Wiley Rein LLP

EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | November 2013

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Injured Party Cannot Pursue Direct Action Against Insurer Before Obtaining Judgment Against the Insured

The New Mexico Court of Appeals has held that an injured third-party claimant cannot pursue a direct action against an insurer prior to obtaining a judgment against an insured, absent a contractual or statutory provision authorizing such an action. *Cohen v. Cont'l Cas. Co.*, No. 32,391 (N.M. Ct. App. Sept. 23, 2013). Wiley Rein represented one of the insurers in the litigation.

The claimants filed a malpractice lawsuit against their former attorneys. After the attorneys' professional liability insurers denied coverage, the claimants amended their complaint to add the two insurers as defendants, seeking a declaratory judgment

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No Duty to Defend Suit Demanding Only Injunctive Relief

A California Court of Appeal has held that an insurer's duty to defend an insured was not triggered by a claim seeking injunctive relief. *San Miguel Comm. Ass'n v. State Farm Gen. Ins. Co.*, 2013 WL 5658825 (Cal. Ct. App. Oct. 1, 2013). In addition, the court held that the insurer did not commit bad faith because it did not misrepresent its communications with claimant's counsel.

The insureds, a residential community association and its officers, were embroiled in a dispute with some community residents over enforcement of parking regulations. The residents requested non-binding mediation but did not identify any damages or demand compensation in the mediation request. The association tendered the request to its insurer. The policy required the insurer to "defend any claim or suit seeking damages covered under this policy." Based on its review of the mediation request and statements by the claimants' attorney that the claimants had not suffered any injury or out-of-pocket expenses, the insurer concluded that no coverage was available because the claimants

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California Court of Appeal Holds That There Can Be No Bad Faith Failure to Settle Where Claimant Has Not Made a Settlement Demand or Shown Interest in Settlement

The California Court of Appeal, applying California law, has held that an insurer is not liable for bad faith failure to settle if no settlement demand had been made by the claimant and the claimant had not expressed an interest settlement, even if the insured's liability is clear and the possibility of an excess judgment exists. *Reid v. Mercury Ins. Co.*, 2013 WL 5517979 (Cal. Ct. App. Oct. 7, 2013).

The insured was involved in an automobile accident that resulted in serious injuries to another driver. Shortly after the accident, the insurer advised the injured party that it "was accepting liability and that there may be a 'limits issue.'" The insurer then requested an interview with the injured party and asked for her medical records, which were not made available. Although the insurer and attorney for the injured party subsequently exchanged correspondence, the injured party never made a settlement demand. The injured party then filed suit against the insured about three months after the collision,

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Vague Description of "Possible Claim" Not Sufficient Under Claims-Made-and-Reported Policy

The United States District Court for the Middle District of Florida, applying Florida law, has held that a title agent did not provide adequate notice of a claim against it to trigger coverage under its claims-made-and-reported professional liability policy. *Lake Buena Vista Vacation Resort v. Gotham Ins. Co.*, 2013 WL 5532677 (M.D. Fla. Oct. 7, 2013). The court also held that the claim, asserting the title agent fraudulently converted escrow funds, was barred by exclusions for services in an attorney capacity, damages from conversion, breach of express contract, and willful or intentional failure to comply with escrow instructions.

The underlying claimant, standing in the shoes of the insured title agent, sought coverage for its cross-claim against the policyholder. The policyholder sent a letter to the insurer's agent during the policy period referencing a "possible claim . . . arising as a result of alleged negligence and/or defalcation of monies by certain employees and agents of the insured." The policyholder declined to provide additional details. Over a year later, the insured and its principal were named in a cross-claim alleging that the principal committed ethical breaches as an attorney to the claimant and that the insured title agent, along with the principal "intentionally and fraudulently defalcated, converted, and/or misappropriated . . . deposits from [the insured]'s escrow trust account."

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Evidence of Prevailing Industry Standards Necessary in Bad Faith Action

The United States District Court for the District of Colorado, applying Colorado law, has held that summary judgment on a bad faith claim was premature where neither party had provided evidence of the prevailing insurance industry standards. *Larson v. One Beacon Ins. Co.*, 2013 WL 5366401 (D. Colo. Sept. 25, 2013).

Former clients of the insured attorney brought a malpractice action against her, alleging that her substance abuse compromised her representation in an underlying case. Although there was evidence that the clients' damages exceeded $4 million, the clients twice offered to settle for the $1 million limits of the attorney's professional liability policy. The insurer consulted with the attorney each time, but the attorney indicated that she did not wish to settle. The attorney later declared bankruptcy, and the trustee of her estate entered into a $4.5 million settlement with the clients. The trustee then brought suit against the insurer, asserting claims for breach of contract and bad faith. With respect to the bad faith claim, the trustee alleged that the insurer had failed adequately to investigate the allegations in the underlying suit, to advise the attorney of her potential exposure to liability above the policy limits, or to recommend that she retain independent counsel.

The court held that, under Colorado law, in order to succeed on a bad faith claim, a plaintiff must show that an insurer's conduct was unreasonable, which is to be determined objectively according to the standards generally applicable in the insurance industry. The court found that neither party had come forward with evidence from expert witnesses or other sources establishing the relevant insurance industry standards and practices. The court determined such evidence

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Lawsuit Alleging Defective Architectural Design Barred by "Professional Services" Exclusion

Applying Louisiana law, a federal district court has held that, where an underlying complaint alleges injury exclusively arising from defective architectural design, a professional services exclusion bars coverage. *Wisznia Co. v. Gen. Star Indem. Co.*, Civ. A. No. 11-2657 (E.D. La. Sept. 27, 2013).

The insured architectural firm entered an agreement to design a performing arts center for a Louisiana parish. The parish filed suit against the insured, alleging injury arising from the firm's "breach of its contractual warranty, negligence, and lack of professional skill . . . ." After the insured tendered the claim to its commercial general liability insurer, the insurer disclaimed coverage, citing a professional services exclusion. The exclusion provided, in pertinent part, that there was no coverage for injuries "arising out of the rendering of or failure to render any professional services . . . ." The policy's definition of "professional services" included "[t]he preparing, approving, or failing to prepare or approve, maps, shop drawings, opinions, reports, field orders, change orders or drawings, and specifications."

In the coverage litigation that followed, the court held that the professional services exclusion precluded coverage for the underlying claim. The court noted that the parish made six specific allegations, accusing the insured of "[d]esigning and preparing a defective set of plans," "[f]ailing to coordinate the design," and "[u]nder-designing the project." The court held that, because "each of these . . . allegations involved the failure to render professional services" and there was not "even the slightest accusation of non-professional misconduct," the insurer did not have a duty to defend the policyholder. ■

Prior Knowledge Condition Not Met Where Attorney Had Pre-Inception Knowledge of Disciplinary Complaint Asserting Failure to File Suit in a Timely Manner

Applying Pennsylvania law, the United States District Court for the Eastern District of Pennsylvania has held that the prior knowledge provision in a professional liability policy was not met where the insured attorney knew, before the policy's inception, that a disciplinary action had been filed against him based on his alleged failure to file a civil rights lawsuit prior to the expiration of the applicable statute of limitations. *Fishman v. The Hartford*, 2013 WL 5429272 (E.D. Pa. Sept. 27, 2013).

The underlying action arose from the attorney's alleged negligence in advising an inmate who sustained serious injuries during a beating by a corrections officer. Following the beating, the inmate began communicating with the attorney regarding a possible civil rights action. After initially indicating his interest in taking on the representation, the attorney allegedly failed to respond to the inmate's written requests until December 22, 2008—after the statute of limitations had run. On May 5, 2009, the attorney received notice that the inmate had filed a disciplinary complaint against him with the state's governing ethics body. Although the complaint was ultimately dismissed, the inmate filed suit against the attorney and his firm on November 24, 2010, alleging negligence based on the attorney's failure to file a civil rights claim in a timely manner and failure to pursue other tort claims against the corrections officer. The firm's professional liability insurer denied coverage based on the policy's prior knowledge provision, which made it a condition precedent to coverage that, as of August 25, 2010—the effective date of the policy—"no 'insured' knew or could have foreseen that [the act, error, omission or 'personal injury' giving rise to the claim] could result in a 'claim.'" The insurer asserted that the attorney had notice of the disciplinary complaint as early

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Suit for Misuse of Investment Funds Does Not Allege Act in Performance of "Mortgage Broker Services" Within Definition of "Insured Services"

The United States District Court for the Northern District of Texas has held that underlying claims that the insureds misused investment funds intended for the purchase of nonperforming mortgages did not allege negligent acts, errors, or omissions in performing "mortgage broker services" within the policy's definition of "Insured Services." *Axis Surplus Ins. Co. v. Halo Asset Mgmt., LLC*, 2013 WL 5416268 (N.D. Tex. Sept. 27, 2013).

Between December 2010 and August 2011, the claimants invested approximately $5 million in a plan to purchase nonperforming mortgage notes and repackage and restructure the notes into performing loans. A number of third parties proposed to repurchase and restructure the mortgages, and the insureds agreed to process and service the mortgages. Alleging that their funds never were used to purchase mortgages, the investors filed suit against the third parties and insureds, asserting causes of action for, among others, fraud, breach of fiduciary duty, negligence, breach of contract, unjust enrichment, and violation of the Texas Securities Act. The insurer denied coverage and sought a declaration that it had no duty to defend or indemnify its insureds.

Ruling on the insurer's motion for summary judgment, the court held that the insurer did not have a duty to defend the suit under Texas's eight-corners rule. Examining the allegations of the underlying complaint and the policy's insuring agreement, the court held that the alleged misuse of invested funds did not involve "mortgage broker

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No "Wrongful Act" Where Complaint Alleges Only Fraud

Applying Massachusetts law, a Massachusetts appellate court has held that a lawsuit regarding the fraudulent issuance of insurance policies did not allege a "wrongful act" and thus did not trigger a duty to defend or indemnify under an E&O policy. *Utica Mut. Ins. Co. v. Amity Ins. Agency, Inc.*, 2013 WL 5177167 (Mass. App. Ct. Sept. 17, 2013).

The insurer issued an E&O policy to an insurance brokerage, which provided specified coverage for "loss arising out of wrongful acts . . . in rendering or failing to render professional services." "Wrongful act" was defined in the policy to mean "any negligent act, error, or negligent omission to which this insurance applies." The brokerage was named as a defendant in a lawsuit alleging that its former employee accepted premiums and issued fraudulent insurance policies. The brokerage settled the underlying action and sought defense and indemnity coverage from the insurer. The insurer denied coverage, concluding that the underlying action alleged only intentional and criminal conduct by the brokerage's employee and thus did not allege a "wrongful act" involving "professional services." Coverage litigation followed, and the trial court granted summary judgment in favor of the insurer, concluding that the underlying action did not allege a "wrongful act" and was not the result of "professional services." The insured brokerage appealed.

The appellate court affirmed and concluded that no duty to defend or indemnify existed under the terms of the E&O policy. According

> The source of the allegations in the underlying complaint was "intentional, criminal conduct, which cannot be viewed as a negligent act, error or omission."

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No Bad Faith for Settling Claim Against Insured

Applying Oregon law, the United States District Court for the District of Oregon has held that an insurer cannot be held liable for settling a claim in accordance with the express provisions of the policy. *Parvin v. CNA Fin. Corp.*, 2013 WL 5530618 (D. Or. Oct. 4, 2013).

A physician's medical malpractice liability policy contained an endorsement that stated: "We will . . . [n]ot settle any claim without your consent, or the consent of the Association's Committee formed to this purpose." In a malpractice action filed against the physician, the insurer requested consent to settle shortly before trial. The physician refused but the appropriate committee said the insurer had consent to settle as soon as the physician testified at trial. Thus, after the physician concluded his testimony, the insurer settled the action for an amount within the policy limits. The physician subsequently filed suit against the insurer, alleging that settling without his consent was a breach of the policy and of the duty of good faith, which had resulted in harm to his reputation and loss to his medical practice.

The court granted summary judgment for the insurer, finding that the policy expressly permitted the insurer to settle with the consent of either the physician or the committee, and the committee had provided consent. The court opined that the physician's argument essentially ignored the policy language permitting the insurer to settle with the committee's consent. The court rejected the physician's attempt to rely on Oregon cases holding that an insurer could be found in bad faith for failing to settle, finding that Oregon courts have never held that an insurer is liable for bad faith for exercising its contractual right to settle a claim. ■

Mere Notice of Potential Extra-Contractual Liability Is Not a Claim

Applying Illinois law, a federal district court has held that a letter from a claimant to an insured driver that references extra-contractual exposure to the driver's automobile insurer does not constitute a claim under a professional liability policy issued to that automobile liability insurer. *Lexington Ins. Co. v. Horace Mann Ins. Co.*, No. 11-CV-2352 (N.D. Ill. Sept. 4, 2013).

A motorcyclist injured in a collision with a truck offered to settle his claims against the truck's driver in June 2008. The driver's automobile insurer rejected the claimant's demand to settle for the automobile insurance policy's limit of $25,000. On September 14, 2010, the claimant sent the driver a letter proposing mediation and maintaining that "the only way" for the driver to avoid an adverse judgment would be "if the [automobile insurer] agree[d] to acknowledge [its] extra-contractual exposure and 'open' [its] limits." The automobile insurer received this letter on September 20, 2010.

A professional liability insurer issued to the automobile insurer a claims-made-and-reported policy with a policy period of September 28, 2010 to September 28, 2011. On December 17, 2010, the automobile insurer provided notice of a potential claim to the professional liability insurer in connection with the motorcycle accident and the September 14, 2010 letter. The professional

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Prior Acts Exclusion Is Inapplicable When Acts Took Place During Prior Policy Issued by Same Insurer

The United States District Court for the District of Oregon has held that a prior acts exclusion does not bar coverage under an insurance policy when the acts at issue took place during a prior consecutive policy issued by the same insurer and containing the same material terms. *Keizer Campus Operations, LLC v. Lexington Ins. Co.*, 2013 WL 4786521 (D. Or. Sept. 5, 2013). In addition, the court ruled that the policy's bodily injury exclusion did not apply because the underlying complaint alleged emotional harm unrelated to any "bodily injury" and because, in any event, the policy was ambiguous as to whether unwanted but beneficial medical treatment constituted "bodily injury." Finally, the court held that the policy's automatic extended reporting period applied even though the insured decided not to renew its policy and to instead purchase coverage from a different insurer.

The insured operated a senior health care facility. From 2008 until 2011, it was continuously insured by one insurer under three successive health care professional liability policies. During the second policy period, the insured received notice of a potential claim by a personal representative for the estate of a former resident at the insured's facility. Later, three days after the third policy period, the representative filed a suit against the insured alleging that, in the course of treating the former resident, the insured violated the resident's "do not resuscitate" order by providing emergency medical services to her. The medical services were allegedly rendered during the second policy period. The insured tendered the suit to its insurer, and the insurer denied coverage. A coverage action followed.

On cross-motions for summary judgment, the court ruled in favor of the policyholder and held that the insurer breached its obligations when it refused to defend the insured in the underlying litigation. First, the court rejected the insurer's argument that the "prior acts" exclusion in the third policy barred coverage. As a threshold matter, the court ruled that the insurer waived any argument with respect to the prior acts exclusion because it was raised for the first time in its response to the policyholder's motion for summary judgment. Alternatively, the court ruled that the prior acts exclusion did not apply because the relevant "acts" at issue occurred

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Failure to Supervise Employee Does Not Constitute "Professional Services"

Applying Minnesota law, a federal court has found that an insured's failure to supervise an employee and related breach of contract did not constitute a wrongful act in the rendering or failure to render professional services. *Jackson Title Life Ins. Co. v. Catlin Spec. Ins. Co.*, 2013 WL 4519382 (D. Minn. Aug. 26, 2013). The court also held that the policy's use of the article "the" indicated that the named insured must have been alleged to have rendered or failed to render professional services in order to trigger coverage.

The insured entered into a selling agreement with a life insurance company pursuant to which the insured sold the life insurance company's annuities. Pursuant to the agreement, the insured represented that all of its employees selling the annuities would be registered with the insured and that the insured would properly supervise all such registered representatives. The insured also agreed to indemnify the life insurance company for claims resulting from untrue or misleading statements by registered representatives or negligence by the insured in the course of selling the annuities, among other things.

One of the insured's representatives, at the request of his father-in-law, who was not employed by the insured, falsely certified that he had discussed a particular annuity with a client and that he knew of the client's investment goals before the client made a $1.1 million investment. The client was told by the father-in-law that the annuity would never fall below the value of her initial investment, but later discovered that it was worth well below that amount. The life insurance company agreed to rescind the annuity, refunded the client her money, and filed suit against the

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Possible Future Judgment Against Insured Does Not Support Claimant's Motion to Intervene as of Right

The United States District Court for the District of Nevada has held that an underlying claimant's "hope of an eventual judgment" arising out of a suit for legal malpractice was not a legally protected interest such that the claimant could intervene in a related coverage action "as of right." *Colony Ins. Co. v. Schwartz*, 2013 WL 5308254 (D. Nev. Sept. 19, 2013).

The coverage action arose of out a claim for malpractice against an insured attorney. While that suit was pending, the insured's professional liability insurer filed a coverage action against the insured, which sought a declaration of no coverage based on the insured attorney's alleged failure to timely report the claim and alleged failure to disclose certain information on the application for coverage. The suit also named the underlying claimant, but the insurer was unable to effectuate service on the claimant of the summons and complaint and, ultimately, voluntarily dismissed the claimant from the case. The insurer and the insured attorney subsequently settled the coverage action. Before the case was dismissed, however, the claimant filed a motion to intervene.

The court denied the motion, holding there was no basis for intervention as of right under Rule 24(a)(2) of the Federal Rules of Civil Procedure. In reaching this conclusion, the court pointed out that the underlying malpractice suit was still ongoing and without a judgment. As such, according to the court, the "hope of an eventual judgment" was not sufficient to meet the requirement of a "legally protectable interest relating to the property or transaction that [was] the subject of the [coverage] action." The court also observed that the claimant had not shown that the two suits involved the same legal issues, noting that the underlying malpractice suit involved alleged breach of fiduciary duties whereas the declaratory judgment action involved fraud. ■

Property Damage Exclusion Bars Coverage for Negligence and Breach of Fiduciary Duty Claims

The United States District Court for the Southern District of Texas, applying Texas law, has held that an insurer had no duty to defend two lawsuits asserting negligence and breach of fiduciary duty claims where the relevant policy contained a property damage exclusion and the claims arose out of property damage related to Hurricane Ike. *Landing Council of Co-Owners v. Fed. Ins.Co.,* 2013 WL 4787954 (S.D. Tex. Sept. 9, 2013).

The insured, a homeowners' association that managed and maintained a condominium development, sought coverage for three different lawsuits filed after the property was damaged during Hurricane Ike. The insurer denied coverage for the lawsuits based on the property damage exclusion contained in the relevant policy, which barred coverage for claims "based upon, arising from, or in consequence of any actual or alleged . . . damage to or destruction of any tangible property including loss of use thereof whether or not it is damaged or destroyed." After the insured filed a coverage action in federal district court, the insurer moved for summary judgment, arguing that the exclusion precluded coverage for the underlying suits.

Granting the insurer's motion in part and denying it in part, the court concluded that the insurer had no duty to defend two of the three lawsuits but had a duty to defend the third. In so doing, the court considered the applicability of the property damage exclusion to each cause of action asserted in the lawsuits, explaining that, under Texas law, the phrase "arise out of" is interpreted to mean "but for" causation. According to the court, the first lawsuit only asserted a negligence

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Maryland Notice-Prejudice Statute Potentially Applies to Notice Provision of Claims-Made-and-Reported Policy

The United States District Court for the District of Maryland, applying Maryland law, has held that Maryland's notice-prejudice statute, Maryland Code § 19-110, precluded dismissal where a claim allegedly was made during the policy period of a claims-made-and-reported policy but the insurer denied coverage because the claim was not reported within 60 days after the end of the policy period as the insuring agreement and notice provision required. *McDowell Building, LLC v. Zurich Amer. Ins. Co.*, 2013 WL 5234250 (D. Md. Sept. 17, 2013).

In June 2006, the client of the insured, a design firm, brought suit against the insured for failing to file an application with the Maryland Historical Trust to receive historic preservation credits. The client served the insured with the complaint but stayed the action pending the outcome of its proceeding against the Maryland Historical Trust.

In 2009, the insured tendered the lawsuit to the insurer. The insurer denied coverage based on the insured's failure to provide notice in accordance with the provisions of the policy in effect at the time that the suit was filed in June 2006. The policy's insuring agreement provided coverage for claims first made and reported during the policy period but also provided for a grace period for reporting claims up to 60 days after the expiration of the policy. The insured subsequently settled with the client and assigned its rights under the policy to the client. The client then brought suit against the insurer and argued that the insurer must prove prejudice to deny coverage based on late notice based on Maryland Code § 19-110 ("An insurer may disclaim coverage on a liability insurance policy on the ground that the insured . . . has breached the policy by not giving the insurer required notice only if the insurer establishes by a preponderance of the evidence that the lack of . . . notice has resulted in actual prejudice to the insurer."). The insurer moved to dismiss the complaint by arguing that Section 19-110 did not apply to claims-made-and-reported policies.

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Court Finds That "Defense Costs" Include In-House Legal Costs

An Oregon federal trial court has held that in-house litigation counsel's salary constitutes "defense costs" recoverable under an insurance policy that did not define the term. *City of Portland v. Ins. Co. of the State of Pa.*, 2013 WL 5524125 (D. Or. Sept. 30, 2013).

The relevant policy did not define the term "defense costs." The policyholder municipality claimed coverage for fees incurred by its in-house trial counsel with respect to certain litigation. The carrier disputed coverage, arguing that the term "defense costs" applied only to amounts paid to outside counsel.

Applying Oregon law, the court examined the term "defense costs" in context to determine its meaning. The policy used the term several times, including a provision that described exhaustion of a retention "by payment to a third party of judgments, settlements, or defense costs." The court reasoned that by specifying that only defense costs paid to a third party could exhaust the retention, but not so specifying in other parts of the policy, the policy implicitly recognized that the term "defense costs" without the "paid to a third party" qualifier would encompass in-house counsel acting as trial counsel.

The court further reasoned that the carrier could have specified that defense costs do not include in-house trial counsel. Accordingly, the court ruled in favor of the policyholder. ■

No Duty to Defend Suit Demanding Only Injunctive Relief *continued from page 1*

sought only enforcement of community parking regulations and not compensatory damages.

After the coverage denial, the claimant filed a complaint and first amended complaint against the insureds seeking only injunctive relief and punitive damages. The insurer denied coverage for the first amended complaint because the claimant sought only injunctive relief and punitive damages—neither of which, it contended, constituted damages under the policy.

The claimants then filed a second amended complaint, which sought compensatory damages. The insurer ultimately accepted coverage but refused to pay defense costs incurred before the tender of the second amended complaint. The insureds then filed suit against the insurer for failing to pay all defense costs and for allegedly making misrepresentations concerning the statements by the claimants' attorney.

The court held that the insurer had no duty to defend the insureds until the second amended complaint was tendered because the mediation request and previous complaints did not seek compensatory damages—only injunctive relief and non-covered punitive damages. The insureds contended that the mediation request, original complaint, and first amended complaint implied that claimants sought monetary damages. The court rejected this contention, opining that neither the claimants' allegation that there was no adequate remedy at law nor claimants' counsel's initial statement that his clients were not seeking compensatory damages would support an inference that damages would be sought. Moreover, the court opined that the claimants' request for punitive damages, even though it would have required the award of compensatory damages, did not imply a request for compensatory damages given the non-existence of any allegation of compensatory damages.

The court also held that the insurer had not committed bad faith by "making up the phone call" with claimants' counsel, in which he stated that his clients had sustained no damages. The court held that the evidence supported the insurer's contention that claimants' counsel had represented to the claims handler that his clients were not attempting to recover for any minimal damages they may have suffered. Moreover, the insurer could not have acted in bad faith in its handling of the claim before the tender of the second amended complaint because there was no coverage under the policy until the second amended complaint was tendered. ■

Prior Knowledge Condition Not Met Where Attorney Had Pre-Inception Knowledge of Disciplinary Complaint Asserting Failure to File Suit in a Timely Manner *continued from page 4*

as May 5, 2009, meaning that he "could have foreseen" that a malpractice suit would follow.

In the ensuing coverage litigation, the district court granted the insurer's motion for judgment on the pleadings. The court observed that the Third Circuit uses a mixed, subjective-objective standard for analyzing prior knowledge provisions, requiring an assessment of: 1. what facts were subjectively known to the insured; and 2. whether a reasonable lawyer in possession of such facts would have a basis to believe that the lawyer breached a professional duty. Applying this test, the court held that a reasonable attorney with pre-inception knowledge of the facts known to this insured—*i.e.*, that the statute of limitations on the inmate's civil rights claims had run and that the inmate had initiated a disciplinary proceeding alleging that the attorney was responsible for the missed deadline—could have foreseen that a claim might be asserted. The court rejected the insureds' argument that they could not have anticipated certain allegations in the malpractice suit that the inmate did not raise in the disciplinary complaint, noting that the prior knowledge provision does not require an insured to foresee the "precise contours" of a claim.

The court also rejected the insureds' two public policy arguments. First, the court interpreted Pennsylvania case law as establishing that the state's notice-prejudice rule does not apply to prior knowledge provisions in claims-made policies. Second, the court declined to credit the insureds' assertion that the omission of the word "reasonably" from the prior knowledge provision rendered coverage illusory. The court observed that the Third Circuit prior knowledge test requires the use of an objective standard, even where the subject policy does not expressly reference "reasonableness." ■

Property Damage Exclusion Bars Coverage for Negligence and Breach of Fiduciary Duty Claims *continued from page 8*

claim based on the insured's alleged failure to clean up and repair the property after the hurricane. Similarly, the second lawsuit included a negligence claim based on the insured's purported failure to exercise reasonable care to preserve the value of the claimants' property. The second lawsuit also included a breach of fiduciary duty claim based on the insured's alleged mismanagement of insurance proceeds received as a result of the hurricane. The court reasoned that the first and second lawsuits both asserted causes of action only arising from property damage related to the hurricane and therefore coverage for those suits was precluded by the property damage exclusion.

With respect to the third lawsuit, the court determined that the insurer had a duty to defend that suit because "some of the causes of action in that case are not specifically alleged to have arisen from property damage"—namely, a breach of fiduciary duty claim based in part on the insured's failure to collect assessments after the hurricane due to an undisclosed interest in selling the property, and a claim for breach of the Texas Property Code based in part on the insured's alleged "fail[ure] to make and assess assessments for common expenses, including security." According to the court, such claims appeared to be "separate and independent of the hurricane," and thus did not fall within the exclusion. ■

Mere Notice of Potential Extra-Contractual Liability Is Not a Claim *continued from page 6*

liability insurer disclaimed coverage on the basis that the letter constituted a claim that was first made prior to the inception of the policy on September 28, 2010. The policy defined a claim as a "written demand for monetary damages" or "a judicial, administrative, arbitration, or other alternative dispute proceeding in which monetary damages are sought." After a $17 million jury verdict was awarded against the driver, the automobile insurer settled its claim with the motorcyclist for $7 million in excess of the $25,000 limit of liability contained in the automobile policy.

The automobile liability insurer sought coverage for the settlement under its professional liability policy. In coverage litigation that followed, the court held that the letter did not constitute a claim. The court determined that the letter was not a "written demand for monetary damages" because it was not addressed to the automobile insurer directly, did not demand monetary damages, and merely referenced extra-contractual exposure in excess of the limits of liability. Further, the court held that the letter did not constitute "a judicial, administrative, arbitration, or other alternative dispute proceeding in which monetary damages [were] sought" given that it was not addressed to the automobile insurer and simply provided notice of mediation rather than constituting an "alternative dispute proceeding" itself. ■

Prior Acts Exclusion Is Inapplicable When Acts Took Place During Prior Policy Issued by Same Insurer
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during one of the insurer's prior policy periods and that the exclusion would not apply when the insured was covered under "consecutive and substantively identical policies with the same insurer throughout the relevant time period." The court then ruled that, since the policies were continuously in effect, the real issue was whether the timing of the policyholder's notice was prejudicial, and the court concluded that the insurer failed to carry its burden on this point because it did not brief the issue. As such, the court held that the prior acts exclusion did not apply.

Second, the court ruled that the policy's exclusion for "any bodily injury . . . sustained by [the insured's] patients or residents" did not bar coverage for the claim that the insured violated the resident's rights. The court first determined that the representative's claims for emotional distress she allegedly suffered as a result of "having to make the decision to end the life of her grandmother" were unrelated to the resident's alleged "bodily injury" and thus that the insurer had a duty to defend those claims. In addition, the court ruled that the term "bodily injury" did not unambiguously include allegations of "unwanted life sustaining treatment" since the alleged treatment, even if characterized as "battery," did not actually damage, hurt, or injure the resident's body.

Third, the court ruled that the policy's automatic extended reporting period was not rendered inapplicable, as contended by the insurer. First, the court rejected the insurer's argument that the automatic extended reporting period only applied when the insurer terminates coverage or decides not to renew the insured's policy, noting that nothing in the automatic extended reporting period provision provided for that result. In addition, while the insurer maintained that the automatic extended reporting period was not implicated because the policyholder obtained "other insurance [that] cover[ed] [it] or would cover [it] if its limits of insurance had not been exhausted," the court rejected that argument after observing that the later insurer denied coverage on prior knowledge grounds and thus the policyholder was not covered under the terms of another insurance policy. ■

Maryland Notice-Prejudice Statute Potentially Applies to Notice Provision of Claims-Made-and-Reported Policy *continued from page 8*

The court denied the insurer's motion to dismiss the complaint. The court reasoned that, at least at the pleadings stage, the insured sufficiently had pled that the requirement to give notice within 60 days after the policy expired constituted a covenant, rather than a condition precedent, under Maryland law. The court noted that certain judges applying Maryland law at the summary judgment stage have held that Section 19-110 does not apply to seemingly indistinguishable notice provisions that constitute a condition precedent to coverage, such as a claims-made policy in which timely notice is a requirement to triggering coverage under the insuring agreement. However, the court opined that the law on this issue is "very much in flux" and that, at least as a matter of pleading, the allegation that a claim was made during the policy period and coverage was denied due to late notice was sufficient to state a claim that the notice provision was a covenant, rather than a condition precedent, even though it was found in the policy's insuring agreement and identified as a condition to coverage. ■

Injured Party Cannot Pursue Direct Action Against Insurer Before Obtaining Judgment Against the Insured *continued from page 1*

as to the rights and liabilities of the parties under the professional liability policies. The insurer represented by Wiley Rein moved to dismiss the complaint for, *inter alia*, failure to state a claim. The trial court granted the motion, holding that the claimants had no "present rights" under the policy because they had yet to obtain "a judicial determination of liability" against the insured attorneys. Pursuant to stipulation, the claimants then dismissed the second insurer from the action.

On appeal, the New Mexico Court of Appeals affirmed, concluding that the New Mexico Supreme Court's decision in *Rhodes v. Lucero*, 444 P.2d 588 (N.M. 1968), controlled the issue. First, the court rejected the claimants' reliance on extra-jurisdictional authority holding that a declaratory judgment action does not constitute a "direct action." The court observed that, even if there is a difference between "direct" and "declaratory" actions, "the latter is still prohibited" under *Rhodes*. Second, the court declined to extend the narrow rule of New Mexico law that requires an automobile insurer to join both its insureds and the injured parties in the same coverage action. The court reasoned that a claimant's "contingent" interest in a policy does not present a justiciable controversy and therefore does not permit the initiation of a declaratory judgment action against an insurer. Third, the court refused to credit the claimants' policy-based arguments regarding judicial waste and efficiency, observing that it is up to the New Mexico Supreme Court to announce new policy. Fourth, the court rejected the claimants' contention that the common law prohibition on the joinder of an insurer by injured parties is "obsolete." The court distinguished each of the cases relied on by the claimants as involving statutory provisions that specifically authorized suits against insurers, and held that New Mexico's declaratory judgment statute does not itself provide such a right. Finally, the court concluded that the public policy exception that allows injured parties to join an insurer to an underlying suit "where the insurance coverage [at issue] is mandated by law for the benefit of the public" did not apply because professional liability insurance for attorneys is "not strictly mandatory." Because each of the claimants' arguments proved unavailing, the appellate court concluded that the lower court did not err in following the binding precedent set forth in the *Rhodes* decision. ■

California Court of Appeal Holds That There Can Be No Bad Faith Failure to Settle Where Claimant Has Not Made a Settlement Demand or Shown Interest in Settlement *continued from page 2*

and the injured party provided the insurer with her medical records about seven months after the accident. The insurer eventually offered the injured party the policy limits of $100,000, but she rejected the offer. The injured party proceeded to trial, obtaining a judgment against the insured for approximately $5.9 million. Because the insured had declared bankruptcy during the lawsuit, the bankruptcy trustee assigned to the injured party any potential rights the insured had against the insurer. The injured party then sued the insurer for bad faith failure to settle, and the trial court granted summary judgment in favor of the insurer.

> The court noted that an "opportunity to settle" does not arise simply because there is a significant risk of an excess judgment.

On appeal, the California intermediate appellate court affirmed the trial court's ruling, explaining that for bad faith liability to attach to an insurer's failure to settle, "there must be, at a minimum, some evidence either that the injured party has communicated to the insurer an interest in settlement, or some other circumstance demonstrating the insurer knew that settlement within policy limits could feasibly be negotiated." In the absence of such evidence, the court reasoned, "there is no 'opportunity to settle' that an insurer may be taxed with ignoring." Because there was no settlement offer from the injured party, and no evidence from which any reasonable juror could infer that the insurer knew or should have known that she was interested in settlement, the court held that the insurer had no duty to initiate settlement negotiations or offer its policy limits. In so holding, the court noted that an "opportunity to settle" does not arise simply because there is a significant risk of an excess judgment. ■

Evidence of Prevailing Industry Standards Necessary in Bad Faith Action *continued from page 3*

to be essential, and therefore summary judgment would be premature, even though many of the underlying facts were undisputed.

The court also dismissed the breach of contract claim because the trustee had not pointed to any express provision of the policy that was allegedly breached. The court concluded that the only basis for the breach of contract claim was a violation of the duty of good faith and fair dealing—the same as the bad faith claim—and this claim properly sounded in tort rather than contract. ■

No "Wrongful Act" Where Complaint Alleges Only Fraud *continued from page 5*

to the appellate court, the underlying action did not allege a "wrongful act" because the source of the allegations in the underlying complaint was "intentional, criminal conduct, which cannot be viewed as a negligent act, error or omission." As such, "losses arising from that conduct are not covered under the policy." In so holding, the appellate court rejected the brokerage's reliance on the fraud exclusion in the policy, the terms of which only applied "to insureds who participated in, acted with knowledge of, or acquiesced to such conduct." The brokerage contended that it was entitled to coverage because it was unaware of the former employee's misconduct. The appellate court rejected the argument, noting that the exclusionary language is "irrelevant" because the alleged misconduct "did not amount to 'wrongful acts' within the coverage of the policy." ■

Failure to Supervise Employee Does Not Constitute "Professional Services" *continued from page 7*

insured to recoup its loss. The life insurance company prevailed and sought coverage for the judgment under the insured's professional liability policy. The insurer denied coverage and coverage litigation ensued.

In concluding that the policy did not respond to the underlying judgment, the court first noted that liability in the underlying action was predicated on the insured's breach of the selling agreement. According to the court, the breach of the agreement was not "the rendering or failing to render Professional Services." The policy defined "Professional Services" as "the supervision of conduct or activities [by employees], in accordance with statutes, regulations or procedures established by governmental or self-regulatory authorities . . . or duties imposed under common law." The court determined that the insured's liability was not based on the violation of governmental regulations or common law duties, but on the insured's obligations under the agreement. Thus, the matter did not arise out of the "rendering or failure to render Professional Services."

The court also rejected the insured's argument that the employee's wrongful act brought the matter within coverage. According to the court, the insured's liability resulted from its failure to supervise its employee, not from the employee's actions. Moreover, the policy specifically provided coverage for damages "*the*" insured became legally obligated to pay because of a claim made against "*the*" insured. Thus, the court explained, the policy's specificity made irrelevant whether an employee of the insured rendered "Professional Services" because liability had to be predicated on "Professional Services" rendered by the insured entity. ■

Vague Description of "Possible Claim" Not Sufficient Under Claims-Made-and-Reported Policy

continued from page 2

The court determined that the policyholder's initial letter did not provide sufficient notice under the policy to trigger coverage for the later cross-claim. The letter, held the court, identified only a "possible claim," and did not identify the potential claimant, the project or amount of money at issue or, "except in the vaguest possible terms, describe the circumstances giving rise to the potential claim." The letter did not itself constitute a "claim," which the court defined for the sake of argument as "the assertion of an existing right; any right to payment or to an equitable remedy, even if contingent or provisional." The letter, the court reasoned, merely stated that some party may at some point in the future assert a right to payment. Accordingly, the letter did not satisfy the policy's reporting requirement so as to bring the later cross-claim within coverage.

In addition, the court found that coverage for the cross-claim was barred by an exclusion for "damages resulting from attorney services" because the cross-claim was "shot through" with allegations that the insured title agent, through its principal, provided legal services to the underlying claimant. Moreover, the policy barred coverage for damages from conversion, misappropriation, commingling, or defalcation of funds, as well as for breach of any express contract and willful or intentional failure to comply with escrow instructions. The claimant argued that it was attempting to collect damages for the policyholder's failure to supervise its principal, and its breach of fiduciary duty, and failure to advise the claimant of the alleged thefts—not the thefts themselves or any breach of contract. The court rejected this argument, holding that "the theft of the escrow funds was at the core of the allegations set forth in the cross-claim, despite [the claimant]'s current effort to reinterpret that document. The exclusions therefore apply."

Finally, the court rejected the claimant's reliance on self-serving factual findings inserted into the underlying judgment upon its *ex parte* motion to amend. The court distinguished case law precluding an insurer from challenging findings in an underlying judgment after wrongfully declining to defend. The court noted that the insurer here did not decline to defend the underlying cross-claim, as it had no notice of the cross-claim within the policy period. Moreover, even if it had declined to defend, it would not have acted wrongfully, as the allegations of the cross-claim were not within the policy's coverage. In any event, the gratuitous findings inserted into an amended judgment here were not material to the judgment. ■

Suit for Misuse of Investment Funds Does Not Allege Act in Performance of "Mortgage Broker Services" Within Definition of "Insured Services"

continued from page 4

services," an undefined term within the policy's definition of "Insured Services." In so holding, the court rejected the insureds' reliance on "generic and overly broad definitions . . . isolated from the mortgage context." The court instead relied on *Black's Law Dictionary*'s definition of "mortgage broker," which states that "[a] mortgage broker does not originate or service mortgage loans." This, according to the court, was the role the insureds allegedly had agreed to play. The court further noted that "[t]he fact that the proposed investment scheme was supposed to involve mortgages does not overshadow the fact that the allegations ultimately stem from fraud and misappropriation of funds."

The court denied the insurer's motion with respect to the duty to indemnify. Holding that "an insurer may have a duty to indemnify its insured even if the duty to defend never arises," *D.R. Horton-Texas, Ltd. v. Markel International Insurance Co.*, 300 S.W.3d 740, 744 (Tex. 2009), the court noted that liability had not yet been established in the underlying action. ■

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