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EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | July 2013

ALSO IN THIS ISSUE

continued on page 2

New York High Court: Insurer May Not Rely on Policy Exclusions If It Breaches Duty to Defend

The New York Court of Appeals, applying New York law, has held that, where an insurer breaches its duty to defend, the insurer "may not later rely on policy exclusions to escape its duty to indemnify the insured for a judgment . . . ." *K2 Invest. Group, LLC v. Am. Guar. & Liab. Ins. Co.*, 2013 WL 2475869 (N.Y. June 11, 2013). The court also held that the lower court properly dismissed claims alleging bad faith for failing to accept a demand within limits prior to the entry of the default judgment. Both the insurer and an insurance trade association, Complex Insurance Claims Litigation Association (CICLA), have filed motions for reargument.

The insurer issued to a law firm a professional liability policy with a $2 million aggregate and per claim limit of liability. Plaintiffs in the underlying action made loans to a real estate investment

continued on page 9

New York High Court: Public Policy Does Not Bar Coverage for Portion of "Disgorgement" Not Traceable to Policyholder's Own Improper Gains

New York's highest court has reinstated a lawsuit seeking coverage for a payment of "disgorgement" as a result of a Securities and Exchange Commission (SEC) settlement regarding allegations of market timing and late trading by Bear Stearns. The court rejected the carriers' "no loss" defense, holding that, at the motion to dismiss stage, the carriers had not shown as a matter of law that the policyholder was seeking indemnification for amounts traceable to its own improper gains. *J.P. Morgan Sec., Inc. v. Vigilant Ins. Co.*, No. 113 (N.Y. June 11, 2013).

A 2003 SEC investigation of Bear Stearns over allegations of late trading and market timing led to a 2006 settlement in which Bear Stearns agreed to pay $160 million as disgorgement. Bear Stearns settled without admitting liability and maintained that it

continued on page 8

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ALSO IN THIS ISSUE

Illinois Supreme Court Holds TCPA Damages Are Insurable

The Illinois Supreme Court, applying Illinois law, has held that the Telephone Consumer Protection Act of 1991 (TCPA) is a remedial statute and not penal, and thus minimum statutory damages prescribed under the TCPA and paid as part of a class action settlement for alleged TCPA violations do not constitute uninsurable punitive damages. *Standard Mutual v. Lay*, 2013 WL 2253203 (Ill. May 23, 2013). The court reached the issue after concluding that the insurer did not waive its policy defenses regarding coverage where the insurer's reservation of rights letter specifically identified potential coverage defenses and a conflict of interest and where the insurer brought a declaratory judgment action concerning coverage.

The insured, a real estate agency, was sued in a class action lawsuit alleging violations of the TCPA. The insured, which was sued in connection with its role in sending thousands of unsolicited faxes, subsequently sought coverage for the lawsuit. Agreeing to defend the insured subject to a reservation of rights, the insurer drafted a letter notifying the insured that the policies may not cover the alleged conduct because, among other things, the TCPA "may constitute a penal statute" and the policies excluded coverage for willful violations of penal statutes. Because a conflict of interest existed, the insurer

continued on page 11

Email Clarifying Oral Conversation That Included Demand for Monetary Relief Is a Claim

The United States District Court for the District of Maryland, applying Maryland law, has held that an email clarifying an oral conversation that included a demand for monetary relief constituted "a written demand . . . for monetary or non-monetary relief." *Fin. Indus. Regulatory Auth. v. Axis Ins. Co.*, 2013 WL 2946950 (D. Md. June 12, 2013).

An employee of the insured retained counsel and was contemplating filing age discrimination charges. An assistant general counsel for the insured employer had an oral conversation with the employee's attorney, in which the employee's attorney apparently made an oral offer to settle these charges. Subsequently, the employee's attorney wrote an email to the assistant general counsel disagreeing with the assistant general counsel's characterization of the conversation and noting that he had stated in the oral conversation that "just so we are clear, I did not ask for 5 years of 'severance pay' . . . . I added that [my client] would settle [the potential age discrimination] claim for a sum equal to 5 years pay."

After this email was sent, the employee filed a charge of discrimination before the U.S. Equal Employment Opportunity Commission (EEOC). The employer sought coverage for the EEOC charge of discrimination under a claims-made-and-reported employment liability insurance policy in effect at the time. The policy defined a "claim" as, in relevant part, "the receipt by any Insured of . . . a written demand against any Insured for monetary or non-monetary relief[.]" The insurer denied

> The court explained that the email was of sufficient formality to constitute a claim because it went beyond a "mere request for explanations, complaining, or lodging of a grievance" and made a demand for monetary relief.

continued on page 11

Unfair Trade Practices Exclusion Inapplicable to Claims Arising Under Fair Debt Collection Statutes; Statutory Damages Covered

The United States District Court for the Middle District of Pennsylvania has held that an E&O policy issued to a now-bankrupt credit counseling company did not cover claims arising under unfair trade practices statutes, but did cover claims arising under fair debt collection statutes. *Hrobuchak v. Fed. Ins. Co.*, 2013 WL 2291875 (M.D. Pa. May 24, 2013). The court also held that carve-outs from the policy's definition of loss did not preclude coverage for statutory damages or damages representing the return of fees paid to the insured.

In 2008, a putative class action lawsuit alleging violations of the federal Fair Debt Collection Practices Act, the Pennsylvania Fair Credit Extension Uniformity Act and Pennsylvania's Unfair Trade Practices Act (UTPA) was filed against the insured. After the insured filed for chapter 11 bankruptcy protection in January 2009, the class action was stayed, and a class proof of claim was filed with the bankruptcy court on behalf of the same class. The bankruptcy court subsequently entered a "Judgment Allowing Proof of Claim," effectively certifying a class of claimants against the insured for alleged damages resulting from improper debt collection practices and authorizing the claimants to enforce the judgment against the debtors' insurance policy. Following the bankruptcy court's adoption of the insured's liquidation plan, class representatives filed a declaratory judgment action against the insurer in federal district court. After unsuccessfully moving to dismiss the declaratory judgment action, the insurer moved to vacate the bankruptcy court confirmation order

continued on page 14

Malpractice Complaint and Previous Counterclaim Constitute a Single Claim Made in Prior Policy Period

Applying New Jersey law, the United States Court of Appeals for the Third Circuit has held that a malpractice complaint filed against an insured attorney in 2009 arose out of the same wrongful acts as a prior counterclaim filed against the same attorney in 2007, and thus was deemed first made in 2007 under a prior policy period. *Szaferman, Lakind, Blumstein & Blader, PC v. Westport Ins. Corp.,* 2013 WL 2233915 (3d Cir. May 22, 2013).

In 2007, an attorney filed suit against several former clients for unpaid fees. One of the clients filed a counterclaim alleging incompetence on the part of the attorney. The attorney ultimately settled with the filer of the counterclaim and dismissed the fee collection suit against all of the former clients. Subsequently, the attorney joined another law firm and was added as an insured under the new firm's professional liability policy for the claims-made policy period of July 4, 2008 to July 4, 2009. In 2009, one of the former clients who had been named as a defendant in the attorney's collection action filed a malpractice complaint against the attorney making allegations similar to those found in the 2007 counterclaim.

The insurer denied coverage for the claim on the grounds that the 2009 complaint and the 2007 counterclaim were considered a single claim first made in 2007, before the policy's inception. In this regard, the policy's related claims provision provided that claims "arising out of a single Wrongful Act . . . or a series of related or continuing Wrongful Acts, shall be a single Claim . . . considered first made on the date on which the earliest Claim was first made." The court held that the allegations and demands in the 2007 counterclaim and the 2009 complaint arose from the same or related wrongful acts regarding the insured attorney's negligence in the handling

continued on page 13

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Connecticut Supreme Court: Losses Caused by Different Sets of Negligent Acts with Common Precipitating Factor Are Not "Related"

The Connecticut Supreme Court has held that losses suffered by multiple patients of a nursing home were not "related" for purposes of determining the number of applicable limits of liability under a professional liability policy, despite their common origin in a single fire. *Lexington Insurance Co. v. Lexington Healthcare Group, Inc.*, 2013 WL 2482997 (Conn. June 18, 2013). The court also determined that an endorsement to the policy applied a $1 million limit of liability for each insured location—rather than a $10 million limit of liability—and that a $250,000 self-insured retention applied to each loss, but was not subtracted from the $500,000 per-incident limit of liability.

More than a dozen nursing home patients or their heirs instituted litigation for injuries stemming from a fire caused by another patient. Certain of the claims involved the nursing home's decision to admit the patient who caused the fire and thereafter to supervise and treat her properly. Additional claims concerned general safety and emergency failures, such as inadequate staffing, training and fire prevention equipment, while still other claims made specific allegations of negligence, such as staff members' failures to respond properly to the fire by closing particular doors and windows.

The nursing home's professional liability policy afforded coverage subject to a $500,000 limit of liability for each "medical incident" and provided that claims arising from "continuous, related, or repeated medical incidents shall be treated as arising out of one medical incident." The insurer contended that all of the claims by the injured patients or their representatives stemmed from the same root cause—the admission of the patient who started the fire and the alleged failure

continued on page 15

Actual Notice Through an Intermediary Sufficient to Provide Notice Under Policy

The United States District Court for the District of Maryland, applying New York law, has held that notice of a claim that was sent from an insured independent contractor to the broker-dealer for whom he worked, which forwarded the notice to the insurer, satisfied the notice provision of an E&O policy even though the insured did not provide direct notice of the claim to the insurer. *Steinfelder v. Catlin Specialty Ins. Co.*, 2013 WL 2147561 (D. Md. May 15, 2013).

A broker-dealer required its independent contractor representatives to pay for E&O insurance that would be obtained by the broker-dealer. The policy afforded potential coverage to the independent contractor, one of the broker-dealer's representatives, who paid his E&O premiums directly to the broker-dealer.

When Financial Industry Regulatory Authority (FINRA) served an arbitration claim on the insured contractor, the contractor tendered the claim to the broker-dealer, allegedly believing that this was sufficient to put the insurer on notice of the claim. The broker-dealer informed the contractor that the claim was not covered under the policy, and the E&O carrier also subsequently directly informed the contractor that the claim was not covered. In addition, despite repeated requests, the E&O insurer did not provide a copy of the policy to the contractor for approximately six months, until after the policy had terminated.

The contractor sued the E&O insurer and the broker-dealer in federal court, alleging, *inter alia*, breach of contract and fraud. The insurer moved to dismiss, arguing that the failure of the contractor to provide notice to the carrier during the policy period relieved it of an obligation to defend the underlying litigation. The court disagreed, noting that it was "reasonable to infer" that the broker-dealer provided the E&O

continued on page 15

Criminal Acts Exclusion Bars Coverage After Escrow Agent Pleaded Guilty to Stealing Funds from Account

The United States District Court for the Middle District of Florida has held that a professional liability policy's criminal acts exclusion bars coverage for a claim for the return of escrow funds because the title agency's owner had pleaded guilty and admitted to fraudulently disbursing the funds from the agency's escrow account. *Max Specialty Ins. Co. v. A Clear Title & Escrow Exch., LLC*, 2013 WL 2682716 (M.D. Fla. June 12, 2013).

The insurer issued a title agents, abstractors and escrow agents professional liability policy to the agency. The agency's sole owner and manager fraudulently disbursed funds from an escrow account to unauthorized recipients and created fraudulent reports to investors regarding the balance on deposit in the account. The owner was criminally charged with conspiracy to commit wire fraud and pleaded guilty. The insurer brought a coverage action seeking a declaration that there was no coverage for civil claims against the insured by the entities and individuals who had placed money in the escrow account.

In ruling on the insurer's motion for summary judgment, the court analyzed the policy's criminal acts exclusion, which precluded coverage for claims "based on or directly or indirectly arising out of or resulting from . . . any criminal, fraudulent, or dishonest act." The exclusion required the insurer to defend "such allegations" against the policyholder until "final adjudication." The court found that the agency's owner had committed a crime when he took money from the escrow account and that therefore the claim for failure to return the escrow funds clearly arose out of a criminal act. The court also found that the owner's guilty plea constituted a final adjudication of the allegations so as to relieve the insurer of its obligation to defend against the claim. The court rejected the claimant's argument that it had alleged only the agency's negligence and noted that the policy did not make an exception for crimes committed by principals as opposed to by the entity represented by the principal. Finally, the court also determined that the insurer had not waived this coverage defense under Section 627.426(2) of the Florida Claims Administration Statute by not defending because a waiver could not create coverage for claims expressly excluded under the policy. ■

Coverage for Architect's Alleged Negligence Barred by Professional Services Exclusion

A federal district court has determined that a commercial general liability insurer had no duty under Nevada law to defend an underlying third-party contribution action against an insured architectural firm following a traffic accident allegedly caused by a median it designed, holding that the claim was barred by a professional services exclusion. *Beazley Ins. Co. v. Am. Econ. Ins. Co.*, 2013 WL 2245901 (D. Nev. May 21, 2013).

After suffering injuries in a car accident, a passenger filed suit against a driver of another vehicle. In the same action, a project developer filed a third-party complaint against the architectural firm, asserting a claim for professional negligence. The architectural firm tendered its claim to its professional liability insurer and its commercial general liability (CGL) insurer. The professional liability insurer undertook the architectural firm's defense. The commercial general liability insurer also paid a portion of certain defense costs subject to a reservation of the right to decline coverage based on a professional services exclusion barring coverage for bodily injury or property damage claims "arising out of the rendering or failure to render any professional services by [the policyholder] or any engineer, architect or survey or … either employed by

continued on page 12

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Court Looks Outside Underlying Pleadings to Hold That Criminal Conduct Exclusion Barred Coverage for Misrepresentation

The United States District Court for the Southern District of Florida has held that a fraudulent, dishonest and criminal conduct exclusion barred coverage for civil claims filed against an insurance agent when the agent was adjudicated guilty of grand theft and insurance fraud based on the same criminal scheme upon which the civil actions were based. *Certain Interested Underwriters at Lloyd's, London v. AXA Equitable Life Ins. Co.*, 2013 WL 3070885(S.D. Fla. June 18, 2013). In addition, the court held that it was proper to look outside the pleadings in the civil actions to determine whether the insurer had a duty to defend because the operative facts impacting coverage were easily verified and because those facts would not be resolved by the underlying litigation.

The policyholder, an insurance agent, was insured under an insurance professionals E&O policy. After it became known that the insurance agent was involved in an illegal, stranger-originated life insurance scheme, a life insurance company sued the insured insurance agent, alleging that he made false representations in agent certificates provided to the life insurer. In addition, a trust sued the insured life insurance agent after certain life insurance policies it had purchased were rescinded because of the insured's alleged misrepresentations. The insured was also criminally charged with and pleaded guilty to multiple counts of insurance fraud and grand theft, for which a court adjudicated him guilty.

In ruling on a motion for summary judgment in a subsequent coverage action, the court held that the policy's criminal conduct exclusion barred coverage for the claims. After noting that an

continued on page 12

Insurer Entitled to Rescind Lawyers Malpractice Policy Based on Material Misrepresentations in Application

The United States District Court for the Middle District of Florida, applying Florida law, has held that a lawyers malpractice policy was void *ab initio* based on material misrepresentations made by the insured in the application for the policy. *Darwin Nat'l Assur. Co. v. Brinson & Brinson*, 2013 WL 2406154 (M.D. Fla. June 3, 2013). The court also held that the insurer did not waive its right to rescind the policy by agreeing to provide a defense because the insured was not prejudiced by the insurer's defense of the underlying action.

The insured, a law firm, was retained to represent a limited liability company and its manager in a foreclosure action. Before the insured was retained to represent the company and its manager, a default judgment was entered against the company. Four months after the firm's retention and five days before trial in the foreclosure action, the firm filed a motion to set aside the default judgment, which was denied. After trial, a $2.85 million judgment was entered against the company, and the firm filed a notice of appeal.

The appellate court issued an order to show cause why the company's appeal was not premature, and the firm's attorneys failed to respond. The court sanctioned the attorneys and issued an additional order to show cause why the court should not refer the matter to the Florida Bar. When the attorneys did not respond, the appellate court issued an order referring the attorneys to the Florida Bar for investigation and discipline. The appellate court issued an additional show cause order after the attorneys failed to file the initial brief by the required date.

After these events, the firm submitted an application for a lawyers malpractice policy, which requested that the firm respond based on its "knowledge and belief." The firm did not disclose the appellate court's order referring the firm's lawyer to the Florida Bar or an unrelated bar complaint in response to a question asking whether "any attorney [had] been the subject of any bar complaint, investigation or disciplinary

continued on page 13

Tenth Circuit Holds That Multiple Arbitrations Concerning "Churning" of Annuity Accounts Constitute "Interrelated Wrongful Acts"

The United States Court of Appeals for the Tenth Circuit, applying New York law, has held that an arbitration concerning allegations that the insured broker-dealer for a financial services firm "churned" annuity accounts in order to generate higher commissions related back to claims made in two earlier arbitrations that occurred prior to the insurer's policy period, thus falling outside of coverage under that policy. *Brecek & Young Advisors, Inc. v. Lloyds of London Syndicate 2003*, 2013 WL 1943338 (10th Cir. May 13, 2013). However, the court also determined that the carrier was estopped from raising that coverage defense due to its failure to raise the defense promptly and subsequent involvement in connection with the defense and settlement of the arbitrations.

The insured broker-dealer was a respondent in an arbitration before the National Association of Securities Dealers, in which 26 claimants generally alleged that the insured, among other things, sold unsuitable investments products and "churned" annuity accounts of retirees in order to generate higher commissions. The insured tendered notice of the arbitration to its professional liability insurer, which agreed to defend the action under a reservation of rights. At the time, the insurer was aware of two prior arbitrations involving the insured concerning churning allegations that were submitted to the insured's prior carrier. However, the current insurer advised the insured that the prior claims were not "Interrelated Wrongful Acts," and that

continued on page 10

Underwriting Exclusion Bars Coverage for Claim for Failure to Notify Life Insurance Applicants of Adverse Test Results Obtained as Part of Application Process

The Iowa Supreme Court, applying Iowa law, has affirmed a lower court's application of an underwriting exclusion to bar coverage for a claim against an insured life insurance company for its failure to notify applicants of the results of certain medical tests taken during the application process. *Farm Bureau Life Insurance Co. v. Holmes Murphy & Assocs., Inc.*, 2013 WL 2127573 (Iowa May 17, 2013).

The insured, a life insurance company, denied a husband and wife's application for a policy when it learned they were HIV positive. The life insurance company did not inform the applicants of the test results, and the applicants learned they were HIV positive two years later. The applicants sued the life insurance company, among others, alleging negligence in failing to report their HIV-positive status. The life insurance company and applicants ultimately settled the lawsuit. The life insurance company provided notice of the settlement to its broker, which was, in turn, to report the settlement to the life insurer's professional liability insurer. The broker did not report the matter to the professional liability insurer, however, until more than two years after it had received notice of the matter from the insured life insurance company, by which time the professional liability policy had already expired.

The professional liability insurer denied coverage on the basis of late notice and the application of the policy's "bodily injury" and "underwriting" exclusions. The insured life insurance company filed a complaint against the professional liability insurer and the insured's broker. Summary judgment was granted in favor of the professional liability insurer based on untimely notice, which

continued on page 8

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Underwriting Exclusion Bars Coverage for Claim for Failure to Notify Life Insurance Applicants of Adverse Test Results Obtained as Part of Application Process *continued from page 7*

an intermediate appellate court affirmed. The life insurance company filed an amended complaint against the broker, and the court granted the broker's motion for summary judgment on the basis that even if notice was timely provided, the policy's bodily injury and underwriting exclusions would apply to bar coverage. The life insurance company again appealed.

In affirming the lower court's opinion, the Iowa Supreme Court first looked at the underwriting exclusion, which precluded coverage for claims "based upon, arising from, or in consequence of the underwriting of insurance, including any decisions involving the classification, selection or renewal of risks." Because the term "underwriting" was not defined in the policy, the court used a definition found in a dictionary when interpreting the provision. The court concluded that the underwriting exclusion applied, explaining that the insured life insurance company's eligibility investigation and management of information derived from the investigation arose out of its underwriting activity. In addition, the court noted that the professional liability policy's definition of "insurance services," from which a covered claim must arise, did not include activities like the ones at issue and also specifically excluded "medical or health care services."

The court rejected the insured life insurance company's argument that the application of the underwriting exclusion rendered the policy illusory because the professional liability insurer provided an example of circumstances when the policy would, in fact, afford coverage. ■

New York High Court: Public Policy Does Not Bar Coverage for Portion of "Disgorgement" Not Traceable to Policyholder's Own Improper Gains *continued from page 1*

had received only $16.9 million in commissions from its allegedly wrongful actions. After its insurers declined coverage for the settlement payment, Bear Stearns filed coverage litigation. The trial court denied a motion to dismiss, an intermediate appellate court reversed and New York's highest court agreed to hear the dispute.

The court discussed cases holding that the risk of being ordered to return ill-gotten gains is not insurable and did not express disagreement with those authorities. Accepting Bear Stearns's allegations as true, however, only a portion of the $160 million payment—primarily the commissions Bear Stearns earned—allegedly represented Bear Stearns's own profits. According to Bear Stearns, the remainder of the payment, notwithstanding the SEC's "disgorgement" label, allegedly represented improper gains obtained by Bear Stearns's customers. The court opined that in the cases relied upon by the insurers, the SEC's findings conclusively linked the disgorgement payment to improperly acquired funds in the hands of the policyholder. Here, the SEC order recited that Bear Stearns's misconduct had permitted its customers to generate hundreds of millions of dollars in profits. The court accordingly ruled that the trial court properly denied the insurers' motions to dismiss. ■

continued from page 1

company. A lawyer associated with the insured law firm was also a member of the real estate investment company. Plaintiffs alleged that the lawyer, acting as their attorney, failed to record mortgages in plaintiffs' favor to secure their loans. The real estate investment company subsequently became insolvent and never made payments on the unsecured loans. Plaintiffs sued the lawyer and made a settlement demand of $450,000. The insurer denied coverage for the underlying litigation and settlement demand based on policy exclusions for claims arising out of the insured's capacity or status as a director or officer of a business enterprise and for claims arising out of alleged acts or omissions of the insured for any business enterprise in which the insured had a controlling interest. The lawyer failed to appear in the litigation, and a default judgment in excess of the policy limits was entered against him. The lawyer then assigned his claims against the carrier, including bad faith claims, to plaintiffs. In the resulting declaratory judgment action, the trial court found that the insurer breached its duty to defend, and the intermediate appellate court affirmed, holding that the exclusions relied upon by the insurer were inapplicable.

On appeal, the New York high court affirmed. In so doing, the court determined that the underlying complaint "unmistakably [pled] a claim for legal malpractice" within the scope of coverage of the policy. Accordingly, the court noted that it would not reach the issue of whether the exclusions relied upon by the insurer applied to bar coverage because, where it is "quite clear" that the insurer breached its duty to defend, "by breaching its duty to defend [the insurer] lost its right to rely on these exclusions in litigation over its indemnity obligation." Additionally, relying on *Lang v. Hanover Insurance Co.*, 820 N.E.2d 855 (N.Y. 2004), the court stated that an insurer disclaiming coverage "is well advised to seek a declaratory judgment concerning the duty to defend or indemnify the purported insured . . . [because if] it disclaims and declines to defend in the underlying lawsuit without doing so, it takes the risk that the injured party will obtain a judgment against the purported insured and then seek payment." The court explained that "an insurance company that has disclaimed its duty to defend 'may litigate only the validity of its disclaimer.' If the disclaimer is found bad, the insurance company must indemnify its insured for the resulting judgment, even if policy exclusions would otherwise have negated the duty to indemnify."

The court explained that "[t]his rule will give insurers an incentive to defend the cases they are bound by law to defend, and thus to give insureds the full benefit of their bargain." The court noted, however, that there may be exceptions to this rule, citing as an example a scenario in which an insured's conduct was intentional such that public policy could prohibit the insurability of intentional wrongdoing.

The court also held that the lower courts properly dismissed the bad faith claims against the insurer. In this regard, the court stated that "[a]n insurer's rejection of a settlement offer for less than the full amount of its policy does not by itself establish the insurer's bad faith, even when the insured later suffers a judgment greater than the policy limit." The court further noted that the plaintiffs failed to allege any facts that evidenced bad faith on the part of the insurer. ■

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each of the 26 individual claimants asserted separate claims, such that 26 separate $50,000 retentions applied.

The policy provided that "[a]ll Claims based upon or arising out of the same Wrongful Act or Interrelated Wrongful Acts shall be considered a single Claim and each such single Claim shall be deemed to have been made . . . when the earliest Claim arising out of such Wrongful Act or Interrelated Wrongful Acts was first made." "Interrelated Wrongful Acts" was defined to mean "any Wrongful Acts that are . . . similar, repeated or continuous; or connected by reason of any common fact, circumstance, situation, transaction, casualty, event, decision or policy or one or more series of facts, circumstances, situations, transactions, casualties, events, decisions or policies."

In the declaratory judgment action concerning coverage, the district court granted summary judgment to the insured, holding that the claims by the 26 claimants were each interrelated wrongful acts subject to a single retention, but the court denied the insurer's alternative argument that, if the 26 claims in the latest arbitration were related, then they related back to the claims made prior to the insurer's policy period.

On appeal, the Tenth Circuit reversed the district court, finding that the most recent arbitration and the two prior arbitrations "were connected by common facts, circumstances, decisions, and policies" such that the claims "ar[o]se from wrongful acts interrelated to the wrongful acts committed outside the insurer's policy period." In reaching this conclusion, the court recognized that, under New York law, whether claims constitute interrelated wrongful acts "depends upon whether there exists a sufficient factual nexus between" the claims. In finding that the latest arbitration and the two prior arbitrations were interrelated, the court focused on "[s]everal common facts" that connected the three arbitrations, including: 1. all named as respondents the insured and several other parties; 2. "[a]ll of the misconduct was alleged to have taken place during roughly the same time period—from the late 1990s to the mid 2000s"; 3. "[a]ll claims allege the respondents sold unsuitable investment products including various types of annuities"; 4. "all claims involved allegations of churning or flipping of investment accounts in order to enrich the broker/agents at the expense of account holders"; and 5. the insured's "liability was predicated on theories of vicarious liability and failure to supervise its broker/agents in each of the claims." The Tenth Circuit rejected the insured's contention that the "Interrelated Wrongful Acts" provision should be interpreted narrowly, commenting that the policy defined the term and that the parties agreed the term was unambiguous. Because the court found that all three arbitrations were interrelated, the court held that the most recent arbitration related back to the first such arbitration, which was first made prior to the relevant policy period.

Next, the court held that the district court abused its discretion in holding that the insurer was not estopped from raising the defense that all of the arbitrations were interrelated because the insurer "waited too long" to assert that defense after agreeing to defend the arbitration and settling that arbitration. In this regard, the court emphasized that, where "for three years [the insurer] consistently acted as though the claims were covered under the Policy, subject only to a dispute as to the amount of applicable retentions," and the insurer "controlled the defense of the Arbitration throughout its entirety to its termination and contributed to the settlement," "[s]uch a showing is more than adequate to establish prejudice under New York law." The court then remanded the action back to the district court to determine whether the insured was entitled to any recovery beyond the funds the insurer already paid out as indemnity for the settlement, which were paid out under the insurer's argument at the time that 26 separate retentions should apply. ■

Illinois Supreme Court Holds TCPA Damages Are Insurable *continued from page 2*

then gave the insured the option of choosing its own defense attorney or waiving the conflict of interest and accepting counsel provided by the insurer. The real estate agency initially accepted the attorney hired by the insurer, but later decided to hire its own defense counsel. The insured and its own counsel ultimately settled the case, but neither informed the insurer-appointed attorney of the settlement until after it happened.

The insurer subsequently filed a declaratory judgment action, seeking a determination regarding coverage for the underlying lawsuit and settlement. The insurer alleged that the TCPA-prescribed damages of $500 per violation constituted uninsurable punitive damages and that it had no duty to indemnify the insured because it entered into the settlement agreement without its consent. Concluding that there was no coverage, the trial court granted summary judgment in favor of the insurer. The intermediate appellate court affirmed, but addressed only two issues. First, the court determined that the insurer was not estopped from raising coverage defenses. Second, the court concluded that TCPA-prescribed damages constitute uninsurable punitive damages.

On appeal, the Illinois Supreme Court agreed that the insurer was not estopped from asserting coverage defenses. In so doing, the court rejected the real estate agency's argument that the insurer's reservation of rights letter did not adequately inform it of potential coverage defenses and conflicts of interests. The court noted that the letter specifically referred to the conflict of interest regarding violation of penal statutes and also included an extensive list of policy defenses.

The Illinois Supreme Court, however, overturned the intermediate appellate court's ruling concerning whether the TCPA-prescribed damages constitute uninsurable punitive damages, reasoning that the "manifest purpose of the TCPA is remedial and not penal." The court explained that "Congress enacted the TCPA to address telemarketing abuses attributable to the receipt of unsolicited faxes," and that Congress identified the purpose of the TCPA as "prevent[ing] advertisers from unfairly shifting the cost of their advertisements to consumers while simultaneously preventing the use of their fax machines for legitimate purposes." Because the court determined that the TCPA is remedial and not penal, the court held that the TCPA-prescribed damages of $500 per violation do not constitute uninsurable punitive damages. ■

Email Clarifying Oral Conversation That Included Demand for Monetary Relief Is a Claim
continued from page 2

coverage on the basis that the claim was first made during the previous policy period when the claimant's attorney's email had been sent to the insured's assistant general counsel confirming the oral settlement demand. The employer sued the insurer for breach of contract, arguing that the phrasing in the email was merely designed to "avoid any uncertainty or confusion" as to the topics discussed in the oral conversation, and not to make a formal demand for relief.

In ruling on cross-motions for summary judgment, the court disagreed with the employer, holding that the email was a written demand for relief. The court noted that "[i]t [was] of no moment that the email clarifies a prior oral demand, as it still states the demand, and it manifests the demand in written format." The court explained that the email was of sufficient formality to constitute a claim because it went beyond a "mere request for explanations, complaining, or lodging of a grievance" and made a demand for monetary relief.

The court further held that Maryland's statute requiring a showing of prejudice to deny coverage on the grounds of late notice did not apply to a claims-made-and-reported policy. Therefore, because a written demand was made during the first policy period and the insured did not report the claim until after the 60-day grace period after the end of the policy period, as required by the claims-made-and-reported policy, the court held that there was no coverage under either policy. ■

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Coverage for Architect's Alleged Negligence Barred by Professional Services Exclusion

continued from page 5

[the policyholder] or performing work on [the policyholder's] behalf . . . ." After the developer's claim was dismissed, the professional liability insurer sought contribution from the commercial general liability insurer.

The court held that, because the professional services exclusion precluded coverage, the commercial general liability insurer had no duty to defend the insured. First, the court rejected the professional liability insurer's contention that the duty to defend should be determined by reference to the underlying complaint by the accident victim (which did not name the insured), as well as the third-party complaint by the developer against the insured at issue. The court ruled that because the third-party complaint "specifically limits the type of conduct for which [the insured] may be liable," and because the CGL insurer's duty to defend extends only to "a lawsuit that alleges damages against the insured," the third-party complaint alone furnished the relevant allegations.

Next, the court rejected the professional liability insurer's argument that the professional services exclusion was inapplicable because the third-party complaint, asserting that the policyholder "failed to catch [an] open and obvious danger of [a] misaligned median in violation of its contractual duty," alleged ordinary negligence outside the ambit of a professional services exclusion. In analyzing the allegations of the third-party complaint, the court examined "the nature of the particular service allegedly negligently performed (or not performed), and whether that service is recognized as requiring specialized training or expertise." The court held that conduct, such as that alleged in the third-party complaint, within the scope of the contract between the insured and client constitutes professional services. The court determined that the "ordinary negligence" exception to application of professional services exclusions only applies where the insured was alleged to have engaged in wrongful conduct outside the scope of services for which the insured was hired. The court concluded that the allegations of the third-party complaint pertained solely to the architect's alleged "contractual duty to warn [its client] of defects and deficiencies and that [the insured]'s failure to perform this professional service resulted in damage to the plaintiff." ■

The court determined that the "ordinary negligence" exception to application of professional services exclusions only applies where the insured was alleged to have engaged in wrongful conduct outside the scope of services for which the insured was hired.

Court Looks Outside Underlying Pleadings to Hold That Criminal Conduct Exclusion Barred Coverage for Misrepresentation

continued from page 6

insurer's duty to defend is ordinarily governed by the allegations of the complaint, the court opined that it was proper to consider the facts of the underlying criminal case in order to determine whether the insurer had a duty to defend the two civil actions. The court reasoned that when the duty to defend hinges on facts that are easily verified and that will not be resolved by the underlying litigation, a court may properly consider facts outside the underlying pleadings.

The court also ruled that the policy's exclusion for "any Claim . . . directly or indirectly involving . . . [c]onduct which is fraudulent, dishonest, [or] criminal" when "there is a finding or adjudication in any proceeding of such conduct" barred coverage for the suits. After comparing the criminal charges and the allegations in the underlying civil actions, the court found "it clear from the record that the claims against [the insured] in the underlying cases arise from the exact same misrepresentations that [the insured was] convicted of committing." As a result, the court held that the insurer owed no duty to defend or to indemnify the policyholder in the underlying litigation. ■

Malpractice Complaint and Previous Counterclaim Constitute a Single Claim Made in Prior Policy Period *continued from page 3*

of a single collection action. The court therefore found that the 2009 complaint constituted a claim first made in 2007 and thus was not a claim first made during the policy period.

The policy also included a Prior Firm Endorsement, which amended the policy's definition of insured to include the insured attorney "as respects legal services rendered by [him] while associated with a prior firm."

The insureds contended that the Prior Firm Endorsement required coverage for any claim arising out of the attorney's activities at his prior firm and trumped any policy terms that would limit such coverage. The court rejected this argument and found that the Prior Firm Endorsement did not supersede or supplement any policy provisions except to amend the definition of "insured." ■

Insurer Entitled to Rescind Lawyers Malpractice Policy Based on Material Misrepresentations in Application *continued from page 6*

proceeding within the past ten years." The firm also responded that it was not "aware of any claims against the law firm or its attorneys, or any incidents that could result in a claim against the law firm or its attorneys."

Based on the application, the insurer issued a policy to the firm. After the policy's inception, the company's malpractice lawyer sent a letter to the firm and provided notice of a malpractice claim related to the foreclosure action and appeal. The insurer initially retained counsel to defend the malpractice action and required the insured to satisfy the policy's retention. Two months later, the insurer denied coverage for the malpractice claim based on material misrepresentations in the application for the policy and filed a declaratory judgment action seeking to rescind the policy.

The court held that the firm made representations on the application that it knew were false. First, the insured failed to report the referral by the appellate court to the Florida Bar and an unrelated bar complaint filed by another client despite having knowledge of both bar complaints. Second, the court held that the insured failed to disclose the facts surrounding the foreclosure action and appeal when responding to the application question requesting incidents that could result in a claim. The court held that the firm "clearly knew of numerous incidents relating to the representation" of the company in the foreclosure action and appeal that "could result in a claim" against the firm or its attorneys. Namely, the firm and its attorneys knew that they failed to file a motion to set aside the judgment until five days before trial; the motion had been denied and resulted in a $2.85 million judgment against the company; firm attorneys failed to respond to multiple show cause orders and had been sanctioned by the appellate court and the appellate court had referred firm attorneys to the Florida Bar.

The insurer offered an underwriter's testimony that the insurer would not have issued the policy if the information concerning the foreclosure action and the appeal had been disclosed on the application. The insured offered no evidence to rebut the underwriter's testimony. Based on the unrebutted evidence proffered by the insurer, the court held that the misrepresentations were material to the insurer's acceptance of the risk and, if the insurer had known of the undisclosed facts, the insurer would not have issued the policy.

The insured contended that the insurer was estopped from rescinding the policy because it agreed to provide a defense and required the insured to satisfy the retention before seeking to rescind the policy. The court rejected this argument. The court held that estoppel did not apply because the insured offered no evidence that it had been prejudiced by the insurer's defense of the malpractice claim. In fact, the insured benefitted from being provided a defense to which it was not entitled. ■

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and judgment allowing the proof of claim and separately moved for summary judgment. The class claimants moved for class certification and cross-moved for summary judgment.

Addressing the summary judgment motions, the district court first held that the policy did not exclude coverage for claims alleging violation of fair debt collection statutes. A provision of the policy excluded from coverage "any Claim . . . based upon, arising from, or in consequence of allegations of . . . unfair trade practices . . . or any similar provision of any federal, state, or local statutory law or common law." Although the provision excluded coverage for alleged violations of Pennsylvania's UTPA, the court held that the exclusion did not exclude claims for violations of fair debt collection statutes. Those statutes, according to the court, "are not unfair trade practice statutes."

Next, the court held that coverage for the judgment was not barred by the policy's carve-outs from the definition of loss for "the return of fees or other compensation paid to the Insured" and for "taxes, fines or penalties imposed by law." First, the court rejected the insurer's argument that "compensation paid to the Insured" included amounts representing the return of fees allegedly paid to the insured by class members as a result of unlawful collection notices. The insurer argued that allowing coverage for these amounts would result in a windfall. According to the court, however, this provision did not apply "[i]n light of Pennsylvania's limited use of public policy to bar insurance coverage and the finding that there is no possibility of windfall to the tortfeasor in this case" because the insured was bankrupt and would not collect insurance proceeds.

Second, the court rejected the insurer's argument that statutory damages under the federal and state fair debt collection statutes are punitive, rather than compensatory, and thus barred by the carve-out for "taxes, fines or penalties imposed by law." The court distinguished a case holding that statutory damages under the Fair and Accurate Credit Transactions Act are punitive by examining the type of harm caused by the violation, concluding that "the potential risk of harm posed by publication of credit card information [is] markedly different from the type of harm that occurs when an individual personally receives an overbearing collection notice." The court found that in the latter case, "the statutory damage provision . . . provides for administrative efficiency in ascertaining damage to individuals," the "fundamental goal" of which is "to compensate those who suffer legal injury."

The court held, however, that the claims-made policy only provided coverage for claims arising out of wrongful acts occurring after the policy's prior acts date and before the expiration of the policy period, and that the class certified by the bankruptcy court in its order "reflects a larger class" of claims "based on an unlimited temporal scope." But the court did not accept the insurer's contention that the entire claim should fail because the class plaintiffs did not identify which portions of the judgment were attributable to covered activities: "[t]o the extent the [insurer] seeks to challenge the calculations of the judgment, its argument is with the Bankruptcy Court." The district court ultimately held that it could not "provide the ultimate relief the plaintiffs seek, the entry of judgment, because questions remain over which the Bankruptcy Court has retained jurisdiction."

The court also rejected the insurer's motion to vacate as "an untimely appeal" of the bankruptcy court's order, and held that the motion for class certification was moot in light of the bankruptcy court's allowance of the claimants' proof of claim on a class basis. Finally, the court held that, regardless of whether the Pennsylvania direct action statute applied, the class claimants had standing because the insured's liquidation plan as adopted by the bankruptcy court judgment operated as an assignment of the insured's rights under the policy to the plaintiffs. ■

Connecticut Supreme Court: Losses Caused by Different Sets of Negligent Acts with Common Precipitating Factor Are Not "Related" *continued from page 4*

to supervise her—and therefore should be treated as arising out of one medical incident, leading to coverage litigation.

The court first indicated that the term "related" must be interpreted in context. Because each of the injured parties was differently situated in proximity to the fire, access to an exit and personal health and mobility issues, the particular array of negligent shortcomings that led to his or her injury or death necessarily varied. According to the court, the claims were "as dissimilar as they are alike." Accordingly, the court held that it is "far from clear" that the policy's use of the undefined term "related" was intended to aggregate multiple losses suffered by multiple people "each caused by a unique constellation of negligent acts, errors and omissions, simply because they shared a common precipitating factor." The court then held that a separate per-medical-incident limit of liability applied to each injured person's claim.

The court also held that the policy contained, by endorsement, an aggregate limit of liability of $10 million, but only a $1 million limit of liability for each insured location. The court determined that the trial court had improperly equated the phrases "aggregate limit" and "aggregate policy limit." The latter, according to the court, clearly referred to the overall limit for the policy, including both general and professional liability coverage at multiple locations. An endorsement imposing an "aggregate policy limit" did not replace separate policy language setting an "aggregate limit" of liability for particular locations.

In addition, the court rejected arguments by individual defendants that the insurer should "drop down" and pay amounts within the $250,000 per-medical-incident retention because the nursing home insured was insolvent. The court found no language to this effect in the policy and refused to imply it. According to the court, the policy clearly provided that the insurer was liable only for damages in excess of its self-insured retentions.

The court reversed, however, the trial court's conclusion that the $250,000 retention was subtracted from the $500,000 limit of liability, leaving the insurer with a total of $250,000 of exposure per medical incident. The policy provided that the limits of liability "will be reduced by the payment of damages and expenses paid within the self insured retention." The court determined that this language was ambiguous and construed it in favor of the insured "so as not to reduce the coverage limits clearly provided in the declarations." Accordingly, the court found that satisfaction of the policy's retention did not reduce the limit of liability. ■

Actual Notice Through an Intermediary Sufficient to Provide Notice Under Policy *continued from page 4*

carrier with actual notice during the policy period, and that actual notice was sufficient under the policy to provide notice of a claim. Moreover, the insurer's alleged refusal to provide a copy of the policy to the independent contractor until after the policy expired "support[ed] an inference that the Defendants intended to deceive Plaintiff as to the Policies' terms and deny him the benefit of the insurance." ■

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