Wiley Rein LLP

EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | December 2013

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Excess Policies Not Triggered Where Insured Settles with Primary Carrier for Less Than Full Limit

The Washington Court of Appeals, applying Washington law, has held that two excess professional liability insurance policies requiring exhaustion of the full underlying limit by payment by the underlying carrier afford no coverage for costs incurred by the insured in defending against various client claims and governmental investigations arising from its sale of tax shelters where the insured settled its coverage dispute with the primary carrier for payment by the primary carrier of less than half its limit. *Quellos Group, LLC v. Federal Ins. Co.*, No. 68478-7-I (Wash. Ct. App. Nov. 12, 2013). The court affirmed the trial court's entry of summary judgment in the insurers' favor, concluding that the excess policies' exhaustion language "reflects the distinguishing characteristic and function" of the excess policies rather than constituting a condition to coverage. Wiley Rein represented the first-layer excess insurer.

The insured investment advisor developed a proprietary tax shelter, which it sold to several clients from 2000 to 2001.

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Nonprofit Management Liability Policy Does Not Afford Coverage for Reimbursement of Stolen Social Security Benefits

Applying South Carolina law, a federal court has found that amounts required to be repaid to the U.S. Social Security Administration (SSA) pursuant to the insured entity's contract to serve as a representative payee did not constitute covered loss under a nonprofit management liability policy. *Family Assistance Management Services v. Beazley Ins. Co.*, No. 2:13-cv-1142 (D.S.C. Nov. 5, 2013). Wiley Rein represented the insurer.

A former director of the insured, a nonprofit organization that operated as a representative payee for Social Security beneficiaries, admitted to embezzling beneficiary funds. As a result, the SSA required that the insured repay to it the embezzled

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Wiley Rein's Daniel Standish Receives 2013 PLUS Award

Daniel J. Standish, chair of Wiley Rein's Insurance Group, received the Professional Liability Underwriting Society's (PLUS) Founders Award in November during the 26th International PLUS Conference held in Orlando, FL. Presented in honor of the "spirit and dedication" of PLUS Founder Angelo J. Gioia, the award is given to someone who has made "lasting and outstanding contributions to the Society."

Mr. Standish has over 20 years of experience and is nationally recognized as a leading attorney in professional liability insurance coverage matters and disputes. He is regularly ranked in the top tier of Washington, DC insurance lawyers by *Chambers USA*, as well as recognized as a leading lawyer in *The Legal 500 US*. Mr. Standish has played key roles at PLUS since 2001, including having served as a trustee and president and currently serving as a member of the board of directors of the PLUS Foundation, PLUS's charitable arm.

PLUS is a nonprofit organization founded in 1986 by industry professionals who recognized the need for a forum for individuals involved in the field of professional liability. The Founders Award recognizes an active member of the Society who has, among other things, shown "creativity and innovation" to address the organization's tasks, promoted PLUS in the industry and to the general public, and been involved in "developing, implementing, improving and/or continuing its programs." ■

Wiley Rein's Kimberly Melvin Honored by *Business Insurance* Magazine

Business Insurance magazine has named Kimberly M. Melvin, a partner in Wiley Rein's Insurance Practice, to its select list of 2013 "Women to Watch" in the insurance industry. The award spotlights "women leaders doing outstanding work" in risk management, benefits management, commercial insurance, and the legal field. The 25 recipients were honored this month at a leadership workshop and awards luncheon in New York.

Ms. Melvin is well known in the professional liability insurance industry, having carved out a unique and highly pertinent niche at the convergence of insurance and bankruptcy law. In addition, she is a leading lawyer for insurers in cases involving fiduciary liability policies and ERISA claims. Frequently recognized for her work, she was lauded by *The Legal 500 US 2013* for her "amazing knowledge, business acumen and strategizing." She also was named to Washington, DC's "Super Lawyers" list for insurance in 2013, and dubbed a "Rising Star" by *Law360* in 2011.

"What attracted me to these types of cases is there's so much that's on the cutting edge and ripped from the headlines that goes on in this industry," Ms. Melvin told *Business Insurance* in an interview. "In a lot of ways, while we're fighting legal issues, we're also tackling business issues and, as lawyer, I find that interesting and exciting."

Ms. Melvin is the second Wiley Rein attorney selected for this honor by *Business Insurance* in the past two years. Laura A. Foggan, chair of the firm's Insurance Appellate Group, was named to the magazine's prestigious "Women to Watch" list in 2011.

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Complaint Filed With Department of Insurance Is a "Claim"

The United States District Court for the Eastern District of Texas, applying Texas law, has held that a complaint filed with the Texas Department of Insurance (TDI) was a "Claim" because it constituted "a written demand . . . for monetary or non-monetary damages." *Regency Title Co., LLC v. Westchester Fire Ins. Co.*, 2013 WL 4675063 (E.D. Tex. Nov. 15, 2013). The court also held that the investigation commenced by the TDI after receiving the complaint likewise was a "Claim," as it fell within the policy's definition of "a civil, administrative, or regulatory investigation against any insured commenced by the filing of a notice of charges, investigative order, or similar document."

A homebuilder filed a complaint with the TDI regarding a title insurance company. The complaint made allegations against the title insurance company and requested an injunction or damages from the insurer of $100,000. The TDI sent the complaint to the title insurance company and asked the title insurance company to respond. After receiving the response, the TDI mailed a letter to the homebuilder stating that TDI had "concluded its investigation," was "not capable of resolving disputes of fact," and recommended that the homebuilder seek other remedies.

The homebuilder subsequently sued the title insurance company in Texas state court alleging the same wrongful conduct and seeking similar relief. The title insurance company tendered this suit to its E&O carrier, which had issued a claims-made-and-reported policy. The title insurance company had not reported the TDI complaint to the carrier, which was first made prior to its policy period. The carrier denied coverage on that basis.

In this ensuing coverage litigation, the insured argued that, although the TDI complaint and the state court complaint did allege interrelated wrongful acts as defined by the policy, the TDI complaint was not a "Claim" within the meaning of the policy. The court disagreed, holding that the TDI complaint was a "Claim" because it was "a written demand against any insured for monetary or non-monetary damages," which was one of the prongs of the policy's definition. The court rejected the insured's argument that the claim was not "made against any insured" because it was initially sent to the TDI. In that regard, the court noted that the policy did not indicate that the demand must be sent directly from the claimant to the insured, and thus that it could be made through a third-party intermediary.

The court also considered whether the TDI's actions following the complaint were a "Claim" under the policy's definition because it was "a civil, administrative, or regulatory investigation against any insured commenced by the filing of a notice of charges, investigative order, or similar document." The court held that it was because the TDI referred to its work as an investigation, and because the TDI asked for supporting documentation from the title insurance company.

Accordingly, because the court concluded that the TDI proceeding was a "Claim" first made prior to the policy period, the court granted the insurer's motion for judgment on the pleadings. ■

Material Misrepresentations on Medical Center's Insurance Application Entitle Insurer to Rescind Policy

The United States District Court for the Northern District of Illinois, applying Illinois law, has held that an insurer may rescind its policy where the insured medical center made material misrepresentations on its application about its practice of administering weight loss injections to patients. *Essex Ins. Co. v. Galilee Med. Ctr. SC*, 2013 WL 5770537 (N.D. Ill. Oct. 23, 2013).

A former patient sued the medical center and one of its insured doctors for medical negligence based on the doctor's recommendation and administration to her of medical treatment, which consisted of injection of medications for weight loss purposes. Neither the therapy nor the drugs had been approved by the U.S. Food and Drug Administration. The medical center's

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Violations of Consumer Protection Law Considered Intentional Acts That Do Not Constitute a "Wrongful Act"

The United States District Court for the District of Kansas, applying Arizona law, has held that no coverage is available under an E&O policy for a judgment in a Federal Trade Commission (FTC) action against the insured that established that the insured violated certain consumer protection statutes. *Fed. Trade Comm'n v. Affiliate Strategies, Inc.*, 2013 WL 5304082 (D. Kan. Sept. 20, 2013). In so holding, the court ruled that the insured's intentional conduct did not fall within the policy's insuring agreement because the conduct did not constitute a "wrongful act" under the policy and that coverage was further barred by the "regulatory authority" exclusion and dishonesty exclusion.

The FTC and several state attorneys general brought suit against the insured and several other co-defendants alleging that the defendants violated the Telemarketing and Consumer Fraud and Abuse Prevention Act by "marketing and selling goods and services upon the unfounded promise or representation that the buyers of the goods and services would have success in obtaining government grants." The court ultimately ruled against the insured and entered judgment of approximately $1.7 million, which was to be used for "consumer redress," with any remaining funds to go to the U.S. Treasury as disgorgement.

The E&O insurer defended the insured in the underlying action under a reservation of rights. Once judgment was entered against the insured, the FTC filed a writ of garnishment to collect the judgment under the policy. The insurer sought to quash the writ of garnishment.

In the ensuing coverage action concerning the writ of garnishment, the district court held that coverage was not available for the judgment for several reasons. First, the court ruled that the insured's conduct at issue did not constitute a "wrongful act," which was defined as a "negligent act, error or omission." The court found that "[t]he conduct ascribed to [the insured] and her company in [the underlying] order does not constitute negligence. It is intentional and conscious wrongdoing or conscious avoidance of knowledge of other defendants' wrongdoing. Therefore, it is not covered . . . ." The court rejected the FTC's argument that the insured's conduct might have been intentional but that the resulting harm was unintentional, stating that there was "no possibility" that the FTC, standing in the shoes of the insured, would be able to meet its burden under Arizona law for determining an insured's intent.

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Insurer Not Entitled to Dismissal of Coverage Action Based on Late Notice of Claim

A New York trial court has held that an insurer was not entitled to dismissal of an insured's coverage action at the motion to dismiss stage because it was unclear whether the insured was obligated to provide notice of a claim as soon as practicable based on the policy's related claims language. *Sirius XM Radio Inc. v. XL Spec. Ins. Co.*, 2013 WL 5958390 (N.Y. Sup. Ct. Nov. 7, 2013). In addition, the court declined to dismiss the insured's coverage action on the grounds that the insured did not seek consent to incur defense costs.

The directors and officers of the insured, a satellite radio provider, were sued in five actions filed between July 2008 and May 2011. The actions alleged wrongdoing by the directors and officers concerning approval of a merger and mismanagement of the company after the merger. The insured provided notice of the first suit as a notice of potential claim but did not provide notice of that lawsuit or the later lawsuits filed against the insured's directors and officers. The insurer denied coverage for the five lawsuits because the

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Reinsurer Not Obligated to Provide Coverage for Contract Action Even Though Insurer Funded the Defense

Applying Florida law, a federal court ruled that a reinsurer properly denied coverage for an underlying lawsuit that sought relief based solely on the insured's failure to pay under a construction contract because there was no alleged "wrongful act," and the policy contained an exclusion for intentional breaches of contract. *Public Risk Management of Florida v. One Beacon Ins. Co.*, 2013 WL 5705575 (M.D. Fla. Oct. 18, 2013). The court also concluded that the interaction between the insurers did not create coverage through estoppel.

According to the underlying complaint, the dispute involved a construction contract between the insured city and the claimant. During the relevant time frame, the insurer issued a public officials' E&O policy to the city. The policy provided coverage for liability arising from "wrongful acts," which was defined as "any actual or alleged error or miss-statement [sic], omission, act or neglect or breach of duty due to misfeasance, malfeasance, and nonfeasance." The policy also excluded coverage for intentional breaches of contract. The insurer funded the defense of the underlying litigation and sought reinsurance from its carrier. The reinsurer, however, refused to provide coverage under its policy because it argued that the litigation was not covered under the insurer's policy in the first instance. The insurer then sued its reinsurer.

In granting the reinsurer's motion to dismiss, the court examined the underlying complaint and noted that the claimant relied on the construction contract as its basis for its claim against the insured city. According to the court, the claimant did not rely on any alleged negligent acts by the insured. Thus, the court determined that there was no coverage under the policy because there was no allegation of any purported "wrongful act" by the insured. The court noted that, even if there were allegations of a "wrongful act," the contract exclusion would bar such coverage.

The court also rejected the insurer's argument that a reservation of rights letter from the reinsurer conceded coverage. According to the court, the reservation of rights letter reiterated the reinsurer's position that there was no coverage and provided only that the reinsurer would further investigate coverage under a reservation of rights. ■

Insured v. Insured Exclusion Does Not Bar Coverage for Claim by Former Executive of Pre-Acquisition Subsidiary; Possible—but Unpled—Allegations Do Not Trigger Coverage

Applying Oregon law, the United States Court of Appeals for the Ninth Circuit has held that an insured v. insured exclusion does not apply to bar coverage for a suit brought by a former officer of a subsidiary of the insured entity. *Kollman v. Nat'l Union Fire Ins. Co. of Pittsburgh*, Nos. 08-36017, 08-36019 (9th Cir. Oct. 27, 2013). In reaching this conclusion, the court found that the claimant had been an officer of the subsidiary before the subsidiary had been acquired by the insured entity and, as such, did not constitute an insured under the policy for purposes of the exclusion.

The court also held that the suit against the insured, which alleged breach of contract, breach of fiduciary duty, conspiracy and similar claims, but not violations of state or federal securities law, did not constitute a "securities claim" within the meaning of the policy. According to the court, "vague references to potential securities violations [were] not enough, and the fact that [the claimant] may have been able to amend the complaint to state securities claims . . . [was] not relevant." ■

No Coverage Under E&O Policy for Claim for Tortious Interference

The United States Court of Appeals for the Sixth Circuit has held that coverage is not available under a policy providing coverage for claims alleging "negligent act[s], error[s] or omission[s]" for a claim alleging only intentional conduct. *Szura & Co., Inc. v. Gen. Ins. Co. of Am.*, 2013 WL 5912062 (6th Cir. Nov. 5, 2013).

The insured, an insurance brokerage firm, hired an agent who had worked at a competing firm. While employed at the competing firm, the agent had signed a confidentiality agreement. After hiring the agent, the insured was sued for tortiously interfering with the competing firm's business relationships and with the confidentiality agreement. The insured reported the suit to its E&O insurer, which denied coverage. In the ensuing coverage litigation, the court held that the policy only afforded coverage for claims alleging negligent conduct, and this suit alleged only intentional conduct.

The policy afforded coverage for specified wrongful acts, defined in relevant part as "any actual or alleged negligent act, error or omission." The court held that this phrasing did not encompass intentional conduct. Thus, the relevant inquiry, according to the court, was whether the underlying allegations "sound[ed] in negligence." The complaint included counts for tortious interference with a contract, tortious interference with business relationships, and conspiracy to interfere with contract rights and business relationships. These counts required proof that the insured acted intentionally or maliciously. Additionally, the complaint alleged that the insured "intentionally" and "improperly" interfered with the contract, which the court read as an allegation of intentional conduct. ■

Criminal Conduct Exclusion Bars Coverage for Broker's Falsification of Insurance Policy Applications

Applying Florida law, the United States District Court for the Southern District of Florida has held that a criminal conduct exclusion bars coverage for a claim against an insurance broker who pled guilty to insurance fraud. *Certain Interested Underwriters at Lloyds, London v. AXA Equitable Life Ins. Co.,* 2013 WL 5948107 (S.D. Fla. Nov. 7, 2013).

An independent insurance broker completed a life insurance policy application for a client and answered "no" to a question in the application regarding whether the client intended to use the policy as any type of pre-death financial investment. The broker, however, routinely falsified insurance applications to induce insurers to issue policies that later would be sold on the secondary market as investments. The state of Florida brought a criminal proceeding against the broker, and he ultimately pled guilty to multiple counts of insurance fraud. Meanwhile, a client on behalf of whom the broker had submitted a false application brought suit against the broker. The broker settled the claim and assigned to the client his rights under his E&O insurance policy.

In the subsequent coverage action, the broker's insurer moved for summary judgment, arguing first that the client's claim did not allege "professional services," which was defined in the policy as "the marketing, sale or servicing of insurance products." The insurer contended that the broker was selling investment products, not insurance products. The court found that, although this argument was plausible, the record was undeveloped on this issue and thus summary judgment for the insurer was not appropriate on this basis.

Next, the insurer argued that the claim was barred by an exclusion for "[f]alsification of any offer of an insurance contract or document, including but not limited to quotes, binders, indications or policies." The insurer contended that the term "document" encompasses all written or printed information related to the sale of insurance, including policy applications. The claimant asserted that "document" is narrowed by the other words in the exclusion to mean only information

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Prior Settlement Agreement Does Not Provide Basis for Denial Under Prior Knowledge Exclusion

Applying North Carolina law, a federal court has found that a prior settlement agreement did not provide a basis to deny coverage for a subsequent lawsuit between the same parties. *Henderson/Vance Healthcare, Inc. v. Cincinnati Ins. Co.*, 2013 WL 5375612 (E.D.N.C. Sept. 25, 2013).

According to the underlying complaint, the litigation arose out of a mediated settlement agreement between the claimant and the insured based on a dispute regarding patient safety and the insured's alleged retaliatory treatment of the plaintiff, which dispute was resolved by a 2006 settlement agreement. The complaint alleged misconduct based on 1) acts related to the conduct that led up to the 2006 settlement agreement; 2) the insured's disclosure of the plaintiff's records, and 3) disparagement of the plaintiff by the insured's staff. The insured sought coverage from two insurers, each of which had a prior knowledge exclusion in its policy and both of which denied coverage based on that exclusion. The first carrier's exclusion precluded coverage for "any acts, errors, omissions or occurrences taking place prior to . . . the inception date if any insured on or before such date knew or reasonably could have foreseen that such act, error, omission or occurrence might result in a claim," while the second carrier's exclusion barred coverage for "any 'wrongful act' committed, attempted or allegedly committed or attempted prior to the 'policy period' . . . if, prior to . . . the date of inception, any of the policy insureds knew or should have reasonably foreseen that the 'wrongful act' may be the basis of a claim."

In concluding that the prior knowledge exclusions did not apply to bar coverage for the underlying lawsuit, the court first emphasized that North Carolina law required exclusions to be interpreted narrowly. It then stated that the settlement, which purported to resolve existing claims, would not lead a reasonable person to foresee a future suit would be filed. Further, the court noted that a 2007 letter written by the plaintiff's counsel that "alluded to a . . . civil action" did not actually threaten suit and instead indicated that the plaintiff believed the insured would honor the settlement. Accordingly, the court concluded that the insured was not "on notice that it [would] be sued for conduct related to" the settlement agreement or its implementation. The court also emphasized that some of the alleged conduct was based on conduct unrelated to that at issue in the settlement, which conduct would likewise not have been "reasonably foreseeable" by the insured. As a result, the court determined that the prior knowledge exclusions did not apply. ■

Insurance Agent's Employee Not an "Insured" When Alleged to Be Acting on Behalf of an Uninsured Agency

The United States District Court for the Southern District of Texas, applying Texas law, has held that an insurance agent's E&O carrier had no duty to defend the policyholder's employee when he was alleged to have been performing services solely on behalf of another, non-insured agent. *Carter v. Westport Ins. Corp.*, 2013 WL 5934606 (S.D. Tex. Oct. 23, 2013).

The employee of the policyholder, Smith-Reagan & Associates, was named as a defendant in a lawsuit alleging that he and another agent fraudulently collected premiums for policies sold to the underlying claimant. The employee sought coverage under an E&O policy issued to the policyholder. The insurer denied coverage because the underlying complaint alleged that the insurance services at issue were performed solely by a separate agency, Swetnam Insurance Services, or by the policyholder's employee on behalf of Swetnam. In the fourth and fifth amended complaints of the underlying lawsuit,

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Professional Liability Insurer Has Duty to Defend Insured Against Claim for Failure to Comply with Prevailing Wage Laws

The United States District Court for the Western District of Washington has held that a claim against an insured general contractor based on its subcontractor's alleged failure to comply with prevailing wage laws potentially involved "professional services" and thus triggered its professional liability insurer's duty to defend. *Bayley Constr. v. Great Am. E&S Ins. Co.*, 2013 WL 5913424 (W.D. Wash. Nov. 1, 2013).

The insured, a general contractor, was awarded a contract by a municipal owner for the renovation of a community center, and the insured in turn hired a subcontractor to perform certain work on the project. During the course of the project, the municipal owner learned that the subcontractor was illegally paying its workers on the project less than the amount required by the state's prevailing wage law, and after an investigation, it served the insured with a notice stating that it intended to withhold contract payments in the amount of unpaid wages and penalties. The insured tendered the notice to its insurer, which declined to defend the insured on the basis, *inter alia*, that the claim did not involve "professional services." In relevant part, the term "professional services" was defined to mean "Construction Management, Pre-Construction Consulting Services and Design Services."

In the coverage action that followed, the court ruled that the insurer breached its duty to defend because the claim arguably could impose covered liability on the policyholder. In so ruling, the court

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No Coverage for "Innocent" Insureds Based on Broad Language of Customer Funds Exclusion

The United States Court of Appeals for the Eighth Circuit has affirmed summary judgment in favor of an insurer, holding that a "Customer Funds Exclusion" in a professional liability policy issued to a title insurance agency unambiguously barred coverage for claims alleging that the agency and its employees misappropriated funds entrusted to the agency by a title insurer. *Bethel v. Darwin Select Ins. Co.*, 2013 WL 6050750 (8th Cir. Nov. 18, 2013). In addition, the court rejected the argument advanced by several individuals that they should be afforded coverage as "innocent insureds," ruling instead that the plain language of the "Customer Funds Exclusion" barred coverage for any claim that arises out of any loss or improper use of client funds, regardless of whether that loss was caused by a "guilty" insured, an "innocent" insured, or even a non-insured. *Id*.

The policyholder, an insurance agency, entered into an agreement whereby it agreed to serve as an agent for an insurance company. Under that agreement, the agency was responsible for recording mortgages, deeds, and mortgage satisfactions as well as paying fees associated with those recordings, and it also paid off mortgages on behalf of the insurer and its customers in order to facilitate refinancing transactions. To enable the agency to make those payments, the insurance company entrusted it with millions of dollars, which the agency was required to segregate into a separate account. Approximately 14 months into the agreement, the insurance company terminated the parties' relationship and filed a lawsuit against, among other parties, the agency and two individual insureds, alleging a wide-ranging fraudulent scheme to misappropriate funds entrusted to the agency. The complaint also contained counts for negligence and breach of contract based upon the same alleged scheme. The insurer refused to defend the action, contending that the entire complaint fell within the "Customer Funds Exclusion" to its policy.

The Eighth Circuit Court of Appeals affirmed summary judgment on behalf of the insurer. The court applied the "Customer Funds

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Excess Policies Not Triggered Where Insured Settles with Primary Carrier for Less Than Full Limit

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U.S. Internal Revenue Service (IRS) audits of the clients' tax returns led to an IRS investigation of the advisor, as well as a federal criminal probe. Several of the clients also asserted claims, which the insured settled, and a U.S. Senate subcommittee also launched an investigation. The federal criminal investigation resulted in the indictment of the advisor's CEO and tax planning principal, who eventually pleaded guilty to conspiracy to defraud the IRS and counseling false tax returns. The advisor sought coverage for the costs incurred in settling the client claims and responding to the various investigations under a program of investment management insurance. Prior to the criminal convictions, the primary carrier paid less than half of its $10 million primary limit and declined to make any further payments after entry of the guilty pleas. The first- and second-level excess carriers also declined to advance any sums on the basis of various policy exclusions and the primary carrier's failure to exhaust.

Coverage litigation ensued, and the advisor settled with the primary carrier with respect to several policy years concerning different tax strategies. The settlement did not allocate any further payment by the primary carrier under the relevant policy period. The excess insurers moved for summary judgment on the basis of both application of various conduct-related exclusions and the advisor's failure to exhaust the primary coverage. The excess insurers' policies provided that they attached "only after the insurers of the Underlying Insurance shall have paid in legal currency the full limit of the Underlying Limit for such Policy Period" and "only after all of the Underlying Insurance has been exhausted by the actual payment of loss by the applicable insurers thereunder," respectively. The trial court granted the insurers' motion on exhaustion grounds, and the advisor appealed.

The appellate court affirmed, holding that "the plain and unambiguous language compels the conclusion that excess coverage was not triggered by the agreement of the [advisor] to pay the policy limit of approximately $5 million that [the primary carrier] refused to pay." Rejecting the advisor's contention that the exhaustion requirements contained in the excess policies were mere conditions, the court opined that "[t]he language 'only after' reflects the distinguishing characteristic and function of an excess insurance policy." As such, the court "reject[ed] the argument that the exhaustion requirement should be treated in the same manner as a cooperation or notice requirement."

The appellate court further declined to find that the excess policy terms contained "standardized language" that had to be construed against the insurers. The court pointed to the availability of endorsements and other excess policy forms that would have permitted the insured to pay the difference between a carrier's payment and the full underlying limit in order to trigger excess coverage. The court distinguished *Zeig v. Massachusetts Bonding & Insurance Co.*, 23 F.2d 665 (2d Cir. 1928), and its progeny, observing that "[h]ere, unlike in *Zeig*, the plain and unambiguous language of the excess insurance policies unambiguously states how the underlying insurance is exhausted. The policies require the underlying insurer to pay the full amount of its limits of liability before excess coverage is triggered." ■

Wiley Rein's Kimberly Melvin Honored by Business Insurance *Magazine*

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As part of the selection process, a panel of senior editors at *Business Insurance* considered recent professional achievements, influence on the marketplace and contributions to the advancement of women in business. *Business Insurance* is a leading weekly trade publication that provides news for executives responsible for the purchase and administration of corporate insurance and self-insurance programs. ■

Insurer Not Entitled to Dismissal of Coverage Action Based on Late Notice of Claim

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insured failed to provide timely notice under the policy, which required notice of a claim "as soon as practicable after it was first made." The insurer also contended that the insured failed to seek its consent before incurring defense costs in the five actions. The insured filed suit against the insurer to recover fees and costs incurred in defending the suits.

The court held that "[w]hether the deemed date of the later claim relieves the Insured of the obligation to give notice each time a later Claim is made is not sufficiently clear from the words" of the policy "to require dismissal of the complaint . . . ."

The court held that, at the motion to dismiss stage, it could not determine that the insured failed to give timely notice. As an initial matter, the court held that it was required to accept the insured's assertion that it provided timely notice of the first two lawsuits. The insured contended that it provided timely notice of all five actions because the suits constituted related claims and each suit was deemed first made when the first claim was made. The court held that "[w]hether the deemed date of the later claim relieves the Insured of the obligation to give notice each time a later Claim is made is not sufficiently clear from the words" of the policy "to require dismissal of the complaint . . . ."

The court also held that it could not dismiss the insured's cause of action for the insurer's failure to pay defense costs on the grounds that the insured did not seek the insurer's consent before incurring those costs. The insured offered documentary evidence that the initial notice requested the insurer's consent to incur defense costs. The court held that "[t]here is no evidence whether [the insurer] gave its consent, refused it, or simply ignored this part of the notice." So, at the motion to dismiss stage, the insured stated a cause of action for breach of contract.

The court dismissed the insured's request for attorneys' fees in the coverage action because the insured filed the coverage action. The court held that attorneys' fees in a coverage action are only available when "the insurer has cast the insured in a defensive posture" by filing suit against the insured. ■

Nonprofit Management Liability Policy Does Not Afford Coverage for Reimbursement of Stolen Social Security Benefits

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funds that had been entrusted to the insured's care. The insured made a claim for coverage under its crime policy, and the crime insurer paid out the full limit of liability of that policy. The insured then requested that its management liability insurer pay the remaining amount due to the SSA. The management liability insurer denied coverage because, among other reasons, the amounts demanded by the SSA did not constitute covered "loss" within the meaning of the policy. Specifically, as defined, the term did not include "amounts owed under an express written contract."

In the coverage litigation that followed, the court granted the insurer's motion for summary judgment. In doing so, the court highlighted the fact that the application that the insured signed in each instance that it sought to be a representative payee provided that the insured agreed "to reimburse the amount of loss suffered by any beneficiary due to the misuse of funds by me/my organization." The court found that because the former director was acting in her capacity as an employee when she embezzled the beneficiaries' funds, the organization was accountable for the misuse. The court then reasoned that the SSA's demand for repayment cannot be construed as a claim in tort because the beneficiaries do not have statutory authority to file suit against a representative payee like the insured. Thus, according to the court, the SSA's claim for repayment was made pursuant to an express written contract—namely, the applications signed by the insured. On this basis, the court concluded that the amounts owed to the SSA did not constitute "loss" under the policy. ■

Professional Liability Insurer Has Duty to Defend Insured Against Claim for Failure to Comply with Prevailing Wage Laws *continued from page 8*

rejected the insurer's argument that "paying workers the appropriate prevailing wage does not require special skill or judgment, but rather is an obligation common to every public works contractor." The court observed that neither of the parties had supplied any precedent defining the term "professional services" in the context of a construction management or prevailing wage claim, and it found that the insurer should not have relied on "equivocal case law to give itself the benefit of the doubt rather than its insured." The court also found that while the failure to pay workers the prevailing wage might not rise to the level of "professional services" in the abstract, it could "in the context of overseeing a large construction project with multiple subcontractors."

The court also rejected the insurer's argument that the notice sent to the insured did not seek covered relief since the notice referred to the unpaid wages as "liquidated damages," which were carved out from the policy's definition of "loss." The court reasoned that the notice made clear that subsequent administrative proceedings could alter the wages and penalties due, and it concluded that "the mere appearance of the term 'liquidated damages'" was not an appropriate basis for deciding that the claim was "clearly not covered by the policy." The court further found that the claim could seek "loss" given that the insured could be forced to pay prevailing wages twice: once in the form of the subcontractor's lump-sum contract, and again in the form of relief sought by the claim. ■

The court also found that while the failure to pay workers the prevailing wage might not rise to the level of "professional services" in the abstract, it could "in the context of overseeing a large construction project with multiple subcontractors."

Material Misrepresentations on Medical Center's Insurance Application Entitle Insurer to Rescind Policy *continued from page 3*

insurer sought a declaratory judgment that it was entitled to rescind the policy due to material misrepresentations made by the medical center and the doctor in the policy application. In particular, the insurer relied on negative answers regarding whether the practice dispensed drugs or used injections for weight control and whether it used experimental procedures, drugs, or therapy in treatment.

The court held that, under Illinois law, an insurer can rescind coverage due to a misrepresentation on an application that materially affects the acceptance of the risk by the insurer. The court noted that failure to disclose material information could constitute a misrepresentation and that a misrepresentation could void a policy even if made by mistake or in good faith. The medical center and doctor argued that the answers on their applications were not misrepresentations because they used the drug injections for "size reduction" rather than "weight reduction," but the court found this argument to be disingenuous. The court further found that the medical center and doctor had failed to demonstrate that there was a genuine issue of fact as to whether the misrepresentations were material. Rather, the court determined that the insurer's detailed questions about weight reduction, drugs, and injections—in addition to a clear statement in the application that the insurer would rely on the information in issuing the policy—demonstrated that those representations were in fact material. Based on these findings, the court granted summary judgment in favor of the insurer and held the policy to be voided and rescinded. ■

Violations of Consumer Protection Law Considered Intentional Acts That Do Not Constitute a "Wrongful Act" *continued from page 4*

The court also held that coverage was further precluded by the "regulatory authority" exclusion, which barred coverage for any claim by "[a]ny regulatory authority or any administrative actions brought by any federal, state or local governmental entity." The court recognized that "[t]his case involved allegations by the FTC and State Attorneys General that [the insured] violated an FTC regulation" and that the FTC and the state attorneys general constituted regulatory authorities implicating the exclusion. The court rejected the FTC's argument that "regulatory authority" exclusions can only be enforced where the exclusion specifically identifies the regulatory entities. The court further rejected the FTC's contention that the reasonable expectations doctrine should preclude enforcement of the exclusion because the exclusion was not prominently displayed in the policy and was "vaguely phrased," finding that the "exclusion is sufficiently clear and obvious to an insured that it should not be considered contrary to reasonable expectations."

In addition, the court held that coverage was further precluded by the exclusion barring coverage for claims "for, arising directly or indirectly out of, or alleging . . . gain, profit or advantage to which [the insured is] not legally entitled." Addressing this exclusion, the court commented that because the underlying judgment "ordered that [the insured] pay as 'consumer redress' the entire amount of compensation she received while substantially assisting the [statutory] violation," the "award of damages arose 'directly or indirectly' from 'gain, profit or advantage' to which [the insured] was not legally entitled, because it derived from her substantial assistance and facilitation of the [statutory] violation." The court also held that coverage was barred by the exclusion precluding coverage for "[a]n act or omission that a . . . court . . . finds dishonest, fraudulent, criminal, malicious or was intentionally committed while knowing it was wrongful" because the underlying court found that the insured "should pay damages for actions which were intentionally committed while knowing they were wrongful."

While the court granted the insurer's motion to quash the writ of garnishment, the court did comment that, notwithstanding the finding of no coverage, the "money judgment ordered by [the underlying court] reasonably falls within" the policy's definition of "damages," which was defined, in relevant part, as a "money judgment, award or settlement, except those for which insurance is prohibited by law." In this regard, the court noted that the underlying judgment refers to the monetary award as "damages" and that Arizona law does "not always hold that damages awarded as restitutionary relief are prohibited by public policy." ■

Criminal Conduct Exclusion Bars Coverage for Broker's Falsification of Insurance Policy Applications *continued from page 6*

emanating from the insurer that identified significant aspects of the proposed coverage, like a quote or a binder. The court found that both interpretations were reasonable and, therefore, the provision was ambiguous. As such, the court construed the exclusion against the insurer and held that it did not bar coverage for the claim.

Finally, the insurer contended that coverage was precluded by the policy's exclusion for "[c]onduct which is fraudulent, dishonest, criminal, willful, malicious, intentionally or knowingly willful, or otherwise intended to cause damage or injury to personal property" in the event of a final adjudication of such conduct or an admission by the insured. According to the insurer, the broker's guilty plea and the judgment entered by the criminal court established that he had committed fraud by falsifying insurance applications. The court agreed and held that the criminal conduct exclusion barred coverage for the claim. Accordingly, the court granted the insurer's motion for summary judgment. ■

Insurance Agent's Employee Not an "Insured" When Alleged to Be Acting on Behalf of an Uninsured Agency *continued from page 7*

the claimant added the allegation that "according to [the employee] all of [his] actions at issue in this case were performed in the course and scope of his employment with Smith-Reagan and not on behalf of Swetnam Insurance Services." The employee asserted that this allegation triggered a duty to defend by Smith-Reagan's insurer.

The court disagreed. Under Texas's "eight corners" or "complaint-allegation" rule, an insurer's duty to defend is determined solely by comparing the factual allegations of the underlying complaint to the policy at issue. The court concluded that the underlying complaints here did not allege that the employee acted on behalf of the policyholder and therefore that he was not an "insured." The court further determined that the claimant's recitation of the employee's insistence that he acted on behalf of Smith-Reagan was simply not a factual allegation made by the plaintiff and could not trigger coverage.

The court's conclusion was bolstered by further amendments to the underlying complaint that explicitly alleged that the employee acted in the course and scope of his employment with the policyholder, Smith-Reagan, and not on behalf of Swetnam. These allegations were made in a sixth amended complaint filed one day before the employee settled the underlying action. Accordingly, the employee qualified as an "insured" based on the allegations of the sixth and final amended complaint but not based on any prior version lacking such allegations. The court therefore granted the insurer's motion seeking summary judgment that it had no duties arising out of the prior complaints in the underlying lawsuit. ■

No Coverage for "Innocent" Insureds Based on Broad Language of Customer Funds Exclusion *continued from page 8*

Exclusion"—which barred coverage for "any Claim . . . based upon, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving . . . any actual or alleged . . . loss, disappearance, pilferage or shortage of, or commingling or improper use of, or failure to segregate or safeguard, any client or customer funds, monies or securities"—to hold that there was no coverage for the underlying complaint. Observing that Minnesota courts have given the phrase "arising out of" broad meaning, the court determined that the exclusion applied because there was a "direct cause-and-effect relationship between all actionable conduct alleged in [the] complaint and the loss or improper use of customer funds." The court specifically rejected the insureds' argument that the alleged failure to record mortgage instruments could have occurred in the absence of fund misappropriation, concluding that the court would not "imagine a scenario" that was not pled in the underlying suit.

In addition, the court rejected the two individual insureds' attempt to invoke the "innocent insured" doctrine. In so ruling, the court distinguished prior case law applying policy language excluding conduct by "the insured," concluding that the policy language here barred coverage for the acts of anyone—be it a "guilty" insured, "innocent" insured, or even a non-insured—since its terms barred coverage for "any Claim . . . based upon, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving . . . any actual or alleged . . . loss" or improper use of customer funds. ■

The court distinguished prior case law applying policy language excluding conduct by "the insured," concluding that the policy language here barred coverage for the acts of anyone—be it a "guilty" insured, "innocent" insured, or even a non-insured.

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