Wiley Rein LLP

EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | January 2016

Fourth Circuit Holds Two Lawsuits Involve Interrelated Wrongful Acts Constituting Single "Claim" Where Allegations Establish "Common Nexus of Fact"

The United States Court of Appeals for the Fourth Circuit has affirmed a trial court's determination that an adversary proceeding brought by a bankruptcy trustee and subsequent suit by the trustee to recover on the judgment rendered in the first proceeding involved "interrelated wrongful acts" because they involved a "common nexus of fact" linked by common facts, a common transaction, and several common circumstances. *W.C. & A.N. Miller Dev. Co. v. Cont'l Cas. Co.*, 2015 WL 9487938 (4th Cir. Dec. 30, 2015). The court thus held that the two lawsuits constituted a single "Claim" first made before the claims-made policy period incepted. Wiley Rein represented the insurer.

In 2006, several entities and individuals related to the insured, a land development company, were sued in a contract dispute (2006 Lawsuit). In 2010, a judgment was entered in the contract dispute, and the claimant filed the underlying action against the insured to recover on that judgment (2010 Lawsuit). The 2010 Lawsuit detailed the events and contractual dispute at issue that gave rise to the judgment in the 2006 Lawsuit. The insured tendered the 2010 Lawsuit to its insurer, seeking coverage of defense costs under a claims-made policy. The insurer denied coverage on the basis that the 2006 Lawsuit and 2010 Lawsuit involved "Interrelated Wrongful Acts," defined in the policy as "any Wrongful Acts which are logically or causally connected by reason of any common fact, circumstance, situation, transaction, or event." The insurer thus treated the two lawsuits as a single "Claim" first made in 2006 before the policy period incepted.

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Broad Lead-In Language Precludes Coverage for Lawsuit with Even Minimal or Incidental Relationship to Excluded Claims

A California federal court has held that a professional liability policy does not afford coverage for a lawsuit against an insured life insurance agent because the suit fell within the policy's exclusions for claims based upon, directly or indirectly arising out of, or in any way involving premium finance mechanisms or guarantees about future premiums. *Columbia Cas. Co. v. Abdou*, 2015 WL 9244305 (S.D. Cal. Dec. 16, 2015). Wiley Rein represented the insurer.

The insured agent was sued by one of his clients, who alleged that he lost more than $3 million as a result of a premium-financed life insurance agreement that the agent had brokered, and that the agent made misrepresentations regarding future premium payments. The insurer defended the agent under a reservation of rights and initiated this coverage action.

First, the court denied the agent's motion to stay the coverage action pending the resolution of the

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Second Circuit Rejects Use of "Factual Nexus" Test for Related Claims Analysis

The United States Court of Appeals for the Second Circuit has held, under New York law, that a related claims provision should be interpreted and applied pursuant to the "plain language" of the contract, rejecting the "factual nexus" test applied by the lower court. *Nomura Holding Am., Inc. v. Fed. Ins. Co.*, No. 14-3789 (2d Cir. Oct. 21, 2015). In so holding, the Second Circuit affirmed the trial court's grant of summary judgment in favor of the insurer as the trial court's error in analysis was not dispositive to the decision.

The insureds, a holding company, its subsidiaries, and their directors and officers, acted as sponsors, depositors, and underwriters for various securitizations of residential mortgage-backed securities (RMBS). In January 2008, the insureds were named as defendants in a lawsuit alleging that misrepresentations were made in offering the documents for RMBS securitizations. In 2011 and 2012, five additional lawsuits were filed against the insureds alleging misrepresentations in various RMBS securitizations. The insureds tendered the 2011 and 2012 lawsuits to its insurer for coverage under a D&O policy covering the 2011 to 2012 policy period. The insurer denied coverage for the five lawsuits, concluding, in part, that the five lawsuits related back to the 2008 suit and therefore were deemed first made before the inception of the policy. The policy defined "related claims" as "all Claims for Wrongful Acts based upon, arising from, or in consequence of the same or related facts, circumstances, situations, transactions, or events or the same or related series of facts, circumstances, situations, transactions or events." The policy further specified that all related claims are deemed a single claim, made at the time the earliest of the claims was first made.

Following the insurer's denial of coverage for the five lawsuits, the insured initiated coverage litigation. The trial court held that coverage was

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Specific Litigation Exclusion Bars Coverage for Condo Owners' Second Lawsuit against Condo Association

Applying New Jersey law, a New Jersey federal court held that a specific litigation exclusion barred coverage for a second lawsuit brought against a condominium association by the same condominium owners. *The One James Plaza Condo. Assoc., Inc. v. RSUI Group, Inc.*, 2015 WL 7760179 (D.N.J. Dec. 2, 2015). In addition, the court held that the insurer did not act in bad faith because its coverage denial was at least "fairly debatable."

In 2010, condominium owners filed suit against the insured condominium association and its directors and officers, which the insureds settled in 2013. Later in 2013, the same condominium owners filed suit against the insured condominium association and its directors and officers, who tendered the second lawsuit for coverage under a D&O liability policy. The insurer denied coverage based on a specific litigation exclusion. The specific litigation exclusion barred coverage for loss "arising out of or in connection with any Claim made against any Insured alleging, arising out of, based upon or attributable to, directly or indirectly, in whole or in part" the 2010 suit. The insureds filed suit seeking coverage under the policy for the 2013 suit.

The court held that the specific litigation exclusion barred coverage for the 2013 suit because of the substantial overlap in the allegations in the 2010 and 2013 suit and because the 2010 suit serves as the "foundation and logical basis" for the 2013 suit. The suits were brought by the same parties and alleged similar core allegations that the insureds failed to disclose financial information to association members, the insureds maintained a for-profit rental business without separation from the activities of the non-profit condo association, and the insureds commingled assets.

In addition, the court held that the insurer did not act in bad faith when denying coverage for the 2013 suit. The insurer had a reasonable basis to deny coverage for the 2013 suit and provided an "extensive explanation" to the insured concerning coverage, which, at minimum, was fairly debatable. ■

New York Federal Court Allows Recoupment of Defense Costs

A New York federal court has held that an insurer was entitled to recoup defense costs where it expressly reserved its right to contest the duty to defend and to recoup defense costs without any demonstrated objection from the insured. *Maxum Indemn.Co.v. A One Testing Labs., Inc.*, No. CV 14-4023 (S.D.N.Y. Dec. 10, 2015). The court also determined that the insurer had no duty to defend the policyholder because the plaintiff in the underlying lawsuit failed to allege an "occurrence" within the meaning of the policy.

The insurer issued a commercial general liability policy to a testing agency covering "property damage" caused by an "occurrence" during the policy period. A building owner sued the policyholder alleging that the insured negligently performed testing services on a construction project and breach of contract. The insurer defended the action while expressly reserving the right to initiate a coverage action, to contest the duty to defend, and to recoup defense costs. Later, the insurer brought a declaratory judgment action seeking a declaration of non-coverage and a determination that it was entitled to recoup defense costs.

The court granted summary judgment to the insurer, holding that it was entitled to recoup defense costs paid because there was no coverage for the underlying lawsuit as it failed to allege an "occurrence" within the meaning of the policy. In so holding, the court observed that under New York law, an insurer can recoup defense costs upon a determination of non-coverage "so long as the reservation was communicated to the insured, who did not expressly refuse to consent to the reservation." Here, the court found that there was an express reservation of rights to recoup defense costs and there was no indication that the policyholder had objected to that reservation. ■

New Jersey High Court Retroactively Applies Rescission of Medical Malpractice Policy

The Supreme Court of New Jersey has held that a rescinded medical malpractice liability policy should not be reformed to require the insurer to defend and indemnify up to the state mandatory minimum amount of coverage in order to protect innocent third-party claimants whose claims arose prior to rescission. *DeMarco v. Stoddard*, 2015 WL 7722997 (N.J. Dec. 1, 2015).

After a claim was made against the insured podiatrist, the Rhode Island Medical Malpractice Joint Underwriting Association (RIJUA) rescinded the podiatrist's professional liability policy after he conceded that he had falsely claimed compliance with an application requirement that 51% of his practice was generated in Rhode Island. The claimants amended their complaint to name RIJUA. An intermediate appellate court held that the insurer could rescind the policy based on material misrepresentations but must protect an innocent third party, such as the patient whose claim arose prior to rescission, up the minimum amount of required coverage. The lower court based its decision in part on an analogy to the protection afforded by statute to innocent third parties when a motor vehicle policy has been rescinded.

The Supreme Court reversed, holding that a professional who has made a misrepresentation of material fact in an application for professional liability insurance can expect that the policy may be rescinded even with respect to claims that arose prior to the discovery of the misrepresentation. The court held that the lower court erred in reforming the rescinded malpractice policy at issue to provide coverage up to statutorily mandated minimum. The court reasoned that medical liability insurance policies are issued following an analysis of the risk, which is undermined by a misrepresentation of material fact. To permit such reformation "suggests that fraudulent conduct is condoned."

According to the Supreme Court, the compulsory automobile insurance model has no relevance to a fraudulently obtained professional liability insurance policy. The court noted that the legislature had not duplicated the "web of interrelated provisions attending the no-fault automobile liability model" with respect to any other type of liability insurance. According to the court, the lower court's reliance on that

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No Coverage, No Estoppel, No Duty to Settle; Prior Knowledge Exclusion Bars Coverage for Insured's Malpractice Claim

The Kansas Court of Appeals has held that an insurer owed no duty to defend or settle a malpractice lawsuit against its insured because the attorney had knowledge of acts reasonably giving rise to the claim before the policy period began. *Becker v. Bar Plan Mutual Ins. Co.*, 2015 WL 9459771 (Kan. Ct. App. Dec. 23, 2015). The court also held that the insurer was not estopped from denying coverage even though it undertook the defense before issuing a reservation of rights and that the insurer had no duty to settle.

The attorney purchased a claims-made-and-reported professional liability policy. The policy contained an exclusion that barred coverage for any claim "against an Insured who before the Policy effective date knew, or should reasonably have known, of any circumstance, act or omission that might reasonably be expected to be the basis of that Claim." Before the policy incepted, the attorney was terminated by a client after the client learned that the attorney had failed to perfect the client's security for a loan. The attorney tendered the claim to the insurer when the client sent a demand letter several months later. The insurer undertook the defense. At the outset of the case, the client made a settlement demand within a range that defense counsel recommended as reasonable. The insurer thereafter retained coverage counsel, issued a reservation of rights letter, and denied coverage approximately two months later.

The Court of Appeals affirmed the trial court's ruling of no coverage. The court held that a reasonable attorney would have anticipated a claim upon learning that she had compromised her client's security interest and that the client was terminating her services, viewed her work as substandard, and asked her to put her carrier on notice. The court rejected the attorney's argument that she subjectively did not expect a claim because she continued to socialize with the client and the client did not mention a malpractice lawsuit until several months later.

The court also held that the insurer was not estopped from denying coverage. Although labeling the insurer's reservation of rights letter "untimely," the court held that the insurer was entitled to obtain and review the attorney's entire file before issuing a coverage position. The court also held that estoppel would improperly expand the scope of the insurance policy. Finally, the court held that although the insurer denied coverage after the client made a settlement offer, the insurer did not have or breach a duty to settle because the attorney was not entitled to coverage under the policy. ■

Second Circuit Rejects Use of "Factual Nexus" Test for Related Claims Analysis *continued from page 2*

precluded because the five lawsuits were related claims, all of which related back to the 2008 suit, and therefore were deemed first made before the inception on the policy. The court reached this decision by applying a "factual nexus" test, whereby "[a] sufficient factual nexus exists where the Claims are neither factually nor legally distinct, but instead arise from common facts and where the logically connected facts and circumstances demonstrate a factual nexus' among the Claims."

The Second Circuit affirmed the trial court's decision with respect to the application of the related claims provision contained in the policy, but stated that the trial court erred in employing the "factual nexus" test instead of, as required under New York law, interpreting the policy pursuant to its "plain language." According to the court, the proper analysis is focused on whether the underlying claims are "based upon, arising from, or in consequence of the same or related facts, circumstances, situations, transactions or events or the same or related series of facts, circumstances, situations, transactions or events," and not whether the claims "are neither factually nor legally distinct, but instead arise from common facts and circumstances demonstrate a factual nexus' among the Claims." However, because the Second Circuit agreed that there was no genuine dispute that the claims in the five lawsuits were related to the claim first made in 2008, as defined within the policy, the court upheld the decision of the trial court for the insurer. ■

Fourth Circuit Holds Two Lawsuits Involve Interrelated Wrongful Acts Constituting Single "Claim" Where Allegations Establish "Common Nexus of Fact" *continued from page 1*

In the ensuing coverage action, the trial court granted judgment on the pleadings in favor of the insurer, holding that the two lawsuits "shared a common nexus" because they involved allegations of "a common scheme involving the same claimant" that "logically and causally" connected the two lawsuits.

On the insured's appeal, the Fourth Circuit affirmed, holding that the conduct alleged in the 2006 and 2010 Lawsuits shared a "common nexus of fact" and thus involved interrelated wrongful acts under the policy. As an initial matter, the court stated that the policy's definition of "interrelated wrongful acts" was "expansive" and unambiguous. The court thus concluded that the two lawsuits involved interrelated wrongful acts because they were linked by (1) "a multitude of common facts," (2) "a common transaction," and (3) "common circumstances" that logically and causally connected the two lawsuits. In so holding, the court rejected the insured's argument under *ACE American Insurance Co. v. Ascend One Corp.*, 570 F. Supp. 2d 789 (D. Md. 2008), that the allegations in the two lawsuits merely involved a "common motive" insufficient to establish interrelatedness. ■

New Jersey High Court Retroactively Applies Rescission of Medical Malpractice Policy *continued from page 3*

model ignored the "longstanding rule" that an insured professional cannot expect insurance coverage to respond to third-party claims when the policy has been rescinded due to material misrepresentations in the application. ■

Broad Lead-In Language Precludes Coverage for Lawsuit with Even Minimal or Incidental Relationship to Excluded Claims *continued from page 1*

underlying lawsuit, concluding that the coverage action did not require a determination regarding the conduct at issue in the underlying lawsuit. The court also denied the agent's motion to dismiss, which was premised partly on the grounds that the insurer had not provided the agent with a copy of the policy or sufficient notice of the relevant exclusions. The court determined that the insurer had sufficiently alleged that the agent had a copy of the policy, including an allegation that the agent had sought coverage under the same policy, and held that the agent could not interject alleged facts not contained in the complaint on a motion to dismiss. The agent also argued that the insurer must defend the agent because the client's claim was "potentially covered," but the court found that the insurer had plausibly alleged that there was no possibility of coverage.

The court then turned to the insurer's motion for summary judgment. The policy contained exclusions for claims "based upon, directly or indirectly arising out of, or in any way involving" (1) a life insurance policy paid for through a premium finance mechanism or (2) representations made about future premium payments. The court held that the phrases "arising out of" and "in any way involving" are interpreted broadly under California law, and that the lawsuit would be excluded from coverage if it included "even a minimal or incidental relationship to" excluded claims. In that regard, the court found that all of the allegations in the client's complaint arose out of the agent's sale of premium-financed life insurance to the client. The court also noted that the agent's counsel had admitted in the underlying action that each of the client's causes of action arose from the purchase of premium-financed life insurance policies.

The court rejected the agent's argument that the client could amend his complaint to include covered claims, noting that an insurer's duty to defend depends upon facts known to the insurer at the inception of the suit. The court also held that it did not matter that the agent denied liability for the allegations asserted against him. Finally, the court considered again the agent's argument that he had not received a copy of the policy, but concluded that this did not prevent entry of summary judgment. The insurer had submitted a declaration from the broker who had provided the agent's policy, describing how the policy and exclusions were given to the agent. The court concluded that the agent's conclusory, self-serving affidavit to the contrary was not sufficient to create a genuine issue of material fact. The court also held that discovery would not change the result because the agent did not identify specific facts that further discovery would reveal or why those facts would preclude summary judgment. ■

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