Wiley Rein LLP

EXECUTIVE SUMMARY

Legal Developments Affecting Professional Liability Insurers | July 2016

Wiley Rein Secures Favorable Outcome for Insurer in Jury Trial Related to Ponzi Scheme Coverage

On June 3, 2016, after a multi-day trial in a hotly contested case, a New York jury found that Continental Casualty Company did not unreasonably delay in seeking to rescind an accountants professional liability policy and therefore had not waived its right to rescind the policy. Wiley Rein partner Richard A. Simpson represented Continental, leading a team that included consulting counsel Ashley E. Eiler and partner Kimberly A. Ashmore. *Continental Cas. Co. v. Marshall Granger & Co., LLP*, Case No. 11 Civ. 3979 (S.D.N.Y.).

In 2011, Continental filed an action in the United States District Court for the Southern District of New York, seeking to rescind an accountants professional liability policy it had issued to Marshall Granger & Co., LLP, after it came to light that former Marshall Granger partner Laurence M. Brown had been perpetrating a Ponzi scheme. Joseph J. Boughton, Jr. and Northstar Investment Group, Ltd., who had asserted claims against Marshall Granger, intervened in the rescission litigation after obtaining an assignment of rights from former Marshall Granger partner Ronald Mangini, who was also implicated in the Ponzi scheme.

In ruling on several rounds of dispositive motions, the Court previously held that Marshall Granger had made material misrepresentations on the application for the policy by not disclosing the Ponzi scheme, and that Continental had a right to rescind the policy in its entirety, including as to any "innocent" insureds, unless it had waived that right by unreasonably delaying in filing the rescission action.

Boughton and Northstar asserted that Continental did not rescind the policy promptly enough and that the time it took to investigate before rescinding was unreasonable. Continental defended its actions, arguing that it acted cautiously, prudently, and properly by not making a final decision to rescind without first completing a detailed and thorough investigation into the complex facts presented by the Ponzi scheme allegations.

The jury quickly returned a verdict in favor of Continental, concluding that Boughton and Northstar had not proven, by a preponderance of the evidence, that Continental had unreasonably delayed in pursuing rescission. ■

Federal Appellate Court Declares "Language of the Policy is King" in Affirming Application of Contract Exclusion

The United States Court of Appeals for the Seventh Circuit has affirmed a trial court's ruling that, under Illinois law, a contract exclusion applied to preclude coverage for a claim stemming from an insured's failure to pay its contractor because all of the claimant's causes of action arose from its contract with the insured. *Altom Transp., Inc. v. Westchester Fire Ins. Co.*, 2016 WL 2956834 (7th Cir. May 20, 2016). The appellate court also dismissed the claimant—a dispensable, non-diverse party—in order to preserve diversity jurisdiction.

continued on page 2

ALSO IN THIS ISSUE

2 Insured Failed to Show Claim Fell Within Exception to Insured v. Insured Exclusion

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

4 Due to Lack of Notice, E&O Carrier Has No Duty to Indemnify Insured Auto Insurer's Settlement Payment Stemming from Bad Faith Claim

4 Prior Acts Date Limits Insurer's Liability for Underlying Judgment

5 Insured v. Insured Exclusion, Allocation Do Not Apply to Related Claims

6 Court Limits Discovery in Absence of Bad Faith Claim

6 Insurer Not Required to Produce Post-Litigation Claim File Documents

7 No Coverage for Claims Made After Statutory Coverage Extension Period Upon Notice of Policy Non-Renewal

7 No Coverage for Lawsuit After Policy Period that Does Not Arise from Notice of Circumstances

8 Insurer Did Not Breach Duty to Defend Where it Refused to Defend Insured's Husband and Marital Community

8 Speeches & Events

Federal Appellate Court Declares "Language of the Policy is King" in Affirming Application of Contract Exclusion *continued from page 1*

The case arose when the insured sought coverage for defense costs and a potential settlement in connection with a claim brought by one of the insured's contractors for failure to pay for his services. The contractor asserted various causes of action against the insured, including violation of statute, breach of contract, and unjust enrichment. The insurer denied coverage for the claim and did not respond to the insured when it requested that the insurer reconsider its denial in light of settlement demands made by the claimant that were within the limits of the management liability policy the insurers had issued to the insured.

The insured filed a declaratory judgment action in Illinois state court, asserting that the insurer wrongfully refused to defend the insured in violation of Illinois statute and that the insurer was therefore estopped from asserting non-coverage. The insured also named the claimant as a defendant because the insured believed it was required to do so pursuant to Illinois case law. The insurer removed the case to federal court and filed a motion to dismiss, arguing that policy's unpaid wages and contract exclusions applied. The federal district court granted the motion and the insured appealed.

In affirming the district court's ruling, the appellate court first addressed whether the case fell within the court's diversity jurisdiction in light of the insured and the claimant both being citizens of the same state. To preserve such jurisdiction, the court dismissed the claimant from the suit since he was a "dispensable, non-diverse party" who had no legal interest in the suit. According to the appellate court, claimants are indispensable under Illinois law when an insurer sues its insured for a declaratory judgment defining coverage, but not when the insured initiates the declaratory judgment action, as the insured can sufficiently represent the claimant's interest in that scenario.

Next, the court turned to the coverage issues, explaining that the "language of the policy is King," and, as such, coverage for claims stemming from the insured's contract with third parties was "unambiguously exclude[d]." According to the court, the claimant's allegations against the insured, regardless of the legal theory asserted, "rest fundamentally on the lease agreement under which [the claimant] was performing." As a result, the policy's exclusion for claims "arising out of, attributable to, directly or indirectly resulting from, in consequence of or in any way involving the actual or alleged breach of any contract" applied. The appellate court further determined that the exception to the exclusion for claims the insured would have been liable for in the absence of a contract did not apply because the claims asserted by the claimant all depended on the content of the agreement.

Finally, the appellate court found that the insurer was not estopped from denying coverage because estoppel applies only when an insurer has breached its duty to defend, which was not the case here. ■

Insured Failed to Show Claim Fell Within Exception to Insured v. Insured Exclusion

Applying Arizona law, the United States Court of Appeals for the Ninth Circuit has affirmed the dismissal of a coverage action brought by an insured on the grounds that the insured failed to demonstrate the applicability of an exception to the Insured v. Insured exclusion in a D&O liability policy. *AMERCO v. National Union Fire Insurance Co. of Pittsburgh, PA*, 2016 WL 3157301 (9th Cir. Jun. 6, 2016).

Five plaintiffs filed separate shareholder derivative lawsuits against the insured holding company and a number of its directors and officers. Those suits subsequently were consolidated into one action. The insured company sought coverage for the consolidated action under its D&O policy. Because one of the plaintiffs was an insured under the policy, the insurer denied coverage for the entire consolidated action based on the Insured v. Insured exclusion. This exclusion barred coverage for any claim by a security holder except when "such security holder's claim is instigated and continued totally independent of" any Insured.

In the coverage action that followed, the court found that the insured had failed to allege facts sufficient to establish that the Insured v. Insured exclusion did not apply. Specifically, the court held that the insured company failed to allege that the claims by the other four shareholder plaintiffs were totally independent of the claim by the insured shareholder plaintiff such that the exception to the exclusion applied. The court explained that continued on page 3

Insured Failed to Show Claim Fell Within Exception to Insured v. Insured Exclusion

continued from page 2

while the "insurer has the burden of proving that a policy exclusion is applicable . . . the insured carries the burden of proving that his claim falls within an exception to that exclusionary clause." Here, according to the court, the insured did not meet its burden. ■

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 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. ■

Due to Lack of Notice, E&O Carrier Has No Duty to Indemnify Insured Auto Insurer's Settlement Payment Stemming from Bad Faith Claim

An Illinois federal court, applying Illinois law, has ruled that, due to lack of proper notice, an E&O insurer had no duty to indemnify its insured auto insurance company's $7 million settlement payment stemming from a bad faith claim in an underlying auto accident lawsuit. *Lexington Ins. Co. v. Horace Mann Ins. Co.*, 2016 WL 2977169 (N.D. Ill. May 13, 2016). In so holding, the court found that even if the insured auto insurer provided written notice of a potential Claim, it was still required to provide written notice once a Claim was actually made against it.

The insured auto insurance company had issued an auto policy implicated by a motorcycle accident. The claimant's attorney sent a bad faith "set up" letter to the driver's insurer, offering to settle the entire claim for the bodily injury limits of the insured's insurance policy if the insurer tendered a check within 20 days of the letter. The insurer responded before the 20 days elapsed, acknowledging that it was willing to settle the case for the policy limit, but advised that it needed to review hospital records before settling. The insurer did not receive the medical records within the 20 days and therefore did not tender a settlement check. The claimant filed a lawsuit against the driver, which resulted in a $17 million jury award. While post-trial motions were pending, the motorcyclist's lawyer emailed the auto insurance company's attorney asserting bad faith and demanding the full $17 million from the auto insurer.

The auto insurance company had its own E&O policy. Under the E&O policy, the insured was required to provide written notice of both potential and actual Claims. The policy also provided that the auto insurance company could not enter into any settlement without written consent by the E&O insurer.

The auto insurance company provided notice of a potential claim to the E&O insurer a few weeks before the jury's $17 million award, and the auto insurance company orally reported the bad faith demand by the claimant. The auto insurer and motorcyclist claimant later reached a settlement of $7 million, shortly after the E&O carrier denied coverage for late notice.

In the declaratory judgment action filed by the E&O insurer, the court first analyzed the contractual provisions relating to the definition of "Claim" and those defining "Notice." The Policy defined "Claim" as either (1) a written demand for monetary damages or (2) a judicial, administrative, arbitration, or other alternative dispute proceeding, in which monetary damages are sought. The parties disputed when the motorcyclist's Claim was first made against the auto insurance company. The court determined that the email asserting bad faith and demanding $17 million was a Claim that triggered a contractual duty for the auto insurance company to inform its E&O carrier about the Claim.

The court then determined that the auto insurance company did not provide timely notice of that Claim to its E&O carrier. According to the court, even if the auto insurance company previously gave written notice of a potential claim, the Policy required it to provide a second written notice once it knew that the potential claim had ripened into a Claim. Consequently, the court held that because the auto insurance company settled its case with the motorcyclist before it provided its E&O carrier with written, contractually compliant Notice, the E&O carrier has no duty to indemnify the auto insurance company. ■

Prior Acts Date Limits Insurer's Liability for Underlying Judgment

The United States District Court for the Eastern District of Virginia, applying Virginia law, has held that a lawyer's professional liability insurer's liability was limited because the underlying action arose out of acts, errors, or omissions occurring on or before a prior acts date specified in the policy. *Minnesota Lawyers Mut. Ins. Co. v. Protostorm, LLC*, 2016 WL 3447892 (E.D.Va. June 22, 2016).

The insurer issued a malpractice policy to a law firm. The policy included a split limit of liability, providing $5 million in coverage for any Claim arising out of any acts, errors, or omissions which occurred on or before October 25, 2006, and a $10 million limit for any acts occurring after that date.

continued on page 5

An internet game company retained the law firm in 2000 to prepare and prosecute patent applications. The law firm properly filed a provisional application in 2001, but allegedly made a mistake in a later filing, jeopardizing the company's ability to receive patent protection. The error could have been corrected as late as February 2003; however, the firm abandoned the patent application without informing the company. When the company did not hear from the firm for five years, it investigated and learned in 2008 that the law firm had abandoned the application. The company filed suit. The jury found for the company, awarding compensatory damages of nearly $7 million.

The insurer sought a declaratory judgment that the policy's $5 million limit of liability applied, rather than the $10 million limit, because the underlying judgment arose out of acts, errors, or omissions occurring before October 25, 2006.

The court determined that the lower limit of liability applied. The court reasoned that because the relevant endorsement addressed the insurer's duty to indemnify for claims resulting from the rendering of professional services, the term "Claim" should be read in context to mean "the cause of action within a lawsuit that obligates [the insurer] to pay damages covered by the Policy." In interpreting the phrase "arising out of," the court examined whether there was a "causal connection between a particular fact or source of law and an essential element of the cause of action alleged." The court determined that law firm's liability arose from its failure to prosecute the applications, which could not be corrected after February 2003. Thus, the court reasoned that "all of the elements necessary for the accrual of the malpractice cause of action were present by early 2003 at the latest," and the action could not have been a Claim arising out of an act, error or omission occurring after October 2006.

The court rejected the law firm's theory that the Claim at issue comprised the entire malpractice lawsuit and that the success of that lawsuit depended on some post-October 2006 act to toll the statute of limitations. The court determined that, "[a]s a factual matter, no post-October 2006 act, error, or omission was necessary to the tolling of the statute of limitations," and "[a]s a legal matter, it is clear that under the New York law that governed the malpractice lawsuit that acts tolling the statute of limitations do not affect the date of accrual of the cause of action itself." ■

Insured v. Insured Exclusion, Allocation Do Not Apply to Related Claims

A Delaware trial court has affirmed its ruling that an Insured v. Insured exclusion does not apply to a shareholder derivative demand brought by a director of the company because the demand constitutes a single Claim with an earlier demand made by the same individual before he became a director. *Ameritrans Capital Corp. v. XL Spec. Ins. Co.*, 2016 WL 3475108 (Del. Super. Ct. June 15, 2016). The court also held that the insurer was not entitled to an allocation because the Insured v. Insured exclusion did not apply.

The insured, an investment company, sought coverage for investigation costs related to two shareholder derivative demands made by a single individual in November 2012 and December 2013. Because the individual who made the demands was a director of the company when he made the December 2013 demand, the company's D&O insurer denied coverage for that demand, citing the Insured v. Insured exclusion.

After the investment company sued the insurer, the court ruled for the policyholder. The court adhered to its ruling on the insurer's motion for reconsideration. The court held that, under the policy, the two derivative demands constituted a single Claim first made at the time of the first demand. The court held that the Insured v. Insured exclusion did not apply to the single Claim because the shareholder did not make the November 2012 demand on the investment company when he was an Insured Person. The court opined that its holding did not frustrate the "purpose" of the Insured v. Insured exclusion, as the facts revealed an individual's "shift[] from being an unhappy stockholder to being an officer and board member," not collusion.

Finally, the court rejected the insurer's argument that the policy's allocation clause would necessitate an allocation between costs incurred for the November 2012 demand and the December 2013 demand. The court held that the Insured v. Insured exclusion did not apply, and therefore there were no non-covered losses necessitating an allocation. ■

Court Limits Discovery in Absence of Bad Faith Claim

The United States District Court for the Middle District of Florida, applying federal law, has denied a motion to compel an insurer to produce its claims file, underwriting file, and claims handling protocols in coverage litigation, holding that such documents are not relevant in the absence of bad faith allegations. *Koster v. Landmark Am. Ins. Co.,* 2016 WL 3014605 (M.D. Fla. May 20, 2016). The court further held that, while information about why the insurer denied coverage is relevant and discoverable, information about what steps the insurer took to arrive at that decision is not relevant in the absence of a bad faith claim and is therefore not discoverable.

Plaintiffs sued the insured accounting firm alleging sale of unregistered securities, breach of fiduciary duty, and unjust enrichment. The accounting firm's insurer denied coverage based on prior litigation and professional services exclusions. The accounting firm settled the underlying claims and assigned its rights under the policy to the plaintiffs. In discovery, plaintiffs moved to compel the insurer to produce certain documents, including its claims file, underwriting file, and claims handling protocols.

The court denied the plaintiffs' motion to compel in large part. In support of its relevance objections, the insurer argued that the requested materials only would be relevant to show how it handled the insured's claims for coverage and therefore such requests would be premature unless and until plaintiffs alleged that the insurer's denial of coverage was in bad faith. Plaintiffs argued that such documents would be relevant to interpreting allegedly ambiguous terms in the policy. In denying plaintiffs' motion to compel with respect to the claims file, underwriting file, and claims handling protocols, the court concluded that plaintiffs failed to explain how such documents would clarify any purported ambiguities, and the materials would not be relevant to the coverage dispute.

The court also sustained the insurer's objection to a contention interrogatory that broadly requested that the insurer provide all information it had for each of its denials, affirmative defenses, and counterclaims. The court concluded that contention interrogatories should be used sparingly and narrowly tailored rather than seeking a "detailed narrative of Defendant's entire case." ■

Insurer Not Required to Produce Post-Litigation Claim File Documents

Applying California law, a federal district court has held that an insured is not entitled to discovery of information in its insurer's claims-handling file that post-dated the filing of coverage litigation. *Genesis Ins. Co. v. Magma Design Automation, Inc.*, 2016 WL 3057375 (N.D. Cal. May 31, 2016).

A patent infringement lawsuit and two shareholder securities actions were filed against the insured technology company. The technology company sought coverage for the securities actions from its D&O insurers. In the coverage litigation that followed, the technology company requested discovery of its excess insurer's "claims handling information." The excess insurer had previously produced all of its claim file documents for the time period from the initiation of the securities lawsuits through the date when the technology company had sued the excess insurer in the coverage action. The technology company then sought the excess insurer's claim file for the period following the initiation of the coverage litigation, including information about the excess insurer's reinsurance and reserves. The excess insurer objected on the basis of the litigation privilege created by California Civil Code § 47(b), which protects any "publication" made "[i]n any … judicial proceeding."

The court denied the technology company's discovery request, holding that post-litigation claims-handling information was not discoverable. The court rejected as purely speculative the insured's rationale that the excess insurer's continued refusal to acknowledge coverage for the securities actions must be in bad faith. Deeming the request a "fishing expedition into the heart of the insurer's litigation strategy," the court held that "the insurer has an absolute right to defend against the insured's claims, and opening up its litigation file to its insured would undermine its fair day in court." ■

No Coverage for Claims Made After Statutory Coverage Extension Period Upon Notice of Policy Non-Renewal

The Court of Appeals of Minnesota, applying Minnesota law, has held that claims made after a statutory 60-day coverage extension period after an insured receives notice of policy non-renewal from an insurer are not covered under a claims-made policy. *Minn. Joint Underwriting Ass'n v. Jacy, LLC*, 2016 WL 3223180 (Minn. Ct. App. June 13, 2016).

After the insured, an adult residential care facility, failed to complete a renewal application, on July 11, 2011, the insurer sent the insured a letter stating that the insured's claims-made policy was not renewed effective at the end of the policy period on July 1, 2011. The July 11 letter offered the facility an extended reporting period endorsement for additional coverage. The facility declined the endorsement. In June 2012, the facility received notice that a client's estate was bringing a wrongful-death action against the facility, and notified the insurer of the claim. The insurer denied coverage on the basis that the claim was not made during the policy period and sought a declaratory judgment that it had no duty to indemnify.

The trial court granted summary judgment for the insurer, and the appellate court affirmed. The insured argued that, since the insurer did not give notice of nonrenewal at least 60 days in advance, as required by Minnesota law, the policy automatically renewed for an additional year. The court rejected that argument. The court noted that the Minnesota statute that establishes the 60-day requirement for notice of nonrenewal also provides the remedy if an insurer fails to provide sufficient notice—the policy remains in place until 60 days after the notice of nonrenewal is provided. The court opined that no coverage existed here because the claim indisputably was made almost one year after the notice of nonrenewal. Accordingly, because the claim was made after the 60-day statutorily mandated extension period, coverage was unavailable. ■

No Coverage for Lawsuit After Policy Period that Does Not Arise from Notice of Circumstances

Applying Illinois law, the United States District Court for the Northern District of Illinois has held that no coverage was available under an E&O policy for a lawsuit first made after the policy expired because it did not arise out of a notice of circumstances provided during the policy period. *St. Paul Mercury Ins. Co. v. Hershare Fin. Corp.*, 2016 WL 3227311 (N.D. Ill. June 13, 2016).

During the policy period of a claims-made policy, the insured financial institution provided a notice of circumstances to its insurer. The notice of circumstances stated that, because the insured was subject to a consent decree and other regulatory controls, regulators, shareholders, or others might bring claims against the insured and were likely to allege "negligence, gross negligence, breach of fiduciary duty, and failure to act in good faith." After the expiration of the policy period, a creditor filed suit against the insured for allegedly concealing financial problems when selling subordinated debentures and for later defaulting on those debentures. The bank sought coverage under the policy for that lawsuit based on its tender of the notice of circumstances during the policy period. The policy provided that "any Claims subsequently arising from such circumstances shall be considered to have been made during the Policy Year . . . in which such circumstances and other information was first given to the Insurer." The insurer denied coverage for the lawsuit because it was not a claim first made during the policy period.

The court held that the lawsuit was not a claim first made during the policy period because it did not arise from the notice of circumstances provided by the insured during the policy period. The court reasoned that the lawsuit did not arise out of the notice because the notice did not describe a potential lawsuit by claimants such as creditors, did not mention the potential for misrepresentation and breach of contract causes of action, and did not describe the potential wrongful acts that were alleged in the lawsuit. The court rejected the argument that the insurer must provide coverage for "any claim brought by any party if that claim related to the bank's financial instability." It concluded that such a broad interpretation of the notice of circumstances provision would defeat the purposes of a claims-made policy, which include allowing an insurer to easily identify risks, know in advance its claims exposure, and compute premiums with greater certainty. ■

Insurer Did Not Breach Duty to Defend Where it Refused to Defend Insured's Husband and Marital Community

The United States District Court for the Western District of Washington, applying Washington law, has held that insurers did not breach their duty to defend where they refused to provide a defense for an insured's husband and marital community. *Staheli v. Chicago Ins. Co.*, 2016 WL 2930444 (W.D. Wash. May 19, 2016). The court also held that the insurers could not be liable for bad faith or for violations of the Insurer Fair Conduct Act or Consumer Protection Act.

Two insurers issued professional liability policies covering an individual's psychology practice. The policies identified the individual as the Named Insured in her capacity as the sole proprietor of her practice. Both policies provided that the insurers had a duty to defend "any Suit against the Insured seeking Damages." The insured, her husband, and their marital community were sued for alleged harm arising out of the insured's treatment of a patient. The only allegation against the insured's husband was that he was married to the policyholder. The insurers defended the insured and settled the underlying action. However, the insurers denied coverage for the insured's husband and their marital community.

In the ensuing coverage litigation, the court granted the insurers' motion to dismiss because neither the insured's husband nor the marital community were insureds under the professional liability policies. The court noted that an insurer has a duty to defend any claims against an insured that could conceivably be covered under insurance policies but that the duty to defend did not extend to "any *party* who could conceivably have been covered by its *insurance policy*." In addition, the court concluded that it was irrelevant that the insured's husband or the marital community could have ultimately been liable for the insured's activities under Washington marital community property law because the policies only required the insurers to provide coverage for "all sums which the Insured became legally obligated to pay." The court also rejected the argument that the insured's husband and the marital community were third-party beneficiaries of the policies, reasoning that the contracting parties did not objectively intend that there be any third-party beneficiaries.

The court also rejected the insured's claims of breach of contract and breach of duty to defend because the insurers provided a defense to her and settled the underlying action.

Finally, given the lack of unreasonable conduct by the insurers, the court dismissed the claims for bad faith and violations of the Insurer Fair Conduct Act and Consumer Protection Act. ■

SPEECHES & EVENTS

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

Professional Liability Attorneys

Kimberly A. Ashmore	202.719.7326	kashmore@wileyrein.com
Matthew W. Beato	202.719.7518	mbeato@wileyrein.com
Mary E. Borja	202.719.4252	mborja@wileyrein.com
Edward R. Brown	202.719.7580	erbrown@wileyrein.com
Jason P. Cronic	202.719.7175	jcronic@wileyrein.com
Cara Tseng Duffield	202.719.7407	cduffield@wileyrein.com
Benjamin C. Eggert	202.719.7336	beggert@wileyrein.com
Ashley E. Eiler	202.719.7565	aeiler@wileyrein.com
Jessica N. Gallinaro	202.719.4189	jgallinaro@wileyrein.com
Michael J. Gridley	202.719.7189	mgridley@wileyrein.com
Emily S. Hart	202.719.4190	ehart@wileyrein.com
John E. Howell	202.719.7047	jhowell@wileyrein.com
Leland H. Jones, IV	202.719.7178	lhjones@wileyrein.com
Parker J. Lavin	202.719.7367	plavin@wileyrein.com
Charles C. Lemley	202.719.7354	clemley@wileyrein.com
Jessica C. Lim	202.719.3749	jlim@wileyrein.com
Mary Catherine Martin	202.719.7161	mmartin@wileyrein.com
Kimberly M. Melvin	202.719.7403	kmelvin@wileyrein.com
Laura Lee Miller	202.719.4196	lmiller@wileyrein.com
Jason O'Brien	202.719.7464	jobrien@wileyrein.com
Leslie A. Platt	202.719.3174	lplatt@wileyrein.com
Nicole Audet Richardson	202.719.3746	nrichardson@wileyrein.com
Marc E. Rindner	202.719.7486	mrindner@wileyrein.com
Kenneth E. Ryan	202.719.7028	kryan@wileyrein.com
Gary P. Seligman	202.719.3587	gseligman@wileyrein.com
Richard A. Simpson	202.719.7314	rsimpson@wileyrein.com
William E. Smith	202.719.7350	wsmith@wileyrein.com
Daniel J. Standish	202.719.7130	dstandish@wileyrein.com
Margaret D. Thomas	202.719.4198	mthomas@wileyrein.com
David H. Topol	202.719.7214	dtopol@wileyrein.com
Karen L. Toto	202.719.7152	ktoto@wileyrein.com
Jennifer A. Williams	202.719.7566	jawilliams@wileyrein.com
Bonnie Thompson Wise	202.719.3763	bwise@wileyrein.com