Wiley Rein LLP

EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | June 2014

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Washington Mutual Liquidating Trust Coverage Case Is Not Ripe

The Delaware Supreme Court has held that a liquidating trust's coverage action against insurers of directors and officers of Washington Mutual, Inc. was not ripe. *XL Spec. Ins. Co. v. WMI Liquidating Trust*, No. 449, 2013 (Del. May 28, 2014). The Court therefore reversed the lower court's denial of the insurers' motion to dismiss the case. Wiley Rein represented the primary traditional D&O and Side-A insurers and presented the argument before the Court.

The trust filed the lawsuit against the insurers seeking a declaratory judgment and alleging breach of contract and breach of the duty of good faith based on the insurers' denial of coverage for a demand by Washington Mutual and a creditors committee against the company's former directors and officers. The trust sought a declaration that the demand was covered under policies issued by the insurers and asserted that it held a reserve of $18 million to potentially satisfy Washington Mutual's

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Professional Services Exclusion Bars Coverage for Claims Alleging Mismanagement of Mortgage-Backed Securities Investment Vehicle

The Superior Court of the District of Columbia has granted a group of insurers' motion to dismiss where a policy's unambiguous professional services exclusion barred coverage for claims arising from mismanagement of an offshore entity created to serve as a vehicle for investments in mortgage-backed securities. *Carlyle Inv. Mgmt. L.L.C. v. Ace Am. Ins. Co.,* No. 2013 CA 003190 B (D.C. Super. Ct. May 15, 2014). Wiley Rein represented one of the excess insurers.

In 2006, three policyholder investment companies operating as a global private equity firm organized a new company to invest in residential mortgage-backed securities. Following the

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Right to Independent Counsel Triggered By Possibility of Excess Judgment, Even Where Insurer Did Not Reserve Rights

Applying Illinois law, an Illinois federal district court has held that the "nontrivial possibility" of an excess judgment creates a conflict of interest that entitles the insured to independent counsel, even where the insurer is providing a defense *without* a reservation of rights. *Perma-Pipe, Inc., v. Liberty Surplus Ins. Corp.*, 2014 WL 1600570 (N.D. Ill. Apr. 21, 2014).

By letter dated October 26, 2010, the underlying claimant alleged that pipes manufactured by the insured had suffered "catastrophic failure" and that the claimant intended to hold the insured liable for the resulting damage. The insured's commercial liability carrier initially agreed to provide a defense, but reserved its rights with respect to coverage. Because the carrier's reservation of rights created a conflict of interest, the insured selected its long-time law firm to serve as independent counsel. In February 2012, the manufacturer was named in two lawsuits seeking a combined total of more than $40 million. At that point, the carrier notified the insured that it was withdrawing all bases upon which it had previously reserved rights and was exercising its right to defend the lawsuits through its choice of counsel. After the carrier ignored the insured's request to re-appoint its chosen attorneys as defense counsel, the insured filed suit.

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Settlements Returning Overdraft Fees Found to be Insurable "Damages"

A magistrate judge of the United States District Court for the Western District of Pennsylvania has issued a report and recommendation to the District Court concluding that a bank's settlements of lawsuits seeking the return of allegedly improper overdraft protection fees constituted covered "Damages" under the bank's professional liability insurance policies. *The PNC Financial Services Group, Inc. v. Houston Cas. Co.*, No. 13-cv-331 (W.D. Pa. May 21, 2014).

The bank's customers filed class action litigation alleging that the bank improperly manipulated the order in which it processed customers' transactions in order to cause their accounts to be overdrawn multiple times, maximizing the number of fees it could charge for "overdraft protection services." The bank settled the customer lawsuits, agreeing to pay over $90 million to customers who had been charged multiple overdraft fees. The bank sought coverage for the settlements under its professional liability policies. The policies afforded specified coverage for "Damages," defined to include "a judgment, award, surcharge or settlement as a result of a Claim" but not to include "fees, commissions or charges for Professional Services paid or payable to an Insured" or "monies either paid, accrued or due an Insured as the result of any loan, lease or extension of credit." The bank filed a declaratory judgment action seeking coverage for the settlements under the policies.

The insurers argued that the settlements did not constitute covered "Damages" because they represented the return of overdraft protection

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No Coverage for Legal Malpractice Action Based on Same Conduct as Alleged in Earlier Suit

The United States District Court for the Eastern District of Pennsylvania, applying Pennsylvania law, has held that there is no coverage for a legal malpractice action pursuant to a policy's prior knowledge exclusion and relation back provision where the attorney and his clients had previously been sued for the same conduct in an action for wrongful abuse of civil proceedings. *Ettinger & Assocs., LLC v. The Hartford/Twin City Fire Ins. Co.*, 2014 WL 1672946 (E.D. Pa. May 22, 2014).

The insured attorney represented his clients in a dispute with their realtor, which allegedly had told the clients that a lot adjacent to the lot they wished to purchase could not be subdivided. The clients later learned, prior to closing, that the owners of the adjacent lot had received a zoning variance to subdivide the lot. The clients nevertheless went through with the purchase and were able to resell the lot for a profit. The insured advised them that they still had viable claims against the realtor over the alleged misrepresentation, and commenced a lawsuit against the realtor on the clients' behalf.

The realtor repeatedly asserted that the lawsuit against it was frivolous and warned the insured attorney that it would sue his clients for fraud, abuse of process, and malicious prosecution if the lawsuit was not withdrawn. The court ultimately

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Allegations of General Misconduct by CEO Do Not Arise from Same "Interrelated Wrongful Acts" as Specific Allegations of Fraud

The United States District Court for the Southern District of New York, applying New York law, has held that FDIC demands against a failed bank's directors for their failure to act on allegations of improper conduct by the former CEO did not arise from the same Interrelated Wrongful Acts as a later lawsuit attacking the directors' oversight of the CEO in a specific fraud. *Glasscoff v. OneBeacon Midwest Ins. Co.*, 2014 WL 1876984 (S.D.N.Y. May 8, 2014).

The insureds, directors of a failed bank, sought coverage under a claims-made professional liability policy for a demand the FDIC made against them during the policy period. The FDIC asserted that the directors had committed breach of duty, negligence and gross negligence in connection with their roles in the failure of the bank, generally arising from their failure to oversee the bank to ensure compliance with the law and all regulatory authorities. The FDIC focused primarily on the directors' deficient policies, internal controls, and practices that ultimately led to the bank's failure, such as inadequate loan approval and monitoring policies and failure to establish adequate collection procedures and oversee employee compensation. The FDIC also alleged that the directors failed to act on allegations of improper conduct made against the former president and CEO of the bank.

After the policy period expired, individuals sued the directors under state securities laws for control person and indirect liability in connection with the former CEO's fraudulently inducing the plaintiffs to invest money with two customers of the bank, while actually using the investments to fund the CEO's self-dealing "round trip" transactions. The securities lawsuit alleged that the directors were liable for lax oversight of the CEO and for the bank's lack of sound corporate governance.

Under the policy, multiple claims arising out of Interrelated Wrongful Acts were deemed a single claim made at the time of the earliest claim. "Interrelated Wrongful Acts" was defined as "Wrongful Acts which have as a common

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Washington Appellate Court Holds Reasonable Covenant Judgment Sets Floor, Not Ceiling, for Bad Faith Damages

The Washington Court of Appeals, applying Washington law, has held that the amount of a reasonable covenant judgment sets the floor, not the ceiling, for the damages a jury may award in an insurance bad faith case. *Miller v. Kenny*, 2014 WL 1672946 (Wash. Ct. App. Apr. 28, 2014).

The underlying action arose out of an automobile accident in which three passengers were injured when their vehicle collided with a truck. The driver was covered by the vehicle owner's automobile insurance policy. One of the injured passengers brought suit against the driver, and each of the passengers made settlement demands to the insurer. The driver demanded that the insurer tender its policy limits, but the insurer offered only the limits of a primary policy and did not offer the limits of an umbrella policy until a few months before trial.

Shortly before the trial date, the driver reached a settlement with the three passengers for all of his available insurance proceeds. The driver assigned to the plaintiff passenger his rights to sue the insurer for bad faith in exchange for a covenant not to execute or enforce an excess judgment against him. The insurer stipulated to an order finding that $4.15 million was a

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Criminal Information Seeking Forfeiture Not a "Claim"

A Kansas federal court, applying Illinois law, has held that a criminal information seeking a fine and forfeiture did not subject an insured to "binding adjudication of liability for damages or other relief" as required to fall within a policy's definition of "Claim." *McCalla Corp. v. Certain Underwriters at Lloyd's*, 2014 WL 1745647 (D. Kan. May 1, 2014). The court also held that the forfeiture was both uninsurable under Illinois law and was a "fine or penalty" carved-out of the policy's definition of "loss."

A restaurant franchisee was investigated by federal officials for immigration-related offenses, which resulted in an information charging the franchisee with aiding and abetting the use of a false identification document. The franchisee pled guilty and paid a $300,000 fine and $100,000 forfeiture, and then sought coverage for the forfeiture and defense costs from its D&O carrier, which denied coverage.

The court held that the information did not constitute a "Claim" under the D&O policy. The policy defined "Claim" in relevant part as a "criminal . . . proceeding . . . in which they may be subjected to binding adjudication of liability for damages or other relief . . . ." The court rejected the notion that the criminal proceeding sought "damages," as a criminal case is penal in nature. The court also declined to classify the criminal proceeding as subjecting the insureds to liability for "other relief," as it deemed "relief" in this context to refer to a redress or benefit, including restitution, and not a fine or forfeiture.

The court also held that the $100,000 forfeiture did not qualify as "loss" under the D&O policy. Although the franchisee conceded that the $300,000 fine was a "tax, fine or penalty" carved-out of the policy's definition of "loss," it contended that the forfeiture was not. According to the court, the forfeiture statute "strips the lawbreaker of his ownership interest as a punishment." As such, the court "d[id] not hesitate" to conclude that the forfeiture was a "fine or penalty" carved-out of the definition of "loss." Moreover, the court noted that the amounts paid as a forfeiture represented the proceeds of a crime and thus were uninsurable under Illinois law. ■

Policy Language Prohibits Insurer from Recouping Defense Costs Advanced for Non-Covered Claim

Applying New Jersey law, a New York appellate court held that policy language prohibited an insurer from recouping defense costs advanced for a non-covered claim. *Nat'l Union Fire Ins. Co. v. Turner Const. Co.*, 2014 WL 1923586, No. 11927 (N.Y. App. Div. May 15, 2014).

An insured contractor and subcontractor tendered a lawsuit filed by a building owner to their commercial general liability insurer. The lawsuit alleged that the insureds committed breach of contract, breach of warranty, and negligence during the design and installation of a building curtain wall. The insureds tendered the lawsuit to their insurer, and the insurer agreed to provide a defense under a reservation of rights and filed a declaratory judgment seeking a determination that it had no duty to defend or indemnify the insureds for the lawsuit. The insurer also sought to recoup defense costs it advanced during the pendency of the coverage action.

After holding that the lawsuit was not covered under the commercial general liability policy because faulty design and installation do not constitute an "occurrence," the court held that the insurer could not recoup defense costs it advanced to the insureds in the underlying lawsuit. The court stated that an insurer is normally entitled to reimbursement of defense

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No Summary Judgment for Insurer Regarding Claims for Punitive Damages and Emotional Distress Arising After Insureds' Initial Claim

A West Virginia federal court, applying West Virginia law, has held that triable issues of fact existed with respect to insureds' claims for punitive damages and emotional distress after an insurer admitted that it had intentionally ignored the insureds' claim for coverage and failed to take necessary steps in handling that claim. *Bordas v. ALPS Corp.*, 2014 WL 1962264 (N.D. W. Va. May 15, 2014).

An insurer issued a professional liability policy to insureds who were named in an arbitration proceeding in May 2011. The insureds notified the insurer of the claim in May, August, and December 2011. The responsible claims professional at the insurer admitted that he ignored the insureds' coverage claim and did not take certain necessary steps in handling the claim because of the complexity of the matter. In February 2012, the insurer advised the insureds for the first time that it would retain defense counsel on behalf of the insureds and agreed to contact an attorney requested by the insureds. That attorney could not be retained, and, in August 2012, the insurer agreed to reimburse the insureds for fees incurred by the insureds' existing counsel. One of the insureds was ultimately found liable for $1,000 in damages in the underlying arbitration.

The insureds then initiated this coverage action and alleged breach of contract, breach of the implied covenant of good faith and fair dealing, infliction of emotional distress, and private causes of action for unfair trade practices and sought, among other relief, punitive damages. The insurer moved for partial summary judgment on two separate grounds. First, the insurer asserted that the insureds were not entitled to punitive damages because they could not prove that the insurer intentionally injured the insureds and thus could not prove that the insurer acted with actual malice in handling the insureds' claim. Second, the insurer asserted that the

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Professional Services Exclusion Applies to Global Administrative Decision

Applying Texas law, the United States District Court for the Southern District of Texas has held that a professional services exclusion precludes coverage where an underlying complaint alleges that an insured prison-management company denied inmates scheduled medications. *LCS Corrections Servs., Inc. v. Lexington Ins. Co.*, 2014 WL 1787771 (S.D. Tex. May 5, 2014).

The underlying case, brought by the estate of a prisoner who died in the insured's custody, alleged both medical malpractice and civil rights causes of action. After defending the insured, pursuant to a healthcare professional liability policy, in a trial regarding the medical malpractice allegations, the insurer disclaimed coverage for a subsequent civil rights trial pursuant to a "Professional Liability Exclusion" in a separate umbrella policy. The exclusion provided that "this policy shall not apply to liability arising out of the rendering of or failure to render professional services, or any error or omission, malpractice or mistake of a professional nature committed by or on behalf of the 'Insured' in the conduct of any of the 'Insured's' business activities."

In the coverage litigation that followed, the court held that the professional services exclusion precluded coverage for the underlying claim. The court rejected the policyholder's argument that the exclusion should not apply because the underlying complaint addressed administrative rather than professional conduct in light of a "global administrative decision to deprive inmates of … medical care." In arguing that the underlying complaint challenged a global administrative decision, the insured cited its allegations that "[t]here was no professional or medical discretion

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Contract Exclusion Does Not Apply to Breach of Settlement Agreement

An Idaho federal court has held that a contract exclusion does not bar coverage for purported wrongful acts that resulted in the breach of a settlement agreement under Idaho law. *Idaho Trust Bank v. Bancinsure, Inc.*, 2014 WL 1117027 (D. Idaho Mar. 20, 2014). The court also determined that an original and amended complaint were related and one Claim under the policy.

Following the filing of a lawsuit, the insured bank entered into a settlement agreement concerning the financing for a construction project. The agreement contained mutual releases that were to become effective upon the bank's issuance of future loans. After a dispute arose regarding one of the promised loans, the claimant filed an amended complaint with a count for breach of the settlement agreement. The jury ultimately returned a verdict in favor of the insured on the breach of settlement agreement count, the only count that proceeded to trial.

The insurer initially acknowledged a defense obligation as to the original complaint. After the court dismissed all counts in the action other than the breach of settlement agreement count, the insurer denied coverage based on the policy's contract exclusion, which barred coverage for claims arising out of "any assumption by the company . . . of any liability or obligation under any contract or agreement, or the failure to perform any contract or agreement, unless such company or insured person would have been liable even in the absence of such contract or agreement."

The court first held that the original complaint and amended complaint alleged interrelated wrongful acts (*i.e.*, acts that have as a "common nexus any fact, circumstance, situation, event, transaction or series of facts, circumstances, situations, events or transactions") and thus constituted a single claim made at the time the claimant filed

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Material Misrepresentation in Application Warrants Rescission of Crime Coverage

A California federal court has held that a tower of crime policies was rescinded as a result of a material misrepresentation on the application for the policies. *Kurtz v. Liberty Mutual Ins. Co.*, No. CV 11-7010 (C.D. Cal. Apr. 14, 2014). Accordingly, the policies were deemed void and afforded no coverage.

A property exchange sought to purchase primary and excess crime policies that provided coverage for employee theft and theft of clients' property. The application for the primary policy asked: "Are proceeds from 1031 transactions held in bank accounts segregated from those of your operating funds?" In an application dated July 2, 2007, the exchange answered "no." The primary insurer responded to the exchange's broker that the exchange was ineligible for coverage as a result of this answer. The broker advised the exchange to "correct" the application and it would resubmit the application to the primary insurer. In an application dated August 13, 2007, the exchange answered the question "yes," and the primary insurer issued a policy with a $5 million limit of liability. In addition, based on the later application, three excess insurers issued policies, each with a $5 million limit of liability.

A Chapter 7 bankruptcy petition was subsequently filed against the exchange, and the Chapter 7 trustee submitted claims to the insurers contending that the exchange had misappropriated funds in excess of $35 million. The primary carrier denied coverage, based in part on the position that the second application contained a material misrepresentation in response to the question regarding the segregation of funds.

In the coverage litigation that followed, the court held that the insurers were entitled to rescind the policies. First, the court concluded that the exchange's answer on its second application was both false and material. It was undisputed

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New York Court Rejects "Gap-Filling"

A New York appellate court held that an excess policy was not triggered by settlements in which the underlying insurers only paid a portion of their policy limits and the insured "filled the gap." *Forest Laboratories, Inc. v. Arch Ins. Co.*, 2014 WL 1673096 (N.Y. App. Div.).

The excess policy attached "in the event and only in the event of a reduction or exhaustion of the Underlying Limits of Liability, solely as a result of actual payment of a Covered Claim pursuant to the terms and conditions of the Underlying Insurance thereunder." The court found that such language unambiguously required the underlying insurance to be exhausted through "the actual payment" of the policies' limits before the excess policy is implicated.

In so holding, the appellate court affirmed the trial court's finding that while the defendant excess insurer "could certainly have done a better job of drafting its policy, and has many examples of better language to refer to accomplish that, the language it chose still protects [the excess insurer] in the situation, as here, where the underlying insurers never paid their full policy amounts due to settlements with [the insured]." ■

Insured Cannot "Fill the Gap" to Exhaust Limits of Underlying Policy

Applying Texas law, the United States District Court for the Eastern District of Texas has held that an excess policy is not triggered where the primary carrier paid less than its full policy limit and the insured "filled the gap" up to the limits of the primary policy. *Martin Res. Mgmt. Corp. v. Zurich Am. Ins. Co.*, No. 6:12cv758 (E.D. Tex. May 12, 2014).

An insured company sought coverage under its primary and excess D&O liability policies for a shareholder derivative suit. After the insurers denied coverage for the insured's payment of defense costs and a settlement, the primary carrier ultimately settled with the insured for less than the $10 million limit of the primary policy. The insured argued that its payment of the remainder of the limits up to $10 million exhausts the primary policy and triggers the excess policy. The excess insurer disagreed. Under its terms, the excess policy applies "only after all applicable Underlying Insurance with respect to an Insurance Product has been exhausted by actual payment under such Underlying Insurance."

The court held that the excess policy is not implicated because the primary carrier had not paid its full policy limit. According to the court, exhaustion under the terms of the excess policy required "actual payment" of "all applicable Underlying Insurance." Thus, only payment by the insurer can reduce or exhaust the underlying policy, and the insured's payments cannot be used to "fill the gap." Accordingly, the court granted summary judgment in favor of the excess insurer on the grounds that the excess policy is not triggered. ■

Policy with More Specific "Other Insurance" Provision Trumps Policy with More General Provision

The United States Court of Appeals for the Second Circuit, applying New York law, has held that, with respect two insurance policies providing coverage for malpractice claims against a nurse, the policy with an "other insurance" provision specifically referencing other excess insurance was excess to the policy with a more general "other insurance" provision. Thus, the court held that the more specific policy did not apply until the other policy had been exhausted. *WCHCC (Bermuda) Ltd. v. Granite State Ins. Co.*, 2014 WL 1758662 (2d Cir. May 5, 2014).

A nurse was insured for malpractice claims under two insurance policies: the hospital's policy and a separate policy providing coverage only to the nurse. After a malpractice claim against the nurse was settled, the hospital's insurer filed suit against the nurse's insurer, which had not participated in the settlement. At issue were the "other insurance" provisions of the policies. The hospital's policy provided that it was "excess of any valid and collectible insurance . . . whether such insurance . . . is stated to be primary, contingent, [or] excess." The nurse's policy provided that "if there is other insurance, which applies to the loss covered under this Policy, the other insurance must pay first."

Affirming the district court's grant of summary judgment and award of damages to the hospital's insurer, the Second Circuit held that the more explicit language of the hospital's policy made it excess to the nurse's policy. The court stated that, as a general matter, "when each of two insurance policies 'generally purports to be excess to the other, the excess coverage clauses are held to cancel out each other and each insurer contributes in proportion to its limit amount of the insurance.'" However, this rule does not

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Billing Activities Are Not Professional Services

An Oregon federal court has held that allegations of wrongful billing practices do not constitute wrongful acts under a business liability policy because billing activities are not professional services. *Bennett v. U.S. Liab. Ins. Grp.*, 2014 WL 1660654 (D. Or. Apr. 25, 2014).

The policyholder was sued for inappropriate billing and fee collection practices and sought coverage under a business liability policy. The insurer denied coverage on the basis that the complaint did not allege conduct within the policy's definition of "Wrongful Act" because the lawsuit did not concern the rendering of "Professional Services," which are defined as "services rendered to others for a fee solely in the conduct of the Insured's profession . . . ." The policy also limited coverage "to claims arising 'solely in the performance of Professional Services as a Training Specialist/ Seminar Conductor for others for a fee.'"

The court agreed with the insurer, finding that neither the policy's definition of "Professional Services" nor its specific definition of the policyholder's professional services as "Training Specialist/Seminar Conductor for others for a fee . . . encompass[ed] the inappropriate billing actions alleged in [the] underlying lawsuit." Specifically, the court rejected the policyholder's argument that because the policy's definition of her professional services expressly included the phrase "for a fee" that the parties intended the policy to cover billing and fee disputes. Instead, it determined that "for a fee" added nothing to the definition of "Professional Service" but "merely modifie[d] the type of 'Training Specialist/Seminar Conductor' services that are covered by the policy." The court noted that persuasive authority supported "its conclusion that 'professional services' do not include billing actions." The court also rejected the policyholder's argument that the policy's incorporation of exclusions relating to billing disputes implied coverage for billing activities because the lawsuit has to trigger the policy's insuring agreement before the exclusions have any application. ■

Settlements Returning Overdraft Fees Found to be Insurable "Damages *continued from page 2*

fees collected by the bank and were "fees" and monies paid as the result of a loan, falling within the carve-back to the "Damages" definition. The insurers also argued that Pennsylvania public policy precluded insurance coverage for the return of amounts an insured was alleged to have wrongfully collected from customers because such coverage would result in a windfall to the insured.

The Magistrate Judge concluded that the policies afforded coverage for the settlements. The court reasoned that the term "Damages" should be interpreted in favor of the insured and that carve-outs from that definition for fees or monies paid as the result of loans "were intended to exclude from coverage *first party* losses sustained by [the bank]." According to the court, "permitting the exceptions to the definition of '[d]amages' to apply to third-party claims for improperly assessed fees or loan interest charges would render coverage under the financial institution policy illusory." The court found additional support for its conclusion by reference to the policies' exclusion for claims brought about or contributed to in fact by "profit or remuneration gained by any Insured to which such insured is not legally entitled[,] as determined by a final adjudication in the underlying action." The court stated that the exclusion for improper profits would be "superfluous" if the exceptions to the definition of "Damages" applied to third-party claims. Finally, the court concluded that Pennsylvania public policy did not bar coverage for the settlements because the bank's "conduct has not been judicially determined to have been in bad faith or to violate consumer protection or criminal laws." For these reasons, the magistrate judge recommended granting the bank's motion for judgment on the pleadings seeking a determination that its settlements were covered and denying the insurers' cross-motion seeking a determination of no coverage. ■

Professional Services Exclusion Bars Coverage for Claims Alleging Mismanagement of Mortgage-Backed Securities Investment Vehicle *continued from page 1*

market collapse that wiped out the value of the mortgage-backed securities, investors sued the investment companies alleging forms of misrepresentation and mismanagement of the offshore entity. The policyholders sought defense costs under primary and excess manuscript private equity management and professional liability policies. The insurers denied coverage and moved to dismiss the coverage action based on an exclusion "for Loss in connection with any Professional Services Claim arising from Professional Services provided to" the offshore entity.

Applying the "eight corners rule," the court interpreted the exclusion under the terms of the policy and the allegations of the complaints. Contrary to the policyholders' urging, the court found that the relevant terms of the exclusion were expressly defined within the policy and declined to consider what the parties "may have intended" or may have expected the exclusion to mean. Although it noted that management liability claims "related to acts, errors, or omissions in corporate governance" are generally not excluded in professional liability policies, the court declined to depart from the plain meaning of the exclusion because it found no ambiguity in the primary policy's terms. The court added that "by using defined terms in bold letters in the Exclusion, those terms can have only one meaning." The primary policy defined "Professional Services" as including "the giving of financial, economic or investment advice," rendering "investment management services," "any activity relating to the offer, purchase or sale or solicitation for the purchase or sale" of portfolio entities, "providing advisory, consulting, [or] management . . . services," or "other similar or related services." Accordingly, the court applied the plain language of the defined terms, "Professional Services Claim" and "Professional Services," to the allegations in the investors' and liquidators' complaints. The court concluded that the policy defined "Professional Services" broadly enough to "include virtually all of the conduct alleged" because it found that each claim in each underlying complaint arose from the provision of Professional Services to the offshore entity. ■

Policy with More Specific "Other Insurance" Provision Trumps Policy with More General Provision *continued from page 8*

apply "'when its use would distort the meaning of the terms of the policies involved,' which 'turns on consideration of the purpose each policy was intended to serve as evidenced by both its stated coverage and the premium paid for it, as well as upon the wording of its provision concerning excess insurance.'"

Examining the policy language at issue, the court held that the hospital's policy was excess to the nurse's policy because the latter "contain[ed] no explicit statement about its position with respect to other *excess* policies." The court also stated that the difference in premiums for the two policies was not helpful to the determination of which was excess because they provided different coverage. One policy provided coverage for the entire hospital and its employees, the other provided coverage for one nurse. ■

Washington Appellate Court Holds Reasonable Covenant Judgment Sets Floor, Not Ceiling, for Bad Faith Damages *continued from page 4*

reasonable amount for the covenant judgment. At the trial on the assigned bad faith claims, the passenger moved for partial summary judgment establishing that the amount of the covenant judgment was only the minimal amount of harm for which the insurer could be liable. The trial court granted that motion, and the jury awarded $13 million to the passenger.

On appeal, the insurer contended that the jury should not have been permitted to award damages exceeding the amount set by the stipulated covenant judgment. The Court of Appeals disagreed and held that the damages to the insured are presumptively *at least* the amount of a covenant judgment, and that this amount is added to any other damages found by the jury. Because bad faith is a tort, the court reasoned, an insured would not be limited to economic damages. The court suggested that the insured's other damages might include the potential effect on his or her credit rating, damage to reputation, loss of business opportunities, loss of control of the case, loss of interest, attorneys' fees and costs, financial penalties for delayed payments, and emotional distress.

The Court of Appeals also addressed a number of evidentiary issues raised by the insurer. The court observed that evidence of the insurer's reserves should not ordinarily be admissible because it is irrelevant and the insurer should be solely concerned with ensuring the company's financial stability rather than with the prospect that the amount of reserves might be used against the insurer in later litigation. The court nevertheless found admissible evidence that the insurer had set its reserves significantly higher than its initial settlement offer because this evidence showed that the insurer "had known almost from day one that its insured was exposed to much greater liability." The court further held that testimony from a claims analyst regarding incentive programs for the insurer's employees that linked bonuses to cost control was appropriately admissible to show that the insurer had an improper motive to refuse to settle for policy limits. ■

The court nevertheless found admissible evidence that the insurer had set its reserves significantly higher than its initial settlement offer because this evidence showed that the insurer "had known almost from day one that its insured was exposed to much greater liability."

Policy Language Prohibits Insurer from Recouping Defense Costs Advanced for Non-Covered Claim *continued from page 5*

costs for a non-covered claim because the insured otherwise would be unjustly enriched but that such reimbursement would not be allowed if it contravened the policy's terms. The policy included an endorsement that provided that the insurer "agrees not to take action or recourse against any insured for loss paid or expenses incurred because of any claims made against this policy." The court held that this provision barred the insurer from recovering advanced defense costs. In doing so, the court rejected the insurer's argument that the provision applied only to covered claims because the endorsement did not differentiate between covered and uncovered claims. ■

Washington Mutual Liquidating Trust Coverage Case Is Not Ripe *continued from page 1*

indemnification obligations to the former directors and officers. The insurers moved to dismiss the lawsuit in the trial court, which denied the motion.

On an interlocutory appeal, the Delaware Supreme Court concluded that the trust's claims against the insurers were not ripe. According to the Court, the trust sought a declaratory judgment "that, if made, would necessarily be premised on uncertain and hypothetical facts and that ultimately may never become necessary." The Court reasoned that, because other policies were advancing defense costs, the trust had not pled facts to establish a reasonable likelihood that the targeted policies would be implicated. If the targeted policies were never implicated, any determination about coverage under those policies "would be based on pure speculation about future events."

The Court therefore reasoned that the dispute between the trust and the insurers had not yet assumed a "concrete and final form" and that the trust had not established a present or likely harm that established a cognizable interest in an immediate resolution of the coverage dispute. The potential that claims would go unpaid had yet to become a "real world" problem, the Court held. Moreover, the trust's establishment of a reserve to potentially satisfy Washington Mutual's indemnification obligations was an "illusory" harm to the trust because those "potential obligations exist whether or not coverage is available to the D&Os." The Court concluded that "[t]he Trust's only interest in having its dispute litigated now is apparently to receive judicial guidance about how much coverage *would* be available to the D&Os *if* the Trust were to initiate litigation against them." However, "[t]he Trust's desire to receive advice is not a cognizable interest that will justify a Delaware court exercising its jurisdiction to decide this dispute."

Because the Court found the trust's declaratory judgment count to be unripe, it concluded that the counts for breach of contract and breach of the implied duty of good faith and fair dealing necessarily were also unripe. ■

Contract Exclusion Does Not Apply to Breach of Settlement Agreement *continued from page 6*

the original complaint. According to the court, the complaints were interrelated because they involved the same parties, the same lending relationship, and the same underlying subject matter, and the later complaint would not have existed but for the attempts to settle the original complaint.

The court also held that the contract exclusion did not apply, agreeing with the insured's argument that the policy provided coverage for "lending wrongful acts," which included lending acts that arise from contracts. Even though the post-settlement lending relationship between the parties resulted from the settlement agreement, the court determined that the insured's conduct in connection with the subsequent loans that unraveled the agreement constituted a lending wrongful act. The court further opined that applying the exclusion would eliminate coverage for the risk the parties intended to cover. ■

continued from page 3

dismissed the suit against the realtor, and the realtor then filed a lawsuit against the clients and the insured attorney, alleging wrongful abuse of civil proceedings. The attorney defended both himself and his clients in the realtor's action.

Subsequently, the clients filed a malpractice claim against the attorney, alleging negligence both in advising them to bring suit against the realtor and in failing to advise them of the conflict of interest in his dual representation of himself and the clients in the realtor's lawsuit. The attorney sought coverage for the legal malpractice action under his claims-made professional liability policy and brought this declaratory judgment action against the insurer.

The court first held that the policy's prior knowledge exclusion barred coverage for the malpractice suit. Under Pennsylvania law, a prior knowledge exclusion applies where, based on the facts known to the insured, a reasonable attorney would have a basis to believe that he had breached a professional duty. The court found that the attorney had actual knowledge before the policy period that he had filed and continued to pursue the suit against the realtor, even after he was warned that the claims asserted were baseless, and that the realtor had filed suit against both him and his clients based on the filing and pursuit of the lawsuit against it. The court held that a reasonable attorney would know that the filing of a wrongful abuse of civil proceedings suit, which requires the plaintiff to prove that the attorney failed to perform in accordance with professional standards, constitutes an allegation of professional negligence for purposes of the prior knowledge exclusion. The court observed that the realtor had specifically alleged that the attorney knew that his clients' claims against the realtor were wrongful and malicious, and that he had encouraged and/or permitted his clients to pursue the claims even after being warned of the consequences. The court rejected the attorney's argument that he did not have a basis to believe that the clients would pursue a claim against him because they had "begged" that he represent them in the suit against the realtor, holding that an attorney's subjective understanding of his former clients' motives and desires is not controlling, and that the proper inquiry is what a reasonable attorney would have concluded.

The court also considered whether, in light of the policy's "relation back" provision, the malpractice suit constituted a claim first made during the policy period where the wrongful abuse of civil proceedings action had been filed prior to the policy period. The "relation back" provision stated that all claims arising out of the same or related negligent acts would be treated as a single claim deemed made when the first claim was made. The court concluded that the clients' malpractice allegations regarding the insured's bad advice related back to the realtor's suit because they shared a common nexus of facts and arose out of the same occurrence of wrongful acts—the attorney's alleged professional misconduct in filing and pursuing the suit against the realtor. Thus, that aspect of the malpractice action was not a claim first made during the policy period. That said, the court found that the clients' malpractice allegations regarding the attorney's dual representation of himself and the clients in the realtor's suit was unrelated to the realtor's claim and thus did not implicate the relation back provision. The court ultimately determined, however, that this conclusion was immaterial because the prior knowledge exclusion clearly barred coverage for the dual representation allegations because the attorney knew that he had undertaken the dual representation prior to the policy period. ■

Under Pennsylvania law, a prior knowledge exclusion applies where, based on the facts known to the insured, a reasonable attorney would have a basis to believe that he had breached a professional duty.

Right to Independent Counsel Triggered By Possibility of Excess Judgment, Even Where Insurer Did Not Reserve Rights *continued from page 2*

The court first held that Illinois law applied because Illinois had the most significant contacts with the insurance policy, given that: the insured was domiciled in Illinois; the contract was delivered to the insured in Illinois; and the premiums were paid by the insured from Illinois.

The court next held that the carrier breached its contractual duty to defend by refusing to pay for independent counsel. According to the court, the underlying lawsuits presented a "nontrivial probability" that an excess judgment would be rendered against the insured because the claimants sought more than $40 million—well in excess of the policy's $1 million per occurrence limit of liability. The court rejected the carrier's argument that there could not be a conflict of interest given that the insured knew about the possibility of an excess judgment from the outset of the lawsuits and had ample opportunity to notify its excess insurers. The court explained that because excess insurance applies only after the exhaustion of primary coverage, its existence did not vitiate the conflict between the insured and its primary carrier (*i.e.*, the possibility that, because the primary carrier's exposure is capped by the policy's limits, the carrier would opt to try the claims notwithstanding the risk that the insured could be held liable for a far greater amount). ■

No Summary Judgment for Insurer Regarding Claims for Punitive Damages and Emotional Distress Arising After Insureds' Initial Claim *continued from page 5*

insureds had been represented at all times in the underlying arbitration and therefore could not show emotional distress as a result of the claims handling.

The court rejected the insureds' argument regarding intentional injury, agreeing that, under West Virginia law, the "actual malice" standard for an award of punitive damages requires a party to introduce evidence of intentional injury, but concluding that that the insureds alleged facts sufficient to create a triable issue of fact. Specifically, the court noted that the insurer had admitted to ignoring the insurance claim and to "fail[ing] to meet reasonable good faith standards for claim handling . . . ."

The court also denied the insurer's motion for summary on the emotional distress claim. The insurer had argued that the insureds were in the same position as they would have been if the insurer had promptly provided a defense for them because they were represented by counsel throughout the underlying arbitration. The court concluded, though, that triable issues of fact existed because the insureds also alleged that they suffered emotional distress as a result of the insurer's delay in addressing coverage issues and "the feeling of abandonment from [the insurer]." ■

Professional Services Exclusion Applies to Global Administrative Decision *continued from page 6*

exercised in the failure to supply [the underlying claimant] his medications" and that "it was [the insured's] company policy . . . administratively administered by non-medical and non-professional management personnel . . . not to give inmates scheduled medications." The court found the asserted distinction unavailing, holding that, under the plain meaning of the umbrella policy, where an administrative decision resulted in a "failure to render professional services," the professional services exclusion applied. ■

Allegations of General Misconduct by CEO Do Not Arise from Same "Interrelated Wrongful Acts" as Specific Allegations of Fraud *continued from page 3*

nexus any fact, circumstance, situation, event, transaction or series of related facts, circumstances, situations, events or transactions." The directors contended that the FDIC demand and the securities lawsuit arose from the same Interrelated Wrongful Acts and therefore constituted a single claim made during the policy period. Accordingly, the securities lawsuit would be deemed made during the policy period.

The court disagreed. The court noted that, in prior cases with similar definitions of Interrelated Wrongful Acts, courts have required that claims share a "sufficient factual nexus" to be deemed a single claim. The court observed that "[w]hen courts have found a sufficient factual nexus, the two claims had specific overlapping facts." Here, the court considered the factual overlap between the two claims to be "tenuous at best." According to the court, "[i]f painted in broad strokes, the two Claims may arise out of the same deficient corporate structure or Plaintiffs' lack of oversight." However, the court concluded that references in the FDIC claim to the former CEO's "general misconduct" did not sufficiently overlap with "specific allegations of his fraud" by the securities plaintiffs. Accordingly, the court found that the FDIC demand and the securities lawsuit did not share a sufficient factual nexus and that no coverage was available for the securities lawsuit under the claims-made policy. ■

Material Misrepresentation in Application Warrants Rescission of Crime Coverage *continued from page 7*

that the exchange held its clients' funds in the same bank account in which it kept its operating expenses, despite its contrary answer on the application. The court noted that materiality could be shown by the fact that the question had been included on the application and that the insurers testified that they would not have issued the policies if the exchange had answered the question differently. Second, the court stated that the insurers did not need to prove that the misrepresentation was intentional. Third, the court decided that the insurers had not waived the right to deny coverage by failing to investigate the changed answer. The exchange had not provided inconsistent answers but different answers at different times, and the trustee presented no direct evidence that the insurers knew that the exchange had provided a false answer on the second application. Finally, the insurers raised rescission or material misrepresentation as affirmative defenses in the coverage litigation, which satisfied the requirements that the insurers give notice of the defense and offer to restore the benefits they had received under the contract.

The court also held that the insurers were not estopped from denying coverage for failure to comply with a regulation requiring a prompt response to an insured's claim. While the primary insurer did not formally deny the claim until almost four years after it was submitted, the trustee could not show any harm from the delay, particularly because the policies were deemed void *ab initio*. The court stated that estoppel could not be used to create coverage where none existed. ■

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