Wiley Rein LLP

EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | September 2013

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Fee Dispute Not Covered Under Legal Malpractice Policy

The United States District Court for the Western District of Louisiana has held that a lawyer's professional liability policy does not afford coverage for a fee dispute with a former client. *Pias v. Cont'l Cas. Ins. Co.*, No. 2:13-cv-00182-PM-PJH (W.D. La. Aug. 6, 2013). Wiley Rein represented the insurer.

The insured lawyer represented a client in a worker's compensation matter, which ultimately settled for $95,000 to the client plus an additional $40,607 made payable to the client for the initial Medicare Set Aside Account. The lawyer retained $86,221.60 of the $95,000, contending that he was entitled to that amount as his fee. The client, through new counsel, then filed a "Motion for Return of Funds Held as Attorney's Fees" with

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Seventh Circuit Holds That Multiplied Portion of Attorneys' Fees Award Is Covered

The United States Court of Appeals for the Seventh Circuit, applying Illinois law, has held that an insurer must pay the full amount of a $3.15 million attorneys' fees award, concluding that a provision precluding coverage for "the multiplied portion of multiplied damages" did not apply to the use of a multiplier in calculating attorneys' fees. *Carolina Casualty Ins. Co. v. Merge Healthcare Solutions Inc.*, Nos. 12-2275 & 12-2341 (7th Cir. July 16, 2013).

After the insured agreed to merge with another company in a transaction valuing the insured's shares at $5.35 each, certain shareholders of the insured filed a lawsuit in Massachusetts state court contesting the adequacy of the proxy statement used to seek approval of the merger. The lawsuit eventually was settled, however, when another suitor offered $6.05 a share. The difference resulted in a $26 million gain for the shareholders. The lawyers who filed the shareholder suit then sought attorneys'

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No Coverage for Restitution of Illegal Overdraft Fees

Applying Georgia law, a federal district court has held that the return of allegedly illegal overdraft fees may constitute uninsurable restitution and would in any event fall within an exclusion for indemnification arising from fee disputes. *Fidelity Bank v. Chartis Specialty Ins. Co.*, No. 1:12-CV-4259-RWS (N.D. Ga. Aug. 7, 2013).

The policyholder bank's depositors alleged that by charging a flat fee regardless of the amount advanced in an overdraft withdrawal, the policyholder was charging usurious interest. The insurer disclaimed coverage for sums paid to settle the underlying claim. The policy provided that the insurer was not liable for "Loss in connection with any Claim made against any Insured . . . alleging, arising out of, based upon or attributable to, directly or indirectly, any dispute involving fees, commissions or other charges for any Professional Service rendered . . . by the Insured . . . ."

The court found "compelling" the insurer's argument that the return of illegal overdraft fees constituted restitution that is uninsurable as a matter of law. Citing case law from various jurisdictions, the court further opined that allowing the policyholder to recover insurance proceeds for disgorgement of "ill-gotten gains" would allow policyholders to profit from illegal conduct. Noting an absence of Georgia case law on point, however, the court declined to "announce a 'new' Georgia rule" and held instead that the policy's fee-dispute exclusion precluded coverage. The court observed that, even though the underlying complaint classified overdraft charges as usurious "interest," the charges could be classified as "fees" as well. ■

Insured vs. Insured Exclusion Bars Coverage for FDIC Failed Bank Suit

A Georgia federal trial court has held that an insured vs. insured exclusion bars coverage for the Federal Deposit Insurance Corporation's (FDIC) suit against former officers of a failed bank. *St. Paul Mercury Ins. Co. v. Miller*, 2013 WL 4482520 (N.D. Ga. Aug. 19, 2013).

After the FDIC took over the failed Community Bank & Trust of Cornelia, Georgia, it filed suit against two former officers in connection with their role in approval of loans. After agreeing to provide a defense under reservation of rights, the carrier filed a declaratory judgment action against the individuals and the FDIC. The policy contained an exclusion that barred coverage for claims "brought or maintained by or on behalf of any Insured or Company in any capacity," with certain exceptions. The carrier filed a motion for summary judgment based on the terms of the exclusion, and the FDIC filed a motion seeking discovery regarding the interpretation of the exclusion.

The court denied the FDIC's discovery motion. Under Georgia law, the court observed, if the policy was ambiguous, the court was required to interpret it in favor of coverage. Accordingly, whether or not the policy was ambiguous, discovery was unnecessary.

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Eighth Circuit Holds Prior Knowledge Exclusion Bars Coverage for Title Insurer Indemnification Claim

The United States Court of Appeals for the Eighth Circuit, applying Missouri law, has held that no coverage is available where a land title agent had knowledge at the time of the inception of an E&O policy that a future indemnification demand by a title insurer was likely. *Lexington Ins. Co. v. Integrity Land Title Co., Inc.*, 2013 WL 3924320 (8th Cir. July 31, 2013). The court further held that the policy's exclusion for claims arising out of the release of funds without obtaining proper lien waivers independently barred coverage.

The insured land title agent had issued title commitments and title insurance policies for a number of properties in residential developments. In so doing, the title agent had failed to investigate whether subcontractors had been paid or to include exclusions in the title insurance policies for later-filed mechanics liens. The title agent had also disbursed funds for certain aspects of the development, but failed to obtain lien waivers prior to disbursement. The title insurer that underwrote the policies defended, and made payments on behalf of, the title-insurance policyholders, and then demanded indemnification from the title agent. The title insurer filed suit against the title agent in Missouri state court, also naming as a defendant the title agent's E&O insurer.

The title agent's E&O insurer filed a declaratory judgment action seeking a determination of its defense and coverage obligations regarding the title insurer's indemnification claim and several other claims against the title agent, and the title insurer intervened in the coverage action. The trial court denied the title insurer's motion for a stay to allow the coverage issues to be decided in

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Louisiana Statute Providing for Automatic Damages Is a Penalty and Not Covered Loss

The Superior Court of Delaware, applying Delaware and Louisiana law, has held that a Louisiana statute that provided for an automatic award to the claimant for violations results in a "penalty" that was not covered Loss under an E&O policy. *Homeland Ins. Co. v. CorVel Corp.*, 2013 WL 3937022 (Del. Super. Ct. June 13, 2013).

Louisiana's "PPO Act" authorizes payment of health care costs within the framework of a preferred provider organization (PPO) at lower negotiated rates if a patient presents a benefit card at the time of service, or if written notice is given in advance to the provider. The statute provides that failure to comply with these notice provisions subjects the PPO "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."

A health insurer entered into a PPO agreement with a hospital in Louisiana, which provided that the hospital would discount rates for certain medical services. However, the agreement was silent as to the payment to be given for medical services in the context of workers compensation claims, which were paid. The health insurer paid for such medical services at the rates given for comparable services under the PPO agreement, but these rates were allegedly below the rates set forth in Louisiana's workers compensation fee schedule.

The hospital filed an arbitration proceeding against the health insurer. Additionally, a putative class action suit was subsequently filed alleging that the health insurer violated Louisiana's PPO Act on the grounds that the health insurer did not provide any notice that it was to pay workers compensation claims below the rate set by

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By Delaying Disclaimer of Coverage for 105 Days, Insurer Waived Right to Rely on Policy Exclusions

The United States District Court for the Eastern District of New York, applying New York law, has held that an insurer's 105-day delay in disclaiming coverage for a suit alleging that an insured sexually assaulted others was untimely as a matter of law, thus waiving the insurer's right to deny coverage based on the criminal acts exclusion of the policy. *Jewish Cmty. Ctr. of Staten Island v. Trumbull Ins. Co.*, 2013 WL 3816735 (E.D.N.Y. July 22, 2013).

A supervising employee of the insured nonprofit organization pled guilty to three counts of forcible touching in connection with allegations that the supervising employee forcibly spanked under-age employees during breaks at work. The family of one of the victims brought suit against the insured nonprofit organization for negligent supervision, among other causes of action. The insured provided notice to its Nonprofit D&O Liability insurer shortly after the suit was served against it. The insurer issued a denial of coverage 105 days later based on the policy's criminal acts exclusion. The insured then initiated coverage litigation, contending that the underlying lawsuit fell within the coverage grant of the policy and that the insurer had waived its right to rely upon the criminal acts exclusion by failing to provide its disclaimer of coverage in a timely manner, as required by New York Insurance Law (NYIL) § 3420(d)(2). Section 3420(d)(2) provides that "[i]f under a liability policy issued or delivered in [New York], an insurer shall disclaim liability or deny coverage for death or bodily injury arising out of . . . any other type of accident occurring in this state, it shall give written notice as soon as is reasonably possible of such disclaimer of liability or denial of coverage to the insured and the injured claimant or any other claimant."

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Intentional Misrepresentation Claim Within "Liable in Absence of Contract" Carve-Back to Contract Exclusion; Fraud of VP and Chief Technology Officer Not Imputed to Company Under Severability Provision

The United States District Court for the District of Rhode Island has held that a policy's contract and fraud exclusions did not bar coverage for a jury award on a claim for intentional misrepresentation because 1. the contract exclusion contained a carve-back for liability that would have existed in the absence of the contract and 2. the fraudulent acts of the company's vice president and chief technology officer could not be imputed to the company under the policy's severability clause. *TranSched Sys. Ltd. v. Fed. Ins. Co.*, 2013 WL 3974143 (D.R.I. Aug. 2, 2013).

In 2011, TranSched Systems obtained a favorable verdict in its action against an insured company for breach of contract and intentional misrepresentation related to a 2005 asset purchase agreement entered into by the two companies. The defendant company's insurer, which had provided a defense to the underlying action, denied any duty to indemnify the award against its insured pursuant to the policy's fraud and contract exclusions. TranSched then filed suit against the insurer seeking coverage for the jury award and damages for statutory and/or common law bad faith. The insurer moved to dismiss the action, arguing 1. that there was no indemnity coverage for the award and 2. that the plaintiff's bad faith claims were improper because it was neither an insured nor an assignee of the insured.

Examining the policy exclusions at issue, the court held that the plaintiff sufficiently pleaded

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Texas Court Finds Ambiguity Between Related Claims Provision and Prior or Pending Litigation Exclusion

Applying Texas law, a Texas intermediate appellate court has held that a prior or pending litigation exclusion conflicted with a related claims provision contained in a D&O liability policy, creating an ambiguity construed in favor of coverage for the insured. *Gastar Exploration, Ltd. v. U.S. Specialty Ins. Co.*, 2013 WL 3693603 (Tex. App. Ct. July 16, 2013).

The insurers issued claims-made primary and excess D&O liability policies to the insured covering a policy period from November 1, 2008 to November 1, 2009. The policies contained an interrelated claims provision providing that "[a]ll Claims, alleging, arising out of, based upon or attributable to the same facts, circumstances, situations, transactions or events or to a series of related facts, circumstances, situations, transactions or events will be a single Claim and will be considered to have been first made at the time the earliest such Claim was made." In addition, the policies contained an endorsement with a prior or pending litigation exclusion, which barred coverage for any claim "arising out of, based upon or attributable to any pending or prior litigation as of 5/31/2000, or alleging or derived from the same or essentially the same facts or circumstances as alleged in such pending or prior litigation."

The insured was named in 10 lawsuits alleging fraud in an investment scheme involving thoroughbred breeding mare leases. Seven of these lawsuits were filed during the policy period, but three had been filed in 2006, prior to the inception of the policies. The insurers denied coverage for the seven lawsuits filed during the policy period on the grounds that the claims were related to the three previously filed lawsuits pursuant to the related claims provision. The insured filed the instant coverage action, contending that the related claims provision was ambiguous and conflicted with the prior or pending litigation endorsement because the endorsement excluded only related claims filed prior to May 31, 2000. The trial court granted

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Fifth Circuit Says Insurers Do Not Have to Show Prejudice to Enforce Notice Provisions in Pollution Buyback Endorsements

In two separate cases, the United States Court of Appeals for the Fifth Circuit, applying Texas law in one case and Louisiana law in the other, has held that insurers were not required to show prejudice before denying coverage for a pollution occurrence that the insured did not report within the 30 days required by the policies' pollution buyback endorsements. *Starr Indemnity & Liability Co. v. SGS Petroleum Service Corp.*, 719 F.3d 700 (5th Cir. June 18, 2013), and *In re Settoon Towing, L.L.C.*, 720 F.3d 268 (5th Cir. June 18, 2013).

In *SGS Petroleum*, an accidental release of a chemical occurred while one of the insured's employees was conducting operations at a plant in Texas. Although the insured learned of the release on the same day, it did not initially notify its excess insurer of the incident because the preliminary estimate for clean-up costs was within the limits of liability of its primary policy. The insured did not report the incident to the excess insurer until 59 days after learning about it. The excess insurer subsequently sought a declaratory judgment that it was not required to show prejudice before denying coverage because the insured did not report the incident within 30 days, as required by a pollution buyback endorsement contained in the policy. The trial court granted the insurer's motion for judgment on the pleadings, and the insured appealed.

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Insured Bears the Burden to Allocate Settlement Between Covered Losses and Excluded Contract Damages

The Superior Court of Pennsylvania has affirmed a trial court's ruling that the insured bears the burden of allocating between covered and uncovered settlement amounts. *Executive Risk Indemnity, Inc. v. CIGNA Corp.*, 2013 WL 3756763, (Pa. Super. Ct. July 18, 2013). The court held that the insured had not met its burden to allocate between amounts attributable to covered Racketeer Influenced and Corrupt Organizations Act (RICO) allegations and those attributable to breach of contract allegations, which were excluded from coverage under the professional liability policy at issue.

The underlying claim against the policyholder—a health insurer—consisted of class action litigation alleging that the policyholder and other HMOs had systematically underpaid claims. The insured settled the litigation, which included allegations of both breach of contract and violations of RICO, and sought coverage from its excess professional liability insurer. The insurer denied coverage on the basis that breach of contract claims were excluded under the professional liability policy, and the insured had not proven the allocation of its settlement between excluded and covered amounts. The policyholder argued that the insurer should bear the burden to prove the portion of the settlement allocated to excluded matters.

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Insurer's Declaratory Judgment Action Stayed Because of Overlapping Issues With Underlying Litigation Against Insured

The United States District Court for the Southern District of California stayed an insurer's declaratory judgment action because the coverage issues substantially overlapped with issues in dispute in the underlying litigation against the insured. *Admiral Ins. Co. v. Shah & Assocs., Inc.*, 2013 WL 3831331 (S.D. Cal. July 23, 2013).

The insured engineering firm was sued by the estate of a deceased pilot who crashed into an unmarked meteorological tower designed and built by the insured. The engineering firm tendered the suit to its insurer. After initially denying coverage for the suit, the insurer agreed to provide a defense subject to a reservation of rights. The insurer then sought a declaratory judgment that it had no duty to defend or indemnify the engineering firm because 1. the insured had prior knowledge of the incident that gave rise to the claim but did not report the incident on the application for the policy, and 2. the claim against the insured involved alleged product and construction defects rather than errors in the insured's design or engineering services that would fall within the scope of the policy at issue. The insured moved to stay the declaratory judgment proceeding.

The court stayed the coverage litigation pending the outcome of the underlying litigation because of the overlapping issues in the proceedings. As to the prior knowledge issue, the court noted that the underlying complaint also alleged that the defendants knew that the tower constituted a hazard to air navigation. Thus, both the underlying lawsuit and the coverage action would involve evidence regarding the insured's knowledge of circumstances that could give rise to the incident at issue. With respect to the insurer's design vs. product/construction defect argument, the court noted that the underlying lawsuit alleged product defects and both design and construction errors and that each defendant was jointly and severally liable for all of the alleged errors. Thus, both lawsuits would involve evidence regarding defects in the tower and whether and by whom design errors were committed. Accordingly, the court held that resolution of each coverage issue would require the resolution of factual disputes at issue in the underlying litigation. ■

Primary Insurer Does Not Owe Direct Duty of Care to Excess Insurer

The United States District Court for the District of Colorado, applying Colorado and Utah law, has held that a primary insurer does not owe a direct duty of care to an excess insurer and that an excess insurer therefore cannot pursue a negligence claim against a primary insurer. *Okland Construction Co. v. Phoenix Ins. Co.*, 2013 WL 3866608 (D. Colo. Jul. 26, 2013).

A construction company purchased a series of one-year commercial general liability policies from a primary carrier from 2004 through 2010. The same company purchased excess policies from a different insurer for the period of 2007 to 2010.

The primary insurer provided a defense to the company subject to a reservation of rights and, in its initial correspondence to the insured company, referenced the 2005-2010 primary policies as "under consideration for coverage." The primary insurer later added the primary policy for the 2004-2005 policy period as a policy "under consideration for coverage." The excess insurer received copies of the primary insurer's coverage letters and concluded that the primary insurer was "defending and indemnifying the insured up to policy limits on the 04/05 policy." The excess insurer also concluded that the later policy years, including its own, were not implicated by the underlying litigation and, in March 2011, sent a letter to the insured advising it that the excess insurer was closing its file. The excess insurer copied the primary insurer on its closing letter but

> The court agreed with the primary insurer that the primary insurer did not owe a direct duty to the excess carrier and noted that policy considerations weighed against allowing such negligence claims.

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Coverage for *Qui Tam* Action Barred by Prior and Pending Litigation Exclusion

A Pennsylvania state court has held that a prior and pending litigation exclusion bars coverage for a False Claims Act (FCA) *qui tam* action even though the insured was unaware of the sealed filing before the operative date in the exclusion. *Amerisourcebergen Corp. v. ACE Am. Ins. Co.*, No. 12101128 (Penn. Ct. of Common Pleas, First Judicial District July 16, 2013).

The insured provides drug distribution services, clinical education, and marketing and business resources to health care providers and pharmaceutical manufacturers. A *qui tam* action was filed under seal on June 13, 2006, alleging that the insured, among others, violated the federal FCA by falsely inflating the average sales price of a particular drug, which "systematically caused the submission of false Medicare claims." The insured received certain "back channel" information regarding the filing no later than February 2009, including a redacted version of an amended complaint, which still had not been served on the defendant at that point. The court subsequently ordered the case unsealed on December 17, 2009, and the insured was served with the operative complaint on January 5, 2010.

The insurer had issued an excess liability policy to the insured for the one-year period of May 1, 2006 to May 1, 2007. The insurer subsequently dropped down to provide primary coverage for the insured, issuing three successive one-year claims-made policies beginning May 1, 2007. The insured first reported the litigation to the insurer on July 8, 2009, under the policy in effect for the period of May 1, 2009 to May 1, 2010. The insured later reported that it had been served, and the insurer denied coverage under all three policies on multiple grounds on April 5, 2010.

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Insurer's Equitable Estoppel Defense Raises Issue of Fact with Respect to Insurer's Reasonable Reliance on Information Provided by Insured

The United States District Court for the Eastern District of New York, applying New York law, denied an insurer's motion for reconsideration of a decision denying an insurer's motion for summary judgment. *Intelligent Digital Systems, LLC v. Beazley Ins. Co.*, 2013 WL 3356051 (E.D.N.Y. Jul. 3, 2013). The court had previously held that issues of fact regarding whether an individual was a "duly elected or appointed" board member precluded the application of the "insured v. insured" exclusion and the insurer's defense of equitable estoppel. Here, the court declined to reconsider its ruling on the equitable estoppel defense. A summary of the court's prior decision was published in the January 2013 *Executive Summary*.

The insurer issued a D&O policy to a company after receiving a renewal application that identified an individual, the owner of another company, as a member of the company's board of directors. After a sales transaction between the two companies closed, the owner of the other company took a seat on the board of directors, but he resigned from the board and, along with the other company, brought suit against the insured company when the insured company failed to meet its obligations under a purchase agreement.

The insured company tendered notice of the litigation to the insurer and identified the claimant as a former director. The insurer denied coverage based on the "insured v. insured" exclusion. The underlying litigation settled, and the insured company assigned its rights under the D&O policy to the claimant. In the coverage action that followed, the insurer and claimant disputed the individual's status as a duly elected or appointed board member of the insured company. The insurer also raised equitable estoppel as a defense, arguing that it had relied on information from the insured that identified the individual as a board member and therefore an insured in relying

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Insured's Failure to Provide Timely Notice of a Potential Claim Defeats Coverage

Applying Pennsylvania law, the United States District Court for the Eastern District of Pennsylvania has held that an insured's failure to notify its insurer of a potential claim violated the notice provision of the policy. *Pelagatti v. Minn. Lawyers Mut. Ins. Co.*, 2013 WL 3213796 (E.D. Pa. June 25, 2013). In so doing, the court held that the insurer was not required to show that it was prejudiced by the late notice and that whether the insured's failure to provide timely notice negates coverage is determined under a "hybrid subjective/objective test."

The insured lawyer represented a father in a wrongful death action against Ocean City, New Jersey, concerning the drowning of the client's son at a beach in 2006. The insured lawyer filed a complaint against Ocean City within the statutorily prescribed period, but failed to file a "Notice of Claim" with the city within 90 days of the accident, as required by the New Jersey Tort Claims Act (NJTCA). For this reason, the court dismissed the plaintiff's complaint in 2007. All attempts by the lawyer seeking relief to file a late Notice of Claim were denied. In 2010, the client filed a legal malpractice claim against the lawyer based on his failure to comply with the NJTCA. Shortly thereafter, the lawyer reported the suit to its insurer, which had issued to the lawyer a claims-made-and-reported policy. The policy specified that a claim is made when "an INSURED first becomes aware of any act, error

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or omission by any INSURED which could reasonably support or lead to a demand for damages." The insurer denied coverage for the malpractice claim on the grounds that the claim was made in 2006 when the insured became aware that he had failed to file the Notice of Claim required by the NJTCA, and that notice of the matter was untimely under the 2010 policy.

In the coverage litigation that followed, the district court granted the insurer's motion for summary judgment. The court rejected the insured's argument that the phrase "reasonably support" in the policy is ambiguous, stating that "courts have consistently interpreted clauses such as those in the Policy to impose an objective standard on the insured." Applying an objective standard, the court held that the phrase "reasonably support" is not ambiguous.

The court then addressed whether the insured violated the terms of the policy by failing to notify the insurer of a potential claim. In this regard, the court noted that the insurer "is not required to show that it was prejudiced by [the insured's] failure to provide timely notice of a potential claim in order to deny coverage under the Policy." The court stated that:

> Whether [the insured] violated the terms of the Policy by failing to timely report a claim is determined under a hybrid subjective/objective test. [The insurer] must establish two factors in order to satisfy this two-pronged test: 1. that [the insured] was aware of a given set of facts; and 2. that a reasonable attorney in possession of those facts would have believed that those facts could support or lead to a demand for damages. Under this two-pronged approach, the Court consider[s] the subjective knowledge of the insured and then the objective understanding of a reasonable attorney with that knowledge.

(Internal citations and quotations omitted.)

Applying this test, the court first held that the insured "was subjectively aware that [the underlying plaintiff's] initial suit and subsequent appeal were both dismissed on procedural grounds," making him subjectively aware of a potential claim at that time, prior to applying for his 2010 policy.

Next, the court found that a "reasonable attorney would believe that failure to comply with a statute of limitations could be grounds for a legal malpractice claim." The court noted that the fact that the insured alleged that the underlying plaintiff told him she "had no intention of suing him" does not support the insured's argument that a "reasonable attorney would have been justified in failing to anticipate a future malpractice suit." The court therefore found that the insurer satisfied both the subjective and objective components of the two-pronged test and that the insurer "was not obligated to afford coverage" to the insured for the underlying plaintiff's suit.

The court noted that the fact that the insured alleged that the underlying plaintiff told him she "had no intention of suing him" does not support the insured's argument that a "reasonable attorney would have been justified in failing to anticipate a future malpractice suit."

Lastly, the court rejected the insured's argument that the insurer violated the Pennsylvania Bad Faith Statute by failing to indemnify him. The court stated that the burden is on the insured to show by clear and convincing evidence that the insurer had no reasonable basis for denying coverage for the claim. Because the insured "point[ed] to no evidence rebutting [the insurer's] reasons for denying him coverage," the court rejected the insured's bad faith claim. ■

Texas Court Finds Ambiguity Between Related Claims Provision and Prior or Pending Litigation Exclusion *continued from page 5*

summary judgment to the insurers and the insured appealed.

The Texas intermediate appellate court reversed the trial court, holding that the related claims provision was ambiguous when applied in conjunction with the prior or pending litigation endorsement. First, the appellate court rejected the insurers' argument that the related claims provision differed from the prior or pending litigation exclusion because it was a condition to coverage under the policies. According to the appellate court, the related claims provision "is effectively an exclusion because it narrows the coverage originally created by the Insuring Agreement." In turn, the appellate court determined that the related claims provision "renders [the prior or pending litigation exclusion] meaningless because any 'Claims' that would be excluded from coverage by [the prior or pending litigation exclusion] would already be excluded by operation of" the related claims provision. As such, the appellate court concluded that the provisions conflict or, at a minimum, create an ambiguity that must be construed in favor of coverage for the insured. According to the appellate court, the prior or pending litigation exclusion was endorsed to the policies and "demonstrates the parties' intent to restore coverage for claims that arose out of the same facts as litigation filed between May 31, 2000, and the inception date of the policy." ■

Primary Insurer Does Not Owe Direct Duty of Care to Excess Insurer *continued from page 7*

did not otherwise communicate with the primary insurer about its interpretation of the primary insurer's coverage position.

In August 2011, the excess insurer was informed of a mediation and demand from the insured to settle the underlying litigation. In September 2011, the excess insurer discussed the matter with the primary carrier, and the primary insurer clarified that it had not identified the policy year that was triggered. On October 3, 2011, the primary insurer informed the excess insurer that it had identified the 2009-2010 policy as the policy implicated by the underlying litigation and that it had agreed to tender its $1 million limit of liability on that policy. On October 7, 2011, the parties agreed to settle the underlying litigation for $11.5 million at a mediation, which the excess insurer attended. The excess insurer did not commit to provide funds for the settlement and, in January 2012, informed the insured that coverage was not available under its excess policies.

In the ensuing coverage litigation, the excess insurer asserted a cross-claim for negligence against the primary insurer and alleged that the primary insurer failed to provide information about the underlying litigation, the policy years that might be implicated, and the excess insurer's potential exposure.

The court agreed with the primary insurer that the primary insurer did not owe a direct duty to the excess carrier and noted that policy considerations weighed against allowing such negligence claims. The court stated that the national trend among courts was not to recognize such a duty and that general negligence principles supported this outcome. In addition, the court noted that the excess insurer was aware of the underlying litigation and primary insurer's coverage position but made "virtually no effort to investigate or resolve [the insured's] claim based on an obviously incorrect interpretation of [the primary insurer's] position regarding coverage." Accordingly, the court found that "there is no legal justification to hold [the primary insurer] responsible for [the excess insurer's] failure to protect its own interests." ■

The Fifth Circuit affirmed the trial court's decision on appeal, explaining that an insurance company does not always have to show prejudice to deny coverage for a failure to comply with a policy's notice provisions. The court reasoned that extending the notice period would expose the insurer to a broader risk than that expressly insured under the excess liability policy. In so doing, the court rejected the insured's argument that the modern trend in Texas case law is to require prejudice before enforcing a notice provision. The court found such cases distinguishable because they involved general notice requirements—not a specifically negotiated buyback provision—that were not "an essential part of the bargained-for exchange." Accordingly, the court held that the 30-day notice requirement, specifically bargained for when the pollution buyback endorsement was added to the policy, trumped the policy's general requirement that notice of an occurrence likely to cause liability be given "as soon as practicable."

The Fifth Circuit reached a similar conclusion in *Settoon Towing*. In that case, a towing company obtained a collision liability insurance policy with three layers of excess liability coverage. All three excess policies excluded coverage for pollution liability, but contained pollution buyback endorsements providing that the pollution exclusion would not apply if, among other things, the insured reported the occurrence giving rise to pollution liability within a specified amount of time. When one of the insured's vessels struck an oil well, causing oil to discharge into the water, the insured failed to notify the insurers within the time specified in the endorsements. As a result, the excess insurers sought a declaratory judgment that they were not liable because the insured did not satisfy the endorsements' notice requirements. The trial court held that the second- and third-layer excess insurers were not liable because the insured failed to comply with the notice provisions, but held that the first-layer excess insurer was liable because it had delayed delivery of the policy to the insured.

Agreeing with the trial court, the Fifth Circuit held that the pollution exclusions in the second- and third-layer excess policies barred coverage because the insured did not comply with the notice requirements of the pollution buyback endorsements. The court rejected the insured's argument that its noncompliance with the endorsements' notice provisions should not bar liability for three reasons: 1. the insurers were required to show that they were prejudiced by the delay; 2. in light of the policies' general notice provision requiring notice "as soon as reasonably practicable," delays beyond the specified notice period were permissible; and 3. the doctrine of impossibility excused the insured's failure to provide notice within the specified period. Rejecting the first argument, the court maintained that "both parties were sophisticated businesses," and that failure to comply with an "immediate notice" provision—which was an express condition precedent to coverage—precluded coverage regardless of whether the insurer was prejudiced by the delay. The court also rejected the insured's second and third arguments, explaining that the endorsements had primacy over the policies' other parts and that the doctrine of impossibility only applied to the failure to perform contractual obligations. Because the insured was not contractually obligated to satisfy conditions precedent, the court reasoned that the doctrine of impossibility was inapplicable.

Notwithstanding its rulings concerning the second- and third-layer excess policies, the court held that the first-layer excess insurer could not rely on the pollution exclusion contained in its policy because that insurer violated La. Rev. Stat. § 22:873(A), which requires insurers to deliver policies within a reasonable period of time after issuance. Because the first-layer excess insurer did not send the insured the excess policy until over two months after receiving the insured's premium payment (and after the insured notified the insurers of the incident), the court determined that the insured could not have known about the specific terms of the pollution buyback endorsement. The court further explained that, under Louisiana law, "an insurer cannot take advantage of favorable policy terms where it delayed delivery of the policy after the insured pa[id] the premium." ■

Insured Bears the Burden to Allocate Settlement Between Covered Losses and Excluded Contract Damages *continued from page 6*

The court rejected the policyholder's argument that the insurer bore the burden to prove the allocation of excluded amounts once a *prima facie* case of coverage was established. The court concluded that "proof of a policy exclusion and proof of allocation of excluded policy claims are distinctly different inquiries." According to the court, "apportionment is not a straightforward process in the context of a settlement agreement." The determination is "vital to the insurer for purposes of indemnification," held the court, "and best proven by the insured, the party that has access to the evidence and the parties' intent behind the settlement process." Because the insured has better access to information and the intentions of the parties to the underlying settlement, the court determined it is "not only reasonable, but logical, that the insured bears the burden to allocate."

Accordingly, the court affirmed the trial court's determination that the insured did not present sufficient evidence to show that the portion of the settlement attributable to covered RICO allegations would reach the excess insurer's attachment point. The trial court had found that: 1. the insured's counsel stated at the time of the settlement that the RICO allegations were weak; 2. the insured failed meaningfully to assess the RICO exposure in memoranda or correspondence; 3. the insured analyzed only the contract exposure and represented to the underlying court that this was the heart of the underlying case; and 4. the underlying settlement was contract-focused. The appellate court found no abuse of discretion in these findings and therefore affirmed the trial court's rejection of the insured's proffered allocation weighted toward RICO exposure. ■

Fee Dispute Not Covered Under Legal Malpractice Policy *continued from page 1*

the worker's compensation office. In the motion, the client argued that the insured lawyer failed to advise her up front of his fees and that, in any event, the insured was not entitled to any fees whatsoever because he had failed to file the "Application for Approval of Attorney's Fees" as required by state statute. The lawyer tendered the matter to his insurer, which declined coverage on two grounds: 1. the motion did not seek any relief against the lawyer "by reason of" any conduct allegedly committed in the performance of "legal services" within the scope of the policy's insuring agreement; and 2. the motion did not constitute a claim for covered "damages" within the meaning of the policy.

In the coverage action that followed, the court granted the insurer's motion for judgment on the pleadings, concluding that a "straightforward fee dispute" is not a claim that falls under a legal malpractice policy's coverage because it does not arise from the performance of legal services. In so ruling, the court rejected the insured lawyer's argument that, at a minimum, the motion for return of fees triggered the duty to defend because the client alleged that the lawyer had acted negligently by failing to keep her informed as to his fees and by failing to file the application for fees as required by state statute. The court also rejected the lawyer's reliance on the policy's dishonesty exclusion, which set forth the obligation to defend a claim until a final adjudication establishing the insured's misconduct, noting that "an exclusion cannot create coverage that would not otherwise exist."

Additionally, the court held that the return of fees did not constitute covered "damages" under the policy. In reaching this conclusion, the court pointed out that the policy's definition of the term carved out "legal fees . . . paid or incurred or charged by [the insured] no matter whether claimed as restitution of specific funds, forfeiture, financial loss, set-off or otherwise . . . ." The court also rejected the lawyer's reliance on the fact that the motion sought to impose "sanctions" on him for failing to file the required application. ■

Seventh Circuit Holds That Multiplied Portion of Attorneys' Fees Award Is Covered

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fees based on the difference between the two suitors' bids. The insurer had issued a policy covering as part of the insured "loss" not only what the insured paid its own lawyers in litigation but also what the insured must pay to opposing counsel. When the state court awarded plaintiffs' counsel $3.15 million, derived from a lodestar of $630,000 times five, the insurer filed a declaratory judgment action in federal court, arguing that the policy limited coverage to the $630,000 lodestar because the policy contained a provision stating that "[l]oss shall not include . . . the multiplied portion of multiplied damages . . . ." The district court disagreed, and held that the insurer owed the entire $3.15 million.

On appeal, the Seventh Circuit affirmed the district court's ruling. Rejecting the insurer's argument that the provision applied to the state court judge's use of a multiplier in calculating attorneys' fees, the court opined that "an award of attorneys' fees differs from 'damages.'" In so doing, the court noted that the underlying litigation rested in part on state and federal securities law, which treated attorneys' fees as "costs" and not "damages." The court further explained that the policy provision "covers a category of losses that insurers regularly exclude to curtail moral hazard." According to the court, the phrase "multiplied portion of multiplied damages" contained in the provision likely was intended to address treble damages, not attorneys' fees.

In addition, the court rejected the insured's argument that the insurer acted in bad faith by contending that its policy covers only 20% of the award. The court explained that the insurer "did just what Illinois prefers" by "fil[ing] a declaratory-judgment action to resolve the meaning of the policy" and paying the insured's costs of separate counsel under a reservation of rights. ■

Insurer's Equitable Estoppel Defense Raises Issue of Fact with Respect to Insurer's Reasonable Reliance on Information Provided by Insured

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on the "insured v. insured" exclusion.

In its motion for reconsideration, the insurer challenged the court's holding that questions of fact existed with regard to "whether [the insurer] was justified or reasonable in relying on [the insured's] representations that the [individual] was a director on the Board." The insurer argued that New York law does not require an insurer "to verify or investigate factual information provided by its insured" and that the court's order imposed an obligation on insurers that "does not reflect applicable New York law."

The court rejected this argument and distinguished the cases on which the insurer relied. The court noted that the insurer relied on rescission cases in which the issue was whether the insurer had accepted an application for a policy, that might otherwise have been refused, based on information provided by the insured and whether an insurer in that context could rely on information from the insured without verifying it. The court stated that the defense of equitable estoppel required the insurer to show, among other elements, "that its detrimental reliance [on the misrepresentation] was reasonable under the circumstances," which was not an element of an insurer demonstrating that a policy should be void *ab initio* due to a misrepresentation (alteration in original). The court therefore held that issues of fact remained with respect to whether the insurer reasonably relied on information provided by its insured and denied the insurer's motion for reconsideration. ■

Insured vs. Insured Exclusion Bars Coverage for FDIC Failed Bank Suit *continued from page 2*

The court further held that the policy's insured vs. insured exclusion barred coverage for the FDIC's suit. The court found that, by operation of federal law as interpreted by the Supreme Court of the United States, the FDIC had stepped into the shoes of the failed bank such that the FDIC was an "insured" for purposes of the exclusion. To rule otherwise, the court observed, would be to ignore exclusion's use of the phrase "on behalf of," which in almost any conceivable circumstance would only apply to an FDIC suit on behalf of the bank. The court rejected the FDIC's contrary arguments, noting that the FDIC relied on cases in which courts had interpreted exclusions with distinguishable wording, that the FDIC's arguments based on the assumed "purpose" of the exclusion could not overcome unambiguous policy language, and that arguments based on public policy could not justify rewriting a private contract. The court accordingly granted the carrier's motion for summary judgment. ■

Eighth Circuit Holds Prior Knowledge Exclusion Bars Coverage for Title Insurer Indemnification Claim *continued from page 3*

its state court suit and granted summary judgment to the E&O insurer. The appellate court affirmed.

The court held that the E&O policy's prior knowledge exclusion applied to bar coverage for the title insurer's indemnification claim. The court noted that the terms of the exclusion, which precluded coverage for claims "based upon or arising out of any alleged act, error omission or circumstance likely to give rise to a Claim that an Insured had knowledge of prior to the effective date of this policy," were similar to a question on the policy's application. The court found that, prior to the policy's effective date and the application date, the title agent had received calls from homeowners who had been served with liens, had forwarded numerous lien claims to the title insurer, had been sued by one of the unpaid subcontractors, and had been quoted in a newspaper article saying that the property owners should contact their title insurers. Based on this information, the court found that the title agent had actual knowledge of facts that could possibly give rise to lien claims against property owners, claims against the title insurer, and ultimately indemnification claims against the title agent by the title insurer. The court rejected the argument that neither the title insurer's nor the title agent's liability had been firmly established by the policy inception date, finding that this interpretation unreasonably attempted to read the term "likely" out of the exclusion.

The court also held that the policy's lien-waiver exclusion, which barred coverage for "any claim arising out of any release of funds without receipt of . . . appropriate waivers or releases of liens from any contractor, subcontractor, or materials or service provider," barred coverage. The court found that the title insurer had specifically alleged that the title agent was negligent in failing to obtain lien waivers, failing to place funds into escrow, failing to apply funds to unpaid contractors, and failing to postpone closing pending payment to contractors. The court rejected the argument that the E&O insurer had waived this defense by not raising the exclusion when it initially denied coverage. The court held that, under Missouri law, an insurer may later raise additional coverage exclusions if they are not inconsistent with the original basis for denying coverage.

Finally, the court also held that the trial court had not abused its discretion in declining to stay the federal declaratory judgment action. The court found that the pending state court actions, including the title insurer's indemnification suit, were unlikely to address the coverage issues between the title agent and its E&O insurer. ■

Louisiana Statute Providing for Automatic Damages Is a Penalty and Not Covered Loss

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Louisiana's fee schedule. Both the suit and the arbitration settled. The health insurer tendered the claims to its two E&O carriers for two different policy years. Each of the policies provided that "Loss," as defined in the policies, did not include "penalties." The E&O carriers denied coverage and brought a declaratory judgment suit on the grounds that the settlement was a penalty and not insurable Loss. The E&O carriers filed motions for summary judgment, which were granted.

The court determined that Delaware law applied to the construction of the insurance policy but that Louisiana law was relevant to whether the statute provided for a "penalty." The court determined that the damages sought under the Louisiana statute fell within the plain meaning of a "penalty," and thus were not covered Loss. The court reasoned that the statute provided that the failure to comply with the notice requirements resulted in an automatic payment that has "no correlation to the amount of actual damages suffered." In addition, the court read the legislative history of the statute to evince a purpose that the statute was to constitute a penalty. ■

Intentional Misrepresentation Claim Within "Liable in Absence of Contract" Carve-Back to Contract Exclusion; Fraud of VP and Chief Technology Officer Not Imputed to Company Under Severability Provision

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a claim for coverage. Although the policy excluded coverage for the breach of contract claim in the underlying action, the court held that the intentional misrepresentation claim was not excluded because a carve-back to the policy's contract exclusion provided that the exclusion did not apply "to the extent that an Insured Organization would have been liable in the absence of the contract or agreement." The court held that sufficient facts were alleged to find that some of the underlying conduct and liability related to misrepresentations that occurred before the contract existed and that the exclusion thus did not bar coverage for the misrepresentation claim. The court separately held that the fraud exclusion did not bar coverage for the insured company because the exclusion applied only to "'any deliberately fraudulent act or omission' by '*such* Insured,'" and the conduct of the company's vice president and chief technology officer could not be imputed to the company under the policy's severability clause, which provided that only "facts pertaining to" the company's chief executive officer, chief financial officer, president, or chairperson "shall be imputed to" the company.

Finally, holding that Rhode Island law was unclear as to whether the claimant in the underlying proceeding could bring a claim for bad faith against an insurer on a theory of "equitable assignment," the court declined to rule on the insurer's motion with respect to the bad faith claims. Instead, the court stayed the bad faith claim until coverage for the underlying claims has been determined. ■

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The court first addressed whether the underlying action fell within the insuring agreement of the policy, which provided coverage for "CLAIMS EXPENSES and DAMAGES that the INSURED becomes legally obligated to pay for any CLAIM(s) first made against the INSURED for a WRONGFUL ACT(s) which arise solely out of the discharge of an INDIVIDUAL INSURED'S duties on behalf of the ENTITY." The court stated that the insuring agreement's language "is unambiguous and supports only one common sense interpretation: that the [underlying] lawsuit does, indeed, fall within the scope of the policy's coverage provision." In reaching this conclusion, the court focused on the fact that the underlying lawsuit alleged "wrongful acts" of vicarious liability for workplace harassment against the insured. Further, the court disposed of the parties' disagreement concerning whether the supervising employee was an "individual insured," recognizing that New York courts broadly interpret the phrase "arising out of" and stating that the supervising employee's "malicious activities arose solely out of his role as a supervisor of [the victim]."

Next, the court examined the parties' argument concerning the criminal acts exclusion and application of NYIL § 3420(d)(2), concluding "that § 3420(d)(2) does apply and that [the insurer] failed to timely assert the exclusion provision under that statute's requirements." In so holding, the court rejected the insurer's argument that § 3420(d)(2) did not apply because the claim at issue arose from the supervising employee's intentional acts, and was not an "accident," as required by the statute. While recognizing that the insurer's contention has support from certain New York intermediate appellate and federal district court cases, the court ultimately cited decisions from the New York Court of Appeals standing for the proposition that, when determining whether there has been an "accident," the court must look at, "*from the point of view of the insured*, whether the loss was unexpected, unusual and unforeseen." Based on this case law, the court held that the supervising employee's actions were "unexpected, unusual and unforeseen" from the point of view of the insured organization. The court also held that "[t]here can be no dispute that the [insured] seeks coverage for an accident involving 'bodily injury,'" and thus that § 3420(d)(2) applied to this case.

Having found that §3420(d)(2) applied, the court stated that it must determine whether the insurer provided written notice of its disclaimer "as soon as [was] reasonably possible." The court stated that "[a]n insurer's delay is measured from the point at which it has sufficient knowledge of facts entitling it to disclaim, or knows that it will disclaim coverage," and that "it is the insurer's burden to demonstrate a reasonable excuse for its delay in disclaiming coverage." (Internal quotations omitted.) Relying on a host of cases finding that a delay shorter than the insurer's delay in this case was unreasonable, the court held that the insurer's 105-day delay in disclaiming coverage was unreasonable as a matter of law. And because the insurer "simply failed to meet its burden of providing a legally sufficient explanation or excuse for its delay," the court held that, under § 3420(d)(2), the insurer waived any right to rely on policy exclusions, including the criminal acts exclusion. The court thus found that the insurer was obligated to defend and indemnify the insured in the underlying action. ■

The court stated that "[a]n insurer's delay is measured from the point at which it has sufficient knowledge of facts entitling it to disclaim, or knows that it will disclaim coverage," and that "it is the insurer's burden to demonstrate a reasonable excuse for its delay in disclaiming coverage."

In the coverage litigation that followed, the court determined the 2009-10 was the applicable policy. In this regard, the court noted that the policies defined "claim" to include "a written demand against any Insured for monetary damage" and "a civil proceeding against any Insured seeking monetary damages . . . commenced by the service of a complaint or similar proceeding." The court held that an unsealed complaint did not constitute a written demand against an insured and that the earliest the complaint could be considered such a demand was when it was publicly available on PACER on February 11, 2009. The court also held, however, that because the term "civil proceeding" was a more specific term than "written demand," the latter took precedence for purposes of determining the existence of a claim under the policy. Accordingly, the court concluded that the claim was made against the insured at the time of service on January 5, 2010.

Exclusion L in the 2009-10 policy barred coverage for any claim based upon or arising out of any prior or pending litigation filed or commended on or before the effective date of the first policy issued by the insurer of which the 2009-10 policy was a continuous renewal or replacement. The court rejected the insured's argument that the May 1, 2006, effective date of the initial excess policy was the operative date, finding that the switch from excess to primary coverage did not constitute a "renewal or replacement." Rather, the operative date for applying the exclusion was the effective date of the first primary policy—*i.e.*, May 1, 2007. Because the *qui tam* action initially was filed on June 13, 2006, the court held that the exclusion barred coverage. The court held that this was the case even though the complaint had been filed under seal and not served until years later. According to the court, the exclusion was not anchored to the definition of "claim," and the use of the term "litigation" incorporated the situation in which a suit is docketed, but not necessarily served on a party.

Additionally, the court held that coverage for the *qui tam* action was barred by Exclusion Y, which applies to "[c]laims alleging, based upon, arising out of, or attributable to any false, deceptive or unfair business practices or any violation of consumer protection laws." Although it found that the Medicare and Medicaid Patient Protection Act at issue was not a "consumer protection law," the court held that the insured's potential liability under the FCA results from false or deceptive business practices. ■

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