Wiley Rein LLP

EXECUTIVE SUMMARY

Legal Developments Affecting Professional Liability Insurers | February 2017

Eleven Claims Arising Out of Negligently Repackaging Two Drugs Are "Related Claims"

In a win for an insurer represented by Wiley Rein, the United States District Court for the Southern District of Florida, applying Florida law, has held that eleven claims by patients against a pharmacy and pharmacist for negligently repackaging two preservative-free drugs for injections by the same doctor to treat the same condition constituted "related claims." *Amer. Cas. Co. of Reading, Pa. v. Belcher*, 2017 WL 372094 (S.D. Fla. Jan. 26, 2017).

A Florida pharmacy contracted with a south Florida ophthalmologist to repackage two, nearly identical drugs from larger vials into single-dose syringes for injections into the eyes of patients to treat age-related wet macular degeneration. The drugs did not include any preservatives to prevent microbial contamination and were required to be repackaged under sterile conditions. During the repackaging of the drugs over a six-month period, a pharmacy technician allegedly failed to use any of the mandated procedures to ensure a sterile repackaging process—using only non-sterile gowning and equipment to repackage the drugs in a storage

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Quality of Services Exclusion Bars Coverage for Online Auction Service's Alleged Misrepresentations About Its Reliability

In another win for an insurer represented by Wiley Rein, the United States District Court for the Middle District of Florida, applying New Jersey and Florida law, has held that the quality of services exclusion in a technology errors and omissions policy barred coverage for a claim that the insured negligently misrepresented the safety and reliability of its online auction service. *Equipmentfacts, LLC v. Beazley Ins. Co.*, 2017 WL 119651 (M.D. Fla. Jan. 12, 2017).

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Quality of Services Exclusion Bars Coverage for Online Auction Service's Alleged Misrepresentations About Its Reliability *continued from page 1*

The insured online auction service assisted two clients with purchasing heavy equipment using the insured's online auction platform. After the clients placed the highest bid in two auctions, the clients paid for the equipment but never received it from the seller. The clients filed suit against the insured for negligent misrepresentation and alleged that the insured represented that its online auction service was "fast, reliable, secure, and surpassed the limitations of on-site auctions." The consumers asserted that the representation was false because the online auction did not comply with Florida statutes for auctions. The online auction service submitted the lawsuit to its insurer, and the insurer denied coverage based on the quality of services exclusion, which barred coverage for claims "for or arising out of or resulting from the failure of goods, products, or services to conform with any represented quality of performance contained in Advertising." After the insurer denied coverage, the insured filed suit against the insurer.

The court held that the quality of services exclusion barred coverage for the lawsuit. The court rejected the insured's argument that the negligent misrepresentation allegations arose from the failure to have safeguards in place as required by Florida statutes. Instead, the court held that "[t]he harm alleged in the negligent misrepresentation counts arose from the false statements in its advertising, evidence of which was the alleged non-compliance with Florida statutes" and "[t]he negligent misrepresentation counts ar[o]se out of the alleged failure of the auction to conform to the represented quality or performance." ■

Eleven Claims Arising Out Of Negligently Repackaging Two Drugs Are "Related Claims" *continued from page 1*

room at the pharmacy. The pharmacist-in-charge of the facility also allegedly took no measures to ensure that the drugs were being properly repackaged.

Several of the syringes allegedly became contaminated during the repackaging process and were injected into the eyes of almost three dozen patients. Eleven of those patients who suffered severe vision loss and/or blindness as a result of swelling related to the contaminated injections made claims against the pharmacy and pharmacist-in-charge for purported negligent repackaging of the drugs from larger vials into single-dose syringes.

Both the pharmacy and pharmacist-in-charge tendered the eleven claims to their professional liability insurer. Both were insured under separate errors and omissions policies issued by the same insurer. Each policy had a $1 million per claim and $3 million aggregate limit of liability. The insurer agreed to defend its insureds under a reservation of rights but asserted that the eleven claims were "related claims," subject to the $1 million per claim limit of liability under both policies. The insurer negotiated a high/low settlement agreement, resulting in a complete release of its insureds but allowing the insurer and claimants to litigate the related claims issue to determine the amount owed under the policies for the eleven claims.

The court held that the related claims language in the policies was unambiguous. Both policies provided that claims were related if they arose out of "acts, errors or omissions in the rendering of professional services or placement services that are logically or causally connected by any common fact, circumstance, situation, transaction, event, advice or decision." Relying on Eleventh Circuit precedent, the court reasoned that the express requirement of a logical or casual connection rendered the related claims definition "clear and unambiguous."

Applying the related claims language to the eleven claims, the court held that all eleven claims were logically connected because both drugs "were negligently repackaged by the same individual at the same pharmacy for the same doctor over a relatively short period of time." It rejected claimants'

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Eleven Claims Arising Out Of Negligently Repackaging Two Drugs Are "Related Claims"

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contention that the claims could not be related because the insurer could not prove the cause of each contaminated syringe. The court held that the cause of the contamination was irrelevant because the related policy language also applied when claims were logically connected and "the individual responsible for the contaminated syringes, the general processes used to repackage those syringes, and the precise location where the contaminations originated are common to all of the Claimants' claims." It also rejected claimants' contention that the claims could not be related because the insureds had no "common scheme or plan" to distribute contaminated drugs. The court determined that the insureds engaged in a single course of conduct—repackaging the two drugs using the same non-sterile process across the same six-month period—thus logically connecting all claims arising from that conduct. ■

Florida Statute Does Not Estop Insurer from Denying Reimbursement of Pre-Tender Defense Costs

The United States Court of Appeals for the Eleventh Circuit, applying Florida law, has held that a thirty-day statutory deadline to deny coverage did not apply to an insurer's refusal to reimburse the insured for its pre-tender defense costs because this refusal did not constitute a "coverage defense" within the meaning of the statute. *Embroidme.com, Inc. v. Travelers Property Cas. Co. of Am.*, 2017 WL 74694 (11th Cir. Jan. 9, 2017).

The insured, a promotional products franchise company, was sued for copyright infringement by a software company in April 2010. However, the insured failed to tender the claim to its liability insurer. Instead, the insured retained defense counsel and paid legal expenses from June 2010 until October 2011. The insured ultimately gave notice of the lawsuit to its insurer on October 10, 2011, and the insured and the insurer discussed the claim three days later. On November 21, 2011, the insurer agreed to defend subject to a reservation of rights but refused to pay any pre-tender defense costs. The insured filed a breach of contract suit seeking reimbursement for its pre-tender defense costs. On cross-motions for summary judgment, the insured contended that the insurer was estopped from denying payment of the pre-tender defense costs because its reservation of rights letter was issued after the thirty-day deadline for notification of coverage defenses imposed by Florida's "Claims Administration Statute." The insurer, in turn, argued that the statutory time frame did not apply because the policy provisions precluding the insured from incurring legal fees without prior approval constituted exclusions rather than coverage defenses. The district court agreed with the insurer and granted summary judgment in its favor.

On appeal, the court affirmed and held that the insurer was not required to comply with the statute when it refused to reimburse the insured for pre-tender defense costs because the policy expressly carved out pre-tender defense costs from the scope of coverage. The court highlighted the fact that the policy itself provided that "no insured will, except at the insured's own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without our consent." Citing Florida Supreme Court authority, the court explained that the statute only applied to defenses that would preclude coverage for amounts that otherwise would fall within the policy's scope of coverage. Because this policy did not provide coverage for pre-tender defense costs, the insurer was not estopped from refusing to reimburse the insured for such costs.

The court also noted that the text of the statue does not apply the statutory time frame with respect to the duty to defend, only to the duty to indemnify. Further, the policy considerations underlying the Florida statute were not implicated because the statute's purpose is to inform the insured of coverage defenses so the insured can stake steps to protect itself. As such, the court characterized the statute as being "forward-looking" in order to protect an insureds' future decisions and interests. Because the insured had already incurred defense costs before it ever notified the insurer or triggered the insurer's obligation to send a reservation of rights, the insurer's decision to refuse to pay pre-tender defense costs had no impact on the insured's future decisions in the ongoing litigation. ■

No "Final Adjudication" Where Parties Settled After Court Issued Opinion But Prior to Judgment

The Delaware Superior Court, purporting to apply Delaware and California law, has held that there was no "final adjudication" for purposes of triggering a conduct exclusion where the parties to the underlying action settled after the court issued an interlocutory memorandum opinion containing findings of fraud. *Arch Ins. Co. v. Murdock,* 2016 WL 7414218 (Del. Super. Ct. Dec. 21, 2016).

An officer and minority owner of a publicly-traded company sought to acquire the remaining outstanding shares of the corporation and take it private. Shareholders of the corporation brought suit against the corporation challenging the fairness of the transaction. In a memorandum opinion, the Delaware Chancery Court found breaches of the duty of loyalty and assessed liability against the officer and the company. In the opinion, the Vice Chancellor repeatedly cited to "fraud" and "fraudulent activity" by the defendants. At that time, the court did not issue the final judgment. Shortly after the decision, the shareholders and defendants settled for 100% of the liability assessed by the Vice Chancellor plus interest, so an appeal ensued. The court issued an order and final judgment approving the settlement.

The defendants sought coverage for the settlement from their D&O carriers. The defendants' D&O insurers denied coverage, asserting that the conduct exclusion in the policy applied, which barred coverage for claims "based upon, arising out of or attributable to . . . any deliberately criminal or fraudulent act . . . if established by a final and non-appealable adjudication adverse to such Insured in the underlying action."

In the ensuing coverage litigation, the trial court granted the insureds' motion to dismiss in part, holding that a "final adjudication" had not been rendered in the underlying case that established a finding of a deliberately fraudulent act. According to the court, the memorandum opinion, without an entry of judgment, was not a final and non-appealable adjudication. Rather, according to the court, the only final and non-appealable adjudication was the order and final judgment approving the settlement. According to the court, "the Settlement and the ensuing Order and Final Judgment . . . [were] carefully crafted to mitigate the findings in the Memorandum Opinion," and there was no docket entry entered in connection with the memorandum opinion. ■

Insurer Entitled to Rescind Policy for Insured's Failure to Disclose Prior Losses

The United States Court of Appeals for the Third Circuit, applying New York law, has held that an insurer was entitled to rescind a policy based on an insured's omission of prior loss data on an insurance application. *H.J. Heinz Co. v. Starr Surplus Lines Ins. Co.,* 2017 WL 108006 (3d Cir. Jan. 11, 2017).

The insured, a large food products company, purchased insurance coverage for losses arising from accidental contamination or government-imposed product recalls. In its application, the insured submitted a spreadsheet showing a loss history disclosing only one loss greater than its requested $5 million retention over a ten-year period. Two weeks after its policy incepted, authorities informed the insured that baby food it manufactured in China was contaminated with lead. The insured food products company notified its insurer of the loss. The insurer then hired two consultants to investigate. During the investigation, the insurer learned that the insured had previously incurred a loss of more than $10 million after discovering excessive levels of nitrite in baby food manufactured in China but did not disclose that loss, as well as several others, with its application. In ensuing coverage litigation, a trial court ruled that the insurer was entitled to rescind the policy.

On appeal, the court affirmed. First, the court applied New York law to the rescission issue in light of the New York choice-of-law clause in the policy. In so doing, the court determined that a service-of-suit amendatory endorsement, which stated that "all matters . . . shall be determined in accordance with the law and practice of such Court," did not modify the choice-of-law provision but instead spoke only to forum and venue. The court also rejected the insured's argument that the insurer ratified the policy by seeking to enforce its choice-of-law provision, ruling instead that the choice-of-law provision by its terms also applied to matters regarding the "validity" of the policy.

The court also held that there were clearly misrepresentations (in the losses omitted from the loss history) and that they were material (which the court observed to be "self-evident"). While the court determined that the trial court erred in not requiring the insurer to prove reliance, it affirmed the ruling as harmless error given that it was "highly probable" that the outcome would be the same given the overwhelming evidence that the insurer relied upon the misrepresentations in underwriting the policy.

Finally, the court rejected the insured's argument that the insurer waived its right to rescission. First, the court affirmed the district court's finding that the fact that one of the insurer's underwriters had reviewed internet stories about certain losses that were not disclosed did not prove waiver because, without more, it "would not trigger a reasonably prudent insurer to follow-up further." Second, the court ruled that the insurer did not fail to promptly assert rescission after a period of investigation. On that point, the court observed that the knowledge gained by the consultants hired to investigate the loss could not be imputed to the insurer for purposes of rescission, but even if it could, the five-month delay between their knowledge of those facts and the insurer's claim for rescission was not unreasonable. ■

Insurer Entitled to Rescind Lawyers Professional Liability Policy Where Insured Made Material Misrepresentations in Application

The U.S. District Court for the Southern District of Illinois, applying Illinois law, has held that an insurer was entitled to rescission of a policy where the insured made material misrepresentations in its application. C*arolina Cas. Ins. Co. v. Robert S. Forbes PC,* 2017 WL 86136 (S.D. Ill. Jan. 10, 2017). The court also held that the insurer did not waive its right to rescind because, even though the insurer took a year to investigate the claim, the insurer consistently reserved its right to rescind the policy.

An attorney applied for a professional liability insurance policy for his firm. On the application, the attorney represented that neither the firm nor any attorney in the firm was aware of any fact or circumstance that might reasonably be expected to result in a professional liability claim or suit. The attorney also represented that no attorney in the firm was aware of an actual or alleged act, omission, circumstance, or breach of duty that a reasonable attorney would recognize might reasonably be expected to result in a claim. At the time the application was executed, however, the attorney was aware that his failure to timely file a document adversely impacted his client's appeal in a workers compensation case. In addition, the attorney was also involved in disciplinary proceedings for alleged misconduct over a period of several years. After the insurance policy was issued, the client in the workers compensation case sued the attorney alleging malpractice. The attorney provided notice of the claim to the insurer, and the insurer issued two reservation of rights letters which, among other things, reserved the insurer's rights to rescind the policy based on the misrepresentations. After investigating the claim, the insurer filed a declaratory judgment action seeking a declaration that there was no coverage for the action, or in the alternative, rescission of the policy.

The court granted summary judgment to the insurer, concluding that rescission of the policy was appropriate. First, the court determined that because the policy was issued to a corporation, rescission was not barred by an Illinois statute prohibiting rescission of personal lines policies after a policy has been in effect for more than a year. The court then rejected the attorney's argument that the misrepresentations on the application were not material as a matter of law. According to the court, "a misrepresentation is material if it would have increased the premium paid for the insurance because the risk would have been greater than that actually anticipated by the insurer." The court determined that it was "clear that a reasonably careful underwriter would regard the real facts. . .to substantially increase the chances of a malpractice claim so as to cause [the insurer] not to issue the policy on the terms it did." Finally, the court held that the insurer did not waive its right to rescind because, even though it waited a year to file suit after learning of the relevant facts, the insurer consistently reserved its right to rescind and did nothing to indicate it was waiving any rights. ■

Insured v. Insured Exclusion Bars Coverage for Claim by FDIC Receiver Against Failed Bank's Directors and Officers

The United States Court of Appeals for the Ninth Circuit, applying California law, has held that an insured v. insured exclusion in a directors and officers policy, which expressly barred coverage for actions brought by a "receiver," precluded coverage for a claim against a failed bank's directors and officers by the Federal Deposit Insurance Corporation (FDIC) in its capacity as receiver. *FDIC v. BancInsure, Inc.,* 2017 WL 83489 (9th Cir. Jan. 10, 2017).

The FDIC, acting as the receiver of a failed bank, brought an action against the bank's former directors and officers for damages arising from their alleged wrongful conduct. The FDIC then filed coverage litigation against the bank's insurer, seeking a declaratory judgment that the bank's D&O policy provided coverage for the underlying action. The United States District Court for the Central District of California granted summary judgment for the FDIC, holding that the bank's D&O policy covered the FDIC's claims.

On appeal, the insurer asserted that the policy's insured v. insured exclusion barred coverage. That exclusion precluded coverage for claims arising from legal actions "by, or on behalf of, or at the behest of" the insured bank, a person insured under the policy, or "any successor, trustee, assignee or receiver" of the insured bank. The FDIC argued that it was not acting as a "receiver" within the meaning of the exclusion, but as successor to the interests of the bank's shareholders, such that an exception to the insured v. insured exclusion for losses arising from a shareholder derivative action should apply.

The Ninth Circuit rejected the FDIC's argument and reversed the district court's decision, holding that the exclusion barred coverage. The Ninth Circuit explained that causes of action against a corporation's former directors and officers "belong to the corporation—not to the shareholders" and that the FDIC, as receiver, succeeded to the right of the corporation to bring the suit. The court reasoned that reading the policy in context, the exception to the insured v. insured exclusion for shareholder derivative suits would not extend to suits brought by the FDIC, since its right to bring a derivative claim as a successor to the interests of the shareholders is secondary to its right to bring the same claims directly as the bank's receiver. The Ninth Circuit concluded that, under the insured v. insured exclusion, "the term 'receiver' is clear and unambiguous and includes the FDIC in its role as receiver of the [failed bank]." ■

Insured v. Insured Exclusion Bars Coverage for Shareholders' Suit Spearheaded by Former Director

Applying Minnesota law, the United States Court of Appeals for the Eighth Circuit has held that a policy's insured versus insured exclusion bars coverage for a suit filed against the insured company by a former director and two other shareholders regarding share value. *Jerry's Enterprises, Inc. v. U.S. Specialty Ins. Co.,* 2017 WL 104468 (8th Cir. Jan. 11, 2017). The court refused to allocate any portion of the claim brought by the former director's non-insured shareholder daughters to covered loss.

The daughter of a founder of a closely held corporation was appointed to the board of directors, wherein she raised concerns about the value of her shares and those of her daughters. After her resignation from the board, she and her two daughters filed suit against the company and certain of its directors and officers alleging misconduct that had lowered the value of their shares. The company's D&O insurer denied coverage for the claim based on the policy's insured versus insured exclusion, which barred coverage for any claim "brought by or on behalf of, or in the name or right of . . . any Insured Person, unless such Claim is: (1) brought and maintained independently of, and without the solicitation, assistance or active participate of . . . any Insured Person."

The district court held that the exclusion barred coverage for the claim, and the appellate court affirmed. The appellate court determined that the former director, undisputedly an Insured Person under the policy, was an active participant in the lawsuit, and thus the exclusion was triggered and the assistance carve-out did not apply. The court rejected the insured company's argument that the claims of the former director should be treated differently from the claims of her non-insured daughters, holding that the lawsuit is a single claim to which the exclusion applies. Similarly, the court rejected the company's request to apply the policy's allocation provision, finding that the insured director was the "driving force of the litigation," and thus her assistance in the litigation defeated coverage for her non-insured daughters. ■

Court-Appointed Receiver Acts "On Behalf Of" Court, Barring Application of Insured v. Insured Exclusion

The United States District Court for the District of Rhode Island, applying Rhode Island law, has held that an insured v. insured exclusion in a directors and officers liability insurance policy does not apply to a court-appointed receiver because the receiver acts as an agent of the court under Rhode Island law, rather than on behalf of the company in receivership. *Philadelphia Indem. Ins. Co. v. Providence Cmty. Action Program, Inc.,* 2017 WL 354279 (D.R.I. Jan. 24, 2017). The court also held that an endorsement in the policy, which expressly defined the receiver as an insured and as "contracted to perform services" for the company, did not alter the inapplicability of the insured vs. insured exclusion.

A Rhode Island non-profit corporation purchased a directors and officers liability insurance policy and shortly thereafter was forced into receivership by financial strain. A court-appointed receiver then brought a breach of fiduciary duty action against two former officers of the company and tendered a claim based on the suit to the company's insurer. The insurer denied coverage on the ground that the claim fell within the policy's insured v. insured exclusion, which excludes claims "brought or maintained by, at the behest, or on behalf of the Organization." The policy also contained an endorsement, added to the policy when the company went into receivership, that defined the insured to include the receiver and labeled him as an "Independent Contractor," defined in the endorsement as "an individual who is contracted to perform services for the Organization." The insurer filed a declaratory judgment action, and the parties filed cross-motions for summary judgment.

The court framed the case around two issues: first, whether a court-appointed receiver acts "on behalf of" the company in receivership or the court under Rhode Island law; and second, whether the policy overrode that relationship because the endorsement defined the receiver as an "Independent Contractor" who "perform[s] services for the Organization."

Relying on Rhode Island law, the court determined that a receiver acts on behalf of the court that appointed him, not the company placed into receivership, as evidenced by a court's possession of a company in custodial egis when a company goes into receivership. The court also relied on the fact that, in this case, the company's incorporation had been revoked by a Rhode Island official, making it impossible for the company to have a contingent interest in the proceeds of any lawsuit brought by the receiver.

The court also considered whether, irrespective of its holding that a receiver acts on behalf of the court, the policy's amended definition of the receiver as an insured "contracted to perform services" for the company necessitated the finding that the receiver acts "on behalf of" the company. The court rejected this argument, first finding that an insurer lacks the authority to alter a receiver's duty to the court. "To hold otherwise," the court stated, "would allow private parties to contract away a receiver's legal authority (and, by extension, the authority of the [court]) to collect the receivership entity's assets." Second, the court concluded that because the phrases "on behalf of" and "perform[ing] services for" contain different terms, the phrases denote different ideas. The court further determined that the absence from the endorsement of any reference to the insured v. insured exclusion weighed against its application to the exclusion. ■

NY Appeals Court Holds FCRA Statutory Damages Are Covered Damages

A New York state intermediate appeals court has affirmed a lower court's holding that statutory damages paid as part of a settlement of a Fair Credit Reporting Act (FCRA) suit are covered compensatory damages, rather than non-covered penalties under the relevant errors and omissions liability policy. *Navigators Ins. Co. v. Sterling Infosystems, Inc.,* 2016 WL 7470505 (N.Y. App. Div. Dec. 29, 2016).

The insured was sued by a putative class that alleged that the insured's business practices violated the FCRA and caused them injury including, in some cases, termination from employment. With its errors and omissions liability insurer's consent, the insured settled with the putative class. The insurer then sought a declaration that it was not obligated to indemnify the defendants for the settlement because the statutory damages that the insured paid to settle the action constituted a penalty, rather than covered compensatory damages. The trial court rejected this argument, and held that the settlement was covered, and the insurer appealed.

The appellate court affirmed, concluding that the FCRA damages were not "penalties." The FCRA allows the consumer to elect either actual or statutory damages, and may also provide punitive damages, so the appeals court concluded that the actual and statutory damages serve the same purpose. It further reasoned that the statute provides separately for a civil penalty, recoverable by the Federal Trade Commission (FTC). The court indicated that the insurer's argument that the payments were "penalties" for willful conduct was unavailing because the statute's willfulness standard included reckless violations as well as knowing violations. The court therefore held that the damages were compensatory and, as a result, covered by the policy. ■

Notice by One Insured Does Not Satisfy Notice Requirement for Different Insured

The Ohio Court of Appeals, applying Ohio law, has held that a medical malpractice insurer correctly denied coverage where the insured did not provide notice of the claim until after the policy expired even though the insurer had actual knowledge of the claim from another insured. *Wright State Physicians, Inc. v. The Doctors Company,* 2016 Ohio App. LEXIS 5183 (Ohio Ct. App. Dec. 23, 2016).

The insurer issued separate claims-made medical malpractice policies to a physicians group and a medical center. Each policy provided that a claim would only be covered if the incident took place before the policy expiration date and if the insurer "receives a Claim Report from you during this Policy Period." In December 2009, an attorney sent a letter to the medical center alleging malpractice by a member of the physicians group while providing services at the medical center. The medical center tendered the claim to the insurer within the policy period. It also forwarded the letter to the physicians group. The physicians group, however, did not tender the claim to the insurer until after the policy period expired.

The insurer denied coverage for the physicians group on late notice grounds and the physicians group sued. The parties agreed that the only ground for denial was the insureds' failure to provide proper notice. The insureds appealed after the trial court granted summary judgment to the insurer.

The appellate court agreed that the insureds' late notice barred coverage. The court noted that the insurer had been apprised of the malpractice claim by its other insured, the medical center. However, the court held that, under the language of the policy, the physicians group needed to provide its own notice of the claim under its policy. The court ruled that notice provisions are "conditions precedent" and have particular importance in claims made policies so that insurers can define their scope of liability. The court reasoned that the policy imposed on the insured the duty to notify the insurer about the claim in writing, and it would be contrary to this intent to enable "an unrelated party" to satisfy the notice requirements on behalf of the insureds. Therefore, even if the insurer had actual notice of the claim through another policy, the insureds' failure to provide notice barred their claim for coverage. ■

Tenth Circuit Finds Notice of Temporary Restraining Order Against Insured Did Not Constitute Proper Notice of Subsequent Lawsuit

The Tenth Circuit, applying Oklahoma law, has held that an insured's notice of a temporary restraining order did not constitute sufficient notice of a subsequent lawsuit under a professional liability insurance policy. *Thames v. Evanston Ins. Co.,* 2016 WL 7228800 (10th Cir. Dec. 14, 2016).

The insured, a real estate company, was named as a defendant in a lawsuit arising out of the insured's alleged misappropriation of client funds that were deposited in an escrow account. Prior to the lawsuit, the claimant obtained a temporary restraining order (TRO) against the insured regarding the misappropriated funds. The insured tendered the TRO to its insurer under a professional liability policy, and the insurer denied coverage. The claimant then filed the lawsuit against the insured, but the insured did not provide any notice or documentation regarding the lawsuit to the insurer, including the petition, an amended petition, the claimant's bankruptcy default judgment, or the insured's acceptance of an offer to confess judgment. The lawsuit proceeded and was resolved by the parties via confessed judgment without any involvement from the insurer. The claimant then sought to collect the judgment from the insurer in a garnishment action, but the insurer argued that coverage did not exist because the insured had failed to provide proper notice of the lawsuit under the policy. The trial court held in favor of the insurer, and the claimant appealed.

The appellate court affirmed, finding that notice of the TRO was inadequate to trigger coverage for the lawsuit under the policy. The court relied on the policy's notice provision, which required written notice of any claim made against the insured as a condition precedent to coverage. The court further noted that the notice provision required the insured to "immediately forward to [the insurer] every demand, notice, summons or other process received." Placing particular emphasis on the word "every," the court found that notice of the lawsuit was required by the policy, regardless of the prior notice regarding the TRO. The appellate court concluded that the lack of notice prejudiced the insurer because the insurer was deprived of the opportunity to control the defense in the lawsuit and was not able to participate in the negotiations that led to the confessed judgment. ■

Claims Not Related When Prior Demands Would Not Have Been Covered

The Court of Appeal of Louisiana, applying Louisiana law, has held that a class arbitration claim that was covered under an errors and omissions policy was not "related" under the policy's related claim provision to two earlier contractual demands for indemnity and workers compensation first made prior to the policy period. *Williams v. SIF Consultants of Louisiana, Inc.,* 2016 WL 7475860 (La. Ct. App. Dec. 29, 2016).

The insurer was sued by a class of medical providers under Louisiana's direct action statute. The class alleged that the insured failed to comply with mandatory notice provisions of billing discounts under state statutory law. The insured admitted that it had not complied. The trial court granted the class plaintiffs' motion for summary judgment against the insurer.

On appeal, the insurer argued that the statutory claim was "related" to a prior claim first made against the insured prior to the policy period under the policy's related claims provision. The related claims provision defined "related claims" as "all Claims for Wrongful Acts based on, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving the same or related facts, circumstances, [or] situations . . . whether related logically, causally or in any other way." The insurer pointed to two prior demands—a demand for contractual indemnity and a workers' compensation claim as the first "Related Claims." The Court of Appeal affirmed the trial court, holding that in order for the earlier claims to be "related" to the statutory claim for which coverage was sought, "those instances must . . . be 'Claims' that are covered under [the insurer's] policy." The Court explained that, because the policy excluded workers' compensation claims and tort claims, neither of the prior demands would have been covered and were therefore not related to either of the two prior claims. ■

Multiple Clients' Claims Against Accountant Deemed Related and Subject to Lower Limit of Liability Due to Insureds' Prior Knowledge of One Client's Claim

The United States District Court for the District of South Carolina, applying South Carolina law, has held that multiple clients' claims against an accountant and his former firm constitute a single claim under a professional liability policy because they are logically connected to the accountant's loss of faculty from Parkinson's disease. *CAMICO Mutual Insurance Co. v. Jackson CPA Firm,* No. 15-cv-1823, 2016 WL 7403959 (D.S.C. Dec. 22, 2016). The Court also applied a known claims endorsement to limit the total recovery available to the clients because the firm "might reasonably have expected" a potential claim before the policy's effective date.

The accountant was diagnosed with Parkinson's disease in 2006 but continued to serve clients until August 2011. During that period, the accountant missed deadlines, incurred penalties and interest, and lost tax savings on behalf of multiple clients due to negligence stemming from loss of faculty. By the end of 2010, the accounting firm had become aware that the accountant had lost over $20,000 in tax savings for a business client. It also began to discover issues with the accountant's services for other clients. In January 2013, the accounting firm received a letter from an attorney representing multiple firm clients, in which the attorney formally alleged that the accountant had committed malpractice.

The firm held a series of claims-made-and-reported policies with the same carrier. The firm first reported the business client's lost tax savings issues to the carrier in September 2011, during the January 28, 2011 to January 28, 2012 policy period. The policy defined claim to include "two or more Claims arising out of . . . Multiple Acts, Errors or Omissions in rendering Professional Services." Multiple Acts, Errors or Omissions was defined to include all acts, errors or omissions that are "logically or causally connected by any common fact(s), circumstances, situation, transaction(s), event(s), advice or decision(s)." The policy also stated that a single per-claim limit "applies to a Claim arising from Multiple Acts, Errors or Omissions, regardless of the number of claimants, lawsuits, or Insureds involved."

The $1 million per-claim limit was subject to a known claims endorsement stating that, if the insured became aware of a potential claim in the twelve months prior to the policy's effective date, coverage would be limited to the lesser of $100,000 or 25% of the per claim limit (the "Known Claims Endorsement"). The policy defined a "potential claim" as "an event or circumstances that any Insured might reasonably expect would be the basis for a Claim."

Based on the insureds' December 2010 knowledge of the issues with the business client, which was during the twelve months prior to the policy's inception, the insurer took the position that the Known Claims Endorsement was triggered and therefore the claim was subject to a reduced $100,000 limit of liability. On behalf of the insured, the insurer settled the business client's claim.

The other impacted clients filed three separate lawsuits against the accountant and the firm in South Carolina state court, in which they alleged negligence and wrongful concealment of the accountant's disease. The insurer defended the insureds under a reservation of rights, and later filed a declaratory judgment action in federal court to determine its obligations under the policy. In the coverage action, the insurer contended that all of the matters against the accountant and firm constituted a single claim subject to the Known Claims Endorsement. The insureds disputed that position, contending that the insurer breached the policies and acted in bad faith.

Following a bench trial, the Court held that all of the claims against the insureds constituted a single claim subject to the Known Claims Endorsement and $100,000 limit of liability. First, the Court noted that the endorsement was triggered because the phrase "might reasonably expect" in the definition of potential claim "sets a low threshold" satisfied by knowledge of

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Multiple Clients' Claims Against Accountant Deemed Related and Subject to Lower Limit of Liability Due to Insureds' Prior Knowledge of One Client's Claim *continued from page 13*

the business client's loss in 2010. The Court rejected the insureds' argument that the endorsement was inapplicable because the insureds subjectively did not think that a claim would be raised. The Court reasoned that the word "reasonably" injects an objective standard under which the test is whether a reasonable person would have anticipated a claim in late 2010.

Second, the Court held that the remaining clients' claims were related to the business client's claim and therefore also were subject to the same $100,000 limit. Relying on other federal decisions in the state and in the Fourth Circuit, the Court concluded that the policy's definition of Multiple Acts, Errors or Omissions was "unambiguous and expansive," and "links claims that share even a single logically connective fact, circumstance, or situation." Under this broad standard, all of the clients' claims were related because the accountant's disease and subsequent loss of faculty played a causal role in all of the matters. ■

Court Finds EEOC Charge and Subsequent Lawsuit to Be Two Separate Claims Under Claims-Made Policy

The United States District Court for the Northern District of Illinois, applying federal and Illinois law, has found that an employment discrimination lawsuit was "first made" within a professional liability policy's policy period despite the fact that the lawsuit's required precursor, an Equal Employment Opportunity Commission (EEOC) charge, was filed before the policy period. *John Marshall Law Sch. v. Nat'l Union Fire Ins. Co.,* 2016 WL 7429221 (N.D. Ill. Dec. 26, 2016). The court also refused to dismiss an insured's request for a declaratory judgment that would prevent the insurer from raising policy defenses, as well as the insured's claim for vexatious refusal to pay under an Illinois statute.

The insured, a law school, was sued by one of its professors for alleged disability discrimination during the policy period of the insured's claims-made liability insurance policy. Before the policy period, the professor had filed a charge based on the same allegations with the EEOC, as required before he could sue in court. The insurer denied coverage for the lawsuit on the basis that the insured's claim was first made when the EEOC charge was filed, which was outside the policy period. The insured disagreed, arguing that the lawsuit was first made within the policy period, independent of the preexisting EEOC charge. The insurer filed a motion to dismiss.

The Northern District of Illinois denied the insurer's motion to dismiss, finding the policy ambiguous as to when a claim is "first made" when two legal proceedings arise from the same facts. Noting that the policy did not define when a claim is "first made," the court articulated the issue as "whether the EEOC charge and the lawsuit are two separate claims as the policy defines that term, or just one." The court stated that if the two proceedings constituted one claim, then the insurer would be entitled to dismissal because the claim was first made when the EEOC charge was filed against the insurer.

The court found that, construing the policy in the insured's favor, the EEOC charge and lawsuit were two separate claims. Relying on *Lodgenet Entertainment Corp. v. American International Specialty Lines Insurance Co.*, 299 F. Supp. 2d 987 (D.S.D. 2003), the court found that two policy provisions implied that multiple claims could arise from the same facts. First, the policy's notice / claim reporting provision stated, "if written notice of a Claim has been given… then any Claim which is subsequently made… arising out of [the same facts] shall be considered made at the time such notice was given." Second, the policy contained an exclusion stating that "the insurer is not liable to pay for a loss 'in connection with a Claim made against an insured… alleging, arising out of, based upon or attributable to the facts alleged, or to the same or Related Wrongful Act alleged or contained

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Court Finds EEOC Charge and Subsequent Lawsuit to be Two Separate Claims under Claims-Made Policy *continued from page 14*

in any Claim' reported under an earlier policy of which the current policy is a renewal." Based on these provisions, as well as the fact that the EEOC charge and lawsuit each fell under the policy's definition of "claim," the court found that the two proceedings could reasonably constitute separate claims, and therefore, the lawsuit was a claim first made within the policy period.

The court also found that the insurer was not entitled to dismissal of the insured's request for declaratory judgment, because the policy contained language sufficient to give rise to a duty to defend. Similarly, the court did not dismiss the insured's claim for vexatious refusal to pay, as the insured sufficiently alleged that the insurer had no bona fide basis to deny coverage. ■

Insurer Has No Duty to Defend Claim Seeking Restitution and Other Unspecified Relief

An Illinois federal district court has held that a lawsuit seeking to recover amounts an insured wrongfully refused to pay to another sought only uninsurable restitutionary-type relief, not "Damages," and thus did not trigger an insurer's defense obligations under an E&O policy. *Westport Ins. Corp. v. M.L. Sullivan Ins. Agency, Inc.,* 2017 WL 56635 (N.D. Ill. Jan. 5, 2017).

The insureds, an insurance broker and one of its employees, were sued by an insurer for allegedly misrepresenting underwriting data to it when procuring coverage on behalf of their clients. The insurer alleged that the insureds operated a fraudulent scheme in which they calculated premiums based on certain data from their clients, but before remitting premiums to the insurer, they changed the data to decrease the premium amounts – and they then kept the difference. The underlying suit alleged causes of action for negligent misrepresentation and intentional wrongdoing, and it sought "to recover premiums collected and wrongfully withheld" as well as unspecified "compensatory damages" and "all such further and other relief." The insureds tendered the suit under their professional liability policy, and the insurer filed a coverage action seeking a declaration that it owed no duty to defend or indemnify the underlying suit.

In ruling on the professional liability insurer's motion for summary judgment in the coverage action, the court ruled first that the complaint alleged a "negligent act, error, or omission" and thus a "Wrongful Act" under the policy. The court noted that while the complaint generally alleged an intentional scheme, the federal rules permit pleading in the alternative, and the complaint contained a count specifically for negligent misrepresentation. On that basis, the court determined that the complaint arguably alleged negligent conduct and thus potentially implicated coverage notwithstanding that the main thrust of the underlying claim was that the insureds defrauded the claimant.

The court next held, however, that the insurer had no duty to defend because the underlying suit did not seek "Damages." The court noted that the term "Damages" did not include "reimbursement or return of premiums," "restitution" payments, or "matters deemed uninsurable under the law." The court held that any of those three prongs would preclude coverage here. In so ruling, the court noted that disgorgement under Illinois law is not "loss" and is uninsurable. The court also rejected the insureds' argument that the underlying suit's demand for "compensatory damages" and "all such further and other relief as the Court deems just and appropriate" alleged covered "Damages" and thus implicated a duty to defend, ruling instead that such "boilerplate" language did not expand the relief sought and could not be used to create a duty to defend. ■

Personal Profit Exclusion Does Not Relieve Insurer of Duty to Advance Defense Costs for Other Pending Causes of Action

Applying Montana law, the United States District Court for the District of Montana has held that a D&O policy's personal profit exclusion, which was implicated by a finding of conversion against an insured director, did not relieve the insurer of the duty to advance defense costs for the other remaining causes of action against the director. *Johnson v. Federated Rural Elec. Ins. Exch.*, 2016 WL 7243526 (D. Mont. Dec. 14, 2016).

The insured director was sued for breach of fiduciary duty, conversion, unjust enrichment, constructive fraud, conspiracy, and tortious interference with business relations. The insurer agreed to advance defense costs to the director subject to a reservation of rights, but the director filed suit alleging the insurer had failed to pay the full amount of fees and costs incurred in the underlying litigation. While the coverage action was ongoing, the court in the underlying action found the director liable on one conversion claim for approximately $14,000. The insurer issued an amended reservation of rights letter indicating that, due to the finding of conversion, the policy's personal profit exclusion barred coverage for the underlying litigation.

The court agreed with the insurer that the director's conversion implicated the personal profit exclusion, which barred coverage for "Loss in connection with any claim[] or claims made against the Insureds . . . which results in a finding of personal profit, gain or advantage." However, the court found that the "any claim" prefatory language signaled to an ordinary reader that individual claims should be segregated. Therefore, the court considered each cause of action asserted against the director to be a separate claim. Because the other causes of action were not "in connection with" or "inextricably related to" the conversion, the court found they were not subject to the exclusion.

Accordingly, the court held that the insurer had no further duty to advance defense costs for the conversion count but did have the duty to advance defense costs for the remaining causes of action. Looking to Ninth Circuit precedent, the court further held that the insurer must advance defense costs at the time they were incurred because that was when the director was legally obligated to pay the costs.

The insurer also sought reimbursement of the defense costs already paid in connection with the conversion claim. The court recognized that Montana law allows an insurer to recoup defense costs for claims outside the scope of coverage if the insurer timely and explicitly reserves the right of recoupment. However, because the insurer's first reservation of rights letter to the director did not explicitly reserve the right to recoup, the court held that the insurer was not entitled to reimbursement of defense costs related to the conversion claim. The court noted that even if it were to allow reimbursement, it would be impossible to distinguish between defense costs advanced to defend the conversion claim as opposed to the other causes of action against the director. ■

Temp Nurse Deemed an "Employee" Under Hospital Insurance Policy Despite Staffing Agreement Stating Otherwise

The United States Court of Appeals for the Fourth Circuit has held that, under Maryland law, a nurse placed by a staffing agency to work at a hospital qualifies as a hospital "employee" under the hospital's insurance policy despite a separate contract describing the nurse as an employee of the agency, not the hospital. *Interstate Fire & Cas. Co. v. Dimensions Assurance, Ltd,* 2016 WL 7099822 (4th Cir. Dec. 6, 2016).

A temp nurse and a hospital were sued for malpractice. The hospital's insurer refused to defend the nurse, claiming that she was not a hospital employee. The staffing agency's professional liability insurer defended the nurse, ultimately settling the case. That insurer then filed an equitable contribution action against the hospital's insurer, claiming that the nurse was an "employee" and thus entitled to coverage under the hospital policy.

The professional liability section of the hospital's policy described present and former employees as protected persons; however, the general liability section stated that persons working on an agency or contract basis were not protected persons. The policy did not define the term "employee." The staffing agreement between the agency and the hospital stated that agency-provided staff were employees of the agency, not the hospital. Relying on the terms of the staffing agreement, the trial court held that agency-provided workers were not employees under the hospital policy and granted summary judgment to the hospital insurer. On appeal, the agency insurer argued that the nurse qualified as an employee under the hospital policy's plain terms and that the trial court erred in relying on a separate contract to determine the meaning of the policy.

The appellate court agreed with the agency insurer and reversed the trial court's decision. First, the appellate court pointed to the policy language excluding agency-placed practitioners as protected persons under the general liability section. The court reasoned that the absence of similar language in the professional liability section reflected an intentional decision and therefore the term "employee" in the professional liability section included such individuals. Second, the court rejected the argument that the staffing agreement controlled the meaning of the hospital policy, holding that Maryland principles of contract interpretation require courts to look only to the unambiguous policy itself and to interpret it as written. ■

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