Wiley Rein LLP

EXECUTIVE SUMMARY

Legal Developments Affecting Professional Liability Insurers | October 2016

No Coverage for Voluntary Remediation Because Insured Not "Legally Obligated to Pay" for Work

In a win for a Wiley Rein client, the United States District Court for the District of New Jersey, applying New Jersey law, held that no coverage was available under an errors and omissions policy for remediation work performed by an insured because the insured was not "legally obligated to pay" for the remediation. *Wyndham Constr., LLC v. Columbia Cas. Co.*, 2016 WL 5329585 (D.N.J. Sept. 21, 2016). In addition, the court held that the remediation costs were not covered "damages" because they were incurred without the insurer's consent. Wiley Rein represented the insurer.

An insured construction company was contracted to perform work on a road widening project for a state highway authority. The state highway authority alleged that the insured's construction of a wall system was out-of-tolerance and demanded that the insured cure the defect. Over a three-week period, the insured incurred over $250,000 to cure the purported defect. It then sought coverage from its E&O insurer for the remediation costs. The insurer denied coverage for the remediation costs, and the insured filed suit.

The court held that no coverage was available for the remediation costs because the insured was not "legally obligated to pay" those amounts, as required to trigger the policy's insuring agreement. Relying on a prior case from the United States Court of Appeals for the Third Circuit, *Permasteelisa v. Columbia Cas. Co.*, 377 F. App'x 260 (3rd Cir. 2010), the court reasoned that the insured was not "legally obligated to pay" because it did not perform the remediation work due to a finding of liability by a court. Even if the insured was contractually obligated to perform the remediation work, the court held that a contractual obligation was insufficient under the Third Circuit's holding.

The court also held that coverage for the remediation costs was foreclosed by the policy's definition of "damages," which required that "[a]ll settlements must be made with [the insurer's] consent." Because the insured did not seek the insurer's consent before performing the remediation work, the costs associated with the remediation were not "damages."

Finally, the court rejected the insured's argument that the insurer was estopped from denying coverage because it never asserted these grounds in its coverage denial letter. The court held that estoppel did not apply because the insurer never conveyed that coverage was available and reserved its rights to rely on additional grounds to deny coverage. ■

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Certain Extrinsic Evidence Permissible for Purposes of Establishing No Duty to Defend under Illinois Law

The United States Court of Appeals for the Seventh Circuit, applying Illinois law, has held that extrinsic evidence that does not decide an "ultimate issue" in the underlying claim may be admitted in a declaratory judgment action for purposes of establishing that an insurer has no duty to defend. *Landmark Am. Ins. Co. v. Hilger,* 2016 WL 5239833 (7th Cir. Sept. 22, 2016).

An insurance broker contracted with several credit unions to sell life insurance-related products. The credit unions sued several executives associated with the broker, asserting that the individuals overstated the value of collateral for certain loans. The suits asserted counts for fraud, negligence, negligent misrepresentation, conspiracy, and related legal theories.

One of the executives sued was not an officer or director of the broker, but an executive at another company that was involved in the creation of the products. That third-party executive sought coverage under the broker's E&O policy, which provided specified coverage to principals, partners, officers, directors, employees, or independent contractors of the broker. The E&O insurer denied coverage, asserting that the third-party executive was not an "independent contractor" of the broker.

In the ensuing coverage litigation in the district court, the insurer offered extrinsic evidence that purported to show that the third-party executive was an agent of the broker, and not an independent contractor. In ruling on the insurer's motion for judgment on the pleadings seeking a determination that the insurer had no duty to defend the executive, the district court held that the underlying complaints were "ambiguous" as to whether the third-party executive was an agent or an independent contractor of the insured. The district court refused to consider extrinsic evidence offered by the insurer to show that the executive was in fact an agent of the insured, concluding that doing so was impermissible under Illinois law.

The court of appeals reversed. The court agreed that Illinois law does not permit consideration of extrinsic evidence if an insurer chooses to deny coverage without seeking a declaratory judgment or defending under a reservation of rights. However, the court went on to hold that, under Illinois law, consideration of extrinsic evidence is permissible to determine whether an insurer has a duty to defend, where the insurer has sought a declaratory judgment as to its coverage obligations, and where the extrinsic evidence does not tend to determine an ultimate issue in the underlying case. Because none of the counts in the underlying cases turned on whether the executive was an agent or independent contractor of the insured, the court of appeals held that consideration of extrinsic evidence was permissible, and it remanded the case to the district court for consideration of that evidence. ■

Ninth Circuit Upholds Rescission of Crime Policies Based on Misrepresentation in Application

Applying California law, the United States Court of Appeals for the Ninth Circuit has upheld the district court's rescission of a tower of crime policies based on the insured's material misrepresentation in the application for the policies. *Kurtz v. Liberty Mutual Ins. Co.*, 2016 WL 4547366 (9th Cir. Sept. 1, 2016).

The insured, a purported qualified intermediary for tax-advantaged real estate transactions, sought to purchase primary and excess crime policies that provided coverage for employee theft and theft of clients' property. The application for the primary policy asked: "Are proceeds from [Internal Revenue Code Section] 1031 transactions held in bank accounts segregated from those of your operating funds?" In an application dated July 2, 2007, the insured company answered "no." The primary insurer responded to the company's broker that the company was ineligible for coverage as a result of this answer. The broker advised the insured to "correct" the

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application and it would resubmit the application to the primary insurer. In an application dated August 13, 2007, the company answered the question "yes." Thereafter, the primary insurer and three excess insurers issued policies to the company.

A Chapter 7 bankruptcy trustee later brought suit against the insurers to recover under the policies for the misappropriation of client funds by the intermediary's principal. It came to light that the company did not segregate 1031 transaction funds from its operating funds. The insurers denied coverage based on the company's misrepresentation in the application regarding the segregation of client funds. The district court held that the insurers were entitled to rescind the policies based on the misrepresentation.

On appeal, the Ninth Circuit affirmed, holding that the application question was unambiguous because the only reasonable interpretation of the question is whether the intermediary holds proceeds from 1031 transactions in separate bank accounts from its operating funds. Additionally, the appellate court upheld the district court's conclusion that the insurers had not waived their misrepresentation defense due to a failure to investigate the intermediary's changed answer on the second application. According to the appellate court, the intermediary's misrepresentation was not an "obvious red flag." ■

Insurer that Rejected Exception from Release Language Liable for Bad Faith Failure to Settle Despite Offering Policy Limits

A California intermediate appellate court has held that an insurer is liable for bad faith failure to settle, even though it had made a timely offer to settle for its full policy limits, where the insurer declined to agree to release terms proposed by the claimants to which the insured refused to agree. *Barickman v. Mercury Cas. Co.*, 2016 WL 4274674 (Cal. Ct. App. July 25, 2016).

An insured, driving while intoxicated, struck and seriously injured two pedestrians in a crosswalk. The driver's insurer offered to settle with the pedestrians for the available coverage limits of $15,000 each. Before the pedestrians accepted that offer, the insured was sentenced to three years in state prison and ordered to pay approximately $165,000 in restitution. The pedestrians later informed the insurer that they would accept its policy limits offer, but they insisted on the following language in a release agreement: "This does not include court-ordered restitution." A representative of the insurer allegedly spoke with the pedestrians' attorney, who explained that the purpose of the language was to ensure that the settlement would not affect the pedestrians' right to the $165,000 restitution award. The insurer sought the consent of the insured driver's criminal defense attorney to add the requested language to the release, but the attorney refused to provide its consent. When the settlement was not completed, the pedestrians brought suit against the driver. They later obtained a stipulated judgment of $3 million, coupled with an agreement not to execute on the driver's personal assets, and they sued the insurer for bad faith failure to settle. The trial court ruled in favor of the pedestrians.

The appellate court affirmed, agreeing with the trial court's decision that the insurer's refusal to agree to the added release language or to propose additional language to clarify the scope of the requested additional language was unreasonable under the circumstances. The court also rejected the insurer's argument that its early tender of its policy limits precluded a finding of bad faith, stating that that position, if accepted, "would mean an insurer that at one point acted in good faith during settlement negotiations has fully discharged its obligations under the implied covenant and has no further responsibility to make reasonable efforts to settle a third party's lawsuit against its insured." The court also rejected the insurer's argument that it relied upon the withheld consent of the insured driver's criminal defense attorney, finding that the insurer had failed to communicate all relevant facts to the criminal defense attorney, including the substance of the insurer's communications with the pedestrians' attorney about the intent of the added release language. As a result, the court affirmed the judgment of $3 million plus interest against the insurer. ■

One Lawsuit Equals One Claim, Regardless of the Number of Causes of Action

The United States District Court for the Eastern District of Pennsylvania has held that a lawyer's professional liability policy's per-claim limit of liability, rather than its aggregate limit of liability, applied to an underlying lawsuit because the suit's multiple causes of action were all related and therefore constituted a single claim under the policy. *Westport Ins. Corp. v. Mylonas*, 2016 WL 4493192 (E.D. Pa. Aug. 25, 2016).

The claimant retained the insured, a lawyer, to advise the claimant on forming a corporation. The claimant alleged that the insured negligently transferred and endorsed stock, which froze the claimant out of the corporation and converted the corporation's bank account and assets. The claimant sued the insured for legal malpractice and asserted three causes of action against the insured in his complaint: (1) negligence and/or gross negligence; (2) breach of fiduciary duties of loyalty, honesty, and candor, undue influence, and conflict of interest; and (3) breach of contract. The insured tendered the complaint to the insurer under his professional liability policy and the insurer provided a defense. The jury found in favor of the claimant and awarded damages in the amount of $525,000. The policy, however, contained a per-claim limit of liability of $500,000 and an aggregate limit of liability of $1 million. The policy defined "claim" to mean "a demand made upon any insured for loss, … including … service of suit … against any insured." The policy also provided that two or more claims arising out of a single wrongful act or a series of related or continuing wrongful acts constituted a single claim. The insurer took the position that the per-claim limit of liability applied, while the insured argued that there were multiple claims asserted such that the entire judgment was covered by the $1 million aggregate limit of liability.

In the coverage litigation that followed, the court concluded that the three causes of action in the claimant's complaint were all related, and that the policy's per-claim limit of liability applied. The court noted that the underlying suit involved "only one plaintiff suing one defendant, which resulted in only one recovery." The court explained that the number of counts in a legal malpractice suit is not dispositive of the number of claims under an insurance policy. Rather, the various errors committed by an insured are related if they are committed by the same attorney, as to the same client, arising out of the same transaction, and resulting in the same injury. The court found that, although the legal services performed by the insured contained several components, they were all related to the representation of the claimant with respect to the corporation. The claimant's legal malpractice claim stemmed from those legal services. Therefore, the causes of action in the suit were related and continuous, and constituted a single claim under the insurance policy triggering only the per-claim limit of liability of $500,000. ■

Consent Judgment with Covenant Not to Execute Is Covered Loss

The United States District Court for the Eastern District of New York, applying New York law, has held that a consent judgment accompanied by a covenant not to execute by the claimant was covered "Loss" under a D&O insurance policy where there was no waiver of the right to pursue the insurer. *Intelligent Digital Systems, LLC v. Beazley Ins. Co.*, 2016 WL 5390390 (E.D.N.Y. Sept. 16, 2016).

A business partner and several related parties sued certain former directors of the insured surveillance technology company for negligence, common law fraud, securities fraud, and non-payment of promissory notes. The parties settled pursuant to three separate stipulations, in which the former directors consented to judgments against them individually, the business partner agreed to "unconditionally forbear" the collection of the judgments against the individuals, and the individuals agreed to assign their claims for indemnification under the technology company's D&O insurance

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Consent Judgment with Covenant Not to Execute Is Covered Loss

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policy. Each stipulation stated, "Nothing contained in the Stipulation shall constitute a waiver or release of the [business partner parties'] right to assert any claim or rights of [sic] against [the D&O insurer]." The business partner parties then filed a coverage lawsuit against the insurer.

During the trial of the coverage action, the insurer filed a motion for judgment as a matter of law, arguing that, because the settlement included an agreement that the judgment would not be enforced against the individual former directors, those individuals never suffered a "Loss" within the meaning of the policy. The policy defined "Loss" to include amounts which insureds "become legally obligated to pay."

The court declined to grant judgment as a matter of law, finding that the insurance policy covered the consent judgments, notwithstanding the business partner's agreement not to execute the judgment against the former directors, because the assignment did not release the insurer from liability. The court noted that both New York courts and those in other jurisdictions recognize the right of assignees to pursue coverage on behalf of insureds even when the assignment is coupled with a covenant not to execute and emphasized that the stipulations expressly provided that the settlement did not constitute a waiver to assert a claim or right of action against the insurer.

The court distinguished *U.S. Bank National Association v. Federal Insurance Co.*, 664 F.3d 693 (8th Cir. 2011), relied upon by the insurer, because the definition of "Loss" in that case excluded amounts for which the insured person was "absolved from payment by reason of any covenant, agreement or court order." The court also declined to follow *Jones v. Southern Marine & Aviation Underwriters, Inc.*, 888 F.2d 358 (5th Cir. 1989), which had held that a consent judgment and stipulation absolved an insured from liability to pay, as non-binding and representing a minority view.

Subsequent to the court's order on the motion for judgment as a matter of law, the jury entered a verdict in favor of the insurer, concluding that one of the business partner parties had been a director or officer of the insured technology company, triggering the policy's insured vs. insured exclusion. ■

Lawyer's Material Misrepresentations in Policy Renewal Applications Justify Rescission

A federal district court in Illinois has granted an insurer's motion for summary judgment rescinding three consecutive professional liability policies. This comes after the court determined under Illinois law that the insured attorney made material misrepresentations in each of the renewal applications. *Minn. Lawyers Mut. Ins. Co. v. Schulman*, 2016 WL 4988006 (N.D. Ill. Sept. 19, 2016).

The insurer issued consecutive claims-made professional liability policies to a patent and trademark attorney. The application for each policy required the insured to certify that he was "not aware of any claims or circumstances that could result in claims or disciplinary actions that have not been reported to" the insurer. The insured also represented that if a client "decides to abandon a patent application or allow a patent application to expire," such decision is "memorialized in writing[.]" The insured failed to disclose that he had allowed various patent applications to expire for two clients and that neither client had agreed in writing to abandon the application process. When the clients ultimately brought complaints against the attorney, he tendered the claims to the insurer.

The insurer moved to rescind its policies. The court noted that, under Illinois law, an insurer may rescind in the event of misrepresentations that materially affect the acceptance of the risk. The court agreed that the attorney misrepresented both that he required written client acknowledgment to abandon a patent application and that he had no knowledge of any circumstances that could result in claims. Although the insured argued that he did not believe that any claim existed with respect to the two clients, the court

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Lawyer's Material Misrepresentations in Policy Renewal Applications Justify Rescission
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held that an objective standard applied and was satisfied in light of the attorney's repeated omissions and client inquiries about their patent applications.

The court held that the misrepresentations were material under an objective test that asks "whether a reasonably careful and intelligent underwriter would regard the facts as stated to substantially increase the chances of the event insured against." The court held that an affidavit from the insurer's underwriter averring that the insurer would have declined to renew the policies, or, at a minimum, would have required substantially more premium, constituted competent summary judgment evidence, noting that "it borders on the surreal to think that the nondisclosure was immaterial." ■

Notice to Insurance Agent Does Not Constitute Notice to Insurer

The United States District Court for the Southern District of Texas has held that notice of a potential claim provided to an insurance agent is not considered notice to an insurer for the purposes of determining when a claim is first reported. *Evanston Ins. Co. v. Cheetah, Inc.,* 2016 WL 4494440 (S.D. Tex. Aug. 26, 2016).

The insurer sought a declaration that it had no duty to defend or indemnify an insured on the grounds that the insured did not provide timely notice of an incident giving rise to a subsequent lawsuit. The insurer argued that it first received notice after the end of the policy period corresponding to the date of the incident, and coverage was therefore barred under subsequent policies because the insured had knowledge "of the incident that gave rise to the Lawsuit prior to the inception" of those policies.

In response to the insurer's motion for summary judgment, the insured offered evidence that it had provided notice of the incident to its insurance agent during the policy period.

The court granted the insurer's motion for summary judgment, holding that coverage was barred because the insured had failed to provide timely notice. The court held that notice to the insurance agent did not constitute notice to the insurer because it was "undisputed" that the insurance agent was the insured's agent and not the insurer's agent. Moreover, the evidence established that the insured had knowledge of the incident in question but did not disclose that information to the insurer as required under the terms of the other policies, in contravention of the policy terms. ■

Insured Stated Claim for Breach of Contract and Bad Faith Against Claims Administrator

Applying California law, the United States District Court for the Southern District of California has held that a policyholder stated a claim against the claims administrator for a policy because the plaintiff had pleaded a plausible factual allegation that the claims administrator issued the policy, which was sufficient to survive a motion to dismiss. *Reno v. Nat'l Union Fire Ins. Co.*, 2016 WL 4595955 (S.D. Cal. July 27, 2016).

An insured filed suit against an insurer and the insurer's claims administrator for breach of contract and bad faith. In its complaint, the policyholder alleged that the name of the claims administrator appeared on coverage correspondence and was referenced throughout the policy. Thus, the policyholder asserted that it was unclear if the claims administrator issued the policy along with the underwriting entity identified in the policy. The claims administrator moved to dismiss the complaint for failure to state a claim because it did not issue the policy.

The court held that the policyholder stated a claim against the policy administrator for breach of contract and bad faith. Although an entity can only be sued for breach of the policy and breach of the policy's implied covenant of good faith and fair dealing if it actually issued the policy, the court held that the policyholder sufficiently pled a claim that the claims administrator may have issued the policy because the claims administrator's name appeared throughout the policy. In addition, the court rejected the argument that the complaint's allegations should be ignored because they were contradicted by the policy, which was an exhibit to the complaint. The court held that it could not disregard the allegations in the complaint because there was no "inescapable" contradiction between the complaint and the exhibits concerning whether the claims administrator issued the policy. ■

SPEECHES & EVENTS

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

Trying a Case and Strategies for Handling Legal Malpractice Cases

Richard A. Simpson, Speaker

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

October 25, 2016 | New York, NY

Women in Insurance Networking and CL Workshop

Cara Tseng Duffield, Co-Chair

American Bar Association

October 20, 2016 | Washington, DC

The In-House Perspective on Outside Counsel

Karen L. Toto, Moderator

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

October 20, 2016 | Washington, DC

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