Wiley Rein LLP

EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | January 2015

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Communications Stating That Insured May Be Liable For Damages Constitute a "Claim"

A Minnesota federal court, applying Minnesota law, has held that no coverage exists under a general liability policy for claims involving a defective adhesive product because the claims were first made before the policy incepted. *Ritrama, Inc. v. HDI-Gerling Am. Ins. Co.*, 2014 WL 4829088 (D. Minn. Sept. 29, 2014). In so holding, the court concluded that communications sent to the insured stating that the insured may be liable for damages constituted a "claim."

The insurer issued a general liability policy to a manufacturer of cast vinyl adhesives used in labels for various products providing coverage for claims first made during the policy period of March 31, 2009 to March 31, 2011. Beginning in February 2008, the insured received communications detailing alleged deficiencies with its product. In September 2008, the claimant provided the insured with a spreadsheet of multiple alleged claims involving the defective product totaling monetary damages of approximately

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Contract Exclusion Does Not Bar Coverage for Intentional Misrepresentations During Pre-Contract Negotiations

The United States District Court for the District of Rhode Island, applying Rhode Island law, has held that a contract exclusion did not bar coverage for a jury verdict holding in part that the insured's intentional misrepresentations had induced the claimant to enter into a disputed contract. *TranSched Sys. Ltd. v. Fed. Ins. Co.*, 2014 WL 7251184 (D.R.I. Dec. 22, 2014).

The claimant entered into an agreement with the insured to purchase certain transportation software assets. The software assets were not delivered as expected, and the claimant later learned that two of the insured's vice presidents had made material misrepresentations about the time frame and viability of the software during the negotiation and execution of the agreement.

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Notice of Violation Alleging Refusal to Tender Benefits Owed Constitutes a "Claim"

The United States District Court for the Middle District of Florida, applying Florida law, has held that a civil remedy notice of insurer violation made pursuant to a bad-faith statute and alleging an insurer's failure to tender benefits owed constitutes a "claim" made against the insurer. *Windhaven Managers, Inc. v. Chartis Specialty Ins. Co,* 2014 WL 6674609 (M.D. Fla. Nov. 24, 2014).

An insurer issued a claims-made professional liability policy to an automobile insurer for the policy period of May 1, 2011 to May 1, 2012. The policy defined a "claim" as a "written demand for monetary damages" or a "judicial . . . proceeding in which monetary damages are sought." The policy deemed a claim first made against the insured when "written notice of such [c]laim is received by the [i]nsured, or by the [insurer], whichever comes first."

In December 2009, after suffering an injury in a car accident, the underlying claimant sued the automobile insurer, alleging that she was entitled to the motor vehicle policy's limit. That same month, the underlying claimant filed a civil remedy notice of insurer violation (CRN) pursuant to Florida's bad-faith statute, alleging that her automobile insurer had refused to settle her claim in bad faith and refused to tender benefits owed under her policy. On July 14, 2011, the underlying claimant filed a complaint against the automobile insurer for bad faith failure to settle. On August 26, 2011, the automobile insurer sent its professional-liability insurer notice of a "possible claim" made against it. The professional-liability insurer denied coverage, arguing that, *inter alia*, the claim was not first made during the claims-made policy period.

In the coverage litigation that followed, the court held that, because the CRN detailed the allegations behind the underlying bad-faith failure to settle action and because it demanded payment of benefits owed under the automobile insurance policy, the CRN constituted a "written demand for monetary damages" and hence a "claim" first made in 2009, before the applicable policy period. In the court's view, "[b]ecause this [claim] was outside the policy period, no coverage exist[ed] under the policy." ■

Business Pursuits Exclusion Bars Coverage for Activities after Alleged Ponzi Schemer Left Law Firm

A federal magistrate judge has determined that legal malpractice insurers need not defend an attorney for claims arising from his activities as manager of a fraudulent investment fund after settling allegations covering the time period he worked as a lawyer at the insured firm. *Duckson v. Cont'l Cas. Co.*, No. 14-cv-1465 (D. Minn. Dec. 8, 2014).

Investors sued an attorney for drafting materially misleading private placement memoranda for an investment fund. The attorney drafted the memoranda while employed by the insured law firm as the fund's outside counsel and later also as a member and manager of the fund and its investment manager. The alleged fraud continued after the attorney left the insured law firm. The law firm settled with the claimants, who released all claims against the attorney arising during the time he was employed by the insured law firm. Thereafter, the firm's legal malpractice insurers withdrew the defense of the attorney based on the policy's exclusion for claims "based on or arising out of an Insured's capacity as . . . a former, existing or prospective officer, director, shareholder, partner, manager, member or trustee of any entity including . . . investment fund or trust, if such entity is not named in the Declarations."

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Professional Association's Investigation of Ethical Complaints and Credentialing of Members Constitute Professional Services

Applying Minnesota law, a federal district court in Minnesota has held that an association's certification of one of its members as a radiologic technologist constitutes professional services. *Assurance Co. of Am. V.A. Registry of Radiologic Techs*., 2014 WL 6772742 (D. Minn. Dec. 1, 2014).

An association of radiologic technologists was sued in numerous lawsuits by plaintiffs alleging that one of the association's members had caused them to contract Hepatitis C. The plaintiffs alleged that the association had previously received a complaint that the technologist, who had Hepatitis C, was using hospital syringes to inject himself with narcotics and then reusing those syringes on patients. The association had investigated the complaint and ultimately determined to take no action against the technologist and later re-certified him, which the plaintiffs contend was negligent.

The association sought coverage under its commercial general liability insurance policy, which precluded coverage for bodily injury or property damages arising out of the rendering or failure to render professional services. Although "professional services" was not defined in the policy, the exclusion provided certain examples of professional services. The insurer argued that the association's credentialing of the technologist was a professional service. The association argued that credentialing was not a

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No Rescission of Renewal Policy Where Original Application Not Incorporated into Application for Renewed Policy

Applying Illinois law, a state appellate court has reversed the rescission of a renewed insurance policy, holding that a misrepresentation in an original application does not justify rescission of a renewal of the policy where neither the renewal application nor the resulting policy incorporated the initial application. *Illinois State Bar Ass'n Mut. Ins. Co. v. Brooks, Adams & Taurulis,* 2014 WL 7273947 (Ill. App. Ct. Dec. 23, 2014). In addition, the court reversed the rescission of the original policy, holding that a client asserted a claim against an insured attorney when the client requested relief for alleged misconduct, not when the client subsequently filed a lawsuit against the attorney.

In November 2002, a music company notified its attorney that it would seek redress after the insured attorney's alleged negligence caused the dismissal of the client's breach of contract action. More than two years later, the client sued the attorney and his law firm for legal malpractice. Prior to that suit, the attorney changed law firms, and when the new firm completed an application to change its malpractice insurance in December 2007, the firm represented that no claims had been made against its members in the last five years. A year later, the firm applied for and obtained a renewal of the policy. During that policy period, three individuals filed claims against the firm. The insurer brought a coverage action seeking rescission of both policies based on misrepresentations in the firm's application for the original policy. The trial court held that both policies were rescinded.

On appeal, the firm first argued that no evidence justified rescission of the renewal policy. Citing Illinois statutory law and the general principle that "public policy disfavors insurance forfeiture," the court agreed, concluding that it could not "add language to the Code to make one misrepresentation defeat all subsequent insurance contracts, when the insured made no misrepresentation in its application for the subsequent insurance."

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Coverage Determined By Date Notice Is Received By Insurer, Not By Date It Is Sent

Applying Florida law, the United States Court of Appeals for the Eleventh Circuit held that notice under a claims-made-and-reported policy must be received by the insurer during the policy period, and not merely sent by the insured during the policy period. *Lake Buena Vista Vacation Resort L.C. v. Gotham Ins. Co.*, 2014 WL 7003820 (11th Cir. Dec. 19, 2014).

The insured performed escrow services for a client. After money was stolen from the escrow account, the client brought suit against the insured. The insured had a claims-made-and-reported E&O policy that required a claim to be reported to the insurer in writing. Because the insured failed to make its monthly premium payment, the insurer cancelled the policy effective at 12:01 a.m. on October 4, 2007. That same day, the insured sent notice of the suit to the insurer, which the insurer received on October 10, 2007. The insurer denied coverage for the claim.

In the litigation that followed, the court rejected the argument that by mailing the notice before the policy period ended, the insured timely reported the claim to the insurer. According to the court, to be effective, the notice of claim had to be received by the insurer during the policy period. Therefore, because the insurer did not receive written notice of the claim from the insured until six days after the cancellation date, the policy did not afford coverage for the suit. ■

Civil Lawsuit Alleging Ethical Violations Is Not a "Disciplinary Proceeding" Under a Lawyers Professional Liability Policy

Applying Missouri law, a federal district court has held that a civil lawsuit alleging ethical violations by a law firm and its attorneys does not constitute a "disciplinary proceeding" under a lawyers professional liability policy. *The Hullverson Law Firm, P.C. v. Liberty Ins. Underwriters, Inc.* (E.D. Mo. Oct. 22, 2014).

The court also held that a series of disciplinary proceedings brought against five different insured attorneys were subject to the policy's limit of liability applicable to "any one" disciplinary proceeding because they were based on one complaint that alleged related wrongful acts and because the matters were treated as a single disciplinary proceeding by all of the involved parties.

A consumer sued the insured law firm and several of its attorneys in federal court, alleging that the attorneys engaged in false and misleading advertising in violation of the Lanham Act and various Missouri Supreme Court Rules of Professional Conduct. The consumer delivered a copy of the civil complaint to the Missouri Office of Chief Disciplinary Counsel, which initiated five disciplinary proceedings against the five insured attorneys. The attorneys sought coverage under their professional liability policy for both the civil lawsuit and the disciplinary proceedings. The policy included a "Special Benefits" coverage part, which provided that the insurer would reimburse up to $25,000 in reasonable costs incurred in the defense of "any one disciplinary proceeding" and up to $100,000 in the aggregate for "all disciplinary proceedings." The insurer issued a check to the law firm for $25,000 and denied any further liability under the "Special Benefits" coverage part. In response, the attorneys argued that the $100,000 aggregate limit applied because (1) the civil suit asserted five separate "disciplinary proceedings," given that it alleged ethical violations against five different attorneys; and (2) the Missouri Office of Chief Disciplinary

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Health Care Professional Services Exclusion Applies Where Injury Would Not Exist But-For Failure to Provide Medical Attention

The Supreme Court of Mississippi held that a health care professional services exclusion applies where the damage alleged in an underlying claim would not exist but-for paramedics' failure to provide medical attention under Mississippi law. *Gray v. Arch Spec. Ins. Co.*, No. 2013-CA-01124-SCT (Miss. Oct. 23, 2014).

The underlying claimants filed a wrongful death suit against the insureds, alleging that the paramedics employed by the insureds were negligent in rendering medical care to an automobile accident victim, resulting in his death. The underlying claim also alleged negligent hiring, negligent training, and failure to implement appropriate triage protocols. After the insurer denied coverage, the underlying claimants procured a default judgment against the insureds. The underlying claimants subsequently filed a writ of garnishment against the insurer. The insurer's policy excluded coverage for damages "result[ing] from the performance or failure to perform 'health care professional services,'" defined in pertinent part as "[m]edical, surgical, dental, x-ray, nursing, mental, or other similar health care professional services or treatments."

Accepting the underlying claimants' allegations as true in light of the default judgment entered against the insureds, the Mississippi high court held that the health care professional exclusion barred coverage for the underlying claim given that "the [underlying claimants] would not have been damaged but for the paramedics' failure to provide medical attention, which [wa]s an excluded service" under the exclusion. According to the court, the "exclusion applie[d] to damages arising from the failure to provide medical services regardless of the theories of liability asserted." Accordingly, the court rejected the underlying claimants' argument that the underlying claim's allegations of negligent hiring, negligent training, and failure to implement appropriate protocols triggered coverage. ■

Automated Calls to Advertise Insurance Services Do Not Constitute Professional Services

An Illinois intermediate appellate court has ruled that an insurance agent/broker's automated calls to advertise its services did not constitute "professional services" and therefore did not trigger coverage under its professional liability policy. *Margulis v. BCS Ins. Co.*, 2014 IL App (1st) 140286 (Ill. App. Ct. Nov. 26, 2014).

The policyholder, an insurance agent/broker, was named in an underlying class action lawsuit alleging that it violated the Telephone Consumer Protection Act (TCPA) by making unsolicited automated telephone calls advertising its services. It tendered that suit to its professional liability insurer, but the insurer disclaimed coverage. The policyholder later settled with the underlying plaintiffs subject to the plaintiffs' agreement that they would seek to recover solely from the policyholder's insurer. The plaintiffs then filed a declaratory judgment action against the insurer. The trial court granted summary judgment in the insurer's favor, holding that the policy did not afford coverage.

On appeal, the court affirmed the decision in favor of the insurer, holding that the allegedly negligent acts of the policyholder—transmitting automated, unsolicited telephone calls advertising its services—did not arise out of the conduct of the policyholder's business in rendering services

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Automated Calls to Advertise Insurance Services Do Not Constitute Professional Services

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for others as an insurance agent, general agent, or broker. The court rejected the plaintiffs' argument that there was a "substantial nexus" between the insured's telemarketing activity and its business as an insurance professional, noting that the policy did not contain any "nexus" language. The court also observed that the call recipients were not the policyholder's customers, and thus that it could not have been rendering services for the call recipients as an agent or broker. Instead, the court ruled that the policy was not triggered because it would effectively have to "delete the 'rendering services for others' language" from the policy's insuring agreement in order to find coverage. ■

Civil Lawsuit Alleging Ethical Violations Is Not a "Disciplinary Proceeding" Under a Lawyers Professional Liability Policy

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Counsel opened five different file numbers, likewise representing five different "disciplinary proceedings" against five different attorneys.

In an opinion addressing only the availability of coverage under the "Special Benefits" coverage part, the court first held that the civil lawsuit was not a "disciplinary proceeding" within the meaning of the policy. The court explained that the policy defined "claim" to include a lawsuit, an arbitration proceeding, *or* a disciplinary proceeding—a distinction that necessarily recognizes that a lawsuit is *not* a disciplinary proceeding. The court further noted that the policy's definition of "disciplinary proceeding" requires that the proceeding be brought "before a tribunal of competent jurisdiction which shall make a determination" as to whether the alleged misconduct warrants discipline. Here, the court in the underlying civil action dismissed the consumer's allegations of ethical violations without making any determination regarding discipline based on its conclusion that the allegations did not support a civil cause of action.

The court next held that the five disciplinary proceedings opened by the Missouri Office of Chief Disciplinary Counsel were properly treated as a single disciplinary proceeding pursuant to the policy provision stating that "[c]laims alleging, based upon, arising out of or attributable to the same or related wrongful acts shall be treated as a single claim." The court rejected the attorneys' argument that applying the related claims provision to disciplinary proceedings rendered the $100,000 aggregate limit for "all disciplinary proceedings" meaningless. The court explained that, if separate disciplinary complaints alleging unrelated wrongful acts were brought during the policy period, the law firm might be entitled to the aggregate limit. The court also disagreed that the use of the undefined term "related" rendered the policy ambiguous, pointing to past Missouri court decisions holding that the term "related" is broad but unambiguous and encompasses both causal and logical connections. The court noted that, notwithstanding the use of five different file numbers and the naming of five different attorneys, the disciplinary proceedings were all based on a single consumer complaint that alleged related wrongful acts by the insureds. The court thus concluded that, even putting aside the policy's related claims provision, the $25,000 single limit applied because the matters were treated as a single disciplinary proceeding by everyone involved, including the insureds. ■

Contract Exclusion Does Not Bar Coverage for Intentional Misrepresentations During Pre-Contract Negotiations *continued from page 1*

The claimant obtained a jury verdict against the insured in the underlying action in which the jury found against the insured on three grounds: (1) intentional misrepresentation, (2) breach of contract, and (3) breach of the covenant of good faith and fair dealing. The jury awarded the claimant $500,000 but did not allocate the damages among the three counts.

The claimant brought suit against the insurer seeking satisfaction of the underlying judgment. The insurer argued that two exclusions in the policy—the contract exclusion and the fraud exclusion—barred coverage for any damages awarded for the insured's intentional misrepresentations.

Ruling on the parties' cross-motions for summary judgment, the court considered the policy's contract exclusion, which barred coverage for claims arising from the insured's liability under a contract. The court found that the evidence at the underlying trial supported the claimant's assertion that the misrepresentation claims concerned only pre-transaction conduct. The court therefore held that the intentional misrepresentation claims were not excluded from coverage because the misrepresentations were made *before* the agreement was executed, and the agreement therefore was not the cause of the intentional misrepresentation claim but the result of it. Because the insured's tortious conduct preceded the agreement, it was independent of the terms of the contract itself.

The court also looked to the policy's fraud exclusion, which barred coverage based upon, arising from, or in consequence of any deliberate fraudulent act or omission by the insured if established by a final and non-appealable judgment. The policy also contained a severability provision, which provided that only the facts pertaining to and knowledge possessed by certain specified officers would be imputed to the insured organization for purposes of the fraud exclusion. The court determined that the fraudulent conduct was not perpetrated by any of the specified officers, and therefore it could not be imputed to the insured company.

The court then considered whether the damages could be allocated between the intentional misrepresentation count and two uncovered counts. Although the court observed that, under Rhode Island law, the insured bears the burden to allocate, the court held that the insurer has a duty to inform its insured that allocation through a special jury verdict is advisable where a suit contains the potential for both covered and uncovered counts. Since the insurer had failed to propose an allocated verdict form, the court held that the insurer could not now impose an unreasonable burden on the claimant to request allocation. In order to avoid re-litigating the underlying facts, however, the court ordered the parties to mediate how the damages should be allocated.

Finally, the court held that the claimant could not recover under Rhode Island's "rejected settlement offer" statute, which allows for the recovery of interest on an underlying judgment, even if it exceeds the applicable policy limits, where the insurer rejected a pre-trial settlement demand within the policy limits. Although the claimant had filed the coverage action in Rhode Island and the court was deciding the coverage issues under Rhode Island law, the court held that the Rhode Island statute did not apply because the underlying suit was litigated in Delaware, the underlying settlement discussions took place in Delaware, and the Delaware court had already awarded pre-judgment interest. The court observed that the determination of the scope of coverage under the policy had nothing to do with whether the insurer should be liable for the consequences of a rejected settlement demand. ■

Communications Stating That Insured May Be Liable For Damages Constitute a "Claim

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$53,000. Representatives of the insured and the claimant attempted to resolve the dispute in the fall of 2008 to no avail. In January 2011, an attorney for the claimant sent the insured two demand letters related to the faulty adhesive claims. In April 2011, the claimant filed a lawsuit against the insured. The insured tendered the lawsuit to the insurer for coverage under the general liability policy, which provided specified coverage for "[a] claim for damages . . . first made against any insured . . . during the policy period." "Claim" was not a defined term within the policy. The insurer denied coverage on grounds that the claim was first made prior to the policy period. The insured filed the present action against the insurer, and the insurer moved for summary judgment.

The federal court granted summary judgment for the insurer, concluding that the claim involving allegedly faulty adhesive was first made prior to the inception of the policy. In so holding, the court rejected the insured's argument that "claim" should be defined narrowly to include only a legal demand for monetary relief by an attorney. According to the insured, the communications before the policy incepted did not constitute a "claim" under the policy because they were "only ordinary communications . . . made in an attempt to solve a business issue." The court concluded otherwise, holding that "a 'claim' is properly understood as an assertion by a third party that the insured may be liable to it for damages within the risks covered by the [p]olicy." According to the court, the policy distinguishes between a "claim" and a "suit," defining "suit" specifically to mean a "civil proceeding," thus suggesting that "claim" means something different than "suit." The court concluded that the insured "had ample warning that there was an issue with respect to the [adhesive product] and sufficient notice that [the claimant] had made a claim" prior to the policy period. ■

Professional Association's Investigation of Ethical Complaints and Credentialing of Members Constitute Professional Services

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professional service because it was not one of the examples in the exclusion. The court rejected the association's argument, holding that because the exclusion bars coverage for "any professional service, including but not limited to" the listed examples, other activities involving specialized knowledge or skill could constitute professional services. According to the court, the association's investigation of the complaint and its decision to re-certify the technologist was an exercise of judgment guided by specialized training and experience. As such, it was a professional service excluded by the policy.

The association also sought coverage under an umbrella policy with a different professional services exclusion that barred coverage for "establishments engaged in promoting the business interests of their members." The association contended that it was not formed for the purpose of promoting its members' business interests but instead was formed to credential members based on their achievement of educational and ethical requirements. The court ruled for the umbrella insurer, holding that the exclusion does not turn on the purpose for which the association was formed but rather on what services it currently performs. The court held that the association regularly engages in activities that promote the business interests of its members, including market research and publication of information for members. The court also rejected the association's argument that application of the exclusion would render coverage illusory, holding that the insurer had identified instances in which coverage would be available, and, in any event, the association could not identify any portion of the premium it paid for the umbrella policy specifically allocated to claims arising from its credentialing services. Thus, the court held, the exclusion bars coverage for the claims against the association. ■

Business Pursuits Exclusion Bars Coverage for Activities after Alleged Ponzi Schemer Left Law Firm

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The attorney contended that his activity constituted covered legal work and that coverage extended beyond the termination of his employment by the insured law firm under the policy's "related claims" provision. Under that provision, claims "arising out of a single act or omission or arising out of 'related acts or omissions' in the rendering of 'legal services'" were considered to be a single claim. The attorney argued that his conduct in drafting a fraudulent private placement memorandum after he left the insured firm was sufficiently connected to legal services performed at the firm when he drafted earlier memoranda.

Applying the laws of Illinois and Minnesota—found not to be in conflict—the court determined that the insurers had no duty to defend. The court rejected the attorney's "related claims" argument, reasoning that the purpose of the "related claims" provision "is to accumulate and determine the number and amount of deductibles and per claim policy limits that apply to a legal malpractice claim or lawsuit." According to the court, the "related claims provision does not provide coverage for activities that would otherwise not be covered by the policy, such as [the attorney's] Fund related business activity for his own profit."

The attorney also contended that the insurers breached fiduciary duties to him by approving a settlement with the claimants without the attorney's participation or consent that settled covered claims but left uncovered claims for the attorney to defend. Although the uncovered claims were left in the case, the court reasoned, the attorney never had coverage for those claims, so he was better off after than the settlement than he was before. Accordingly, the insurers did not breach any duty to the insured by failing to settle uncovered claims. ■

No Rescission of Renewal Policy Where Original Application Not Incorporated into Application for Renewed Policy

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The court also reversed the trial court and held that the firm made no misrepresentation in the original application because the client brought its claim against the attorney more than five years before the firm completed the application. In reaching that conclusion, the court found that the policy defined "claim" consistently with "common practice in the insurance industry" and, construing any ambiguity in the policy and the application against the insurer, reasoned that the client's notice of a possible malpractice action constituted a claim. The court added that the insurer could have posed alternate or additional questions on the application to obtain information regarding claims older than five years or lawsuits instituted during that period. ■

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