Wiley Rein LLP

EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | April 2014

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Insured Cannot Sue Insurer for Amounts Paid to Settle Claim Without Insurer's Consent

The United States District Court for the Northern District of Georgia has dismissed an insured's complaint seeking coverage for amounts it paid to settle an underlying lawsuit because the insured failed to obtain its insurer's consent to the settlement. *Piedmont Office Realty Trust, Inc. v. XL Spec. Ins. Co.*, No. 1:13-cv-02128-WSD (N.D. Ga. Mar. 28, 2014). In so ruling, the court rejected the insured's argument that consent was not required since the insurer unreasonably withheld consent. Wiley Rein represented the insurer.

The insured, a real estate investment trust, was sued in an underlying class action for securities fraud. In litigating that case, the insured exhausted the full primary layer of its D&O policy and incurred nearly $4 million in defense costs into its first layer excess D&O policy. During a subsequent mediation, and after it had prevailed on a summary judgment motion, the insured sought the consent of its excess insurer to settle the case for $4.9 million.

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SEC Administrative Order Does Not Trigger Dishonesty Exclusion

A New York state court has found that Securities Exchange Commission administrative orders and related settlements do not trigger the final adjudication language in a policy's dishonesty exclusion. *J.P. Morgan Securities Inc. v. Vigilant Ins. Co.*, 2014 WL 804129 (N.Y. Sup. Ct. Feb. 28, 2014).

The SEC and other regulatory entities investigated a broker-dealer and a clearing firm for alleged late trading and deceptive market timing on behalf of certain mutual fund customers. The insured ultimately settled with the SEC and agreed to pay $160 million as "disgorgement" and $90 million as a civil penalty "solely for the purpose of these proceedings" and "without admitting or denying findings." The insured also agreed to a series of findings by the New York Stock Exchange and paid $14 million to settle related civil class action lawsuits.

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Insured v. Insured Exclusion Does Not Preclude Advancement of Defense Costs in Failed Bank Litigation

Applying Puerto Rico law, the United States Court of Appeals for the First Circuit has held that an insured v. insured exclusion does not preclude an insurer's obligation to advance defense costs for the former directors and officers of a failed bank in a claim asserted by the Federal Deposit Insurance Corporation (FDIC) as receiver for the bank. *W Holding Co., Inc. v. AIG Ins. Co.—Puerto Rico*, 2014 WL 1280246 (1st Cir. Mar. 31, 2014).

The FDIC, as receiver for a failed Puerto Rican bank, filed an action against the bank's former directors and officers in connection with a pattern of allegedly recklessly underwritten loans. The insurer for the bank and the directors and officers denied coverage and refused to advance costs based on the policy's insured v. insured exclusion, which precludes coverage for claims against an insured "brought by, on behalf of or in the right of, an Organization or any Insured Person." According to the insurer, the FDIC, as receiver for the bank, had stepped into the shoes of the bank and thus was asserting the claim

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No Prejudice Required for Late Notice in Claims-Made-and-Reported Policies in Massachusetts

Applying Massachusetts law, the Superior Court of Massachusetts has held that an insurer is not required to demonstrate prejudice from a late notice under a claims-made-and-reported policy. *Catlin Spec. Ins. Co. v. Am. Superconductor Corp.*, 2014 WL 840693 (Mass. Super. Jan. 29, 2014).

The insurer issued claims-made professional and pollution legal liability policies to an energy technology company for the policy periods April 1, 2010 to April 1, 2011 and April 1, 2011 to April 1, 2012. On December 6, 2010, during the first policy period, a customer notified the policyholder that it was terminating a license agreement and that the customer might pursue a suit for gross negligence.

On May 12, 2011, during the second policy period, the customer commenced an arbitration proceeding against the policyholder based on the same allegations asserted in the December 6, 2010 letter. On May 26, 2011, the policyholder tendered the claim to the insurer. The insurer defended pursuant to a reservation of rights and brought suit seeking a declaration that the policy did not afford coverage for the lawsuit because, among other things, the policyholder was late in reporting a claim first made during the first policy period.

The trial court granted summary judgment in favor of the insurer on the issue of late notice. The court decided that, under Massachusetts law, the notice requirement of a claims-made-and-reported policy is enforceable and the insurer need not prove prejudice from late notice. Thus, the court held that insurer had no duty to defend or indemnify the policyholder in connection with the lawsuit under the 2010 or the 2011 policies due to the policyholder's failure to timely report the claim during the period of the 2010 policy. ■

Insurer Required to Prove Prejudice to Deny Coverage for Late Notice Under Claims-Made-and-Reported Policy in Maryland

Applying Maryland law, the United States District Court for the District of Maryland has held that an insurer must demonstrate prejudice to support a late notice defense to coverage under a claims-made-and-reported policy. *Navigators Spec. Ins. Co. v. Med. Benefits Admin. of Md., Inc.*, 2014 WL 768822 (D. Md. Feb. 21, 2014).

A professional liability insurer issued successive claims-made-and-reported policies to a third-party underwriting entity for the policy period of October 31, 2009 to October 31, 2010 (the "09-10 Policy") and the policy period of October 31, 2010 to October 31, 2011 (the "10-11 Policy"). The underwriting entity contracted with a Lloyd's of London syndicate to issue policies on behalf of the syndicate, and the syndicate appointed the underwriting entity's affiliate as the claims administrator for the policies. The claims administrator was named as an additional insured in the underwriting entity's professional liability policies. The syndicate terminated the underwriting and claims administration contracts in 2007, audited the claims handling of the policies, and, in January 2010, ultimately demanded that the claims administrator pay $1 million to the syndicate for mismanagement of the program. Subsequently, on June 30, 2011 and during the

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Prejudice Required for Late Notice Defense Under Claims-Made Policy in Louisiana

A Louisiana federal court, applying Louisiana law, has rejected a late notice defense under a claims-made financial institutions bond where notice of a claim was given during the policy period, even though notice did not comply with a provision specifying that notice must be given within 60 days of the discovery of a claim. *Grubaugh v. Central Progressive Bank*, 2014 WL 793994 (E.D. La. Feb. 27, 2014). The court, however, concluded that if the insurer could prove prejudice from the breach of the 60-day notice provision, then coverage would be barred.

In July 2008, a customer filed regulatory complaints against a bank after discovering allegedly fraudulent activity related to his checking account. The customer then filed suit in May 2009 against the bank, bank employees, and an insurer that issued a bond to the bank for the period of February 1, 2007 to November 15, 2009. The bank provided notice of the lawsuit to the insurer in July 2009.

The bond stated that it applied "only to loss first discovered by a director or officer of the ASSURED during the BOND PERIOD" and required the bank to provide notice "at the earliest practicable moment, not to exceed sixty (60) days after the discovery of a loss . . . ." The insurer moved for summary judgment on the ground that the bank discovered the loss in July 2008 when the regulatory complaints were filed but did not provide notice until almost a year later. The court agreed with the insurer on the timing of the bank's discovery of the loss and that the bond was a claims-made policy. The court, however, noted that, unlike some claims-made policies, the notice provision did not specify that notice within 60 days was a condition precedent to coverage and stated that it would not read the 60-day reporting period as an express condition precedent to coverage. Furthermore, the bank provided notice to the insurer during the bond period. The court decided that "coverage exists under [the] bond even though the precise time line for reporting was not followed" and that the "scope of the [insurer's] bargained-for coverage has not been expanded . . . ." The court stated, however, that "if [the insurer] can prove that it was prejudiced by the late notice, [the customer] could still be precluded from bringing a direct action." ■

FIRREA Precludes Insurer's Declaratory Judgment Action Against D&Os of Failed Bank

The United States District Court for the Northern District of Georgia has dismissed an insurer's declaratory judgment action against insured directors and officers and the Federal Deposit Insurance Corporation (FDIC), holding that the insurer's proposed amendment of its complaint would not vest the court with subject matter jurisdiction. *OneBeacon Midwest Ins. Co. v. FDIC*, 2014 WL 869286 (N.D. Ga. Mar. 5, 2014). According to the court, even if the FDIC were dropped as a party to the amended complaint, the court nonetheless would lack subject matter jurisdiction over the action pursuant to § 1821(j) of the Financial Institutions Reform, Recovery, and Enforcement Act of 1989 (FIRREA).

In 2011, the FDIC, as receiver for an insured bank, sent a letter seeking payment of civil damages to directors and officers of the failed bank. The bank's D&O insurer subsequently filed a declaratory judgment action against the directors and officers and the FDIC seeking declarations that various policy provisions barred coverage for the FDIC's claim. In March 2013, the court granted the D&O defendants' motion to dismiss for lack of subject matter jurisdiction. The court held that a declaratory judgment would affect the FDIC's ability to collect money due to the bank, and therefore the insurer's claims were "precluded by the broad jurisdictional bar of

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Alleged Misappropriation of Professional Service Business Potentially Implicates "Professional Services" Coverage

The United States District Court for the Western District of Pennsylvania has held that a claim alleging that two insureds misappropriated tax lien business from a law firm arose out of the insureds' professional services and therefore was potentially covered by their professional liability policy. *Mun. Revenue Serv., Inc. v. Houston Cas. Co.*, 2014 WL 869505 (W.D. Pa. Mar. 5, 2014).

In an underlying case, a law firm sued a company and an individual accountant, among others, alleging that they unlawfully misappropriated confidential information from the law firm and used it to move tax lien services business away from the law firm. The law firm also accused the accountant of secretly stealing and transferring files from the law firm to a remote Internet location. The company and the accountant tendered the suit to an insurer that had issued them a professional liability policy, but the insurer refused to defend them. The insureds then brought suit seeking coverage under the policy.

The policy at issue afforded coverage for "any actual or alleged negligent act, error, omission or breach of duty committed or alleged to have been committed, or for failure to render, such Professional Services as are customarily rendered in the profession of the Insured …." Further, the policy defined the term "Professional Services" to include "[s]olely … the performance of providing a Tax preparation and/or Bookkeeping Service and/or providing Tax Lien Services, for others for a fee …." Relying on those provisions, the insurer moved to dismiss the coverage suit on the grounds that the policy afforded no coverage for the underlying claim because it was based on a business dispute over client files and retention rather than any act, error, or omission in professional services. The court disagreed, ruling that there was a plausible argument—sufficient to survive a motion to dismiss—that the insured's acts, whether illegal or not, included elements or actions that could be conducted in the course of its professional work. Therefore, the court denied the insurer's motion to dismiss. ■

Insurer May Recoup Uncovered Defense Costs in Suit Filed After Final Adjudication of Its Coverage Obligations

Applying New York law, the United States District Court for the Southern District of New York has held that, where an insurer reserves rights to recoup uncovered defense costs and a court subsequently deems these costs uncovered, the insurer may recoup these costs even if it did not seek them in prior coverage litigation. *Women's Integrated Network, Inc. v. U.S. Spec. Ins. Co.*, 2014 WL 894501 (S.D.N.Y. Mar. 7, 2014).

After the insured tendered an underlying claim to its D&O insurer, the insurer agreed to pay a portion of the insured's defense costs while reserving its right to deny coverage. The relevant policy provided that: "[i]f it is finally determined that any Defense Costs paid by the Insurer are not covered … the Insureds agree to repay such non-covered Defense Costs to the Insurer." After a trial court subsequently ruled that the policy did not afford coverage for the underlying action, the insurer sought repayment for the defense costs it had advanced. The insured then sought a declaratory judgment that the insurer could not recover these costs because, *inter alia*, its recoupment claim was a compulsory counterclaim in the parties' earlier coverage dispute and, accordingly, res judicata barred this claim. The court granted the insurer's motion to dismiss the insured's complaint, leaving only the insurer's recoupment counterclaim in the instant action.

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Carve-Outs to Definition of "Professional Services" Operate as Exceptions to Professional Services Exclusion

Applying New Mexico law, the United States Court of Appeals for the Tenth Circuit has held that enumerated carve-outs to a D&O policy's definition of "professional services" extended coverage to the enumerated carve-outs, even if they were arguably excluded by other policy provisions. *Western Heritage Bank v. Fed. Ins. Co.*, 2014 WL 903469 (10th Cir. March 10, 2014).

A bank that had issued a loan to a borrower for improvements on a property foreclosed on the loan and repossessed the borrower's personal property upon the borrower's default. The bank also recorded a lien on the leasehold interest of another company on the property to secure the loan. When the bank refused to release the lien, the company sued the bank, some of its officers, and its attorneys. The bank tendered the claim to its professional liability insurer for a defense under a D&O liability policy. The insurer denied coverage, arguing that the policy excluded coverage for loss on account of any claim based upon or arising from the performance of professional services or lending services. The bank then sued the insurer, and the district court entered summary judgment in favor of the insurer, holding that the exclusion for lending services barred coverage.

On appeal, the court evaluated the policy's exclusion for professional services and lending services. The policy's definition of "professional services" expressly carved out (1) legal services, (2) services performed by an entity which the insured had acquired ownership or control of as security for a loan (*i.e.*, post-control actions), and (3) lending services. Although the policy defined "lending services" broadly enough to potentially encompass both legal services and post-control actions, the court rejected this reading as rendering the first two carve-outs to the definition of professional services as mere surplusage. The court also rejected the insurer's argument that the carve-outs to the definition of professional services should only be read to narrow the definition of that term rather than to create exceptions to the professional services exclusion, finding that anything that falls outside the ambit of the carve out language that would otherwise be covered falls within the policy's coverage. Accordingly, the court concluded that legal services and post-control actions were exceptions to the professional services exclusion under the language of the policy.

Nonetheless, the court ultimately held in favor of the insurer, concluding that the bank failed to

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Fourth Circuit Holds That Personal-Profit and Conversion Exclusions Do Not Preclude Coverage for Underlying Fraud Suit

Applying Maryland law, the United States Court of Appeals for the Fourth Circuit has held that, where an underlying complaint seeks restitution but does not allege that the policyholder itself gained any profit or advantage, an E&O insurer may not disclaim coverage on the basis of a personal-profit exclusion. *Cornerstone Title & Escrow, Inc. v. Evanston Ins. Co.*, 2014 WL 631098 (4th Cir. Feb. 4, 2014). The court also held that an exclusion for claims "based upon or arising out of" conversion did not apply where the policyholder allegedly improperly delivered a check, but the payee did not receive the check.

A state attorney general sued the policyholder, a title insurer, and ten co-defendants, seeking restitution and alleging that the defendants defrauded homeowners on the brink of foreclosure through sale-leaseback agreements whereby homeowners sold their houses to the co-defendants only for them to rent the houses back to the homeowners at inflated rates. The policyholder allegedly provided settlement services for the sale-leaseback transactions and failed to deliver the sale proceed checks to the homeowners. The attorney general sought to hold the policyholder responsible for the co-defendants' acts as well as its own, eventually garnering a settlement wherein the policyholder paid $100,100 in restitution. After the insurer denied coverage for the underlying claim, the policyholder filed suit against the insurer, alleging breach of its duties to defend and indemnify the insured.

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Reporting Requirement in Policy Conditions Does Not Create Claims-Made-and-Reported Coverage

The United States District Court for the Northern District of California, applying California law, has denied an insurer's motion to dismiss its insureds' claim for breach of contract and bad faith, holding that a claims-made policy that includes a condition requiring claims to be reported "as soon as practicable, but in no event later than 30 days after the Policy Period" is not a claims-made-and-reported policy. *Newlife Scis. LLC v. Landmark Am. Ins. Co.*, 2014 WL 631141 (N.D. Cal. Feb. 18, 2014). As a result, the court concluded that the insurer was required to show prejudice due to the insureds' breach of the reporting condition. The court also held that the statute of limitations on the bad faith claim was tolled when the insureds tendered their defense and that the question of whether the insurer failed to comply with the California Insurance Code involved factual determinations not appropriately resolved on a motion to dismiss.

In June 2008, a cross-complaint was filed against the insured medical device manufacturer and two of its executives. An amended cross-complaint alleging what the insureds believe to be injury covered under their professional liability policy subsequently was filed in November 2008. One year later, the insureds tendered the defense of the amended cross-complaint to their insurer. The insurer denied coverage because the claim was reported more than 30 days after the expiration of the relevant policy. In May 2012, a second amended cross-complaint was filed and, in December 2012, the insureds again tendered the defense of the claim. After the insurer denied coverage a second time, the insureds filed suit against the carrier for breach of contract, bad faith, and unfair business practices based on the failure to comply with the claims-made notice requirements of the California Insurance Code.

Denying the insurer's motion to dismiss, the court first held that a notice requirement in the policy conditions only applied to bar coverage if the insurer was prejudiced by the insureds' breach. In so holding, the court distinguished

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No Irreparable Harm Where Insurer Declined to Advance Defense Costs

The United States District Court for the Western District of Kentucky, applying Kentucky law, has held that insureds were not entitled to a preliminary injunction to have their defense costs advanced in connection with two lawsuits for which they were seeking coverage. *C.A. Jones Mgmt. Grp., LLC v. Scottsdale Indem. Co.*, 2014 WL 811654 (W.D. Ky. Feb. 28, 2014). The court held that the insureds failed to demonstrate a substantial likelihood of success on the merits of the coverage questions at issue and that the insureds would not suffer irreparable harm because their potential injury was purely monetary.

A management consulting company and several of its affiliates, officers, and directors were insureds under a business and management indemnity policy. The policy was renewed for a second term, but cancelled after approximately five months for non-payment of premium. An investor had filed suit against the insureds, alleging mismanagement that rendered some of the affiliated companies nearly insolvent. The investor stipulated to the voluntary dismissal of the suit upon the appointment of a receiver to assume control over the companies' operations. The insureds did not request coverage for their defense costs during the pendency of the lawsuit, and purportedly did not report the suit to the insurer until after its dismissal, approximately three months after the expiration of the original policy period.

The investor subsequently filed a second lawsuit, alleging that the insured companies had resold

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Lawsuit Implicates Health Care Professional Liability Policy and Falls Within D&O Policy's Medical Malpractice Exclusion

Applying Illinois law, an Illinois appellate court has held that a suit brought against a hospital by participants of a discontinued vaccine trial arises out of professional services, meaning that it implicates the hospital's professional liability policy but falls within the medical malpractice exclusion of the hospital's D&O policy. *Rosalind Franklin Univ. of Med. & Sci. v. Lexington Ins. Co.*, 2014 WL 905547 (Ill. App. Ct. Mar. 7, 2014). The court also held that the hospital's professional liability insurer was not estopped from asserting coverage defenses because, even though its appointed counsel defended the suit for several months before the insurer notified the hospital of any coverage issues, the hospital could not show resulting prejudice.

For nearly two decades, the insured hospital administered a study to evaluate the efficacy of a vaccine, which was funded with money donated by the physician who developed the vaccine. When the hospital ended the study in 2004, 50 study participants filed suit against the hospital, alleging that the discontinuation of the study put their lives at risk. The lawsuit sought injunctive relief and also asserted a variety of common law and statutory claims. Early in the litigation, the parties agreed to settle for $3 million, including a $2.5 million payment to a trust to resume the study and a $500,000 payment directly to the plaintiffs for pain and suffering.

At the time the suit was filed, the hospital was insured under primary and excess "Healthcare Professional Services Liability" policies issued by the same insurer. The hospital also had a D&O liability policy issued by another insurer. The D&O insurer denied coverage for the suit based on its policy's medical malpractice exclusion. The professional liability insurer did not confirm its position until after the execution of the settlement agreement, at which point it

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Late Notice and Voluntary Payments Preclude Coverage Even Where Insurer May Have Knowledge of the Claim

The United States District Court for the Southern District of New York, applying New York law, has held that a general liability insurer could rely on late notice and voluntary payments defenses to coverage where the insured had not properly provided notice for at least two years after a claim was made or sought consent before making payments for cleanup of contamination. *Travelers Indemnity Co. v. Northrop Grumman Corp.*, 2014 WL 721637 (S.D.N.Y. Feb. 25, 2014). The court found no coverage was available even though the insurer allegedly had independent knowledge of the claim and some of the contamination and remediation efforts at issue because the insurer at no time waived its right to written notice.

The general liability policies at issue covered several policy years and required that the policyholder, immediately, provide notice to the insurer of any claim and forward the relevant claim document to the insurer and, as soon as practicable, provide written notice in the event of property damage. The policyholder did not provide notice to the insurer of property damage despite many facts exposing groundwater contamination at a certain facility through the late 1970s. In January 1984, the policyholder sent to the insurer a December 1983 letter from the state Department of Environmental Conservation initiating a formal adversarial

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Policyholder's Bankruptcy Does Not Relieve Insurer's Obligations for "Loss"

The Court of Appeals of Wisconsin, applying Wisconsin law, has held that a policyholder's bankruptcy did not relieve an insurer of its obligations to pay for "loss" under a policy endorsement that included a bankruptcy provision. *Hollingsworth v. Landing Condos. of Waukesha Ass'n, Inc.*, 2014 WL 839244 (Wis. Ct. App. Mar. 5, 2014).

Individual condominium owners sued a condo association's directors for breach of their fiduciary duties. The directors filed for bankruptcy protection and were dismissed from the lawsuit. The association sought insurance coverage under a CGL policy that included an endorsement affording coverage for "loss" arising from the wrongful acts of its directors and officers. The endorsement also provided that the bankruptcy of an insured would not relieve the insurer of its obligations under the policy. The insurer sought and obtained a declaratory judgment in the trial court, which ruled there was no coverage because the directors could no longer incur personal liability to trigger "loss" under the endorsement given their dismissal from the underlying suit. Although the trial court acknowledged that "there may be coverage under the policy," it rejected the owners' motion for reconsideration because it found "no methodology for [the directors] to be held liable."

The owners appealed, arguing that the endorsement's bankruptcy provision preserved coverage. The Wisconsin appellate court agreed. It rejected the insurer's argument that the dismissal of the directors nullified coverage because without their legal liability to pay there could be no "loss" under the policy. The court reasoned that to deny coverage would render the bankruptcy provision "meaningless." It added that, by issuing the endorsement with the bankruptcy provision, the insurer "plainly agreed that its obligations would remain" in the event that the directors "would be obligated to pay due to a legal liability but instead sought bankruptcy protection." Taking into account the "reasonable expectations of the insured" and construing the policy "against the insurer that drafted it," the court found that the "bankruptcy provision derails any argument . . . that the directors' claimed insolvency absolves [the insurer's] obligation." ■

Adequate Notice of Reduction in Coverage Required at Renewal

Applying Oklahoma law, the United States District Court for the Western District of Oklahoma has held that an insurer failed to give adequate notice of a policy renewal that resulted in a reduction in coverage. *Cactus Drilling Co., LLC v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, 2014 WL 547180 (W.D. Okla. Feb. 10, 2014).

The policyholder had purchased a Commercial Umbrella Liability Policy for the period from 2006 to 2007. The policy was subsequently renewed for the periods from 2007-08, 2008-09, and 2009-10. All four policies provided coverage for "bodily injury" that occurs during the "policy period" as a result of an "occurrence" but excluded coverage for "bodily injury . . . expected or intended" from the standpoint of the insured. However, the 2006-07 policy contained an endorsement that excluded coverage for "[b]odily injury resulting from an act which is determined to have been committed by you with the belief that an injury is substantially certain to occur," in five designated states, not including Oklahoma. The three subsequent policies issued did not include this endorsement.

In 2009, two of the policyholder's employees were killed during the course and scope of their employment. The deceaseds' estates initiated a suit against the policyholder. The insurer denied coverage for the suit on the grounds that the policy did not cover the incident. The policyholder sued the insurer and moved for summary judgment that the 2006-07 "substantial certainty" endorsement should be incorporated into the 2009-10 policy. The insurer argued that under Oklahoma law, the "occurrence" and "intended or expected" language in the "bodily injury" exclusion excluded "substantial certainty" torts as a matter of law and that the endorsement did not change the analysis. Therefore, the insurer contended that the elimination of the endorsement in its subsequent policies was not a reduction in coverage for which it was required to provide notice.

The court held that the 2006-07 "substantial certainty" endorsement should be incorporated into the 2009-10 policy. The court found that the policy was ambiguous and, construing that ambiguity in favor of coverage, the insured had a reasonable expectation that such claims would be covered. Because the insured had a reasonable expectation of coverage, the court found that the elimination of the endorsement reduced the insured's coverage, and the insurer was required to give notice when it issued subsequent policies that did not contain the endorsement. The court found that two letters issued by the insurer notifying the insured that the 2006-07 policy "will not be renewed, and replacement coverage 'may' be issued, which 'may' include reduction in coverage" did not provide sufficient notice because the 2007-08 policy clearly stated that it is a renewal of the 2006-07 policy, thereby rendering the letters inapplicable. Additionally, the court found that a draft letter provided by the insurer listing the amended provisions with instructions to review the policy for a complete description of coverage was insufficient under the facts to give "clear and inconspicuous" notice of reduction in coverage. ■

Insurer May Recoup Uncovered Defense Costs in Suit Filed After Final Adjudication of Its Coverage Obligations *continued from page 5*

With respect to the counterclaim, the court held that, given that only compulsory counterclaims are subject to res judicata, res judicata did not preclude the insurer's recoupment effort. The court determined that this counterclaim was not compulsory in prior coverage litigation given that it was not ripe at that stage, as there had not yet been a final determination that its advanced defense costs were uncovered. The court additionally noted that, where a party engages in actionable conduct after a suit's commencement, res judicata does not preclude the adverse party from bringing a subsequent suit based on that conduct. The court maintained that, because the "actionable conduct" giving rise to the insurer's counterclaim—the insured's decision to file suit rather than repay defense costs at the insurer's behest—occurred after the filing of the prior coverage litigation, res judicata could not bar the insurer's recoupment counterclaim. ■

SEC Administrative Order Does Not Trigger Dishonesty Exclusion *continued from page 1*

The insured sought coverage for the settlements under its professional liability insurance. The insurers denied coverage on several bases, including the application of a dishonesty exclusion. In the coverage litigation, the insured argued that the operative administrative orders and settlements were not judgments or other final adjudications required to trigger the exclusion. The exclusion provided that the policy applied unless "judgment or other final adjudication thereof adverse to such Insured shall establish that such Insured was guilty of any deliberate, dishonest, fraudulent or criminal act or omission."

The court agreed with the insured, determining that a consent judgment or settlement embodied in the SEC and NYSE administrative orders were not final adjudications or judgments establishing that the insured engaged in the wrongful conduct included in the dishonesty exclusion. Relying on the language "solely for the purposes of these proceedings . . . ," the court reasoned that the factual findings were neither admitted nor denied except as to the SEC's jurisdiction and were not the subject of a ruling by a trier of fact. Additionally, the court noted that the insured reserved the right to take contrary legal and factual positions in future non-SEC proceedings. The court also rejected the insurer's public policy argument, finding that the insurer expressly agreed to the final adjudication requirement in the dishonesty exclusion and could not write that requirement out of the policy. ■

Insurer Required to Prove Prejudice to Deny Coverage for Late Notice Under Claims-Made-and-Reported Policy in Maryland *continued from page 3*

policy period of the 10-11 Policy, the syndicate filed suit against the underwriting entity and the claims administrator for mismanagement of the syndicates' insurance program and sought more than $1 million in damages. The insureds tendered the suit for coverage, and the insurer denied coverage on the grounds that the claim was not first made and reported during the policy period of either the 09-10 Policy or the 10-11 Policy.

In the coverage litigation that followed, the court held that the syndicate had made a claim during the 09-10 Policy. The 09-10 Policy defined "claim" as a "demand for money or services." The court held that two communications from June 2009 did not constitute a claim because they did not demand payment of money, threaten litigation, or signify that the syndicate was investigating more than a discrepancy in an accounting matter. However, according to the court, a January 2010 letter constituted a claim because it expressly accused the claims administrator of wrongdoing, demanded payment of $1.1 million, and threatened litigation if the matter was not resolved. In reaching this conclusion, the court noted that the insured's belief that the allegations in the January 2010 letter lacked merit was immaterial to whether the letter was a claim. The court also found that the June 2011 lawsuit was a claim related to the January 2010 letter such that the lawsuit and letter constituted a single claim first made during the 09-10 Policy. In this regard, because the claim was first made during the 09-10 Policy and before the inception of the 10-11 Policy, the court concluded that the 10-11 Policy did not afford coverage for the lawsuit.

With respect to the 09-10 Policy, despite the fact that the insured failed to report the claim during the policy period, the court held that the insurer could not deny coverage without demonstrating prejudice. In reaching this conclusion, the court recognized that there was a difference of opinion among the federal courts in Maryland whether the notice-prejudice rule imposed by Maryland Code § 19-110 applied in the context of a claims-made-and-reported policy, and concluded that it did. The court also found that the insurer here could not prove as a matter of law that it had been prejudiced by the late notice of the claim because the insurer had no evidence that its earlier involvement in the claim could have resolved the dispute short of litigation. ■

Late Notice and Voluntary Payments Preclude Coverage Even Where Insurer May Have Knowledge of the Claim *continued from page 8*

proceeding regarding the facility. The letter was sent to an address that was not the business or other address for the insurer, and no insurer witness recalled seeing it. The insurer was orally informed of the Department's requests concerning the facility at a 1989 meeting, and some of the insurer's internal memoranda discussed the matter, but the insured did not request coverage in writing until 2012. The insured argued that the insurer had received adequate notice before that time. The insured argued in addition that the requirement to give notice of additional claims made in 2002 was excused because the insurer had indicated it would not defend prior administrative proceedings or claims for equitable relief.

The court found that the policyholder's late notice precluded coverage. Prior to 1983, the court found that, even if the insured, as a legal matter, could argue that it had a good faith belief that it was not liable, and therefore was not required to provide notice of property damage, no such belief was reasonable in light of the factual evidence of contamination. Notice was therefore required. The court found further that the insured's 1984 letter sent to the wrong address was not effective notice, even though that address had been provided by the insurer for communications involving an unrelated claim.

Moreover, the court found that the insurer's knowledge of the Department proceedings in fact would not eliminate the insured's notice obligations. Neither oral discussions with the insurer nor internal memoranda by the insurer concerning the claim waived the insurer's right to receive written notice as required by the policies. The insurer's own memoranda did not cure late notice because they were written two years after a claim was made—a period the court found to be neither "immediately" nor "as soon as practicable." According to the court, "a two-year delay in the context of this type of matter is untimely as a matter of law." And the insurer's indication that it would not cover certain equitable obligations was not an across-the-board denial of coverage that in some cases may excuse notice.

The court also found that coverage was barred by policy language prohibiting an insured, except at his own cost, from voluntarily making any payment. The policyholder had incurred more than $40 million in clean-up and remediation costs at the relevant facility without the insurer's consent. The policyholder argued that the insurer had waived its right to rely on the policies' voluntary payments provisions by refusing to participate in the process or to provide a defense. The court rejected this argument. At no time, found the court, did the insurer receive notice of the purpose or amounts of payments by the policyholder or intentionally waive its rights with respect to such payments. ■

FIRREA Precludes Insurer's Declaratory Judgment Action Against D&Os of Failed Bank *continued from page 4*

12 U.S.C. § 1821(j) of [FIRREA]," which provides that "no court may take any action . . . to restrain or affect the exercise of powers or functions of the [FDIC] as a conservator or a receiver."

Ruling on the insurer's motion for reconsideration and leave to amend, the court held that the insurer's proposed amendment dropping the FDIC as a defendant did not cure the jurisdictional defects. After noting that it is in the court's discretion to grant a motion to amend where amendment will vest the court with jurisdiction, the court held that, "even as amended, Plaintiff's claims affect the FDIC in its exercise of power and trigger the jurisdictional bar of § 1821(j)." According to the court, even if not a party to the action, the "FDIC has an interest (albeit contingent and speculative) in the Policy as a tort claimant." In so holding, the court refused to follow the Northern District of Illinois, which reached the opposite result in *FDIC v. OneBeacon Midwest Insurance Co.*, 2013 WL 951107 (N.D. Ill. Mar. 12, 2013). ■

Carve-Outs to Definition of "Professional Services" Operate as Exceptions to Professional Services Exclusion *continued from page 5*

establish that it met either the legal services or the post-control actions exception. The court found that the bank failed to present any evidence that the allegations in the underlying action arose out of the bank's performance of legal services, noting that the recording of liens and subsequent refusal to release them would not inherently require a license to practice law and the failure of the insureds to provide any other factual support for that argument. The court also held that the post-control exception did not apply to the bank's conduct in foreclosing on the loan equipment or repossessing personal property, reasoning that the post-control exception applies to the conduct of entities acquired by the bank, not to the conduct of the bank itself. As such, the court concluded that the insurer had no duty to defend or indemnify the bank. ■

Insured Cannot Sue Insurer for Amounts Paid to Settle Claim Without Insurer's Consent *continued from page 1*

The insurer refused to provide its consent, agreeing to contribute no more than $1 million toward any settlement. Without its insurer's consent, the insured settled the class action, and that settlement was subsequently approved by the district court. The insured then brought a coverage action against its insurer.

Ruling on the insurer's motion, the court dismissed the insured's complaint, reasoning that the insured's claim for coverage was not actionable given that it had failed to obtain the insurer's consent to the settlement as required by the terms of its policy. In so doing, the court rejected the insured's argument that consent was not required because the insurer "unreasonably withheld" its consent in breach of the policy terms. Instead, even assuming that the insured's assertions were true, the court ruled that the plain language of the policy barred it from bringing suit until a judgment exceeding the potential settlement was entered against it after an actual trial. In this case, since the insured had unilaterally settled the underlying case, the court ruled that it was barred from bringing suit.

In the alternative, the court ruled that there was no coverage for the settlement since the insured was never "legally obligated" to pay the settlement. In so ruling, the court noted that the insured's unilateral decision to settle the case constituted a "voluntary act" rather than a legal obligation that could trigger coverage. The court rejected the argument that the underlying court's approval of the settlement altered this result, ruling that "the district court's approval of the settlement d[id] not convert an uncovered settlement into a covered amount under the insurance agreement."

Finally, the court gave effect to the "no action" clause in the policy, which provided that the insurer could only be sued if the insured complied with all of the terms of the policy and "the amount of the [insured's] obligation to pay shall have been finally determined either by judgment … after actual trial … or by written agreement of the [insured], the claimant and the [insurer]." In so doing, the court rejected the insured's argument that the insurer was estopped from relying on the "no action" clause since it allegedly had breached the insurance contract by unreasonably withholding its consent, characterizing the insured's position as a "shallow argument … based on a fundamental misapplication of basic contract law principles." Instead, the court ruled that estoppel could not apply in this case, since the insurer funded the defense of the underlying claim, resulting in the insured prevailing on summary judgment, and the insured unilaterally decided to settle the litigation without the insurer's consent. ■

Reporting Requirement in Policy Conditions Does Not Create Claims-Made-and-Reported Coverage

continued from page 6

claims-made and claims-made-and-reported policies, stating that the notice-prejudice rule applied only to the former:

> The reporting requirement in a "claims made and reported" policy is, thus, not a condition of coverage but part of the coverage definition itself. Whereas an insurer bears the burden to show it was prejudiced by the insured's failure to comply with a reporting condition, it is the insured that bears the burden to show the claim was timely reported in a "claims made and reported" policy.

The insurer argued that the reporting requirement in the policy conditions was made part of the insuring agreement—thus rendering the coverage claims-made-and-reported—because the insuring agreement only obligated the insurer to pay damages because of injury "to which this insurance applies." The court rejected this contention, noting that the insurer cited no authority for this position and stating that "[s]uch a reading would defeat the interpretive rules . . . in which the onus is on the insured to prove a claim falls within the basic scope of insurance and on the insurer to prove any exclusions or conditions apply."

The court also denied the insurer's motion to dismiss the claims for bad faith and failure to comply with the California Insurance Code. With respect to the bad faith claim, the court held that (1) the insureds' tender of the amended cross-complaint tolled the applicable two-year statute of limitations, and (2) whether the "genuine dispute" doctrine precluded a finding of bad faith presented factual issues not amendable to resolution on the pleadings. With respect to the insureds' claim that the insurer had engaged in unfair business practices by failing to comply with the notice requirements for claims-made policies set forth in Cal. Ins. Code § 11580.01, the court held that factual issues—specifically, whether the insurer "substantially complied"—precluded dismissal. ■

Fourth Circuit Holds That Personal-Profit and Conversion Exclusions Do Not Preclude Coverage for Underlying Fraud Suit

continued from page 6

The trial court had held that two policy exclusions precluded coverage: (1) an exclusion for claims "based upon or arising out of" the policyholder's gaining any profit or advantage to which the policyholder was not legally entitled; and (2) an exclusion for claims "based upon or arising out of the actual or alleged … conversion … [of] any escrow funds, monies, monetary proceeds, or any other assets, securities, negotiable instruments … irrespective of which individual, party, or entity actually or allegedly committed or caused in whole or part the [excluded act]."

On appeal, the Fourth Circuit reversed the district court, holding that neither exclusion defeated coverage. The court held that the personal-profit exclusion did not apply because, although the underlying complaint alleged that the other co-defendants wrongfully profited from their conduct and sought restitution from the defendants collectively, it did not allege that any profit or advantage inured specifically to the policyholder's benefit. Further, the court noted that, given that the underlying complaint alleged claims based on the failure to make required statutory disclosures, the attorney general could have prevailed against the policyholder independent of any claims stemming from the defendants' unlawful receipt of profit or advantage.

The court further held that the conversion exclusion did not apply because, under Maryland law, a claim against a third-party based on improper delivery of a check does not amount to conversion unless the payee receives the check. The court found that, in the instant case, the policyholder misdirected the settlement checks before the payee homeowners received the checks, and therefore such actions could not amount to conversion. The court further noted that, because the underlying complaint sought to hold the insured responsible for failing to make required disclosures, prematurely recording deeds, and making misleading statements, the underlying complaint made claims that were not based upon or arising out of conversion. ■

No Irreparable Harm Where Insurer Declined to Advance Defense Costs *continued from page 7*

international versions of textbooks in the U.S. in violation of copyright and trademark law. Thereafter, several months after the renewal policy was cancelled, a third lawsuit was filed against certain insureds similarly alleging the improper marketing of international textbooks. The insureds sought coverage under the policy for the second and third lawsuits and filed a declaratory judgment action. The insureds also sought a preliminary injunction that the insurer was required to advance their defense costs incurred in the two underlying actions.

In determining whether to issue a preliminary injunction, the court first considered whether the insureds had a substantial likelihood of prevailing on the merits of the coverage questions at issue. The court found that all three lawsuits were related because they shared a common nexus of facts, circumstances, and events, and consequently constituted a single claim that arose at the time of the first lawsuit. The court observed that, even though the first lawsuit was not reported until after the required notice period for the first policy year, under Kentucky law, the renewed policy provided seamless coverage. The court therefore held that all three lawsuits fell within the insuring agreement of the policy.

However, upon considering the potential limitations and exclusions to coverage, the court concluded that the insureds were unlikely to succeed on the merits of their claims. The court specifically evaluated whether the insureds had made material misrepresentations on their policy application, whether the insured v. insured exclusion barred coverage, whether the fraudulent and criminal acts exclusion barred coverage, whether two exclusions barring claims alleging copyright violations applied, whether a securities fraud exclusion applied, and whether certain individuals and entities qualified as insureds. Because several of the exclusions likely precluded coverage, and the policy only required the insurer to advance defense costs as to claims for which coverage existed, the court determined that the insureds were unlikely to succeed on the merits of their claim.

The court then considered whether the insureds would suffer irreparable injury in the absence of their requested injunctive relief. The court rejected the insureds' argument that financial pressure, the potential for adverse rulings, and the stress of litigation were an immediate and direct injury sufficient to warrant an injunction, finding that these stresses accompany virtually every lawsuit. The court concluded that any potential remaining injury was purely monetary and therefore did not constitute irreparable harm. Finally, the court observed that issuance of the injunction would cause harm to the insurer and that the public interest would be unaffected by denying the insureds' motion for an injunction. The court therefore declined to issue a preliminary injunction requiring the advancement of defense costs. ■

Insured v. Insured Exclusion Does Not Preclude Advancement of Defense Costs in Failed Bank Litigation *continued from page 2*

on behalf of or in the right of an insured against other insureds. In response, the directors and officers argued that the insurer had an obligation to advance defense cost because there was a "remote possibility" that the insured vs. insured exclusion did not apply. The directors and officers contended that the exclusion did not, or at minimum might not, apply because the FDIC was also purporting to assert claims on behalf of non-insureds, including the bank's third-party creditors and depositors.

The district court ruled in favor of the directors and officers and directed the insurer to advance defense costs. The appellate court affirmed, holding that Puerto Rico law requires an insurer to advance defense costs if there is a "remote possibility" of coverage. Here, the court found, there is at least a remote possibility that the FDIC is suing on behalf of depositors and account holders in addition to the insured bank, and thus the insured vs. insured exclusion might not apply. As such, the court held that the insurer had a duty to advance defense costs. ■

denied coverage. The hospital filed suit against both insurers. The trial court held that both insurers had a duty to indemnify the hospital, but rejected the insured's "bad faith" claim against the professional liability carrier.

The appellate court affirmed in part and reversed in part. As a threshold matter, the court rejected the hospital's argument that its professional liability insurer was estopped from asserting any coverage defenses. Although the evidence showed that the insurer appointed the attorney who defended the hospital in the underlying action, the court concluded that the hospital did not surrender control of its defense to the insurer-appointed counsel. Instead, its general counsel remained involved. Accordingly, the court concluded that the hospital could not show that it had been prejudiced because there was nothing indicating that the defense would have been conducted differently with independent counsel.

Next, the court turned to the coverage defenses raised by the carriers. First, the court held that the settlement did not constitute uncovered disgorgement. The insurers argued that the money donated to fund the study was earmarked solely for the vaccine program, meaning that the hospital forfeited its right to the funds when it ended the study. As a result, the insurers argued that the settlement represented a disgorgement of wrongfully retained funds rather than covered "damages" or "loss." The court disagreed. Although the court did not dispute that "there is no insurable loss where an insured is compelled to turn over money that it had never had a right to possess," it concluded as a factual matter that (1) the terms of the donation required only that the funds be used for cancer research generally; and (2) the settlement represented a compromise of *all* the plaintiffs' claims, "including the nondisgorgement claims," as shown by the hospital's use of its general operating fund to pay the settlement.

Second, the court considered the professional liability carrier's argument that the underlying lawsuit did not arise out of "professional services." The court held that the gravamen of the underlying complaint alleged activity that involved "specialized medical knowledge" rather than "wrongful administrative acts." The court reasoned that the plaintiffs' claims were all based on the decision to shut down the study—a decision that constituted "an exercise of medical judgment" given that it was made based on safety concerns and the vaccine's unproven efficacy. According to the court, therefore, the complaint implicated the professional liability policies' insuring agreements, which covered damages "resulting from a medical incident arising out of professional services."

The court also rejected the professional liability carrier's argument that it never consented to the settlement, noting that the carrier knew of the settlement negotiations and failed to raise any objections before the settlement was consummated. Similarly, the court determined that the carrier's contention that it had no duty to defend because it was never informed that its policy's retention had been satisfied was without merit because the carrier had voluntarily undertaken the hospital's defense by appointing counsel to defend the underlying action.

The court then considered the D&O carrier's arguments and agreed that the underlying complaint fell within the D&O policy's exclusion barring coverage for claims "based upon or attributable to any medical or professional malpractice[.]" It also held that the portion of the settlement representing a $500,000 payment for "pain and suffering" fell within the D&O policy's bodily injury exclusion, even if it was actually intended to compensate the plaintiffs for their attorneys' fees. In any event, the court concluded that the $500,000 payment would fall within the D&O policy's medical malpractice exclusion.

Finally, the court held that the trial court did not abuse its discretion in concluding that the professional liability insurer's actions did not constitute either statutory or common law "bad faith" under Illinois law. ■

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