Wiley Rein LLP

EXECUTIVE SUMMARY

Legal Developments Affecting Professional Liability Insurers | July 2017

"Non-Specific," "Boiler-Plate" Notice of Potential Claim Insufficient as a Matter of Law

In a significant victory for Wiley Rein's client, a Tennessee federal court has held that an insured's "general, boiler-plate . . . broad, [and] non-specific" notice that purported to give notice of a potential claim was untimely and insufficient to provide notice of an actual claim made during the policy period and omitted from the notice. *First Horizon Nat'l Corp. v. Houston Cas. Co.,* No. 15-cv-2235-SHL-dkv (W.D. Tenn. June 23, 2017). In so ruling, the court held that an email that "stated [a] settlement offer of $610 million and requested a counterproposal from" the insured was a written demand for monetary relief, and thus a "Claim," that should have been reported to the insurers. Wiley Rein represents the primary carrier and argued the motions before the district court.

A bank was investigated by the U.S. Department of Justice ("DOJ") for alleged violations of the federal False Claims Act. In May 2013, prior to the inception of the policies at issue, the DOJ made a presentation to the insured that

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Duty to Defend Does Not Extend to Prosecution of Affirmative Counterclaims

The Supreme Judicial Court of Massachusetts has held that under a duty to defend policy, "the insurer's duty to defend does not require it to prosecute affirmative counterclaims on behalf of its insured." *Mount Vernon Fire Ins. Co. v. Visionaid, Inc.,* 2017 WL 2703949 (Mass. June 22, 2017).

The insured terminated one of its employees after discovering that the individual appeared to have misappropriated company funds. Subsequently, the former employee commenced an action for wrongful termination and related employment claims against the insured. The insurer agreed to defend the company against the former employee's lawsuit, but maintained that the policy did not require it to prosecute the company's counterclaim for misappropriation of funds, asserting that the duty to

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included "a summary of preliminary findings that [the insured] was in violation of the [False Claims Act]." The presentation also stated that "the investigation and settlement discussions would continue." The presentation was then emailed to the bank, which did not provide a copy or otherwise give notice to its E&O insurers. Those E&O insurers subsequently issued renewal policies to the bank.

In April 2014, during the period of those policies, a DOJ attorney conveyed an oral settlement offer by phone for damages in the amount of $610 million, which was confirmed in writing via email. The email stated that the insured "should provide a counterproposal" to the offer. The next month, the insured provided a notice regarding the investigation to its E&O insurers. The notice was specifically described as a "notice of circumstances that may give rise to a claim" ("NOC") and stated that the matter "could lead to a demand or claim under the federal False Claims Act." The notice did not mention the $610 million settlement proposal. Months later, subsequent to the policy period, the insured provided notice of a claim to the insurers, asserting that the claim was first made in a December 2014 presentation that reiterated the $610 million settlement offer and stated that the DOJ "plan[ned] to file suit unless [it] receive[d] a serious settlement offer" in response.

The bank settled for $212.5 million and sued the E&O tower for coverage. The insurers denied coverage on the grounds that, inter alia, the claim was made prior to the policy period, or alternatively was first made during the policy period but not properly noticed to the insurers. The court ultimately granted the insurers' cross-motion for summary judgment in material part, dismissing the case.

The court first considered whether the claim had been made prior to the policy period. The court held that the May 2013 presentation did not "quite" constitute a claim, observing that while the presentation did assert that the bank had violated the False Claims Act, it also stated that the investigation was still "ongoing" and involved a small sample of loans. However, the court held that the presentation "does, however, at a minimum, constitute the first 'circumstance[] which may reasonably be expected to give rise to a Claim,' sufficient to trigger a NOC by Plaintiffs in that policy period, should they have chosen to do so."

The court next considered whether the April 2014 $610 million settlement proposal constituted a written demand for monetary relief, and thus a "Claim," under the policies. The bank argued that the settlement offer was not a "formal" offer, but rather a "methodology to calculate damages," and therefore not a demand. The court disagreed, holding that the email was the first "Claim" made by the DOJ.

Finally, the court considered whether the NOC provided during the policy period was sufficient notice under the subject policies. The court held that it was not, which entitled the insurers to summary judgment and dismissal of the coverage complaint. First, the court held that the NOC was not timely submitted. The policies required that a NOC be submitted, if at all, during the policy period in which the bank first became aware of circumstances that may be reasonably expected to give rise to a "Claim." The court held that the first such circumstances occurred no later than the May 2013 presentation, before the policies' inception, and that the NOC was thus untimely.

Second, the court held that the NOC was not sufficient notice of the $610 million settlement proposal—the first "Claim." The court held that the notice was insufficient because it omitted

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Insured Versus Insured Exclusion Bars Coverage for Claim by Liquidating Trust

The United States Court of Appeals for the Sixth Circuit, applying Michigan law, has held that an insured vs. insured exclusion bars coverage for a claim against an insured company's former officers assigned during bankruptcy to a liquidating trust. *Indian Harbor Ins. Co. v. Zucker,* 2017 WL 2641085 (6th Cir. June 20, 2017).

The insured, a holding company, owned community banks in seventeen states. The company filed for Chapter 11 bankruptcy. As part of its bankruptcy plan, the company, as debtor in possession, assigned all of its causes of action to a liquidating trust, which in turn asserted a claim against former company officers for mismanagement. The company's D&O insurer denied coverage based on exclusion for "any claim made against an Insured Person … by, on behalf of, or in the name or right of, the Company." Coverage litigation ensued, and the district court ruled for the insurer.

On appeal, the Sixth Circuit affirmed the judgment in favor of the insurer. The court rejected the insureds' argument that the insured vs. insured exclusion referred to "the Company" only in its pre-bankruptcy form, ruling instead that the company's voluntary transfer of the claim through the bankruptcy process did not render the exclusion inapplicable. The court noted that the insureds' argument "would not make sense" in light of the "Change in Control" clause in the policy, which provided that coverage would continue even during bankruptcy of the Company. While recognizing that the debtor in possession and the pre-bankruptcy debtor were legally distinct entities for bankruptcy purposes, the court determined that they should not be treated differently for purposes of applying the insured vs. insured exclusion.

One judge dissented, opining that the exclusion should not apply to claims brought by any bankruptcy trustee, including a liquidating trustee, because such entities are legally distinct from the pre-bankruptcy company. ■

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mention of the settlement proposal and other significant developments and therefore was "not reflective of the state of affairs at the time." The court stated that "[t]he general, boiler-plate type language contained in the NOC was not sufficient notice of this Claim," and that to permit the bank to rely on the NOC as notice of the settlement proposal would "defeat[] the policy behind a claims-made policy, wherein the purpose of the notice requirement is to inform the insurer of its exposure to coverage." The court also rejected the bank's argument that the insurers had waived their right to contest the NOC, noting that the insurers had "no knowledge that a Claim had occurred here" and therefore could not have knowingly relinquished that coverage defense.

The court also held that a Civil Investigative Demand and subpoena did not constitute a "Claim" under the policies at issue, and that the claim by DOJ was not sufficiently interrelated to a prior loan underwriting claim to fall within the scope of the insured's release of the insurers that funded the settlement of the earlier claim. ■

Prior Acts Exclusion Bars Coverage for Claims Arising Out of Actions Predating Policy

The United States Court of Appeals for the Eleventh Circuit, applying Florida law, has held that a prior acts exclusion barred coverage under a directors and officers liability policy for claims brought against insured persons for alleged fraudulent transfers, even though the transfers occurred within the policy period. *Zucker v. U.S. Specialty Ins. Co.*, 2017 WL 2155414 (11th Cir. May 16, 2017).

Two insured persons, executives at a bank, were sued by the bank's bankruptcy administrator for breaching fiduciary duties to the bank. They allegedly approved two tax return transfers to the bank's subsidiary in 2009 that were made when the bank was insolvent and thus violated the Florida Uniform Fraudulent Transfers Act. In November 2012, the administrator made a written settlement demand. After the demand was forwarded to the D&O insurer, the insurer denied coverage based on the policy's prior acts exclusion. The exclusion provided that the insurer would not be liable for any Claim "arising out of, based upon, or attributable to any Wrongful Act committed or allegedly committed, in whole or in part, prior to [November 10, 2008]." The claim was ultimately settled for $15 million to be paid either by the insurer or the insured persons individually. The settlement agreement assigned the insured persons' rights under the policy to the administrator. The administrator then brought suit against the insurer based on its denial of coverage. The district court ruled in favor of the insurer on cross-motions for summary judgment, holding that the policy's prior acts exclusion barred coverage for the fraudulent transfer claims and that the insurer did not breach the insurance contract. The administrator appealed.

On appeal, the court held that the prior acts exclusion barred coverage for the fraudulent transfer claims because the fraudulent transfer claims "arose from" wrongful acts that predated the policy's effective date. In so holding, the court noted that the exclusion's language, which barred coverage for any claim "arising out of" any wrongful act committed prior to the inception date of the policy, had a broad meaning. Although the transfers were made after the prior acts date, the underlying conduct rendering the bank insolvent—and the transfers fraudulent—occurred before the priors acts date. The court concluded that the fraudulent transfer claims "arose from" wrongful acts that predated the policy's effective date and thus fell within the scope of the prior acts exclusion.

Further, the court held that the exclusion did not render coverage illusory or ambiguous because the exclusion did not eliminate all coverage under the policy. Rather, the exclusion simply excluded coverage for a subset of claims that arose exclusively from conduct that happened before the effective date of the policy. ■

Eighth Circuit Holds No Coverage under Commercial Crime Policy for Theft of Property Owned by Third Party

The United States Court of Appeals for the Eighth Circuit has held that a commercial crime policy does not provide coverage for stolen earnings because the insured did not own the funds at the time they were stolen. *3M Co. v. National Union Fire Ins. Co of Pittsburgh, PA*, 2017 WL 2347105 (8th Cir. May 31, 2017).

The insured, a manufacturing company, invested its employee benefit plan assets in a private equity firm. Its investment was structured as a limited partnership interest in the private equity firm. It was later discovered that two principals of the firm had engaged in a massive Ponzi scheme, diverting hundreds of millions of dollars from investors' accounts. The insured sought insurance coverage for the stolen earnings under the Employee Dishonesty provision of its commercial crime policy, which provided coverage for "direct Losses of Money, Securities or other property caused by Theft or forgery by any Employee of any Insured acting alone or in collusion with others." Another provision of the policy provided that "insured property may be owned by the Insured, or held by the Insured in any capacity whether or not the Insured is legally liable[.]" The insurers denied coverage, and the insured filed this coverage action. On cross motions for summary judgment, the trial court ruled for the insurers.

On appeal, the Eighth Circuit affirmed the trial court's grant of summary judgment in favor of the Insurers, holding that the policy's ownership requirement applied to the Employee Dishonesty provision because the only reasonable construction of that provision limits coverage to insured property. Further, the court rejected the insured's argument that its limited partnership interest in the private equity firm satisfied the ownership requirement, holding that property acquired with partnership funds is partnership property and therefore the insured did not own the stolen earnings at the time they were diverted. ■

Duty to Defend Does Not Extend to Prosecution of Affirmative Counterclaims

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defend did not include the duty to prosecute an affirmative counterclaim.

In response to certified questions from the United States Court of Appeals for the First Circuit, the state high court held that under the plain language of the policy, which obligated the insurer to "defend" the company against any "Claim," defined as "any proceeding initiated against [the company] . . . seeking to hold [the company] responsible for a Wrongful Act," there was no contractual obligation to prosecute affirmative counterclaims. According to the court, "[a]s the plain meaning of the word 'defend' is clear, we do not deviate from it." The court also concluded that the "in for one, in for all" doctrine does not extend to the prosecution of affirmative counterclaims because the doctrine does "not change the meaning of the word 'defend,'" and requires only that an insurer defend claims brought against the insured. The court also concluded that because the duty to pay defense costs is coextensive with the duty to defend under Massachusetts law, such a duty does not require an insurer to fund the prosecution of a counterclaim on behalf of the insured. ■

Insurer Not Estopped from Asserting Policy Defenses Where Insured Had Duty to Defend; Insured-v.-Insured Exclusion Does Not Bar Coverage for Claims by Former Shareholders

An Illinois federal court, applying Illinois law, has held that an insurer who declined to advance defense costs was not estopped from asserting policy defenses in a coverage action later filed by the policyholder corporation. *Vita Food Prods., Inc. v. Navigators Ins. Co.*, 2017 WL 2404981 (N.D. Ill. June 2, 2017). The court also held that the policy's prior notice provision precluded coverage for the underlying lawsuit, filed during the 2009 policy period, because it related back to a 2007 letter that the corporation tendered to the insurer during a prior policy period. In addition, the court held that the security holder exclusion barred covered to the extent that the claimants against the corporation were shareholders at the time the original claim was first made.

The insured corporation received a letter from a shareholder in 2007 alleging that its directors had violated their fiduciary duties in agreeing to issue stock to one of the directors on "very favorable prices and terms." The letter urged the corporation to adjust the terms of the deal and requested documentation regarding the deal. The company reported the matter to its directors and officers liability insurer as a notice of circumstance that could lead to a claim, and the insurer agreed to treat the letter as such. In 2009, 24 former shareholders filed a complaint against six directors asserting racketeering, breach of fiduciary duty and negligence claims arising out of a 2009 merger in which outstanding shares were sold to the same director for an allegedly inadequate price. The insurer denied coverage under the 2009 policy on the grounds that it arose out of wrongful acts that were the subject of a claim made prior to the policy period. The insured filed suit seeking coverage under the 2007 and 2009 policies.

The insured argued that the insurer was estopped from raising any policy defenses because it did not provide a defense to the underlying action, relying on the Illinois rule under *Employers Ins. of Wausau v. Ehlco Liquidating Trust* that an insurer may not simply refuse to defend an insured, but instead must either defend under a reservation of rights or seek a declaratory judgment that the policy does not provide coverage for the claim. The court rejected this argument, distinguishing between an insurer's duty to defend and the duty to advance defenses costs in the policy at issue, noting that the policy specifically stated that the insured corporation had the duty to defend claims.

The court also held that the 2007 letter constituted a "claim," rather than just a notice of circumstances that could lead to a claim, because it was a demand for non-monetary relief. The court determined that the 2009 lawsuit arose out of the same or related "wrongful acts" as the 2007 letter, as both alleged breaches of fiduciary duty arising out of the same transaction. The two therefore constituted a single claim first made during the 2007 policy period, and the prior notice exclusion in the 2009 policy barred coverage for the lawsuit.

With respect to the 2007 policy, the insurer contended that no coverage was available based on the security holder, or insured-v.-insured, exclusion, because two of the plaintiffs in the suit were directors of the insured corporation. The exclusion contained an exception stating that it did not preclude coverage where the

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Separate Lawsuits Part of a Single Claim First Made Prior to Policy Period

The United States District Court for the District of Colorado, applying Colorado law, has held that two lawsuits were connected by the "single scheme" of a contractor to interfere with a government contract for a surveillance camera system. *Ciber, Inc. v. Ace Am. Ins. Co.*, 2017 WL 2537092 (D. Colo. June 9, 2017). The district court further held that, because the lawsuits were connected, they were part of a single claim first made prior to the inception of a claims-made professional liability policy. As a result, there was no coverage under the policy.

In 2003, the New Orleans police used private security footage to investigate a car wash shooting. Finding the footage useful, the Mayor of New Orleans solicited bids for a public surveillance system and awarded the contract to a private contractor. The city also hired a second contractor to assist, who in turn hired city-employed subcontractors. A dispute arose between the private contractor and the second contractor in which the first contractor alleged that the second contractor and its city-employed subcontractors interfered with the implementation of the contract. The case settled.

A few years later, a technology company sued the first contractor, the second contractor, and several defendants named in the earlier action. The company alleged that it had created the surveillance technology in collaboration with the first contractor, and further alleged that both contractors had colluded with city employees to win the government contract. The second contractor tendered the lawsuit to its liability insurer, who denied coverage on the basis that the operative "claim" was first made when the prior lawsuit occurred, and therefore outside the policy period.

The district court agreed, framing the issue as whether the two lawsuits involved "interrelated wrongful acts," which the policy defined as "all wrongful acts that have as a common nexus any fact, circumstance, situation, event, [or] transaction." The insured urged the court to require a causal connection between the lawsuits, but the court rejected the argument, stating, "[The insurer] points out that the 'problem with [the] 'but-for' standard is that it would require the Court to rewrite the Policy, which Colorado law forbids.'"

Instead, the district court focused on whether there was a "connection" between the two suits and found that there was. In particular, the court determined that both lawsuits involved the same contract and were connected by the second contractor's "single scheme" to "cut out the originators of [the surveillance] system from current and future business dealings" in favor of city employees. Thus, the court held that, because the claim arose prior to the inception of the claims-made policy, no coverage existed. ■

Insured vs. Insured Exclusion Bars Coverage for Claim Brought by Insured and Officers Against Another Officer

The Superior Court of New Jersey, Appellate Division, applying New Jersey law, has held that an insured vs. insured exclusion bars coverage under a directors and officers liability policy for counterclaims brought against an officer by the company and fellow officers. *Abboud v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA,* 2017 WL 2665133 (N.J. Super. Ct. App. Div. June 21, 2017).

The insured officer brought suit against the company and four of its managers for allegedly attempting to remove him from the board of managers and from his position as chief executive officer. The company and other managers asserted various counterclaims against the officer, alleging that he had engaged in self-dealing and exploited the company's opportunities for his own personal gain. They then obtained partial coverage for the former officer's claim from the company's D&O and EPL insurer for the lawsuit under the EPL insuring agreement. However, the officer did not notify the insurer until seven months after the counterclaim against him was filed. The insurer did not respond to the officer's notice, and the officer filed a declaratory judgment action against the insurer, seeking indemnity and defense coverage for the counterclaims under the D&O coverage part. The insurer argued in its motion for summary judgment that the insured vs. insured exclusion, which in relevant part bars coverage for any claim "made against the Insured . . . which is brought by or on behalf of a Company or Individual Insured, other than an Employee of the Company," precluded coverage for the counterclaims. The trial court granted the insurer's motion for summary judgment, determining that the insured vs. insured exclusion plainly barred coverage for the counterclaims. In so holding, the court rejected the officer's arguments that the exclusion applied only if there was collusion among the insureds and that the enforcement of the exclusion would frustrate his reasonable expectations.

On appeal, the court held that the insured vs. insured exclusion plainly and unambiguously barred coverage. The court noted that the exclusion barred coverage when the claim was made by either an executive of the company or the company itself. Because the counterclaims asserted against the officer were brought by the company itself and four of its executives, the exclusion applied. The court rejected the officer's collusion and reasonable expectations arguments. As to the officer's collusion argument, the court examined the history behind the insured vs. insured exclusion and highlighted that its original purpose was to bar coverage both for collusive suits and for suits arising out of disputes between members of a corporation. In rejecting the officer's reasonable expectations argument, the court recognized that the policy language was straightforward, that the policy had been issued to a sophisticated consumer, and that the public at large had no identified interest in finding coverage. ■

Insurer's Consent to Settle Not Required Following Effective Denial of Coverage

Applying New York law, a New York intermediate appellate court has held that insurers' unreasonable delay in addressing an insured's claim and their repeated insistence that several policy provisions barred coverage for the claim alleviated the insured's obligation to seek the insurers' consent to settle. *J.P. Morgan Securities Inc. v. Vigilant Ins. Co.*, 2017 WL 2744405 (N.Y. App. Div. June 27, 2017).

An insured bank sought coverage for an investigation by the Securities and Exchange Commission. The bank's insurance carriers asserted that the investigation did not constitute a claim under the applicable policies, and additional coverage issues may apply to bar coverage for any settlement. Thereafter, the bank settled the claim with the SEC and sought coverage for the settlement.

In the ensuing coverage litigation following the carriers' refusal to cover the settlement, the carriers argued that the bank violated the policies' consent-to-settle requirement. The court disagreed, finding that the carriers' "unreasonable delay in dealing with [the bank's] claims" and their consistent position that the investigations raised several dispositive coverage issues constituted a "repudiation of liability" for the bank's claims that excused the bank from its obligation to seek the insurers' consent prior to entering into a settlement with the SEC. ■

Insurer Not Estopped from Asserting Policy Defenses Where Insured Had Duty to Defend; Insured-v.-Insured Exclusion Does Not Bar Coverage for Claims by Former Shareholders *continued from page 1*

security holder bringing the claim acted totally independent of and without the solicitation, assistance, active participation or intervention of any director or officer of the company. The court held that the exclusion applied only to the claims of the two directors, reasoning that the policy's allocation provision specifically provided for segregation of covered and non-covered claims.

The insured corporation asserted that the exclusion could not apply to those claimants that were former shareholders. The court agreed, but held that the relevant time period to consider the claimants' shareholder status was at the time the 2007 demand letter was sent. The court could not determine which claimants were shareholders at the time of the letter, but held that, to the extent the claimant shareholders were shareholders at the time of the 2007 letter, the policy did not afford coverage as to their claims. ■

Bermuda Insurer Required to Post Bond to Compel Arbitration Against New York Insured

Judge Martin Glenn of the U.S. Bankruptcy Court for the Southern District of New York has held that a Bermuda insurer must post a bond pursuant to N.Y. Ins. Law § 1213 after it filed a motion to compel arbitration. *MF Global Holdings Ltd. v. Allied World Assur. Co., Ltd*., 2017 WL 2533353 (Bankr. S.D.N.Y. June 12, 2017).

A Bermuda-based insurer issued a policy to a New York-based insured. The insurer delivered the policy to the insured's Bermuda-based broker, which sent the policy to the insured at its New York address. After a coverage dispute, the insured ultimately filed a complaint initiating coverage litigation against the insurer. In response, the insurer filed a motion to compel arbitration in Bermuda pursuant to the alternative dispute resolution clause in its policy. Thereafter, the insured filed a motion to compel compliance with N.Y. Ins. Law § 1213, which requires unauthorized foreign insurers to post a bond "sufficient to secure payment of any final judgment which may be rendered in [a] proceeding" prior to "filing any pleading in any proceeding." The insurer opposed the motion, arguing that its motion to compel arbitration was not a "pleading," and that the policy was not "issued or delivered" in New York. The insurer also argued that the New York Convention on the Recognition and Enforcement of Foreign Arbitral Awards (the "New York Convention") preempted enforcement of the statute.

The court granted the insured's motion to compel compliance with N.Y. Ins. Law § 1213, rejecting all of the insurer's arguments. First, the court noted that courts have interpreted the term "pleading" broadly as it appears in § 1213, including to encompass motions to compel arbitration. Second, the court held that the policy was "issued" and "delivered" to the insured in New York, noting that the insurer "fully expected that the [policy] would ultimately be delivered to New York" when it sent the policy to the Bermuda-based broker. Third, the court held that the New York Convention did not preempt enforcement of the statute, because the statute was not an "impediment" to arbitration. Rather, the court viewed the bond provision as a "security device in aid of the arbitration." The court required the insurer to post a bond in the amount of the limit of liability of the policy. ■

Antitrust Exclusion Precludes Duty to Defend

The New York Supreme Court for the County of New York, applying Michigan law, has held that an antitrust exclusion bars coverage for an antitrust lawsuit despite limited allegations of covered disparagement. *Carfax, Inc. v. Ill. Nat'l Ins. Co.*, No. 655198/2016 (N.Y Sup. Ct. May 16, 2017).

The insurer issued a policy that required the insurer to defend against "defamation, libel, slander, product disparagement, or other tort related to disparagement." The policy also contained an exclusion barring coverage for claims alleging antitrust violations, including violations of the Sherman Act or Clayton Act. A number of auto dealers sued the insured alleging that the insured had unlawfully monopolized the sale of vehicle history reports. The insurer denied coverage for the action, asserting that the antitrust exclusion applied.

The court granted the insurer's motion to dismiss the declaratory judgment action, reasoning that while the complaint made "limited, sporadic references to 'stigmatization' and 'disparagement,'" these allegations were made within the context of pleading antitrust violations. The court observed that there was no separate theory of recovery based on a tort related to disparagement, and the complaint did not "plead facts that support a reasonable inference that the plaintiff auto-dealers sustained damages due to disparagement . . . as opposed to damages for anticompetitive injury." The court therefore held that the insurer had no duty to defend the action. ■

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