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EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | October 2013

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No Coverage for Claim Expenses Where Insured Did Not Obtain Prior Written Consent of Insurer

The United States District Court for the District of New Jersey, applying New Jersey law, has held that a policy provision requiring written consent of the insurer in order for claims expenses incurred by the policyholder to be reimbursed is unambiguous. *Paulus Sokolowski & Sartor, LLC v. Cont'l Cas. Co.*, No. 12-7172 (D.N.J. Aug. 30, 2013). Wiley Rein represented the insurer.

The insured, a design and engineering firm, was retained during the construction of a residential townhouse community. The developer of the community and the community's condominium

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No Coverage for Employment Action Filed After Policy's Expiration

Applying Michigan law, the United States District Court for the Eastern District of Michigan has held that a letter from an insured company to its insurer that referenced newspaper articles about the company's improper investment activities was insufficient notice to preserve coverage for a subsequent employment claim made after the policy had expired. *Lemons v. Mikocem, LLC,* 2013 WL 5291513 (E.D. Mich. Sept. 19, 2013). The court also held that the employment claim did not relate back to any of the lawsuits filed during the policy period. Wiley Rein represented the insurer.

The insured company, which operated cemeteries and funeral homes, purchased a liability insurance policy for the policy period of April 20, 2005 to October 20, 2006. After the insurer opted not to renew the policy, the insurer received a letter on October 19, 2006 from the chief executive officer (CEO) of the insured company purporting to provide notice of potential future claims against the company. The letter stated the CEO's understanding that the insurer had elected not to renew the policy because an Internet search had revealed newspaper articles "referring to the funds being invested improperly according to the state." The letter also stated that "at this time no formal demands have been made against the company." The insurer later learned that five lawsuits had been filed against the company during the policy period.

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Exclusion for Liability "Assumed or Asserted" Under Contract Is Not Limited to Claims Under Indemnity Agreements

The United States District Court for the Middle District of Alabama has held that an exclusion precluding coverage for liability "assumed or asserted" under contract is unambiguous and not limited in application to claims involving liability assumed under an indemnity agreement. *Landmark Am. Ins. Co. v. Indus. Dev. Bd. of the City of Montgomery*, 2013 WL 4788588 (M.D. Ala. Sept. 9, 2013).

The insured development company entered into option contracts with a group of landowners for the right to purchase land in exchange for price guarantees. The landowners brought several suits against the development company for breach of contract. The company reported the suits to its D&O insurer, which denied coverage on the basis of a contract exclusion. That exclusion precluded coverage in connection with claims "arising out of or based upon any actual or alleged liability" of the insured "assumed or asserted under the terms, conditions, or warranties of any contract or agreement . . . ."

In the coverage litigation that followed, the development company argued that the contract exclusion was implicated only in the case of liability assumed under an indemnity contract. In support of this position, the development company pointed to case law indicating that the term "assumed" meant the assumption of liability under an indemnity agreement. The trial court, however, noted that the exclusion also included the term "asserted," which the court found to incorporate the breach of any contract, including the insured's own contracts.

The court also rejected the insured's argument that its "reasonable expectations" required a finding of coverage because the exclusion was unambiguous. In this regard, the court recognized that the development company was a "sophisticated entit[y]" and ruled that enforcing the exclusion as written was not unconscionable or violative of public policy. ■

Consent Judgment Coupled With Agreement Not to Execute Against the Insured Is Enforceable Under New Jersey Law

Applying New Jersey law, the United States District Court for the District of New Jersey has held that a consent judgment that assigns the rights of an insured against an insurer to a third party and limits execution to the policy proceeds is enforceable. *First Mercury Ins. Co. v. Markowitz*, 2013 WL 4430831 (D.N.J. Aug. 14, 2013).

The case involved a professional liability policy issued to a lawyer. The insured was sued for malpractice in connection with a real estate transaction. The insurer initially defended the action, but later withdrew the defense upon a determination that the policy did not afford coverage. The insured assumed his own defense and subsequently agreed to a consent judgment with the claimants for $310,000, which represented $240,000 in compensatory damages and $70,000 in attorneys' fees. The insured further agreed to pay $5,000 in partial satisfaction of the judgment and to assign to the claimants all of his rights under the policy and claims against the insurer, and the claimants agreed not to seek the unpaid balance of the judgment from the insured and to limit satisfaction of the judgment to any amounts they recovered from the insurer.

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Exclusion for Claims Arising Out of Bankruptcy or Insolvency May Bar Coverage for Claim Under Broker's E&O Policy

The United States Court of Appeals for the Tenth Circuit, applying Oklahoma law, has held that a bankruptcy or insolvency exclusion may bar coverage for the insured broker's claim, where the broker's actions were connected to the bankruptcy of its client's former insurer. *C.L. Frates & Co. v. Westchester Fire Ins. Co.*, 2013 WL 4734093 (10th Cir. Sept. 4, 2013).

The insured broker had obtained stop-loss insurance for one of its clients from a company that subsequently filed for bankruptcy. The broker then investigated and learned that the company was not an insurance company and had filed for bankruptcy to stall litigation against it in another state. The broker recommended that its client move its policy to another insurer, but the broker was forced to reimburse the client for the difference in higher deductibles. The broker then sought coverage under its own E&O policy. The E&O insurer argued that the broker's claim arose out of the bankruptcy of the stop-loss insurance company, therefore falling within the policy exclusion barring coverage for claims "arising out of" bankruptcy or insolvency. The broker contended that the claim instead arose out of the stop-loss insurance company's

> The court held that, under Oklahoma law, the phrase "arising out of" is broadly interpreted as requiring only some connection to the injury.

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Municipal Insurer's Professional Liability Policy Does Not Cover Settlement Within Limits of the Underlying Policy

The United States District Court for the Middle District of Alabama, applying Alabama law, has held that a professional liability policy issued to a municipal insurer afforded no coverage for the municipal insurer's settlement of a lawsuit alleging it failed to settle underlying litigation against its policyholder town within the limits of the underlying policy. *Scottsdale Ins. Co. v. Alabama Mun. Ins. Corp.*, 2013 WL 5231928 (M.D. Ala. Sept. 16, 2013)

The municipal insurer refused to settle an underlying auto accident claim within the $2 million limit of liability of the policy it issued to an Alabama town, believing the town's and its liability to be limited to $200,000. Following the refusal to settle, the underlying plaintiffs obtained a $4 million jury verdict against the town. The underlying plaintiffs then sued the municipal insurer for breach of contract and bad faith for refusing to settle.

The municipal insurer had a professional liability policy covering loss resulting from claims alleging an act, error, or omission in the performance of professional services, including claim handling and adjusting. The policy excluded coverage for any claim arising from, based upon, attributable to, or related in any way (directly or indirectly) to any obligation assumed by the municipal insurer arising out of any written contract, unless the municipal insurer would have been liable in the absence of the contract. The policy also contained a "hammer clause," permitting the professional liability carrier to withdraw the defense of a claim if an insured refused to accept a settlement the carrier recommended.

The professional liability carrier invoked its hammer clause and recommended that the municipal insurer settle the underlying bad faith

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Dishonesty and Profit Exclusions Bar Coverage for Suits Against Former City Employee for Approving Excessive Salaries

The United States District Court for the Central District of California, applying California law, has held that dishonesty and profit exclusions barred coverage for civil suits alleging that an insured former city employee approved excessive salaries and benefits for city employees and conspired to hide the information from the public. *Rizzo. v. Ins. Co. of the State of Penn.*, 2013 WL 4675063 (C.D. Cal. Aug. 30, 2013). The court also held that the California Insurance Code barred coverage for the defense of a state criminal prosecution of the former employee.

An insurer issued a policy to the City of Bell, California. The policy defined "insured" to include individuals who were "elected or appointed officials of [the city] . . . while acting on behalf of the Named Insured." In September 2010, the Attorney General of the State of California (the AG) brought suit against the city's former chief administrative officer—an appointed official and employee of the city—for misuse of city proceeds by approving contract terms for himself and others that were excessive and wasteful and for conspiring to conceal those acts from the public. In the same action, the city filed a cross-claim against the former employee. The AG also filed three criminal complaints against the former employee for misappropriation of public funds and conspiracy.

The insurer agreed to provide a defense for the civil action under a reservation of rights but refused to defend the employee against the criminal complaints, and the former employee filed suit against the insurer for breach of the duty to defend and breach of the duty of good faith.

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No Coverage for Claim First Made Before Policy Inception But After Retroactive Date

A Florida federal trial court has held that a claims-made-and-reported policy does not provide coverage for a claim first made prior to the policy's inception. *Rowland v. Diamond State Ins. Co.*, 2013 WL 5278219 (S.D. Fla. Sep. 18, 2013).

This lawsuit arose out of a negligence action filed in September 2007 by the personal representative of a deceased child who sued the insured foster parent, among others, for negligently causing the child's death. The foster parent agreed to a consent judgment against her and assigned her rights to bring a coverage action against her insurer.

The relevant claims-made-and-reported policy had a policy period of February 14, 2009 to February 14, 2010. The insuring agreement provided coverage "only if a claim . . . is first made against the insured and reported to us during the policy period." The policy also had a wrongful act retroactive date of February 14, 2003, under which the insurance "does not apply to injury caused by a wrongful act that . . . was committed before [February 14, 2003]." The policyholder was named as a defendant in a lawsuit served in September 2007, and first reported to the carrier in September 2009.

The policyholder sued for coverage on the theory that the retroactive date "brings the claim within the Policy period." The court rejected that argument, holding that the "clear and unambiguous" language of the insuring agreement provided coverage only for claims made and reported during the policy period, which the underlying claim indisputably was not. Accordingly, the court granted summary judgment to the carrier. ■

Claim for Employee Embezzlement Alleges a Wrongful Act But Is Excluded

The United States District Court for the Middle District of Georgia, applying Georgia law, has held that a professional liability policy afforded no coverage for the obligation of an insured billing and collection servicer to indemnify its client for employee embezzlement. *Nat'l Reimbursement Grp., Inc. v. Gemini Ins. Co.*, 2013 WL 4495846 (M.D. Ga. Aug. 21, 2013). The court concluded that an exclusion for claims arising out of criminal, fraudulent, dishonest, or knowingly wrongful acts precluded coverage.

The insured provided medical billing and collection services and learned that one of its employees had been diverting medical insurance checks payable to a client to her personal bank account. The client demanded that the insured repay losses incurred as a result of the embezzlement, and the insured sought coverage from its professional liability insurer. The insured contended that its negligent supervision of the embezzling employee constituted a "negligent or unintentional breach of duty imposed by law" and was therefore a "Wrongful Act" under the policy.

The insurer denied coverage in part on the basis that the underlying lawsuit did not allege a "Wrongful Act" because the insured's obligation arose under a contract rather than a duty "imposed by law." The court rejected this argument: the fact that the insured's billing services were performed pursuant to a contract did not, the court held, negate the coverage for billing services afforded by the policy. The court noted that the insured likely had a contractual relationship with all of its clients and had an independent duty to exercise reasonable care in the supervision of employees. Accordingly, the court found the claim to fall within the scope of coverage and proceeded to consider whether any exclusions applied to the insured's claim.

The policy barred coverage for claims arising out of any actual or alleged criminal, fraudulent, dishonest, or knowingly wrongful act omission committed by or with the knowledge of any "Insured," which was defined to include any employee rendering professional services on behalf of the named insured. The policyholder argued that its employee was not an "Insured" because the embezzlement was outside the scope of her employment. The court concluded that this argument "although creative, is without merit." According to the court, "the fact remains that [the employee] embezzled funds while engaging in billing services for [the named insured]." The policyholder's interpretation of the exclusion would, the court reasoned, render the exclusion meaningless: if committing any dishonest act would nullify that person's status as an insured, the exclusion would never apply to precluded claims arising out of an employee's criminal acts. Accordingly, the court concluded that the policy barred coverage for any claim for negligent supervision arising out of the employee's embezzlement. ■

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No Coverage for Claim Expenses Where Insured Did Not Obtain Prior Written Consent of Insurer

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association later sued the firm for professional negligence, seeking damages for construction defects at the site. The firm sought coverage under its architects and engineers professional liability policy. The insurer provided a defense and ultimately settled the claims against the firm. The firm later sought reimbursement for claim expenses it incurred when its employees assisted the insurer and its engineering expert. The insurer denied the request for reimbursement on the grounds that the firm had not obtained written consent prior to incurring the expenses and that the firm had a duty to assist in the defense.

The court dismissed the firm's breach of contract claims, determining that the policy provision requiring the insurer's written consent prior to the policyholder incurring claim expenses was unambiguous, and that the firm's complaint had conceded that there had been no explicit consent from the insurer. In reaching this conclusion, the court noted that interpretive principles calling for insurance policies to be interpreted against the insurer are less applicable where the policyholder is a large business with the resources to bargain for particular policy provisions, as was the case with the insured. The court additionally dismissed the firm's claims for unjust enrichment and *quantum meruit* because the express written contract covered the issues in dispute.

The court also dismissed the firm's claims for breach of the duty of good faith and fair dealing, breach of fiduciary duty, and bad faith. The court concluded that the firm had failed to allege facts demonstrating that the insurer had bad motive or intention and that the implied covenant of good faith and fair dealing could not override the express terms of a contract. The court further held that the insurer did not owe the firm a fiduciary duty in the context of reimbursing claim expenses. ■

No Coverage for Employment Action Filed After Policy's Expiration

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In 2007, after the policy's expiration, a former employee of the insured company filed an action for wrongful termination. After the employee obtained a judgment against the company, the employee initiated a garnishment proceeding against the insurer to recover its judgment. The insurer moved for summary judgment on the grounds that the employee's claim was not made during the policy period. The insurer argued that the October 19, 2006 letter from the CEO was not notice of a potential claim sufficient to preserve coverage for the employee's claim, and that the employee's claim did not relate back to any of the lawsuits filed during the policy period.

The court ruled for the insurer. The policy's reporting provision permitted an insured to provide notice of circumstances that "could give rise to any Claim, other than an Employment Claim or Third Party Claim," but required much more specificity of notice in order to preserve coverage for future Employment Claims. The court held that, because the employee's claim indisputably was an "Employment Claim" under the policy, a notice of circumstances could not be used to preserve coverage for the claim. In addition, the employee had argued that his action and the lawsuits filed during the policy period were "Related Claims" and thus a single claim under the policy. The employee argued that the insurer had treated the matters as related in its coverage correspondence and during its investigation of the prior lawsuits. The court rejected the employee's argument, noting that some of the correspondence was written before the employee's claim even was filed, and the later correspondence clearly stated that the insurer would not treat the matters as related. As such, the court held that the employee's claim could not be deemed made during the policy period. ■

Consent Judgment Coupled With Agreement Not to Execute Against the Insured Is Enforceable Under New Jersey Law *continued from page 2*

The insurer filed suit against the insured and claimants for a declaration of no coverage, and the claimants counterclaimed for breach of contract and bad faith. The insurer filed a motion to dismiss for failure to state a claim, arguing that a consent judgment that releases the insured of all liability likewise releases the insurer of liability to the claimants. In making this argument, the insurer contended that New York law applied. The court disagreed, recognizing that in the absence of a conflict of laws, it was required to apply the law of the forum state—*i.e.*, New Jersey. In this regard, the court held that both New York and New Jersey law allow for the assignment of an insured's interests against an insurer to a third party. The court further held that, for purposes of New York law, the assignment here was valid because it did not actually release the insured from all liability; rather, even though the claimants agreed not to execute the balance of the judgment from his personal assets, the insured remained liable for the judgment entered against him.

Turning to New Jersey law, the court recognized that a consent judgment and assignment of rights is enforceable against the insurer if the insurer wrongfully denies coverage and the settlement is reasonable and entered into in good faith. The court found that the amount of the judgment was reasonable, notwithstanding that the negotiations among the parties were limited, because the dispute involved claimed damages in excess of $240,000 for which the insured could have been found liable. The court also found that the insurer had presented no facts to support the contention that the insured and the claimants had colluded to defraud the insurer. The court did not address the propriety of the insurer's coverage position, but did find that the insurer had failed to prove the consent judgment was unenforceable at the pleadings stage, and accordingly denied the motion to dismiss the counterclaims. ■

Exclusion for Claims Arising Out of Bankruptcy or Insolvency May Bar Coverage for Claim Under Broker's E&O Policy *continued from page 3*

deception. The trial court granted summary judgment to the broker.

On appeal, the Tenth Circuit reversed and remanded the case, holding that a fact-finder could reasonably infer that the broker's injury arose out of the stop-loss insurer's bankruptcy or insolvency and therefore could fall within the bankruptcy or insolvency exclusion. The court held that, under Oklahoma law, the phrase "arising out of" is broadly interpreted as requiring only some connection to the injury. The court observed that the broker's investigation into the stop-loss insurer was prompted by news of the bankruptcy and that the broker had recommended that its client switch insurers because of the insurer's financial problems. Accordingly, the court held that the trial court's grant of summary judgment was inappropriate. ■

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The court first held that the former employee was an "insured," as defined in the policy. The insurer argued that the former employee was not an insured because the alleged acts of approving excessive salaries and covering up those acts were outside the scope of his employment duties. The court held that the alleged acts were performed in his capacity as the city's chief administrative officer because the former employee was charged with approving employment terms and because the alleged abuse of that discretion did not "evince a complete departure from his job duties that was unforeseeable in the context of the City's usual course of business." The court also rejected the insurer's argument that it had no duty to defend the former employee in the civil actions because the former employee's actions were "antagonistic to the [insured city's] interests." It held that neither the policy's terms nor public policy supported the insurer's argument and that the court was constrained not to "read additional terms into the contract that are not supported by the text."

The court also held that the civil actions sought "damages." Although that term was not defined in the policy, the California Supreme Court interpreted the term to mean "compensation, in money, recovered by a third party for loss or detriment that it has suffered through the acts of another" other than restitution. The AG's civil suit alleged violation of California Civil Procedure Code § 526a for waste of public funds, and the AG disclaimed that it was seeking damages from the former employee. The court reasoned that, although the statute only restrained the illegal expenditure of funds, the suit sought damages because an award to remedy harm from the approval of excessive salaries to other employees constitutes "damages." The AG's proclamation that it did not intend to seek damages from the former employee was not determinative because those representations did not preclude the AG from later seeking monetary amounts. The court likewise held that the city sought recovery of "damages" in its cross-claim because the city sought the award of monetary damages for the former employee's alleged wrongdoing.

The court then concluded that two policy exclusions barred coverage for the civil actions. The first exclusion barred coverage for claims "[a]rising out of an alleged willful commission of a crime by [the Insured] or other dishonest, fraudulent, or malicious act." The second precluded coverage for claims "[a]rising out of [the Insured's] wrongful act for gain, profit, or advantage to which you are not legally entitled." The insured contended that these exclusions first required a final adjudication, but the court held that the exclusions did not require a final adjudication to be implicated because the policy provided that the insurer was not required to defend an insured for claims falling within the exclusions.

The court held that the exclusions applied even though the civil actions alleged claims that "theoretically need not arise out of dishonesty, fraud, malice, or wrongful acts for gain, profit, or advantage." The civil actions alleged that the former employee negligently enriched himself and negligently approved contracts without first reviewing them. However, the court held that those covered allegations were "inseparably intertwined" with the non-covered allegations so that the exclusions were triggered.

The insurer was also found not to have a duty to defend the former employee against the criminal complaints. First, the court held that the policy's plain terms did not provide coverage for the criminal complaints. Second, the court held that Section 533.5 of the California Civil Code prohibited an insurer from providing a defense to state criminal prosecutions.

Because the court held there was no duty to defend any action, the court held that the insurer had no duty to indemnify the former employee and the court dismissed the insured's claim for bad faith since there was no reasonable potential for coverage. ■

litigation for $2 million—the limit of liability of the policy it issued to the town. The municipal insurer and the professional liability carrier agreed to split the settlement and reserve their rights to litigate concerning coverage under the professional liability policy.

The professional liability carrier sought declaratory judgment that it had no obligation to pay any portion of the settlement. The court agreed. First, the court rejected the argument that the carrier waived its ability to rely on its contract exclusion. The carrier timely issued a general reservation of rights letter, which is sufficient under Alabama law for the insurer later to deny coverage under a specific policy provision. Second, the court found that the contract exclusion barred coverage for the settlement. According to the court, the professional liability policy affords coverage only for negligent acts and omissions in the municipal insurer's handling of claims, not for its liability to its insureds for breaching its insurance contracts. In other words, the court stated, the policy does not require the professional liability carrier to take the place of the municipal insurer with respect to the latter's insurance contract. The court further held that the inclusion of a "bad faith" count was not dispositive because the relevant inquiry is whether the municipal insurer's loss "arose out of its contractual obligations to its insured." The court reasoned that the municipal insurer's refusal to settle for the policy amount and the resulting bad faith lawsuit did not convert its contractual liability to its insureds into an error or omission under the professional liability policy.

The court also rejected the municipal insurer's claim that its professional liability carrier violated the "enhanced duty of good faith" by forcing the municipal insurer to accept a settlement with the underlying plaintiff. The court found that the professional liability carrier had a reasonable and sincere belief that the municipal insurer was liable for $2 million and that accepting the settlement was in the municipal insurer's own interest since refusing the settlement would expose it to over $4 million in liability. Accordingly, the professional liability carrier did not breach its duties. ■

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