Wiley Rein LLP

EXECUTIVE SUMMARY

Developments in Affecting Professional Liability Insurers | May 2016

Bank Settlements Returning Overdraft Fees—Including Plaintiffs' Attorneys' Fee Awards—Are Not "Damages"

The United States Court of Appeals for the Third Circuit has held that a bank's $102 million payments to settle lawsuits alleging improper collection of overdraft protection fees are not covered "Damages" under the bank's professional liability insurance policies. *The PNC Financial Services Group, Inc. v. Houston Cas. Co.*, 2016 WL 1730734 (3d Cir. May 2, 2016). Applying Pennsylvania law, the court also reversed the District Court's finding that plaintiffs' attorneys' fees awarded out of the settlement funds were covered. Wiley Rein represents the insurer in the litigation.

The bank's customers filed class action litigation alleging that the bank improperly manipulated the order in which it processed customers' transactions in order to cause their accounts to be overdrawn multiple times, thus maximizing the number of fees it could charge for "overdraft protection services." The bank settled the customer lawsuits, agreeing to pay approximately $102 million, of which $30 million was later awarded to plaintiffs' attorneys for legal fees. The bank sought coverage for the settlements under its professional liability policies. The policies afforded specified coverage for "Damages," defined to include "a judgment, award, surcharge or settlement as a result of a Claim" but not to include "fees, commissions or charges for Professional Services paid or payable to an Insured." The bank filed a declaratory judgment action seeking coverage for the settlements under the policies.

The Third Circuit agreed with the District Court that the bank's settlement payments "in fact refunded overdraft fees" and therefore that the "professional services charge exception" from covered "Damages" quoted above unambiguously precluded coverage. The court rejected the bank's argument that the policy language is ambiguous and could reasonably be read to apply only to "first-party" losses or where there has been a "final adjudication." The court concluded that the professional services charge exception did not render the policy illusory and did not conflict with the policy's "personal profit exclusion," which is "much broader" and does not "speak to the same subject" as the professional services charge exception. The court therefore rejected the bank's argument that the final adjudication requirement of the personal profit exclusion should apply to the professional services charge exception.

The court reversed the District Court's finding that approximately $30 million awarded to the underlying plaintiffs' counsel as attorneys' fees and costs did not fall within the professional services charge exception. The court noted that the policy covers only "Loss" that the bank was "legally obligated to pay." Therefore, "[a]lthough the settlement agreements contemplated that some attorneys' fees would likely be paid to class counsel, [the bank] was not legally obligated to pay those fees under the terms of the settlement agreements." Instead, the fees and costs were paid "by the class out of the settlement funds." According to the court, "[t]hat some money from each common fund was subsequently paid to counsel upon order of the respective courts does not change the purpose of the funds—to resolve the class members' claims for wrongly collected overdraft fees." The court therefore concluded that the entire $102 million in settlement payments made by the bank constituted a refund of fees or charges for Professional Services that class members paid and, as such, was not covered pursuant to the professional services charge exception from covered "Damages." ■

ALSO IN THIS ISSUE

Fourth Circuit Upholds Summary Judgment for Insurer Based on Late Notice Because Insurer Suffered Actual Prejudice Due to Default Judgment

The United States Court of Appeals for the Fourth Circuit, applying Maryland law, has affirmed the entry of summary judgment in favor of an insurer where it received late notice of a suit in which the underlying court had entered default judgment against the insured, finding that the insurer was actually prejudiced by the delay. *St. Paul Mercury Ins. Co. v. Am. Bank Holdings, Inc.,* 2016 WL 1459517 (4th Cir. Apr. 14, 2016).

The insured, a bank, was served with a complaint and summons for an action in Illinois state court, but because of an internal oversight, the insured did not timely respond to the summons. The Illinois court entered a default judgment against the insured for $98.5 million. Eight months after the bank was served with the summons, the plaintiff in the state court action began to attempt to collect the default judgment in Maryland, where the insured was based, and the insured notified its insurer of the lawsuit. The insurer denied coverage due to late notice. The plaintiff in the state court action offered to settle the suit for an amount within policy limits, and the insured provided the insurer with a settlement demand. The insurer reiterated its denial of coverage. The insured ultimately was able to have the default judgment vacated and the suit dismissed, but incurred significant defense costs in doing so.

The insurer filed suit, seeking a declaration that it had no duty to pay for the insured's defense costs in the state court action to have the default judgment vacated and further defend that action. The insurer and insured filed cross-motions for summary judgment, and the Maryland district court entered summary judgment for the insurer. The district court concluded that because the insured did not provide the insurer with notice "as soon as practicable" as required by the terms of the policy and because the late notice caused the insurer prejudice, the insurer properly denied coverage.

The Fourth Circuit affirmed. First, the court rejected the insured's argument that notice was timely because it was not obligated to notify the insurer until it had actual knowledge of the underlying suit. The court determined that the plain language of the notice obligation did not require that the insured have actual notice; instead, the insured was obligated to provide notice of a claim as soon as practicable. Because the policy defined "claim" to mean a proceeding commenced by the service of a complaint, the court held that the requirement to give notice was triggered by service of a complaint. The court also held that even if actual notice were required, the insured had actual notice when the complaint was served on one of its agents. The court also rejected the insured's argument that the language "as soon as practicable, but in no event later than . . . sixty days after expiration of the Policy Year" set two alternative deadlines for notice. The court determined that this language sets "as soon as practicable" as the only deadline and further provides that notice may never be later than sixty days after expiration.

Next, the Fourth Circuit further agreed with the district court that the insurer suffered actual prejudice because of the delay, reasoning that the insurer was precluded from exercising essentially all of its rights under the policy to participate in the defense, to advance credible defense strategies before the default judgment was entered, to participate in the selection of counsel, and to possibly negotiate a settlement with the plaintiff prior to incurring substantial costs to vacate the judgment. In this regard, the court stated that, "[w]hen a late notice precludes an insurer from exercising meaningful contractual rights provided to it by the policy—in this case, all the contractual rights—we agree with the district court that the insurer has suffered actual prejudice."

The court also rejected the insured's argument that the insurer waived or was estopped from asserting its late notice defense based on a telephone conversation during which the insurer's claim examiner allegedly told the insured's general counsel that coverage existed for the action. The court noted that there was no evidence that the insured had changed its position based upon this conversation, and the insurer repeatedly asserted that it retained the right to raise any coverage issues and assert appropriate defenses. Thus, the Fourth Circuit held that it could not find an actual intention on the part of the insurer to relinquish an existing right as required under Maryland law.

Finally, the court determined that the insurer did not act in bad faith in denying coverage because the insured could not satisfy the statutory requirement that there be a finding in favor of the insured that coverage actually existed. ■

Alaskan Law Prohibits Recoupment of Non-covered Defense Costs

On a certified question from the United States Court of Appeals for the Ninth Circuit, the Alaska Supreme Court has held that an insurer is not entitled to reimbursement of defense costs for non-covered claims and that policy provisions allowing for such reimbursement are unenforceable under Alaskan law. *Attorneys Liab. Prot. Soc'y, Inc. v. Ingaldson Fitzgerald, P.C.*, 2016 W: 1171299 (Alaska Mar. 25, 2016).

The case arose from a demand for coverage under a professional liability policy by a law firm for a suit concerning its disbursement and withdrawal of fees against a client's retainer. The insurer accepted the defense of the claim subject to a reservation of rights, including the right to deny coverage on the grounds that the suit included allegations of activities that did not constitute covered professional activities, as well as allegations that implicated the policy's exclusion for claims arising from conversion or disputes over fees. The insurer's letter to the insured also reserved rights under the provision in the policy providing that the insured would reimburse the insurer for fees and costs incurred defending non-covered claims. The insured retained independent defense counsel, whose fees were paid by the insurer.

After the resolution of the underlying lawsuit against the insured, the insurer sought a judicial declaration of no coverage and sought reimbursement of defense costs from the insured. The insured did not contest the declaration of no coverage, but it argued that the insurer was not entitled to reimbursement. The federal district court agreed. The insurer appealed the ruling to the court of appeals, which certified two questions to the state high court, distinguishing between the situation in which an insurer has a duty to defend because of the possibility of covered loss but ultimately faces no liability and the situation in which the duty to defend never arises because there never was a possibility of coverage. In both instances, the court concluded that reimbursement is not available under Alaska law.

The court based its conclusions in large part on the state's independent counsel statute—Alaska Stat. § 21.96.100—which provides that an insurer required to provide independent counsel because of a conflict of interest "shall be responsible for the fees and costs of defending those allegations for which the insurer either reserves its position as to coverage or accepts coverage." According to the court, because the statutory scheme mandates payment and does not expressly provide for reimbursement of fees and costs, reimbursement is prohibited and cannot be avoided by a contract provision to the contrary. The court further held that this same conclusion applies to the situation where the duty to defend never actually arises but the insurer nonetheless provides a defense subject to a reservation of rights "out of an abundance of caution" because there should be no incentive for an insurer "to automatically reserve rights in hopes of obtaining reimbursement for attorney's fees and to protect itself from claims of bad faith or breach that could result from a repudiation of the policy." ■

Insured v. Insured Exclusion Bars Coverage for Liquidation Trust's Claim Against Insured Directors and Officers

A Michigan federal court has held that an insured v. insured exclusion barred coverage for a claim asserted by a liquidation trust against the insured debtor's former officers and directors. *Indian Harbor Ins. Co. v. Zucker*, 2016 WL 1253040 (W.D. Mich. Mar. 31, 2016).

A bank holding company filed for Chapter 11. During the proceedings, the creditors' committee and the debtor agreed to a settlement agreement in which various causes of action belonging to the debtor were transferred to a liquidation trust. The agreement also required the liquidation trustee to pursue those assigned causes of action in court for the benefit of the creditors. The bankruptcy court approved the settlement agreement and eventually approved a liquidating plan. The liquidation trustee filed a complaint against various former directors and officers of the bank, alleging breach of fiduciary duty, which was a claim assigned to the trust by the debtor.

The bank holding company held a D&O policy that provided specified coverage to the former directors and officers sued by the trustee. The D&O policy also provided specified coverage to the "Company," which was defined to include the bank holding company and various subsidiaries and affiliated entities. The D&O policy included an insured v. insured exclusion that barred coverage for claims made against "Insured Persons" and brought "by, on behalf of, or in the name or right of, the Company or any Insured Person." The insured v. insured exclusion included several carve-backs, but none of the carve-backs dealt with any circumstance involving bankruptcy of

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an insured. The D&O insurer denied the directors' and officers' request for coverage for the liquidation trustee's suit, asserting that this exclusion applied.

The court overseeing the ensuing coverage action granted the insurer's motion for summary judgment, holding that the insured v. insured exclusion barred coverage. The court began by detailing what it described as "inconsistent decisions across the country from courts encountering disputes over the insured v. insured exclusion," and endorsed a fact-specific view as to whether such exclusions apply in any given circumstance. Here, the court pointed to the fact that the Company agreed to create the liquidation trust in a voluntary agreement and transferred the causes of action that it had against its former directors and officers, and that the liquidation trustee's suit asserted those causes of action. Under these circumstances, the court found that the suit was therefore brought "in the name or right of . . . the Company" because there was a "direct connection between the debtor/company/insureds and the Liquidation Trust, which was created by agreement of the Debtors and the Creditors' Committee," and the liquidation trust asserted the causes of action transferred to it by the insured debtor in the underlying claim at issue in the coverage action. ■

Restitution for Criminal Acts Uninsurable Under Pennsylvania Law

The U.S. District Court for the Middle District of Pennsylvania, predicting Pennsylvania law, has held that restitution for criminal acts is uninsurable as a matter of public policy. *Darwin Nat'l Assurance Co. v. Luzerne Cty. Transp. Auth.*, 2016 WL 1242283 (M.D. Pa. Mar. 30, 2016). The court accordingly found that criminal proceedings against a public official fell within a public officials liability insurance policy's limit of liability for claims exclusively seeking non-monetary relief. The court further held that a second public official's guilty plea barred coverage for him pursuant to the policy's exclusion for deliberate misconduct.

The Pennsylvania Office of Attorney General initiated criminal proceedings against the former executive director and former operations manager of the insured, a county transportation authority, alleging that the individuals conspired to create false bus ridership data to defraud the Pennsylvania Department of Transportation and obtain excess grant money, which was allegedly used to pay various operating expenses of the transportation authority, including the officials' own salaries. The executive director subsequently pleaded guilty to several counts of tampering with public records, a third-degree felony. The two individuals sought coverage for the criminal proceedings under the transportation authority's public officials liability insurance policy.

The court first determined that no coverage was available for the executive director as a result of his guilty plea. The policy contained an exclusion for "any Claim brought about or contributed to in fact by . . . any deliberate misconduct or deliberate dishonest, fraudulent, criminal or malicious act, error, or omission by any Insured." The applicability of the exclusion required a final adjudication or an admission by the insured, and the exclusion further provided that the insured must reimburse any defense expenses advanced by the insurer. The court held that the executive director's admission to submitting false bus ridership data and to committing a third-degree felony triggered the exclusion, and the court ordered the executive director to reimburse the insurer for the $50,000 in defense expenses that had been previously advanced by the insurer.

Next, the court considered which of the policy's two insuring agreements applied to the criminal proceedings brought against the operations manager. The insurer argued that the proceedings fell within the insuring agreement for claims exclusively seeking non-monetary relief, which contained a limit of liability of $100,000 for defense expenses only. The operations manager argued that the proceedings fell within the public officials wrongful acts coverage part, which provided a $1,000,000 limit of liability for loss, with coverage for defense expenses available outside the limit. The operations manager argued that the criminal allegations mandated a sentence including restitution, thus constituting monetary relief that would trigger the public officials wrongful acts coverage part.

The court agreed with the insurer, holding that the insuring agreement for claims seeking only non-monetary relief applied. In so holding, the court rejected the operation manager's argument that the larger limit of liability applied because the policy's definition of "Loss" did not specifically exclude restitution. Moreover, the court predicted that the Pennsylvania Supreme Court would reject an attempt to seek coverage for restitution for criminal acts on grounds of public policy. Specifically, the court stated

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that "the Pennsylvania Supreme Court would reject the insured's petition for greater insurance coverage based on restitution arising out of criminal acts, especially here, where the alleged conduct involved an intentional criminal conspiracy to commit fraud" and that to allow such coverage "would effectively permit the purchase of a 'freedom of misconduct' that is inconsistent with the purpose of restitution, which is to impress upon the offender the gravity of his actions." ■

Insurer Not Estopped from Denying Coverage for Failing to Send Second Coverage Letter

Applying Massachusetts law, the United States District Court for the District of Massachusetts has held that an insurer is not estopped from denying coverage for a subsequent claim when it already issued a coverage letter for litigation based on the same facts and involving the same coverage issues. *American Guar. & Liab. Ins. Co. v. Lamond*, 2016 WL 1312008 (D. Mass. Apr. 4, 2016). In addition, the court held that the insurer did not act in bad faith by failing to settle the litigation.

The insured lawyer represented a client in the purchase of real property and made certifications to the mortgagor that the land was free of any encumbrances. He made this certification despite knowledge that the land was the site of a burial ground and was subject to a preservation restriction. After the purchase, the client learned of the development restriction and defaulted on the mortgage. The mortgagor foreclosed on the property but was unable to develop or sell the land because of the restriction. The mortgagor then filed suit against the lawyer and the client, which the insured lawyer tendered to his insurer. The insurer agreed to defend the lawyer under a complete reservation of rights and appointed defense counsel. Later, the client filed a third-party claim against the lawyer, which the insurer's appointed counsel defended, but the insurer did not issue a reservation of rights for the third-party claim. After the client's third-party claim against the insured went to trial and resulted in an adverse judgment, the insurer filed suit seeking a declaration that its policy did not provide coverage for the judgment in the third-party claim based on coverage defenses raised in the reservation of rights letter issued with respect to the original mortgagor suit.

First, the court held that the insurer was not estopped from denying coverage for the judgment in the third-party claim. The court held that a second reservation of rights letter was unnecessary because the third-party claim was based on the same allegations of misconduct as the mortgagor's complaint and involved the same coverage issues. In addition, the court reasoned that the insured's purported reliance that the insurer was not reserving rights was unreasonable because he made no effort to obtain assurance or clarification from the insurer concerning the absence of a second coverage letter.

Second, the court held that the insurer did not act in bad faith as a matter of law by failing to settle the client's claim. It held that the insurer could not be held vicariously liable for the acts of retained defense counsel because the conduct of the litigation was the responsibility of defense counsel. It also held that the insurer had no duty to settle the litigation because it was never "reasonably clear" that the policy covered the claim. ■

Insured v. Insured Exclusion Bars Coverage for Former Director's Action Against CEO

The District Court of Appeal of Florida has held that an insured v. insured exclusion barred coverage for an action brought by a former director of the insured company against the company's CEO. *Durant v. James*, 2016 WL 1295100 (Fla. Dist. Ct. App. Apr. 4, 2016).

Under the terms of a final judgment and dissolution of marriage, the former director was forced to sell his shares of the insured's stock. The director later repurchased the stock, but at an inflated price due to certain alleged actions by the insured's CEO. Ultimately, the former director obtained a

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money judgement against the CEO for damages in connection with the stock buyback. He then sought to collect the judgment from the insurer under the company's D&O policy. The insurer denied coverage based on the policy's exclusion for any claim by or on behalf of the insured entity, any affiliate of the insured entity or any insured person. The policy defined "insured person" to mean "any past, present or future director, trustee, officer, employee or honorary or advisory director or trustee of the Company."

In the coverage litigation that followed, the former director contended that his action against the CEO was covered because he had brought the claim in his personal capacity, unrelated to his former position as director. The court disagreed, finding that the underlying action was based on a judgment obtained in an adversarial personal action against the CEO for damages incurred due to the CEO's wrongful act of overvaluing the stock bought back by the former director. Moreover, the court noted that the former director's status as an "insured" resulted from his undisputed status as a past director, and was not specially conferred to advance a particular statutory duty. The court thus held that the clear and unambiguous policy language barred coverage for the underlying action. The court also held that the exception to the exclusion for any claim arising out of the employment of an insured person did not apply because a director is not an employee of a company, and the former director had not accepted any duties beyond those required of a director to make himself an employee. ■

Expert Testimony Regarding the Timing of a Claim and Applicability of Exclusions is Inadmissible

A federal trial court has held that an expert opinion that relates to when a claim was made or the application of certain exclusions is inadmissible in coverage litigation, while expert opinions related to the insurance industry's customs and practices are allowed. *Foundation Health Servs., Inc. v. Zurich Am. Ins.Co.*, 2016 WL 1449678 (M.D.La. April 13, 2016).

The case arose when the insured sought coverage for defense costs and other losses incurred in connection with the settlement of a claim brought by the Department of Justice. The insurer denied coverage for the claim under two separate policies on several bases and the insured filed suit, asserting a claim of bad faith, among others. In support of its position, the insured retained an expert witness to testify "whether [the insurer] met its obligations and responsibilities in connection with the claim at issue under custom and practice in the industry," which the insurer moved to exclude primarily on the ground that the expert drew impermissible legal conclusions.

In excluding the expert's testimony regarding when the relevant claim was made and the application of particular exclusions, the court explained that experts retained in connection with insurance disputes "may be allowed to testify regarding insurance industry standards for claims adjusting, but not the ultimate legal conclusion that an insurance company acted in good or bad faith when adjusting a claim." The court noted that legal conclusions are inadmissible because they "invade[] the court's province and [are] irrelevant." The court allowed the expert's testimony that pertained to the insurance industry's customs and practices, including as to an insurer's claims handling obligations. ■

Claim Based on Acts Pre-Dating Retroactive Date Not Covered

The United States District Court for the Northern District of Mississippi, applying Mississippi law, has granted summary judgment in favor of an insurer, holding that a professional liability policy did not afford coverage for a lawsuit against two insured attorneys because the alleged malpractice occurred before the operative retroactive date in the policy. *Imperium Ins. Co. v. Shelton & Assocs., P.A.*, 2016 WL 1260749 (N.D. Miss. Mar. 30, 2016).

Two insured attorneys were sued for alleged instances of malpractice taking place between 2007 and 2011. They sought coverage under a professional liability policy affording coverage for claims first made and reported during the policy period for wrongful acts "occurring on or after the Retroactive Date" of February 1, 2013 that was applicable to the two attorneys.

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Claim Based on Acts Pre-Dating Retroactive Date Not Covered *continued from page 4*

While defending the underlying action under a reservation of rights, the insurer brought suit seeking a declaration that it had no duty to defend or indemnify the two attorneys in connection with the lawsuit because all of the alleged wrongful acts took place prior to the policy's Retroactive Date. Based upon the "clear and unambiguous terms" of the policy, the court agreed, and upon finding no genuine issues of material fact, granted summary judgment in favor of the insurer on that basis. ■

SPEECHES & EVENTS

Local Government on Trial: Wrongful Conviction Lawsuits

Benjamin C. Eggert, Speaker

PRIMA's 2016 Annual Conference

June 7, 2016 | Atlanta, GA

Fiduciary Liability Insurance

Kimberly M. Melvin, Speaker

American Conference Institute's 12th National Forum on ERISA Litigation

June 28, 2016 | San Francisco, CA

Coverage Masters: Mastering the Claims Investigation Process and Evaluating the Latest Hot and Emerging Coverage Issues

Laura A. Foggan, Speaker

FDCC 2016 Annual Meeting

July 23-30, 2016 | La Malbaie, Quebec, Canada

Achieving Reasonable Expectations and Employing Effective Tactics in a Securities Class Action Mediation

Kimberly M. Melvin, Speaker

American Conference Institute's National Forum on Directors & Officers and Management Liability

July 27, 2016 | New York, NY

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