Wiley Rein LLP

EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | July 2014

ALSO IN THIS ISSUE

continued on page 2

Settlements Returning Overdraft Fees Are Not "Damages"

The United States District Court for the Western District of Pennsylvania, applying Pennsylvania law, has concluded that amounts paid to customers in settlement of lawsuits seeking the return of allegedly improper overdraft protection fees do not constitute covered "Damages" under a bank's professional liability insurance policies. *PNC Financial Services Group, Inc. v. Houston Cas. Co.*, No. 13-cv-331 (W.D. Pa. June 24, 2014). Wiley Rein represented the excess insurer in the litigation.

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, thus 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

continued on page 10

New York Court of Appeals Declines to Impose "As Soon As Reasonably Possible" Requirement on All Insurer Disclaimers

The New York Court of Appeals, applying New York law, has held that an insurer is not required to disclaim coverage for environmental contamination claims on late notice grounds "as soon as reasonably possible," a standard drawn from a statute applicable only to death and bodily injury claims arising out of New York accidents and brought under New York liability policies. *KeySpan Gas East Corp. v. Munich Reinsurance Am., Inc.*, 2014 WL 2573382 (N.Y. June 10, 2014). Wiley Rein represented *amicus curiae* Complex Insurance Claims Litigation Association in this case.

The insured electrical power and natural gas utility had been engaged in ongoing negotiations with state regulatory actors over a

continued on page 11

ALSO IN THIS ISSUE

Insured v. Insured Exclusion Bars Coverage for Entire Consolidated Action with Multiple Non-Insured Claimants

An Arizona federal court has held that an insured v. insured exclusion barred coverage for the entirety of a consolidated action originally consisting of five lawsuits, only one of which was brought by an insured claimant. *Amerco v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 2014 WL 2094198 (D. Ariz. May 20, 2014).

A former director of a holding company brought suit against current directors and officers of the holding company. Separately, four other claimants brought four separate suits against the holding company. The former director and the current directors and officers were insureds under the holding company's D&O policy, but the four other claimants were not. The five suits were consolidated by the trial court. Thereafter, the five claimants filed an amended, "merged" complaint in the consolidated action. The holding company sought coverage for the defendant directors and officers for the portion of the consolidated action involving the four noninsured claimants. The holding company's D&O insurer

continued on page 12

Offer to Settle Within Policy Limits Not a Requirement for Bad Faith Failure to Settle Claim

The United States District Court for the Western District of Washington, applying Washington law, has held that an offer to settle within policy limits is not a requirement for a bad faith failure to settle claim. *Cox v. Cont'l Cas. Co.*, 2014 WL 2011238 (W.D. Wash. May 16, 2014).

Hundreds of dental malpractice claims were made against an insured dentist. From 2008 to 2012, the insurer settled individual claims on behalf of its insured, rather than pursuing a global settlement of all claims. In 2012, the insurer attempted to negotiate a global settlement with the remaining claimants. After rejecting the proposed settlement, the claimants proceeded to arbitration and secured a judgment exceeding policy limits.

Pursuant to a settlement with the insured, and an assignment by the insured of his claims against the carrier, the claimants brought an action against the insurer stemming from the insurer's allegedly bad faith settlement conduct. The claimants alleged that there were multiple opportunities to pursue a global settlement, including in connection with a 2008 letter from counsel for a plurality of claimants, in which counsel demanded that the insurer tender the policy limits, and to which the insurer failed to respond.

The insurer moved to dismiss the bad faith claims, arguing that, in order to state a claim for bad faith failure to settle, the claimants were required to allege that a specific opportunity to settle the claims on a

continued on page 12

Privileges Protecting Communications Regarding Underlying Suit Not Waived by Placing Causation "At Issue"

The United States District Court for the Southern District of Florida, applying Florida and federal law, has held that a policyholder did not waive its attorney-client privilege or work product protection for communications regarding an underlying claim by bringing a negligence action against its insurance broker and agent. *Guarantee Ins. Co. v. Heffernan Ins. Brokers, Inc.*, 2014 WL 2653480 (S.D. Fla. June 13, 2014). The court also held that disclosure of a pre-litigation opinion letter analyzing the merits of the potential claim did constitute a subject-matter waiver.

The policyholder, a workers compensation insurer, was sued by a claimant alleging intentional infliction of emotional distress arising from the insurer's handling of a claim. Before the claimant filed suit, the insurer's counsel sent a letter to its primary insurer and its insurance broker, in which it analyzed the claim and essentially concluded that it was meritless.

Following settlement of the underlying dispute, the insurer brought the present action for negligence and breach of fiduciary duty against the agent and the broker for failure to timely notify its excess carrier of the claim. In part to advance their position that the alleged breach did not cause damage to the policyholder because the underlying suit was meritless, the agent and broker sought discovery of various materials related to the underlying claim. In response, the insurer argued that attorney-client privilege and work product protection shielded the materials from disclosure.

In its order, the court rejected the argument that the insurer waived its privilege by filing the negligence action and thereby placing the merits of the underlying suit "at issue." Instead, the court concluded that the insurer did not put causation

continued on page 11

Primary Insurer's Bad Faith Refusal to Settle Within Primary Limits Not Actionable Where Excess Insurer Could Not Prove It Would Have Accepted the Offer

The United States Court of Appeals for the Eleventh Circuit, applying Florida law, has held that an excess insurer could not prevail against a primary insurer for bad faith failure to settle when there was no evidence that the excess insurer would have agreed to the proposed settlement. *Westchester Fire Ins. Co. v. Mid-Continent Cas. Co.*, 2014 WL 2766764 (11th Cir. June 19, 2014).

A claimant sued an insured after suffering severe injuries while operating one of its concrete trucks. The insured tendered the suit to its insurers, and its primary insurer provided it with a defense. The primary insurer attempted to settle the underlying case within its $1 million policy limits, but it failed to do so. Ultimately, after a jury trial, the claimant was awarded $1.7 million in damages and nearly $300,000 in costs. At that point, the claimant offered to settle the case in its entirety for $1.6 million, but the primary insurer—without consulting an excess carrier—rejected the offer, apparently believing that the insured was entitled to a setoff for a greater amount than the discount on the judgment. After the court ruled that the setoff did not apply, the excess carrier sued the primary insurer and alleged that the primary carrier acted in bad faith by failing to notify it of the post-verdict settlement offer. In that suit between the insurers, the court found for the excess insurer and awarded it the difference between what it would have paid under the $1.6 million settlement versus what it was obligated to pay under the judgment of close to $2 million.

On appeal, the court reversed. The appellate court determined that the district court erred in awarding the excess carrier damages without any evidence of causation—i.e., that it would have accepted the $1.6 million offer had it been properly informed of it. The court held that, even assuming the primary insurer acted in bad faith, that bad faith was not actionable since it was not shown to have caused the harm at issue. ■

Notice Six Months Late Was Not "As Soon As Practicable"; No Prejudice Showing Required Under Claims-Made Policy

A New Jersey appellate court has held that coverage under a claims-made policy is barred by the insured's unexplained six month delay in notice and that the insurer is not required to show prejudice to deny coverage on late notice grounds under a claims-made policy. *Templo Fuente De Vida Corp. v. Nat'l Union Fire Ins. Co. of Pitt., Pa.*, 2014 WL 2533810 (N.J. Super. Ct. App. Div. June 6, 2014). The court also found that the insurer was not estopped from relying on the late notice defense.

The insured, a mortgage firm, sought coverage for a lawsuit arising out of the insured's alleged failure to secure a real estate loan under a claims-made D&O policy with a policy period of January 2006 to January 2007. The insurer denied coverage based on a number of grounds without specifically denying coverage on late notice grounds. After a settlement and assignment, the plaintiff-assignee filed coverage litigation. The trial court granted summary judgment in favor of the insurer, holding that coverage was barred because the insured mortgage firm did not provide notice of the claim "as soon as practicable."

The appellate court affirmed, noting that it had previously found that a delay of five and one-half months in notifying an insurer was not "as soon

continued on page 9

No Coverage for Claim When Insured Had Knowledge of Incident Before Prior Acts Date

The United States District Court for the District of New Jersey, applying New Jersey law, held that no coverage was available for a lawsuit because the insured was aware of a counseling incident before the policy's prior acts date. *Drew v. Church Mut. Ins. Co.*, 2014 WL 2436273 (D.N.J. May 29, 2014).

In 2011, the insured, a priest, was sued for breach of fiduciary duty and negligent infliction of emotional distress by a former parishioner. In 2009, the claimant sought counsel from the priest concerning his marriage, and the priest counseled the claimant not to take efforts to save his marriage and to accept his wife's decision to seek a divorce. After the counseling session, the claimant learned in 2009 that the priest was having an affair with claimant's wife and informed the priest of his knowledge of the affair by text message. The priest then fled the United States to avoid service of a potential suit by the claimant but later returned to the United States. The priest tendered the suit to the insurer, and the insurer denied coverage because the priest had knowledge of a counseling incident before the policy's prior acts date of July 1, 2010.

The policy was an occurrence-based policy that provided coverage for counseling incidents, which were defined as "any act or omission in the performance of counseling services" that took place during the policy period. The policy also provided prior acts coverage for any counseling incident that occurred before the inception of the policy provided that the insured had no knowledge of the "counseling incident" before the policy's July 1, 2010 prior acts date.

The court held that no coverage was available under the policy because the priest had knowledge of a counseling incident before July 1, 2010. Before July 1, 2010, the insured provided counseling services to the claimant, received a text message from the claimant concerning the affair, informed his superiors of the text message from claimant regarding the affair, and was advised to flee the country to avoid potential service of process. Thus, the court held that the insured's contention—that he was unaware of a counseling incident until he was served with claimant's complaint in October 2010—was "unpersuasive." ■

A Civil Contempt Proceeding Is Part of the Same "Claim" as the Underlying Civil Action from Which It Arises

Applying Washington law, a federal district court has held that a civil contempt proceeding is not a separate and distinct "claim" from the civil action from which it arises. *Great Am. Ins. Co. v. Sea Shepherd Conservation Soc'y*, 2014 WL 2170297 (W.D. Wash. May 23, 2014).

In December 2011, a research group filed suit against the insured environmental nonprofit organization, seeking to enjoin the nonprofit from attacking whaling research vessels. After the trial court rejected the research group's request for a preliminary injunction, the insured nonprofit moved forward with its annual "whale defense campaign" to prevent the research group from capturing whales in the Southern Ocean. In December 2012, after the campaign had begun, the United States Court of Appeals for the Ninth Circuit issued a *sua sponte* injunction barring the nonprofit from physically attacking or approaching any whaling vessels operated by the research group, pending an appeal of the trial court's ruling. Allegedly, the "whale defense campaign" proceeded notwithstanding the injunction, resulting in several purported violations of the Ninth Circuit's order. As a result, the research group filed a motion for contempt against the insured nonprofit and certain of its directors on February 13, 2013. That same day, the nonprofit sought coverage for the contempt proceeding from its insurer—the first time the nonprofit provided notice to the insurer of the research group's lawsuit.

continued on page 13

Other Insurers Impacted by Determination of Relationship of Claims are Necessary Parties in a Declaratory Judgment Action

A federal district court in California has held that, where an insured and an excess insurer dispute whether certain claims are related, and the resolution of that dispute would affect the availability of coverage under policies issued by other carriers, the other carriers are necessary and indispensable parties to the coverage litigation. *Navigators Ins. Co. v. Dialogic, Inc., et al.*, 2014 WL 2196403 (N.D. Cal. May 27, 2014).

An excess insurer under a 2007 policy filed a declaratory judgment action against a policyholder, seeking a determination of its coverage obligations. The policyholder was covered under a 2007 and a 2010 primary policy, both issued by the same insurer, and a 2010 excess policy issued by another excess insurer. In 2008, the policyholder filed a claim with its 2007 primary insurer, and the insurer provided a defense. In 2011, the policyholder faced another claim, and the policyholder and the 2007 excess insurer disputed whether the claim related back to the 2007 policy period.

In the coverage litigation between the 2007 excess carrier and the policyholder, the court held that the primary insurer under the 2007 and 2010 policies and the 2010 excess insurer were necessary parties under Rule 19 of the Federal Rules of Civil Procedure. Because the resolution of whether the 2008 and 2011 claims were related claims would determine the coverage obligations of both of those insurers, and because a judgment in this action would not otherwise bind those insurers, the court concluded that joinder of those insurers was necessary to avoid inconsistent judgments. After finding that joinder would destroy diversity, the court also held that the other insurers were indispensable parties, concluding that judgments rendered in their absence would prejudice them and that relief could not be fashioned in a way to avoid such prejudice. Therefore, the court granted the policyholder's motion to dismiss the 2007 excess insurer's declaratory judgement action. ■

Dishonesty Exclusion Does Not Preclude Insurer's Duty to Defend Where Underlying Complaint Does Not Allege Knowing or Willful Conduct

The United States District Court for the District of Maryland, applying Maryland law, has held that a dishonesty exclusion does not apply to preclude an insurer's duty to defend where an underlying complaint does not allege that the insured committed certain acts "knowingly or willfully" and does not contain any state of mind allegations against the insured. *Cornerstone Title & Escrow, Inc. v. Evanston Ins. Co.*, 2014 WL 2215822 (D. Md. May 28, 2014). The court also held that an exclusion for claims arising out of the Real Estate Settlement Procedures Act (RESPA) or "any similar state or local legislation" did not apply where the underlying alleged violations of a state consumer protection law are not similar to RESPA.

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 its own acts and those of the co-defendants, eventually reaching a settlement under which the policyholder paid $100,100 in restitution. After the insurer denied coverage for the claim, the policyholder filed suit against the insurer, alleging breach of its duties to defend and indemnify the insured.

The district court originally held that a personal profit exclusion and conversion exclusion

continued on page 12

Allegations Related to the Improper Characterization of an Employee for Purposes of Employee Benefits Program Constitutes an "Employee Benefits Injury"

A federal appellate court has held that ERISA claims related to the improper characterization of an employee as an independent contractor constituted an "employee benefits injury" under a comprehensive general liability policy. *Euchner-USA, Inc. v. Hartford Cas. Ins. Co.*, 2014 WL 2576348 (2d Cir. June 10, 2014). The U.S. Court of Appeals for the Second Circuit also determined that making such a characterization fell within the policy's definition of "administration" of an employee benefits plan.

A former employee sued the insured, alleging that the insured "improperly classified" the employee as an independent contractor, and asserted causes of action under ERISA. The insured sought coverage under a comprehensive general liability policy that provided coverage for "employee benefits injury," which was defined as an "injury that arises out of any negligent act, error or omission in the 'administration' of [the insured's] 'employee benefits program.'"

The policy defined "administration" to include "handling records in connection with 'employee benefits program.'"

The insurer denied coverage because the policy excluded coverage for fraudulent conduct and for liability resulting from the insured's failure to comply with regulatory reporting requirements associated with an employee benefits program. The insured filed a declaratory judgment action, and the lower court determined that the insurer did not have a duty to defend the insured.

In reversing the lower court's decision regarding the insurer's duty to defend, the appellate court determined that the former employee's ERISA claims raised a reasonable possibility of negligent conduct by the insured. The appellate court explained that the ERISA claims did not allege that the insured improperly classified the former

continued on page 13

Repayment of Improperly Received Funds May Constitute Covered Loss; Coverage is Not Precluded on Public Policy Grounds

A Pennsylvania federal court, applying Pennsylvania law, has held that the relief sought in connection with the repayment of funds paid to a charter school may constitute covered "loss" under the E&O policy issued to a charter school and did not constitute "tuition expenses," which were carved out of the definition of "loss." *Peerless Insurance Co. v. Pennsylvania Cyber Charter School*, 2014 WL 1917486 (W.D. Penn. May 13, 2014). The court also concluded that coverage for such loss was not excluded on public policy grounds because there was no indication that the insured acted negligently, intentionally, or otherwise unlawfully, and there would be no windfall to the insured from the insurer's reimbursement of the funds.

The insured charter school received payments from school districts for its kindergarten program, which admitted students one year younger than those admitted in the school districts' respective kindergarten programs. The Pennsylvania Supreme Court determined that, under the state's charter school statute, the insured was not entitled to such payments. Based on that decision, certain school districts filed suit against the charter school seeking repayment of those funds, along with interest. After the charter school sought coverage under the policy, the insurer agreed to defend the insured and filed a declaratory judgment action to determine its obligations. The insurer argued that the amounts sought by the school districts did not constitute "loss" under the policy because the repayment of funds was equitable relief in the form of restitution; that the amounts sought were excluded pursuant to the "tuition expense" carveout; and that the amounts were uninsurable under Pennsylvania public policy.

The court disagreed with the insurer, concluding that a covered "loss" may include a claim for restitutionary relief in certain circumstances. According to the court, if ordered to repay the funds, the insured would have expended its own resources to educate certain kindergarteners

continued on page 10

Co-Insurers Share Indemnity Obligations Where Policies Cover Same Loss

Applying Minnesota law, the United States District Court for the District of Minnesota has held that co-insurers share a common liability for an insured's settlement where both insurers' policies cover the same loss, even if they do not insure the same risk. *Lexington Ins. Co. v. Axis Surplus Ins. Co*., 2014 WL 2508730 (D. Minn. June 4, 2014).

An insured contractor was sued for alleged negligence in the design and construction of a building. The parties settled the claim with payments by, among others, the contractor's professional liability insurer, whose policy insured the contractor's negligence in architecture and engineering. The contractor's general liability insurer, whose policy insured property damage but not professional services, denied coverage and refused to contribute to the settlement. The professional liability insurer filed suit seeking contribution from the general liability insurer.

The general liability insurer moved to dismiss, arguing first that a right of contribution between co-insurers exists only as to defense costs, not indemnity payments. The court disagreed, finding that nothing in Minnesota law precludes contribution in indemnity cases, and, moreover, refusing to permit contribution would reward insurers who wrongfully fail to participate in a settlement.

The general liability insurer also argued that the two insurers do not have a common liability for the settlement because their two policies

continued on page 9

A-Side DIC D&O Policy Is Excess to Primary D&O Policy

A California federal court has held that an A-side difference in condition (DIC) D&O policy is excess to a primary D&O policy under California law, even where the A-side policy does not specifically identify the underlying insurance or a numerical attachment point. *Progressive Cas. Ins. Co. v. St. Paul Fire & Marine Ins. Co.*, 2014 WL 2212020 (N.D. Cal. May 28, 2014).

The primary D&O carrier sought contribution from an A-side carrier for certain defense and settlement costs. The A-side carrier maintained that its policy was excess to the primary policy and that it therefore had no contribution obligations. The court agreed that the A-side policy was excess based on the policy's insuring clause, which limited coverage to loss not "paid by any other insurance or as indemnification from any source." In so holding, the court rejected the primary carrier's argument that a policy must identify an underlying policy or predetermined amount of primary coverage to qualify as excess. The court further posited that, even if the A-side policy's language was ambiguous, extrinsic evidence demonstrated that the insured and the A-side insurer intended the policy to be excess to the primary policy. Because the two insurers' policies did not insure the same risk at the same level of coverage, the primary insurer could not seek contribution under California law. ■

Absence of Parallel State Court Proceedings Does Not Require Federal Court to Exercise Jurisdiction Under Declaratory Judgment Act

A federal appellate court has held that a lower court did not abuse its discretion in declining to exercise jurisdiction under the Declaratory Judgment Act even though there was not a parallel state court proceeding because the litigation addressed issues of state law that were better suited to be resolved in the state court system. *Rox-Ann Reifer v. Westport Ins. Corp.*, No. 13-2880 (1st Cir. April 29, 2014).

The insured, a law firm, was sued by one of its clients for malpractice and sought coverage under its claims-made insurance policy. The insurer denied coverage because the insured provided notice after the policy had expired. The insured admitted liability and assigned its rights under the policy to its client. The client filed a declaratory judgment action in state court seeking a declaration that the insurer "must pay" the judgment. The insurer removed to federal court, and the federal court declined to exercise jurisdiction and remanded the case to state court.

In the appeal that followed, the appellate court first determined that a remand order entered pursuant to the Declaratory Judgment Act is a "final decision" under 28 U.S.C. 1291 and is reviewable on appeal. Next, the court determined that the Declaratory Judgement Act applied, explaining that although the complaint sought a declaration that the insurer "must pay" the judgment, in substance the complaint sought a declaration that the insured was covered under the policy. The primary question, according to the court, was one of coverage, and the fact that additional recovery may flow from the court's declaration did not render the Declaratory Judgment Act inapplicable.

The court held that the district court did not abuse its discretion in declining jurisdiction because the insured's client raised issues of state law that were particularly within the purview of and better decided in the state court system. In reaching its decision, the court determined that the absence of a parallel state proceeding did not prohibit the district court from declining to exercise jurisdiction. According to the court, the existence or non-existence of parallel state court proceeding is only one of the factors that a lower court should consider when deciding whether to decline jurisdiction under the Declaratory Judgment Act. The appellate court also set forth a non-exhaustive list of seven other factors that a lower court should consider. ■

Federal Court Abstains from Declaratory Judgment Action in Favor of Underlying State Court Proceeding

A New Jersey federal court has abstained from exercising jurisdiction over a removed insurance coverage declaratory judgment action where the underlying action was ongoing in state court. *Owen v. Hartford Ins. Co.*, 2014 WL 2737842 (D.N.J. June 17, 2014). The court did so because the underlying action could have been consolidated with the coverage action, even though the insured had not yet moved to consolidate the two actions at the time of removal.

An officer of a local service organization allegedly crashed a car into a building, injuring an employee working in the building. The employee brought a tort claim against the officer in New Jersey state court. The officer filed a separate declaratory judgment action in state court, seeking a declaration that the organization's D&O carrier owed coverage. After the carrier removed the case to federal court, the officer sought to remand the case back to state court. The officer argued that, had the carrier not removed the case to federal court, he would have moved to consolidate the insurance coverage action with the underlying proceeding, and the federal court should thus abstain from jurisdiction.

The court decided to abstain from hearing the declaratory action and remanded the case to state court. Citing Third Circuit precedent, the court stated that it should give "substantial weight" to the presumption that it should abstain from jurisdiction over a declaratory judgment action if a parallel state proceeding existed. The court noted that it was "uncontroversial for New Jersey courts to consolidate an underlying personal injury action with a declaratory [coverage] action." Thus, because the insurance issues could "quite clearly" be adjudicated in the underlying litigation, the underlying litigation constituted a parallel proceeding. The court then held that declining jurisdiction would best serve the interests of avoiding "duplicative" litigation. ■

Notice Six Months Late Was Not "As Soon As Practicable"; No Prejudice Showing Required Under Claims-Made Policy *continued from page 4*

as practicable" under the terms of a similar policy, and that the corporation here had failed to produce any evidence explaining the six month delay. The court also held that because the policy was a claims-made policy, the insurer did not have to show prejudice to invoke the notification requirement of the policy. The court explained that to hold otherwise would result in "an unbargained-for expansion of coverage, *gratis*, resulting in the insurance company's exposure to risk substantially broader than that expressly insured against in the policy." Finally, the court rejected the plaintiff's argument that the insurer should be estopped from denying coverage because it did not specifically raise late notice as a defense in its three disclaimer letters. The court found that the insurer never conceded in its correspondence that the notice requirements had been met and gave no indication that the claim would ever be accepted. ■

Co-Insurers Share Indemnity Obligations Where Policies Cover Same Loss *continued from page 7*

insure different risks: faulty construction under the general liability policy and faulty design under the professional liability policy. The court held that co-insurers share a common liability if their policies cover the same loss, regardless of whether they also insure the same risk. Here, the court found, the professional liability insurer had alleged that the claim against the contractor and the settlement of that claim encompassed both negligent construction and negligent design. Thus, the court held that the general liability insurer and the professional liability insurer could share equal liability for the settlement. ■

Settlements Returning Overdraft Fees Are Not "Damages" *continued from page 1*

"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." 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 fees collected by the bank and thus were "fees," falling within the exception 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.

A Magistrate Judge issued a report and recommendation on the parties' cross-motions for judgment on the pleadings, concluding that the policies afforded coverage for the settlements. Following objection by the insurers, however, the District Court adopted the Magistrate Judge's report only in part. The District Court agreed with the insurers that the portions of the overdraft litigation settlements paid to class members fall within the fee exception because they constitute a refund of fees for professional services and concluded that there was "no other way for the Court to construe the Fee Exception other than to encompass the settlements at issue." The court also rejected the bank's reliance on the policies' so-called "personal profit exclusion," finding that no final adjudication was required under the policy language to apply the fee exception to the definition of "Damages." Accordingly, the court concluded that settlement amounts refunded to customers therefore were not covered.

The court determined, however, that other amounts paid in the settlements—plaintiffs' attorneys fees and expenses and incentive payments—did not fall within the fee exception and did constitute covered "Damages." Because these amounts exceeded the retention of the primary policy, the court concluded that coverage under the primary policy had been implicated to at least some extent. ■

Repayment of Improperly Received Funds May Constitute Covered Loss; Coverage is Not Precluded on Public Policy Grounds *continued from page 7*

without any compensation in return. Thus, there would be no windfall for the insured if the amount repaid were recoverable under the policy. The court also determined that, even if the return of the payments did not fall within the policy's definition of "loss," the "damages" and interest sought pursuant to the school districts' prayers for relief would constitute "loss" under the policy.

The court further concluded that the payments at issue were a legislatively-mandated funding transfer and did not constitute "tuition expenses," which the policy expressly carved out of the definition of "loss." The court also determined that the "loss" claimed by the insured was not uninsurable on public policy grounds. The court explained that the insured was collecting funds that it believed it was entitled to and was using those funds to educate children, and there was no indication that the insured's actions were negligent, intentional, or otherwise unlawful.

In rejecting the public policy argument, the court also relied on the fact that the insured would not receive a windfall if insurance were to reimburse the insured for its repayment obligations because the insured had to expend its resources in the first instance in educating the children.

Finally, the court determined that the policy's illegal profit exclusion did not apply to bar coverage because the underlying complaints did not allege that the insured knew it was violating the law or doing something improper when it requested the funds from the school districts, which funds were given without protest. Rather, at the time, the parties thought the payments were required by law. ■

New York Court of Appeals Declines to Impose "As Soon As Reasonably Possible" Requirement on All Insurer Disclaimers *continued from page 1*

number of years concerning the cleanup of seven manufactured gas plant sites. Several claims had been asserted against the utility relating to contamination emanating from the sites, and the utility began proactively investigating and remediating its sites. However, the utility did not notify its insurers of the potential for liability until many years later. Upon receiving notice, the insurers issued timely letters expressly reserving the right to deny coverage on late notice grounds and requesting more information from the insured.

In a subsequent coverage action between the utility and its excess carriers, the insurers included late notice as an affirmative defense in their answers. The insurers then sought summary judgment on the grounds of late notice. The trial court found as a matter of law that the utility's notice was late as to one site, but held that genuine disputes of material fact remained as to the other sites. The trial court specifically rejected the utility's contention that the insurers had waived the late-notice defense for each of the sites because they did not immediately disclaim coverage on that basis. On cross-appeals of the trial court's ruling, the intermediate appellate court held that the utility's notices at two sites were late as a matter of law. However, the court ruled that summary judgment was premature because material issues of fact remained as to whether the insurers had waived their rights to disclaim based on late notice. The intermediate appellate court stated that there would be a waiver if the insurers had not met an "obligation to issue a written notice of disclaimer on the ground of late notice as soon as reasonably possible after first learning of the accident or of grounds for disclaimer of liability."

The New York high court reversed, holding that the intermediate appellate court erred in stating that the insurers had an "obligation" to disclaim coverage "as soon as reasonably possible." The court observed that the lower court had essentially recited the language of New York Insurance Law § 3420(d), which applies only to cases involving death and bodily injury claims arising out of a New York accident and brought under a New York liability policy. The court held that the environmental contamination claims in this case did not fall within the scope of the statute and that the courts should not extend the statute's prompt disclaimer requirement beyond the limits set by the legislature. The court remanded the case to the intermediate appellate court to determine if, under the common law doctrine of waiver, there were triable issues of fact as to whether the insurers had clearly manifested an intent to abandon their late notice defense. ■

Privileges Protecting Communications Regarding Underlying Suit Not Waived by Placing Causation "At Issue" *continued from page 3*

directly at issue because its claims did not require that the conduct of the broker and the agent be the sole cause of its damages. For that reason, the court concluded that the "at issue" waiver, disfavored under Florida law, did not apply to the disputed materials. Applying federal law to the work product issues, the court similarly concluded that, because the insurer held the protection and did not attempt to prove any of its claims by disclosing an attorney-client communication, the insurer did not waive work product protection.

The court also concluded, however, that the insurer waived all protections with respect to a letter analyzing the merits of the potential litigation by disclosing the letter to its broker and primary insurer. The court rejected the insurer's argument that privilege protected the letter from disclosure to third parties under the "common interest doctrine" because it found that, at the time the insurer sent the letter with notice of the claim to its primary insurer, the parties did not share sufficient common interest because without prior notice of the claim, the primary insurer "could not have already accepted the defense obligations." The court concluded that, by intentionally disclosing the letter without indicating intent to prevent disclosure to third parties, the insurer waived its attorney-client privilege for communications regarding that specific subject matter. Balancing fairness to the parties, the court limited the scope of the waiver to the insurer's communications that took place before the underlying suit was filed. The court further concluded that the insurer only waived work product protection for the actual document that was produced. ■

Insured v. Insured Exclusion Bars Coverage for Entire Consolidated Action with Multiple Non-Insured Claimants *continued from page 2*

denied coverage for the consolidated action on the basis of an insured v. insured exclusion.

In the ensuing coverage action, the court agreed that the insured v. insured exclusion barred coverage for the consolidated action as a whole. The insured holding company argued that the consolidation was merely administrative, and the insured claimant did not actually assist with the entirety of the action. The court disagreed, noting that the insured claimant took a "leading role" in prosecuting the consolidated action and that he therefore participated in the action as a whole, and that the claimants chose to file a single merged complaint after consolidation. Accordingly, the court found that the action was not continued "totally independent of, and totally without the solicitation of, or assistance of, or active participation of, or intervention of" any insured as required by the exclusion's carveback. The court also noted that the policy lacked an express allocation provision, and that the policy thus did not contemplate scenarios where an exclusion could bar coverage for only a portion of loss in connection with a claim. ■

Offer to Settle Within Policy Limits Not a Requirement for Bad Faith Failure to Settle Claim *continued from page 2*

global basis existed. In rejecting this argument, the court ruled that such an opportunity is not an explicit element of the tort of bad faith in Washington. According to the court, the claimants need merely allege that a receptive climate for settlement existed, and not that there was an "unmistakable offer from all known and potential claimants accompanied by an explicit promise of a release from liability," as suggested by the insurer. The court held that the claimants plausibly alleged that the insurers acted in bad faith by ignoring the 2008 letter from counsel, and instead pursuing a strategy of settling each claim individually, which eventually resulted in a judgment in excess of policy limits against the insured. ■

Dishonesty Exclusion Does Not Preclude Insurer's Duty to Defend Where Underlying Complaint Does Not Allege Knowing or Willful Conduct *continued from page 6*

precluded a duty to defend. On appeal, the United States Court of Appeals for the Fourth Circuit reversed and remanded the case to the district court to consider the applicability of the dishonesty exclusion and RESPA exclusion. (A prior Executive Summary article addressing the Fourth Circuit's opinion can be found here.)

On remand, the district court first addressed the dishonesty exclusion, which barred coverage for claims "based upon or arising out of any dishonest, deliberately fraudulent, malicious, willful or knowingly wrongful act or omission committed by or at the direction of the Insured." The court noted that, as to the acts of the insured title insurer, the underlying complaint only alleged that the insured delivered the settlement checks to the other co-defendants and that the statutory violations at issue were not "by or at the direction of the Insured." The court also stressed that neither of the statutes at issue—*i.e.*, the Maryland Consumer Protection Act (CPA) and Protection of Homeowners in Foreclosure Act (PHIFA)—"require that a defendant acted knowingly or willfully in order to be held liable" and that the underlying complaint "does not specifically attribute any state of mind to [the insured]" such that any potential liability would not necessarily implicate the dishonesty exclusion. Based on this reasoning, the court held that "there remains a potentiality—however slight—that those claims may fall outside of" the dishonesty exclusion.

Next, the court held that the exclusion precluding coverage for claims "based upon or arising out of [RESPA] or any similar state or local legislation" did not apply to relieve the insurer of its duty to defend. The court recognized that, while RESPA regulates real estate settlements and PHIFA and the CPA regulate aspects of real estate transactions, PHIFA regulates foreclosure consulting services and the CPA affects consumer goods, services, and contracts. The court held that "[a]lthough all three may share the ultimate goal of protecting consumers, vague coincidence of purpose is plainly not what is meant by the exclusion." ■

A Civil Contempt Proceeding Is Part of the Same "Claim" as the Underlying Civil Action from Which It Arises *continued from page 5*

In the coverage litigation that followed, the nonprofit's insurer asserted that the contempt proceeding, together with the underlying litigation, constituted a single "claim" that was first made in December 2011 but not reported until February 13, 2013, meaning that there was no coverage for the matter under either the 2011-2012 policy *or* the 2012-2013 policy, both of which were issued by the insurer on a claims-made-and-reported basis. The court agreed.

First, the court held that the 2011-2012 policy did not afford coverage for the underlying litigation or the associated contempt proceeding. The court declined to decide whether the policy was properly construed as a claims-made or claims-made-and-reported policy because, in either event, the insured did not report the litigation or the contempt proceeding until February 2013, "well beyond" the 2011-2012 policy's notice deadline. The court also rejected the nonprofit's argument that an insurer must show prejudice in order to deny coverage under a claims-made policy.

Addressing coverage under the 2012-2013 policy, the court held that the underlying litigation and the contempt proceeding constituted a single "claim" that was first made in December 2011, prior to the inception of the policy period. The court noted that the policy's definition of "claim" includes a "civil proceeding, including any appeals therefrom." According to the court, the contempt proceeding was "indisputedly part of an 'appeal' from" the underlying litigation. The court also reasoned that federal courts construe a civil contempt proceeding to be a continuance of the underlying litigation rather than a separate civil proceeding, even where the contempt proceeding involves new allegations and new contemnors, and even where the contempt proceeding is governed by a separate scheduling order.

Finally, the court held that, even if the contempt proceeding were properly considered a separate "claim," it would nonetheless be treated as a single claim with the underlying litigation because both proceedings involve "the same Wrongful Act or Related Wrongful Acts," within the meaning of the 2012-2013 policy's related claims provision. The court reasoned that the underlying litigation and the contempt proceeding were causally connected because, but for the initiation of the underlying litigation, there would have been no basis for the contempt proceeding. Thus, the court held that the 2012-2013 policy did not afford coverage for the contempt proceeding because, together with the underlying litigation, it constituted a single claim that was first made prior to the inception of the 2012-2013 policy. ■

Allegations Related to the Improper Characterization of an Employee for Purposes of Employee Benefits Program Constitutes an "Employee Benefits Injury" *continued from page 6*

employee as a contractor with the purpose of interfering with her benefits, and the claims did not require that intent be established. Although the complaint stated that the insured "improperly and unlawfully" characterized the former employee as a contractor, the appellate court determined that the allegation did not fall within the exclusion for intentional wrongdoing because it was a legal conclusion and not a factual allegation.

The appellate court also found that determining the former employee's eligibility for the 401-K plan may reasonably be considered part of the program's recordkeeping function. The appellate court disagreed with the insurer's argument that "administration" entailed only ministerial actions, noting that classification of an individual as either an independent contractor or employee for purposes of eligibility is not a matter of discretion. ■

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