Wiley Rein LLP

EXECUTIVE SUMMARY

Legal Developments Affecting Professional Liability Insurers | June 2016

Cyber Policy Does Not Cover Indemnification Payments to Credit Card Processor After Data Breach

In one of the first cases directly addressing the scope of coverage under a cyber insurance policy, an Arizona federal district court has dismissed an insured's complaint seeking coverage for amounts paid to its credit card processor for assessments resulting from a data breach. *P.F. Chang's China Bistro, Inc. v. Fed. Ins. Co.*, No. 2:15-CV-01322-SMM (D. Ariz. May 31, 2016).

The insured, a large restaurant chain, learned that computer hackers had obtained and posted on the internet approximately 60,000 credit card numbers belonging to its customers. Nine months later, MasterCard issued a report and imposed three assessments on the insured's credit card processor: (1) a "Fraud Recovery Assessment" of $1.7 million; (2) an "Operational Reimbursement Assessment" of $163,123; and (3) a "Case Management Fee" of $50,000. The insured's credit card processor subsequently sent a letter demanding the insured reimburse the assessments pursuant to the indemnity provisions in the parties' agreement. The insured paid the assessments in order to continue operations and not lose its ability to process credit card transactions, and it sought coverage under its cyber policy for those payments. The insurer refused, and the insured brought suit. The court ultimately ruled in favor of the insurer and dismissed all claims asserted by the insured.

The court first evaluated an insuring clause providing coverage for "Loss on behalf of an Insured on account of any Claim first made against such Insured . . . for Injury." "Injury" was defined to include "Privacy Injury," which in turn was defined to mean "injury sustained or allegedly sustained by a Person because of actual or potential unauthorized access to such Person's Record." The term "Person" was defined as a natural person or an organization, and the term "Record" included "any information concerning a natural person . . . pursuant to any federal, state . . . statute or regulation, . . . where such information is held by an Insured Organization or on the Insured Organization's behalf by a Third Party Service Provider" or "an organization's non-public information that is . . . in an Insured's or Third Party Service Provider's care, custody, or control."

The court agreed with the insurer that this insuring clause was not triggered because the credit card processor did not itself sustain a "Privacy Injury" as its own "Records" were not compromised. The court noted that the definition of "Privacy Injury" required an "actual or potential unauthorized access to *such* Person's Record," which did not occur.

The court rejected the insurer's argument, however, that a second insuring clause was not triggered. That insuring clause afforded coverage for "Privacy Notification Expenses incurred by an Insured resulting from [Privacy] Injury." In turn, "Privacy Notification Expenses" was defined to mean "the reasonable and necessary cost[s] of notifying those Persons who may be directly affected by the potential or actual unauthorized access of a Record, and changing such Person's account numbers, other identification numbers and security codes." Under the facts presented, the court ruled that the Operational Reimbursement Assessment set forth in the credit card processor's demand letter—which reflected the costs to notify cardholders affected by the incident and to reissue and deliver payment cards, new account numbers, and security cards to those

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cardholders—fell within the definition of "Privacy Notification Expenses." The court therefore ruled that that portion of the assessment was potentially covered under the policy.

The court also found that a third insuring clause might be triggered. That insuring clause afforded coverage for "Extra Expenses . . . an Insured incurs during the Period of Recovery of Services due to the actual or potential impairment or denial of Operations resulting directly from Fraudulent Access or Transmission." The court found that the insured experienced Fraudulent Access during the data breach. In addition, the court ruled that the insured's ability to perform its regular business activities would be potentially impaired if it did not pay the "Case Management Fee" assessment because the credit card processor would be entitled to terminate its agreement with the insured, which in effect would eliminate the insured's ability to process credit card transactions. The court found an issue of fact, however, as to when the insured's services were restored, thus precluding summary judgment on whether the Case Management Fee would be recoverable given the temporal limitations in this insuring clause.

While the court did find coverage triggered as a matter of law under one insuring clause, and coverage potentially triggered under a second, the court nonetheless ruled in favor of the insurer on the basis of two exclusions and on the policy's definition of "Loss." One of the exclusions barred coverage for "Loss on account of any Claim, or for any Expense . . . based upon, arising from or in consequence of any . . . liability assumed by any Insured under any contract or agreement." Similarly, in connection with the two insuring clauses the court ruled were in play, the policy excluded "any costs or expenses incurred to perform any obligation assumed by, on behalf of, or with the consent of any Insured." Finally, the policy's "Loss" definition under one insuring clause did not include "any costs or expenses incurred to perform any obligation assumed by, on behalf of, or with the consent of any Insured." The court opined that these provisions were "[f]unctionally . . . the same in that they bar coverage for contractual obligations an insured assumes with a third-party outside of the Policy." Here, in connection with the demand letter from the credit card processor, the court ruled that these provisions barred coverage in its entirety because the demand letter was made pursuant to the insured's agreement to indemnify and hold harmless the credit card processor. As a result, the court ruled that there was no coverage for any of the amounts sought. ■

Colorado Supreme Court: No Prejudice Required to Deny Coverage for Settlement Without Consent

The Colorado Supreme Court has held that an insurer had no duty to cover a settlement entered into by an insured regardless whether the insured's failure to obtain the insurer's consent prejudiced it in any way. *Travelers Prop. Cas. Co. v. Stresscon Co.*, 2016 WL 1639565 (Colo. Apr. 25, 2016). Wiley Rein represented an *amicus curiae* in support of the insurer.

The insured, a concrete subcontractor, caused a serious construction accident. The general contractor sought damages from the insured, and the insured and the general contractor entered into a settlement agreement without consulting with the insurer. The insured later sought to obtain reimbursement for that settlement from the insurer.

In the trial court, the insurer argued that the insured's settlement—without the insurer's consent—was not covered. The policy stated that "[n]o insured will, except at the insured's own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without our consent." The trial court concluded that the insurer was required to show, and had not shown, that it suffered prejudice from the settlement. That decision was affirmed by an intermediate appellate court.

On appeal, the Colorado Supreme Court reversed, and it held that the lower courts erred by imposing a prejudice requirement on the policy's voluntary payment provision. The court observed that such provisions have important implications for the risks insured and that the consent requirement is not "a mere technicality imposed upon an insured in an adhesion contract." The court also found that imposing a prejudice requirement in the settlement context would "ignore the competing interests and risks of collusion or fraud" and would "effectively deny insurers the ability to contract for the right to defend against third-party claims or negotiate settlements in the first instance." ■

Seventh Circuit: A Breach of Contract is Not a "Negligent Act"

The United States Court of Appeals for the Seventh Circuit has affirmed a ruling holding that an underlying action alleging only breach of contract did not allege a negligent act, error, or omission required to trigger coverage under the policy at issue. *Hartford Cas. Ins. Co. v. Karlin, Fleisher & Falkenberg, LLC*, 2016 WL 2849449 (7th Cir. May 16, 2016).

A former employee of a law firm sued the firm for breach of contract and violations of the Illinois Wage Payment and Collection Act. The complaint generally alleged that the law firm was required to pay the former employee for his accrued vacation and sick leave when he left the firm, but that the firm did not do so. The law firm held an employee benefits liability policy that provided specified coverage for "employee benefits injury," which was defined to mean "injury that arises out of any negligent act, error or omission in the 'administration' of your 'employee benefits program.'" The insurer denied coverage on several grounds, including that a breach of contract was not a "negligent act" as that term is used in insurance policies.

In the ensuing coverage litigation, the Seventh Circuit affirmed the trial court's grant of summary judgment to the insurer. The court of appeals agreed that the insurer owed no duty to defend or indemnify against the underlying complaint, explaining that insurance policies are "presumed" not to insure against breaches of contract due to moral hazard problems.

The complaint alleged a cause of action for violation of the Illinois Wage Collection and Payment Act (IWPCA), which the insured argued sounded in negligence and therefore triggered a duty to defend. The court disagreed, explaining that "the only violation of the Act that they alleged is the breach of contract." The policyholder also argued that the insurer was estopped from denying coverage under the doctrine announced in *Employers Ins. of Wausau v. Ehlco Liquidating Trust*, 708 N.E.2d 1122, 1135 (Ill. 1999) because the insurer took seven months to respond to the request for coverage. The court of appeals disagreed, stating that "a delay in such a response can't create coverage when there clearly was no duty to defend." ■

Competitor's Claims That Broker Engaged in Unfair Business Practices Involve Professional Services and Are Not Precluded by the "Unfair Competition of Any Type" Exclusion

Applying Massachusetts law, the United States Court of Appeals for the First Circuit has held that unfair business practices claims brought against an insured insurance broker by a competitor involved professional services within the scope of its professional liability policy and that an exclusion for "unfair competition of any type" did not apply because the allegations did not involve consumer confusion. *Utica Mutual Ins. Co. v. Herbert H. Landy Ins. Agency*, 2016 WL 1566644 (1st Cir. April 19, 2016).

The insured, an insurance broker for real estate professionals, was sued by one of its competitors in California for unfair business practices and negligence. The suit alleged that the broker violated California state law by improperly offering surplus lines insurers' policies despite the adequacy of the admitted market. Under California law, an insurance broker is only allowed to offer surplus lines insurers' policies (with lower premiums) when the admitted pool is deemed inadequate.

The broker sought a defense from its insurer, and the insurer filed suit seeking a declaratory judgment that it owed no duty to defend the broker against the competitor's claims because the competitor's negligence claims did not arise out of professional services and because the exclusion for unfair competition precluded coverage. The trial court granted summary judgment in favor of the broker, which the appellate court affirmed.

In doing so, the court first explained that the competitor's complaint can reasonably be construed to "sketch" a professional liability claim and thus covered under the policy. The court pointed to the allegations that the broker "failed to act with reasonable care in the solicitation and placement [of insurance policies]" and "failed to conduct a diligent search of the admitted market, filed falsified documentation relating to the search, and evaded scrutiny . . . by failing to file required statements." According to the court, "these activities – soliciting and placing insurance policies, searching the

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Competitor's Claims That Broker Engaged in Unfair Business Practices Involve Professional Services and Are Not Precluded by the "Unfair Competition of Any Type" Exclusion

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admitted market, and filing related documentation – are part of the professional activity of an insurance agent or broker" as they require "knowledge and skills particular to the insurance profession." The court also dismissed the insurer's arguments that professional liability insurance does not cover claims by competitors and that the policy does not apply because the broker did not breach any professional duties owed to the competitor.

The court then turned to the exclusion for "unfair competition of any type," and held that even though the lawsuit alleged unfair business practices in violation of state law, the lawsuit did not allege consumer confusion, which is how "unfair competition" is defined according to Massachusetts law. The court explained that Massachusetts's interpretation necessarily means that "unfair competition" will not encompass the full range of unfair business practices prohibited by state statutes that do not deal with consumer confusion. Additionally, the court explained that, contrary to the insurer's position, the modifier "any type" does not make the exclusion applicable to claims that do not allege any kind of consumer confusion. According to the court, the traditional core of unfair competition is consumer confusion as to the source or origin of goods or services, and that even the expanded meaning taken by some courts to include "confusion as to sponsorship, endorsement, or some other affiliation" would still not capture the competitor's allegations of negligence against the broker. ■

D&O Policy Forum Selection Clause Not Binding on Individual Insured

The United States District Court for the Eastern District of New York, applying international law, has held that a Swiss forum selection clause in a D&O policy issued to the Federacion Internationale de Football Association (FIFA) did not apply to an individual insured because the individual, a FIFA executive, was not a signatory to the policy and was not domiciled in the country of the insurers or the named insured. *Li v. Certain Underwriters at Lloyd's, London*, 2016 WL 1706125 (E.D.N.Y. Apr. 27, 2016). Pursuant to its ancillary jurisdiction, which was triggered as a result of the underlying criminal proceedings against the insured executive, the court ordered the insurers to advance the executive's defense costs.

The executive had held a number of positions within FIFA and its member associations, including serving as a member of several FIFA standing committees. In May 2015, a federal grand jury in the Eastern District of New York returned an indictment charging the executive and other FIFA-connected defendants with participating in an international racketeering conspiracy and related crimes. The executive was arrested in Switzerland and extradited to the United States. The executive sent a letter to FIFA's insurers, notifying them of his indictment and extradition and requesting payment for the cost of his defense under a D&O policy issued to FIFA.

The insurers denied coverage, and the executive filed suit in New York state court. The insurers removed the case to federal court in the Eastern District of New York, but advised the federal court that subject-matter jurisdiction may not exist. The executive moved for a preliminary injunction directing the insurers to pay his defense costs, and the insurers moved to dismiss based on the policy's Swiss forum selection clause and on forum non conveniens grounds.

The court first determined that it could decide the coverage dispute pursuant to its ancillary jurisdiction, triggered by the criminal proceedings against the executive pending before the court. The court found that the criminal proceedings and the insurance coverage dispute were factually interdependent and that successful management of the criminal case required preventing any obstacles to a timely, efficient, and fair trial. Although the court acknowledged that the insurers were not parties to the criminal proceedings, it concluded that the exercise of ancillary jurisdiction would not prejudice the insurers because they had voluntarily come before the court by removing the executive's suit from New York state court.

The insurers argued that the suit should be dismissed pursuant to the D&O policy's forum selection clause,

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which provided: "For any disputes arising under this insurance relationship, a Swiss place of Jurisdiction and the application of Swiss Law shall be deemed to be agreed." In addressing the insurers' argument, the court first determined that the Lugano Convention, an international treaty to which Switzerland is a party, applied to the dispute. The court then looked to a case decided by the European Court of Justice, which interpreted the relevant portion of the treaty and held that a jurisdiction clause in an insurance policy cannot be relied upon against a beneficiary who has not expressly subscribed to the clause and who is domiciled in a country other than that of the policyholder or insurer. Based on this international jurisprudence, the court held that the policy's Swiss forum selection clause did not apply to the executive and that the coverage action could proceed in New York federal court.

The court also rejected the insurers' motion to dismiss on forum non conveniens grounds. While noting that a plaintiff's choice of forum normally is entitled to less deference where it is not the plaintiff's home forum, the court observed that the executive chose to sue in New York because it is where he is facing criminal trial. Weighing the relevant factors, the court concluded that it would be more efficient and convenient for the parties and the court to apply Swiss law than for a Swiss court to re-litigate factual issues that would already be resolved by the New York court in the criminal proceedings.

Finally, the court granted the executive's motion for a preliminary injunction requiring the insurers to advance his defense costs. The court did not apply a heightened standard, as is generally required when an injunction will require a positive act, because it found that the insurers already should have advanced the executive's legal fees under the terms of the policy, subject to their right to recoup the payments if successful on the merits in the coverage litigation. The court concluded that the failure to advance defense costs would cause irreparable harm to the executive and that the executive had established a clear and substantial likelihood of success on the merits in the coverage dispute. Specifically, the court found that the indictment triggered coverage for defense costs and investigative costs under the policy and that the legal fees incurred in connection with the executive's extradition triggered coverage for extradition costs. The court further concluded that the balance of hardships favored the executive because, if no injunction were issued, the executive would never receive the benefit of his bargain, would likely be deprived of his chosen counsel, and might sustain a conviction he would otherwise have avoided. Conversely, the insurers faced only monetary loss which might be recouped as provided for in the policy. ■

Claim for Trademark-Infringing Telephone Scam Not Interrelated with Claim for Internet Scam

The United States District Court for the Eastern District of Pennsylvania, applying Pennsylvania law, has held that a telephone marketing scam and an internet false advertising scam were not interrelated wrongful acts precluding coverage because the conduct behind the alleged wrongful acts was different. *Connect America Holdings, LLC v. Arch Ins. Co.*, 2016 WL 1254073 (E.D. Pa. Mar. 31, 2016).

The insured, a producer of medical alert response systems, was sued by a competitor for trademark infringement and other claims regarding an alleged fraudulent telemarketing operation where the insured was claimed to have misled consumers by creating the impression that they were purchasing products from the well-known claimant. The insured sought coverage for the telemarketing lawsuit under its management liability and crime insurance policy. The insurer denied coverage, asserting that the current lawsuit was based on interrelated wrongful acts alleged in a prior lawsuit in which the claimant had alleged that the insured violated its trademarks through internet advertisements and manipulating keyword searches.

The court denied summary judgment for the insurer, holding that the current lawsuit and prior disputes were not based on interrelated wrongful acts. The policy defined interrelated wrongful acts as "Wrongful Acts that have as a common nexus any fact, circumstance, situation, event, transaction, cause or series of causally connected facts, circumstances, situations, events, transactions or causes." The court stated that "the focus

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Claim for Trademark-Infringing Telephone Scam Not Interrelated with Claim for Internet Scam
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of the interrelatedness inquiry is on the acts, not on the parties or the goals." As such, even though the insured allegedly misused the same trademarks with the goal of misleading consumers into believing they were doing business with the claimant, the court concluded that the gravamen of the current lawsuit was that the insured engaged in a phone scam, whereas the earlier disputes focused on the insured's use of the claimant's trademarks on the insured's website and other internet media. The court found the factual nexus between these acts insufficient to deem the two claims interrelated. ■

Replacement Professional Liability Policy Sufficiently "Similar" to Original Policy to Prevent Application of Extended Reporting Period

Applying Indiana law, the United States District Court for the Northern District of Indiana has held that a policy which insures the same pool of risk and offers professional liability coverage for the insured law firm for professional acts provides "similar coverage" as that term is used in the firm's previous professional liability policy despite the fact that the later policy contained an additional exclusion. *Levy & Dubovich, v. Travelers Cas. & Surety Co. of Am.*, 2016 WL 1244018 (N.D. Ind. Mar. 30, 2016). In light of that conclusion, the court further held that the Automatic Extended Reporting Period (AERP) under the previous policy terminated when the law firm purchased the subsequent policy.

The insured law firm filed a collection action to recover fees allegedly owed to it. A few days later, the law firm's professional liability insurer declined to renew its policy. However, that policy provided for an AERP to take effect, in certain circumstances, at the termination of the policy period. Under the terms of the policy, the AERP would terminate either 60 days after cancellation or non-renewal or the date on which another policy "provid[ing] similar coverage for Professional Services" takes effect, whichever is the earlier date. Following notice from its former insurer that its policy would not be renewed, the law firm purchased another professional liability policy from a different insurer, which contained an exclusion for any suits arising out of or related to claims for fees brought by the firm. The former policy did not contain such an exclusion. After the effective date of the second policy, but before the AERP would have expired under the 60-day provision, the client against whom the law firm had brought its collection action brought a counterclaim for legal malpractice. The law firm tendered the counterclaim to its first insurer, which denied coverage on the grounds that the claim was not made during the policy period or made and reported to the insurer during any applicable AERP because the AERP terminated upon the effective date of the subsequent policy. The law firm and several individual attorneys then filed the instant declaratory judgment action.

On cross-motions for summary judgment, the sole issue before the court was whether the subsequent policy, which excludes coverage for fee disputes, provides "similar" professional liability coverage under the terms of the first policy. In granting the insurer's motion for summary judgment, the court held that the second policy provided "similar coverage" as that term is used under the first policy, concluding that both policies insured the same pool of risk and provided professional liability coverage for the law firm for professional acts. In so holding, the court construed the word "similar" to require that the second policy have characteristics in common with the original policy, but not that it be "identical" in terms of its terms, conditions and exclusions. Thus, the court determined that the AERP terminated when the law firm obtained the second policy, and the first insurer had no duty to defend or indemnify the law firm for the counterclaim because notice of the counterclaim was provided outside the policy period. ■

Appeals Court Vacates Ruling that Breach of Contract Exclusion Barred Coverage, Remands for Consideration of Choice of Law

A New Jersey intermediate court of appeals has vacated and remanded a case in which the trial court held that an insurer had no duty to defend based on a breach of contract exclusion, because the appellate court could not determine whether the exclusion applied without a choice of law analysis. *Pharmacy & Healthcare Commc'ns, LLC v. Nat'l Cas. Co.*, 2015 WL 10793944 (N.J. Super. Ct. App. Div. May 11, 2016).

The policyholders, a marketing company and a publishing company with common ownership, were hired by a pharmaceutical company and its advertising agency to fax advertisements about a drug to 250 pharmacies. The policyholders apparently indicated they had specific permission to send faxes to these pharmacies and that the fax advertising services complied with all applicable federal and state laws. After one pharmacy sued the pharmaceutical company and advertising agency, the advertising agency filed a third-party complaint against the policyholder that provided marketing services. The complaint alleged breach of contract, intentional misrepresentation, negligent misrepresentation and promissory estoppel.

The policyholders sought coverage under a business and management indemnity policy, and the insurer denied coverage based on the D&O coverage part's professional services and breach of contract exclusions. The policyholders retained defense counsel and incurred $588,724.68 in defense and $400,000 to settle the suit, then filed a declaratory judgment action against the insurer. The trial court concluded that the breach of contract exclusion applied, and declined to rule on the application of the professional services exclusion. The policyholder appealed.

The appellate court vacated and remanded, holding that, while the breach of contract exclusion barred coverage for the breach of contract claim, it could not determine whether the exclusion barred coverage for the other claims asserted in the third-party complaint. The record below did not show which state's laws the insurer applied in analyzing coverage, so the appellate court could not determine whether the non-contract counts could be asserted independent from the contract between the parties, and in turn, whether the breach of contract exclusion also applied to bar coverage for the additional causes of action. The court therefore remanded for consideration of whether the law of the jurisdiction the insurer applied in reaching its coverage determination supports that determination, as well as whether the insurer's application of the laws of that jurisdiction was appropriate. ■

Excess Insurer Can Pursue Statutory and Common Law Bad Faith Claims Against Primary Insurer as Assignee of Insured

Applying Rhode Island law, the United States District Court for the District of Rhode Island has held that an excess insurer can maintain a cause of action for bad faith failure to settle against a primary insurer. *Columbia Cas. Co. v. Ironshore Spec. Ins. Co.*, 2016 WL 2930927 (D.R.I. May 19, 2016). In addition, the court held that the enactment of statutory bad faith did not preclude a cause of action for common law bad faith under Rhode Island law and that an excess insurer could bring a statutory bad faith claim against a primary insurer as an assignee of the insured's rights.

A patient and his wife filed a medical malpractice lawsuit against the insured hospital after the patient suffered severe and permanent brain injury under its care. The hospital tendered the claim to its primary and excess professional liability carriers. The hospital had a $6 million self-insured retention; $15 million in primary coverage; and $11 million in excess coverage. The claimants made a demand for $32 million, the entirety of the self-insured retention and the primary and excess insurance. At the outset of trial, the primary insurer negotiated a high/low settlement agreement with the claimant based on the outcome of the trial against the hospital with a low payment of $15 million and a high payment of $31.5 million. The claimants won at trial, and the primary and excess insurer paid their respective policy limits to fund the $31.5 million due under the high/low agreement. The primary insurer filed a declaratory judgment action against the excess insurer after the

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Excess Insurer Can Pursue Statutory and Common Law Bad Faith Claims Against Primary Insurer as Assignee of Insured *continued from page 7*

excess insurer demanded that the primary insurer reimburse it for the $11 million it paid toward the settlement. The excess insurer filed a counterclaim alleging that the primary insurer had committed common law and statutory bad faith under Rhode Island law for failing to settle the case for the primary insurer's $15 million limit of liability.

The court held that the excess insurer stated a claim for statutory and common law bad faith and denied the primary insurer's motion to dismiss the excess insurer's counterclaim. The court held that the excess insurer stated a claim for common law bad faith because the primary insurer allegedly failed to settle the claim within the primary insurer's limit of liability. It rejected the primary insurer's argument that the excess carrier's common law bad faith claim was foreclosed because the excess carrier consented to the high/low agreement. The court reasoned that the bad faith claim was not foreclosed because the high/low agreement did not result in a settlement within the limit of liability of the primary policy.

The court also held that the excess insurer could pursue the primary insurer for statutory bad faith. Although a primary insurer's obligations to act in good faith run only to the insured, the court held that Rhode Island law recognizes that an assignee of the insured can pursue a statutory bad faith claim, and the excess insurer obtained a written assignment from the insured of its bad faith claim against the primary insurer. The court also held that the existence of statutory remedies for bad faith did not preclude the excess insurer from also pursuing a common law bad faith claim. ■

SPEECHES & EVENTS

Local Government on Trial: Wrongful Conviction Lawsuits

Benjamin C. Eggert, Speaker

PRIMA's 2016 Annual Conference

June 7, 2016 | Atlanta, GA

Fiduciary Liability Insurance

Kimberly M. Melvin, Speaker

American Conference Institute's 12th National Forum on ERISA Litigation

June 28, 2016 | San Francisco, CA

Achieving Reasonable Expectations and Employing Effective Tactics in a Securities Class Action Mediation

Kimberly M. Melvin, Speaker

American Conference Institute's National Forum on Directors & Officers and Management Liability

July 27, 2016 | New York, NY

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