Wiley Rein LLP

EXECUTIVE SUMMARY

Legal Developments Affecting Professional Liability Insurers | September 2016

Insured Required to Reimburse Defense Costs Paid by Insurer for Non-Covered Claim

In a win for a Wiley Rein client, the United States District Court for the Southern District of California, applying California law, has held that an insured is required to reimburse his insurer for defense costs incurred for a non-covered claim where the insurer properly reserved its right to recoupment. *Columbia Cas. Co. v. Abdou*, 2016 WL 4417711 (S.D. Cal. Aug. 18, 2016).

The insured life insurance 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 a coverage action. The court held that no coverage was available for the suit because it 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. However, the court did not address the insurer's request for reimbursement of the defense costs it had already expended on the suit, and the insurer filed a motion to alter the judgment.

Citing *Buss v. Superior Court*, 16 Cal. 4th 35 (1997), the court held that California law clearly allows insurers to be reimbursed for attorneys' fees and other expenses paid in defending against claims for which there was no obligation to defend, and an insurer that properly reserves its rights is entitled to reimbursement of defense costs as a matter of law, even where the policy does not provide for reimbursement. The court found that the insurer in its coverage correspondence "adequately reserved its right to assert non-coverage and seek reimbursement." The court rejected the agent's argument that the policy language required the insurer to continue to defend, finding that the exclusions eliminated both the insurer's liability for any monetary judgments or settlements and its duty to pay the costs of defending.

The court determined that the agent did not need discovery regarding the amount paid by the insurer, concluding that the insurer's evidence, including declarations by its claim consultant and cancelled checks made out to the agent's defense counsel, was sufficient. The court also refused to stay the reimbursement order while the agent appealed because of his low likelihood of success on the merits. ■

ALSO IN THIS ISSUE

Prior Knowledge Precludes Coverage Where Undisclosed "Events Bore the Seeds of a Malpractice Claim" Against Insured Lawyer

The United States Court of Appeals for the Sixth Circuit, applying Michigan law, has held that an insured attorney's failure to disclose a potential claim on her renewal application precluded coverage for a later filed suit. *Thomson v. Hartford Cas. Ins. Co.*, 2016 WL 4036403 (6th Cir. July 28, 2016).

An insured lawyer was hired to establish a family trust. The trust agreement named the insured as the independent trustee, and, in that role, she was responsible for managing the trust's sole asset, a life insurance policy. The insured allegedly failed to provide notice to her client of a potential lapse of the policy, and the policy later lapsed when premium payments were not made. In May 2009, the client filed a petition to remove the insured as trustee of the trust, noting the circumstances surrounding the lapse of the policy, and the next month the insured resigned as trustee.

The following year, the insured applied to renew her malpractice insurance policy. The application asked whether the insured was "aware of any act, error or omission that could result in a professional liability claim being made," but the insured answered "no." After the policy was renewed, the client brought a malpractice claim against the insured. The insurer denied coverage on prior knowledge grounds. After the client obtained a judgment against the attorney, it brought a garnishment action against the insurer. The insurer prevailed in the trial court, however, on the basis that the policy barred coverage for claims arising from an act or omission where, prior to inception, the insured "knew or could have foreseen that such act, error, [or] omission could result in a 'claim.'"

On appeal, the court affirmed. The court rejected the argument that this result was "unfair" because the insured had purchased "seamless, uninterrupted" insurance coverage from the same insurer from before the acts giving rise to the claim through the period in which the claim was made. Instead, the court noted that the insured could have reported the potential claim during an earlier period, but had simply failed to do so. The court also rejected the argument that the insured "had a reasonable belief that she had not committed any act … that may give rise to a 'claim,'" concluding instead that "[a]ny reasonable lawyer would have known that this course of events bore the seeds of a malpractice claim." ■

Contract Exclusion Bars Coverage for Suit Alleging Breach of Special Relationship and Conversion

The United States Court of Appeals for the Ninth Circuit, applying Washington law, has held that a contract exclusion precluded defense or indemnity coverage for a suit alleging breach of special relationship and conversion torts that were predicated on premature termination of a contract. *X2 Biosystems, Inc. v. Federal Ins. Co.*, 2016 WL 4120694 (9th Cir. Aug. 3, 2016).

A technology company licensed some of its technology to a manufacturer pursuant to a license agreement. After receiving the monetary consideration due under the contract, the technology company terminated the contract. The manufacturer brought a suit against the technology company alleging various business torts. Two of the torts were "breach of special relationship" and conversion. The breach of special relationship cause of action asserted that, due to a "special relationship" between the two companies, the technology company owed a duty to disclose its intent to terminate the agreement after receiving the monetary payments. The conversion cause of action asserted that the technology company wrongfully retained the monetary payments made under the contract.

The technology company tendered the suit to its E&O insurer, which denied defense and indemnity coverage, citing the contract exclusion. That exclusion precluded coverage for claims "based upon, arising from, or in consequence of any actual or alleged liability of an Insured Organization under any written or oral contract or agreement, provided that this Exclusion . . . shall not apply to the extent that an Insured Organization would have been liable in the absence of the contract or agreement."

In the ensuing coverage litigation, the district court granted the insurer's motion

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Contract Exclusion Bars Coverage for Suit Alleging Breach of Special Relationship and Conversion *continued from page 2*

to dismiss, holding that the contract exclusion operated to preclude coverage. The court of appeals affirmed the judgment of the district court. The insured argued that the "breach of special relationship" and conversion torts were independent of any duties the insured owed under contract. The court of appeals disagreed, holding that both causes of action arose out of or were a consequence of the license agreement. As the court of appeals noted, the two companies would not have had a "special relationship" absent the license agreement, and the breach of special relationship tort thus arose out of the contractual agreement. The court of appeals also held that the conversion claim was "closely tied" to the contract, because the "premature termination of the [agreement] . . . gave rise to the conversion allegation." ■

SEC Letter and Order Directing Private Investigation Held Not to Allege Wrongful Acts

The United States District Court for the District of Colorado, applying Colorado law, has granted summary judgment in favor of an insurer, holding that a letter from the SEC's Division of Enforcement advising that the agency was conducting an inquiry into a company's operations did not allege a Wrongful Act as defined by a D&O policy. *Musclepharm Corp. v. Liberty Ins. Underwriters, Inc.*, 2016 WL 4179784 (D. Colo. Aug. 4, 2016). The court also granted summary judgment for the insurer on the insured's statutory and common law bad faith claims.

The insured company received a letter from the SEC's Division of Enforcement stating that the agency was conducting an inquiry into the company's operations and requesting voluntary production of documents. Two months later, the company received an "Order Directing Private Investigation and Designating Officers to Take Testimony" from the SEC, stating that the agency had "information that tends to show" various "possible violation[s]" of federal securities laws. The Order directed that a "private investigation be made to determine whether any persons or entities have engaged in . . . any of the reported acts or practices." The insurer denied coverage for both the SEC letter and the Order on the ground that neither communication was a "Claim" against an insured. The insured filed suit seeking reimbursement for the defense costs it incurred in complying with the Order and alleging causes of action for statutory and common law bad faith denial of coverage.

In granting summary judgment in favor of the insurer, the court held that the policy did not afford coverage for the letter or the Order because the investigation did not allege a "Wrongful Act." The policy provided coverage for Loss arising from a Claim "for a Wrongful Act," which was defined to mean "any actual or alleged error, misstatement, misleading statement, act, omission, neglect, or breach of duty." The court reasoned that the term "alleged" ordinarily means "'declared or stated to be as described; asserted.'" Given that definition, the court determined that an alleged error or omission must "involve a positive assertion that the implicated error or omission is believed to have actually occurred, even if still subject to proof." The court found that neither the letter nor the Order made such an assertion. The Order's purpose, according to the court, was to authorize the SEC to determine whether hypothetical violations occurred. The court emphasized that the letter and the Order contained disclaimers that evidenced that the SEC "was not averring violations *had* occurred" but rather, "sought only to determine *whether* they had."

Finally, the court granted summary judgment for the insurer on both the statutory and common law bad faith claims, reasoning that the insurer had a good faith basis rooted in the policy language to deny coverage. ■

Non-Specific Notice of Potential Claim Insufficient Under Claims-Made Policy

Applying Pennsylvania law, a federal district court has held that an insured's notice of potential claim was insufficiently detailed to trigger coverage under a claims-made policy. *University of Pittsburgh v. Lexington Ins. Co.*, 2016 WL 3963104 (S.D.N.Y. July 21, 2016).

The insured, an architectural firm, submitted a "notice of occurrence/claim" on the last day of the coverage period for its claims-made insurance policy. The notice stated only that its senior management had been advised by its client, a university, that "this project is experiencing problems and delays in its early stages." The policy required that written notice of a potential claim include the actual or alleged breach of duty, a description of the professional services rendered, and a description of the injury or damage that might result in a claim. After reviewing the notice, the insurer requested additional information but did not receive a response. The insurer therefore apprised the architectural firm that its notice was insufficient, and any subsequent claim would not be deemed to have been made during the policy period. The university ultimately sued the firm and, under an assignment of rights, instituted coverage proceedings against the insurer.

The court denied the university's motion for partial summary judgment, holding that the architectural firm's "perfunctory," "non-specific" notice was deficient because it did not provide the information required by the plain terms of the policy. The court further noted that, under Pennsylvania law, an insurer need not show prejudice to deny coverage when an insured has breached the notice requirement of a claims-made policy. The court therefore invited the insurer to file its own dispositive motion. ■

Attorney's Reporting of Alleged Ethics Violations Not "Professional Services"; Eight-Month Delay in Providing Notice Precludes Coverage as a Matter of Law

An Illinois federal district court has granted a commercial general liability insurer's motion for summary judgment that it had no duty to defend or indemnify an insured law firm or its principals in a defamation action based on the insureds' failure to comply with the notice provisions in the policy. *Sentinel Ins. Co., Ltd. v. Cogan*, 2016 WL 4270213 (N.D. Ill. Aug. 15, 2016). The court, however, rejected the insurer's argument that coverage for the insured's reporting of alleged ethical violations of a competitor was precluded by the policy's "professional services" exclusion.

The insured law firm was formed by two attorneys who previously worked together at another law firm. The prior firm sued the attorneys and their new firm for alleged wrongful conduct in connection with their departure from the prior firm. After the lawsuit commenced, one of the insured attorneys emailed a judge's law clerk to report allegedly unethical conduct by an attorney of the prior firm. In response, the prior firm sent the insured firm a cease and desist letter and amended its complaint to include defamation allegations. Eight months after the defamation claims were added to the lawsuit, the insured firm tendered the amended complaint to its commercial general liability insurer. The insurer denied coverage, contending that the insured firm failed to comply with the notice provisions contained in the policy, and, in any event, coverage was precluded by the "professional services" exclusion contained in the policy. The "professional services" exclusion precluded coverage for claims "arising out of the rendering of or failure to render professional services as a lawyer."

In the coverage litigation that followed, the court held that the defamation allegations did not trigger the "professional services" exclusion contained in the policy. According to the court, the attorney's reporting of the alleged unethical conduct did not constitute "professional services" because the conduct was not done on behalf of a client or performed in the service of another.

The court, however, granted summary judgment to the insurer based on the insured's failure to provide timely notice of the amended complaint to the insurer. The policy required that the insured give notice to

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the insurer "as soon as practicable" after any suit was brought against an insured. The insured failed to inform the insurer for more than nine months after receiving a cease and desist letter, and eight months after the complaint was amended. In arguing that coverage was not precluded by the notice provisions, the insured argued that its delay was the result of its confusion regarding the nature of coverage provided by its insurance policies and the terms and conditions of the policy. The court found that the insureds' delay in providing notice was unreasonable in light of the "as soon as practicable" language of the policy, noting that the sophistication of the insureds, the insureds' awareness of the cease and desist letter and amended complaint, and their lack of diligence in pursuing coverage supported that conclusion. The court held that the insurer had no duty to defend and indemnify the insured as a result of the insured's failure to comply with its notice obligations under the policy. ■

No Coverage for Claim Related to Lawsuit Filed Prior to Policy's Inception

Applying New Jersey law, a federal district court has held that a prior and pending litigation exclusion barred coverage for a claim related to an action filed prior to the policy's inception. *Old Bridge Mun. Utils. Auth. v. Westchester Fire Ins. Co.*, 2016 WL 4083220 (D.N.J. July 29, 2016).

An independent municipal division that provides water and sewer treatment to a township was named as a defendant in multiple suits. On February 17, 2009, a development company and its owner sued the municipal division for allegedly failing to meet its contractual obligation to provide services to the development company's properties. The suit also alleged constitutional violations. In 2010, the same owner sued the municipal division on behalf of different development companies he owned. The 2010 suit alleged that the municipal division and other defendants engaged in racketeering and violated the same sewer and water service agreements at issue in the 2009 action. The 2010 action also alleged constitutional violations.

The municipal division sought coverage for the 2010 action under a claims-made-and-reported policy for the policy period of November 8, 2009 to November 8, 2010. The policy contained an exclusion for any claim alleging, based upon, arising out of or attributable to "(1) any prior or pending litigation or administrative proceeding . . . filed on or before the effective date of the first policy. . . or (2) any other Wrongful Act whenever occurring which, together with a Wrongful Act underlying or alleged in such prior or pending proceeding, would constitute Interrelated Wrongful Acts." The policy defined "Interrelated Wrongful Acts" as "all Wrongful Acts that have as a common nexus any fact, circumstance, situation, event, transaction, cause or series of related facts, circumstances, situations, events, transactions, or causes." The insurer denied coverage for the 2010 action on the grounds that it and the 2009 action involved Interrelated Wrongful Acts, and thus coverage was barred by the prior and pending litigation exclusion.

In the subsequent coverage litigation, the court ruled for the insurer. The court held that the two actions involved overlapping parties and the same allegations regarding the municipal division's failure to comply with its service agreements. This "substantial overlap," the court held, was sufficient to find that the two actions involved Interrelated Wrongful Acts. Accordingly, because the 2009 action was filed prior to the policy's inception, the court held that coverage for the 2010 action was precluded under the policy's prior and pending litigation exclusion. ■

Fact Issues Regarding "Relatedness of Claims" Preclude Motion for Judgment on the Pleadings

The United States District Court for the District of Arizona has held that mere reference to a "pyramid scheme" in a prior lawsuit is insufficient to warrant judgment on the pleadings regarding the relatedness of a later claim alleging a pyramid scheme. *Hanover Ins. Co. v. Vemma Int'l Holdings, Inc.*, 2016 WL 4059606 (D. Ariz. July 29, 2016). The court also held that the possibility of reputational and financial harm to an insured individual is sufficient to demonstrate irreparable harm for the purposes of seeking a preliminary injunction for advancement of defense costs.

The Federal Trade Commission (FTC) filed a lawsuit against the insured entity and an insured director alleging, among other allegations, that the insureds had participated in a pyramid scheme. The insureds notified their insurer of the lawsuit, seeking coverage under the company's directors and officers and entity liability policy. The insurer denied coverage for both the insured entity and the director and filed a declaratory judgment action. The insurer argued in a motion for judgment on the pleadings that coverage was unavailable on the ground that the FTC action was not a claim first made during the relevant policy period because it was related to other claims asserted prior to the policy period. The insureds sought a preliminary injunction for reimbursement of defense expenses.

The court denied the insurer's motion, concluding that further discovery was needed to determine whether prior lawsuits were based on the same marketing and compensation scheme as the FTC action, and that a previous claim including allegations of a pyramid scheme did not necessarily preclude coverage for a later pyramid scheme claim.

However, the court denied the insured company's request for a preliminary injunction because the insurer had shown that the insured company might not succeed on the merits with regard to whether the claims were related. Nevertheless, the court granted the insured director's request for a preliminary injunction for advancement of defense costs, subject to the policy's allocation provision, because the insurer identified no evidence that any prior claims were brought against the insured individual. The court concluded that the director had demonstrated the likelihood of irreparable harm if the injunction was not granted, as the director had produced evidence of likely reputational harm and the potential for financial ruin in the absence of an insurer-funded defense. ■

Contract Exclusion Applies Where Insured Assumes Liability of a Third Party

A federal trial court, applying California law, has held that coverage for three underlying lawsuits is not barred by a contract exclusion in a professional liability policy because applying the exclusion to any claim involving a contract would render the coverage illusory. *Ironshore Specialty Ins. Co. v. 23andMe, Inc.*, 2016 WL 3951660 (N.D. Cal. July 22, 2016). According to the court, the exclusion applies only where an insured specifically contracted to assume liability for a third party's negligence. The court also found that a civil investigative demand did not constitute a "claim" under the policy at issue.

The case arose when the United States Food and Drug Administration sent the insured, a "personal genome service," a warning letter regarding certain aspects of the insured's service. Several lawsuits were then filed against the insured alleging that the insured made false representations in its advertising, provided inaccurate and incomplete results in connection with the genetic testing offered, misled its customers into believing that the government had approved its service, and did not disclose that it would use the genetic information gathered from its customers to create a database that it would then market to doctors and pharmaceutical companies. The state of Washington also issued a Civil Investigative Demand.

The insured tendered the lawsuits and the investigative demand to the insurer for coverage under a professional liability policy. The insurer accepted the defense of the lawsuits subject to a reservation of rights and filed a coverage action seeking a declaration that it had no duty to defend or indemnify the insured because the policy's contract exclusion, which barred coverage for claims arising out of the insured's "assumption of liability or obligations in a contract or agreement," applied. The insurer

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Contract Exclusion Applies Where Insured Assumes Liability of a Third-Party

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also asserted that the investigative demand did not constitute a "claim" under the policy, which defined the term as "a written demand for damages, services or other non-monetary relief," as well as a "suit." The policy defined "suit" as "a civil proceeding seeking recovery of damages," and "a civil legal proceeding as well as an arbitration proceeding or alternative dispute resolution proceeding."

The court first addressed the contract exclusion, explaining that it did not preclude coverage for claims involving any contract entered into by the insured, as the insurer argued. Rather, the court predicted that a California court would apply a "plain meaning" approach to interpreting the policy, and focused on the term "assumption" in concluding that the exclusion did not bar coverage for the underlying lawsuits because its terms applied only where an insured specifically contracted to assume liability for a third party's negligence. Although a cause of action for breach of contract had been asserted in the underlying lawsuits, the court pointed to the fact that the "vast majority" of the underlying claims were for false advertising, unfair competition, and fraud, in support of its conclusion. Additionally, the court explained that if it adopted the insurer's interpretation of the contract exclusion, then "virtually all" claims relating to the insured's professional services would be excluded from coverage, which would "defeat the professional liability coverage for which [the insured] bargained."

The court also determined that the investigative demand did not constitute a "claim" based on the language of the policy. The court noted that, despite the fact that the state had sought answers to interrogatories and document production from the insured, it had not yet filed suit. As a result, the insurer did not have a duty to defend because, according to the court, no such duty arose prior to the filing of a "claim" or "suit." ■

Rescission Warranted When Policyholder Failed to Disclose Past Department of Insurance Investigations in Application

Applying Arizona law, a federal district court has held that an insurance brokerage firm's failure to disclose past investigations by the Department of Insurance in response to a specific question on its professional liability insurance application warranted rescission of its policy. *Admiral Ins. Co. v. AZ Air Time, LLC*, No. CV-15-00245-PHX-SRB (D. Ariz. Aug. 10, 2016).

In the underlying case, an insurance brokerage firm was sued for defrauding its client while acting as its broker for a professional liability policy. In order to obtain its professional liability insurance coverage, the brokerage firm had completed an application that specifically asked whether any past or present agency personnel had been the subject of complaints filed, investigations, and/or disciplinary action by any insurance or other regulatory authority in the past five years. The brokerage firm answered no, although its personnel had been involved in multiple investigations by the Department of Insurance.

The insurer sought a declaration that there is no coverage under the policy and an order voiding and rescinding the policy. The court held that rescission of the policy was warranted because the brokerage firm's failure to disclose the Department of Insurance investigations was legally fraudulent, involved facts material to the insurer's risk, and resulted in the insurer issuing a policy it would not otherwise have issued. ■

Rescission Voids All Policy Provisions, Including Innocent Insured Provision

Applying Georgia law, a federal district court has held that rescission of an insurance policy based on a material misrepresentation in the application voids all provisions of the policy, including the "innocent insured" provision, such that the insureds who had no knowledge of the fraud cannot rely on that provision to preserve coverage for themselves. *ProAssurance Cas. Co. v. Smith*, 2016 WL 4223666 (S.D. Ga. Aug. 9, 2016).

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Rescission Voids All Policy Provisions, Including Innocent Insured Provision

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In June 2014, one of the two named partners of a law firm completed a renewal application for professional liability coverage. As part of that application, the partner represented on behalf of the firm that there were "no circumstances, acts, errors or omissions of which [he] was aware that have been or could result in a professional liability claim." As it turns out, however, several months earlier, that partner had forged the signatures of two clients, settled their claims without their knowledge and deposited the resulting $500,000 in settlement funds into his personal account. In light of these undisputed facts, the court found that his representation on the application regarding acts that could result in a malpractice claim was both objectively false and material, entitling the insurer to rescind the "entire policy" that had been issued to the firm.

The law firm and the other named partner argued that because they had no knowledge of the theft or of the falsity of the representation on the application, the policy was not rescinded as to them. In support of this position, they pointed to the policy's "innocent insured" provision, which stated that "if a claim is made involving the dishonest, criminal … or fraudulent act, error or omission of an Insured, this policy will apply to any Insured who did not participate [or] acquiesce in … such acts, errors or omissions." The court rejected the insureds' argument, holding that because the policy is void on account of a material misrepresentation in the application, "the innocent insured provision is inapplicable [as] there … never was a contract for insurance." In reaching this conclusion, however, the court did note that an insurer may agree to limit its right to rescind to an insured who knew of a falsity in the application for coverage with express language to that effect, but no such language existed in the policy at issue. ■

No Rescission Based on Application Signer's Fraud; Fraudster's Knowledge Cannot Be Imputed to Bank

Applying Louisiana law, the United States District Court for the Western District of Louisiana has held that an insurer cannot rescind a fidelity bond issued to a bank because it could not prove as a matter of law that the bank intended to deceive the insurer. *Everest Nat'l Ins. Co. v. Tri-State Bancshares, Inc.*, No. 5:15-cv-1491 (W.D. La. Aug. 2, 2016). Even though the officer who signed the bond application admittedly perpetrated the fraud, the court held that the officer's intent to deceive could not be imputed to the bank.

In 2014, a Louisiana bank learned that its vice president of operations had embezzled almost $1.8 million from the bank by manipulating the bank's internal controls to disguise imbalances in the bank's ledgers. After receiving the bank's proof of loss, the insurer filed a declaratory judgment action to rescind the bond. The insurer argued that the vice president and the bank's president, both of whom signed the application, made material misrepresentations about the bank's internal controls and had knowledge of facts that could give rise to a loss covered by the fidelity bond.

The court held that the insurer could not rescind the fidelity bond based on material misrepresentations by the bank's vice president because his knowledge could not be imputed to the bank. Under Louisiana law, an insurer must prove that an insured's material misrepresentations were made with an intent to deceive. The bank did not dispute that the vice president made material misrepresentations or that he personally intended to deceive the insurer. However, the bank contended that the vice president's knowledge could not be imputed to it under the "adverse interest" exception. The court agreed, holding that an agent's knowledge is not imputed to his principal if an agent is acting adversely to his principal and solely for his own benefit. The court reasoned that the vice president acted adversely to the bank by embezzling funds and made the misrepresentations for his sole benefit, namely, to prevent his fraud from being discovered. The court rejected the insurer's argument that it was protected by the "innocent third party" doctrine, which shields a third party who deals with the principal in good faith from the adverse interest exception. The court held that insurers are excepted from the innocent third party doctrine and the bank purchased insurance expressly to protect against employee theft.

The insurer also argued that it was entitled to rescind because the bank's president also signed the application. The court held that disputed issues of material fact prevented summary judgment as to the president's knowledge about the design of the bank's internal controls and intent to deceive the insurer. ■

Capacity Issues, Personal Profit Exclusion, and Insured v. Insured Exclusion Do Not Preclude Duty to Defend

A federal appellate court, applying Utah law, has held that an insured v. insured exclusion did not preclude a duty to defend where one insured entity had changed its name and disaffiliated from the other insured entity. *Church Mut. Ins. Co. v. Ma'afu*, 2016 WL 3997212 (10th Cir. July 21, 2016). The court also held that the insurer had to defend the suit notwithstanding uncertainty over whether the capacity provisions in the policy and the personal profit exclusion would ultimately operate to preclude a duty to defend.

A power struggle at a local church led to a lawsuit in which two different entities sought control over the church assets. One of the entities asserted a claim for breach of fiduciary duty against a church trustee. The trustee tendered the suit to a D&O insurance carrier, which denied coverage on several independent grounds.

In the ensuing coverage litigation, the court granted summary judgment to the insured trustee, holding that he was entitled to a defense. The court first rejected the insurer's argument that the trustee was not entitled to coverage because he was acting outside of his authority as a director or officer and was thus not sued in an insured capacity. The court reviewed the underlying complaint and determined that it was "unclear" whether the trustee was sued for acting outside of his authority. Because it was "plausible" that the trustee was sued in his capacity as a trustee for the church named as an insured, the court held that the insurer could not avoid a defense on these grounds.

The court then determined that an insured v. insured exclusion did not bar coverage. The relevant exclusion precluded coverage for claims brought by or on behalf of any insured. In the course of the dispute, the church congregation had changed its name. The church was a named insured on the D&O policy under its old name, and was identified as an "affiliated congregation." The court stated that it was therefore possible to read the policy language as covering the church only when it was "affiliated" with the relevant national religious entity. The court determined that the complaint could plausibly be read to allege that the church had disaffiliated with the national entity. As a result, the court held that the insurer could not avoid a defense on these grounds.

Next, the court rejected the insurer's argument that the personal profit exclusion in the policy precluded coverage. While the complaint asserted that the church trustee improperly converted church assets, the court noted that this did not mean that he personally profited from those assets. ■

Employee Stock Ownership Plan Participant Cannot Pursue Fiduciary Breach and Bad Faith Claim Against Insurer of Plan's Fiduciaries

Applying Mississippi law, a federal district court has held that a participant in an employee stock ownership plan cannot pursue his claims against the insurer of the plan fiduciaries because those claims were previously released in a settlement agreement between the plan fiduciaries and the insurer. *Sealey v. Beazley Ins. Co. Inc., et al.*, 2016 WL 4392624 (S.D. Miss. Aug. 17, 2016).

A company, on the advice of its attorney, created an employee stock ownership plan. Lawsuits against the company followed, as the U.S. Department of Labor and two plan participants alleged that certain plan transactions violated various ERISA provisions. The ultimate trial ended with a judgment of more than $6 million entered against the company owner and the plan fiduciaries, along with an additional $3.1 million in attorneys' fees and expenses awarded to the private plaintiffs. The company owner had tendered the underlying actions to the company's fiduciary liability insurance carrier. The insurer responded by reserving its rights and issuing a coverage position,

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which included a refusal to consent to the attorney who had advised the company on the ESOP to act as defense counsel.

The insureds filed a coverage action against the insurer, demanding defense and indemnity without a reservation along with the right to select their own independent counsel. The parties eventually signed a confidential settlement agreement and release that resolved the coverage action whereby the insurer agreed to withdraw its reservation of rights, pay defense and indemnity but at reduced policy limits, and allow the coverage action plaintiffs to retain independent counsel to represent them in the ERISA actions. The insureds chose the disputed attorney, who represented the insureds throughout the ERISA actions, ultimately exhausting policy limits before the judgments were entered.

One of the successful plan-participant plaintiffs, who had obtained assignments from the plan fiduciaries of any claims they may have had against the insurer, proceeded to institute this case against the insurer, asserting that the insurer breached fiduciary duties and engaged in bad faith. The insurer filed a motion to dismiss based on the affirmative defense of release, which the court granted, dismissing the claims with prejudice.

In so deciding, the court explained that the dispute was whether the agreement actually released the plan fiduciaries' claims, whether the agreement constitutes an unenforceable anticipatory release, and whether the agreement is unconscionable.

The court concluded that the agreement unambiguously releases any and all claims—known or unknown—related to the insurer's handling of the ERISA actions, and that such a release includes all the claims the plaintiff asserted. The court then addressed the plaintiff's argument that, under Mississippi law, claims that accrued after the agreement was executed were not released by the agreement as a party may not use an anticipatory release as a means to escape liability for tortious acts. In rejecting this argument, the court stated that the plaintiff's claims that the insurer failed to provide coverage under the policy, and that the insurer breached various duties concerning the insured's counsel were both litigated in the coverage action. The court also noted that even if those issues had not already been litigated, the parties' intent to release future claims is expressed in clear and unmistakable language in the agreement that was fairly and honestly negotiated.

The court also rejected the plaintiff's contentions that even if the claims were released in the agreement, the agreement cannot be enforced due to the presence of undue influence (in the form of the plan fiduciaries' attorney) and unconscionability. As to undue influence, the court explained that the plan fiduciaries' attorney, who the plaintiff claimed took advantage of the plan fiduciaries to enter into the agreement to benefit himself personally, was an adverse party to the insurer in the context of the coverage action, not the insurer's fiduciary, as well as an attorney who the plan fiduciaries picked on their own, at their own peril. Finally, observing that the agreement was not a contract of adhesion and not procedurally unconscionable, the court noted that it is not a substantively unconscionable result that the plaintiff lacks the ability to resurrect claims that the plan fiduciaries, represented by counsel of their choice, agreed to release. ■

Minnesota Federal Court Rejects First to File Rule and Transfers Coverage Litigation to Washington Despite Issuance of Policy in Minnesota

The United States District Court for the District of Minnesota has held that a coverage dispute must be transferred to federal court in Washington, in deference to the insured's later-filed coverage action pending in that court. *Everest Indem. Ins. Co. v. Ro*, 2016 WL 4007578 (D. Minn. Jul. 26, 2016). The court also concluded that, under 28 U.S.C. § 1391, venue was improper because no substantial events or omissions giving rise to the claim occurred in the District of Minnesota.

The insured, an investment advisor, sought coverage from the insurer after he was sued by his client in Washington state court. The insurer denied coverage. The insured ultimately settled the underlying action,

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Minnesota Federal Court Rejects First to File Rule and Transfers Coverage Litigation to Washington Despite Issuance of Policy in Minnesota *continued from page 10*

and sent a letter to the insurer asking the insurer to confirm the reasonableness of the settlement. The insured's letter also asserted that he intended to bring a cause of action against the insurer pursuant to Washington's Insurance Fair Conduct Act. The insurer responded, reiterating its position that no coverage was available under the policy and denying that it had engaged in any wrongdoing. The insurer then filed a declaratory judgment complaint in the United States District Court for the District of Minnesota, seeking a judicial declaration that no coverage was available. The insured subsequently filed his own coverage action in the United States District Court for the Western District of Washington, in which he asserted claims against the insurer under Washington's Insurance Fair Conduct Act and sought a declaration that he was entitled to coverage under the policy.

The court first concluded that the insured maintained substantial contacts with Minnesota sufficient to establish that the court had specific personal jurisdiction over the insured. Nonetheless, the court determined that the matter should be transferred to the Western District of Washington, where the insured's later coverage action had been filed.

The court rejected the application of the "first-filed rule," which favors the venue chosen by the first party to file, where parallel litigation has been filed in different jurisdictions. The court noted that the first-filed rule can be abrogated under "compelling circumstances," including where the party that filed the first lawsuit was "on notice" that the opposing party intended to file its own lawsuit imminently, or where the first lawsuit filed was an action for declaratory judgment. The court found that both circumstances were present and, therefore, it need not apply the first-filed rule.

Finally, the court held that transfer of the case was appropriate because venue was improper under 28 U.S.C. § 1391. The court explained that no substantial events or omissions giving rise to the coverage dispute occurred in Minnesota. Although the policy was issued in Minnesota to the investment advising firm with which insured advisor was affiliated, the issuance of the policy did not "give rise" to the dispute. To the contrary, all of the events leading to the coverage dispute occurred in Washington, where the advisor was based and operated and where the advisor sought coverage. ■

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Daniel J. Standish, Speaker

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September 21, 2016 | New York, NY

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Kimberly A. Ashmore, Speaker

American Bar Association's 2016 National Legal Malpractice Conference

September 22, 2016 | Chicago, IL

Private Equity and M&A Insurance: Not Your Mother's D&O Policy

Kimberly M. Melvin, Speaker

American Bar Association's 2016 Women in Insurance Networking and CL Workshop

October 20, 2016 | Washington, DC

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Richard A. Simpson, Speaker

American Conference Institute's Advanced Forum on LPL/Legal Malpractice

October 25, 2016 | New York, NY

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