Wiley Rein LLP

# EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | June 2013

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## No Coverage for Claim First Made Prior to Inception of Claims-Made-and-Reported Policy

The United States District Court for the District of New Hampshire, applying New Hampshire law, has held that no coverage is available for a legal malpractice lawsuit because the claim was first made before the inception of the claims-made policy. *Clauson & Atwood v. Professionals Direct Ins. Co.*, No. 12-cv-199 (D.N.H. May 13, 2013). Wiley Rein represented the insurer.

The insured, a law firm, represented a client in a trespass action, which was dismissed because the suit was filed after the expiration of the statute of limitations. During the pendency of the appeal of the adverse trial court ruling, the client's malpractice action lawyer sent a letter to the firm stating that the client had

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## FTC Investigation Does Not Constitute a Claim for a Wrongful Act

The United States Court of Appeals for the Sixth Circuit has held that a formal investigation of an insured by the Federal Trade Commission (FTC) sought only to determine *whether* a wrongful act had occurred—and did not *allege* an antitrust violation—and therefore did not constitute a "claim," defined in part as a demand or proceeding "against an Insured for a Wrongful Act." Because the FTC's investigation did not allege wrongdoing and was thus not a claim, the court held that the insured's failure to provide notice of the investigation did not preclude coverage for the subsequent administrative and civil actions brought by the FTC. *Employers' Fire Ins. Co. v. ProMedica Health Sys., Inc.*, 2013 WL 1798978 (6th Cir. Apr. 30, 2013).

In July 2010, the FTC opened a "non-public preliminary investigation" into the insured healthcare provider's proposed acquisition of a not-for-profit hospital "to determine whether the acquisition . . . may be anticompetitive." In August 2010, the FTC transitioned the investigation to "full-phase"; issued a resolution authorizing the use of compulsory process in connection with the investigation; issued subpoenas to employees of the insured and the hospital and issued subpoenas and Civil Investigatory

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# Trial Court Concludes That Grand Jury Subpoenas Are "Claims"

A New York state trial court has determined that state and federal grand jury subpoenas issued to Syracuse University and its former basketball coaches constituted "claims" under a not-for-profit individual and organizational insurance policy. *Syracuse University v. Nat'l Union Fire Ins.Co. of Pittsburgh, Pa.*, No. 2012EF63 (N.Y. Sup. Ct. Mar. 7, 2013). The court also held that the insurer was required to advance defense costs on behalf of the insured in connection with the subpoenas.

State and federal grand jury subpoenas were issued to Syracuse seeking information concerning alleged misconduct by one of its assistant basketball coaches. The insurer denied coverage for the subpoenas on the basis that they did not constitute a "claim" for an "actual or alleged wrongful act of the organization." The policy defined "claim" as "(1) A written demand for monetary, non-monetary or injunctive relief; (2) A civil, criminal, administrative, regulatory or arbitration proceeding for monetary or nonmonetary relief which is commenced by: (i) service of a complaint or similar pleading; or (ii) return of an indictment, information or similar document (in the case of criminal proceeding)."

The court first concluded that the grand jury's investigations and subpoenas constitute a "written demand . . . for non-monetary relief." The court reasoned that the meaning of "non-monetary relief" included "remedy," defined as the "means of enforcing a right or preventing or redressing a wrong." According to the court, "[a] subpoena is a grand jury's means of preventing or redressing a wrong by enforcing the public's right to 'every man's evidence.'" The court also determined that "a grand jury's investigations are criminal proceedings for monetary or non-monetary relief and that common sense dictates that a criminal investigation is an integral part of a

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# *Qui Tam* Claim and Anti-Retaliation Claim Based on Alleged False Reporting by Company Are Single Claim

The United States District Court for the Western District of Washington has held that coverage exists for a *qui tam* claim that was first made and reported after the policy period because it arose out of related wrongful acts to an anti-retaliation claim that previously was made and reported during the policy period. *Carolina Cas. Ins. Co. v. Omeros Corp.*, No. C12-287RAJ (W.D. Wash. Mar. 11, 2013). The court also held that, even though the claims were treated as a single claim made at the time of the anti-retaliation claim, the insurer could not rely on the policy's employment-related exclusion to deny coverage for the *qui tam* claim.

The insured biopharmaceutical company's former chief financial officer (CFO) sued the company, alleging that he was wrongfully terminated, in violation of the anti-retaliation provisions of the False Claims Act (FCA), for internally reporting the company's alleged false reports to the National Institutes of Health. The company's insurer agreed to defend the company, subject to a reservation of rights, under the management liability insurance policy's employment practices liability coverage. Following discovery in the anti-retaliation suit, the former CFO amended his complaint to include a *qui tam* action on behalf of the U.S., asserting that the company violated the FCA. The insurer then brought a declaratory judgment action to determine its coverage obligations for the *qui tam* suit.

The insurer argued that the policy's D&O coverage did not apply to the *qui tam* action because the claim was made and reported after the policy

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## False Claims Act *Qui Tam* Action Over Billing Practices Does Not Involve Professional Services; Claim Is Barred by Fraud Exclusion

Applying Washington law, the United States District Court for the Western District of Washington has determined that a False Claims Act (FCA) *qui tam* lawsuit against a medical management services organization regarding billing practices was not covered under the organization's professional liability policy because it did not allege a negligent act, error or omission arising from the organization's "professional services" and because the policy's fraud and dishonesty exclusion precluded coverage. *MSO Washington, Inc. v. RSUI Group, Inc.*, 2013 WL 1914482 (W.D. Wash. May 8, 2013). Additionally, the court ruled that the insurer had no duty to indemnify or defend and that common law and statutory bad faith counts asserted against the insurer therefore failed.

The insured provided administrative and management services to health care providers, including billing and collection services. A federal FCA *qui tam* complaint was filed against the insured alleging that it engaged in a scheme to defraud programs such as Medicare and Medicaid by over-representing the cost of services supplied to patients. The complaint was filed under seal, however, and the insured was served with subpoenas from the U.S. Department of Health and Human Services seeking documents "in connection with an investigation regarding the submission of possibly false, fraudulent or improper claims."

The insured submitted the subpoenas to its professional liability insurer for coverage, and, following settlement of the *qui tam* lawsuit, provided notice of that action as well. The medical professional liability policy at issue afforded coverage for sums the insured became legally obligated to pay as damages or claim expenses

> The court also concluded that an FCA claim did not fall within the policy's coverage grant for damages arising out of a negligent act, error or omission, because "[a] party cannot be held liable pursuant to the [FCA] for mere negligence."

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## Breach of Contract Exclusion Bars Coverage for Claims Naturally Resulting from Breach

Applying Michigan law, the United States Court of Appeals for the Sixth Circuit has held that a breach of contract exclusion precludes coverage for retaliation claims that are the natural and foreseeable result of a breach of contract. *City of Warren, Mich. v. Int'l Ins. Co. of Hannover, Ltd.*, 2013 WL 1798989 (6th Cir. April 30, 2013).

Pursuant to a contract executed with a waste-transport contractor, a municipality was required to use "commercially acceptable best efforts" to install and make operational an additional "Direct Dump System." After the municipality failed to install a third compactor to handle yard waste, a part of the "Dump System" according to the contractor, the contractor began to withhold royalty payments from the municipality. In response, the municipality withheld payments from the contractor's monthly invoices. The contractor sued the city for, *inter alia*, breach of contract, retaliation in violation of 42 U.S.C. § 1983 and a conspiracy to retaliate, consequently procuring a settlement. After the municipality tendered the underlying claim, the insurer denied coverage, citing, among other defenses, an exclusion for errors and omissions "arising out of . . . breach of a contractual obligation."

In the coverage litigation that followed, the court held that the breach of contract exclusion unambiguously precluded coverage for the

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## Prior Knowledge Exclusion Bars Coverage for Utility's Failure to Repair Dam

A Wisconsin intermediate appellate court has held that an insured utility's failure to maintain a dam, coupled with its knowledge that such failure was likely to precipitate a government-ordered drawdown of an adjacent lake and lawsuits by affected property owners, barred coverage for the landowners' suit based on a prior knowledge exclusion contained in the utility's directors and officers liability policy. *Laufman v. Safeco Ins. Co.*, 2013 WL 2157891 (Wis. Ct. App. May 21, 2013). The court also held that there was no coverage for the same claim under the insured's separate general liability policy because the claim arose from its intentional conduct.

The policyholder, a privately-held electric public utility, owned and operated a hydroelectric dam. In 1997, the insured learned that it would cost approximately $1 million to bring the dam up to federal licensing standards. At that time, the policyholder knew that it would either have to abandon (and remove) the dam or transfer it to another owner. Despite its attempts, however, the insured was unable to transfer ownership of the dam. In fact, the insured could not give the dam away even when it offered to include money and land. The dam stopped producing power in 1997.

In 1998 and 1999, a state agency inspected the dam, and in May 1999, it sent the insured a copy of its inspection report together with a proposed timeline for required repairs. The following year, in June 2000, the policyholder's board of directors met and decided to abandon the dam. One month later, in July 2000, the state agency ordered the insured immediately to draw down the lake above the dam to the lowest possible level in order to complete emergency repairs. When the lake was drawn down, it reverted to a river, at which point local lakefront property owners sued the insured. The policyholder's insurers intervened in that action and moved for a coverage determination.

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## No Coverage for Complaints Against Insured Law Firm Alleging Improper Withholding of Fees

The United States District Court for the Northern District of California, applying California law, has held that coverage is not available under a lawyers professional liability policy for two suits alleging that the insured law firm wrongfully withheld amounts exceeding the statutorily allowable fees recovered in an underlying matter because such allegations are not based on the provision of "legal services." *Colony Ins. Co. v. Fladseth*, 2013 WL 1365988 (N.D. Cal. Apr. 3, 2013). The court also held that coverage for one of the suits was further precluded because the complaint sought only restitution or disgorgement of funds, which are carved out from the definition of covered "Damages" under the policy. Finally, the court held that coverage also would be precluded by the fee dispute and personal profit exclusions.

The insured law firm and its sole practitioner were sued in two separate actions, each alleging that the insured improperly withheld fees in excess of the maximum amount allowed under California law pursuant to California Business and Professions Code Section 6146. Each of the lawsuits asserted causes of action against the insured for money had and received, fraud, conversion, accounting and violations of California's Unfair Competition Law. The lawsuits sought, among other forms of relief, disgorgement, as well as punitive and special damages. The insured tendered notice of the actions to its insurer, which agreed to defend under a reservation of rights. The insurer then filed a declaratory judgment action seeking a declaration that it did not owe a defense or indemnity for the actions, and filed a motion for summary judgment.

The California federal district court granted the insurer's motion for summary judgment. First, the court held that the underlying actions did not trigger the insuring agreement, which provided coverage for "sums any insured becomes

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## Judgment Creditor Collaterally Estopped by Default Judgment Against Insured

The United States District Court for the Northern District of Georgia, applying Georgia law, has held that a default judgment against an insured in a rescission action precluded any subsequent recovery under the policy by a judgment creditor of the insured. *Old Republic Nat'l Title Ins. Co. v. Hartford Accident & Indem. Co.*, 2013 WL 1943427 (N.D. Ga. May 9, 2013).

An insurer issued a professional liability policy to insureds that served as title issuing agents for insurance companies for several consecutive claims-made-and-reported policy periods. The insureds applied for the initial policy in August 2008 and stated on the application that they were not aware of any acts, errors or omissions that could lead to a professional liability claim being made. The insureds made similar statements on renewal applications.

In August 2010, a company for which the insureds served as the title issuing agent sued the insureds for the alleged misuse of funds and professional negligence. The insureds sought coverage under their current policy, and the insurer retained defense counsel while investigating the claim for coverage. In 2011, following the insurer's investigation of the claim and discovery in the underlying action against the insureds, the insurer tendered the policy premium to the insureds and filed a declaratory judgment action seeking to rescind the policy. In support of rescission, the insurer argued that the insureds were involved with multiple instances of professional negligence as a title issuing agent prior to 2008 and that the insureds did not report knowledge of these potential claims on the initial

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## Eighth Circuit Rejects Multiple Trigger Theory and Applies Reasonable Expectations Doctrine to Find Coverage Under One Policy Year

The United States Court of Appeals for the Eighth Circuit, applying Iowa law, has rejected the application of the multiple trigger theory to a claim for wrongful arrest, prosecution and incarceration claims. *Chicago Ins. Co. v. City of Council Bluffs*, 2013 WL 1798995 (8th Cir. April 30, 2013). The court also held that the policy in effect when the claimants were arrested was triggered, and it provided coverage pursuant to the reasonable expectations doctrine because, even though it excluded coverage for damages resulting from intentional acts, it expressly provided coverage for damages resulting from malicious prosecution.

The claimants were arrested and convicted for the murder of a retired police officer in 1978 and received life sentences that same year. In 2003, the Iowa Supreme Court concluded that the claimants' due process rights to a fair trial were violated and released the claimants from prison. The claimants filed suit against the insured, among others, alleging violations of their civil rights sounding in malicious prosecution.

The insured sought coverage under two excess policies issued by one insurer for successive annual periods between 1983 and 1985 and under five additional excess policies issued by a different insurer for successive annual periods between 1977 and 1982. The insurers filed a declaratory judgment action to determine which, if any, policy or policies responded to the matter.

In reaching its decision, the Eighth Circuit examined its prior decision in *Genesis Insurance Co. v. City of Council Bluffs*, 677 F.3d 806 (8th Cir. 2012), which was a related action regarding whether two policies issued by a third insurer provided the insured with coverage for the same claim. In *Genesis*, the court rejected application of the multiple trigger theory in the context of wrongful arrest, prosecution and incarceration claims and predicted that the Iowa Supreme Court would hold that "the tort of malicious prosecution occurs, for insurance purposes, on

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## Insurer Not Required to Establish Prejudice Under Claims-Made-and-Reported Policies

Applying Missouri law, the United States District Court for the Eastern District of Missouri has found that an insurer is not required to demonstrate that it was prejudiced by its insured's failure to provide timely notice under a claims-made-and-reported policy. *Secure Energy, Inc. v. Phila. Indem. Ins. Co.*, 2013 WL 2145927 (E.D. Mo. May 15, 2013).

The insurer issued successive annual claims-made-and-reported directors and officers liability policies to the insured from October 2007 to October 2012. In April 2009, the insured was named in a suit by a claimant seeking commissions he was allegedly owed. In June 2009, the claimant voluntarily dismissed the suit, but re-filed it in July 2009 against the same defendants. The insured did not provide notice of the claim to the insurer until May 2011.

In denying the claim, the insurer stated that the insured failed to timely report the claim as provided for in the applicable policy under which the claim had been first made. The relevant policy language provides that: "In the event that a Claim is made against the Insured, the Insured shall, as a condition precedent to the obligations of the Underwriter under this Policy, give notice . . . as soon as practicable after [it] . . . first become[s] aware of such Claim but, no later than 60 days after the expiration of this Policy, Extension Period, or Run–Off Policy, if applicable."

After the insurer denied coverage, the insured filed coverage litigation. In response to the insurer's motion for summary judgment that there was no coverage because notice was untimely, the insured argued that, since its insurer suffered no prejudice, the untimely notice did not preclude coverage. In finding in favor of the insurer, the court rejected the insured's argument that the insurer was required to establish prejudice in order to prevail. The court found that it is well settled under Missouri law that an insurer is not required to show prejudice in a "claims-made" policy, as opposed to an "occurrence" policy, given that "claims-made" policies place special reliance on notice. ■

## Settlement for Statutory Damages, Calculated Without Reference to Actual Damages Incurred, Is for Penalty, Not Covered Loss

A Delaware trial court has held that a settlement for statutory damages paid by a health care organization represents uncovered penalties rather than covered loss. *Executive Risk Spec. Ins. Co. v. First Health Group Corp.*, No. 09C-09-027 (Del. Super. Ct. May 7, 2013). The court further held that the portion of the settlement attributable to attorneys' fees was also not covered.

The policyholder, which issued and underwrote medical service plans, allegedly violated a Louisiana statute regulating reimbursement of health care providers by preferred provider organizations. The statute provides that failure to comply will subject the offender to "damages payable to the provider of double the fair market value of the medical services provided, but in no event less than the greater of fifty dollars per day of noncompliance or two thousand dollars, together with attorney fees to be determined by the court." The underlying claimants alleged that the policyholder violated the statute a total of 130,931 times, which under the statute yielded a minimum damages number of $261,862,000. After the claimants obtained a judgment for that amount in a Louisiana trial court and prevailed in an intermediate appeal of that judgment, the policyholder settled with the claimants for $150,500,000 and an assignment of rights against the policyholder's E&O carriers. Coverage litigation ensued.

The governing policy's definition of loss provided, in relevant part, that "Loss shall not include . . . fines, penalties, taxes, and punitive, exemplary and multiplied damages." The carrier argued that the settlement represented payment of a penalty. The court agreed.

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## Sexual Harassment Suit Interrelated With Earlier Disparate Treatment Proceeding Before Division of Civil Rights

The United States District Court for the District of New Jersey has held that a claimant's administrative complaint to the New Jersey Division of Civil Rights, which alleged disparate treatment in pay because of gender, was interrelated with a later lawsuit making the same allegations but adding allegations of sexual harassment. *Regal-Pinnacle Integrations Industries, Inc. v. Phila. Indem. Ins. Co.*, No. 2013 WL 1737236 (D.N.J. Apr. 22, 2013). However, the court held that the carrier might have created coverage for a settlement of the later suit by orally agreeing to fund a settlement.

In 2007, the underlying claimant, a former employee of the policyholder, filed a complaint with the New Jersey Division of Civil Rights alleging that the policyholder paid her less than male counterparts and fired her for complaining about the disparate treatment. In 2009, she filed suit in state court making the same allegations but adding claims based upon alleged sexual harassment. The relevant policy contained a prior litigation exclusion barring coverage for claims pending before a date in 2008. The policy also provided that "[a]ll Loss arising out of the same Wrongful Act and all Interrelated Wrongful Acts shall be deemed one Loss on account of one claim. Such Claim shall be deemed to be first made when the earliest of such Claims was first made." The policy defined an Interrelated Wrongful Act to be "any causally connected Wrongful Act or series of the same, similar or related Wrongful Acts."

According to the policyholder's complaint against the carrier, although the carrier initially denied coverage, it later agreed to indemnify the policyholder for a settlement up to $100,000. After the policyholder settled the suit, the carrier withdrew its offer to fund any portion of the settlement. The policyholder then filed suit seeking, among other things, a declaratory judgment as to coverage and damages for breach of contract.

The court determined that there was a substantial overlap between the administrative action and the later civil suit. The proceedings involved identical parties and made similar claims based upon state

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## Prior Acts Exclusion Bars Coverage for Suit Against Bank Alleging Lending Act

The United States District Court for the Middle District of Georgia, applying Georgia law, has held that a lawsuit against a bank alleged a "lending act" and was barred from coverage by a prior acts exclusion because the suit arose from extensions of credit made by the bank before the prior acts date. *Bank of Camilla v. St. Paul Mercury Ins. Co.*, 2013 WL 1333519 (M.D. Ga. Mar. 29, 2013). The court also held that the insurer did not waive its coverage defense by failing to disclaim coverage based on the prior acts exclusion because the insurer had a duty to advance defense costs and not a duty to defend.

The insured, a bank, was sued by the investors of one of its customers. The investors first filed suit in April 2009 and alleged that the bank destroyed the customer's business by seizing and selling the customer's assets after the customer defaulted on promissory notes, which the customer allegedly issued to the bank with the bank's knowledge of improprieties by the customer. The bank did not tender the suit to the insurer because the bank did not believe that coverage was available for the suit. In October 2010, the investors filed an amended complaint alleging that the bank assisted the bank in a Ponzi scheme and misrepresented the customers' financial condition to investors. After receiving notice of the amended complaint, the insurer denied coverage for the investors' suit and later disclaimed coverage for the suit based on

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## California State Law Does Not Bar Defense for Federal Prosecution

An intermediate appellate court in California has held that Section 533.5(b) of the state insurance code does not apply to preclude insurance coverage for criminal actions brought by federal prosecutors. *Mt. Hawley Ins. Co. v. Lopez*, 2013 WL 1818627 (Cal. Ct. App. May 1, 2013).

A U.S. attorney brought federal charges against an insured physician, alleging that he had transplanted a liver into a patient who was not next in line on the "waiting list" in violation of applicable federal regulations. The insurer refused to provide a defense, contending that Section 533.5(b) precluded it from doing so. This provision of the insurance code states:

> No policy of insurance shall provide, or be construed to provide, any duty to defend . . . any claim in any criminal action or proceeding or in any action or proceeding brought pursuant to [California's unfair competition law] in which recovery of a fine, penalty, or restitution is sought by the Attorney General, any district attorney, any city prosecutor, or any county counsel, notwithstanding whether the exclusion or exception regarding the duty to defend this type of claim is expressly stated in the policy.

Citing to the federal appellate court's opinion in *Bodell v. Walbrook Ins. Co.*, 119 F.3d 1411 (9th Cir. 1997), the insured argued that the proscription on coverage set out in the statute applied only to prosecutions by the state and local authorities. The state appellate court agreed, holding that Section 533.5(b) did not apply to criminal actions prosecuted by the federal government. In reaching this conclusion, the court rejected the insurer's argument that the statute was limited to prosecutions by the four identified state and local authorities only with respect to civil actions brought under the state's unfair competition laws and that coverage for all other criminal actions was prohibited, regardless of the prosecuting authority. The court also pointed out that "there is no public policy in California against insurers contracting to provide a defense to insureds facing criminal charges" and that to conclude otherwise would make individuals reluctant to serve on boards of directors out of fear of having to fund their own defense costs. ■

## Court Dismisses Claim for Coverage for a First-Party Loss Under a Third-Party Liability Policy

The United States District Court for the Northern District of Texas has dismissed a claim for coverage under a D&O liability policy, holding that the loss at issue did not arise from "a claim for a wrongful act," but rather only from a wrongful act on the part of the insured's president such that the loss was an uninsured first-party loss. *Am. Constr. Benefits Grp., LLC v. Zurich Am. Ins. Co.*, 2013 WL 1797942 (N.D. Tex. Apr. 29, 2013).

The named insured—a captive benefits group—provided insurance for one of its member construction companies. During negotiations with its reinsurer, the group's president agreed to a coverage exclusion for the cost of a heart transplant operation for the child of an employee of the construction company. As a result, the benefits group itself was forced to pay the construction company's claim for the transplant costs. The benefits group sought coverage for that payment under its D&O liability policy, contending that the loss resulted from the president's wrongful act in agreeing to the exclusion. The D&O insurer declined coverage, and the insured brought suit.

The court granted the insurer's motion to dismiss, finding that the group failed to state a plausible claim for breach of contract because its complaint did not allege that the construction company had made a claim against the group "for a Wrongful Act." According to the court, the construction company's claim against the group was not a claim for a wrongful act committed by the group's president but rather for coverage under its insurance contract with the group, regardless of whether the president's conduct in agreeing to the exclusion caused the loss incurred by the group. The court concluded that the insured could not "transform its D&O liability policy into a first-party policy to provide coverage for its own loss." ■

## Professional Services Exclusion Precludes Coverage for Design Defect Claims

Applying Nevada law, a federal district court has held that an insurer has no duty to defend or indemnify claims alleging damage from design defects in houses constructed by the insureds due to the policy's professional services exclusion. *St. Paul Fire & Marine Ins. Co. v. Del Webb Communities, Inc.*, 2013 WL 1181904 (D. Nev. Mar. 19, 2013).

The insured construction companies were named as defendants in a class action lawsuit alleging damages as a result of structural seismic design defects in houses. The insureds tendered the lawsuit for defense and indemnity coverage under an excess policy issued by the insurer. The excess policy contained a professional services exclusion precluding coverage for damage "that results from the performance of or failure to perform architect, engineer, or surveyor professional services" including "the preparation or approval of any drawing and specification, map, opinion, report, or survey, or any change order, field order, or shop drawing; and any architectural, engineering, inspection, or supervisory activity." The insurer accepted a defense subject to a reservation of rights and filed a declaratory judgment action seeking a determination that no defense or indemnity obligation existed under the excess policy pursuant to the exclusion.

The court held that coverage was precluded by the plain terms of the professional services exclusion in the excess policy. According to the court, the only damages sought in the class action lawsuit were "damages relating to curing the design defect" that fell directly within the scope of the exclusion. In so holding, the court rejected the insureds' contention that additional discovery was warranted to determine if a concurrent cause for the damages existed that would defeat application of the exclusion. The court noted that the insureds "cannot show that there was a concurrent cause which would defeat the Exclusion because the only allegation in the [underlying action] is that homes were built using the allegedly defective [designs] and are hazardous because they do not meet seismic codes." As such, the court rejected the insureds' request for further discovery and held that no coverage obligations existed for the class action lawsuit under the excess policy. ■

## Fee Exclusion Deemed Ambiguous

The United States Court of Appeals for the Ninth Circuit, applying California law, reversed an order granting judgment on the pleadings to an insurer based on the application of an exclusion for claims based on fees, expenses, or costs paid to or charged by the insured. *Ticketmaster, LLC v. Ill. Union Ins. Co.*, 2013 WL 1777735 (9th Cir. Apr. 26, 2013). The court concluded that the exclusion could be reasonably interpreted in at least two ways and was therefore ambiguous.

An insurer issued an errors and omissions liability policy to a company that sells event tickets online. In 2003, certain ticket purchasers filed a class action lawsuit in which they alleged that the company made false representations about delivery fees and order-processing charges for tickets.

After the company sought coverage for the class action lawsuit, the insurer denied coverage based on an exclusion for claims "based on or arising out of . . . any dispute involving fees, expenses or costs paid to or charged by the Insured" (alteration in original).

The company appealed the district court's decision granting judgment on the pleadings in favor of the insurer. On appeal, the court concluded that the exclusion was "reasonably susceptible to at least two meanings" and was thus ambiguous. Specifically, the court stated that the exclusion 1. "may narrowly refer to a dispute regarding the monetary amount paid to or charged by [the company] for uncontested services" or 2. "may refer to any fee or charge

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### *Fee Exclusion Deemed Ambiguous* *continued from page 9*

for professional services, including a dispute regarding the relationship between services provided and the fees charged." The court noted that some allegations in the underlying class action did not involve the amount charged for uncontested services and therefore involved a dispute that would fall only with the second interpretation. Accordingly, the court decided that the insurer did not meet its burden to show that its interpretation was the only reasonable interpretation of the exclusion.

The court reversed the judgment on the pleadings in favor of the insurer and remanded the case to the district court. ■

### *Eighth Circuit Rejects Multiple Trigger Theory and Applies Reasonable Expectations Doctrine to Find Coverage Under One Policy Year* *continued from page 5*

the date the underlying charges are filed." The court rejected the insured's argument that the policies at issue differed from those in *Genesis* because they only required that some injury arise during the policy period and did not require the injury or damages to arise during the policy period, and noted that the argument that there was continuing misconduct and continuing injury during the terms of the policies was expressly rejected in *Genesis*.

In finding that the policy issued for the period from 1977 to 1978 provided coverage for the matter, the court relied on the reasonable expectations doctrine. Although the policy excluded coverage for damages resulting from intentional acts, it expressly included coverage for damages arising from "malicious prosecution." Thus, the court concluded that an ordinary layperson would have misunderstood the policy's scope of coverage and that, accordingly, the policy in effect when the claimants were arrested—between 1977 and 1978—provided coverage. ■

### *Settlement for Statutory Damages, Calculated Without Reference to Actual Damages Incurred, Is for Penalty, Not Covered Loss* *continued from page 6*

The court looked to *Black's Law Dictionary's* definitions of "penalty," "civil penalty" and "statutory penalty." It further quoted an Illinois case for the proposition that a statutory penalty must "(1) impose automatic liability for a violation of its terms; (2) set forth a predetermined amount of damages; and (3) impose damages without regard to the actual damages suffered by the plaintiff." The court found that the Louisiana statute at issue satisfied that definition because it automatically imposed a remedy without reference to damages actually suffered. The court additionally noted record evidence that the claimants suffered damages of approximately $20 million, rather than the $261 million judgment rendered.

The court also addressed the claimants' argument that the $52.5 million of the settlement that they allocated to attorneys' fees should constitute covered loss. The court observed that the underlying settlement agreement did not specifically allocate any portion of the policyholder's payment to attorneys' fees. In addition, the court reasoned that under Louisiana law, an award of attorneys' fees is punitive in nature, and therefore not within the policy's definition of loss. ■

### Qui Tam *Claim and Anti-Retaliation Claim Based on Alleged False Reporting by Company Are Single Claim* *continued from page 2*

period. The court looked to the policy's related claim provision, which treated all claims based upon or arising out of the same wrongful act or related wrongful acts as a single claim deemed made when the first claim was made. The policy defined "related wrongful acts" as those which are "logically or causally connected by reason of any common fact, circumstance, situation, transaction, casualty, event, or decision." The insurer argued that the anti-retaliation claim sought recovery for wrongs done to the former CFO himself and did not require him to prove that the company actually made false claims, whereas the *qui tam* claim sought recovery for wrongs done to the U.S. and required proof that the company actually made false claims. The court found these differences irrelevant because the alleged false reporting was a common event logically connecting both of the claims sufficient to make the two wrongful acts "related" under the policy.

The insurer also argued that, if the claims were to be treated as a single claim, the D&O coverage exclusion for claims "in any way involving any past, present or future actual or potential employment relationship" should bar coverage. The court rejected this argument as well, finding that "related wrongful acts" are deemed a single claim only for purposes of determining the timing of the claim, not for purposes of applying policy exclusions unrelated to the claims-made nature of the policy. The court noted that the insurer's interpretation of the related claim provision would permit it to decline coverage even for related claims made simultaneously if they consisted of both an employment and non-employment claim. The court held that a more reasonable interpretation was to construe exclusions having nothing to do with the claims-made nature of the policy to apply separately to individual claims, even if they were considered a single claim for purposes of determining when they were first made. ■

### *Judgment Creditor Collaterally Estopped by Default Judgment Against Insured* *continued from page 5*

application for the policy. The insureds did not respond to the insurer's complaint, and the court entered a default judgment against the insureds. The defense counsel appointed by the insurer then withdrew as counsel in the underlying professional negligence action, and the claimant against the insureds obtained a consent order and final judgment against the insureds.

In this action, the claimant, as judgment creditor, sought to recover the amount of the consent judgment under the policy. The court agreed with the insurer that the claimant's action against the insurer was barred by collateral estoppel because the court had already ruled that the policy afforded no coverage for the underlying action and that the policy was rescinded. In doing so, the court rejected three arguments raised by the claimant. First, the court disagreed that the instant action and prior coverage action did not raise identical issues and noted that the claimant cited no authority to support this argument.

Second, the court noted that, under Georgia law, a default judgment was a judgment on the merits for purposes of collateral estoppel and rejected the claimant's reliance on a federal bankruptcy case to argue that the default judgment was not a final judgment on the merits. Third, the court decided that, contrary to the claimant's argument, there was privity between the claimant and the insureds because the claimant derived its rights under the policy through the insureds. Accordingly, the requirements for collateral estoppel were met.

The court therefore decided that the policy had been rescinded in the prior coverage action, there were no remaining obligations or rights under the policy, and, as a matter of law, the claimant could not recover the consent judgment under the policy. ■

## *No Coverage for Claim First Made Prior to Inception of Claims-Made-and-Reported Policy*

*continued from page 1*

retained the lawyer to represent the client in a potential malpractice action against the firm, requesting that the firm provide the letter to its malpractice carrier, and demanding that the firm enter into a tolling agreement. The firm executed the tolling agreement but did not provide notice of the letter to its insurer during the policy period of its legal malpractice policy (the 10-11 policy) then in effect.

The same insurer then issued a subsequent claims-made-and-reported policy to the firm for the policy period of September 29, 2011 to September 29, 2012 (the 11-12 policy). In February 2012, the client filed a legal malpractice action against the firm. The firm tendered the lawsuit to the insurer under the 11-12 policy, and the insurer denied coverage because the claim was first made before the inception of the 11-12 policy. Coverage litigation followed.

> The court held that the firm's subjective beliefs concerning the merits of the potential legal malpractice action were irrelevant to the determination of when a claim was made.

The court held that no coverage was available for the legal malpractice action because it was first made before the inception of the 11-12 policy. The 11-12 policy defined "claim" as "when you first receive oral or written information or have knowledge of specific circumstances involving a particular person or entity which could reasonably be expected to result in a demand or suit for money or services." The 11-12 policy also provided that a claim is first made "when you first receive information or have knowledge of specific circumstances involving a particular person or entity which could reasonably be expected to result in a claim." The court reasoned that it was "inescapable" that the firm's representation of the client "could reasonably be expected to result in a demand or suit" in February 2011—seven months before the inception of the 11-12 policy. At that time, the firm had received a letter from the client's legal malpractice attorney threatening a potential legal malpractice action and demanding that the firm provide the letter to its insurer.

The court also rejected the insured's four contentions that the claim was first made during the 11-12 policy. First, the court held that the firm's subjective beliefs concerning the merits of the potential legal malpractice action were irrelevant to the determination of when a claim was made. Second, the firm's characterization of the February 2011 letter as a mere request for an extension of time was "wishful thinking" because the request for a tolling agreement was intended to allow the firm to focus on appealing the adverse trial court ruling in the client's case. Third, the court distinguished the holding in *Shaheen, Cappiello, Stein & Gordon, P.A. v. Home Insurance Co.*, 143 N.H. 35 (1998), because, in February 2011, the client was not expressing continued confidence in the firm's handling of his case and the trial court had already ruled that the statute of limitations barred the client's suit. Fourth, the court determined that the insurer was not required to prove prejudice to deny coverage. ■

### *Trial Court Concludes That Grand Jury Subpoenas Are "Claims"* *continued from page 2*

criminal proceeding." The court further stated that, "when a District Attorney issues and serves a subpoena in good faith, a proceeding is instituted in the grand jury, just as in an analogous situation a civil action is commenced by the service of a subpoena." The court did not address policy language defining "claim" to include a criminal proceeding commenced by "the return of an indictment, information or similar document."

The court also determined that the insured need not prove that it was a named target of an investigation because "[t]he duty to defend arises when there are any facts or allegations bringing the claim even potentially within the protection that was purchased." In addition, the court noted that the U.S. Attorney's subpoena directed to Syracuse sought information about events and transactions that occurred between employees and police and procedures and documents regarding a sexual abuse scandal at Penn State University. The court concluded that the policy's "wrongful act" requirement was met because the only reasonable interpretation of the prosecutor's questions was whether Syracuse engaged in an institutional cover-up of a scandal similar to that allegedly conducted by Penn State. Accordingly, the court determined that "the information sought meets the standard of a potential claim implicating the policy's coverage." Because the court concluded that the subpoenas potentially implicated the policy's coverage, it determined that the insurer had a duty to advance defense costs relating to the subpoenas, stating that "an insurer's duty to defend and to pay defense costs under liability insurance policies may be construed broadly in favor of the policy holder." ■

### *False Claims Act* Qui Tam *Action Over Billing Practices Does Not Involve Professional Services; Claim Is Barred by Fraud Exclusion* *continued from page 3*

arising out of a negligent act, error and omission for claims first made during the policy period. It excluded coverage for any claim based upon or arising out of dishonest, fraudulent, criminal or intentional acts, errors or omissions. The insurer denied coverage for the subpoenas and the lawsuit, and the insured filed a lawsuit against the insurer for declaratory judgment, as well as common law and statutory "bad faith" and negligence.

The court determined that no coverage was available because "courts in this District and elsewhere have unanimously concluded that the submission of billing claims under the [FCA] does not qualify as a 'professional service.'" The insured contended that billing and collections were among its primary services, in contrast with medical providers, for whom billing is an ancillary activity. The court rejected this argument because the insured had represented to the insurer that it provided primary care as a medical outpatient facility, and the insured issued the medical professional liability policy on that basis.

The court also concluded that an FCA claim did not fall within the policy's coverage grant for damages arising out of a negligent act, error or omission, because "[a] party cannot be held liable pursuant to the [FCA] for mere negligence." Instead, "there must be a knowing presentation of what is known to be false." For the same reason, the court concluded that the policy's dishonesty exclusion precluded coverage. Accordingly, the court determined that the insurer had no duty to defend or to indemnify.

In light of its determination that no coverage was available, the court dismissed the insured's counts against the insurer for "bad faith" and for violation of Washington's Insurance Fair Conduct Act (IFCA) and Consumer Protection Act and for negligence. The court reasoned that, in the absence of coverage, the insured could not show harm, which is an essential element of a bad faith or negligence claim. In addition, the insured lacked a cause of action under the IFCA or Consumer Fraud Act because it could not show an unreasonable denial of coverage or payment of benefits. ■

Demands (CIDs) to the insured and the hospital. Because the transaction was set to close within the month, the FTC also requested that the insured enter into a "Hold Separate Agreement" whereby it agreed to limit its integration of the hospital into its health care system. In January 2011, the FTC filed administrative and civil complaints against the insured, alleging that the acquisition violated Section 7 of the Clayton Act and seeking an injunction restraining further consolidation of the insured's and hospital's operations. The insured provided notice of the actions to its insurer that month.

Taking the position that the FTC's investigation constituted a claim first made in August 2010, during the policy period of the insured's September 2009 to September 2010 claims-made policy, the insurer denied coverage based on the insured's failure to provide notice "as soon as practicable . . . and in no event later than . . . ninety (90) days after the end of the Policy Period." The insurer also denied coverage under the subsequent policy based on the "Related Claims" provision and, alternatively, the insured's failure to disclose the acquisition or FTC investigation in its renewal application. The insurer sought a declaration that the insured was not entitled to coverage under either policy. Ruling on cross-motions for summary judgment, the district court held in favor of the insurer, finding that the FTC investigation constituted a claim first made in August 2010.

The Sixth Circuit reversed, holding that the FTC's investigation was not a claim as defined by the policies and that the insured's notice of the litigation was thus sufficient. Interpreting the policies under Ohio law, the court held that there were four elements required for a claim: 1. a "written demand" or "proceeding"; 2. seeking "monetary, non-monetary or injunctive relief"; 3. "against an Insured"; 4. "for a Wrongful Act." Focusing on the fourth element and the policies' definition of "Wrongful Act" as "any actual or alleged" antitrust violation, the court first gave the term "alleged"—not defined in the policies—"its common, ordinary, and usual meaning" of "asserted to be true as described" or "accused but not yet tried." The court then held that the FTC's investigation was not a claim because "the FTC did not 'assert to be true' or 'declare' that antitrust violations had occurred or would occur . . . . Rather, the communications . . . only indicated that the FTC sought to determine 'whether' such violations had occurred or would occur." In particular, the court noted that the resolution authorizing compulsory process stated that the commission sought "to determine *whether*" the acquisition would violate the antitrust law; that "even 'full-phase' FTC investigations do not necessarily lead to litigation"; and that CIDs can be issued "to 'any person' for the purpose of obtaining information about potential antitrust violations" and do "not indicate that the recipient is accused of antitrust violations."

In reaching its holding, the court rejected the argument that its interpretation of claim rendered meaningless the portion of the definition addressing a "formal investigative order." The court acknowledged that "other formal investigative orders may give rise to a 'claim' because they 'allege' wrongdoing," but stated that "those at issue in this case did not." The court also declined to follow two non-binding district court opinions, *ACE American Insurance Co. v. Ascend One Corp.*, 570 F. Supp. 2d 789 (D. Md. 2008) (holding that an administrative subpoena and CID constituted claims), and *National Stock Exchange v. Federal Insurance Co.*, 2007 WL 1030293 (N.D. Ill. 2007) (holding that formal investigative order alleged a wrongful act). According to the court, neither of those cases "analyzes the plain meaning of the term 'alleged.'"

Separately, the court held that the FTC's investigative actions in August 2010 did not constitute demands or proceedings for "monetary, non-monetary or injunctive relief" as required by the second element of the policies' definition of claim. Finding that "relief" means "the redress or benefit . . . that a party asks of a court," the Sixth Circuit rejected the district court's implied holding that "the 'relief' requirement may be satisfied if 'relief' may be sought in the future" as contrary to the "plain language" of the policies.

Concluding that the FTC first made a claim against the insured in January 2011, during the policy period of the 2010 policy, the court remanded the case to the district court to determine whether the insured's failure to disclose the acquisition or FTC investigation in its renewal application barred recovery under that policy. ■

### *Prior Knowledge Exclusion Bars Coverage for Utility's Failure to Repair Dam* *continued from page 4*

The trial court granted summary judgment in favor of the insurers. On appeal, the court affirmed. The court held that there was no coverage for the underlying suit under the utility's D&O policy. In relevant part, the policy provided coverage for claims arising from a "Wrongful Act," which was defined as "any error, misstatement, misleading statement, act, omission, neglect or breach of duty actually or allegedly committed or attempted by . . . the Directors." The court rejected the insured's contention that its June 2000 decision to abandon the dam was a "Wrongful Act" under the policy because the insured failed to explain how such a decision, rather than the utility's prior failures to repair the dam, constituted the relevant conduct.

The court then concluded that a provision in the policy barring coverage for any claim "[b]ased upon or attributable to a Wrongful Act which any of the Directors or Officers had knowledge of prior to 4/19/00 and that any of the Directors and Officers had reason to believe that such known Wrongful Act could reasonably be expected to give rise to a Claim" precluded coverage for the landowners' suit. Rejecting the insured's argument that the outcome of the events was previously "unclear," the court noted that "[f]or the exclusion to apply, [the insured] need not know with certainty that it would be sued." The policy language only required the insured to have "reason to believe" that its failure to draw down the dam "could reasonably be expected to give rise to a Claim." The court observed that the utility "acknowledged they knew as of 1999 that they were going to receive a DNR drawdown order if they were unable to transfer ownership of the dam." Moreover, the court noted that the insured had admitted in its deposition that it "assumed" it "would be sued" if the lake was drawn down.

The court also held that there was no coverage for the underlying suit under the policyholder's CGL policy issued by another insurer. In so ruling, the court held that there was no "event" or "accident" so as to trigger coverage because the insured's decision not to repair the dam was intentional. ■

### *Sexual Harassment Suit Interrelated With Earlier Disparate Treatment Proceeding Before Division of Civil Rights* *continued from page 7*

anti-discrimination law. All of the allegations in the administrative pleading were included in the later civil complaint. Although the civil complaint added sexual harassment claims, that did not change the fact that all of the assertions related to the policyholder's alleged discrimination on account of the claimant's gender. The court accordingly dismissed the policyholder's cause of action seeking a declaratory judgment.

However, the court denied the carrier's motion to dismiss the breach of contract cause of action. The court stated that, under New Jersey law, the parties' subsequent conduct during settlement negotiations, as alleged in the policyholder's complaint, could permit a conclusion that the parties modified the policy's terms by subsequent oral agreement, notwithstanding the policy's no-oral-modifications clause. Accordingly, the court found that dismissal of the breach of contract claim based solely on the pleadings would be "premature." ■

### *Breach of Contract Exclusion Bars Coverage for Claims Naturally Resulting from Breach*

*continued from page 3*

underlying claim and rejected the insurer's argument that the exclusion did not apply to the Section 1983 and conspiracy-to-retaliate claims since they allegedly did not "arise out of" a breach of contract. The court held that an injury must be "foreseeable" rather than merely "incidental, fortuitous or but for" in order to "arise out of" its supposed cause. According to the court, the dispute over royalty payments was a "natural and foreseeable result" of the municipality's breach of contract. Hence, the court found that the retaliation claims arose out of this breach of contract. ■

### *Prior Acts Exclusion Bars Coverage for Suit Against Bank Alleging Lending Act*

*continued from page 7*

a prior acts exclusion in the policy's lending act coverage part.

The court first held that the insurer did not waive its right to deny coverage based on the prior acts exclusion, although the insurer failed to disclaim coverage for the investors' suit on that basis in its denial letter. The court distinguished Georgia law holding that an insurer waives its right to rely on a coverage defense if the insurer does not raise the coverage defense when denying coverage for a claim. The court held that the waiver doctrine applied only in the context of duty to defend policies. Because the insurer only had a duty to advance defense costs and not a duty to defend, the insurer did not waive its right to rely on the prior acts exclusion to bar coverage for the investors' suit.

The court held that the amended complaint fell within the policy's lending act coverage part, which defined "lending act," in relevant part, as "with respect to a loan, lease, or extension of credit, any error, misstatement, misleading statement, act, omission, neglect, or breach of duty actually or allegedly committed . . . in connection with or relating to any agreement or refusal to grant or extend any such loan, lease or extension of credit." Because the amended complaint alleged that the bank made misrepresentations to investors by extending credit to the customer through payment of overdrafts and allowed the customer to cover up the Ponzi scheme through that and other extensions of credit, the court held that the amended complaint alleged a "lending act" against the bank.

The court then held that the prior acts exclusion in the lending act coverage part barred coverage for the amended complaint. The prior acts exclusion barred coverage for "any Claim made against any insured based upon, arising out of, or attributed to any Lending Act . . . taking place prior to January 19, 2010." Because, the lending acts alleged in the amended complaint took place before December 2007, the court held that the prior acts exclusion barred coverage for the amended complaint. ■

*continued from page 4*

legally obligated to pay as 'damages' because of an act, error or omission arising out of your 'legal services' rendered or that should have been rendered." In so holding, the court found that "the underlying complaints do not create the potential for coverage because they are not based on providing legal services," which are defined in relevant part as the "usual and customary services of a licensed lawyer in good standing." The court explained that "the billing and fee-setting acts at issue are administrative tasks and not the usual and customary services of a lawyer." The court held that "legal services," and the more general phrase "professional services," each make a "distinction between skills or knowledge specific to the profession, and administrative tasks, such as billing, inherent to all businesses, and . . . found that the latter is not encompassed with these terms."

Next, the court held that coverage also was not available for one of the actions because the complaint sought only restitution or disgorgement of funds improperly gained, which are not covered "damages" under the policy. The court noted that a declaration filed in the suit "makes clear that these claims seek return of the money wrongfully taken as fees" and that there is no evidence "that would support an award of damages beyond the compensation of the money that [the insured] is alleged to have acquired wrongfully, apart from the request for exemplary and punitive damages." With regard to the second action, the court found that the insurer had not met its burden to establish the absence of the potential for coverage based upon the allegations in the second complaint that the insured should pay a "penalty" for his improper actions.

The court also found that "[e]ven if there were coverage for either case, there is no material dispute of fact that the [underlying] actions fall into two different exclusions contained in the policy, for disputes over fees for services and the gaining of personal profit or advantage to which the insured was not entitled." The exclusion for fee disputes bars coverage for claims "[b]ased on or directly or indirectly arising out of the rights or duties under any agreement including disputes over fees for services." The court held that the claims at issue "indisputably" concerned disputes over fees, implicating the exclusion. The court rejected the insured's contentions that the underlying plaintiffs might assert additional allegations in the future, stating that, "[b]ecause [the insured is] 'not entitled to justify an argument for coverage based on speculation about claims that have not been alleged or asserted,' the arguments are unavailing."

The court held that "legal services," and the more general phrase "professional services," each make a "distinction between skills or knowledge specific to the profession, and administrative tasks, such as billing, inherent to all businesses, and . . . found that the latter is not encompassed with these terms."

Finally, the court held that indemnity coverage was precluded by the policy's personal profit exclusion, which barred coverage for claims "[b]ased on or directly or indirectly arising out of or resulting from . . . the gaining by any insured of any personal profit, gain or advantage to which an insured is not legally entitled; . . . [h]owever, [the insurer] shall defend such allegations against any insured if it involves a 'claim' otherwise covered under the Policy until final adjudication." The court held that, because the claims "arise out of the insured's unlawful gaining of a profit or advantage to which it wasn't entitled" and because the claims at issue are not otherwise covered by the policy, this exclusion barred indemnity coverage. ■

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