underlying transaction. Underwriters from different insurers will approach the underwriting call differently to conduct their own due diligence, which is based on the parties, underlying transactions, and underwriting approach.

Having completed the underwriting call, the underwriter may propose to negotiate policy terms with the insured. This stage generally addresses general business terms (i.e., notice periods and due dates for the payment of premiums), for which the underwriters often seek to follow broad market trends, in addition to the deal-specific terms that respond to the findings of the underwriting process, including exclusions.

Deal-specific policy terms are also viewed by underwriters as safeguards against "moral hazard" or protection against "adverse selection."

"Moral hazard" can be defined as the risk that the parties will change their behavior as a result of the availability of insurance coverage. In the RWI context, the concern is that the deal process will not be conducted as rigorously as it would have been in the absence of the RWI policy. For example, when there is no RWI placed for a deal, but losses from the seller's breaches of representations and warranties are paid by the seller through an escrow or hold back, sellers have the incentive to negotiate narrowly tailored representations and broadly disclose against those representations in the disclosure schedules. The seller's incentive may not be the same with the presence of RWI. Underwriters may address the removal of the seller's incentive by proposing synthetic comments to the underlying deal agreement (i.e., adding knowledge qualifiers to seller

representations in the transaction document) or deemed disclosures of known, material risks that have not made it into the deal document schedules.

"Adverse selection" in the RWI context can be defined as a situation where insureds seek coverage for riskier transactions. Underwriters may address their concerns of adverse selection in a particular transaction by adding exclusions, which sometimes take the form of bespoke categories. For example, a bespoke exclusion could be added for losses relating to common claims for a target in the particular industry the target is in. Such exclusions are proposed and negotiated between the parties and are tailored to known and material risks that were identified during the buyer's diligence.

Underwriting for RWI insurance is unique in many ways because the underwriter becomes acquainted with the due diligence of the deal with the buyer through access to due diligence reports and data rooms. Therefore, the underwriting and due diligence processes may become relevant to how an RWI claim is later developed and resolved.

RWI Claim Trends

Due to the increased interest in RWI policies in the market, insurers and brokers alike have published reports in recent years summarizing RWI claim trends, noting among other things how many claims are made on the total RWI claims placed, the values of the underlying deals, and frequent categories of representations and warranties that are raised in RWI claims. The historical rule of thumb was that about one in five policies resulted in a claim, but more recent data from certain insurers suggest this frequency has declined to about one in six, though the percentage of claims resulting in payments has increased. For example, one broker claims that over the past five years, 22 percent of claims resulted in payment net of the retention. In addition, AIG, in its 2023 study, noted that loss payouts meaningfully exceeded premiums for transactions with enterprise value below $250 million, perhaps suggesting that more disputes are associated with smaller transactions.

Year-over-year, there is variance in what general categories of representations and warranties in the underlying deal documents result in claims of loss. The top three categories, as noted in AIG's 2023 study, were financial statements, legal compliance, and material contracts. The quantity of claims understates the true significance of these areas, however, because the results are even more dramatic when looking at the number of claims paid or the amount of loss paid. For example, one carrier claims that 65.7 percent of its paid loss was attributable to financial statements and material contracts representations, while legal compliance was a distant third at 9.5 percent of loss paid.

Despite fairly consistent data of the claims being made and some upward trends in RWI policies paying out on a greater percentage of claims being made, each RWI claim is as individual as the underlying transaction itself, leading to varied disputes.

Notable Disputes under RWI Policies

Once the policyholder establishes a claim for a breach of a representation or warranty of the underlying transaction document triggering the RWI policy, the insurer may raise barriers to

coverage in the form of exclusions and loss valuation concerns. Exclusions, loss valuation, subrogation to the seller, and other insurance are common sources of friction in RWI claims.

Exclusions. RWI insurers have sought to disclaim coverage or limit their obligations for breaches of representations of warranties through exclusions that are considered more standard in RWI polices, as well as exclusions that are bespoke to the RWI policy. As with other coverage claims, the RWI insurer typically bears the burden to prove the application of exclusions, which are, as directed by state-specific case law, construed narrowly and in favor of coverage.

Some exclusions are commonly found in RWI policies. For example, one standard RWI exclusion addresses losses arising from breaches of representations and warranties about which the buyer's key figures involved in the deal had actual knowledge prior to the deal closing. There is of course some tension in applying these exclusions due to the unique nature of the underwriting process, wherein the underwriters often have complete access to the due diligence that the insured buyer does and have a similar opportunity to discover potential issues in the transaction. The underwriters' due diligence, and the information learned during the underwriting process, therefore may have a bearing on the application of these types of exclusions. Nonetheless, during the claims adjudication process, RWI insurers may request information from the buyer as to when the breach was discovered to confirm that the buyer did not have actual, subjective knowledge before the policy incepted. Though the "prior knowledge" exclusion has not been fully litigated to the authors' knowledge, the United Kingdom court in *Finsbury Foods Group* indicated in its 2023 decision that a "prior knowledge" exclusion may apply given the involvement of deal team members in issues later raised as part of the RWI claim, indicating that RWI insurers may continue to rely on these types of exclusions in future RWI claims.

RWI policies may also contain bespoke exclusions relating to specific representations and warranties in the underlying deal document. As discussed above, RWI underwriters sometimes identify areas that will require bespoke exclusions. To date, these exclusions do not yet seem to be the subject of extensive RWI litigation; however, that may change as underwriters continue to negotiate unique policy language to address perceived information asymmetry, moral hazard, or adverse selection in the underlying deal.

Loss valuation. Loss valuation is a hot topic for RWI claims. The loss due to a breach of a particular representation or warranty may be not only the economic impact on the insured to indemnify or defend a third-party claim or the damages for first-party losses, but also the value associated with the purchase price of the acquired asset or company. In other words, had the seller truthfully and fully represented or warranted a particular fact, then the asset or company would not have been valued so high and the buyer would not have paid the amount it did to purchase the asset or company. How the purchase price is valued has been subject to debate in RWI claims that have reached litigation.

For example, in *pH Beauty Holdings*, the buyer alleged that the seller had artificially overstated the profits of the company it was selling and had failed to account for millions of dollars in promotional expenses for beauty products, which the buyer contended led to an inflated purchase

price. The purchase price was based on the 2018 earnings of the sold company, multiplied by 13.66. Therefore, the buyer argued that the seller's failure to account for promotional expenses resulted in an overpayment of the purchase price of nearly $33 million and submitted that amount to its RWI insurer as its loss. While the insurer agreed that there was a breach of the deal document and loss under the RWI policy, it disagreed with the valuation of the loss. Hiring an outside forensic accountant, the insurer argued that the purchase price value—and the insured's claimed loss—was significantly offset by a net working capital adjustment, among other accounting bases. The case was settled before motions had been decided; however, the lesson of this case and others is that earnings multipliers and the deal valuation can translate into the "loss" calculation under the policy. In such a case, RWI policyholders should assess not only the impact of a breach of a representation or warranty on their business, but also whether and how such a representation was incorporated into the purchase price and how the purchase price was calculated (by earnings multipliers, fair valuation, or otherwise). That, in turn, could indicate the policyholder's loss" under the RWI policy. Policyholders and insurers alike may find it useful to understand "loss" by retaining accounting experts or even relying on reports and analysis provided by accountants during the deal process.

Subrogation to the seller. Typically, in either the deal document or the RWI policy (or both), the parties agree that the RWI insurer and the buyer are contractually barred from seeking subrogation against the seller entity for loss arising from breaches of representations and warranties except in cases of willful breach, fraud, or intentional misrepresentation. The rationale behind this rule is that the buyer is encouraged to purchase RWI in the first place to remove the risk from the seller that accidental, unintentional, or negligent breaches of representations and warranties will lead to costly indemnification obligations to the buyer. Conversely, the seller is motivated to provide truthful and complete representations and warranties to the buyer to avoid later risks that the buyer or the RWI insurer will later seek payment from the seller. Therefore, RWI insurers may be looking for potential subrogation opportunities against the seller should any questions of intentional breaches of representations and warranties arise. Courts have affirmed the RWI carriers' right to do so. For example, in the case of *Jude McColgan*, the court confirmed that the RWI insurer may seek subrogation directly against the sellers in cases of fraud pursuant to the RWI policy's provisions.

Other insurance. Particularly with third-party claims, the buyer may have third-party insurance policies at its disposal other than its RWI policy. For example, a seller may fail to disclose ongoing third-party bodily injury litigation in the course of the deal transaction. The buyer would argue that the RWI policy is triggered by a breach of a representation or warranty concerning known but undisclosed third-party claims, but the buyer may also have commercial general liability or other policies that could provide coverage for the third-party claim. It is beneficial for policyholders to understand what other insurance may be available relating to their claims, even if those claims trigger RWI insurance, and conversely, RWI insurers may be particularly keen to seek other insured information for third-party claims for this reason.

Dispute Resolution

If the RWI claim is not paid or resolved through negotiation, the parties to an RWI claim may pursue traditional litigation or alternative dispute resolution. For some time, RWI claims were

not frequently litigated due to arbitration provisions. Some RWI policies may also require that the parties first seek resolution through nonbinding mediation or other alternative dispute resolution and, afterwards, allow for a "cool-down" period before arbitration is commenced.

However, RWI policies in recent years do not always require arbitration, and the authors have noted over a dozen litigated cases addressing substantive RWI claims in the U.S. and the United Kingdom, where RWI policies originated. While exhibiting a variety of fact patterns, many of these cases involve underlying transactions or breaches relating to purported failures of sellers to properly disclose material contracts or financial liabilities that are accounted for in the purchase price of the transaction, causing loss to the insured buyer. Rarely do the cases result in substantive rulings, though that reality may begin to change with the January 2024 summary judgment decision in *Novolex Holdings*. In *Novolex*, the Supreme Court of New York County denied summary judgment sought by the policyholder that there were breaches of certain representations and warranties relating to material contracts of the target company, though the court held that there was a fact issue as to whether another representation and warranty for "adverse effects" were implicated by the reduction of business by a key customer of the target company. Also, in July 2024, a San Francisco jury in the *Wing Inflatables* case ordered certain RWI insurers to pay damages for breaches of contract and the covenant of good faith and fair dealing in a 2019 acquisition relating to the insured's claim under RWI, though at least some RWI insurers have indicated their intent to seek a new trial. However, both the *Wing Inflatables* and *Novolex* cases demonstrate that courts have delved, and likely will continue to delve, into RWI policy language and the underlying transaction to adjudicate coverage disputes under RWI policies.

Conclusion

The trends in RWI placement, claims, and disputes are a product of the M&A market, underwriting appetite for insuring potential transactional risks, and policyholder interest in pursuing coverage for a variety of breaches of representations and warranties. Each of these variables will affect the use and development of RWI in the coming years.

Stay tuned for Part II to find out what's on the horizon for D&O coverage for post-transaction claims.

Insurance Coverage Litigation

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Georgia Attempts to Address Settlement Issues with Amended Statute

By Christopher C. Meeks

In 2022, the American Tort Reform Foundation listed Georgia as its number one "judicial hellhole," a title that Georgia retained for 2023.[1] Among other reasons cited by the foundation for Georgia's ranking is the Georgia Court of Appeals' June 2023 decision in *Pierce v. Banks*.[2] *Pierce* concerns whether an enforceable settlement existed after an insurer attempted to accept a claimant's demand by using a check stating that it was "void after 180 days."[3] The court answered the question in the negative in what some would argue is an overly technical and pedantic interpretation of the mirror image rule and the law concerning negotiable instruments. This interpretation has caused a great deal of consternation and rate pressure among Georgia automobile insurers despite the Georgia General Assembly's two attempts since 2013 to establish by statute—Georgia Code section 9-11-67.1—what can and cannot be included in settlement offers. The 12 months following *Pierce* have seen the Georgia Supreme Court deny certiorari while the Georgia Court of Appeals entered two similar decisions in *Patrick v. Kingston* and *Redfearn v. Moore*.[4] This trio of claimant-friendly decisions suggests that Georgia's top billing as a "judicial hellhole" is likely to remain safe for 2024 in the eyes of the American Tort Reform Foundation. However, that ranking may change, as a new and updated third version of section 9-11-67.1 took effect on April 22, 2024, which likely renders *Pierce* and its progeny judicial dead ends by significantly limiting the ability of the plaintiff's personal injury bar to "set up" bad-faith claims against insurers. This article explores the history of Georgia Code section 9-11-67.1; the circumstances surrounding *Pierce*, *Patrick*, and *Redfearn*; and how the 2024 revisions to section 9-11-67.1 may change the dynamics between claimants and insurers that led to *Pierce*, *Patrick*, and *Redfearn*.

The Evolution of Georgia Code Section 9-11-67.1

On May 7, 2013, the first version of Georgia Code section 9-11-67.1 took effect. As originally enacted, section 9-11-67.1 (2013) applied to "any offer to settle a tort claim for personal injury, bodily injury, or death arising from the use of a motor vehicle [] prepared by or with the assistance of an attorney" sent "[p]rior to the filing of a civil action[.]"[5] The statute required that such offers be in writing and contain the following material terms:

(1) The time period within which such offer must be accepted, which shall be not less than 30 days from receipt of the offer;

(2) Amount of monetary payment;

(3) The party or parties the claimant or claimants will release if such offer is accepted;

(4) The type of release, if any, the claimant or claimants will provide to each releasee; and

(5) The claims to be released.[6]

The 2013 version of section 9-11-67.1(e) provided that offers "shall be sent by certified mail or statutory overnight delivery, return receipt requested, and shall specifically reference [Georgia Code section 9-11-67.1]."[7] In addition, the 2013 edition provided that the offeror could "require payment within a specified period . . . not less than ten days after the written acceptance of the offer to settle."[8] Such payment could be made by cash, money order, wire transfer, cashier's check, insurance company check, or electronic funds transfer.[9] To accept an offer under the 2013 statute, a recipient may provide "written acceptance of the material terms outlined in [Georgia Code section 9-11-67.1(a)] in their entirety."

The impetus for section 9-11-67.1 arose in the more than 20-year aftermath of *Southern General Insurance Co. v. Holt*.[10] In *Holt*, the Georgia Supreme Court recognized a common-law claim for a failure to settle where an insurer fails to take the opportunity to settle a claim that presents a case of clear liability against the insured and special damages in excess of the applicable limits.[11] Following that decision, policy limits demands in Georgia became known as "*Holt*" demands and frequently cited the decision. However, clarification of the rights and duties arising in connection with such demands—including "what constitutes an offer to which an insurer must respond, when an insurer's inquiry about medical liens amounts to a counteroffer, and how much time an offeror must provide for a response in order to trigger an insurer's duty to respond"—was slow to come.[12] For instance, the Georgia Supreme Court did not definitively resolve the question of whether "an insurer's duty to settle arises when the injured party presents a valid offer to settle within the insured's policy limits" until 2019, 27 years later.[13] It was against this backdrop of somewhat glacial judicial guidance that the 2013 version was drafted and enacted.[14] As recognized by the Eleventh Circuit, "the [Georgia] General Assembly's goal in passing § 9-11-67.1 was to address the negative effects of [*Holt*]" including "[a] perceived concern . . . that it was arguably enabling plaintiffs to present settlement offers 'with impossible deadlines and expose [the] insurance company to potential "bad faith" claims when it is unable or unwilling to abide.'"[15] The Eleventh Circuit explained:

In enacting § 9-11-67.1, the General Assembly reportedly sought to reduce bad-faith claims by giving insurance companies adequate time to investigate claims and offers before having to decide whether to settle. The Act was arguably meant to be a compromise between the plaintiff and defense bars and to reduce procedural quibbling over the technical sufficiency of a settlement offer.[16]

Facially, the 2013 version sets forth a relatively straightforward procedure. A claimant can submit a demand in writing stating the five items required by section 9-11-67.1(a) (2013) and the recipient can accept the offer by accepting those same five items. Such a result would simplify and clarify the process of reaching settlements, which would be consistent with Georgia's "strong public policy of encouraging negotiations and settlements" while preserving the common-law claim for negligent failure to settle in cases where an insurer fails to settle in response to a demand presenting clear liability and special damages in excess of limits.[17] However, such was not to be the case for Georgia Code section 9-11-67.1 (2013).

In 2017, the Georgia Supreme Court answered certified questions from the Eleventh Circuit concerning whether an insurer's failure to provide payment by the deadline set forth in a demand meant there was no binding settlement with the claimant despite the insurer's acceptance of the five materials terms set forth in section 9-11-67.1(a) (2013).[18] Specifically, the Eleventh Circuit found an ambiguity in the statute between the five material terms set forth in section 9-11-67.1(a) (2013) and the payment provisions of section 9-11-67.1(g) (2013).[19] In answering the certified questions, the Georgia Supreme Court viewed section 9-11-67.1 (2013) through the lens "of [the] large body of law on contract formation generally and settlement formation specifically[,]" which requires that "settlement agreements [] meet the same requirements of formation and enforceability as other contracts."[20] Through that lens, the Georgia Supreme Court determined that offers and acceptances under section 9-11-67.1 (2013) were still subject to the mirror image rule and the rule that "an offeror is the master of his or her offer, and free to set the terms thereof."[21] Accordingly, the Georgia Supreme Court declined to hold that section 9-11-67.1 (2013) "preclude[ed] Pre-Suit Offers from requiring terms in addition to those set forth in subsection (a)[.]"[22] Instead, the Georgia Supreme Court held that "subsection (a) merely sets forth five terms that, at a minimum, must be included in every Pre-Suit Offer."[23] Thus, the Georgia Supreme Court viewed section 9-11-67.1(a) (2013) as setting forth five terms that an offer must include but not prohibiting the inclusion of additional terms not mentioned in that section.[24] Given the existence of Georgia Code section 9-11-67.1(g) (2013) concerning the time period of payment, the Georgia Supreme Court's holding appears to be overly broad, as a narrower holding could have incorporated a payment requirement without viewing section 9-11-67.1 (2013) as establishing only the minimum requirements for offers thereunder.

In addition to the common-law contract rules, the Georgia Supreme Court found support for its holding in section 9-11-67.1(c) (2013), which states that "[n]othing in [Georgia Code section 9-11-67.1 (2013)] is intended to prohibit parties from reaching a settlement agreement in a manner and under terms otherwise agreeable to the parties."[25] Despite this apparently bilateral language, the Georgia Supreme Court held that section 9-11-67.1(c) (2013) "does not preclude a Pre-Suit Offer from requiring acceptance of terms in addition those set forth in subsection (a)."[26] Notably, the insurer argued that this approach rendered section 9-11-67.1 (2013) meaningless; however, the Georgia Supreme Court rejected this argument, noting that section 9-11-67.1 (2013) still provided necessary clarification to questions arising in the wake of *Holt*.[27]

Two justices dissented, asserting that the majority's ruling eviscerated the goal of section 9-11-67.1 (2013) recognized by the Eleventh Circuit, by placing excessive reliance on the freedom to contract.[28] Predicting the litigation that would come, the dissent noted "the majority has re-opened the door for 'plaintiffs to present settlement offers with impossible deadlines [that] expose the insurance company to potential "bad faith" claims' even where, as here, the insurance company accepted the non-conforming Pre-Suit Offer in its written response and sought to secure prompt payment."[29]

Four years later, on May 4, 2021, a revised version of Georgia Code section 9-11-67.1 took effect. The five material terms set forth in the 2013 version remained, but the revised statute required the claimant to itemize what will be provided to the releasee.[30] Further, the 2021 version added a requirement that the claimant provide medical records in the claimant's

possession and allowed the claimant to request an affidavit concerning whether all insurance has been disclosed to the claimant.[31] The 2021 version of section 9-11-67 appeared to attempt to address *Woodard* by revising three subsections. First, for section 9-11-67.1(b), the 2021 version adds that "[u]nless otherwise agreed by both the offeror and the recipients in writing, the terms outlined in [Georgia Code section 9-11-67.1(a)] shall be the only terms which can be included in an offer to settle made under [Georgia Code section 9-11-67.1]." Second, for section 9-11-67.1(c), the 2021 version changes the language from "otherwise agreeable to the parties" to "otherwise agreeable to both the offeror and the recipient of the offer." Third, for section 9-11-67.1(d), the 2021 version adds that "if a release is not provided with an offer to settle, a recipient's providing of a proposed release shall not be deemed a counteroffer." However, the 2021 version of section 9-11-67.1 applies only to causes of action for personal injury, bodily injury, and death arising from the use of a motor vehicle on or after July 1, 2021.[32]

The July 1, 2021, effective date means that there is only one reported decision concerning the revised version of section 9-11-67.1—*Redfearn.* However, *Redfearn* follows the line of cases based on *Woodard* applying the 2013 version of section 9-11-67.1, including, most notably, *Pierce*, which caused significant waves through the bar when the Georgia Court of Appeals entered its decision last June.

Pierce, *Patrick*, and *Redfearn*

In *Pierce*, the claimant sent what the Georgia Court of Appeals described as a "detailed offer letter" requiring the payment of the subject policy's $25,000 limit and written acceptance within 31 days.[33] The offer required, inter alia, that "any payment requiring the name of a payee must be made out to 'Aaron Pierce and Brooks Injury Law, LLC' and that, 'as an act necessary to accept this offer,'" (1) "payment had to 'be received 15 days after [the insurer's] written acceptance of the offer'" and (2) "'the settlement payment and all other documents sent by [the insurer] must not include any terms, conditions, descriptions, *expirations*, or restrictions that are not expressly permitted in this offer.'"[34] In addition, the offer included the following "caution":

Multiple cases demonstrate the hazards of attempting to negotiate agreements without terms and conditions for acceptance being clear, and we want to be clear that this offer must be accepted exactly as stated and that any variance at all from any terms or conditions of acceptance or any variance at all from the quoted language above, even if accidental, will be a rejection of this offer.[35]

Within the 31-day response period, the insurer's counsel sent a letter to the claimant's counsel stating "that the insurer 'had authorized her to accept'" the offer and attaching the settlement check and limited release.[36] The settlement check was made payable to "Aaron Pierce and Brooks Injury Law LLC," without the comma between "Law" and "LLC," and stated that the check was "void after 180 days."[37] Subsequently, the claimant's counsel advised that the insurer's "purported acceptance was not identical to the offer" and that the claimant was rejecting the insurer's "counteroffer."[38] Thereafter, the claimant filed suit, alleging nearly $1,000,000 in medical expenses, and ultimately filed a motion for summary judgment on the issue of whether there was a settlement between the parties after the insureds raised "accord and satisfaction" in their answer.[39] The claimant's motion raised four arguments: (1) The insurer's

counsel communicated only her authority to accept the offer, (2) the insurer did not provide the settlement funds 15 days after its acceptance, (3) the settlement check stated that it was "void after 180 days," and (4) the settlement check did not include the comma between "Law" and "LLC."[40] In response, the insureds argued that the insurer had complied with the five materials terms set forth in section 9-11-67.1(a) (2013) and that the acceptance did not vary from the terms of the offer.[41] In addition, the insureds argued that the claimant's arguments that the insurer sent the settlement funds prior to 15 days after acceptance and that the settlement check did not have a comma between "Law" and "LLC" were "utterly absurd" and immaterial.[42]

The trial court held that there was an accord and satisfaction based on the insurer's compliance with the five materials terms set forth in section 9-11-67.1(a) (2013) and its determination that the offer required only that the claimant receive the settlement funds within 15 days after acceptance.[43] In addition, the trial court held that the statement that the settlement check was "void after 180 days" and missing a comma did not constitute a variance from the offer because Georgia law "does not require a bank to pay on a check that is presented more than six months after its date" and the missing comma was "not language."[44]

Referencing the *Woodard* line of cases, the Georgia Court of Appeals held that the insurer's "purported acceptance" patently failed to accept and comply with the requirements of the offer.[45] The key to the court's reversal is the difference between bilateral and unilateral contracts.[46] In a bilateral contact, the parties create a contract by expressing their mutual intent to be bound according to their agreement to material terms that define their rights and obligations.[47] In a unilateral contract, a contract can exist only if the offeree performs the actions requested by the offeror without any variance from the terms of the offer.[48] Thus, the court rejected the insureds' material terms argument as meritless because the distinction between material and immaterial terms does not exist for a unilateral contract given that the acceptance must be identical to the offer.[49] On this basis alone, the Georgia Court of Appeals essentially rendered meaningless the Georgia General Assembly's purported goal in including the five material terms in Georgia Code section 9-11-67.1(a) (2013).

After placing settlements reached under section 9-11-67.1 (2013) under the umbrella of unilateral contacts, the court addressed two items that it felt varied from and were not identical to the offer.[50]

First, the court found that the insurer's actions of including the check for the settlement funds with the acceptance did not meet the terms of the offer requiring payment on the 15th day after acceptance because all that the 2013 version of section 9-11-67.1 required is that the offeror give the insurer at least 10 days from the time of written acceptance.[51] While the claimant argued that specifying the date of payment was absurd, the court was unconcerned by the implications that giving offerors the control to specify that level of precision in their offers raises because "if a party fails to deliver payment in the manner specified in the offer, then that party did not accept the offer."[52] A concurring opinion further attempted to justify the rejection of the insureds' absurdity argument, noting with approval the claimant's argument that payment was required on a specified date in order for the claimant "to comply with the terms of his own health insurance and those of the Medical Benefits Reimbursement Statute."[53] However, Georgia Code section

33-24-56.1(g) requires only that a claimant provide a benefit provider with "notice of the existence the claim . . . not later than ten days prior to the consummation of any settlement or commencement of any trial. . . ." Further, Georgia Code section 33-24-56.1(g) requires that any such notice "include a request for information regarding the existence of any claim by a benefit provider and an itemization of payments for which the benefit provider seeks reimbursement including the names of payees, the dates of service or payment or both, and the amounts thereof." Thus, while compliance with Georgia Code section 33-24-56.1(g) appears to be solely a matter of concern for claimants, the court disregarded any concerns about gamesmanship that its holding raised.[54]

Second, the court found that the "void after 180 days" language on the settlement check constituted a counteroffer.[55] The insureds argued that the language was standard for bank checks and consistent with Georgia's version of the in the Uniform Commercial Code.[56] However, the court rejected the insureds' argument as overstated, noting that the Uniform Commercial Code does not state that checks are automatically void after 180 days and, instead, states only that a bank is not required to accept a check presented after 180 days.[57] Moreover, the court noted that the insurer could have chosen any number of other means to pay the settlement funds as provided for in section 9-11-67.1(f) (2013), including cash, wire transfer, or electronic funds transfer.[58]

The court's opinion does not address any of the parties' other arguments; and, in a footnote, the court noted that it took no position concerning whether the insurer's counsel's statement in the acceptance that she was authorized to accept the offer and the missing comma from the settlement check "invalidated the acceptance."[59] Nonetheless, the court's holding concerning the arguments it resolved raises significant questions as to what remaining benefits the 2013 version of section 9-11-67.1 provides, especially given the Georgia General Assembly's intent to reduce bad-faith claims and reduce procedural disputes concerning settlements and Georgia's public policy favoring settlement. *Pierce* appears not to recognize or honor either and provides to claimants advantages that the 2013 version of section 9-11-67.1 was not meant to provide.

On July 18, 2023, the insured filed a petition for writ of certiorari with the Georgia Supreme Court. However, on January 9, 2024, the Georgia Supreme Court denied the petition, leaving the Court of Appeals' decision as the final word on the issue, which features prominently in the American Tort Reform Foundation's "judicial hellhole" ranking for Georgia.[60]

Thirty-five days later, on February 13, 2024, the Georgia Court of Appeals reached a similar decision in *Patrick v. Kingston*, involving the same three-judge panel and the same attorneys for the claimants as in *Pierce*.[61] As in *Pierce*, the claimant in *Patrick* sent a detailed pre-suit demand letter to the insurer purportedly pursuant to the 2013 version of section 9-11-67.1, which included this statement:

In addition to the requirements for the release, neither the settlement payment nor any other document sent by Progressive can include any terms, conditions, descriptions, or representations that are not permitted in the release. If Progressive sends any document (e.g., the written acceptance, the release, the settlement check, etc.) that includes any terms, conditions,

descriptions, or representations that are not permitted in the release, it will be a counteroffer and rejection of this offer. . . .[62]

As in *Pierce*, the insurer accepted the offer and provided a draft release and check made payable to the parties specified in the demand that stated it was "VOID IF NOT PRESENTED WITHIN 90 DAYS[.]"[63] However, the claimants rejected the insurer's acceptance, citing (similar to the claimant in *Pierce*) purported variances between the offer and acceptance.[64] As in *Pierce*, the claimants then filed suit, and the insured filed a motion to enforce settlement, which the trial court granted.[65] The only issue addressed by the Georgia Court of Appeals was the voiding language at issue in *Pierce*, and the parties and the court's discussion were almost identical to those in *Pierce* with identical results based on *Pierce*.[66] Thus, the die has been cast with regard to the fate of the 2013 version of section 9-11-67.1. While it may establish some minimum standards for demand letters, it does precious little to simplify the settlement process or prevent the type of gamesmanship that it was intended to deter.

The fate of the 2021 version of Georgia Code § 9-11-67.1 may be no better. One hundred days after *Patrick*, the Georgia Court of Appeals decided *Redfearn v. Moore*, under the 2021 version of section 9-11-67.1.[67] Notably, *Redfearn* involved the same attorneys arguing on behalf of the claimants as in *Pierce* and *Patrick* and one of the same judges from the three-judge panel that decided *Pierce* and *Patrick*. Despite the changes to the 2021 version of section 9-11-67.1, the situation presented and results were similar to those in *Pierce* and *Patrick*. As in *Pierce* and *Patrick*, the demand letter from the claimants contained a large number of specific terms and conditions, requiring acceptance within 31 days of the insurer's receipt of the demand and payment 41 days after the insurer's receipt of the demand.[68] Among other terms and conditions, the demand stated as follows:

As an act necessary to accept this Offer, State Farm must draft and deliver a limited release that complies with the requirements of this Offer exactly as they are specified, required, and stated in this Offer, and any variance between the language of the limited release and the requirements of this Offer exactly as they are specified, required, and stated in this Offer, even if minor or accidental, will constitute a rejection of this Offer.[69]

Further, the demand stated, "It will be a rejection of this Offer if the settlement payment or any other document sent by State Farm includes any terms, conditions, descriptions, expirations, or restrictions that are not expressly permitted in this Offer."[70]

The insurer communicated its acceptance within days, enclosing with the acceptance a proposed release and settlement check.[71] Thereafter, the claimants returned the settlement check and filed suit, taking the position that the insurer's acceptance did not meet the terms of the demand.[72] The insured then filed a motion to enforce settlement, which the claimants opposed on the grounds that the insurer had rejected the demand "by (1) requiring the payment to be endorsed by all payees; (2) omitting commas in the payees' names on the payment; (3) including the claim number, named insured, and date of the loss on the payment; (4) sending payment eight days after the offer was received; and (5) failing to deliver a release identical in language to the

offer."[73] The trial court denied the motion to enforce settlement, and the insured successfully petitioned the Georgia Court of Appeals for an interlocutory appeal.[74]

On appeal, the defendant argued that the 2021 version of section 9-11-67.1 "was intended to address the unfair tactics advanced by plaintiffs in pre-suit offers" and that once there was agreement as "to the five statutory material terms set forth in subsection (a), a binding settlement agreement was created irrespective of whether he agreed with the additional non-statutory terms."[75] While the Georgia Court of Appeals recognized that section 9-11-67.1 was amended in 2021, the court nonetheless returned to the underlying logic of *Pierce* and *Patrick*, noting that even the 2021 version of section 9-11-67.1 "does not change the general law regarding contract formation and settlement formation specifically."[76] Thus, as in *Pierce* and *Patrick*, the court rejected the insured's argument that agreement only as to the material terms was necessary to form a contract; instead, the court relied on the unilateral contract view of settlements, requiring identical acceptance and unvaried compliance with the terms of the offer.[77]

Despite the litany of issues identified by the claimants in the insurer's acceptance, the court focused on a single issue—the endorsement language on the settlement check.[78] Specifically, the settlement check stated on the back that it "MUST BE ENDORSED BY ALL PAYEES."[79] The claimants argued that the demand did not permit and specifically prohibited such language because the claimants lived in Indiana, which would require the check to "embark on a multi-state journey" in order to be endorsed.[80] In response, the insured, similar to the claimant in *Pierce*, argued that the settlement check's endorsement language was consistent with Georgia law concerning negotiable instruments, which should have illustrated the irrelevancy of the claimants' argument.[81] Further, the claimants gave their attorneys the authority to endorse on their behalf any check received due to the case, which would appear to make the objection to the endorsement all the more pointless and irrelevant.[82] However, rather than recognizing the practical and legal effect of that law and the claimants' grant of authority to their attorneys (i.e., the check could be endorsed by all payees through the authority granted to the claimants' attorneys), the court viewed the extension of authority as further grounds for finding that the endorsement language on the settlement check constituted a rejection of the offer.[83] Further, as in *Pierce* and *Patrick*, the court noted that its result was the insurer's fault, despite concerns about gamesmanship, because the insurer could have chosen one of the other methods of payment listed in the 2021 version of section 9-11-67.1(f).[84]

Ultimately, the *Redfearn* court's discussion of section 9-11-67.1 serves only to confirm the position of Georgia's appellate courts on the importance of the two prior versions of section 9-11-67—they matter very little. Indeed, beyond establishing the five items that must be included in an offer, the time ranges for acceptance and payment, and the methods of payment other than check, *Woodard*, *Pierce*, *Patrick*, and *Redfearn* all show that Georgia's appellate courts place more stock in a pedantic view of contract law than they do in applying a statute that was intended to facilitate settlement in a manner that is consistent with the public policy of a state that encourage settlements.

The 2024 Revisions to Section 9-11-67.1

The 2024 version of the statute, it is to be hoped, should unravel the pedantic mess of unilateral contract theory created by *Woodard*, *Pierce*, *Patrick*, and *Redfearn*. First and foremost, the 2024 version of section 9-11-67.1(a) specifies that "[a]ny offer to settle a tort claim for personal injury, bodily injury, or death arising from a motor vehicle collision shall be an offer to enter into a bilateral contract." On this basis alone, it appears that for all settlement offers involving motor vehicle collisions in Georgia following April 22, 2024, *Woodard*, *Pierce*, *Patrick*, and *Redfearn* are irrelevant. Further, the 2024 version of section 9-11-67.1 states that the "only materials terms" of an offer are (A) the date by which it must be accepted, which cannot be less than 30 days from receipt; (B) the amount of monetary payment; (C) the party or parties to be released; (D) whether the release will be full or limited and what the claimant or claimants will provide to the releasees; (E) the claims to be released; (F) the date by which payment shall be delivered, which cannot be less than 40 days from receipt; and (G) if requested, a statement under oath from the insurer concerning the disclosure of insurance that provides or may provide coverage for the subject claim.[85] Any terms beyond those seven "shall be construed as an immaterial term," but parties will have the option to mutually agree to immaterial terms in writing, except any variance in any "immaterial term shall not subject the recipient to a civil action arising from an alleged failure by the recipient to accept an offer to settle such tort claim if [the] recipient otherwise complies with [Georgia Code section 9-11-67.1(i)]."[86] Thus, the 2024 version of section 9-11-67.1 provides protection from common-law failure to settle claims if an insurer attempts to accept an offer in writing in a timely fashion, provides any requested statement under oath concerning available coverage, and either pays the amount demanded or the applicable limits.[87]

These changes in the 2024 version of section 9-11-67.1 go far to addressing the questions raised over 32 years ago in the wake of *Holt.* Arguably, the changes should not have been necessary given the apparent understanding of the purpose behind the 2013 and 2021 versions of section 9-11-67.1. However, it remains to be seen what, if any, challenges the plaintiff's personal injury bar may raise in response to the 2024 version of section 9-11-67.1. Regardless, it should be expected that Georgia's appellate courts will take as narrow an interpretation of the 2024 version of section 9-11-67.1 as possible because they will likely view it as a statute in derogation of common law.[88] Even so, the 2024 version of the statute appears to provide the level of specificity necessary to avoid the results reached in *Pierce*, *Patrick*, and *Redfearn*. That said, it should be noted that the question of whether the insurers' actions in *Pierce*, *Patrick*, and *Redfearn* actually created liability for a common-law failure to settle claims under *Holt* remains to be seen, and a decision holding that the insurers' unsuccessful attempts to settle were not in "bad faith" could eventually show that, while likely costly and time-consuming to resolve, the Georgia Court of Appeals' decisions do not serve to create or expand extracontractual liability. However, it is likely that the damage such potential liability presents has already been done, as auto insurance rates continue to rise in Georgia.[89] Hopefully, the 2024 version of section 9-11-67.1 will reduce the cost of settlements and litigation in Georgia and, by extension, reduce rate pressures on a consuming public that fails to realize that personal injury recovery and insurance premiums are a zero-sum game. Whether such changes will result in a lowering of Georgia's "judicial hellhole" ranking remains to be seen.

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[1] ATR Foundation, *Georgia*, *Judicial Hellholes* (2023–2024) (last visited July 7, 2024).
[2] ATR Foundation, *Georgia*, *Judicial Hellholes*, *supra*; *See Pierce v. Banks*, 368 Ga. App. 496, 890 S.E.2d 402 (2023).
[3] *Pierce*, 368 Ga. App. at 497–98.
[4] *Patrick v. Kingston*, 370 Ga. App. 570, 898 S.E.2d 560 (2024); *Redfearn v. Moore*, No. A24A1028, 2024 Ga. App. LEXIS 199 (May 23, 2024).
[5] Ga. Code Ann. § 9-11-67.1(a) (2013).
[6] Ga. Code Ann. § 9-11-67.1(a) (2013).
[7] Ga. Code Ann. § 9-11-67.1(e) (2013).
[8] Ga. Code Ann. § 9-11-67.1(g) (2013).
[9] Ga. Code Ann. § 9-11-67.1(f) (2013).
[10] *S. Gen. Ins. Co. v. Holt*, 262 Ga. 267, 416 S.E.2d 274 (1992).
[11] *Holt*, 262 Ga. 267, 416 S.E.2d 274.
[12] *See Grange Mut. Ins. Co. v. Woodard*, 300 Ga. 848, 856–57, 797 S.E.2d 814, 821–22 (2017).
[13] *First Acceptance Ins. Co. of Ga., Inc. v. Hughes*, 305 Ga. 489, 492–93, 826 S.E.2d 71, 75 (2019).
[14] *Woodard*, 300 Ga. at 856–57, 797 S.E.2d at 821–22.
[15] *Grange Mut. Ins. Co. v. Woodard*, 826 F.3d 1289, 1299–1300 (11th Cir. 2016).
[16] *Grange Mutual Insurance Co.*, 826 F.3d at 1299–1300.
[17] *See Smith v. Baptiste*, 287 Ga. 23, 29, 694 S.E.2d 83, 88 (2010); *Holt*, 262 Ga. at 269, 416 S.E.2d at 276.
[18] *Woodard*, 300 Ga. at 851–59, 797 S.E.2d at 818–23.
[19] *Woodard*, 300 Ga. at 848, 797 S.E.2d at 818.
[20] *Woodard*, 300 Ga. at 852, 797 S.E.2d at 819.
[21] *Woodard*, 300 Ga. at 853, 797 S.E.2d at 819.
[22] *Woodard*, 300 Ga. at 854, 797 S.E.2d at 820.
[23] *Woodard*, 300 Ga. at 854, 797 S.E.2d at 820.
[24] *Woodard*, 300 Ga. at 854, 797 S.E.2d at 820.
[25] *Woodard*, 300 Ga. at 855, 797 S.E.2d at 821.
[26] *Woodard*, 300 Ga. at 855, 797 S.E.2d at 821.
[27] *Woodard*, 300 Ga. at 857–58, 797 S.E.2d at 822–23.
[28] *Woodard*, 300 Ga. at 859–62, 797 S.E.2d at 823–25 (Melton, Presiding J., dissenting).
[29] *Woodard*, 300 Ga. at 861–62, 797 S.E.2.d at 825 (quoting *Grange Mutual Insurance Co.*, 826 F.3d at 1299–1300).
[30] Ga. Code Ann. § 9-11-67.1(a)(1)(D) (2021).
[31] Ga. Code Ann. § 9-11-67.1(a)(2)–(3) (2021).
[32] Ga. Code Ann. § 9-11-67.1(h) (2021).
[33] *Pierce v. Banks*, 368 Ga. App. 496, 497, 890 S.E.2d 402, 404 (2023).
[34] *Pierce*, 368 Ga. App. at 497, 890 S.E.2d at 404 (emphasis added in original).
[35] *Pierce*, 368 Ga. App. at 497, 890 S.E.2d at 404.
[36] *Pierce*, 368 Ga. App. at 497, 890 S.E.2d at 404.

[37] *Pierce*, 368 Ga. App. at 497–98, 890 S.E.2d at 404–5.
[38] *Pierce*, 368 Ga. App. at 498, 890 S.E.2d at 405.
[39] *Pierce*, 368 Ga. App. at 498, 890 S.E.2d at 405.
[40] *Pierce*, 368 Ga. App. at 498, 890 S.E.2d at 405.
[41] *Pierce*, 368 Ga. App. at 498, 890 S.E.2d at 405.
[42] *Pierce*, 368 Ga. App. at 498, 890 S.E.2d at 405.
[43] *Pierce*, 368 Ga. App. at 499, 890 S.E.2d at 405.
[44] *Pierce*, 368 Ga. App. at 499, 890 S.E.2d at 405.
[45] *Pierce*, 368 Ga. App. at 499–500, 890 S.E.2d at 405–6.
[46] *Pierce*, 368 Ga. App. at 500, 890 S.E.2d at 406.
[47] *Pierce*, 368 Ga. App. at 500, 890 S.E.2d at 406.
[48] *Pierce*, 368 Ga. App. at 500, 890 S.E.2d at 406.
[49] *Pierce*, 368 Ga. App. at 500, 890 S.E.2d at 406.
[50] *Pierce*, 368 Ga. App. at 500–503, 890 S.E.2d at 406–8.
[51] *Pierce*, 368 Ga. App. at 500–501, 890 S.E.2d at 406–7.
[52] *Pierce*, 368 Ga. App. at 501, 890 S.E.2d at 407.
[53] *Pierce*, 368 Ga. App. at 503, 890 S.E.2d at 408 (citing Ga. Code Ann. § 33-24-56.1(g)) (Dillard, Presiding J., concurring).
[54] *Pierce*, 368 Ga. App. at 500–503, 890 S.E.2d at 406–8.
[55] *Pierce*, 368 Ga. App. at 501–2, 890 S.E.2d at 407–8.
[56] *Pierce*, 368 Ga. App. at 501–2, 890 S.E.2d at 407–8.
[57] *Pierce*, 368 Ga. App. at 501–2, 890 S.E.2d at 407–8.
[58] *Pierce*, 368 Ga. App. at 502, 890 S.E.2d at 407–8.
[59] *Pierce*, 368 Ga. App. at 503 n.9, 890 S.E.2d at 408 n.9.
[60] ATR Foundation, *Georgia*, *Judicial Hellholes* (2023–2024) (last visited July 7, 2024).
[61] *Patrick v. Kingston*, 370 Ga. App. 570, 898 S.E.2d 560 (2024).
[62] *Patrick*, 370 Ga. App. at 573, 898 S.E.2d at 563 (alteration and ellipses in original).
[63] *Patrick*, 370 Ga. App. at 574–76, 898 S.E.2d at 563–65.
[64] *Patrick*, 370 Ga. App. at 575, 898 S.E.2d at 564.
[65] *Patrick*, 370 Ga. App. at 575, 898 S.E.2d at 564.
[66] *Patrick*, 370 Ga. App. at 575–78, 898 S.E.2d at 564–66.
[67] *Redfearn v. Moore*, 2024 Ga. App. LEXIS 199 (May 23, 2024).
[68] *Redfearn*, 2024 Ga. App. LEXIS 199, at *1–2.
[69] *Redfearn*, 2024 Ga. App. LEXIS 199, at *2.
[70] *Redfearn*, 2024 Ga. App. LEXIS 199, at *2.
[71] *Redfearn*, 2024 Ga. App. LEXIS 199, at *2–3.
[72] *Redfearn*, 2024 Ga. App. LEXIS 199, at *3.
[73] *Redfearn*, 2024 Ga. App. LEXIS 199, at *3.
[74] *Redfearn*, 2024 Ga. App. LEXIS 199, at *3.
[75] *Redfearn*, 2024 Ga. App. LEXIS 199, at *3–4.
[76] *Redfearn*, 2024 Ga. App. LEXIS 199, at *4.
[77] *Redfearn*, 2024 Ga. App. LEXIS 199, at *4–6.
[78] *Redfearn*, 2024 Ga. App. LEXIS 199, at *6–9.
[79] *Redfearn*, 2024 Ga. App. LEXIS 199, at *6.

[80] *Redfearn*, 2024 Ga. App. LEXIS 199, at *6–7.
[81] *Redfearn*, 2024 Ga. App. LEXIS 199, at *7–8.
[82] *Redfearn*, 2024 Ga. App. LEXIS 199, at *7.
[83] *Redfearn*, 2024 Ga. App. LEXIS 199, at *7–8 ("As Plaintiffs point out, under Georgia law, an agent or representative such as an attorney who has expressly been given authority may endorse a check on behalf of a payee without running afoul of [Georgia Code] §§ 11-3-110 and 11-3-420(a).").
[84] *Redfearn*, 2024 Ga. App. LEXIS 199, at *8–9.
[85] Ga. Code Ann. § 9-11-67.1(b)(1) (2024).
[86] Ga. Code Ann. § 9-11-67.1(c) (2024).
[87] Ga. Code Ann. § 9-11-67.1(i) (2024).
[88] *See Delta Airlines, Inc. v. Townsend*, 279 Ga. 511, 512, 614 S.E.2d 745, 747 (2005) ("[I]t has always been a rule of construction of statutes that those in derogation of the common law, that is those which give rights not had under the common law, must be limited strictly to the meaning of the language employed, and not extended beyond the plain and explicit terms of the statute." (quoting *Thomspon v. Watson*, 186 Ga. 396, 405–6, 197 S.E. 774 (1938))).
[89] Brooke Butler, "Auto insurance rates are skyrocketing in Georgia. The reasons why and what you can do to lower it," *WJCL*, Mar. 11, 2024.

Insurance Coverage

Vol. 33 No. 3

Practice Points»

The Mediators Speak: Mediating when Your Case Is Strong

By Jeff Kichaven and Rachel Ehrlich

Jeff Kichaven:

"I'm not sure we want to mediate this one… Our case is strong."

Every lawyer has voiced this concern. But maybe it's not that simple. You can mediate successfully even when your case is strong. Here are some tips.

Mediate from a Place of Strength

Mediation is a good place to show calm, steady confidence in the strengths of your case. Once you do, it's part of the mediator's job is to make sure your counterparties appreciate your strengths and bargain accordingly.

How to show that confidence? Try these two ideas.

1. Share your mediation brief. Lay your strengths out in writing and send your brief to your counterparties in time for them to think it over before the mediation day. Don't catch them off guard, don't catch them by surprise. That way, they can come to the mediation with a proper top dollar or bottom line in mind.

2. Sit down with your counterparties in a Joint Session. Let them ask questions. Be prepared to answer. Let them try to poke holes. Be prepared to respond. Let them exhaust themselves trying to rebut your showing. Let them then bargain in the face of reality.

Remember, There Are Good Reasons to Settle Even the Strongest Cases

There's a saying sometimes attributed to Mark Twain which goes, "I have been ruined but twice in my life; once when I lost a lawsuit, and once when I won one."

This sentiment may motivate your clients as well. Clients may want to settle a strong case, to pay a little more or take less, to get all the other benefits of settlement – eliminating the risk of a judge or jury getting it wrong, eliminating mental wear and tear, and (no offense, colleagues) eliminating further expense. Victory has a price; not every client is willing to pay it.

Keep an Open Mind
As Judge Learned Hand famously said in 1944, "The spirit of liberty is the spirit which is not too sure that it is right."

That's the spirit of mediation, too. We come together in mediation to learn, to exchange information and perspectives, to add depth to our views. Sometimes, what seems like a lead-pipe cinch at 9 am on the mediation day looks like a real horse-race by noon. If that happens, mediation has served a valuable purpose. The exchange of information will have equipped you to bargain in light of reality, not the too-sure-you-are-right view with which you might have started the mediation day.

With these pointers in mind, even the strongest cases might be settled. Settlement or not, though, exchanges of information, consideration of your clients' many and varied interests, and maintenance of an open mind will ensure that your mediation day is a success. Your clients will make clear, strong decisions in a calm, informed environment. This will create satisfaction with the process, with the result, and, perhaps most importantly, with your performance as their lawyer along the way.

Rachel Ehrlich:

For several months, in multiple mediations, one side or the other was in the mediation *because* their case was strong. Sometimes strength came from liability being clear (or there was clearly no liability) and damages being clear (or were clearly low). Sometimes strength came from procedural wins at trial or on appeal, or grants or denials of dispositive motions, or issue or evidentiary sanctions. Sometimes strength came from clear insurance coverage with high limits and at other times coverage was unclear with low limits and a judgment-proof defendant.

Why were these people in mediation when they had such strong cases? The other side always asked "why are we here if they are so sure their case is so good?" There was "nothing" about which to negotiate, and yet someone (the lawyer, the client, or the other side) suggested that the parties mediate. They were there because nothing is certain until the last appeal is ruled upon and, if applicable, money is paid or collected or injunctive relief obtained and performed. They were there to obtain certainty sooner through settlement and to test case strength.

To leverage case strength in mediation you must educate the mediator about why your case is strong and why you are mediating. "Why" means facts, law, and procedure, not conclusions. Provide to your mediator the ruling or opinion or judgment/verdict that confers advantage, as well as detailed factual information and legal standards that apply to the case. In bad faith cases, please provide a detailed, outline-formatted, chronology of the case so

that the mediator can easily discern key dates and events in the order in which they occurred.

Test case strength in mediation. While the mediator is not going to be deciding your case, it helps to have someone without an interest in the outcome discuss the case with both sides. This allows for reality testing by both sides.

Share with the other side your written submission in advance of the mediation session. Even when your strengths are "obvious" or have previously been articulated in writing by you to the other side, everyone benefits from knowing what you have shared with the mediator.

Consider how you are going to negotiate in the mediation. Discuss this with the mediator. Making an initial offer (whether it is an ask or bid) that allows a lot of room to move sometimes detracts and distracts from the strength of your position. For instance, if you will accept or pay the policy limit and not a penny less or more, then you may be better served to say that and allow the discussion to focus on the substance rather than the numbers. Or, if the only way the case settles is above the policy limit(s), then indicating that with your opening offer can be extremely helpful (you may even consider an opening bracket with the low at or above the limit).

If you are clear about why you are mediating in view of the strengths of your case and behave accordingly your case has the best possible chance of settling because a third party is working with you and the other side to help everyone reach a rational place to settle.

Jeff Kichaven is a mediator based in Los Angeles, California.

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Insurance Coverage Litigation

Vol. 33 No. 3

An Update in "Greenwashing" Developments

By Robert Jacques

In headlines, controversies continue concerning company assertions about ESG-related initiatives, as well as recent state and federal regulatory efforts related to those claims. While often framed as a novel risk, "greenwashing" has been a subject of scrutiny for many years, with the FTC targeting "environmental marketing" claims since at least the 1990s. *See* FTC, *Cases Tagged with Environmental Marketing Cases Tagged with Environmental Marketing*; *see also, e.g.*, Prepared Statement of the FTC, *"It's Too Easy Being Green: Defining Fair Green Marketing Principles*" (June 9, 2009). And rather than a purely domestic issue, greenwashing has taken an international dimension, with the United Nations elaborating on "greenwashing" practices globally, UN, *Greenwashing – The Deceptive Tactics Behind Environmental Claims*, as well as the EU proposing and passing Regulations and Directives providing more guidance on the topic, such as the Directive to Empower Consumers for the Green Transition and the Green Claims Directive.

Domestic and global insurers, in turn, face exposure to their own policyholders' costs and liabilities for ESG-related claims. *See, e.g.*, Kennedys, *Legal Focus: Greenwashing is a Growing Risk for Insurers* (July 19, 2023). Particularly, such claims are an acute risk for companies in the food, drug, and cosmetic space, given their sale of products that consumers ingest or apply to themselves. *See, e.g.*, FTC Press Release, *Truly Organic? The FTC Says No* (Sept. 19, 2019); U.S. FDA, *Key Legal Concepts for Cosmetics Industry*. From resource procurement, to farming and manufacturing, to shipping logistics, to marketing, to regulatory compliance, the life cycle of a product can be complex and full of pitfalls, simply from how companies *describe* that cycle to the public.

As a recent example of regulatory efforts, the U.S. Department of Agriculture has announced guidelines to "strengthen the documentation that supports animal-raising or environment-related claims on meat or poultry product labeling." USDA Press Release No. 0164.24Those guidelines identify examples of agricultural greenwashing, including claims related to animal welfare, breeds, diet, living or raising conditions, negative antibiotic or hormone use, source and traceability, and organic compliance. *FSIS Guideline on Substantiating Animal-Raising or Environment-Related Labeling Claims*, FSIS-GD-2024-0006 (Aug. 2024) And while such claims may be vetted as part of a regulatory review process, or further verified by inspectors, the agency encourages third-party certification initiatives to avoid the reputational harm from greenwashing allegations and to prevent consumer harm.

Given the influx of controversies, claims, and regulatory efforts, companies should ensure that their risk management and insurance programs are aligned to thoughtfully meet those risks—particularly, insurance with personal and advertising injury (CGL), management liability (D&O), product-recall, and even cyber/media-liability coverages. As part of that

process, policyholders should check whether their existing insurance contains any ESG-specific coverage grants or limitations, and then seek adjustments (as necessary) with the help of a broker at renewal. Proactively raising and addressing these issues may help prevent disputes, coverage gaps, and other risks, including the possibility of insurers using the nondisclosure of certain ESG-related risks to deny coverage in the future after a claim arises.

If adequate insurance is not reasonably available, and the risk to a specific company is material, then that reality should inform internal deliberations on ESG issues. Deloitte, *Identifying and Mitigating Greenwashing Risk: Considerations for Insurance Firms* (Jan. 8, 2024) (reporting plans to restrict insurance for certain industries with heightened ESG risk, such as carbon-intensive industries). Processes to consider, decide, and continually assess that ESG risk, including the possibility of risk transfer through insurance, are the only way to properly factor such risks as part of an effective risk-management program.

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