Wiley Rein LLP

EXECUTIVE SUMMARY

Legal Developments Affecting Professional Liability Insurers | June 2017

Second Circuit Upholds Trial Win for Insurer Rescinding Policy

In a win for Wiley Rein's client, the Second Circuit has upheld a judgment declaring an accountants professional liability policy to be void *ab initio* based on material misrepresentations in the insured's application for coverage. *Continental Cas. Co. v. Boughton*, 2017 WL 2416902 (2d Cir. June 5, 2017). The appellate court held that (1) the district court correctly granted summary judgment in favor of the insurer on the claimants' ratification defense; and (2) the district court did not commit reversible error in instructing the jury during the trial on whether the insurer unreasonably delayed in pursuing rescission.

The insured, an accounting firm, submitted an application for professional liability coverage that contained several materially false answers, including a representation that none of the firm's owners or partners were aware of any act, omission, or circumstance that might reasonably be expected to be the basis of a claim or suit. In reality, two principals of the firm were involved in a complex Ponzi scheme in which they solicited firm clients to participate in a nonexistent investment opportunity. After the SEC brought a civil enforcement

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ALSO IN THIS ISSUE

U.S. Supreme Court: ERISA "Church Plan" Exception Applies to Any Benefit Plan Maintained by Certain Church-Associated Organizations

Giving a major win to several religiously-affiliated health care systems, the United States Supreme Court unanimously held on June 5 that pension plans maintained by certain church-associated organizations qualify as ERISA-exempt "church plans," whether or not a church first established the plans. *Advocate Health Care Network v. Stapleton*, No. 16-74 (June 5, 2017). Plaintiffs around the country have alleged that pension plans for employees of several hospitals were not exempt "church plans"

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Eighth Circuit Affirms That Notice Given During Policy Period but Seven Months After Complaint Filed is Not "As Soon As Practicable"

The United States Court of Appeals for the Eighth Circuit, applying Minnesota law, has affirmed summary judgment in favor of an insurer, holding that the condition precedent of timely notice "as soon as practicable" was not met where the insured provided notice of a lawsuit seven months after the lawsuit was filed without offering any reasons for the delay, even though notice was provided during the claims made policy period. *Food Market Merch., Inc. v. Scottsdale Indem. Co.*, 2017 WL 2271363 (8th Cir. May 25, 2017).

The insured company was sued by a former employee seeking unpaid commissions. Six months into the suit, the court granted partial summary judgment in favor of the former employee. The next month – seventh months after the suit was first brought, but still within the policy period – the insured notified its insurer of the lawsuit, seeking defense and indemnification under its Business and Management Indemnity Policy. In addition to the requirement that the claim be made within the policy period, the policy required that the insured, "as a condition precedent to their rights" under the policy, give the insurer written notice of any claim "as soon as practicable, but in no event later than sixty (60) days after the end of the Policy Period."

The insurer tentatively denied coverage on the basis that the lawsuit was not within the scope of coverage, which prompted the insured to file suit. The insurer then formally denied coverage on the basis that notice was untimely and its claim was outside the policy's scope.

The trial court granted summary judgment in favor of the insurer after finding no genuine issue that the insured failed to notify the insurer of the litigation as soon as practicable, and that the insurer's duty to defend was never triggered because timely notice is a condition precedent to coverage under the policy.

On appeal, the Eighth Circuit affirmed. The court found that while it is generally the case that whether notice was given as soon as practicable is a fact-dependent question for the jury to determine, here, the insured had presented no evidence that providing notice over seven months after the lawsuit was filed was "as soon as practicable." The appellate court pointed to the trial court's finding that, during those seven months, the insured "hired counsel, litigated the case, and negotiated with [the claimant], all without seeking [the insurer's] involvement." In so deciding, the court rejected the insured's attempt to insert a prejudice determination into the court's consideration, which the court noted was not required where, as here, notice is a condition precedent to coverage. The court also held that the policy was unambiguous and that the insurer did not waive its timeliness argument by failing to raise it before it formally denied coverage. According to the court, no precedent requires waiver based on preliminary coverage-related communications. ■

An Insured's Prior Knowledge Precludes Coverage for Other Insureds Seeking Coverage; Prior Litigation Exclusion Applies to Arbitration Demand

Applying California law, the United States Court of Appeals for the Ninth Circuit has held that prior knowledge of wrongful acts that could reasonably be expected to give rise to a claim possessed by an insured who is not seeking coverage may bar coverage for other insureds under the same policy. *Woo v. Scottsdale Ins. Co.*, 2017 WL 1532056 (9th Cir. Apr. 28, 2017). The court also held that a prior litigation exclusion was triggered by a demand for arbitration and independently barred coverage.

The insured television manufacturer purchased a business and management indemnity policy from the insurer that provided coverage on a claims-made-and-reported basis. The policy contained a prior knowledge exclusion that excluded coverage for claims "alleging, based upon, arising out of, attributable to, directly or indirectly resulting from, in consequence of, or in any way involving, any Wrongful Act, fact, circumstance or situation which any of the Insureds had knowledge of prior to the Continuity Date and such Insured had reason to believe at the time that such known Wrongful Act could reasonably be expected to give rise to such Claim." The definition of "Insured" extended to general partners, directors, officers, managers, and employees of the insured company. The policy also included a prior litigation exclusion that barred coverage for claims which "in any way" involve "any prior or pending litigation or administrative or regulatory proceeding, [or] demand letter."

During the policy period, one of the insured's suppliers brought suit to enforce a bankruptcy judgment against insured employees stemming from an arbitration commenced several years before. The supplier alleged that the insured fraudulently transferred funds in an attempt to avoid the arbitration award. The supplier filed an amended complaint also during the policy period, and the insured employees immediately tendered the claim. The insurer denied on the bases of the prior knowledge and pending or prior litigation exclusions, and the insured brought suit seeking a declaration regarding the insurer's duty to defend. The district court granted the insurer's motion for summary judgment and denied the insureds' motion, holding that each exclusion independently barred coverage for the supplier's suit.

The Ninth Circuit, in a brief opinion, affirmed. It held that the prior knowledge exclusion applied because certain insureds knew of the facts and circumstances from which the supplier suit derived, even if those individuals were not the ones seeking coverage for the present underlying action. The court further held that the prior litigation exclusion precluded coverage because the original demand for arbitration, which the insureds received in February 2009, predated the Continuity Date of April 2010. The supplier's suit "arose out of" the arbitration even though the two actions had distinct parties and issues. ■

Court Applies 2015 "Proportionality" Amendments to Federal Rules to Preclude Insured's Discovery into Extrinsic Evidence Regarding Insurance Policy

A Pennsylvania federal district court, evaluating the recent amendments to the Federal Rules of Civil Procedure regarding proportionality in discovery, has held that an insured that seeks to discover extrinsic evidence regarding interpretation of an insurance policy must: (1) point to specific language in the policy itself that is genuinely ambiguous (or that extrinsic evidence is likely to render ambiguous); and (2) show that the requested extrinsic evidence is also likely to resolve the ambiguity without imposing unreasonable expense. *Westfield Ins. Co. v. Icon Legacy Custom Modular Homes*, 2017 WL 2021514 (M.D. Pa. May 12, 2017).

An insurer filed a declaratory judgment action against an insured homebuilder. The parties became involved in a discovery dispute regarding the insured's right to discover extrinsic evidence purportedly related to the interpretation of the insurance policy at issue. The court ultimately ruled that the insured was not entitled to discovery of extrinsic evidence because the insured's "bald assertions of ambiguity" regarding policy language did not justify the discovery sought.

In ruling on the parties' discovery dispute, the court noted the "apparent chicken-or-egg problem that coverage cases present: extrinsic evidence may be used to demystify facially ambiguous language, but in the first place, a determination of ambiguity may depend upon or permit consideration of that very same extrinsic evidence." In constructing "a reasonable solution to this somewhat perplexing dilemma," the court held that the insured was required to: "(1) point to specific language in the agreement itself that is genuinely ambiguous or that extrinsic evidence is likely to render genuinely ambiguous; and (2) show that the requested extrinsic evidence is also likely to resolve the ambiguity without imposing unreasonable expense." In crafting that standard, the court analyzed case law and discussed the 2015 amendments to Federal Rule of Civil Procedure 26(b)(1), which focuses on "proportionality" in discovery. Here, finding that the insured could not satisfy this standard, the court refused to order the insurer to provide the requested discovery. ■

Texas Court Holds Disgorgement Amounts Uninsurable as a Matter of Law

The United States District Court for the Southern District of Texas, applying Texas law, and adopting the recommendation of a magistrate judge, has held that reimbursement of excessive executive compensation constitutes disgorgement and is therefore uninsurable as a matter of law under a directors and officers policy. *Twin City Fire Ins. Co. v. Oceaneering Int'l, Inc.*, 2017 WL 1160514 (S.D. Tex. Mar. 29, 2017).

The insurer issued a directors and officers liability policy to the insured corporation. The policy provided specified coverage for "damages," which did not include "amounts for matters uninsurable pursuant to applicable law." The policy also contained a personal profit exclusion precluding coverage for "damages" based upon or arising from the "gaining of any personal profit, remuneration or financial advantage to which such Insured is not legally entitled."

During the policy period, a shareholder filed a derivative action against the insured corporation, alleging that excessive executive compensation was awarded to certain directors and officers, and that these transactions constituted a breach of fiduciary duties. The lawsuit also advanced several unjust enrichment claims and sought disgorgement. During settlement discussions, the insured sought coverage from the insurer for any potential settlement amount. The insurer contended that coverage for any settlement of the lawsuit was precluded because the ultimate settlement amount would constitute uninsurable disgorgement under Texas law, and thus did not constitute "damages" as defined by the policy. The insured argued that the terms of the personal profit exclusion served to enhance coverage under the policy, and that any settlement amount would therefore be covered under the policy. The insurer filed a declaratory action seeking, in relevant part, a declaration that disgorgement and/or restitution damages are uninsurable as a matter of Texas law.

The magistrate judge, in a recommendation that was adopted by the district court, granted summary judgment in favor of the insurer. First, the court concluded that the definition of "damages" contained within the policy is unambiguous and enforceable as written. The court held that any settlement amounts constituting disgorgement of excessive compensation are uninsurable as a matter of Texas law. In so holding, the court relied primarily on *In re TransTexas Gas Corp.*, 597 F. 3d 298 (5th Cir. 2010). In TransTexas, the Fifth Circuit explicitly held that loss as defined in insurance contracts does not extend to amounts that are "restitutionary in character." Accordingly, the court concluded that any settlement amounts for unfair and excessive compensation constitute disgorgement of ill-gotten gains and restitutionary payments, which are uninsurable under Texas law.

Finally, the court held that the insured's reliance on the personal profit exclusion was misplaced, as an exclusion cannot create coverage under the policy. In so holding, the court stated that "[c]onceivably, amounts related to the gaining of personal profit, remuneration, or financial advantage could be insurable under applicable law; in which case, they would fit within the coverage provisions and would be excluded only upon a final adjudication of such gain" pursuant to the terms of the exclusion. ■

Attorney's Prior Knowledge Bars Coverage for Client's Malpractice Claim

The United States District Court for the Northern District of Ohio, applying Ohio law, has granted summary judgment in favor of an insurer, holding that an insured attorney could reasonably have expected a claim where he received a letter addressed to multiple parties indicating that the attorney's former client was represented by new counsel, who was retained to prosecute claims for damages "as applicable." *Gonakis v. Medmarc Cas. Ins. Co.*, 2017 WL 1355653 (N.D. Ohio Apr. 13, 2017).

An attorney represented a client in a real estate transaction involving the client's sale of an apartment building. After the building purchaser breached the purchase agreement, the attorney's client sent the attorney and five others a letter indicating that the client had hired counsel to prosecute claims for damages arising from the transaction and the related foreclosure action "as applicable." The letter also instructed all recipients to forward a copy of the correspondence to their respective professional liability carriers. The attorney reviewed the docket in the foreclosure action and concluded that he was not the client's intended target and that the client's letter did not apply to him.

Following receipt of the client's letter, the attorney applied for professional liability insurance coverage, but did not disclose the client's letter in connection with the application. The insurer subsequently issued a professional liability policy to the attorney. The policy's insuring agreement stated that the insurer would provide coverage in connection with a claim provided "that no Insured knew or should have known of facts that reasonably could have been expected to result in a claim prior to the effective date of this policy." The policy also provided that a claim was deemed made "when the Insured first receives information of specific circumstances involving a particular person or entity that could reasonably be expected to result in a claim." Finally, the policy included a prior knowledge exclusion, which stated that the policy did not apply to any claim "involving any circumstance, act, error, or omission . . . that occurred prior to the continuous coverage effective date, if on that date, the Insured knew or believed, or had reason to know or believe, that the circumstance, act, error, or omission might reasonably be expected to result in a claim."

After the professional liability policy was issued, the client filed a malpractice action against the attorney. The insurer denied coverage, arguing that the claim was first made before the policy incepted when the attorney received the client letter because, at that point, the attorney had "information of specific circumstances involving a particular person or entity that could reasonably be expected to result in a claim."

In the coverage litigation that followed, the attorney argued that the policy afforded coverage because, before the policy incepted, he did not reasonably expect that the client would sue him, and, after the lawsuit was filed, he timely reported the claim to the insurer during the policy period.

The court rejected the insured's position. The court first noted that, based on language of the policy, the pertinent inquiry was whether the attorney was aware of facts that "reasonably could have been expected to result in a claim." The court determined that, even if it liberally construed that language, a reasonable insured would have expected a malpractice claim after receiving the client's letter because it

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Insured v. Insured Exclusion Bars Coverage When FDIC Acts as Receiver

The United States of Appeals for the Ninth Circuit, applying California law, has held that an insured v. insured exclusion in a bank's insurance policy bars coverage for a claim brought by the Federal Deposit Insurance Corporation (FDIC) in its capacity as a receiver of the insured bank. *Hawker v. Doak*, 2017 WL 1147131 (9th Cir. Mar. 27, 2017).

The exclusion provided that "[t]he Insurer shall not be liable to make any payment for loss in connection with any claim based upon, arising out of, relating to, in consequence of, or in any way involving … a claim by, or on behalf of, or at the behest of, any other insured person, the company, or any successor, trustee, assignee or receiver of the company[.]" The FDIC admitted that it was acting as a receiver, but argued that the exclusion did not apply to the FDIC as receiver. The court rejected that interpretation, noting that the plain language of the policy excluded coverage. The court also noted that the omission of a regulatory exclusion present in a prior policy did not change its analysis: "the fact that an exclusion is deleted from a policy does not necessarily mean that everything that was included in the exclusion is now covered under the policy." The court also held that extrinsic evidence offered by the FDIC did not make the exclusion reasonably susceptible to its proposed interpretation. Finally, the court held that the case was distinguishable from other cases where federal courts have not applied insured v. insured exclusions to bar claims by the FDIC as receiver because none of the cases involved policies with an express exclusion for claims brought by a receiver. ■

Attorney's Prior Knowledge Bars Coverage for Client's Malpractice Claim *continued from page 6*

indicated that the client was represented by new counsel and that the claims for damages would relate to the real estate action in which the attorney had represented the client. The court also noted that the letter was addressed to all recipients equally and made no exceptions for the attorney. Finally, the court observed that the attorney's subjective beliefs about the merits of a malpractice claim against him were irrelevant. The court concluded that, because the letter was received several weeks prior to the policy's effective date and the attorney could reasonably have expected a claim, the policy did not afford coverage for the client's lawsuit. ■

Allegations Concerning Wage Fixing in Violation of the Sherman Act Do Not Fall Within Professional Liability Coverage for "Counseling" Services

Applying Colorado law, the United States District Court for the District of Colorado has held that allegations of collusion to fix wages in violation of the Sherman Antitrust Act do not fall within the scope of professional liability coverage for "counseling" services because "counseling" does not include an alleged agreement to fix wages. *Colony Ins. Co. v. Expert Group Int'l Inc.*, 2017 WL 2131368 (D. Colo. May 17, 2017).

The insureds, au pair placement agencies, were sued for allegedly maintaining au pair wages at artificially low rates. The underlying complaint asserted numerous counts, including antitrust violation, negligent misrepresentation, and breach of fiduciary duty. The insureds maintained professional liability policies designed primarily for health care companies and health care professionals. The professional liability insuring agreement in each policy provided coverage for wrongful acts occurring in the conduct of the insured's "professional services." The insurer sought a declaratory judgement that coverage was unavailable under the policies because the professional liability insuring agreement was not triggered by the antitrust count and various policy exclusions applied to bar coverage for the other counts.

The court held that the antitrust count did not fall within the scope of the professional liability insuring agreement. Of the types of professional services included in the insuring agreement, the insureds performed only "counseling" services by providing information and advice to au pairs and host families. Because "counseling" services did not include the insureds' alleged agreement to fix wages, coverage was not triggered. Accordingly, the insurer did not have a duty to defend the insured sued only under the antitrust count.

The court determined, however, that the counts for negligent misrepresentation and breach of fiduciary duty fell within the scope of the professional liability insuring agreement. The court reasoned that there was a duty to defend because the counts alleged that the insureds provided erroneous advice and information, which constituted "counseling." The court then rejected the insurer's argument that various policy exclusions applied to bar coverage, and held that the insurer had a duty to defend the remaining insureds. ■

Court Finds Hotel Worker Not "Employee" Under Policy for Theft Loss Coverage

The United States District Court for the Eastern District of Virginia, applying Virginia law, has held that a hotel's former maintenance worker was not an "employee" as defined by a business insurance policy, thereby precluding coverage for loss resulting from the worker's theft. *GRM Mgmt., LLC v. Cincinnati Ins. Co.*, 2017 WL 1712520 (E.D. Va. May 1, 2017).

A hotel hired a maintenance worker who later stole personal property and building materials while on the job. The hotel tendered the claim to two insurers under policies covering distinct risks. The first policy, providing commercial property insurance, excluded coverage for loss resulting from theft by an employee. The second policy, a business insurance policy, covered loss "resulting directly from 'theft' committed by an 'employee.'" The hotel argued in litigation with the property insurer that coverage existed under the policy because the worker was an independent contractor, not an employee. The parties settled, and the hotel brought suit against the second insurer. The second insurer denied coverage on the basis that the worker was not an "employee" as defined by the policy and filed a motion for summary judgment.

The court granted the insurer's motion and dismissed the case with prejudice. The court pointed to the policy's language, which defined "employee" as a "natural person" whom the hotel "compensate[d] directly" and whom the hotel had "the right to direct and control while performing services." The court found the first two elements were satisfied, but that the third was not. In particular, the court observed that although the hotel directed the ends of the worker's work, it had not controlled the means – the worker used his own tools, had no supervisor or weekly hour requirement, and worked on a project-by-project basis. The court also relied on testimony elicited from the hotel general manager during the hotel's lawsuit with the property insurer, who had described the financial and legal benefits of hiring maintenance workers as independent contractors, rather than employees. Finally, the court relied on the worker's contract, which was a "sub-contractor" agreement in which the hotel disclaimed all liabilities for the worker. ■

U.S. Supreme Court: ERISA "Church Plan" Exception Applies to Any Benefit Plan Maintained by Certain Church-Associated Organizations *continued from page 1*

because the statutory definition requires that such plans be "established and maintained . . . by a church." ERISA was amended to state that a plan "established and maintained . . . by a church" includes a plan maintained by a so-called "principal-purpose organization" controlled by or associated with a church which has as its principal purpose the administration or funding of the plan. The court interpreted this amendment to mean that plans maintained by such "principal-purpose organizations" are exempt from ERISA even if the plans were not originally established by a church.

The court was not asked to determine whether the hospitals in the cases at issue have close enough ties to churches for their internal benefits committees to qualify as "principal purpose" organizations. Plaintiffs can be expected to raise this issue in the dozens of "church plan" cases pending throughout the country, and we may see these cases make their way back to the U.S. Supreme Court in the coming years. ■

proceeding against the two principals and after one of the principals was indicted on criminal charges, the insurer sought rescission of the policy due to the material misrepresentations in the application. Two of the firm's former clients intervened in the rescission lawsuit after entering into an assignment of rights agreement with one of the firm's principals.

Before trial, the district court granted partial summary judgment in favor of the insurer, determining that it had not ratified the policy by taking various affirmative acts before seeking rescission. The case proceeded to trial as to whether the insurer had unreasonably delayed in filing for rescission. After a three-day trial, the jury found in favor of the insurer, answering, "NO!" to the question on the jury verdict form asking whether the claimants had proved that the insurer unreasonably delayed. The jury deliberated for just 64 minutes. The claimants appealed.

In its decision affirming the judgment, the Second Circuit rejected the claimants' argument that the insurer had ratified the policy by taking various affirmative acts before seeking rescission, including by paying some of the insured's defense costs and by offering an extended reporting period. The appellate court reasoned that New York law required the insurer to continue performing its coverage obligations until a judicial determination that the insurer could rescind the policy. Further, the court held that "[m]inisterial changes," such as amending the insured's name and address on the policy, could not serve as ratifying acts. Finally, the court held that the claimants had waived any argument that the insurer ratified the policy by disclaiming coverage for certain of the Ponzi scheme-related claims in an earlier letter.

As to the jury verdict, the claimants argued on appeal that the district court had incorrectly instructed the jury as to when an insurer must seek rescission. The appellate court noted that the difference between the claimants' proposed instruction and the actual instruction delivered to the jury was "vanishingly small and insufficient to justify a new trial." The appellate court also rejected the claimants' argument that the district court had incorrectly placed the burden of proof on the claimants to demonstrate that the insurer had not promptly rescinded. The court held that, even if the jury instruction on the burden of proof was incorrect, the error was harmless when viewing the instructions as a whole and in light of the jury's "speedy and emphatic verdict." ■

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