EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | April 2016

No Coverage for Lawyer's Alleged Self-Dealing

The United States Court of Appeals for the Ninth Circuit has affirmed a decision in favor of an insurer, holding that the business enterprise and trust exclusions in a lawyers professional liability policy barred coverage for a suit alleging self-dealing by the insured attorney and his firm. *Christensen v. Darwin Nat'l Assurance Co.*, No. 14-15914 (9th Cir. Mar. 23, 2016). Wiley Rein represented the insurer before the district court and on appeal to the Ninth Circuit.

A corporate client, which owned property on the Las Vegas Strip, retained the insured law firm and its named partner in connection with an eminent domain matter. During the course of that representation, the attorney purchased a 50% stake in the client through a trust, of which the attorney was the trustee and both he and his family members were beneficiaries. In time, parties associated with the client's original owner sued the attorney and his firm, alleging that they had misrepresented the value of the business in order to acquire the 50% stake at a discount. In addition, the claimants alleged that the attorney used the trust's stake in the business to engage in transactions that benefitted his firm, his family, and himself at the expense of the business. Among other things, the claimants asserted that the law firm and the attorney's family occupied client-owned real estate without paying continued on page 7

Claimant Without a Judgment Has No Standing to Bring Declaratory Judgment Action Against Alleged Tortfeasor's Insurer

A Kentucky federal court has held that a claimant has no standing to bring a declaratory judgment action against her alleged tortfeasor's insurer where the claimant has yet to obtain a judgment in the underlying action. *Summers v. Scottsdale Indem. Co.*, No. 1:15-cv-0092 (W.D. Ky. March 31, 2016). The court also held that, even if there was standing, the insurer did not waive any coverage defenses by initially providing a defense to the alleged tortfeasor before discovering misrepresentations in the application that ultimately served as the basis for rescinding the policy. Wiley Rein represented the insurer.

The claimant was an employee of the insured, which operated an auto-racing facility and amusement park. In 2014, she filed an action in state court against her employer alleging that she was sexually harassed at work. The employer tendered the action to its insurer under an employment practices liability insurance policy. continued on page 8

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Legal Fees Exclusion Bars Coverage for Arbitration Award that "In Substance" Reduced Fees Owed to Insured Law Firm

The United States Court of Appeals for the Seventh Circuit, applying Illinois law, has held that an exclusion barring coverage for "claim[s] for legal fees, costs or disbursements paid or owed to you" applies to bar coverage for an arbitration award adjusting the amount of attorneys' fees owed to an insured law firm. *Edward T. Joyce & Assocs. P.C. v. Prof'ls Direct Ins. Co.*, 2016 WL 1085223 (7th Cir. Mar. 21, 2016).

The insured, a law firm, had won a large damages award in a securities-fraud class action. The insured subsequently retained another law firm to collect the damages award from the defendant's insurers. The plaintiff class members believed the law firm should have handled the collection litigation itself under the terms of the original retainer agreement and took the insured to arbitration over the additional legal fees incurred by hiring the second law firm. The arbitrator found that the insured firm had breached its fiduciary duty to the class plaintiffs and ordered it to reimburse the class members for a portion of the legal costs incurred in the collection litigation, including a portion of the fees charged by the second law firm. The law firm's professional liability insurer paid for the insured's defense in the arbitration but denied coverage for the arbitration award.

In the ensuing coverage litigation, the district court granted summary judgment for the insurer, concluding that coverage for the arbitration award was barred as a sanction under a policy exclusion for "any claim for fines, sanctions, penalties, punitive damages or any damages resulting from the multiplication of compensatory damages."

The Seventh Circuit affirmed, but on the ground that the arbitration award was excluded as a claim for legal fees. The appellate court disagreed with the district court's categorization of the award as a sanction, holding that despite the arbitrator's

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Letter Asserting that State Government "May" Bring an Enforcement Action if Insured Did Not "Voluntarily" Cease a Particular Activity Is a Claim

Applying New York law, the United States Court of Appeals for the Second Circuit has affirmed a ruling that a letter asserting that a state government "may" bring an enforcement action against the insured if the insured did not "voluntarily" cease a particular activity, is a claim. *Weaver v. Axis Surplus Ins. Co.*, No. 14-4180-cv (2d Cir. Mar. 7, 2016).

As set forth more fully in the district court opinion, which was summarized in a November 14, 2014 *Executive Summary* article, an executive at an insured vending machine sales company was indicted in Florida federal court for conspiracy and fraud. According to the indictment, the executive made fraudulent statements regarding the company. The executive sought coverage for the criminal proceeding under a claims-made D&O policy that incepted in 2010.

The insurer denied coverage on multiple grounds, including pursuant to the policy's prior and pending litigation exclusion, which precluded coverage for any claim involving "any demand, suit or other proceeding pending" against an insured brought prior to February 20, 2008, "or any Wrongful Act, fact, circumstance or situation underlying or alleged therein." The insurer asserted that the criminal proceeding involved a demand that was made in a 2007 letter sent from the Maryland attorney general to the insured entity. In the 2007 letter, the Maryland attorney general asserted that the insured made false earning representations to customers and failed to provide investor disclosures as required by Maryland law, and the attorney general threatened to bring an enforcement action against the entity if it did not cease its activities.

In the coverage litigation that followed, the district court ruled in favor of the insurer, and the insured appealed. On appeal, the policyholder conceded that the 2007 letter asserted a fact, circumstance or situation also alleged in the indictment, but

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Sixth Circuit Affirms That Notice-Prejudice Rule Does Not Apply to Claims-Made Policies

A federal appellate court, applying Kentucky law, has affirmed a lower court's ruling that an excess carrier does not need to demonstrate prejudice in order to deny coverage for late notice under a claims-made policy. *Ashland Hosp. Corp. v. RLI Ins. Co.*, 2016 WL 787774 (6th Cir. Feb. 29, 2016).

The insured, a hospital, sought coverage under its primary and excess D&O liability insurance policies in connection with the settlement of a Department of Justice investigation into allegations that the insured billed the government for unnecessary heart procedures. The policies provided coverage on a "claims-made" basis. The insured reported the matter to its primary insurer on the last day permitted under the terms of the primary policy, but it did not notify its excess insurer of the matter until more than six months later. The excess insurer denied coverage for the settlement based on the insured's failure to fulfill the excess policy's notice requirements, and the insured initiated coverage litigation.

In affirming the lower court's ruling for the excess carrier, the appellate court predicted that the Supreme Court of Kentucky would not extend the notice-prejudice rule to a claims-made policy with an unambiguous notice requirement like the excess policy. The appellate court also declined to certify the question to the Supreme Court of Kentucky because the district court already had ruled. ■

Seventh Circuit Holds Insured's Material Misrepresentations in Application Warrant Rescission of Policy

Applying Illinois law, the United States Court of Appeals for the Seventh Circuit has held that a medical service provider's material misrepresentations regarding its use of non-traditional and experimental weight loss drugs and procedures warranted rescission of its professional liability coverage. *Essex Ins. Co. v. Galilee Med. Cntr.,* 2016 WL 851688 (7th Cir. Feb. 10, 2016).

The insurer had issued a professional liability policy to the medical service provider, which provided coverage for the entity as well as for its physicians acting within the scope of their duties as such. In order to obtain such coverage, the medical service provider had completed a number of applications, which asked multiple questions about its use of non-traditional and experimental weight loss drugs and procedures. The insured answered that it did not use drugs for weight reduction for patients nor did its practice include weight reduction or control other than by diet and exercise. The applications stated that the insured would rely on the answers provided in the application when issuing the policy. Subsequently, an affiliate of the insured and one of its physicians were sued for alleged medical negligence based on mesotherapy treatments, a non-surgical procedure designed to dissolve fat deposits in patients. The insurer denied coverage and sought a judicial declaration of rescission of the policy.

Following the grant of summary judgment in favor of the insurer, the Seventh Circuit affirmed. In doing so, the Court rejected the insureds' contention that they did not make misrepresentations in their application because the word "use" includes only the act of giving the procedure and the physician involved performed the procedure at his home office and only recommended the treatment while acting as a physician for the insured. The Court also rejected the insureds' argument that the word "use" is ambiguous and should be construed in the insureds' favor. The Court stated: "We will not permit defendants, who did not pay for coverage for suits arising out of weight loss procedures, to circumvent their duty to make truthful representations to their insurer by reading ambiguity into a clear insurance policy application." The Court further rejected the notion that any misrepresentations were not sufficiently material to warrant rescission, finding that the misrepresentations involving the scope of the physician's medical practice significantly increased the medical service provider's exposure and thus the insurer's risk. Accordingly, the Court concluded that such misrepresentations were plainly material under Illinois's objective test. ■

Maryland Court Holds Insurer Failed to Show Prejudice Resulting from Late Notice

A Maryland intermediate appellate court has ruled that an insurer could not deny coverage based on untimely notice of a claim because the insurer could not show that it was prejudiced by the delay. *Fund for Animals, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, 226 Md. App. 644 (Md. Ct. Spec. App. Feb. 1, 2016).

The insurer issued a claims-made-and-reported policy to the policyholder, a non-profit organization. The policyholder filed a lawsuit under the Endangered Species Act (the ESA case). While the ESA case was pending, a defendant in the ESA case brought a RICO action against the policyholder, alleging that the policyholder had bribed an individual witness in the ESA case to testify falsely. The policyholder did not give the insurer notice of the RICO case until more than two years after that case was filed. By that time, the court in the ESA case had granted judgment in favor of the defendant, and, in so ruling, made a number of factual findings relevant to the RICO case. The insurer denied coverage for the RICO case based on the late notice. The policyholder brought suit for breach of the insurance policy. After a jury trial, the trial court granted the insurer's motion for judgment.

The intermediate appellate court reversed and remanded for further proceedings. The court observed that under Maryland law, an insurer bears the burden of proving that a policyholder breached a policy by not giving it timely notice and that the late notice resulted in actual prejudice to the insurer. The policyholder argued that the insurer failed to show any prejudice. The insurer argued that if it had notice of the RICO case, it would have appointed its own panel counsel to defend the policyholder in the RICO case, monitored the ESA case, participated in the decision to stay the RICO case, and tried to settle the RICO case before the court made its ruling and factual findings.

The court agreed with the policyholder, noting that if the insurer had appointed panel counsel in the RICO case, the panel counsel could not have controlled the prosecution of the ESA case, and there was no evidence that appointing monitoring counsel would have had any impact on the outcome of the ESA case. The court also concluded that there was no evidence that the RICO case would not have been stayed, would have been adjudicated before the ESA case,

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Insurer May Allocate Defense Costs Under Duty to Defend Policy

Applying Louisiana law, the United States District Court for the Eastern District of Louisiana has held that an allocation provision in a duty to defend policy allowed an insurer to allocate defense costs between covered and non-covered causes of action. *Housing Auth. of New Orleans v. Landmark Ins. Co.*, 2016 WL 772649 (E.D. La. Feb. 29, 2016).

The insured, a housing authority, was sued for its demolition of four public housing developments in New Orleans after Hurricane Katrina. The housing authority tendered the suit to its directors and officers liability insurer. The insurer agreed to provide a defense under a reservation of rights, subject to the policy's allocation provision, because certain causes of action could be covered under the policy but refused to pay for the defense of non-covered causes of action. The insurer thus paid an allocated portion of defense costs incurred by the housing authority. The housing authority filed litigation against the insurer seeking coverage for all defense costs incurred in the lawsuit. The insurer contended that it satisfied its obligations under the policy by paying all defense costs attributable to potentially covered causes of action.

The court held that the insurer could allocate defense costs between covered and non-covered causes of action. The insured asserted that the insurer was required to pay all defense costs in the lawsuit because the policy stated that "[i]t shall be the right and duty of the Insurer to defend any Claim against the Insured for which coverage applies under this policy." The insurer argued that the policy expressly provided for allocation of defense costs between "covered and

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Coverage Barred For Hedge Fund's Suit Against Insured Because Related to Prior Securities Class Action

An Arizona intermediate appellate court, applying Arizona law, has affirmed a trial court's rulings in favor of an insurer, holding that a lawsuit against the insured's directors and officers was based in large part on the same or similar "wrongful acts" that were at issue in a previously filed securities fraud class action suit brought against the insured's CEO and CFO. *SP Syntax LLC v. Fed. Ins. Co.*, 2016 WL 831532 (Ariz. Ct. App. Mar. 3, 2016). In so doing, the court not only affirmed the trial court's award of reasonable attorney's fees and costs to the insurer, but also awarded the insurer reasonable attorneys' fees and costs for the appeal.

The insured, a company that manufactured televisions, held two consecutive towers of D&O coverage: Tower One, which was made up of primary policies from four different insurers for the November 30, 2007 to November 30, 2008 policy period, and Tower Two, which was made up of a primary policy, two excess policies, and two Side A coverage policies issued by various insurers (with one insurer issuing both an excess policy and a Side A coverage policy) for the November 30, 2008 to November 30, 2009 policy period.

In November 2007, a securities class action suit was brought against the television manufacturer and its CEO and CFO, alleging that the company had misrepresented its finances and operations in public filings. The insured tendered the Securities action to Tower One.

In November 2008, a hedge fund sued several of the insured's directors and officers, alleging that the defendants induced it to enter into and maintain a $250 million credit facility agreement by making "false and misleading statements and omissions of material fact . . . regarding [the insured's] financial condition, results of

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Prior Knowledge Condition Does Not Bar Coverage for Suit Alleging Negligent Licensure of Foster Parent

Applying Florida law, the United States District Court for the Middle District of Florida has held that a prior knowledge exclusion does not preclude an insurer's duty to defend a foster care licensing agency in a lawsuit alleging negligent licensing. *Diamond State Ins. Co. v. Boys' Home Ass'n, Inc.*, 2016 WL 1110422 (M.D. Fla. Mar. 22, 2016). However, the court ruled that it could not determine the insurer's duty to indemnify until the underlying action concluded.

The insured was a child-placing agency that contracted with Florida to conduct studies of foster parents for minor children and to certify that foster parents met state licensing requirements. Between October 2004 and October 2006, the agency licensed a foster parent who failed to meet licensing requirements because of a criminal background of child abuse and later revoked the license as a result of verified abuse. In 2011, parents of children placed with the foster parent filed suit against the insured for negligent licensure of the foster parent, and the insured tendered the lawsuit to its E&O insurer. The insurer filed suit seeking a determination that it did not owe a duty to defend or indemnify the insured based on a prior knowledge exclusion, which barred coverage for any "claim, suit, or wrongful act that might result in a claim or suit, of which any insured had knowledge or could have reasonably foreseen at the signing date of the application for this insurance [July 20, 2010]."

The court held that the prior knowledge exclusion did not bar coverage for the lawsuit. The insurer contended that, by 2005 or 2006, the insured had actual or constructive knowledge that the foster parent had a criminal abuse history, knew the foster parent had lied about her criminal abuse history, and knew that children placed with the foster parent after 2004 were removed based on verified complaints of child abuse. Rejecting those contentions, the court held that the underlying complaint contained no allegations that, before it signed the application in 2010, the insured was aware that it breached a duty in

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No “Wrongful Act” Where Claim Did Not Involve Conduct “Solely” in Individual’s Capacity as a Director or Officer of an Insured Entity

A Maryland intermediate appellate court has ruled that a claim did not allege a “wrongful act” because the claim was not made against an individual “solely” in his capacity as a director or officer of an insured entity. *Feldman v. Fidelity & Deposit Co. of Md.*, 2016 WL 885041 (Md. Ct. Spec. App. Mar. 7, 2016).

An insurer issued a D&O policy to a bank. An individual serving as a director and officer of the bank notified the insurer of an investigation by the Office of Thrift Supervision (OTS) and other regulatory agencies into certain transactions the individual had been involved in during the policy period. The OTS later issued a Notice of Charges, which alleged that the individual had engaged in misconduct as a member of an unrelated LLC. The individual later settled the OTS claim without an admission of wrongdoing, though he did agree to pay certain monetary penalties. The insured bank’s D&O carrier denied coverage to the individual, who brought suit to recover attorneys’ fees and a settlement payment in connection with the investigation. The trial court ruled in favor of the insurer, and the individual appealed.

The appellate court affirmed the ruling in favor of the insurer. In so doing, the court noted that the only issue presented was whether the OTS claim against the individual alleged a “wrongful act.” The policy at issue defined “wrongful act” to mean “any matter claimed against a Director or Officer solely by reason of his or her status as a director or officer” of the insured bank. The individual claimed that, because the OTS only had jurisdiction over him due to his status as an officer of the insured bank, the “wrongful act” definition was satisfied. The court disagreed, noting that there were *two* reasons the OTS was able to initiate the proceedings against him—(1) his role at the insured bank; *and* (2) his conduct as a member of an outside LLC—and the court therefore reasoned that his status as an officer was not the “sole” reason for the OTS claim. The court also rejected the individual’s argument that he was entitled to coverage given that he always maintained his innocence, noting that the absence of an adjudication of wrongdoing did “not render the alleged wrongdoing meaningless.” ■

Letter Seeking Disbursement of Funds Pursuant to Agreement Was Not “Claim”

The United States District Court for the Western District of Missouri has held that a letter requesting payment of funds pursuant to an agreement was not a demand for monetary relief and therefore not a “claim” under a claims-made D&O policy. *Phila. Indem. Ins. Co. v. Cmty. Found. of the Ozarks, Inc.*, 2016 WL 837951 (W.D. Mo. Mar. 3, 2016).

A community center had made a $500,000 deposit with the insured community foundation pursuant to the terms of a written agreement. The community center later requested the return of the deposit. On January 30, 2012, the community center sent a letter to the foundation enclosing a copy of the agreement and requesting a check in the amount of $500,000. Subsequently, on April 9, 2013, counsel for the community center sent a letter to the foundation demanding payment of the $500,000 with interest under Missouri law. The foundation did not return the funds, and the community center filed a lawsuit.

The foundation sought coverage under its D&O policy, which covered claims for wrongful acts first made against the insured during the policy period and reported to the insurer as soon as practicable but no later than 60 days after the expiration date of the policy. The insurer had issued an initial policy for the period of July 1, 2011 to July 1, 2012 and renewed the same coverage for the period of July 1, 2012 to July 1, 2013. The foundation reported the community center’s claim during the renewal policy period, after its receipt of the April 9, 2013 letter. The insurer then sought a declaratory judgment regarding the availability

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Claims-Made-and-Reported Policies Do Not Violate Louisiana Statute

The United States District Court for the Middle District of Louisiana has held that claims-made-and-reported policies do not violate a Louisiana statute that prohibits insurance contracts from limiting the insured's right of action against the insurer to a period of less than one year from the time when the cause of action accrues, because claims-made-and-reported policies define the scope of coverage rather than limit the insured's right of action. *Treo Staffing, LLC v. AXIS Surplus Ins. Co.*, 2016 WL 923112 (M.D. La. Mar. 10, 2016).

The insured, a labor staffing company, purchased a professional liability policy covering the period from April 13, 2013 to April 13, 2014. The policy was a claims-made-and-reported policy and thus required that a claim first be made against the insured and reported to the insurer in writing within the policy period. On October 24, 2014, the insured received notice from the Department of Labor that its overtime policies violated the Fair Labor Standards Act. The insured entered into a consent decree with the Department of Labor, under which it was required to pay workers approximately $600,000 in back overtime. On November 5, 2014, the insured submitted the claim to its insurer for coverage. The insurer denied coverage because the claim was neither made nor reported during the policy period.

The insured contended that the requirement limiting coverage to claims made and reported within the policy period was void pursuant to a Louisiana statute that prohibits an insurance contract from containing "any condition, stipulation, or agreement limiting right of action against the insurer . . . to a period of less than one year from the time when the cause of action accrues." The court ruled in favor of the insurer, holding that claims-made-and-reported policies do not violate the Louisiana law because such policies limit coverage for claims but do not limit the insured's right of action against the insurer. The court found that viewing a claims-made policy as limiting the insured's right of action would convert claims-made policies into occurrence policies and change the bargained-for exchange between the insurer and the insured. Therefore, the court refused to interpret the statute as prohibiting claims-made policy provisions that limit coverage to claims first made and reported during the policy period. The court thus held that the policy's limiting language did not violate the statute and that the insurer did not act in bad faith by denying coverage. ■

No Coverage for Lawyer's Alleged Self-Dealing *continued from page 1*

full rent and that the attorney caused the client to purchase various assets owned by the attorney and his family under unfair terms.

In the coverage litigation that followed, the district court awarded summary judgment to the insurer. In affirming, the Ninth Circuit first determined that coverage was barred by the policy's "Business Enterprise Exclusion," which applied to "any claim . . . based on, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving . . . the Insured's capacity or status as . . . an officer, director, partner, trustee, shareholder, manager or employee of a business enterprise." In this regard, the court pointed out that the attorney's conduct and alleged wrongdoing was "directly linked" to conduct on behalf of another entity, a trust in which he was a trustee. The court also observed that even if the insured's misconduct took place before the self-dealing, the exclusion still applied because it barred coverage for claims based on acts "in any way involving" the "Insured's capacity or status as: . . . an officer, director, partner, trustee, shareholder, manager or employee of a business enterprise, charitable organization or pension, welfare, profit sharing, mutual or investment fund or trust." The court further determined that the "Trust Exclusion" applied as well. This provision barred coverage for "any claim . . . based on, arising out of, directly or indirectly resulting from, in consequence of, or in any other way involving . . . any act whatsoever of an Insured in connection with a trust or estate when an Insured is a beneficiary . . . of the trust." ■

Claimant Without a Judgment Has No Standing to Bring Declaratory Judgment Action Against Alleged Tortfeasor's Insurer *continued from page 1*

The insurer agreed to defend the employer before discovering two prior undisclosed lawsuits against the employer that involved allegations of sexual harassment. The insurer then sought to rescind the policy in a separate declaratory judgment action in federal court. Ultimately, the insurer and the insured reached a settlement, which provided, among other things, that the policy was void *ab initio* and that the insured was to withdraw its tender of the claimant's action.

The claimant then proceeded to file the instant declaratory judgment action against the insurer in a Kentucky federal court, seeking a declaration of coverage under the policy in order to recover damages arising from the alleged sexual harassment. The court granted the insurer's motion for summary judgment.

First, the court held that the claimant had failed to show standing to bring the suit either under the Constitution or Kentucky law. Kentucky law, as the court explained, requires a plaintiff to obtain a judgment against an insured before seeking enforcement of that judgement against the insurer, which in this case had not yet happened. The court rejected the claimant's argument that such a judgment is not necessary where a claimant only seeks a declaratory judgment regarding coverage, noting that the act of seeking a declaration that an insurer must indemnify the insured does not establish a case or controversy under Kentucky law. The court also noted the similar shortcomings as to constitutional standing, pointing to the fact that the claimant had failed to establish the existence of an injury, causation, and redressability. According to the court, the claimant's only claimed injury, which was that she *may* obtain a judgment from her employer which the insurer *may* refuse to pay, "is simply too conjectural to meet the injury requirement."

Second, the court agreed with the insurer that even if the claimant could establish standing, the claimant could not establish coverage because the policy between the insurer and the claimant's employer had been rescinded. In so concluding, the court rejected the claimant's contention that the insurer had waived its coverage defenses by initially providing a defense to the claimant's employer before the insurer had a basis to suspect any misrepresentations had been made in the application. The court held that Kentucky law does not require "an affirmative duty to investigate coverage defenses prior to partaking in the insured's defense," rather insurers are required to perform reasonable care based only on their "actual knowledge." According to the court, the insurer had no duty to investigate until it had actual knowledge of irregularities in the insured's application. ■

Letter Asserting that State Government "May" Bring an Enforcement Action if Insured Did Not "Voluntarily" Cease a Particular Activity Is a Claim *continued from page 2*

argued that the 2007 letter was not a "demand" sufficient to trigger the prior and pending litigation exclusion. The Second Circuit disagreed, and affirmed the district court's holding that the prior litigation exclusion barred coverage for the criminal indictment. According to the court, "a demand requires an imperative solicitation for that which is legally owed." The 2007 letter requested that the insured entity provide certain documents and that the insured "voluntarily" cease and desist from vending machine sales in Maryland. The letter explained that the attorney general was acting pursuant to his "authority to investigate and take action against any person who violates" a consumer protection law, and stated that the failure of the insured entity to respond "may result in more formal legal action." Because the court concluded that the letter underscored the authority of the attorney general to seek specific forms of monetary and nonmonetary relief, and threatened "more formal legal action" in the event that the insured entity did not respond, the letter constituted a "demand."

Finding this to be a dispositive ground to affirm the district court's grant of summary judgment, the court did not address the district court's additional independent basis for granting summary judgment—that the Interrelated Wrongful Acts language of the policy operated to deem the indictment first made prior to the policy period. ■

Legal Fees Exclusion Bars Coverage for Arbitration Award that "In Substance" Reduced Fees Owed to Insured Law Firm *continued from page 2*

and state court's use of the word "sanction" to describe the award, the award was crafted as a remedy to make the class members whole for a portion of the extra fees they incurred in the collection litigation. However, the court held that the legal fees exclusion applied both to the portion of the award constituting a refund of the insured's fees and the portion of the second firm's fees the insured was ordered to pay. Although part of the arbitration award was not directly an order for reimbursement of legal fees paid to the insured firm, "in substance" the award reduced the legal fees the insured firm was entitled to recover and was therefore excluded. ■

Maryland Court Holds Insurer Failed to Show Prejudice Resulting from Late Notice

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or would have settled for less than it ultimately did had the insurer had timely notice. The court reasoned that the element of insurer control over the claim was missing here, as the insurer had no right to control any aspect of the ESA litigation. Thus, the court determined that there was no evidence that there was something the insurer could and would have done during the delayed notice period that, more likely than not, would have changed the outcome in the ESA case. ■

Insurer May Allocate Defense Costs Under Duty to Defend Policy *continued from page 4*

non-covered causes of action" and only required the advancement of defense costs that the insurer believed to be covered, subject to a later allocation determination.

The court reasoned that there was no conflict between the duty to defend and allocation clauses because the duty to defend only extended to claims "for which coverage applies under this policy" and the housing authority had no reasonable expectation of complete defense coverage for any potentially covered claim because D&O policies do not contain broad duty to defend clauses found in most general liability policies. Thus, the court held that "[r]ead together, [the insurer's] duty to defend is apparent. If the claim is covered, the insurer must provide a defense. If the claim is only partly covered, the parties need to work to allocate expenses. If the claim is not covered, then there is no duty to defend."

In addition, the court held that Louisiana public policy did not prohibit the insurer from contractually limiting its duty to defend to covered causes of action. Because the duty to defend is a contractual duty, the insurer could limit its defense obligations through unambiguous policy language. ■

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Coverage Barred For Hedge Fund's Suit Against Insured Because Related to Prior Securities Class Action *continued from page 5*

operations, and management," and that as a result, it lost millions of dollars. The insured tendered the hedge fund action to the insurers of both towers; however, the Tower Two insurers denied coverage on the ground that the hedge fund action arose out of the same wrongful acts as those at issue in the securities action, and thus was barred from coverage by exclusions precluding claims related to claims tendered under a prior policy, among other provisions. After the hedge fund and the insured reached a stipulated settlement with a covenant not to execute, the insured assigned the hedge fund its rights under the Tower Two policies, after which the hedge fund brought a declaratory judgment action against the Tower Two carriers for breach of contract, including the instant suit against a Tower Two insurer that issued both an excess policy and a Side A policy.

The trial court granted the insurer's motion to dismiss with respect to the excess policy, recognizing that the primary policy, to which the excess policy generally followed form, barred coverage for any claim arising out of any Interrelated Wrongful Act and also included a prior/pending litigation endorsement that specifically referenced the earlier securities class action in its definition of "Interrelated Wrongful Act." The trial court held that the hedge fund action "arose from the same core financial misstatements" as the securities action, and thus coverage was precluded under the excess policy of Tower Two. Similarly, with respect to the Side A policy, the trial court granted the insurer's motion for summary judgment, holding that the "the plain language of the [Side A Policy] relates the [hedge fund action] back to the [securities class action]." The trial court also awarded the insurer reasonable attorney's fees and costs under Arizona statutes.

On appeal, the Arizona intermediate appellate court affirmed the trial court's holdings, concluding that "the allegations in the [hedge fund] complaint arose out of or are similar to the allegations in the [securities action]." The court rejected the hedge fund's argument that its case had certain allegations that were not at issue in the securities class action. The court observed that the exclusions at issue in the primary and excess policy are "not limited to claims *identical*" to the securities action and explained that the hedge fund action constituted one claim that put forth no new alleged representations by the insured that were dissimilar from those in the securities class action.

Concerning the Side A policy, the Arizona Court of Appeals affirmed, rejecting the hedge fund's argument that the insurer's Side A policy defeated the hedge fund's (standing in the shoes of the insured's) reasonable expectations that the insured expected its Side A policy to cover the allegations in the hedge fund suit because no evidence was shown of any such expectation.

Finally, the intermediate appellate court held that the trial court did not abuse its discretion in awarding attorneys' fees based on three factors from *Associated Indemnity Corp. v. Warner*, 143 Ariz. 567 (1985), pointing out that the hedge fund did not rely on controlling authority in bringing its suit or otherwise raise a novel issue. The court also awarded the insurer its fees and costs on appeal. ■

Prior Knowledge Condition Does Not Bar Coverage for Suit Alleging Negligent Licensure of Foster Parent *continued from page 5*

licensing the foster parent. The insured revoked the foster parent's license in 2006 because of verified complaints of abuse, but the court held that there was no allegation that the insured "was aware of its failure to uncover the information which should have disqualified [the foster parent] for licensure and re-licensure at the time of her application." Although the insured knew that the foster parent abused children during the period in which she was licensed by the insured, the court held that the agency was unaware that its licensing failures had allowed the foster parent to be licensed improperly. It stated that a reasonable person may not have plausibly viewed the report of abuse in 2006 as potentially leading to a claim because the insured received hundreds of abuse reports per year but had only been sued once and made two insurance claims.

The court observed that it was appropriate for it to consider extrinsic evidence relevant to the applicability of the prior knowledge exclusion, but the court held that none of the extrinsic evidence proffered by the insurer showed that the insured had knowledge of a wrongful act that might result in a claim or suit.

Because the insurer's duty to indemnify the insured in the lawsuit would require resolution of facts that necessarily overlapped with facts to be determined in the underlying action, the court determined that it could not adjudicate the duty to indemnify until the underlying action concluded. ■

Letter Seeking Disbursement of Funds Pursuant to Agreement Was Not "Claim" *continued from page 6*

of coverage, arguing that the community center first made a claim against the foundation at the time of the January 30, 2012 letter, and that the foundation had failed to report the claim within the time period specified by the initial policy.

The court first considered Missouri's unfair insurance claims settlement practices regulation, which provided that "[n]o insurer shall deny any claim based upon the insured's failure to submit a written notice of loss within a specified time following any loss, unless this failure operates to prejudice the rights of the insurer." Citing Eighth Circuit and Missouri Court of Appeals precedent, the court held that the regulation did not apply to the claims-made policies at issue here because timely notice defines the limits of coverage under a claims-made policy and allows the insurer to more accurately calculate reserves and premiums.

The court then turned to the insurer's argument that the foundation did not give timely notice of the community center's claim. Both of the policies defined "claim" to include "a written demand for monetary or non-monetary relief." The court determined that the January 30, 2012 letter was not a claim because it did not contain a "demand" for monetary or legal "relief" beyond the return of funds pursuant to the agreement that the community center believed entitled it to the money. The court also observed that the letter did not make any allegation of a wrongful act because it did not accuse the foundation of breaching the agreement, and that there were no allegations of any wrongful act prior to the April 9, 2013 letter. Accordingly, the court held that the foundation had timely reported the claim by the community center under the renewal policy. ■

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