Wiley Rein LLP

EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | August 2014

ALSO IN THIS ISSUE

continued on page 2

Qui Tam Settlement Is Disgorgement Not Covered Under a D&O Policy

A Pennsylvania trial court has held that amounts paid in settlement of *qui tam* actions are uninsurable as a matter of law and thus not covered under D&O policies. *Mountainside Holdings, LLC, v. Am. Dynasty Surplus Lines Ins. Co.,* No. 2003-127 (Penn. Ct. Common Pleas June 30, 2014). The court also held that an excess insurer had no coverage obligations until the underlying limits were exhausted by actual payment of covered amounts. It further concluded that a prior litigation exclusion did not apply to a prior *qui tam* action filed under seal and not served on the insureds.

The insureds, physicians and a medical center, had purchased D&O insurance excess of $10 million in underlying insurance. Those excess policies contained a prior litigation exclusion that barred coverage for claims related to litigation commenced prior to a specified date. Before the prior litigation date of the policies, a *qui tam* action was filed against the insureds for alleged overbilling for medical services, but it was filed under seal and was not served

continued on page 13

No Coverage for Claims Arising out of Madoff's Ponzi Scheme

A New York state intermediate appellate court, applying Connecticut law, has held that a liability insurance policy's loss-of-money, personal-profit, sale-of-securities, and insolvency exclusions preclude coverage for claims by investors against an insured bank for amounts lost in connection with Bernard Madoff's Ponzi scheme. *Associated Cmty. Bancorp, Inc. v. St. Paul Mercury Ins. Co.,* 2014 WL 2841137 (N.Y. App. Div. June 28, 2014).

The policy's loss-of-money exclusion barred coverage for claims for "the actual loss of money, securities, property or other items of value in the custody of the [the insured]." The policy's personal-profit exclusion barred coverage for loss "based upon, arising out of, or attributable to [the] Insured gaining in fact any personal profit, remuneration or financial advantage to which such Insured

continued on page 15

ALSO IN THIS ISSUE

Settlement Returning Overdraft Fees Deemed Potentially Insurable

The United States District Court for the District of Minnesota, applying Delaware law, has held that a bank's settlements of lawsuits seeking the return of allegedly improper overdraft protection fees collected by the bank from its customers may constitute covered "Loss" under the bank's professional liability insurance policies. *U.S. Bank Nat'l Ass'n v. Indian Harbor Ins. Co.,* No. 12-cv-3175 (D. Minn. July 3, 2014).

The bank's customers filed class actions alleging that the bank improperly manipulated the order in which it processed their transactions in order to cause their accounts to be overdrawn multiple times, thus maximizing the number of fees the bank could charge for overdraft protection services. The bank settled the customer lawsuits, agreeing to pay $55 million to customers who had been charged multiple overdraft fees, and sought coverage for the settlement under its professional liability policies. The policies afforded specified coverage for "Loss," defined to include "the total amount which [the insured] becomes legally obligated to pay on account of each Claim" but not to include "[m]atters which are uninsurable under the law" or "principal, interest, or other monies paid, accrued or due as the result of any loan, lease or extension of credit by [the insured][.]" The insurers disclaimed coverage for the settlement, arguing that, the amount paid in settlement fell within the specified exceptions to "Loss" and was thus not covered.

continued on page 15

Court Refuses to Stay Rescission Action Pending Outcome of Underlying Proceeding

A California federal court has declined to stay a rescission action pending the outcome of the underlying indemnity proceeding. *Century Sur. Co. v. Cal-Regent Ins. Servs. Corp.,* 2014 WL 3534907 (S.D. Cal. July 16, 2014). The court noted that the issues in the rescission action—whether the insured made a material misrepresentation on its application for insurance—were separate and distinct from the issues in the underlying litigation, and therefore held that there was no prejudice arising from parallel litigation.

After a single-vehicle accident in Mexico, a passenger in the vehicle and his parents brought a personal injury suit against the driver and owner of the vehicle. The driver and owner sought coverage from their CGL insurer, which

continued on page 18

Single Complaint Triggers Two Policy Periods

Applying Puerto Rico law, the United States District Court for the District of Puerto Rico has held that only part of a claim made by the Federal Deposit Insurance Corporation (FDIC) against the directors and officers of a failed bank relates back to a prior claim against the insureds, and thus the complaint triggers two policy periods. *W Holding Co., Inc., v. AIG Ins. Co.,* No. 3:11cv2271 (D.P.R. July 9, 2014). In addition, the court held that the policy's insured v. insured exclusion does not warrant summary judgment for the insurer because the FDIC purports to bring its claim on behalf of non-insureds, including the bank's depositors and accountholders.

In 2009, the FDIC, as receiver for a failed Puerto Rican bank, brought a claim against the bank's former directors and officers in connection with a pattern of allegedly reckless underwriting practices. The FDIC's complaint identified eight particular borrowers for which the FDIC sought damages. One of those borrowers was also at issue in securities lawsuits filed against the directors and officers starting in 2006. Like the FDIC's claim, those earlier lawsuits also alleged negligent and reckless underwriting practices by the bank.

The directors and officers' insurance policy defined "Claim" in relevant part as "a written demand" or "a civil . . . proceeding," and it provided that where the insureds have given written notice of a Claim, then a subsequent Claim "alleging, arising out of, based upon or attributable to the facts alleged in the Claim or alleging any Wrongful Act which is the same as or related to any Wrongful Act alleged in the Claim shall be considered related to the first Claim of which such notice has been given" and is "subject to the one aggregate limit of liability."

The insurers argued that the FDIC's lawsuit was a single "Claim" under the policy definition defining the term as "a civil . . . proceeding," but that argument was not addressed in the Court's opinion despite extensive briefing. In addition,

continued on page 16

Additional Insured Under One Coverage Part Is Not Additional Insured Under Another Coverage Part

The Supreme Court of Rhode Island has held that an insurer had no duty to defend or indemnify a contractor of its insured because the contractor was not an additional insured under the professional liability coverage part of the insured's policy, even though the contractor was an additional insured under the general liability coverage part of the same policy. *Quest Diagnostics, LLC v. Pinnacle Consortium of Higher Educ.,* 2014 WL 2917036 (R.I. June 27, 2014).

An insured university entered into a professional services agreement (PSA) with an independent contractor, making the contractor responsible for performing certain clinical laboratory testing for students and employees at the university's health center. The PSA required both parties to procure four types of insurance coverage, including general liability insurance and professional liability insurance. The agreement obligated the parties to name each other as an additional insured under their general liability policies; however, there was no contractual requirement that the parties do so for the professional liability policies. The university obtained general liability coverage and professional liability coverage under one policy issued by the same insurance company.

In 2006, a student at the university sued the university and the contractor for failing to exercise the "degree and skill expected of a reasonably competent provider of laboratory services" in failing to process a strep test and provide the results in a timely manner. The student settled her claims with the university and its primary and excess insurers, but the contactor did not participate in the settlement. Shortly after the

continued on page 16

Prior Acts Exclusion and Insolvency Exclusion Bar Coverage for Claim Against Broker

A Colorado federal court, applying New York law, has held that a prior acts exclusion and an insolvency exclusion both applied to bar coverage for an arbitration award entered against an insured. *Templeton v. Fehn,* 2014 WL 2861832 (D. Colo. June 24, 2014). The court also concluded that the insurer did not breach its duty to defend.

An insurer issued a professional liability policy to a broker-dealer for the policy period of September 1, 2009 to September 1, 2010. The policy had a retroactive date of September 16, 2005. In November 2009, customers initiated an arbitration proceeding against the broker-dealer and an individual broker after they lost their investments in a company that was placed into receivership. The customers alleged that the broker had sold them unsuitable securities in 2004, when he worked at a different broker-dealer, and again in 2007, when he worked at the insured broker-dealer.

The insurer appointed defense counsel, but the broker-dealer replaced defense counsel with a different firm. The insurer mistakenly understood that the new defense counsel represented both the broker-dealer and individual insured and, at the broker-dealer's request, authorized a settlement with the claimants. The insurer later learned that the claimants settled only with the broker-dealer and that the individual insured did not appear at the arbitration hearing that went forward against him. The arbitrators entered an award against the individual. The claimants and individual later settled for $555,000, for which the broker sought indemnity coverage for the setlement.

In coverage litigation, the insurer argued that an exclusion for any Claim arising out of "any Wrongful Act occurring on or after the Retroactive Date, which, together with a Wrongful Act

continued on page 14

Court Finds Fact Issue Regarding Whether Attorney Misconduct Could Reasonably Be Expected To Give Rise to a Claim

Applying Texas law, a federal district court has held that a jury must decide the issue of whether a reasonable attorney would have expected certain discovery misconduct to give rise to a claim. *OneBeacon Ins. Co. v. T. Wade Welch & Assocs.,* 2014 WL 2863701 (S.D. Tex. June 24, 2014).

The insured law firm defended a client in a litigation matter from 2005 to 2008. After the insured attorney failed to respond to discovery requests within thirty days, the opposing party moved to compel. In February 2006, the court issued an order requiring the client to respond to all requests by March 16, 2006, and providing that, if the client failed to comply in a timely manner, the court could deem the claims established and the client's defenses precluded. The insured attorney agreed to comply with the order. The attorney filed responses on March 16, 2006, but waited several days to produce documents; failed to provide interrogatory responses signed under oath; and failed to identify the documents responsive to the requests. In August 2006, opposing counsel alerted the attorney that, unless his client complied fully by September 1, 2006, "plaintiff will seek appropriate relief." The insured attorney produced an additional 500 documents on September 5, 2006. Opposing counsel did not immediately complain of the attorney's noncompliance with the court's discovery order.

In November 2006, the firm completed an application for professional liability insurance and indicated that neither the firm nor any of its attorneys were aware of any fact, circumstance, act, error or omission that might be expected to be the basis of a claim. The insurer issued a policy to the firm for the period of December 20, 2006 to December 20, 2007 (the "2006–07 Policy").

continued on page 17

Louisiana Direct Action Statute Does Not Preclude Enforcement of Reporting Requirements in Claims-Made-and-Reported Policies

The Louisiana Supreme Court has held that the application of a reporting provision in a claims-made-and-reported policy to bar coverage for claims asserted by a tort claimant who was unaware of the policy's reporting requirements did not violate Louisiana's Direct Action Statute. *Gorman v. City of Opelousas,* 2014 WL 2937129 (La. July 1, 2014). The court also refused to treat two consecutive policies as a single "continuous" policy period under which coverage could be triggered by a claim made in one policy period but not reported until the next. *Id.*

While incarcerated in a city jail, an individual suffered a fatal attack perpetrated by two other inmates. The individual's mother filed a wrongful death action against the city, which was insured under two consecutive claims-made-and-reported policies. In that action, which was brought during the first policy period, the city initially refused to produce its insurance policies. Ultimately, after a motion to compel, the city produced them, and the claimant named the insurer as an additional defendant in the suit (by which time the second policy had incepted). The trial court ruled in the insurer's favor, holding that there was no coverage because the claim was not first made and reported during any one policy period. An intermediate appellate court ruled in favor of the insurer as against the city, but it reversed as to the claimant. The court reasoned that the state's Direct Action Statute gave the claimant a

continued on page 18

Michigan Statute Excusing Failure to Comply with Notice Requirements Can Apply to Claims-Made Policies

A federal district court has held that Michigan's statute excusing an insured's noncompliance with a casualty policy's reporting requirements can apply to claims-made policies in certain circumstances. *Feller v. The Medical Protective Co.,* 2014 WL 2931417 (E.D. Mich. June 30, 2014).

A former patient sued the insured surgeon and her medical practice for malpractice on March 12, 2013. Previously, on August 30, 2012, counsel for the patient had sent a document to the surgeon via certified mail titled "notice of intent to file claim pursuant to MCLA 600.2912(B)," which recounted the patient's treatment history in detail and explained the basis for the patient's claim. On March 27, 2013—approximately two weeks after the patient filed suit—the insured surgeon for the first time alerted her former professional liability insurer of the patient's claim. The insurer had issued a claims-made policy to the surgeon for the policy period of February 1, 2012, to February 1, 2013. The insurer denied coverage based on the policy provision establishing that the insurer "shall have no duty to defend or pay damages on a claim unless it was reported to the Company during the term of this policy or thirty (30) days thereafter."

Following the denial of coverage, the surgeon initiated a declaratory judgment action against the insurer, and the insurer moved for judgment on the pleadings. In response, the insureds conceded that the express terms of the policy precluded coverage but argued that, based on the allegation in the complaint that the insureds were unaware of the August 2012 letter and could not possibly have given notice of the claim before the policy expired or thirty days thereafter, Michigan Insurance Code Section 500.3008 potentially applied. Section 500.3008 provides that an insured's failure to give notice of a claim to the insurer pursuant to the requirements of a casualty policy is excused "if it shall be shown not to have been reasonably possible to give such notice within the prescribed time and that notice was given as soon as reasonably possible."

continued on page 19

Undefined Term "Claim" in a Claims-Made-and-Reported Policy Means a Demand for Relief or Damages

A federal district court in West Virginia has held that, in order to trigger coverage under a claims-made–and–reported policy, the policyholder must show that a demand for relief or damages was made and reported to the insurer within the policy period. *Soyoola v. Oceanus Ins. Co.,* 2014 WL 2778846 (S.D. W. Va. June 19, 2014).

The policyholder, a physician, had purchased a claims-made-and-reported policy with an inception date of August 1, 2004. The insurer terminated the policy on August 1, 2009. During the policy period, the physician received a thank you note from the parents of a child delivered by the physician in a delivery that involved serious complications, thanking the physician for saving their child's life. The physician testified that he believed that he would face a malpractice suit related to the delivery and promptly forwarded the note to the broker. After the termination of the policy, the parents' attorney notified the physician that the parents intended to file a malpractice suit against him. The physician notified the insurer and requested coverage under the policy. The insurer denied coverage, and coverage litigation ensued.

The court held that the physician failed to show that a claim had been made during the policy period and granted the insurer's motion for summary judgment. Although the policy did not define the term "claim," the court concluded that a claim means a demand for relief or damages. Because the thank you note was not a demand for relief or damages, the court held that no claim was made during the policy period. The court further instructed that the policyholder's belief that a claim may be forthcoming was irrelevant to the claims made and reported inquiry. Accordingly, the court concluded, coverage was not triggered under the claims-made–and–reported policy. ■

District Court Holds Damages for Negligence and Breach of Contract Are "Indivisible"

The United States District Court for the District of Rhode Island, applying Rhode Island law, has held that a jury's finding of negligence and breach of duty against an insured constituted a "Wrongful Act" under a D&O policy's entity E&O endorsement. *Bank of Rhode Island v. Progressive Cas. Ins. Co.,* 2014 WL 1931906 (D.R.I. May 15, 2014). The court also held that, where damages awarded against the insured for negligence and breach of contract were "indivisible," the insurer has a duty to indemnify the damages at issue to the extent the amounts would not otherwise be barred by an exclusion. Finally, the court held that an allocation must take place between covered Loss and uncovered amounts in connection with the applicability of the policy's "Internet Services Exclusion."

The insured bank was sued for alleged mismanagement of a client's commercial bank accounts and line of credit in connection with a scheme of one of the client's employees to embezzle funds from the client's bank account. The employee allegedly improperly reconciled sales reports and bank deposits and electronically transferred funds from the client's line of credit to cover the operating accounts. After a jury trial, the jury returned a mixed verdict that found, among other things, that the bank breached its "business loan agreement" with the client by providing online access to the line of credit to the employee and was negligent in breaching its duty of ordinary care to the client. The jury awarded the client $2.1 million in damages and interest. The insured sought coverage under its D&O policy's entity E&O endorsement, and a coverage dispute ensued concerning whether the insurer had a duty to defend and indemnify the insured, and if so, the extent to which an allocation of covered Loss was appropriate.

continued on page 19

Fraud in Application Voids Law Firm's Professional Liability Policy

The United States District Court for the District of New Jersey, applying New Jersey law, has held that an insurer may rescind a professional liability policy and recover damages where it relied on false statements made in the insurance application. *Colony Ins. Co. v. Kwasnik, Kanowitz & Assocs., P.C.,* No. 1:12-cv-00722 (D.N.J. June 27, 2014).

On behalf of his law firm, an attorney submitted an application for a professional liability policy that included three questions regarding allegations of past and potential malpractice or ethical violations brought against the firm or its attorneys. After issuing the policy, the insurer brought the present action alleging that fraudulent answers to those questions voided the policy and entitled it to damages under the New Jersey Insurance Fraud Prevention Act (IFPA).

Ruling on the insurer's motion for summary judgment as to rescission, the court considered whether: (1) the attorney made a false statement (2) that was "material to the particular risk assumed by the insurer" and (3) upon which the insurer actually and reasonably relied in issuing the policy. The court added that rescission of an insurance policy based on fraud does not require knowledge of the statement's falsity "unless the applicant made the statement in response to a subjective question." First, noting the attorney's failure to disclose four past professional liability claims against the firm, a threat of malpractice litigation, and an ethics complaint against the attorney, the court determined that the uncontested facts established numerous false statements in the application. Second, the court held the statements material to the risk assumed because the questions "went to the very heart of the risk assessment." Finally, finding that the insurer neither would have issued the policy but for the false statements nor had any reason to know the falsity of the statements, the court held that the insurer actually and reasonably relied on the attorney's misrepresentations.

Based on those conclusions, the court also granted the insurer's motion for damages under the IFPA because it determined that the uncontested facts established that the attorney knowingly made the material false statements in the application. ■

Timely Notice of Initial Claim Excuses Untimely Notice of Subsequent Related Claims

Applying New York law, the United States Court of Appeals for the Eighth Circuit held that an insured's untimely notice of numerous claims did not violate the policy's notice requirement because the claims are related to, and constitute a single claim with, an earlier claim that was timely noticed. *George K. Baum & Co. v. Twin City Fire Ins. Co.,* 2014 WL 3445713 (8th Cir. July 16, 2014).

In 2003, a company notified its professional liability insurer that it was being investigated by the Internal Revenue Service (IRS) in connection with the company's activities as an underwriter and seller of municipal bonds. Years later, after the IRS investigation had been settled, the company was named as a defendant in dozens of lawsuits alleging wrongdoing by the company in connection with the sale of municipal derivatives. The company's insurance policy provided that, when a claim is made and reported during the policy period, all subsequent related claims will be deemed made at the time of the initial claim, and the claims "shall be considered a single Claim for all purposes." Despite the fact that the derivatives litigation complaints were related to and thus a single claim with the IRS investigation, the company did not provide notice of these complaints to the insurer until over two years after the first complaint was filed. As such, after finally receiving notice, the insurer denied coverage for

continued on page 14

Umbrella Policies Triggered Even When Underlying Policies Exhausted by Payment of Damages Not Covered by Umbrella Policies

Applying Texas law, the United States Court of Appeals for the Fifth Circuit held that umbrella policies were triggered when underlying policies were exhausted by payment of damages covered by the underlying policies even though those damages would not have been covered by the umbrella policies. *Indem. Ins. Co. of North Amer. v. W&T Offshore,* 2014 WL 2853586 (5th Cir. June 23, 2014).

The insured, an offshore drilling company, suffered damages caused by Hurricane Ike in 2008 to over 150 offshore platforms in the Gulf of Mexico. The insured was covered by $150 million in primary insurance and four umbrella policies. The primary insurance provided coverage for property damages and owners' expenses suffered by the insured, but the umbrella policies provided no coverage for property damages and owners' expenses. The limit of liability of the primary insurance was exhausted by payment of property damages and owners' expense, and the insured sought coverage under the umbrella policies for removal of debris, which was covered under the umbrella policies. The umbrella insurers filed suit seeking a declaratory judgment that the umbrella policies were not triggered because the primary policies were exhausted by payment of damages that were not covered by the umbrella policies.

The court held that, because the primary policies had been exhausted, the coverage under the umbrella policies was triggered. The court held that the insuring agreement of the umbrella policies required only that the underlying limits of the primary policies be exhausted. The umbrella policies did not require that the primary policies be exhausted by payment of damages that fell within the coverage of the umbrella policies. So, the umbrella insurers were required to pay all damages covered by the umbrella policies after exhaustion of the limits of the primary policies. ■

Insurer with Knowledge of Potential Claim Cannot Agree with Insured to Cancel Policy

Applying Oklahoma law, the Oklahoma Supreme Court has held that an insurer and an insured cannot agree to cancel a claims–made policy where the insurer has knowledge of a potential claim against the insured. *Chandler v. Valentine,* 2014 WL 2854703 (Okla. June 24, 2014).

In November 2004, an insured doctor operated on a patient while under the influence of prescription medication, and the patient died. The Oklahoma medical review board revoked the doctor's license in March 2005. Thereafter, the doctor contacted his professional liability insurer and asked that his policy be cancelled and his premium refunded. The doctor's broker also provided the insurer with a newspaper article detailing the negligent operation, the patient's death and the revocation of the doctor's license. The insurer agreed to cancel the policy effective March 10, 2005.

Subsequently, in June 2005, the estate of the deceased patient filed suit against the doctor. After the doctor's debts were discharged in bankruptcy, the doctor and the estate entered into a consent judgment. The estate then sought coverage for the judgment from the insurer, but the insurer denied coverage on the grounds that the claim was made after the policy had been cancelled.

The Oklahoma Supreme Court found that the cancellation of the policy violates an Oklahoma statute that prohibits cancellation of a liability insurance policy "by any agreement between the insurer and the insured after the occurrence of any such injury, death or damage for which the insured may be liable." The insurer argued that the statute applies only to occurrence policies, not to claims–made policies like the doctor's policy. The court disagreed, finding that the statute's purpose was to protect injured third parties regardless of policy type, and thus it applies to claims–made policies where there is an agreement between an insurer and an insured that cuts off coverage for a potential claim of which the insurer has actual knowledge. Here, the court found, the insurer agreed with the doctor to cancel the policy with "actual knowledge of the events that would certainly generate a wrongful death action against the insured." Accordingly, the court held that the policy cancellation was ineffective, and the estate is entitled to coverage under the policy for the consent judgment. ■

Inconsistent Policy Provisions Render Policy Ambiguous as to Coverage for Attorney Advertising

The United States District Court for the Eastern District of Missouri, applying Missouri law, has held that a policy was ambiguous because its definition of personal injury provided coverage for the advertising activities of a law firm, but its definition of wrongful act excluded injury arising out of the law firm's advertising. *Hullverson Law Firm, P.C. v. Liberty Ins. Underwriters, Inc.,* 2014 WL 2611814 (E.D. Mo. June 11, 2014). The court also held that recovery of the law firm's profits for a statutory violation did not constitute restitution as excluded by the policy's definition of damages because the claimant was not seeking the return or restitution of fees he paid to the law firm.

An attorney sued his former law firm for advertising that he and another attorney were practicing attorneys at the firm many years after the two attorneys had left the state and were practicing elsewhere. The lawsuit alleged that the law firm violated the Lanham Act and various Missouri Supreme Court Rules of Professional Conduct by presenting false and misleading advertising in phone directories, on the Internet, and on office signage. The insurer denied coverage, and the insured filed a declaratory judgment action. The insurer argued that the underlying claim was not an advertising injury covered under the policy because it did not arise out of the rendering of professional legal services. Alternatively, the insurer argued that the damages sought in the lawsuit were not damages as defined by the policy.

continued on page 20

Court Won't Strike "Expert" Report by Broker on Application Ambiguity and Best Practices

A Maryland federal court has refused to strike a purported expert report by a former broker opining that an insurer "should have" asked clarifying questions about the insureds' response to "ambiguous" application questions. *Humane Soc. of U.S. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.,* 2014 WLJ 3055568 (D. Md. July 3, 2014). However, the court required the broker to provide additional information concerning the bases for his opinions that a warranty exclusion was "not intended to apply" to application answers that that were not material to the insurer and that the underlying lawsuit constituted a claim made during the period of the insurer's policy.

The insurer argued that the broker's report amounted to improper legal conclusions. The court disagreed with the insurer's contentions, in particular with respect to the broker's opinions that certain application questions were "ambiguous as to the information being requested" and that "in light of best practices in the insurance industry [the insurer] should have probed deeper than the questions asked in the application" for which the insured failed to disclose litigation against an affiliated entity. The court concluded that the broker's opinion regarding the insurer's obligation to ask additional questions did not reach the ultimate issue whether the insureds were entitled to coverage and, therefore, that the broker's opinion regarding the clarity of the application questions appeared proper.

The insurer also objected to the broker's opinions (1) that a warranty exclusion was "not intended to apply" to any facts or representation that was not material to the insurer, and (2) that the underlying claim was deemed made during the claims-made period of the insurer's policy and was not deemed made during a prior period. The insurer argued that these opinions were improper legal conclusions. The court declined to strike these portions of the expert report but concluded that the bases for these conclusions was unclear and provided the insureds with 14 days to supplement the expert report. ■

Professional Services Exclusion Unambiguously Excludes Coverage for Negligent Building Design

The United States Court of Appeals for the Fifth Circuit has held that, under Louisiana law, an insurer had no duty to defend by operation of a professional services exclusion because the underlying complaint arose out of the rendering of or failure to render professional services. *Wisznia Co., Inc. v. General Star Indem. Co.,* No. 13-31125 (5th Cir. July 16, 2014).

A design company was sued by a parish for improperly designing a building. The parish alleged that the company agreed to use its professional architectural, engineering and construction administration skills and knowledge to prepare design plans and specifications. The parish alleged that the damages it suffered were the "direct and proximate result of the design company's breach of its contractual warranty, negligence, and lack of professional skill." The insurer denied coverage based on a professional services exclusion. The district court agreed with the position, and the appellate court affirmed.

According to the Fifth Circuit, under Louisiana law, a professional liability exclusion applies where the alleged injury arises out of the rendering or failure to render professional services of any kind as opposed to arising out of a breach of the general duty of reasonable care during the course of rendering professional services. The court held that the underlying petition, even "liberally construed, unambiguously excludes coverage" because the parish hired the design company "for its expertise," and "it is not far-reaching to find that all of the services it rendered in connection with [building] project were professional in nature." Moreover, the court determined that the factual allegations, which included defective building design and construction supervision, did not give rise to an ordinary claim for negligence such as an unreasonably dangerous work site and that the repeated invocation of the word "negligence" in the petition was insufficient to obligate the insurer to defend the company. ■

Criminal Conduct Exclusion Bars Indemnity Coverage for Suit Against Insured Who Pled Guilty to Criminal Misconduct

Applying Florida law, the United States District Court for the Southern District of Florida has held that a criminal conduct exclusion barred indemnity coverage for a claim against an insurance broker who pled guilty to insurance fraud. *Certain Interested Underwriters at Lloyds, London v. AXA Equitable Life Ins. Co.,* No. 10-62061 (S.D. Fla. July 10, 2014). Previously, the court held that the insurer had no duty to defend the insurance broker against the same claim based on the criminal conduct exclusion.

An independent insurance broker completed life insurance policy applications for clients and allegedly defrauded insurance companies by providing materially false information on the applications. The state of Florida brought a criminal proceeding against the broker, and he ultimately pled guilty to multiple counts of insurance fraud. Meanwhile, the life insurer brought suit against the broker for material misrepresentations on five life insurance applications, and the broker's insurer filed a declaratory judgment action seeking a judicial determination that it had no duty to defend or indemnify the broker for the life insurer's suit. The court previously held that a criminal conduct exclusion applied, so the insurer had no duty to defend the broker against the life insurer's suit. The insurer then sought a determination that it had no duty to indemnify the broker in the life insurer's suit. At the time the insurer sought judgment in its favor on the indemnification issue, the life insurer had dismissed the claim against the broker without prejudice.

The court held that the criminal conduct exclusion barred indemnity coverage for the life insurer's suit. The exclusion precluded coverage for claims "based upon, arising out of, directly or indirectly relating to or in any way involving . . . [c]onduct which is fraudulent,

continued on page 20

No Coverage for Claim First Reported to Insurer Two Years After Expiration of Claims Made–and–Reported Policy

The Minnesota Court of Appeals has held that an insurer has no duty to defend or indemnify a default judgment against an insured where the claim was first reported two years after the expiration of the claims–made–and–reported policy. *LeCuyer v. West Bend Mut. Ins. Co.,* 2014 WL 3396491 (Minn. Ct. App. July 14, 2014).

An employee of the insured company sent a letter to the insured company in January 2009 alleging wrongful termination following her complaints of sexual harassment, and filed a suit against the insured in April 2009. A bench trial was held in 2010, but the insured company did not appear and a default judgment of approximately $500,000 was entered against the insured. In June 2011, the employee provided notice to the insured company's employment practices liability insurer seeking coverage for the default judgment. The policy provided that coverage was available "only if . . . [a] 'claim' is both . . . made against any insured . . . during the policy period . . . and [r]eported to us . . . during the policy period . . . ." The insurer denied coverage on the grounds that the claim was not first made and reported during the July 25, 2008 to July 25, 2009 policy period. In the coverage litigation that followed, the trial court granted summary judgment in favor of the insurer, and the employee appealed.

On appeal, the Minnesota intermediate appellate court affirmed, stating that "[b]ecause [the insurer] did not receive timely notice of [the employee's] claim against her employer so as to trigger its obligation under the terms of the insurance contract, [the insurer] is not liable." The court rejected the employee's contention that the language concerning when a claim is first made is ambiguous, holding that "[e]ven if the policy language determining when a claim is made is unclear, the language about when a claim is '[r]eported to' the insurer is not, and the policy requires both a claim and a report to the insurer before coverage . . . . Because neither [the insured company] nor [the employee] reported the claim to [the insurer] within the period mandated under the policy, the policy unambiguously requires no coverage." ■

Demands for Payment on Foreign Exchange Transaction Agreements Were Not Claims for Wrongful Acts

The United States District Court for the District of New Jersey, applying New Jersey law, has held that there is no coverage for demands for payment from an insured corporation under foreign exchange transaction agreements because the demands were not a claim for a wrongful act. *PNY Techs., Inc. v. Twin City Fire Ins. Co.,* 2014 WL 3519074 (D.N.J. July 16, 2014). The court further held that the demands for payment were excluded from coverage by a breach of contract exclusion.

The chief financial officer (CFO) of the insured corporation had executed on behalf of the insured several foreign exchange agreements with four banks. The banks demanded payment from the corporation pursuant to the agreements, and the corporation sought coverage from its directors' and officers' liability insurer because it asserted that its CFO had wrongfully executed the agreements.

The court held that the banks' demands for payment under the foreign exchange transaction agreements were not a claim for a wrongful act by an insured entity. The court found that the banks were not seeking payment from the corporation because they asserted that the corporation or its CFO had wronged them; rather, the banks asserted that the agreements were valid and enforceable against the corporation. The court found unpersuasive the corporation's argument that there was coverage because its CFO had wrongfully executed the contracts. The court reasoned that the policy covered claims by third parties for wrongful acts, not merely wrongful acts. The court further explained that the claims covered by the policy were not the corporation's claims submitted to its insurer but the claims made by the banks against the corporation, and those claims alleged contractual liability rather than wrongful acts.

The court additionally held that the policy's breach of contract exclusion precluded coverage because the banks' demands arose from liability under an agreement. ■

Self-Insurance Policy Considered Primary Insurance Due to Pro Rata Other Insurance Clause

A North Carolina intermediate appellate court has held that a university's self-insurance policy was considered primary insurance due to the policy's pro rata other insurance clause. *Cinoman v. Univ. of N.C.,* 2014 WL 2937050 (N.C. Ct. App. July 1, 2014). Under North Carolina law, the court concluded that the insured could therefore maintain a declaratory judgment action before the conclusion of the underlying action with respect to the self-insurer's duty to indemnify.

A physician was treating a patient at a university; the physician was not employed by the university. The patient sued the physician for alleged medical malpractice. The physician was an insured under an E&O insurance policy. In addition, the physician and the university disputed whether the physician was an insured under a policy issued by a university self-insurance trust. The physician brought a declaratory judgment action against the university self-insurance trust. The self-insurer argued that its policy should be treated as an excess policy and that the declaratory judgment action should be stayed with respect to its duty to indemnify until the underlying action was resolved.

The court determined that the policy was a primary insurance policy and that a justiciable controversy existed for purposes of determining the insurer's duty to indemnify. According to the court, under North Carolina law, a justiciable controversy exists when a primary insurer seeks a declaration that it has no duty to indemnify and that another insurer instead owes coverage, even if the underlying action has not been resolved. If an excess insurer seeks such a declaration, however, the insurer must wait for the underlying action to be resolved in order to pursue a declaratory judgment action. Finally, under North Carolina law, self-insurance policies generally are not treated as primary insurance unless the policy so provides.

In determining that the policy provided primary coverage, the court focused on the policy's other insurance clause, which provided that the insurer shared liability with other collectible insurance according to the respective limits of the various policies. The policy did not indicate that it was excess of any other insurance. Thus, the policy provided primary coverage and a justiciable controversy existed. ■

Medical Records Request Not a "Claim"

A California appellate court has held that a written request for medical records did not constitute a "claim" within the meaning of a claims-made liability policy. *Signature Healthcare Services, LLC v. Certain Underwriters at Lloyd's, London,* 2014 WL 3404966 (Cal. Ct. App. July 14, 2014).

An insurer issued a combined general and professional liability policy that covered the operations and management of a hospital for the claims-made policy period of September 8, 2007 to September 8, 2008. The policy defined "claim" as "a written demand for Damages, money or services that is received by an Insured, including a Suit."

A 14-year-old patient at the insured hospital allegedly was raped by another patient on August 2, 2008. Three weeks later, on August 28, the hospital received a written request from a professional copying service to copy the minor's medical records, which the hospital's independent insurance adjuster forwarded to the insurer on either September 8 or 11, 2008. Meanwhile, on September 3, 2008, the independent insurance adjuster also forwarded to the insurer information regarding the alleged rape as well as a "Loss Advice Form" regarding the incident. On January 29, 2009, the hospital received written notice from counsel for the minor that she intended to sue and that she would seek damages. The minor later filed a complaint against the hospital on July 24, 2009. The insurer denied coverage for the suit on the grounds that the matter was not a claim first made during the

continued on page 21

Fee Exclusion Applies to Malpractice Litigation Where "Essential Character of the Dispute" Concerned Fees

A Delaware state court, applying Delaware law, has held that a fee exclusion barred coverage for a lawsuit where the "essential character of the dispute" was about fees and costs. *Attorneys Liability Protection Society v. Jay W. Eisenhofer, Grant & Eisenhofer, P.A.,* 2014 WL 2884506 (Del. Super. Ct. June 9, 2014).

The insured, a law firm, was co-lead counsel for plaintiffs in a class action. In 2004, prior to an early mediation, the insured agreed that if the mediation resulted in a large settlement, the insured would seek only between 5% and 15% of the amount recovered and would assist plaintiffs in opposing any firm that sought a higher reward. The 2004 mediation was unsuccessful. In 2007, the litigation settled and 14.5% of the settlement was awarded in attorney's fees. Shortly after the settlement, a plaintiff sued the insured alleging that the 2004 fee agreement was still valid even though the early mediation was unsuccessful.

The lawsuit included breach of fiduciary duty, breach of contract, and professional malpractice counts. The insured sought coverage for the suit under its professional liability policy. The insurer denied coverage based on the definitions of professional services and damages and an exclusion related to fee disputes, which applied to "any dispute for fees or costs, or any claim that seeks, whether directly or indirectly, the return, reimbursement or disgorgement of fees, costs, or other funds or property held by an insured."

The court granted summary judgment in favor of the insurer based on the fee exclusion. The court held that the "essential character of the dispute, not how it is pled," determined the exclusion's application. According to the court, the essential character of the dispute was about fees and costs notwithstanding the counts pled and that the plaintiff sought amounts in excess of the law firm's fees. ■

***Qui Tam* Settlement Is Disgorgement Not Covered Under a D&O Policy** *continued from page 1*

on the insureds until after the prior litigation date. The insureds settled the *qui tam* action and sought coverage from the excess insurers for amounts in excess of the $10 million underlying insurance. The excess insurers denied coverage, and coverage litigation ensued.

On summary judgment, the court held that the excess insurers had no coverage obligation because the underlying limits had not been exhausted by actual payment of covered loss. The excess insurers had stipulated that the insureds expended approximately $5 million in defense expenses, but the insureds argued that they had expended more than twice that amount in combined settlement and defense costs. The court rejected the insureds' position for two reasons. First, the court held that there was no coverage for the *qui tam* settlement because the settlement constituted disgorgement of ill-gotten gains and was thus uninsurable as a matter of Pennsylvania law. The court rejected the insureds' argument that it was not established in fact that they had received illegal profits given that the action was resolved by settlement, concluding that the settlement amounted to an agreement by the parties that the insureds were unjustly enriched. As such, amounts paid towards the settlement did not exhaust the underlying limits. Second, the court held that amounts paid by an entity owned by an individual insured that was not itself an insured did not exhaust the underlying limits. Because that entity was separately named in the *qui tam* action, the court reasoned, counting amounts expended by it in the settlement toward exhaustion of the underlying limits would amount to providing coverage for an entity not insured under the policies. Accordingly, the court concluded that the excess insurers' coverage obligations were not triggered.

Finally, the court noted that the policy's prior litigation exclusion barred coverage for claims related to litigation "brought prior to" the prior litigation date. The court concluded in dicta that it was unable to determine, either based on the language of the clause or through reference, whether that phrase was meant to include actions filed under seal. ■

Prior Acts Exclusion and Insolvency Exclusion Bar Coverage for Claim Against Broker

continued from page 4

occurring on or prior to such Retroactive Date, would constitute Interrelated Wrongful Acts" applied to bar indemnity coverage. The court agreed that the individual insured's conduct in 2004 had a "similar factual nexus" to his conduct in 2007 and that the Wrongful Acts thus constituted Interrelated Wrongful Acts. The insurer was not estopped from raising this exclusion because its reservation of rights letter included a broad reservation of the right to deny coverage at any time and a reference to this exclusion, which was sufficient to prevent the insured from claiming justifiable reliance on the letter.

In addition, the court concluded that an exclusion for Claims arising out of the insolvency or receivership of any company in which the Insured placed funds barred indemnity coverage. The court noted that the customers' claims against the broker would not have arisen if the company in which they invested had not become insolvent and placed in receivership. It was irrelevant that the customers' unsuitability claims accrued, for statute of limitations purposes, before the company became insolvent and placed in receivership.

Finally, the court concluded that the insurer did not breach its duty to defend. The insurer initially provide a defense to the broker-dealer and individual broker and understood that the replacement defense counsel was representing both insureds. ■

Timely Notice of Initial Claim Excuses Untimely Notice of Subsequent Related Claims continued

from page 7

the derivatives litigation complaints based on the company's failure to comply with the policy's requirement that all claims be noticed to the insurer "as soon as practicable."

In the appeal of the ensuing coverage litigation, the court first addressed the choice of law question. The company argued that Missouri law applies to this dispute because it is a Missouri corporation, and Missouri law requires an insurer to demonstrate prejudice to deny coverage based on late notice. The insurer argued that New York applies because the policy was issued to the company's New York office at the company's request so that the company could avoid paying Missouri surplus lines taxes, and because the policy included a New York amendatory endorsement with New York-specific provisions. The court agreed with the insurer, finding that New York law, which at the relevant time did not require an insurer to demonstrate prejudice based on late notice, governs the policy's interpretation.

Nevertheless, the court concluded that the company's undisputed late notice of the derivatives litigation complaints does not bar coverage for those complaints because the company gave timely notice of the original IRS investigation. According to the court, because the policy provides that related claims are related "for all purposes," all subsequent claims related to the IRS investigation (including all of the derivatives litigation complaints) constitute a single claim with the IRS investigation "for all purposes," including notice. Thus, the court held that the company's timely notice of the IRS investigation suffices as timely notice of all subsequent related claims.

Finally, the court addressed the issue of the applicable retention. The policy contained a $1 million retention, except with respect to "any CLAIM based upon, arising out of, directly or indirectly, resulting from, in consequence of, or in any manner relating to the INSUREDS' activities as an underwriter or seller of municipal bonds," for which a $3 million retention applied. The company did not dispute that the $3 million retention initially applied to the IRS investigation in 2003, but it argued that the derivatives litigation complaints did not involve underwriting and selling of municipal bonds and thus a $1 million retention must apply. The court disagreed, finding that the derivatives litigation complaints are covered under the policy only because they arose from the same underlying acts as the IRS investigation. Thus, the court held, as related claims are a single claim "for all purposes," the derivatives litigation complaints and the IRS investigation are subject to the same $3 million retention. ■

No Coverage for Claims Arising out of Madoff's Ponzi Scheme *continued from page 1*

was not legally entitled." The policy's sale-of-securities exclusion barred coverage for any claim "based upon, arising out of, or attributable to: (a) the [insured's] underwriting, syndication, or promotion of equity or debt securities; (b) the [insured's] investment banking activities, including the sale and distribution of a new offering of securities; [or] . . . (e) any disclosure requirements in connection [therewith]." The policy's insolvency exclusion barred coverage for loss "based upon, arising out of, or attributable to the insolvency . . . of . . . any investment bank, or any broker or dealer in securities or commodities."

The court held that, because the underlying claimants alleged that their money in accounts with Bernard Madoff was "stolen, unlawfully retained, or misappropriated," the underlying claim alleged an "actual loss of money," precluding coverage under the loss-of-money exclusion. The court also held that, because the underlying claimants alleged that the insured "used incoming funds to pay its own fees and to sustain its custodial business and continue to generate its fees," the underlying claim alleged that the insured gained a "profit" or "financial advantage" to which it was not entitled and, hence, the personal-profit exclusion independently barred coverage. Moreover, according to the court, because the underlying claimants alleged that "by depositing [their] funds in omnibus accounts and allocating shares in those accounts to [the investors], [the insured] engaged in the sale or promotion of unregistered securities and failed to provide the required disclosures," the sale-of-securities exclusion also precluded coverage. Finally, the court held that, even though the insured was independent of Bernard Madoff's insolvent entity, the insolvency exclusion also barred coverage. Interpreting the term "arising out of" broadly to mean "connected with," "had . . . origins in," "grew out of," "flowed from," or "incident to," the court concluded that the underlying claims arose out of Madoff's Ponzi scheme and the insolvency of his firm. ■

Settlement Returning Overdraft Fees Deemed Potentially Insurable *continued from page 2*

In the coverage litigation that followed, the court denied the insurers' motion for judgment on the pleadings, noting that no Delaware authority has expressly held that restitution is uninsurable as a matter of law. The court also noted that the policies excluded coverage for claims "brought about or contributed in fact by any . . . profit or remuneration gained by [the insured] or to which [the insured] [was] not legally entitled . . . as determined by a final adjudication in the underlying action[.]" According to the court, because the parties expressly excluded any restitution resulting from a final adjudication through this exclusion, "they must have not intended to include any restitution not resulting from a final adjudication (say, a settlement) within the definition of 'Loss.'" The court distinguished cases—such as *Level 3 Communications, Inc. v. Federal Insurance Co.,* 272 F.3d 908 (7th Cir. 2001)—cited by the insurers in support of their argument that restitution was uninsurable on the grounds that "they involved policies without a specific provision requiring a 'final adjudication.'"

The insurers also argued that, because overdraft protection constitutes an extension of credit, the policies' extension-of-credit carve-out from the definition of "Loss" precluded coverage. The court rejected this argument on two grounds. First, the court held that this argument was "overbroad" because the carve-out was specifically designed to prevent the insured from procuring coverage for losses from unpaid loans, not losses from overdraft protection, and "untenable" because its application would bar coverage for any professional-liability claim relating to the insured's lending operations. Second, the court maintained that, given that the underlying actions alleged that overdraft fees were charged against transactions while there were still positive balances in customers' accounts, the settlement was not based on an extension of credit. ■

Single Complaint Triggers Two Policy Periods *continued from page 3*

due to the overlapping allegations in the FDIC's claim and the earlier securities lawsuits, the insurers argued that the FDIC's lawsuit relates to and thus is considered a single "Claim" with the earlier lawsuits first made in the 2006–2007 policy period. The directors and officers and the FDIC argued that the FDIC's lawsuit triggers both policy periods, as only the allegations as to the single borrower at issue in the earlier suits relates back to the 2006–2007 policy period, and the allegations as to the remaining seven borrowers are a "Claim" under the 2009–2010 policy period.

The court sided with the directors and officers and the FDIC, holding that the FDIC's claim triggers both policy periods. The court noted that the FDIC's complaint "substantially overlaps with the complaints in the Prior Suits regarding general allegations of grossly negligent practices," but nonetheless held that only the allegations as to the single borrower at issue in the prior suits sufficiently overlap for purposes of the policy's related claims provision. Accordingly, the court held that the FDIC's claim with respect to that single borrower relates back to and is treated as a single claim with the lawsuits first filed under the 2006–2007 policy period, but the FDIC's claim as to the remaining seven borrower is a claim made under the 2009–2010 policy period.

The primary insurer had also argued that coverage is barred by the policy's insured v. insured exclusion, which precludes coverage for claims against an insured "brought by, on behalf of or in the right of, an Organization or any Insured Person." According to the primary insurer, the FDIC, as receiver for the bank, had stepped into the shoes of the bank and thus was asserting the claim on behalf of or in the right of an insured against other insureds. The court held that the primary insurer was not entitled to summary judgment on this issue, as the FDIC at least purports to represent such non-insureds as the bank's depositors, accountholders and depositors insurance fund. Thus, the court held, to the extent the FDIC proves at trial that it represents these non-insureds, the exclusion does not apply. ■

Additional Insured Under One Coverage Part of Policy Is Not Additional Insured Under Another Coverage Part *continued from page 3*

settlement, the contractor demanded a complete defense and indemnification from the university's primary insurer. When the contractor did not receive a response, it filed a declaratory judgment action against the university's primary and excess insurers. The trial court granted the insurers' motion for summary judgment.

On appeal, the contractor argued that it was an insured under the university's primary and excess policies, including the general liability and professional liability coverage parts.

The appellate court analyzed the policy's additional insured provision, which defined an additional insured as "any person, corporation, company, organization, estate or entity but only to the extent the [university] has agreed to do so." The court determined that, because the PSA was the basis of the agreement to extend coverage to the contractor as an additional insured, the policy and the PSA must be construed together. The court concluded that the PSA was "clear and unambiguous in requiring the contractor and university to name one another as additional insureds only under their respective general liability insurance coverage"—and not under the professional liability coverage.

The court also rejected the contractor's argument that, because it was an additional insured under the general liability coverage part of the policy, it was an additional insured under all coverage parts of the policy, including the professional liability coverage part. The court determined that, because there was no requirement in the PSA that the university provide professional liability coverage to the insured, the contractor was not an additional insured under the professional liability coverage part. ■

Court Finds Fact Issue Regarding Whether Attorney Misconduct Could Reasonably Be Expected To Give Rise to a Claim *continued from page 4*

After months of silence, opposing counsel moved for discovery sanctions in February 2007 based on the attorney's alleged failure to respond fully and properly to the discovery requests. On July 20, 2007, the court granted the motion and ordered, among other things, that the plaintiff's claims were established and that the insured's client was precluded from disputing the plaintiff's evidence.

In December 2007, the firm filled out an application for coverage from the same insurer (the "2007 Application") and again indicated that neither the firm nor any of its attorneys were aware of facts, circumstances or situations that "might reasonably be expected to give rise to a claim." The 2007 Application also stated that the firm "must report any known claim, suit, or incident, act, or omission that may in the future give rise to a claim or suit, to your current professional liability insurer before the claims-reporting period under that policy expires." The insurer issued a policy to the firm for the period of December 20, 2007 to December 20, 2008 (the "2007–08 Policy"), which included a prior knowledge exclusion stating that "[t]his policy does not apply to any claim arising out of a wrongful act occurring prior to the policy period if, prior to the effective date of the [2006–07 Policy] . . . (2) you had a reasonable basis to believe that you had committed a wrongful act, violated a disciplinary rule, or engaged in professional misconduct [or] (3) you could foresee that a claim would be made against you."

In April 2008, the insured firm notified its insurer of the client's potential claim. In August 2011, the insured's client agreed to settle the underlying case for $12 million. In February 2012, the client filed an arbitration demand against the firm and ultimately prevailed in arbitration.

During the coverage litigation that followed, the court first held that, on its face, the prior knowledge exclusion applied because (1) prior to the inception of the 2006–07 Policy, the attorney had a reasonable basis to believe that he had violated a disciplinary rule or engaged in professional misconduct by agreeing to the February 2006 discovery order contemplating sanctions and then failing to inform his client about the order; and (2) under Texas's broad interpretation of the phrase "arising out of," the client's claim "arose out of" the attorney's pre- inception "wrongful acts" because it had an incidental relationship to those acts.

The court rejected the insured's argument that the prior knowledge exclusion conflicted with the terms of the 2007 Application. The court agreed that the exclusion "does not require the insured to have reasonably expected the pre-inception wrongful act to result in a claim for the exclusion to apply." By contrast, the 2007 Application required disclosure only if the applicant was "aware of any fact, circumstance, or situation which might reasonably be expected to give rise to a claim." The court held that this application disclosure requirement is used by the insurer "to evaluate whether to issue a policy" and "is not irreconcilable with" the exclusion.

Despite concluding that there was no facial conflict between the prior knowledge exclusion of the 2007–2008 Policy and the 2007 Application, the court nonetheless held that, if the exclusion were interpreted in accordance with its plain language, there would be an unintended gap in coverage. Specifically, the court held that "the retroactive coverage [from January 4, 1995] would be illusory because no 'wrongful act' that the attorney was aware of, but did not think would result in a claim, would be covered," even though the 2007 Application only required the applicant to report to its prior insurer known claims and incidents, acts or omissions "that may in the future give rise to a claim or suit to its former insurer." To avoid this gap, the court held that the prior knowledge exclusion applies only if the claim arose out of a wrongful act that may have reasonably been expected to give rise to a claim.

Finally, the court held that a jury must decide whether, at the time the 2006–07 Policy incepted, a reasonable attorney with the subjective knowledge of the insured attorney would have expected the attorney's pre-December 2006 discovery misconduct to give rise to a claim. ■

Court Refuses to Stay Rescission Action Pending Outcome of Underlying Proceeding

continued from page 2

denied coverage on the ground that the policy provided coverage only within the United States. The driver and owner subsequently settled with the claimants for a judgment in excess of the policy limits, and the driver and owner assigned all claims under the policy to the claimants. The claimants and the CGL insurer eventually settled the ensuing coverage action.

The CGL insurer then brought an arbitration proceeding against its managing agent, which prepared the insurance policy. The CGL insurer sought indemnification for the underlying personal injury suit on the ground that the managing agent should have formatted the policy to exclude coverage outside the United States, but actually formatted the policy in a manner that provided worldwide coverage. The managing agent tendered the arbitration claim to its E&O insurer. Prior to tendering the arbitration claim, the managing agent knew of the underlying personal injury suit when it applied for the relevant E&O insurance policy, but did not report the claim. The E&O insurer sought rescission of the policy on the ground that the managing agent should have reported the claim but did not do so. The managing agent moved to stay the rescission action pending resolution of the arbitration claim.

The court overseeing the rescission action declined to stay the suit pending resolution of the arbitration claim. The court noted that stay of a rescission action was appropriate if the insurer's proof will prejudice its insured in the underlying litigation. In this regard, the court stated that whether the managing agent "was aware of a potential claim within the meaning of the Application is a separate and distinct issue from whether [the CGL insurer] is entitled to indemnity from [the managing agent]," and that the formatting issues raised in the underlying indemnity proceeding did not overlap with the issues raised in the rescission action. Accordingly, the court found that there was no prejudice to the managing agent arising out of parallel litigation. ■

Louisiana Direct Action Statute Does Not Preclude Enforcement of Reporting Requirements in Claims-Made-and-Reported Policies

continued from page 5

vested right at the time the tort was committed that "could not be taken away because of the insured's failure to notify the insurer—a condition over which the plaintiff had no control." The insurer appealed.

On appeal, the Supreme Court of Louisiana reversed, holding that "[w]here a policy unambiguously and clearly limits coverage to claims made and reported during the policy period, such limitation of liability is not per se impermissible." The court reasoned that "in the absence of coverage to the [c]ity, . . . [the claimant] was not deprived of her rights under the Direct Action Statute" because "that statute does not extend any greater right to the injured third party who was damaged by the insured." The court also rejected the assertion that the claimant's right vested at the time of the injury to her son, reasoning that such a ruling would convert the policy into an occurrence policy and upset "the bargained-for exchange between the insurer and insured." Finally, the court rejected the argument that the consecutive policies could be treated as a single "continuous" policy period—with a claim made in the first policy and reported in the second triggering coverage—since "[t]he plain terms of the policies" provided coverage only for claims first made and reported during the same policy period. ■

Michigan Statute Excusing Failure to Comply with Notice Requirements Can Apply to Claims-Made Policies *continued from page 5*

The court agreed with the insured that, pursuant to the Michigan Supreme Court's decision in *Stine v. Continental Casualty Co.*, 349 N.W.2d 127 (1984), Section 500.3008 potentially applied to excuse an insured's failure to report in accordance with a claims-made policy's notice requirements where (as here) the claimant notified the insured of the claim during the policy period. The court also rejected the insurer's argument that Section 500.3008 could not apply where a policy's notice provision is an "essential term" of the policy (*i.e.,* where the policy is a claims-made-and-reported policy rather than a pure claims-made policy). The court reasoned that the language of the policy issued to the surgeon was materially the same as the language considered by the *Stine* Court.

Finally, the court declined to decide whether Section 500.3008 actually applied because, according to the court, that question turns on whether the surgeon can ultimately show that it was not reasonably possible to give timely notice to the insurer during the policy period and that she gave notice as soon as was reasonably possible. ■

District Court Holds Damages for Negligence and Breach of Contract Are "Indivisible" *continued from page 7*

In ruling on the parties' cross motions for summary judgment, the court first addressed whether the underlying action alleged a "Wrongful Act," defined as "any actual or alleged act, error, omission, misstatement, misleading statement, neglect or breach of duty by the Company or by any person or entity for whom the Company is legally responsible." In this regard, the court held that "the jury's findings of negligence and breach of duty clearly establish that a Wrongful Act occurred. The verdict demonstrates a finding that [the insured bank] engaged in an act, error, omission, neglect, or breach of duty resulting in a loss."

The court rejected the insurer's contention that the jury's award was attributable to the breach of contract claim and that the insured was not "legally obligated to pay" such amounts. The court noted that "despite separate and distinct causes of action and conduct that gave rise to liability . . . [the client's] suffered damages were indivisible." The court further held that "[s]imply because the damages could not be parsed between various causes of action does not change the fact that [the insured bank] suffered a Loss because of the jury's negligence verdict and nor does it relieve [the insurer] of its obligation to pay the Loss incurred."

The court next addressed the applicability of the policy's "Internet Services Exclusion," which provided, in relevant part, that coverage was precluded for "any Claim arising out of or in any way involving the Company's providing . . . services through the transmission of data to or from an Internet website." The court recognized that "at least some of the negligence claims against [the insured bank] in some way involved providing services through the transmission of data over the internet" but that "many of the facts supporting the negligence claims against [the insured] do not fall within the exclusion," such as the failure to notify the client of the transactions. The court therefore concluded that the "Internet Services Exclusion excludes some portion of the negligence award and it does not exclude other significant portions." For this reason, the court held that, pursuant to the policy's allocation provision calling for the parties to use their "best efforts" to reach a proper allocation, an "allocation must take place" between covered Loss and uncovered amounts from the jury's verdict. ■

Inconsistent Policy Provisions Render Policy Ambiguous as to Coverage for Attorney Advertising

continued from page 9

The policy covered damages caused by a wrongful act, which it defined as an "act, error, omission, or 'personal injury' arising out of the rendering of 'professional legal services.'" Personal injury was defined to include "'injury arising out of an offense occurring in the course of the named insured's advertising activities, including but not limited to infringement of copyright, title[,] slogan, patent, trademark, trade dress, service mark or service number.'" The court concluded that a "law firm's advertising will never arise out of the rendering of professional legal services" because advertising activities are neither legal services nor activities performed for others as lawyers. Thus, the court concluded, the "policy's definition of personal injury appear[ed] to provide coverage for the [law firm's] advertising activities, but the definition of wrongful act then t[ook] that coverage away." The court determined that "reading the policy as a whole, the definition of 'personal injury,' which include[d] injury in the course of the named insured's advertising activities . . . is rendered illusory by the policy's requirement that the personal injury must arise out of the rendering of professional legal service." Construing the ambiguity in favor of the insured, the court found that the lawsuit triggered coverage.

Next, the insurer argued that the damages sought in the lawsuit—equitable relief, the return or restitution of legal fees, and statutory damages including treble damages—did not constitute damages as defined under the policy because the policy excluded from its definition of damages the return or restitution of legal fees. The court disagreed, determining that damages sought by the claimant did not meet the dictionary definition of restitution because the claimant was seeking to recover all profits and advantages gained by the firm and its attorneys from using the claimant's name in its advertising, and not the return or restitution of any fees the claimant paid to the firm. ■

Criminal Conduct Exclusion Bars Indemnity Coverage for Suit Against Insured Who Pled Guilty to Criminal Misconduct

continued from page 10

dishonest, criminal, willful, malicious, intentionally or knowingly willful, or otherwise intended to cause damage or injury to personal property" in the event of "an admission by an Insured of such conduct." The court held that the broker's guilty plea—including an admission that the broker had committed insurance fraud on the five applications that were the basis of the life insurer's suit—barred indemnity coverage for the life insurer's suit and that the insurer was entitled to a judgment "resolving this question for all time."

In doing so, the court rejected the life insurer's argument that the insurer's suit was moot because the life insurer previously had dismissed its suit against the broker. The court held that the coverage dispute was ripe for adjudication because the issue was ripe when the insurer filed the declaratory judgment action and the dismissal of the life insurer's claim against the broker was without prejudice, allowing the life insurer to re-file the suit against the broker in the future. In the alternative, the court held that its previous decision finding that the insurer had no duty to defend the broker meant that the insurer had no duty to indemnify the broker because, under Florida law, "a finding of no duty to defend . . . necessarily includes a finding that there is no duty to indemnify." ■

policy period because the claim was first made on January 29, 2009, when the insurer received the written notice of intent to sue, and the policy did not provide for the reporting of potential claims.

In the ensuing coverage litigation, the hospital asserted that the Loss Advice Form, sent together with information regarding the incident, as well as notice to the insurer that the hospital had received a request for medical records were communications that constituted "claims." The insured argued that the definition of "claim" must be read in conjunction with the policy's notice provision, which required the submission of a "Loss Advice Form." The Loss Advice Form in turn included a section titled "Basis for Reporting," which listed, among other items that the insured could select as the basis for reporting, "request for medical records" and "unexpected outcome." Accordingly, the hospital asserted that the inclusion of these categories on the Loss Advice Form indicated that the definition of "claim" included unexpected outcomes and medical records requests.

The appellate court noted that the Loss Advice Form did not use the word "claim" or provide that a "medical record request" or "unexpected outcome" constituted a claim. As such, the hospital's proposed interpretation would render the definition of "claim" nugatory and nullify the policy's coverage provision, which conditioned coverage on a "claim" as defined in the policy. The court also rejected the argument that the request to copy the minor patient's medical records was a written demand for services with respect to the alleged rape because a hospital is statutorily prohibited from copying medical records pursuant to a request from a professional copy service. The court also pointed out that the request made no reference to the alleged rape.

Additionally, the court rejected the hospital's argument that the insurer's failure to respond to the Loss Advice Form and communications regarding the medical records request waived the insurer's right to deny coverage. The court concluded that, because these communications did not constitute claims, the insurer had no obligation to accept or deny coverage. ■

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