Wiley Rein LLP

EXECUTIVE SUMMARY

Legal Developments Affecting Professional Liability Insurers | September 2017

Missouri Federal Court Denies Motion to Stay Coverage Action Pending Resolution of State Insolvency Proceedings Against Insured

In a win for Wiley Rein's client, a Missouri federal court has denied a motion to stay a coverage action against an insolvent insurer pending the resolution of insolvency proceedings in state court, holding that the insolvent insurer had failed to demonstrate that the case presented one of the exceptional cases where abstention is appropriate. *Allied World Surplus Lines Ins. Co. v. Galen Ins. Co.*, 2017 WL 3503473 (E.D. Mo. Aug. 16, 2017).

The insurer sought rescission of two consecutive professional liability policies issued to related insurance companies, as well as declaratory relief as to coverage for a claim against the insurance companies. After the rescission complaint was filed, a Missouri state court entered an order of liquidation in a separate proceeding against one of the defendants.

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Ninth Circuit Applies Invasion of Privacy Exclusion to Bar Coverage for TCPA Claims under D&O Policy

The Court of Appeals for the Ninth Circuit, applying California law, has held that an invasion of privacy exclusion in a D&O policy barred coverage for a claim alleging violations of the Telephone Consumer Protection Act (TCPA). *Los Angeles Lakers, Inc. v. Federal Ins. Co.*, 2017 WL 3613340 (9th Cir. Aug. 23, 2017).

The insured, a professional basketball team, was sued for violations of the TCPA after it sent text messages

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ALSO IN THIS ISSUE

Single Lawsuit Alleging Multiple Wrongful Acts Constitutes Single Claim

The United States Court of Appeals for the Third Circuit, applying Pennsylvania law, has held that a single lawsuit alleging three causes of action and up to eight discrete wrongful acts constituted a single claim under a professional liability insurance policy. *Westport Ins. Corp. v. Mylonas*, 2017 WL 3327798 (3d Cir. Aug. 4, 2017).

The insured, a law firm, was sued in connection with its work in forming a corporation on behalf of the claimant. The lawsuit alleged that the insured negligently transferred the corporation's stock without shareholder consent, in violation of the corporate documents that the insured had prepared. As a result, the claimant lost his company and its assets. The complaint pleaded three causes of action for negligence, breach of fiduciary duties, and breach of contract. The insurer paid $420,000 in defense costs, and the jury awarded the claimant damages totaling $525,000. However, the policy limited coverage, inclusive of defense costs, to $500,000 per claim or $1 million in the aggregate. In arguing that the per-claim limit of liability applied, the insurer referred to the policy's definition of "claim" as a "demand made upon any INSURED for LOSS . . . including, but not limited to, service of suit or institution of arbitration proceedings or administrative proceedings against any INSURED." The district court determined that, under the terms of the policy, the single suit constituted a single claim.

On appeal, the Third Circuit affirmed and held that the policy unambiguously stated that the lower, per-claim limit applied because the lawsuit constituted a single claim. The court explained that a "claim" is not the underlying wrong or wrongs, but rather the demand for loss made upon the insured. As such, the court found that "one demand for loss is one claim." Because the claimant had served the insured with one suit, the claimant made only one demand for redress of his losses and thus one claim. Although the court acknowledged that the form of pleading does not determine what constitutes a claim, it emphasized that it would consider only the number of demands for loss made upon the insured, as required by the policy. ■

No Coverage for $3.5 Million in Pre-Notice Defense Expenses Where Notice Was a Year Late

Applying Delaware law, a federal court in New York has held that where an insured waited more than a year to report a lawsuit to its insurer and during that period incurred more $3.5 million in legal fees, the insurer had no obligation to pay pre-tender defense costs, without regard to whether the insurer could show prejudice from the delay in notice. *Abrams v. RSUI Indem. Co.*, 2017 WL 3433108 (S.D.N.Y. Aug. 10, 2017).

In March 2015, an officer and director of the insured holding company was sued by an investor for breach of contract. More than a year later, in April 2016, the insured sent a letter to its insurer notifying it of the lawsuit and seeking coverage under its $3 million D&O Policy for the defense expenses incurred since the lawsuit was filed, which totaled more than $3.5 million.

In addition to a policy provision requiring the insured to give the insurer notice of a claim made as soon as practicable but in no event later than thirty days after the policy's expiration, the D&O Policy provided that "[n]o Insured may incur any Defenses Expenses… without the Insurer's prior written consent" and that notice was a "condition precedent to the Insurer's obligation to pay[.]"

After the insurer refused to reimburse those defense costs, the insured sued alleging that the insurer breached the D&O Policy. The parties cross-moved for summary judgment. The holding company argued that the insurer was liable for the pre-notice defense expenses because the D&O policy did not explicitly disclaim pre-notice defense expenses or even mention "voluntary" payments. The insured also argued that the insurer should be required to show prejudice from the delay to support its declination. The court rejected both arguments as without merit. First, according to the court, the import of the policy's explicit, repeated and unambiguous references to consent prior to coverage was that any expenses incurred by the insureds prior to providing notice would be voluntarily paid by the insured and thus properly disclaimed by the defendant. That the policy did not contain a no-voluntary-payments provision was of no moment. Second, the court found that Delaware courts routinely enforced these provisions without issue and without requiring an insurer to show prejudice. Accordingly, the court denied the insured's motion for summary judgment and granted summary judgment in favor of the insurer. ■

Missouri Federal Court Denies Motion to Stay Coverage Action Pending Resolution of State Insolvency Proceedings Against Insured *continued from page 1*

The defendants then moved to stay the coverage action, pending resolution of the state court insolvency proceeding.

In denying the motion to stay, the federal court considered established abstention doctrines, including *Burford* and *Colorado River,* and concluded that the defendants had failed to demonstrate that "any one of the extraordinary and narrow exception[s] to the duty of the District Court to adjudicate a controversy before it applies." *Id*. at *6 (internal quotations omitted). In particular, the federal court found that the coverage action and the state liquidation proceeding were not parallel proceedings and that the contractual issues raised in the coverage action were not pivotal to the liquidation proceeding and, in fact, would not be resolved in the state liquidation proceeding. Further, the court concluded that proceeding with the coverage action would not disrupt or interfere with the state liquidation proceeding. In that regard, the court disagreed with defendants' assertion that the policies were assets of the insolvent insurer's estate, noting contrary authority holding that, while a debtor's insurance policy may be property of the debtor's estate, the proceeds of such policy are not. ■

Ninth Circuit Applies Invasion of Privacy Exclusion to Bar Coverage for TCPA Claims under D&O Policy *continued from page 1*

to numerous individuals. The basketball team tendered the suit under its D&O policy. The insurer denied coverage on the basis that the policy barred coverage for any claim "based upon, arising from, or in consequence of … invasion of privacy." After disputing the denial, the basketball team filed a coverage action against the insurer, arguing that the underlying suit alleged only economic injuries and did not seek damages for the violation of privacy interests. The district court granted the insurer's motion to dismiss and held that the invasion of privacy exclusion barred coverage for the underlying suit. The team appealed.

On appeal, the Ninth Circuit affirmed the dismissal in favor of the insurer. First, after citing the language of the exclusion, the court concluded that the breadth of the exclusion (in light of the "arising from" and "based upon" lead-in language) required only "a minimal causal connection or incidental relationship" between the underlying claim and any invasion of privacy. Next, the court analyzed the phrase "invasion of privacy" and the TCPA, ultimately concluding that "a TCPA claim is, by its nature, an invasion of privacy claim." On that basis, the court held that the complaint, which only alleged violations of the TCPA (and specifically disavowed personal injury claims), was barred by the invasion of privacy exclusion. It affirmed the dismissal in favor of the insurer on that basis.

In a concurring opinion, one judge concluded that while the underlying claim alleged violations of privacy, the court need not determine that all TCPA claims are necessarily claims for invasion of privacy. In a dissenting opinion, another judge suggested that because a TCPA plaintiff is not required to prove invasion of privacy, and because the plaintiff in the underlying case expressly disavowed common law invasion of privacy claims, the invasion of privacy exclusion did not apply. ■

Court Grants Summary Judgment to Insurer Based on Failure to Disclose Prior Claims in Application

A California federal district court, applying California law, has held that an insurer was entitled to summary judgment that it had no duty to defend a suit against its insured because the insured failed to disclose a related claim in its application, and the claim therefore predated the policy period. *Kelly v. Starr Indem. & Liab. Co.,* 2017 WL 3457145 (S.D. Cal. Aug. 10, 2017).

A real estate development company received a letter from an investor in August 2010 identifying two delinquent promissory notes and threatening legal action. In May 2011, the company executed an application for a directors and officers liability policy and did not disclose the investor demand. In November 2011, the investor sent another demand letter identifying additional delinquent promissory notes, alleging misrepresentations concerning anticipated payments on the original two delinquent notes, and again threatening legal action. After the insured tendered the November 2011 letter, the insurer denied coverage based on the insured's failure to disclose the August 2010 demand on its application. The insurer also contended that coverage was barred based on the prior knowledge exclusion and the professional services exclusion, and because the claim was first made before the policy incepted.

In the coverage action that followed, the court held that the insured's failure to disclose the August 2010 demand letter on the application precluded coverage. The application had asked the insured to confirm that no parties for whom the insurance was sought had knowledge of any fact, circumstance, situation or information that may give rise to a claim, and it further provided that, if any such knowledge or information existed, any claim "based upon, arising from, or in any way relating to" that information would be excluded from coverage.

The court determined that, when the insured completed the application, it had knowledge that the investor had asserted that it was liable for non-payment of the promissory notes. Therefore, at the time of the application, the insured "had notice of a claim, whether actual or potential, arising from the [p]romissory notes," and any claim that arose out of or related to the promissory notes would not be covered. In reaching this determination, the court rejected the insured's assertion that the August 2010 demand letter was merely a "bill" and its argument that the application language was ambiguous. The court also rejected the insured's argument that the insurer had waived the right to rely on the application language by including a non-rescindability clause in the policy, noting that "[i]t is well-established that rescission is not an exclusive remedy."

The court ultimately concluded that that there was no coverage for the November 2011 demand because it arose out of or was related to the August 2010 demand and the claim predated the inception of the policy. ■

Insurer May Not Rescind Renewal Policy Based on Misrepresentations in Prior Policy's Application

An Illinois intermediate appellate court, applying Illinois law, has held that a renewal insurance policy may only be rescinded based on material misrepresentations made in the renewal application, and not based on misrepresentations made in applications for prior policies. *Ill. State Bar Ass'n Mut. Ins. Co. v. Rex Carr Law Firm*, 2017 WL 2805126 (Ill. App. Ct. June 27, 2017). The court also held that application of the policy's prior knowledge provision depended on the insured law firm's subjective expectation of whether the relevant circumstance might lead to a claim.

Several investors in a security company retained the insured law firm in connection with a dispute with another group of investors that was operating the company. The investors represented by the insured firm filed a suit against the operating investors and a second suit against eight companies they alleged had conspired with the operating investors. Both were transferred to the same court under a forum selection provision in a prior release among the investors. The court granted summary judgment in favor of the defendants, holding that the prior release, which had been executed before the plaintiff investors retained the insured law firm, was valid and enforceable. The release contained a fee-shifting provision, and the court awarded fees to the defendants. It also held that the plaintiff investors' attorneys were jointly and severally liable with their clients as to a portion of the fees.

The plaintiff investors sued the insured law firm, broadly alleging professional negligence and seeking damages in the amount of the fees awarded against them. The insured law firm tendered the claim under its lawyers professional liability policy, and its insurer sought a declaratory judgment that it had no duty to defend and sought to rescind the policies it had issued to the insured firm. After the trial court entered summary judgment in favor of the insured firm, the insurer appealed.

The intermediate court of appeals held that the insurer could not rescind coverage based on the insured's omission of a prior malpractice claim from its application for its 2008 policy. The insurer contended that, had the insured firm disclosed the earlier suit, it would not have issued the 2008 policy or the renewal policies, including the 2012 policy, under which the instant claim was tendered. The court held, however, that each renewal policy is a new contract, and that under the Illinois Insurance Code, only material misrepresentations made with respect to the relevant policy may form the basis for rescission.

The insurer also contended that the claim against the insured firm did not seek Damages, because the policy excluded "legal fees, costs or expenses paid or incurred by the claimant" from the definition of Damages. The court noted, however, that the allegation of damages from the insured firm's professional negligence was open-ended and not limited solely to the legal fees. Resolving any doubt in favor of the insured, the court held that the complaint stated facts that were potentially within the coverage of the policy.

Finally, the insurer contended that the policy's prior knowledge provision precluded coverage, because the insured firm had knowledge that the court in the underlying action had granted summary judgment in favor of the defendants prior to the inception of the relevant policy. The

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Disputes Over Amounts of Premiums and Claims Paid Prevent Summary Judgment in Rescission Case

The United States District Court for the Southern District of Indiana, applying Indiana law, denied an insurer's motion for summary judgment based on rescission, holding that there was a question of material fact where the insurer did not provide evidence of the amount of claims paid or premiums received for the policies to be rescinded. *Proassurance Indemn. Co., Inc. v. Wagoner,* 2017 WL 3421983 (S.D. Ind. August 9, 2017). The court also held that there was an issue of material fact regarding when the insurer knew about the insured's alleged breach of the policy that may entitle the insurer to rescind the policies.

The insurer issued numerous medical professional liability policies to the defendants. The defendants pled guilty over a number of years where policies were in place to felonies for knowingly prescribing controlled substances outside of the usual course of professional practice. The insurer filed a declaratory judgment action seeking to rescind the policies on the ground that the defendants had made material omissions in their applications for issuing the policies and for renewing the policies. The parties filed cross-motions for summary judgment.

The court denied summary judgment to all parties with a limited exception. First, the court observed that Indiana courts have established procedural requirements for rescission, including that the insurer must return or offer to return the premiums received within a reasonable time after acquiring knowledge of the fraud. The court also noted that there is an exception where the insurer has paid a claim which is greater than the amount of the premiums paid. The insurer argued that it offered to return the premiums in one of its filings in the declaratory judgment action and that it has paid claims greater than the premiums received. The insured disputed the amount of premiums paid and argued that the insurer had waited too long to offer to return the premiums. The court held that there was a genuine issue of material fact regarding the amount of the claims paid and premiums received that precluded summary judgment. The court also held that there was an issue of fact regarding when the insurer became aware of its right to rescind.

The court granted summary judgment for the insurer on the limited issue of whether the defendants could claim that they pled guilty because of an expectation of coverage from the insurer. The court reasoned that motivations of the guilty pleas were not relevant to the disputes at hand. ■

Insurer May Not Rescind Renewal Policy Based on Misrepresentations in Prior Policy's Application *continued from page 6*

court held, however, that a subjective standard applied to both inquiries, regarding the insured's actual knowledge of the circumstances and the expectation as to whether a claim may result. The court found no evidence that the insured law firm had known that its clients might pursue a claim arising out of the entry of summary judgment against them. The appellate court therefore affirmed the trial court's entry of judgment in the insured firm's favor. ■

Insurer's Allegations that Declaratory and Injunctive Relief Are Not Covered Loss Survive Motion to Dismiss

The United States District Court for the Northern District of California has denied an insured's motion to dismiss an umbrella insurer's declaratory judgment action. *Great American Ins. Co. v. Quintana Homeowners Ass'n*., 2017 WL 3453394 (N.D. Cal. Aug. 11, 2017). The insurer alleged that it had no duty to defend or indemnify after exhaustion of the primary policy. The court concluded that the insurer's complaint sufficiently alleged that the claims for declaratory and injunctive relief in the underlying action did not constitute covered "Loss" under the policy.

The plaintiff in the underlying action sued the insureds, a homeowner's association and an association board member/developer, seeking declaratory and injunctive relief, punitive damages, and attorney's fees related to a breach of contract for failure to enforce the association's "covenants, conditions and restrictions" and for fraud and misrepresentation by the developer. The umbrella insurer filed an action for declaratory judgment, seeking a declaration that it had no obligation under its policy to defend or indemnify the insureds after the primary policy was exhausted. The insurer alleged that because the underlying action sought only relief excluded from the definition of "Loss," no defense or indemnity obligation could arise. In addition, the insurer alleged that it had no obligation to defend and indemnify the developer based on the application of a "Builder, Developer or Sponsor" Wrongful Act exclusion.

The insureds argued in their motion to dismiss that (1) the underlying complaint alleged numerous "Wrongful Acts" within the meaning of the policy, triggering defense obligations, (2) the policy did not exclude claims for injunctive relief and required only that a claim be made for a "Wrongful Act," (3) attorney's fees accompanying injunctive relief are compensable losses, and (4) the underlying complaint identified the developer as a "volunteer," and therefore the "Builder/Developer" exclusion did not apply.

The court denied the insureds' motion to dismiss. The court found that the declaratory and injunctive relief sought is "not predicated upon the absence of a 'claim' or 'wrongful act' in the underlying state court action"; rather the insurer "alleges that the state law claims for injunctive and declaratory relief do not constitute a covered 'Loss' within the meaning of the [umbrella policy]." Next, the court found that although "Loss" includes "attorney fees," an award of attorney's fees as to a prevailing party falls outside of the scope of insurable "Loss." Finally, the court found that the insurer's allegations regarding the application of the "Builder/Developer" exclusion were sufficient at the pleading stage. ■

Insurer's Duty to Defend Ends at Tender of Policy Limits

The United States District Court for the Eastern District of Kentucky, applying Kentucky law, has held that an insurer's duty to defend under a medical professional liability policy ended when the insurer tendered policy limits to the insured, despite the ongoing lawsuit against the insured. *Mt. Hawley Ins. Co. v. MESA Med. Grp., PLLC,* 2017 WL 3082662 (E.D. Ky. July 19, 2017).

The insureds, a group of medical professionals, were sued for alleged medical malpractice. Their medical professional liability insurer initially paid for defense counsel for the lawsuit, but the insurer subsequently tendered the policy limits to the insureds during the lawsuit and discontinued the defense. The insureds rejected the tender, arguing that the insurer could not "dump" its policy limits and avoid its duty to defend. The insureds also argued that the insurer's ability to tender policy limits would render two policy endorsements illusory and would significantly reduce the policy's value. Specifically, one endorsement provided that claims expenses, including defense costs, would not erode the limit of liability. The endorsement also provided that "[n]othing contained in this endorsement shall operate to prevent the Company from tendering its limits of liability . . . and by such action eliminating its responsibility for future Claims Expenses." A second endorsement provided that the insured had the right to reject settlement, but claims expenses incurred after the rejection would erode the limit of liability.

The district court held that the policy language permitted the insurer to tender its limit and end its defense obligation. Specifically, the court held that the endorsement providing that claims expenses would not erode the limit of liability also gave the insurer the option to "absolve itself of future claims expenses by tendering the full policy amount." The court further explained that "[w]hether agreeing to reduce the value of the policy's liability limit is sensible or a bad idea or even something that the insured would have wanted with twenty-twenty hindsight is of no matter to this Court . . . . The parties agreed to it. Clearly, [the insurer] felt it was important to set a cap on its possible obligation under the Agreement and, presumably, bargained for that." Thus, the court held that the insurer had neither breached the policy nor violated the duty of good faith and fair dealing by tendering the policy limits. ■

Fraudulent Instruction Loss Caused by Social Engineering Scheme Does Not Trigger Computer Fraud Coverage Under Commercial Crime Policy

A Michigan federal district court has held that a fraudulent instruction loss caused by a social engineering scheme did not constitute a "direct loss" that was "directly caused by computer fraud" and therefore did not trigger computer fraud coverage under a commercial crime policy. *American Tooling Ctr., Inc. v. Travelers Cas. & Sur. Co. of Am.,* 2017 WL 3263356 (E.D. Mich. Aug. 1, 2017).

The insured, a manufacturer, sent an email to a vendor requesting copies of all outstanding invoices. In response, the insured received an email purportedly from the vendor, but the email was actually from a fraudster. The fraudster's email included new banking instructions. Without verifying the changed instructions, and after confirming that the work claimed on the invoices was due and owing, the insured initiated payments totaling $800,000. It later learned of the fraud but was unable to recover the payments. The insured sought coverage under the computer fraud coverage section of its commercial crime policy, but the insurer denied coverage.

In ensuing coverage litigation, the district court granted summary judgment in favor of the insurer. The relevant insuring clause provided coverage for "direct loss . . . directly caused by Computer Fraud." "Computer Fraud" was in turn defined to include "[t]he use of any computer to fraudulently cause a transfer." In ruling for the insurer, the court determined that the intervening events between the insured's receipt of the fraudulent emails and its authorized transfer of funds meant that it did not suffer a "direct" loss "directly caused" by the use of any computer. The court also concluded that while fraudulent emails were used to impersonate a vendor and dupe the insured into transferring funds, those emails did not constitute the "use of any computer to fraudulently cause a transfer" because there was no infiltration or hacking of the insured's computer, and because those emails did not directly cause the transfer of funds (which instead were transferred based on the insured's authorized instructions). For those reasons, the court ruled that there was no coverage for the loss, and it granted summary judgment in favor of the insurer. ■

Events:

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