Wiley Rein LLP

EXECUTIVE SUMMARY

Legal Developments Affecting Professional Liability Insurers | October 2017

Eleventh Circuit Affirms that 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 Court of Appeals for the Eleventh Circuit, 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,* No. 17-10848, 2017 WL 4276057 (11th Cir. Sept. 27, 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 repacking process—using only non-sterile gowning and equipment to repackage the drugs in a storage room at the pharmacy. The pharmacist-in-charge of the facility

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Pre-Trial Settlement and Assignment of Rights Unenforceable Against Insurer with No Duty to Defend

Applying Texas law, the United States Court of Appeals for the Seventh Circuit has held that public policy prohibits enforcement of a settlement arrangement in which an insurer with no duty to defend played no role in the settlement, the plaintiff promised to seek damages only from the insurer, and the insured defendant admits liability, stipulates to damages, and assigns its claim against the insurer

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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 suffered severe vision loss and/or blindness as a result of swelling related to the contaminated injections, and they made claims against the pharmacy and pharmacist-in-charge for purported negligent repackaging of the drugs.

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 what amount was owed under the policies for the eleven claims.

Applying the unambiguous related claims language to the eleven claims, the district 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." A summary of the district court's decision can be found here.

The Eleventh Circuit affirmed the district court's ruling that the eleven claims constituted "related claims" under both policies. As a threshold matter, the court determined that the "related claims" analysis was not determined by "whether there are any differences between the defendants' individual claims" but by whether the claims are logically or causally connected by any common fact or circumstance. The court determined that the claims were logically connected because each syringe was prepared in the same location, by a single technician supervised by the same pharmacist, and the technician "used the same process to prepare all the syringes, repeating the same violations of health and safety regulations." The court also rejected claimants' contention that its interpretation would make coverage illusory. It held that its interpretation did not negate the aggregate limit because there could be situations where multiple claims were distinct and because the policies provided coverage for the claims, albeit confined to the $1 million per claim limit. ■

Profit Exclusion Does Not Apply to Judgment Against Insured for Antitrust Violation

The United States Court of Appeals for the Ninth Circuit, applying Idaho law, has affirmed a lower court's decision that a judgment against an insured for a violation of the Clayton Act did not preclude coverage under a liability insurance policy's "financial gain" exclusion. *St. Luke's Health Sys., Ltd. v. Allied World Nat'l Assurance Co.,* 2017 WL 3727010 (9th Cir. Aug. 28, 2017).

The insured, a hospital, was found liable for anti-competitive conduct violating the Clayton Act in connection with the insured's acquisition of a medical facility. The judgment against the insured centered on the improper bargaining power gained by the insured as a result of the anti-competitive merger.

The insured tendered defense costs incurred in the antitrust action to a liability insurer, which reimbursed $8 million of the insured's costs subject to a reservation of rights. The insurer later denied coverage and requested repayment, arguing that the antitrust violation fell within a policy exclusion that barred coverage for loss arising from "financial advantage" if a judgment established that the insured was not legally entitled to the advantage.

In the resulting coverage litigation, the lower court held that the exclusion did not apply, finding no evidence to suggest that the insured gained an actual "financial advantage" as a result of the bargaining power it improperly received from the merger.

The Ninth Circuit affirmed, holding that the policy's definition of "loss" plainly included defense costs resulting from a violation of the Clayton Act. The court further rejected the insurer's argument that an anti-competitive merger necessarily meant that the insured improperly gained a financial advantage, noting that under Idaho law, exclusions must be "clear and precise" to restrict coverage. ■

Pre-Trial Settlement and Assignment of Rights Unenforceable Against Insurer with No Duty to Defend continued from page 1

to the plaintiff. *Hendricks v. Novae Corporate Underwriting, Ltd.*, 2017 WL 3573390 (7th Cir. Aug. 18, 2017).

The insured entered into a contract with another company, but one of the company's shareholders later sued the insured for alleged misrepresentations and negligent claims-handling. The insurer denied coverage for the lawsuit and remained uninvolved because it did not owe a duty to defend under the policy. The insured and the shareholder ultimately resolved the litigation by entering into a settlement agreement. Under the terms of the settlement agreement, the insured agreed to stipulate to the entry of judgment in the amount of $5.12 million in favor of the shareholder, an assignment to the shareholder of the insured's right to recover from the insurer, and a covenant by the shareholder not to execute the judgment against the insured. The shareholder then sued the insurer to recover the stipulated judgment. The district court determined that the insurer owed no duty to indemnify because the judgment was not binding under Texas law. The shareholder appealed.

On appeal, the Seventh Circuit affirmed and held that the settlement agreement and subsequent assignment of rights under the policy were unenforceable as contrary to Texas public policy. The court first determined that Texas law as opposed to Illinois law applied because the location of the subject matter of the settlement agreement focused on resolving a Texas state litigation. The court then noted that Texas law has a history of disallowing assignments in order to avoid the multiplication of suits and to uphold the idea that rights at common law are to be determined by the identity of the particular individuals involved and their circumstances. The court also highlighted that the Texas Supreme Court has previously prohibited assignments of this nature on the grounds that pre-trial settlements and assignments are collusive. The court rejected the shareholder's argument that the settlement and assignment were lawful because the insurer failed to tender a defense. In so holding, the court explained that the insurer had no contractual duty to defend the insured under the terms of the policy. The court thus held that the settlement and assignment were collusive and impermissibly distorted, complicated, and prolonged the litigation by engaging an insurer that otherwise had no obligation to be involved, and as such were unenforceable. ■

Coverage Barred for Claim Made During Initial Policy Period and Reported in Renewal Period

The Ninth Circuit, applying Alaska law, has held that coverage was not afforded under a company's professional errors and omissions insurance policy for a claim made against the company during the policy period but not reported until the renewal policy period. *Alaska Interstate Constr., LLC v. Crum & Forster Specialty Ins. Co.,* 2017 WL 3601728 (9th Cir. Aug. 22, 2017).

The company purchased an initial E&O policy, with a policy period of December 1, 2011 to May 1, 2013, and then a renewal policy, with a policy period of May 1, 2013 to May 1, 2014, from the insurer. Both policies provided coverage for claims made and reported during the policy period, which was defined as "the period shown in the Declarations." It was undisputed that the company received a claim on January 10, 2013, during the policy period of the initial policy, but it did not report the claim to the insurer until June 19, 2013, during the renewal policy period. The insurer denied coverage for the claim, arguing that notice was untimely under the policy. In subsequent coverage litigation, the district court granted summary judgment for the insurer, and the company appealed.

The Ninth Circuit affirmed and rejected the company's proposed interpretation of "policy period" as encompassing both the initial and renewal periods. The appellate court noted that while Alaskan courts had not addressed the issue, most courts have held that renewing a claims-made policy did not extend the reporting period and that the cases cited by the insured "represent[] a minority view that has been criticized." Finally, the appellate court also held that the insured was not entitled to an extended reporting period under the terms of the initial policy because only cancellation or non-renewal would trigger that provision. ■

Events:

Beyond Cognition: The Role of Emotional Intelligence in Effective Claim Management and Resolution

Kimberly A. Ashmore, Speaker

2017 PLUS International Conference

November 2, 2017 | Atlanta, GA

Professional Services Exclusion Bars Coverage in Connection with Pipeline Explosion

A California appellate court has held that a pipeline owner's insurer is not entitled to reimbursement of defense costs and settlement payments from the insurer for the staffing agency that supplied personnel to the pipeline because the professional services exclusion in the staffing agency's policy unambiguously barred coverage. *Energy Ins. Mut. Ltd. v. ACE American Ins. Co.,* 2017 WL 3476705 (Cal. Ct. App., July 11, 2017).

The underlying lawsuits arose out of an explosion caused by an excavator striking an unmarked pipeline. The pipeline owner's insurer settled the lawsuits against the pipeline owner and then filed the instant coverage action seeking reimbursement for defense costs and settlement payments from the insurer for the staffing agency on the ground that the pipeline owner was an additional insured under the staffing agency's policy. The trial court granted summary judgment for the staffing agency's insurer on the ground that the professional services exclusion in its policy, which provided that the policy "does not apply to any liability arising out of the providing or failing to provide any services of a professional nature," unambiguously barred coverage for the underlying claims.

On appeal, the court affirmed the trial court's decision, holding that the underlying claims arose out of the pipeline owner's and the staffing agency's failure to render professional services and therefore the professional services exclusion precluded coverage. In so holding, the court concluded that, although the underlying cases also alleged ordinary negligent acts and other causes of action, the gravamen of the actions was that the staffing agency and the pipeline owner failed to mark the pipeline, and therefore the claims arose out of their rendering or failure to render professional services.

The pipeline owner's insurer also argued that, even if the claims arose out of the staffing agency's professional services, they did not arise out of the professional services of the pipeline owner and therefore, based on the policy's severability provision, the professional services exclusion did not preclude coverage for the pipeline owner. The court agreed that the relevant inquiry with regard to coverage for the pipeline owner is whether it engaged in professional services, but in any event, the court found that the pipeline owner did more than just passively own the pipeline and therefore the claims against it also arose out of its professional services.

Finally, the appellate court rejected the pipeline owner's insurer's argument that interpreting the professional services exclusion in this manner would render coverage under the staffing agency's policy illusory, concluding that the business liability policy was intended to cover accidental occurrences involving ordinary negligence, not professional negligence. ■

Following New Jersey Statutory Merger, Surviving Entity Acquires All Rights and Obligations Under Target Entity's Insurance Policy

A New Jersey federal court has held that, following a statutory merger under New Jersey law, the surviving entity acquired the target entity's rights under its directors and officers liability insurance policy by operation of law and was entitled to reimbursement for post-merger defense costs incurred in defending the target entity's directors in shareholder class actions. *BCB Bancorp, Inc. v. Progressive Cas. Ins. Co.,* 2017 WL 4155235 (D.N.J. Sept. 18, 2017).

This coverage dispute arose out of the statutory merger of two banks pursuant to the New Jersey Business Corporation Act ("NJBCA"). Following the merger, shareholders of the target entity filed class actions against the merging entities and their directors and officers. The target entity provided notice of the lawsuits pursuant to its directors and officers insurance policy. The policy's "other insurance" provision provided that the policy was excess of any indemnification any insured is entitled to from any other entity. The insurer ultimately denied coverage on the basis that, by operation of the policy's "other insurance" provision, any post-merger coverage applied in excess of the surviving entity's indemnification obligation pursuant to the merger agreement. The banks initiated this coverage action, seeking a declaration that the surviving entity is entitled to reimbursement for post-merger costs incurred in defending the target entity's directors and officers. The insurer argued that it had no coverage obligations to the surviving entity because it is not an insured under the policy and that the policy's "other insurance" provisions barred reimbursement for post-merger defense costs.

On cross-motions for summary judgment, the court ruled in favor of the banks, holding that, by operation of a statutory merger pursuant to the NJBCA, the surviving corporation steps into the shoes of the merged entity and therefore acquires all of the target entity's rights and liabilities, including all rights under the target entity's insurance policies. In other words, by consummation of the merger, the surviving entity was effectively the insured under the policy and therefore was entitled to reimbursement for post-merger defense costs.

The court rejected the insurer's argument that the policy's anti-assignment provision precluded this effect, concluding that an insurance policy must contain specific exclusionary language to prevent a transfer of rights to the surviving entity following a statutory merger and that the policy's general anti-assignment provision did not suffice. In so holding, the court was careful to distinguish between statutory mergers and asset purchases where, unlike in a statutory merger, the general rule is that the successor entity does not retain the assets and liabilities of the selling company.

Finally, the court rejected the insurer's argument that the "other insurance" provision applied based on similar logic. The court concluded that, by operation of the merger, the surviving entity had assumed all of the target entity's liabilities and that one such liability was the target entity's obligation to indemnify its officers and directors. Therefore, as the policy provided coverage to the target entity for such indemnification obligations, the surviving entity was entitled to the same rights under the policy following the merger. ■

Failure to Pay Wages Not a "Wrongful Act"

The United States District Court for the Northern District of California has found that an insurer was not obligated to cover an insured's settlement in a wage and hour class action lawsuit because the failure to pay wages was not a "wrongful act" under the policy. *W.G. Hall, LLC v. Zurich Am. Ins. Co.,* 2017 WL 3782771 (N.D. Cal. Aug. 31, 2017).

The insured, a staffing services company, settled a wage and hour class action lawsuit alleging violations of state labor codes for failure to pay wages and other claims related to failure to compensate employees. The insured sought coverage for the settlement under its professional liability insurance policy. The insurer declined coverage, asserting that the failure to pay wages did not constitute a "wrongful act" as required under the policy. The policy defined "wrongful act" in relevant part as an "error or omission" in the course of providing staffing services. The insured sued the insurer for breach of contract, declaratory judgment, and related claims.

The court granted partial summary judgment to the insurer, concluding that the failure to pay wages was not a "wrongful act." The court cited California case law holding that an insured's alleged refusal to make a payment under a contract does not give rise to a loss caused by a wrongful act. The court reasoned that in this case, the insured was required to pay employee wages, never claimed that no employment contract existed between itself and the plaintiffs in the underlying litigation, and conceded that at least oral contracts existed with the plaintiffs. The court further reasoned that the claims asserted under the labor code would not exist but for an employment contract. Therefore, the court found that the alleged failure to pay wages was not insurable under the policy.

The court also granted summary judgment for the insurer based on the policy's exclusion of coverage for any claim "based upon or arising out of, in whole or in part … [a]ny liability assumed by an insured under any contract or agreement, unless such liability would have attached to the insured by law in the absence of such contract or agreement." The court found the policy's use of the word "any" distinguished this case from prior opinions holding that similar exclusions applied only to contracts or agreements under which the insured assumes the liability of another.

Finally, the court found that the settlement did not constitute "damages" as defined in the policy. The policy provided that the term "damages" did not include "[p]ersonal profit or advantage to which the insured is not legally entitled; [and] 3. [c]riminal or civil fines, penalties (statutory or otherwise), fees or sanctions." The settlement was allocated to unpaid wages, statutory penalties, and interest due on the wages. The court found that the portions of the settlement attributed to wages and penalties plainly were carved out of the definition of "damages," and that the interest did not constitute damages because "[i]t would make very little sense for the Court to consider wages and civil penalties as excluded from the definition of 'damages' only to find that the interest incurred as a result of the unpaid wages was considered damages." ■

Alternative Dispute Resolution Provision Not Satisfied Where Parties Communicated with Mediator During Cooling Off Period

The United States District Court for the District of South Carolina has held that an insurance policy's alternative dispute resolution condition precedent prior to initiating litigation was not satisfied where the parties communicated with the mediator during the provision's cooling-off period, even though the parties disputed whether the communications concerned insurance coverage. *Allied World Surplus Lines Ins. Co. v. Blue Cross & Blue Shield of N.C.,* 2017 WL 3671172 (D.S.C. Aug. 24, 2017).

An insurer issued E&O and D&O policies to a health insurer. The policies contained mandatory Alternative Dispute Resolution ("ADR") provisions requiring the parties to arbitrate or mediate "all disputes which may arise under or in connection with this Policy." The ADR provision also had a cooling-off period of 120 days, providing that no judicial proceeding may be commenced until that number of days following the "termination" of mediation had elapsed.

Following a coverage dispute, the D&O/E&O insurer brought a declaratory judgment action against the health insurer. The parties engaged in mediation prior to the filing of the declaratory judgment action. However, the parties disputed whether the mediation had "terminated," and the insured health insurer moved to dismiss on that ground. The court looked to American Arbitration Association rules, which provide that a mediation terminates "[w]hen there has been no communication between the mediator and any party or party's representative for 21 days following the conclusion of the mediation conference." The court asked the parties to answer whether the mediator had "communicated with any party in the 21-day period following the last relevant mediation." In response, the insured health insurer stated that the mediator had done so. The D&O/E&O carrier agreed that there had been communications with the mediator about the mediation of the underlying actions, but stated that there had been no communications with the mediator about the mediation of the instant coverage dispute.

Following the supplemental briefing, the court dismissed the action without prejudice, holding that the suit was not ripe because the mediation condition precedent was not yet satisfied. The court refused to "undertake an evidentiary hearing" as to the "substance of matters discussed during mediation of a dispute," noting that doing so would contradict Federal Rule of Evidence 408 as well as a local rule. Because the court would not do so, it found that the parties' shared view that communications had occurred between the mediator and the parties in the 120 days prior to the litigation was sufficient to conclude that mediation had not terminated. ■

Prior Knowledge Exclusion Bars Coverage for Claim Against Insured Attorney

Applying Florida law, a federal district court has held that a prior knowledge exclusion bars coverage for a claim against an insured attorney where the attorney knew, prior to applying for the policy, that he had failed to meet his client's expectations for the representation. *David R. Farbstein, P.A. v. Westport Ins. Co.,* 2017 WL 3425327 (S.D. Fla. Aug. 9, 2017).

An attorney was retained by a client in connection with a real estate sales transaction. The property at issue had a mortgage with a pre-payment penalty, and the client retained the attorney to negotiate a sales contract that would have the purchaser assume the mortgage and release the client from the pre-payment penalty obligation. Shortly before the closing, however, the parties discovered that the sales contract did not require the purchaser to assume the mortgage or pay the penalty. The attorney advised his client to go through with the sale in any event, as otherwise the client could be sued for specific performance. Accordingly, the client proceeded with the sale and paid the penalty at the time of closing on July 21, 2015.

Approximately one month after the closing, the attorney completed a renewal application for a lawyers professional liability policy. The application asked whether the attorney was aware of any act, error or omission that might be expected to be the basis of a malpractice claim, and the attorney answered "no." The attorney likewise signed a warranty statement swearing to a lack of knowledge of any such circumstances that could give rise to a claim. The insurer issued a policy effective October 12, 2015. The policy contained an exclusion for any claim arising from a Wrongful Act "if the Insured at the effective date of the Policy Period… knew or could have reasonably foreseen that such Wrongful Act might be expected to be the basis for a Claim." When the client filed a malpractice claim against the attorney, the insurer denied coverage based on the policy's prior knowledge exclusion.

In subsequent coverage litigation, the court agreed with the insurer that the exclusion precludes any defense or indemnity coverage. The court found that the client's complaint against the attorney alleged that, prior to the closing, the attorney knew that he had failed to negotiate a sales contract that released the client from the mortgage and pre-payment penalty but counseled the client to go forward with the sale anyway. Accordingly, the court held that, as of the closing on July 21, 2015, which predated the policy's inception, the attorney could have reasonably foreseen that the alleged error might give rise to a claim by the client. ■

Insurer Has No Duty to Defend or Indemnify Insured for Action Alleging Solely Intentional Wrongdoing

A Delaware superior court, applying Tennessee law, has held that a professional liability insurer is entitled to judgment that it has no duty to defend or indemnify its insured because the underlying action against the insured alleged only intentional wrongdoing. *Catlin Spec. Ins. Co. v. CBL & Assocs. Prop., Inc.,* 2017 WL 4173511 (Del. Super. Ct. Sept. 20, 2017).

The insureds, a managing agent for a shopping center and several related entities, were sued by one of the shopping center's tenant companies. The tenant alleged that the shopping center and the insureds fraudulently inflated the tenants' utility bills for about a decade. The tenant asserted claims on behalf of a purported class for unjust enrichment, breach of contract, breach of the covenant of good faith and fair dealing, and violations of the Racketeer Influenced and Corrupt Organizations Act, as well as violations of the Florida Deceptive and Unfair Trade Practices Act and the Florida Civil Remedies for Criminal Practices Act. The insureds sought coverage under a professional liability policy. The insurer agreed to defend under a reservation of rights and sought a declaration that it had no duty to defend or indemnify the insureds.

As a threshold matter, the insureds argued that Florida law governed the dispute because they faced liability in Florida for claims arising under Florida law. The court held that in complex insurance cases with risks in multiple states, the most significant factor for the conflict-of-laws analysis in Delaware is the principal place of business of the insured, and thus agreed with the insurer that Tennessee law applied.

The court also rejected the insureds' argument that the policy's insuring agreement – which provided coverage for loss resulting from a "negligent act, error or omission" – could be triggered by a non-negligent act or omission. The court held, as it noted most other courts have, that elementary grammar dictates that the term "negligent" modifies the terms "act," "error," and "omission," and that non-negligent errors or omissions therefore could not trigger coverage.

The court went on to find that the underlying action against the insureds alleged only intentionally wrongful conduct. The insureds argued that the complaint allowed for a finding that they erroneously overcharged tenants in a manner that was negligent or unintentionally misleading. In particular, the insureds pointed to the causes of action that do not require a showing of intent as an element of liability. The court concluded, however, that the underlying action was based on a plainly pled theory that the insureds engaged in a pattern of intentional, knowing, wrongful, and fraudulent conduct and that the complaint contained no hint that the insureds acted in a negligent fashion. Because the underlying action alleged only intentional conduct, and because the policy does not afford coverage for intentional acts, the court entered judgment for the insurer that it had no duty to defend or indemnify the insureds. ■

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