Wiley Rein LLP

EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | February 2014

Wrongfully Withheld Compensation Not "Disgorgement"

The United States Court of Appeals for the Sixth Circuit, applying Michigan law, has held that a settlement based upon wrongfully withheld compensation was not based upon "disgorgement" as used in a carveout from a definition of "Loss" in an insurance policy. *William Beaumont Hosp. v. Fed. Ins. Co.*, 2014 WL 185388 (6th Cir. Jan. 16, 2014). The court also held that Michigan public policy did not bar coverage for wrongfully withheld compensation.

A putative class of nurses sued eight hospital systems, arguing that the hospitals engaged in anticompetitive behavior designed to depress the wages of the nurses. The district court in the underlying action allowed the nurses to pursue a claim under the Sherman Act under the theory that the hospitals had improperly shared compensation information in a manner designed to depress the nurses' wages. The nurses eventually settled with one of the hospitals. That hospital had an insurance policy that provided specified coverage for antitrust claims, but explicitly carved out "disgorgement" from the definition of "Loss." The carrier denied coverage for the settlement, arguing that the settlement amount was based upon wrongfully withheld wages and thus constituted disgorgement. In the ensuing coverage action, the Sixth Circuit affirmed a lower court's grant of summary judgment to the insured hospital, holding that settlements based upon wrongfully withheld wages do not constitute "disgorgement."

> The court distinguished disgorgement from restitution and explained that "money unlawfully retained is not the same in its legal character as money wrongfully *acquired*."

The court noted that the policy stated that only "disgorgement" was not a covered loss. The court distinguished disgorgement from restitution and explained that "money unlawfully *retained* is not the same in its legal character as money wrongfully *acquired*." According to the court, because the hospital never gained possession of the nurses' wages illicitly, but merely kept them illicitly, the money paid in settlement was not "disgorgement."

The court also held that Michigan public policy did not bar coverage for the settlement. The court looked to cases discussing Michigan public policy, and concluded that it generally prohibited insurance coverage for losses related to an insureds' intentional tortious or criminal acts. The court noted that a "rule of reason" violation of the Sherman Act was not per se illegal and that Michigan did allow coverage for some intentional acts. ■

ALSO IN THIS ISSUE

Insured Real Estate Agency's "Blast Fax" Property Advertisements Do Not Involve Professional Services

An Illinois intermediate appellate court has held that a professional services exclusion did not bar coverage for a class action alleging that an insured real estate agency violated the Telephone Consumer Protection Act (TCPA) by sending "blast faxes" that advertised a property offered for sale. *Standard Mut. Ins. Co. v. Lay*, 2014 WL 272773 (Ill. App. Ct. Jan. 23, 2014). In addition, the court ruled that an insurer could not rely on a consent-to-settlement provision because the insurer "surrender[ed] control of the defense" and "its right to control the settlement" when the insured obtained independent counsel after the insurer's reservation of rights. *Id*.

The policyholder, a real estate agency, was sued for alleged TCPA violations after it sent approximately 5,000 faxes advertising the sale of a particular property. One of the fax recipients filed a class action lawsuit against the insured, seeking statutory damages of $500 for each fax sent. The policyholder tendered defense of the suit to its commercial general liability (CGL) insurer, which accepted the defense under a reservation of rights. The insurer then hired counsel to defend the insured after the insured agreed to waive the potential conflicts of interest in light of the insurer's reservation of rights. Subsequently, however, the insured retained new counsel, which advised the insurer that the insured was exercising its right to obtain independent counsel because of the conflicts of interest created by the insurer's reservation of rights. Later, the insured settled the class action without the insurer's consent.

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Declaratory Judgment Action Not Ripe When No Underlying Suit Had Been Filed Against Insured

The United States District Court for the Northern District of Texas dismissed a lawsuit against an insurer seeking a declaration of the insurer's duty to defend and to indemnify because it was not ripe. *Am. Construction Benefits Group, LLC v. Zurich Am. Ins. Co.*, 2014 WL 144974 (N.D. Tex. Jan. 15, 2014).

An insurer issued a D&O policy to a company that was responsible for obtaining reinsurance for its member company. During the company's policy-renewal negotiations with the reinsurer, its president agreed to a certain coverage exclusion. The excluded event later occurred, and the reinsurer declined coverage for that event. The insured company paid its member company's expenses for that excluded event and alleged that its officer's actions in connection with the reinsurance renewal were "wrongful acts" under the D&O policy.

The company tendered the expenses that it paid in connection with the excluded event to the D&O insurer. The company also advised the insurer that it expected the company's members to file a derivative action against the company as a result of the incident. The insured then sought a declaratory judgment that the insurer was obligated to defend and to indemnify the company in the forthcoming derivative action, despite the fact that the carrier had not yet responded to the tender.

The insurer challenged the court's jurisdiction, contending that the declaratory judgment action was not ripe because, under Texas law, the duties to defend and to indemnify depended on the existence of an action against the insured by a third party. The court agreed that it could not decide the issue of the insurer's duty to defend before the derivative action was filed. The court noted that Texas followed the "eight-corners" rule to determine an insurer's duty to defend and, therefore, absent an underlying lawsuit, it could not undertake the necessary analysis. The court also concluded that the claim for the duty to indemnify was not ripe because a suit for indemnity required some liability to be established, either through a judgment or settlement.

The court then stated that the company's claim was not ripe for the separate reason that the company had not alleged that it would suffer any hardship if the court withheld consideration of the dispute. To the contrary, absent an underlying lawsuit against it, the company "face[d] no immediate risk that it will be forced to contribute

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Legal Malpractice Claim Alleging Overbilling Is Not a Claim for Damages

In a brief opinion, the First Department of the New York Supreme Court, Appellate Division, has affirmed a trial court order holding that an insurer was not obligated to defend or indemnify its insureds against an underlying legal malpractice claim and was entitled to reimbursement for amounts spent defending that claim. The appellate court held that "[a] claim for the return of legal fees is not a claim for 'damages' . . . as defined in the professional liability policy . . . ." The court also affirmed the trial court's award of attorneys' fees to the insurer for the coverage action. *Certain Underwriters at Lloyd's London Subscribing to Policy Number SY v. Lacher & Lovell-Taylor, P.C.*, 112 A.D.3d 434 (N.Y. App. Div. Dec. 5, 2013).

In affirming the ruling, the appellate court stated that "[a] claim for the return of legal fees is not a claim for 'damages' in a legal malpractice action." Because the underlying complaint alleged only that the insureds "overbilled their client in the underlying estate proceeding" and not that, "but for their negligence, [claimants] could have achieved a better result," there was no coverage for the underlying action under the policy. The court also noted that the insurer "reserved its right to seek reimbursement of its defense costs in the event of a finding of no coverage." ■

Verdict Requiring Bank to Return Money to Customer Not Covered "Loss"

The United States District Court for the District of Montana, applying Montana law, has determined that a judgment against a bank requiring it to return money it wrongfully took for principal and interest on a loan was not covered under professional liability policies for multiple reasons. *BancInsure, Inc. v. First Interstate Bank*, 2013 WL 5933652 (D. Mont. Sept. 23, 2013). In addition, the court concluded that the bank gave untimely notice of the underlying lawsuits as a matter of law but that this issue did not affect coverage because the matter was excluded regardless of the late notice issue.

An insurer issued three successive claims-made policies to a bank. The bank loaned money to an entity that intended to use the funds to finance a condominium project, and the entity executed a promissory note in favor of the bank. The entity's president also executed a personal guaranty of the entity's obligations to the bank under the loan agreement and promissory note. The president had a personal deposit account at the bank. On April 2, 2009, asserting alleged contractual rights, the bank sued the president under the personal guaranty, declared the loan in default, and declared itself unsecure under the loan agreement. The bank then removed $2,623,396.40 from the president's personal account and applied it as a loan payment to reduce the entity's liability for principal and interest under the promissory note. On June 25, 2009, the president filed a counterclaim against the bank, alleging that the bank violated the contracts and should be required to repay the amount taken from his personal account. The president obtained a jury verdict in his favor that required the bank, to repay the funds that the bank had taken from his personal account.

On October 10, 2010, the bank formally notified the insurer of the counterclaim against it by an email that also stated, "They won't be happy with the late notice, but these cases have been very well defended and there has been no prejudice." The bank pointed to June 30, 2009 and June 2010 letters it had provided its senior management at First Interstate BancSystem, Inc. that summarized litigation pending against it and the fact that First Interstate BancSystem in turn provided those to the insurer's underwriting department in connection with the policy renewal process. However, the letters did not make any demand on the insurer or otherwise suggest that the insured was providing notice of a claim, though the June 2009 letter stated that "all claims involve a common nucleus of facts—the decision of the bank to deem itself insecure, make demand under [the personal] guarantee,

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Negligence Lawsuits Following Nursing Home Fire Do Not Arise from "Related Medical Incidents"; Per-Incident Limit Applies Separately to Each Lawsuit

The Supreme Court of Connecticut has held that the alleged acts, errors, or omissions underlying lawsuits brought by the representatives of the victims of a nursing home fire do not constitute "related medical incidents" such that a single per-medical-incident limit of liability would apply. The court also ruled that coverage was limited to the $1 million aggregate limit of the operative policy's professional liability coverage part, rather than the $10 million aggregate policy limit cited by the insured. *Lexington Ins. Co. v. Lexington Healthcare Grp., Inc.*, 2014 WL 223664 (Conn. Jan. 28, 2014).

In 2003, several residents of a nursing home died or were injured when another resident set the nursing home on fire. Representatives of the victims subsequently filed 13 lawsuits naming as defendants the nursing home, the owner and lessor of the property, the lessee of the property, and the operator of the nursing home. Some of the actions related to the decision to admit and the supervision of the patient who started the fire; others concerned "general safety and emergency failures." Following a dispute over the amount of coverage available under the professional liability coverage part of a policy issued to the lessee of the property, the insurer filed a declaratory judgment action. Ruling on cross-motions for summary judgment, the trial court held that "the acts, errors or omissions underlying each [patient's] injuries or death constituted separate medical incidents and did not collectively comprise related medical incidents" for the purposes of applying the policy's per-medical-incident limit of liability. The trial court also held that the policy's $10 million "aggregate policy limit," and not its $1 million "aggregate limit" for professional liability claims, applied.

On appeal, the Connecticut Supreme Court affirmed the trial court's ruling regarding the application of the per-incident limit of liability to related medical incidents, holding that the acts, errors, and omissions underlying the claims "are not 'related' within the meaning of the policy." The court rejected the insurer's contention that the term "related," although undefined in the policy, was unambiguous in light of other courts' rulings: "one court's determination that the term related was unambiguous, in the specific context of the case that was before it, is not dispositive of whether the term is clear in the context of a wholly different matter." The court noted that while other courts have interpreted the term to "cover a broad range of connections," they also have suggested that "at some point a line must be drawn to prevent aggregation of events whose connections to each other are simply too weak." Thus, according to the court, the term "may be ambiguous if the facts fall on the margins of a broad reading."

As to the present case, the court was "not convinced that the various acts, errors and omissions alleged by each [underlying plaintiff] . . . fit comfortably within the realm of connections contemplated by the parties to the policy when they agreed to aggregated related medical incidents." In particular, the court noted that, "[a]lthough some allegations pertain to negligent supervision . . . , others aver a wide variety of different safety and response failures" and that "the particular array of negligent shortcomings that ultimately led to [each patient's] injury or death necessarily varied." Further, the court stated that "to the extent similar acts, errors or omissions appear across multiple complaints, they nevertheless are alleged to have caused multiple, distinct loses to different individuals." Accordingly, the court concluded that the various actions at issue did not arise from related medical incidents.

The Connecticut Supreme Court then considered the potential applicable limits and concluded that only $1 million of professional liability coverage was available for all of the individual claims. Overruling the trial court, the supreme court held that the endorsement to the policy providing for a $10 million "aggregate policy limit" did not alter the $1 million "aggregate limit" of the policy's professional liability coverage part. Noting that, "[t]ypically, when different terms are employed within the same writing, different meanings are intended," the court refused to conflate "aggregate limit" and "aggregate policy limit" and read the endorsement to provide that $10 million was "the maximum amount of insurance available under the entire policy when claims for both general liability and professional liability coverage, at all insured locations, are combined."

Lastly, the court held that the insurer was not required to "drop down" and provide coverage within the limit of the policy's self-insured retention amount due to the insolvency of the insured. ■

Declaratory Judgment Action Not Ripe When No Underlying Suit Had Been Filed Against Insured

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to a settlement agreement or face a bad-faith suit." The court therefore decided that the company had not met its burden to show the existence an actual case or controversy.

Finally, the court dismissed a claim for extracontractual damages under Texas Insurance Code Section 541.060(a)(4)(A) based on the insurer's failure to affirm or deny coverage for the tendered expenses paid by the company. In doing so, the court emphasized that the Texas statute provided that the insurer must decide whether it had a duty to defend "within a reasonable time *after the filing of a suit*" and must decide whether it had a duty to indemnify "within a reasonable time *after a judgment or settlement*" (emphasis added in opinion). The company had not alleged that it had been sued or that it was party to a settlement. Thus, the company failed to state a claim that the insurer failed to affirm or deny coverage within a reasonable time. The court also noted that the statute required the company to show that it had sustained actual damages but the company had failed "to plausibly allege" actual damages. Its only claimed damages—that it would be injured by the still-unfiled derivative action—were hypothetical and did not constitute "actual damages." ■

Verdict Requiring Bank to Return Money to Customer Not Covered "Loss"

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and setoff his deposit account in the amount of nearly $2.7 million . . . ." Following the insured's formal notice of the counterclaim, the insurer filed a declaratory judgment action seeking a declaration that the policies afforded no coverage for the counterclaim and jury verdict.

The policies provided that the insurer had no duty to defend. The court therefore rejected the bank's argument that the insurer waived its defense to coverage by breaching a duty to defend since no such duty existed.

The policies' definition of "Loss" carved out "any principal, interest or other monies paid, accrued or due as the result of any loan, lease or extension of credit." The court noted that the bank sought indemnification for the exact amount that the bank took from the president's personal account and was ordered to repay. Thus, "the jury simply made the Bank return what the Bank wrongfully took," and the bank did not suffer a covered loss. The court concluded that the insurer was entitled to summary judgment on this basis.

In addition, the policies contained several exclusions that the insurer raised as defenses to coverage. First, the policies excluded coverage for loss in connection with any claim arising out of "any insured person or the company gaining in fact any profit or advantage to which they were not legally entitled." The court concluded that the jury verdict and the bank's own description of the litigation showed that "all the litigation centered on the question whether the Bank took money it was not legally entitled to take [and] there is simply no other interpretation possible." The bank argued that the exclusion was ambiguous but the court noted that it did not "advance any credible ambiguity." This exclusion therefore applied.

The policies also excluded loss in connection with any claim arising out of "any assumption by the company or an insured person of any liability or obligation under any contract or agreement, unless such company or insured person would have been liable even in the absence of such contract or agreement." The court noted that the litigation began as a contract dispute that the bank initiated "under the guise of its own contract rights." The court held that the underlying litigation also fell within the scope of this exclusion.

Finally, the court concluded that the claim against the bank was made no later than June 26, 2009, over a year before the October 2010 notice was provided to the insurer. According to the terms of the applicable policy, the bank was required to provide notice as soon as practicable and no later than 60 days after the expiration of the applicable policy period. The court rejected the bank's argument that June 2009 letter to senior management that summarized the litigation was notice and instead observed that the letter supported the conclusion that the bank did not give notice as soon as practicable. As such, the bank's notice to the insurer failed as a matter of law to comply with the policy provision, and the insurer was entitled to a judgment that the bank failed to meet a condition precedent to coverage.

The court therefore granted summary judgment in favor of the insurer. ■

Insured Real Estate Agency's "Blast Fax" Property Advertisements Do Not Involve Professional Services *continued from page 2*

In a subsequent coverage action, on remand from a decision from the Illinois Supreme Court holding that the settlement for statutory damages did not represent a settlement of uninsurable punitive damages, the intermediate appellate court ruled that the CGL policy afforded coverage for the underlying suit. First, the court rejected the insurer's argument that the policy's professional services exclusion barred coverage, reasoning that the insured was a real estate agency—not an advertising company—and thus that the exclusion did not apply given the absence of any allegations that the insured "incorrectly performed real estate services." Second, the court rejected the insurer's argument that the insured breached the policy's consent-to-settlement provision, concluding that "when an insurer surrenders control of the defense, it also surrenders its right to control the settlement of the action and to rely on a policy provision requiring consent to settle." Under the circumstances here, where the insurer reserved rights and permitted the insured to retain independent counsel, the court ruled that the insurer "had no right to require [the insured] to obtain permission to settle the underlying suit or to object to it itself." In addition, the court observed that the insurer provided no evidence that it was prejudiced by the settlement, positing that the settlement was "supported by simple math" given that liability was clear and that the amount of statutory damages per violation was fixed. ■

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