UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

GOSPEL LIGHT MENNONITE CHURCH MEDICAL AID PLAN, Plaintiff, v. HUDSON EXCESS INSURANCE COMPANY, Defendant.	)	CASE NO. 5:22-cv-00581 JUDGE DAVID A. RUIZ **ORDER**

On March 4, 2022, Plaintiff Gospel Light Mennonite Church Medical Aid Plan, doing business as Liberty Healthshare (hereafter "Liberty"), filed a Complaint in the Stark County Court of Common Pleas against Defendant Hudson Excess Insurance Company (hereafter "Hudson"). (R. 1-1). Plaintiff seeks declaratory judgment stating that Defendant owes Plaintiff a duty to defend and indemnify under the terms of a Directors and Officers (D&O) insurance policy. Plaintiff also alleged claims for breach of contract and bad faith. *Id*. On April 11, 2022, Hudson filed a Notice of Removal, (R. 1), followed by an Answer to the Complaint on May 2, 2022. (R. 7). Hudson admits that it issued a Not-For-Profit Defender Policy No. HFP-HE-NPP-5016-040121 (hereafter "Policy") to Plaintiff, with a policy period of April 1, 2021, to April 1, 2022, and that a duplicate of said Policy was attached to Plaintiff's Complaint as Exhibit A. (R. 7, PageID# 200, ¶ 7).

At the parties' request, the Court permitted the parties to file cross-motions for summary judgment on the duty to defend. (R. 18). The parties have filed their respective motions, (R. 27; R. 28), with each side filing opposition briefs, (R. 31; R. 32), as well as replies in support of their respective motions, (R. 34; R. 35).

I. Background

Liberty and several of Liberty's past and present directors, officers, trustees, and/or employees (hereafter collectively "directors" or "officers"),[1] were named as defendants in a Class Action Lawsuit, *Glasgow v. Beers*, No. 5:21-cv-2001, in the District Court for the Northern District of Ohio, on October 21, 2021.[2] In the Amended Complaint filed therein,[3] Plaintiffs allege the following eight counts: (1) breach of contract and covenant of good faith and fair dealing against Defendant Liberty; (2) money had and received against all Defendants; (3) unjust enrichment against Defendant Liberty; (4) civil Racketeer Influenced and Corrupt Organizations Act (RICO) action against the four Corporate Defendants and Defendant Daniel J. Beers; (5) conversion against all Defendants; (6) breach of fiduciary duty against Defendant Liberty; (7) intentional, or alternatively, negligent misrepresentation against Defendant Liberty; and (8) an accounting against Defendant Liberty.

In the present lawsuit, Plaintiff Liberty filed this action after Defendant Hudson

---

[1] Plaintiff claims that "Hudson does not dispute that the Individual Insureds are, in fact, 'insureds' under the Policy." (R. 27, PageID# 439, n.1).

[2] That case is also before the undersigned District Court Judge, and the Court is very familiar with the allegations in that matter.

[3] An Amended Complaint was filed in that action on November 14, 2022. (*Glasgow*, No. 5:21-cv-2001, R. 76). The notice of claim that was submitted to Hudson occurred on November 11, 2021—prior to the filing of the Amended Complaint. (R. 27-1, PageID# 462). Nevertheless, both sides appear to agree that it is the allegations in the Amended Complaint that must be considered in determining whether the duty to defend applies. (R 28, PageID# 655-R. 31, PageID# 825).

determined that the Policy did not provide for coverage due to a Managed Care Activities exclusion contained within the Policy. (R. 27-1, PageID# 465). Joanna DiNardi, a senior claims specialist with Hudson, conceded that the Policy would cover allegations of self-dealing, mismanagement of corporate assets, and conflicts of interest if it were not otherwise excluded by exclusions contained within the Policy. (*Id.* at PageID# 468). Specifically, Hudson's denial was "predicated on the managed care activities exclusions subject to a reservation of rights on the other exclusions." (*Id*. at PageID# 469).

The managed care activities exclusion in the Policy reads as follows:

> **XXIV. EXCLUSIONS APPLYING TO ALL LIABILITY COVERAGE PARTS**
>
> The Insurer shall not pay **Loss** under this Policy in connection with any **Claim** based upon, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving any actual or alleged:
>
> > (A) act, error or omission in the performance of, or failure to perform, **Managed Care Activities** by any **Insured** or by any individual or entity for whose acts, errors or omissions any **Insured** is legally responsible, except with respect to any **Claim** for an actual or alleged act, error or omission in connection with the performance of, or failure to perform, **Provider Selection** otherwise covered under any **Liability Coverage Part** of this Policy;
>
> ***
>
> **"Managed Care Activities"** means any of the following services or activities, whether provided on paper, in person, electronically, or in any other form and whether performed for or on behalf of the **Company** or by the **Company** for itself or on behalf of any other party for a fee: **Provider Selection; Utilization Review;** advertising, marketing, selling, or enrollment for health care, consumer directed health care, behavioral health, prescription drug, dental, vision, long or short term disability, automobile medical payment, or workers' compensation plans; Claims Services; establishing health care provider networks including tiered networks; provision of information with respect to tiered networks and/or consumer directed health care plans, including cost and quality information regarding specific providers, services and/or charges; reviewing the quality of **Medical Professional Services** or providing quality assurance; design and/or implementation of

> financial incentive plans; design and/or implementation of Pay for Performance Programs; wellness or health promotion education; development or implementation of clinical guidelines, practice parameters or protocols; triage for payment of **Medical Professional Services**; and services or activities performed in the administration or management of health care, consumer directed health care, behavioral health, prescription drug, dental, vision, long or short term disability, automobile medical payment, or workers' compensation plans.

(R. 28-2, PageID# 706–07).

II. Factual Allegations of the *Glasgow* Amended Complaint

In *Glasgow*, Plaintiffs allege that Defendant Liberty and the other Defendants purported to operate a faith-based healthcare sharing ministry (HCSM). (*Glasgow*, No. 5:21-cv-2001, R. 76, PageID# 53, 65). Generally, Plaintiffs describe HCSMs as medical cost-sharing organizations where members of the same religious faith pay a premium or "contribution" to the HCSM, which then ostensibly redistributes the premiums to cover medical costs. *See generally id.* Plaintiffs allege that Defendant Liberty materially misrepresented that "the plans being offered were legitimate and legal HCSMs that would provide medical coverage, rather than the illegal and fraudulent contrivance they actually were, the true purpose of which was to circumvent state and federal insurance laws in a scheme to funnel money collected as premiums or 'contributions' to Liberty that were subsequently redirected to the Affiliated Defendants." (*Id.* at PageID# 1012–13, ¶ 92). In a nutshell, Plaintiffs allege as follows:

> Liberty's scheme is simple in concept. As a registered non-profit 501(c)(3) business and self-proclaimed faith-based "cost-sharing" agent for the payment of medical expenses, Liberty portrays the illegal health insurance it sells as HCSM plans—even though Liberty and the plans plainly do not meet the requirements under federal and state law for HCSMs—in an illegal scheme devised to avoid otherwise applicable federal and state law, including limitations on the percentage of premiums that can be diverted to purposes other than the payment of benefits.
>
> ***
>
> Liberty's scheme has proven to be an extremely lucrative—but illegal—

> arrangement by which its principals have amassed millions of dollars in illegal profits. Rather than pay the covered medical procedures and bills incurred by Plaintiffs and the other Class Members, which it was required to do, Liberty funneled the money collected as premiums or "contributions" to itself and its principals through affiliated for-profit entities so as to further circumvent and violate federal and state law limiting the distributions, profits, and compensation paid to non-profit principals.

(*Id.* at PageID# 989–90, ¶¶ 7–8). Despite holding itself out as an HCSM, Plaintiffs allege that Liberty is actually an unlicensed insurer because it fails to meet federal and state requirements for the exception. (*Id.* at PageID# 1003, ¶ 57).

More germane to the case at bar are the allegations that despite Liberty's designation as a non-profit corporation, Liberty's officers "conducted business through related entities and affiliated for-profit enterprises in a scheme to surreptitiously funnel profits to the Affiliated Defendants."[4] (*Id.* at PageID# 1017, ¶ 105). Plaintiffs allege that "Liberty's arrangements with the Affiliated Defendants were not arm's length transactions as they should have been, but instead, part of a larger self-dealing scheme that diverted member funds from Liberty and lined the pockets of its founders in a way totally contrary to its mission as a purported HCSM and charitable organization." (*Id.* at PageID# 1020, ¶ 115). The Amended Complaint alleges that "there was never any bid process to ensure that Liberty paid market prices for business services expenses." (*Id.* at PageID# 1021, ¶ 121). "Instead, vendor selection was subject to Defendant Dan Beers's approval and control without any due diligence," and the Affiliated Defendants Medical Cost Savings Solution, LTD; Cost Sharing Solutions, LLC; and SavNet International,

[4] The Amended Complaint defines "Affiliated Defendants" as "illegal constructs of [Liberty's] board members and/or family members whose relationship was not properly disclosed in order to charge over-market prices for services, thereby significantly eroding the portion of member contributions available for 'sharing.'" (*Id.* at PageID# 1017, ¶ 106). This was allegedly done despite Liberty's claim that "[o]ur Board Members are independent, non-compensated decision makers who follow a strict conflict of interest policy." *Id*. ¶ 107.

LLC, were all businesses over which Defendant Dan Beers "exercised command, control, and/or material influence." *Id.* Plaintiffs allege that Liberty's Chief Legal Officer Sandy Cheshire became aware of the dealings with the Affiliated Defendants and prepared a critical report only to be barred from the next Board meeting and terminated. (*Id.* at PageID# 1022, ¶ 124).

In Count Six of the Amended Complaint alleging a breach of fiduciary duty, Plaintiffs allege that Liberty and its officers owed a fiduciary duty to Plaintiffs but Liberty "squandered, stole, and converted members' contributions in order to enrich its owners, de facto owner Daniel J. Beers, Beers's family, and other third parties." (*Id.* at PageID# 1048, ¶¶ 231–32). Despite Liberty's fiduciary duty, it "failed to protect and favor members' interests and allowed its owners and other third parties to line their pockets while members were left with millions of dollars in covered but unreimbursed medical expenses." *Id*. ¶ 233.

III. Ohio Law Concerning Insurance Policies, Exclusions, and the Duty to Defend

Turning to the instant case, the parties here agree that Ohio law applies and whether an insurance policy extends coverage is a question of law for the court. (R. 27, PageID# 445 (citing *Westfield Ins. Co. v. Factfinder Mktg. Rsch., Inc.*, 168 Ohio App. 3d 391, 2006-Ohio-4380, 860 N.E.2d 145, 150 (Ohio Ct. App. 2006)); R. 32, PageID# 839 (citing *Gomolka v. State Auto. Mut. Ins. Co.*, 436 N.E.2d 1347, 1348 (Ohio 1982))).

Ohio courts have "held that the duty to defend is broader than and distinct from the duty to indemnify." *Ward v. United Foundries, Inc.*, 129 Ohio St. 3d 292, 2011-Ohio-3176, 951 N.E.2d 770, 773 (Ohio 2011) (citing *Ohio Govt. Risk Mgt. Plan v. Harrison*, 115 Ohio St. 3d 241, 2007-Ohio-4948, 874 N.E.2d 1155, 1159–60 (Ohio 2007)). Further, "the duty to defend is determined by the scope of the allegations in the complaint." *Id.* Where the allegations state a claim that "potentially or arguably falls within the liability insurance coverage," an insurer must

defend the insured. *Id.*; *see also Sharonville v. Am. Emps. Ins. Co.*, 109 Ohio St. 3d 186, 2006-Ohio-2180, 846 N.E.2d 833, 837 (Ohio 2006) ("An insurer has an absolute duty to defend an action when the complaint contains an allegation in any one of its claims that could arguably be covered by the insurance policy, even in part and even if the allegations are groundless, false, or fraudulent."). "Once an insurer must defend one claim within a complaint, it must defend the insured on all the other claims within the complaint, even if they bear no relation to the insurance-policy coverage." *Sharonville*, 846 N.E.2d at 837. Conversely, "if all the claims are clearly and *indisputably* outside the contracted coverage, the insurer need not defend the insured." *Ward*, 951 N.E.2d at 773 (emphasis added).

Here, Defendant has argued that a policy exclusion applies. "[W]here an insurer relies on an exclusion to deny coverage, the insurer has the burden of proving the applicability of the exclusion." *U.S. Specialty Ins. Co. v. Drake Aerial Enters., LLC*, 328 F. Supp. 3d 781, 784 (N.D. Ohio 2018) (alteration in original) (quoting *Will Repair, Inc. v. Grange Ins. Co.*, 2014-Ohio-2775, 15 N.E.3d 386, 391 (Ohio Ct. App. 2014)). As with general contract principles, in insurance law, the agreement will be construed strictly against the drafter (the insurer) and liberally in favor of the non-drafting party (the insured). *See, e.g., Lane v. Grange Mut. Cos.*, 45 Ohio St. 3d 63, 543 N.E.2d 488, 490 (Ohio 1989). Nevertheless, "[w]here an exclusionary clause in an insurance contract is unambiguous, Ohio law requires that the plain language of the clause be given effect." *Thomas Noe, Inc. v. Homestead Ins. Co.*, 173 F.3d 581, 583 (6th Cir. 1999) (citing *Park-Ohio Indus., Inc. v. Home Indem. Co.*, 975 F.2d 1215, 1218 (6th Cir. 1992)). "An insurance policy exclusion must be *clear and exact* in order to be given effect. When the language of the policy is doubtful or uncertain, the language will be construed strictly against the insurer and liberally in favor of the insured party." *Acme Steak Co. v. Great Lakes Mech. Co.*,

2000-Ohio-2566, Nos. 98-CA-146, 98-CA-243, 2000 WL 1506199, at *6 (Ohio Ct. App. Sept. 29, 2000) (emphasis added) (citation omitted) (citing *U.S. Fid. & Guar. Co. v. Lightning Rod Mut. Ins. Co.*, 80 Ohio St. 3d 584, 1997-Ohio-31, 687 N.E.2d 717, 719 (Ohio 1997); *Faruque v. Provident Life & Accident Ins. Co.*, 31 Ohio St. 3d 34, 508 N.E.2d 949, 952 (Ohio 1987)). "Although Ohio courts have let stand broad coverage provisions, they have not allowed broad exclusions to bar indemnification for claims otherwise covered." *Owens Corning v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, No. 97-3367, 1998 WL 774109, at *3 (6th Cir. Oct. 13, 1998)

Finally, Ohio courts have determined that an insurance policy is "illusory" where "it appears to grant a benefit to the insured, although in reality it does not." *Will Repair, Inc. v. Grange Ins. Co.*, 2014-Ohio-2775, 15 N.E.3d 386, 392–93 (Ohio Ct. App. 2014) (quoting *Beaverdam Contracting v. Erie Ins. Co.*, 2008-Ohio-4953, No. 1-08-17, 2008 WL 4378153, at *10 (Ohio Ct. App. Spet. 29, 2008)). "In general, an insurance contract is not illusory unless it fails to confer 'some benefit to the insured.'" *Yarbrough v. Erie Inspection Servs., Inc.*, 2024-Ohio-1712, 242 N.E.3d 881, 886 (Ohio Ct. App. 2024) (quoting *Pierson v. White Pine Ins. Co.*, 2022-Ohio-2702, 194 N.E.3d 765, 781 (Ohio Ct. App. 2022)). "If a provision in an insurance contract renders a contract illusory, that provision is void." *Michaels v. Michaels*, 197 Ohio App. 3d 643, 2012-Ohio-118, 968 N.E.2d 550, 556 (Ohio Ct. App. 2012). "Courts will attempt to interpret a contract so as to avoid a result which renders the contract illusory or unenforceable." *State v. Stanley*, 2002-Ohio-4372, 2002 WL 1965273, at *5 (Ohio Ct. App. Aug. 31, 2002) (per curiam) (citing *State ex rel. Gordon v. Taylor*, 79 N.E.2d 127 (Ohio 1948)); *see also Orchard, Hiltz & McCliment, Inc. v. Phoenix Ins. Co.*, 676 F. App'x 515, 523 (6th Cir. 2017) (applying Michigan law and noting that as "[a]pplied to insurance contracts, the illusory coverage doctrine requires 'an insurance policy to be interpreted so that it is not merely a delusion to the insured'"

(quoting *Emprs. Mut. Casual Co. v. Helicon Assocs., Inc.*, 880 N.W.2d 839, 843 (Mich. Ct. App. 2015) (per curiam))).

IV. Analysis

Defendant Hudson has asserted that "all of the facts alleged in the Underlying Litigation fall within the Managed Care Activities Exclusion, and therefore, Hudson has no duty to defend Liberty Healthshare." (R. 32, PageID# 841). The Court agrees that the Managed Care Activities exclusion clearly excludes many of the allegations and possibly several of the causes of action in this case. However, as noted above, "[o]nce an insurer must defend one claim within a complaint, it must defend the insured on all the other claims within the complaint, even if they bear no relation to the insurance-policy coverage." *Sharonville*, 846 N.E.2d at 837.

Defendant Hudson's Rule 30(b)(6) witness, DiNardi, testified that "[w]e reviewed every allegation in the complaint and believed that the underlying component of all of those allegations was the sale and marketing of illegal health plans." (R. 27-1, PageID# 467). First, the Court wholly disagrees with this characterization of the Complaint. Arguably, the unjust enrichment claim, the civil RICO claim, the conversion claims, the breach of fiduciary duty claim, the accounting claim, and possibly even the violation of the duty of good faith and fair dealing claims do not derive from the sale and marketing of illegal health plans. Instead, they stem from the voluminous allegations in the *Glasgow* Amended Complaint, partially summarized above, that Liberty, through its directors and officers, engaged in malfeasance by siphoning funds away from Liberty to third parties, who were allegedly controlled by Liberty's directors or their family members. In a nutshell, the *Glasgow* litigation does *not* solely involve allegations of illegal health insurance masquerading as a cost-sharing ministry as Defendant Hudson asserts, and such an interpretation ignores large swaths of the *Glasgow* Amended Complaint. Rather, it is replete

with allegations that have nothing to do with the *nature* of Plaintiff Liberty's business—as allegations of serious breaches of fiduciary duty could apply to any business or charity.[5] Therefore, Defendant Hudson's interpretation of the *Glasgow* Amended Complaint is as untenable as it is one-sided.

Furthermore, an insurance policy exclusion must be *clear and exact* in order to be given effect, and language should be construed strictly against the insurer where it is not. *Acme Steak Co.,* 2000 WL 1506199, at *6. First, the Court finds that Liberty's alleged decisions to engage third parties through a no-bid process and to select companies owned by its own directors or their family members does not fall into Managed Care Activities. Such decisions, alleged to violate the fiduciary duty Liberty's directors owed to its members, do not derive from managed care activities. Despite filing three separate briefs on the issue, Defendant Hudson does not make any meaningful attempt to explain how the alleged malfeasance of Liberty's directors involves activities that fall under the Policy's definition of Managed Care Activities, resorting instead to conclusory language.

Second, the language of the Managed Care Activities exclusion is not clear and exact but rather is written so broadly that the Court cannot discern any reasonable boundary between managed care activities and the duties of directors and officers in a business or charity whose sole focus is healthcare.[6] To reiterate, it states that Hudson "shall not pay Loss under this Policy

[5] Naturally, the Court has no position as to whether there is any merit to the allegations in the *Glasgow* Amended Complaint, but the duty to defend does not rise or fall on the merits of claims.

[6] The Court makes no determination whether the Managed Care Activities exclusion would be enforceable where a different insured's business only partially involves managed care activities. Under the facts of this case, the exclusion, interpreted as broadly as it has been by Hudson, would preclude any coverage. This Court declines to interpret the exclusion so broadly that it defeats all coverage and renders the contract illusory. *Stanley*, 2002 WL 1965273, at *5.

in connection with any Claim based upon, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving" the performance or failure to perform Managed Care Activities. (R. 28-2, PageID# 706–07). Because Defendant Liberty receives funds from its members that are anticipated to be paid out to members when they incur qualifying medical costs, one could argue that any and all actions of Liberty and its directors involve, directly or indirectly, managed care activities. The Court, however, declines to read the exclusion as expansively as Defendant Hudson does.[7] "D&O policies are more narrowly drafted and designed specifically to protect directors and officers from liability arising from negligence or misconduct in managing a business. Consequently, professional [Errors & Omissions] exclusions in D&O policies must be interpreted more narrowly to avoid negating the entire coverage scheme through the operation of an overly broad exclusion." *Great Am. Ins. Co. v. Geostar Corp.*, Nos. 09-12488, 09–12608, 09–14306, 2010 WL 845953, at *12 (E.D. Mich. Mar. 5, 2010).

The Court agrees with Plaintiff that *Atlantic Healthcare, LLC v. Argonaut Insurance Company*, 2020 WL 6393114 (S.D. Fla. Oct. 15, 2020), presents an analogous situation. There, an insurer also denied its insured a defense under a D&O policy where the estate of a nursing home patient sued the insured for breach of duties owed to the patient while she resided at the insureds' nursing home. *Id*. at *1–3. The estate asserted that the insured breached its fiduciary duties by accepting monies for her care but instead enriching himself and commingling his personal funds with the companies' assets. *Id*. Factually, this allegation is similar to those here that the *Glasgow* plaintiffs contributed money to a pool from which members' qualifying medical expenses would be reimbursed but Liberty squandered those assets by engaging in self-

[7] Defendant Hudson disclaims that it is arguing that its determination is based on the nature of Liberty's business, but its own arguments undercut its disclaimer. (R. 35, PageID# 876).

dealing and siphoning money to third parties for the enrichment of its directors and their families.

The insurer in *Atlantic Healthcare* argued that "the entirety of the Underlying Complaint f[ell] under the managed care activities exclusion because Plaintiffs' business 'by its very nature' is managed care." *Id*. at *8. The District Court held:

> [The defendant insurer] focuses on the description of Plaintiffs' business rather than the language of the D&O Policy and specific allegations in the Underlying Complaint. Again, while some allegations arguably pertain to performing, rendering, or failing to render managed care activities as set forth in the exclusion, others do not. Defendant points only to the allegations in Paragraphs 82-86 of the Underlying Complaint, which relate to Plaintiffs' understaffing of nurses, increasing of the overall acuity level of patients at the Facility without providing increased staff, and failure to provide adequate healthcare and meet residents' needs…. Defendant makes no argument whatsoever about how the remaining allegations about the Venture and Plaintiffs' taking Ms. Coombs's assets despite her being a vulnerable adult constitute managed care. This exclusion sets forth specific language and Defendant makes no attempt to interpret that language or relate it to all the claims in the Coombs Lawsuit. If the managed care activities exclusion applies to everything alleged in the Underlying Complaint simply because Plaintiffs operate a nursing home, then the D&O Policy provides no coverage at all.

Id. at *8, 13 (granting summary judgment in favor of the insureds, reasoning that the insurer failed to "meet its burden of persuasion to show how *all* of the claims brought by the Coombs estate fall *entirely* within the exclusionary provisions" (emphasis in original)).

Again, Hudson disclaimed that it is making an argument akin to the one the insurer made in *Atlantic Healthcare*. (R. 35, PageID# 876). Defendant's actual argument, however, only bolsters the notion that it considers *all* actions taken by Liberty and its directors to be managed care activities because they involve the handling of member funds that were ostensibly to be used for medical care claims. Citing paragraphs 115, 178, and 236 of the *Glasgow* Amended Complaint, Hudson emphasizes that although the allegations therein concern mismanagement, all

three involve allegations that member funds—intended for medical claims—were diverted, misappropriated, or kept by Defendants as profit despite Liberty's non-profit status. (R. 32, PageID# 842–43). Hudson asserts that all these allegations involve managed care activities "because they involve the payment of claims." *Id*. Breaking down this line of argument, the Court disagrees that the cited paragraphs of the *Glasgow* Amended Complaint "involve the payment of claims." Rather, reading those paragraphs, and the *Glasgow* Amended Complaint as a whole, the allegations assert that the general pool of funds was depleted due to the self-dealing of Liberty and its directors. To be sure, the funds were ostensibly pooled together to cover members' medical care expenses. Hudson is essentially considering anything touching upon the contributions of members as being related to "the payment of claims." As Liberty is ostensibly a non-profit faith-based healthcare sharing ministry, it is fair to presume that nearly all of Liberty's funds stem from member contributions. Thus, Defendant Hudson, by treating all monies Liberty collected as designated for "the payment of claims" or for other services under the managed care activities rubric, is indeed making the same argument that the insurer in *Atlantic Healthcare* did. In other words, Hudson considers the whole of Liberty's business to be managed care.

Under Hudson's limitless interpretation of the Managed Care Activities exclusion, every activity of Liberty involves, in some way, directly or indirectly, the handling, distribution, disbursement, or transferring of funds intended for the payments of medical claims. Under such a reading, the D&O Policy is rendered completely illusory. As indicated above, Ohio courts have determined that an insurance policy is "illusory" if it does not grant any benefit to the insured. *Will Repair, Inc.*, 15 N.E.3d at 392–93. Because courts are to interpret an insurance contract so as to avoid rendering coverage under the contract illusory or unenforceable, this Court declines to adopt Hudson's interpretation that would negate all conceivable coverage. *Stanley*, 2002 WL

1965273, at *5.

In sum, the Court concludes that the D&O Policy covers at least some of the claims alleged in the *Glasgow* Amended Complaint, thereby triggering Defendant Hudson's duty to defend.

V. Conclusion

For the foregoing reasons, Plaintiff Liberty's motion for partial summary judgment, (R. 27), is GRANTED, and Defendant Hudson's motion for summary judgment on the duty to defend, (R. 28), is DENIED.

IT IS SO ORDERED.

s/ *David A. Ruiz*
David A. Ruiz
United States District Judge

Date: June 24, 2025