Wiley Rein LLP

EXECUTIVE SUMMARY

Legal Developments Affecting Professional Liability Insurers | November 2016

In Absence of Alleged Malpractice, No Professional Liability Coverage Available

In a win for an insurer represented by Wiley Rein, the United States Court of Appeals for the Fifth Circuit, applying Louisiana law, has held that a lawyers professional liability policy afforded no coverage for a suit alleging no act or omission by the insured in providing legal services. Edwards v. Continental Cas. Co., 2016 WL 6500668 (5th Cir. Nov. 2, 2016).

The insured lawyer filed suit against his client's former employer for alleged injuries suffered by the client during a sea dive off of an oil platform. Before trial, the client reached a settlement with the employer, from which the lawyer received a portion of the settlement payment under a contingency fee arrangement. Less than a year later, the employer filed suit against the client to recover the settlement payment because the client allegedly feigned his injuries and lied under oath regarding the nature and extent of the injuries. The employer's complaint alleged that the lawyer was unaware of the client's conduct but sought the return of attorneys' fees paid to the lawyer from the settlement funds.

The suit against the client and lawyer was ultimately dismissed, but the lawyer sought coverage from his insurer for defense costs. The insurer denied coverage because the lawsuit was not one "arising out of an act or omission, including personal injury, in the rendering of or failure to render legal services" so as to trigger the policy's insuring agreement. The insured filed suit against the insurer, and the district court held that the insurer had a duty to defend. The insurer appealed.

The appellate court reversed and held that the insurer had no duty to defend the lawyer against the employer's suit. It held that the employer's lawsuit did not "arise out of an act or omission . . . in [the lawyer's] rendering of or failure to render legal services" because it did not "allege a single professional act or omission by [the lawyer]." The court noted that,

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while the claim for restitution/unjust enrichment against the insured may have had "some general and remote relation to [the insured's] representation of [the client]," the employer did not allege a single professional act or omission by the insured that gave rise to the claim. Instead, according to the court, the insured was only named in the suit because he received a fee from the settlement funds at issue. The court reasoned that the insured's representation of his client "[a]lone . . . cannot serve as an act or omission in [the insured's] rendering of legal services" because that interpretation "would effectively read the words 'act or omission' out of the policy's definition of claim." ■

Documents Relating to Other Insureds, Reserves, Reinsurance Communications, Claims Handling and Underwriting Manuals Not Discoverable

In a favorable ruling for a Wiley Rein client, a Tennessee federal court has rejected an insured's motion to compel documents and interrogatory responses relating to reserves, reinsurance communications, claims and underwriting manuals, and other claims against other insureds. *First Horizon Nat'l Corp. v. Houston Cas. Co.*, 2016 WL 5869580 (W.D. Tenn. Oct. 5, 2016). Wiley Rein represents the primary carrier.

In 2012, the United States government initiated an investigation of an insured bank. The bank eventually entered into a settlement with the government in 2015. The bank's E&O insurers denied coverage for the settlement on numerous grounds, including that the underlying claim was related to prior claims first made during earlier policy periods. In addition, the insurers argued that the bank "deliberately hid the ball and failed to give notice of the" underlying claim until "well-after [it] learned the United States first asserted the Claim." During written discovery, the bank sought to compel the insurers to disclose (1) information and documents concerning the insurers' treatment of other insurance claims, (2) claims-handling and underwriting manuals, (3) claim reserve information, and (4) reinsurance communications.

The court rejected all of these arguments. First, the court held that discovery of information related to other claims made against other insureds was neither relevant nor proportional to the needs of the case. With respect to both the insured's coverage and "bad faith" claims, the court held that the insurers' "conduct in other claims necessarily depends upon a number of variables and involves circumstances unique to each policyholder" and was not relevant. The court also held that it would not permit this discovery even if the information were relevant because responding to the requests would require a "massive burden involving time, effort, expense, and disruption of business operations" on the part of the insurers, "lead to even further discovery disputes and create extended mini-trials," and "indeed result in a fishing expedition."

Second, the court rejected discovery of claims-handling and underwriting manuals from three excess carriers. The court held that interpretation of the excess policies "depends on the interpretation of the language of the . . . primary policy." Accordingly, the court held that the claims manuals were "not relevant to interpretation of the meaning of these terms if the court finds an ambiguity in the language of the . . . primary policy." Similarly, the court held that it was "undisputed that notice to the underwriting departments of" the excess carriers

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Documents Relating to Other Insureds, Reserves, Reinsurance Communications, and Claims Handling and Underwriting Manuals Not Discoverable *continued from page 2*

was insufficient as a matter of law to provide notice of a claim, and that discovery of these documents was irrelevant as well.

Third, the court rejected the insured's argument that discovery of reinsurance communications was permissible. Although the court compelled the carriers to disclose reinsurance contracts pursuant to Rule 26(a)(1), the court held that communications with reinsurers were not discoverable in this instance because the defendants submitted affidavits that asserted that the reinsurance communications did not address the substantive issues in the case.

Fourth, the court denied the insured's request to compel reserve information. The court found that reserve information reflected a "business judgment," not a "legal determination of the validity of the Plaintiffs' claim against them," was irrelevant, and was protected by the attorney-client privilege and work product doctrine. ■

Computer Fraud Provision of Crime Policy Does Not Cover Loss from Business Email Compromise and Social Engineering Scheme

Applying Texas law, the United States Court of Appeals for the Fifth Circuit has held that a business email compromise loss involving social engineering did not "result[] directly from the use of any computer to fraudulently cause a transfer" and thus did not trigger Computer Fraud coverage under a commercial crime insurance policy. *Apache Corp. v. Great American Ins. Co.,* 2016 WL 6090901 (5th Cir. Oct. 18, 2016)

In March 2013, the insured, a large oil and gas exploration and production company, received a telephone call from a person identifying herself as a representative of one of the insured's legitimate vendors. The caller instructed the insured to change the account information for its payments to that vendor. The insured's employee replied that the request could not be processed without a formal request on the company's letterhead, and a week later, the insured received an email from a similar, but inauthentic, domain name – that had been created by the criminals to send a fraudulent email. The email included an attachment with instructions on the vendor's letterhead to change its account information. The insured subsequently paid legitimate invoices from the vendor, albeit to the bank account belonging to the fraudster. While the company was able to recover some of the $7 million paid to the fraudster's account, it failed to recover approximately $2.4 million.

The insured then sought coverage under the "Computer Fraud" provision of its crime insurance policy. In relevant part, that provision covered "loss of, and loss from damage to, money, securities and other property resulting directly from the use of any computer to fraudulently cause a transfer." The insurer denied coverage on the grounds that the insured's "loss did not result directly from the use of a computer nor did the use of a computer cause the transfer of funds." A coverage dispute ensued, and the district court granted summary judgment in favor of the insured after ruling that the fraudulent email was a "substantial factor" in the scheme. In so doing, the court rejected the argument that coverage under the policy was limited to losses caused by computer hacking.

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Computer Fraud Provision of Crime Policy Does Not Cover Loss from Business Email Compromise and Social Engineering Scheme *continued from page 3*

On appeal, the Fifth Circuit reversed the decision and rendered judgment for the insurer. The court recognized a "cross-jurisdictional uniformity in declining to extend coverage when the fraudulent transfer was the result of other events and not directly by the computer use," and it found that authority persuasive. The court determined that the "computer use" at issue here "was an email with instructions to change a vendor's payment information." While the court acknowledged that the use of "email was part of the scheme[,] … the email was merely incidental to the occurrence of the authorized transfer of money." The court further noted that "[t]o interpret the computer-fraud provision as reaching any fraudulent scheme in which an email communication was part of the process would … convert the computer-fraud provision to one for general fraud." On that basis, the court ruled that the business email compromise loss caused through social engineering did not "result[] directly from the use of any computer to fraudulently cause a transfer." ■

Insured Not Prejudiced by Insurer's Failure to Attend Settlement Meetings; Alaska Law Precluding Recoupment of Defense Costs Preempted by Federal Risk Retention Group Statute

The Ninth Circuit Court of Appeals has reversed a district court's denial of an insurer's motion for summary judgment and held that the insurer, which was organized as a risk retention group, was entitled to reimbursement of defense costs incurred in defense of a non-covered claim because Alaska's statutory bar against recoupment conflicts with the federal statute pursuant to which the risk retention group was formed. *Attorneys Liability Protection Society, Inc. v. Ingaldson Fitzgerald, P.C.,* 2016 WL 5335036 (9th Cir. 2016). The court also rejected the policyholder's argument that the insurer should be estopped from asserting defenses to coverage because it acted in bad faith by failing to attend settlement meetings.

The law firm policyholder was sued by a bankruptcy trustee for the estate of a former client regarding the firm's handling of a $150,000 retainer. The law firm notified its professional liability insurer, which agreed to defend under a reservation of rights and specifically reserved the right to recoup fees incurred in defense of claims that were found not covered under the policy. The law firm retained independent counsel, and the insurer paid the defense fees and sought a declaration that the policy did not cover the claims against the law firm and to recover the expenses incurred defending the law firm.

The district court held that the policy did not cover the claim, but concluded that the policy's reimbursement provision did not comply with Alaska law and was therefore unenforceable. The Ninth Circuit then certified two questions to the Alaska Supreme Court, which held that an insurer is not entitled to reimbursement, even where it explicitly reserved the right to seek reimbursement and the insured accepted the defense subject to a reservation of rights, regardless whether the claims are later determined to be excluded from coverage or it is later determined that the duty to defend never arose because there was no possibility of coverage. The Ninth Circuit then held that that the Alaska statute prohibiting reimbursement, § 21.96.100(d), as applied to risk retention groups, was preempted by the federal Liability Risk Retention Act of 1986. The court found that § 21.96.100(d) conflicted with the Act governing insured-owned risk retention groups,

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Insured Not Prejudiced by Insurer's Failure to Attend Settlement Meetings; Alaska Law Precluding Recoupment of Defense Costs Preempted by Federal Risk Retention Group Statute *continued from page 4*

and that none of the exceptions—regarding unfair claim settlement laws, deceptive trade practices laws, taxes levied against other insurers, registration requirements and financial stability regulations—applied.

The court of appeals also held that the insurer was not estopped from denying coverage under Alaska law due to its failure to attend settlement meetings in connection with the underlying claim. The court concluded that the law firm could not establish that it was prejudiced by the insurer's failure to attend settlement meetings, noting that the group informed the law firm from the outset that it intended to assert coverage defenses, provided independent counsel, and acted consistently with its view that coverage did not exist. The court also noted that the law firm was never at risk of an excess judgment based on the amount at issue. The insurer therefore would not be estopped from asserting its defenses to coverage. ■

Claim Brought by Lenders Against Officers Based on Company's Misstated Financials Barred by Bankruptcy and Creditors Exclusion

Applying Texas law, the United States Court of Appeals for the Fifth Circuit has held that an exclusion barring coverage for any claim brought or maintained by or on behalf of any creditor of the company precluded coverage for claims by lenders against company officers alleging that they misrepresented the financial condition of a company. *Markel Am. Ins. Co. v. Verbeek*, 2016 WL 5400412 (5th Cir. Sept. 27, 2016)

Two individuals were owners and officers of a large wholesale flower distributor. In 2012, the company refinanced its debt by entering into a series of loan agreements. Later, the company defaulted on its loans and filed for bankruptcy. The lenders later sued the two officers alleging that they misrepresented the company's financial condition, including by overvaluing its inventory, and that those misrepresentations hid the company's true financial condition. The officers tendered the suit under a D&O policy, but the insurer denied coverage pursuant to the policy's "Bankruptcy and Creditors" exclusion, which barred coverage for "Loss on account of … any Claim brought or maintained by or on behalf of … [a]ny creditor of a Company … in the creditor's capacity as such." The insurer also filed a declaratory judgment action, and the district court ruled that the insurer had no duty to defend or indemnify because the exclusion barred coverage in its entirety.

On appeal, the court affirmed that the Bankruptcy and Creditors exclusion applied. First, the court rejected the officers' argument that the parent company of one of the underlying creditors was an "investor" and "administrative agent" and not a "creditor" for purposes of the exclusion. The court reasoned that the factual allegations in the litigation "indicate that all damages originate from the loans the [officers] and others fraudulently induced the [claimants] to extend" to the company, and that because all alleged damages stemmed from the claimants' roles as defrauded creditors, the exclusion applied. Second, the court rejected the officers' argument that the bankruptcy court's approval of a liquidation plan rendered the exclusion inoperative because, after that ruling, the plaintiffs were no longer "creditors." The court noted that the exclusion barred coverage for "any Claim brought or maintained by" a creditor, and because the plaintiffs were creditors at the outset and the exclusion was written in the disjunctive, the exclusion applied. ■

Insured-versus-Insured Exclusion Deemed Ambiguous as Applied to FDIC as Receiver

The United States Court of Appeals for the Ninth Circuit, applying California law, has held that an insured-versus-insured exclusion was ambiguous where the plaintiff FDIC, in its capacity as receiver, sued the directors and officers of a defunct bank. *St. Paul Mercury Ins. Co. v. Federal Deposit Ins. Corp.,* 2016 WL 6092400 (9th Cir. Oct. 19, 2016). The court also held that the policy's "unrepaid loan" carve-out from the definition of damages did not unambiguously bar coverage for damages that were based on loan charge-offs.

The FDIC filed suit against the directors and officers of a defunct bank in its capacity as the bank's receiver. The bank's D&O insurer argued that the insured-versus-insured exclusion barred coverage for the directors and officers. The district court disagreed, determining that the exclusion's language was ambiguous. The insurer also argued that the policy's "unrepaid loan carve-out" barred coverage for the damages sought by the FDIC. The district court found that this carve-out did not unambiguously bar coverage, reasoning that the FDIC did not seek loan repayment, but instead used charge-offs on loans to calculate the losses caused by the directors' and officers' allegedly tortious conduct in carrying out the bank's lending functions. The insurer appealed.

The Ninth Circuit affirmed, holding that the insured-versus-insured exclusion was ambiguous and must be construed in favor of the FDIC. The court reasoned that it was ambiguous whether the FDIC as a receiver was pursuing its claims against the directors and officers "on behalf of" the bank within the meaning of the exclusion because the FDIC "represents a number of interests and does not operate as a normal successor in interest." The court also noted that the exclusion did not refer to claims brought by the FDIC as receiver, and the insurance policy did not have a regulatory exclusion.

The court also affirmed the district court's holding regarding the unrepaid loan carve-out. The court emphasized that "it was reasonable for the insured to expect that the policy would provide coverage for damages awarded as a result of tortious mismanagement by the bank's directors and officers." Because the provision was subject to a reasonable interpretation that allowed coverage, the court affirmed the district court's holding that the carve-out did not bar coverage. ■

Insurer Has a Duty to Defend Lawsuits Potentially Seeking Damages Not Flowing From a Contractual Obligation

The California Court of Appeal has held that an errors and omissions insurer had a duty to defend lawsuits seeking amounts owed under contract because the lawsuits potentially sought non-contractual damages for breach of fiduciary duty and non-disclosure. *Health Net, Inc. v. Am. Int'l Spec. Ins. Co.,* 2016 Cal. App. Lexis 7296 (Cal. Ct. App. Oct. 6, 2016).

The insured, a managed care company, was sued in three consolidated class actions for violating the Employee Retirement Income Security Act (ERISA) by failing to pay the usual, customary, and reasonable charge for services by out-of-network medical providers to subscribers and beneficiaries of the insured's health plans. The insured sought coverage from its primary and excess errors and omissions insurers for the defense and indemnification of the consolidated class actions. In a previous appeal, the court held that no coverage was available under the policies for the insured's alleged failure to pay promised benefits under its health plans because amounts owed under contract are not covered damages. However, the appellate court remanded for the trial court to determine whether the plaintiffs sought relief other than amounts owed under contract. On remand, the trial court determined that the plaintiffs did not seek non-contractual damages. It also held that no coverage was available for one of the class actions based on the willful acts exclusion and Section 533 of the California Insurance Code and that the insured failed to state a claim against the excess insurers because the primary policy had not exhausted its policy limits. The insured appealed.

The appellate court held that the primary carrier

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Insurer Has a Duty to Defend Lawsuits Potentially Seeking Damages Not Flowing From a Contractual Obligation *continued from page 6*

had a duty to defend the underlying claims because plaintiffs potentially sought relief other than amounts owed under their health plans. First, the court determined that Section 502(a)(3) of ERISA, which provides for "appropriate equitable relief" for breaches of fiduciary duties and non-disclosures, did not preclude the award of damages other than amounts owed under a covered health plan. Second, the court held that the plaintiffs in the underlying actions potentially sought damages other than amounts under their health plans. Although not specifically alleged in the complaints, the court concluded that plaintiffs made allegations regarding fiduciary violations and non-disclosures to plan participants for which damages outside of amounts owed under health plans could have been awarded.

The appellate court also held that the trial court erred by ruling that the primary policy's willful acts exclusion and Section 533 of the California Insurance Code barred coverage for one class action. The exclusion barred coverage for claims "arising out of any Wrongful Act committed with the knowledge that it was a Wrongful Act." Section 533 provides that an insurer is "not liable for a loss caused by a willful act of the insured." The court rejected the insurers' argument that a finding by the court in the underlying action that the insured knowingly and willfully used outdated data to determine its reimbursement rates triggered these exclusions. The court reasoned that the underlying action did not completely arise from knowingly willful conduct because the plaintiffs alleged other conduct that did not arise out of the use of outdated data. The court further held that coverage for an alleged violation of the Racketeer Influenced and Corrupt Organizations Act was not precluded because the alleged predicate act could be proven by reckless rather than intentionally wrongful conduct.

The appellate court affirmed the trial court's dismissal of the insured's breach of contract cause of action against the excess insurers. The excess policies were not triggered until exhaustion of the primary policy's limits "solely as a result of actual payment of claims or losses thereunder." The court held that the primary insurer's exhaustion of its policy limits was a condition precedent to coverage under the excess policies, so the excess insurers had not failed to meet any contractual obligations owed to the insured. ■

Insured Lawyers' Material Misrepresentations Warrant Rescission and Coverage also Barred by Prior Knowledge Exclusion

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 the insurer is entitled to rescind a lawyers professional liability policy based on the insured attorneys' material misrepresentations in the insurance application. *Imperium Ins. Co. v. Shelton & Assocs. P.A.,* 2016 WL 5477635 (N.D. Miss. Sept. 29, 2016). The court also held that, even if the policy were not rescinded, the malpractice actions against the attorneys were excluded from coverage based on the policy's Prior Knowledge Exclusion.

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. While defending the underlying action under a reservation of rights, the insurer brought suit seeking a declaration, under the Prior Knowledge Exclusion, that it had no duty to defend or indemnify the two attorneys in connection with the lawsuit because the attorneys knew or could have reasonably foreseen that their failures with respect to representing their clients from 2007 to 2011 might later be the basis for a claim against them. The insurer also asserted that it was entitled to rescind the policy because the insured attorneys made material misrepresentations of fact in the insurance application.

The court agreed with the insurer, finding that the insured attorneys did in fact make a misrepresentation in the application for the insurance policy at issue when they responded "No" to the question: "After inquiry, are any attorneys in your firm aware. . . of any legal work or incidents that might reasonably be expected to lead to a claim or suit

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against them?" According to the court, the fact that the attorneys had been aware of their failures, which resulted in adverse judgments against their clients, made this answer a misrepresentation. Further, the court found the misrepresentation was material because the uncontested facts demonstrated that, had it known the true facts, the insurer would not have issued the policy to the attorneys without at least an incident exclusion for one of the actions.

The court further found that even if the policy were to remain in effect, the Prior Knowledge Exclusion would preclude coverage. That provision barred coverage for claims if "the Insured at or before the effective date knew or could have reasonably foreseen that such Wrongful Act might be expected to be the basis of a Claim." After first noting that neither the Mississippi Supreme Court nor the Mississippi Court of Appeals had yet addressed a similar exclusion, the court explained that it would apply the subjective/objective two-prong approach adopted by many other jurisdictions.

The court found that the attorneys' filing of motions in their client's case that sought to remedy their failure to take action on their client's behalf, which happened more than a year prior to the policy's effective date, shows that the insured attorneys were subjectively aware of the facts giving rise to the underlying malpractice action prior to the policy's effective date. The court then found that the objective prong was met because courts consistently find that when an attorney's negligent failures result in an adverse judgment against their client, a reasonable attorney could have reasonably foreseen the potential for a malpractice claim, and it did not matter that the attorneys' client never indicated that a malpractice claim would be brought. ■

Litigation Hold Letter Was Not a Claim

The United States District Court for the Western District of Oklahoma, applying Oklahoma law, has held that a litigation hold letter requesting that an insured preserve documents did not constitute a "claim" as defined by the excess liability policies at issue. *Colony Ins. Co. v. Chesapeake Energy Corp.,* 2016 WL 5416517 (W.D. Okla. Sept. 28, 2016).

The insurer issued two successive excess claims-made liability insurance policies to the insured for policy periods running from July 2012 to July 2013 and July 2013 to July 2014, with $1 million and $2 million, respectively in underlying limits. An individual was injured at the insured's well site in January 2013, and the insured settled the resulting lawsuit. Prior to the lawsuit, the insured received a litigation hold letter from the injured individual's attorney in February 2013, but the insured did not provide the insurer with a notice of circumstances until June 2014 when the underlying lawsuit was filed. The insurer paid a portion of the settlement, subject to an agreement with the insured that coverage issues would be litigated at a future time. In the ensuing coverage litigation, the insurer and the insured moved for summary judgment on the issue of whether the litigation hold letter was a claim that triggered the 2012-13 policy, or was a claim first made under the 2013-14 policy when the complaint was filed.

The insured argued that the litigation hold letter constituted a claim and therefore the 2012-13 policy was triggered. The insurer argued that the letter did not meet the definition of a claim and therefore the 2013-14 policy was implicated instead. The policy defined "claim" to mean "any demand or suit against any Insured for damages because of bodily injury, personal injury, or property damage." The policy defined notice of circumstance to mean "written notice by the Insured to the Company of any Occurrence or circumstances which appear likely to give rise to a Claim against the Insured."

The court determined that the litigation hold letter did not constitute a claim and that only the later policy for the 2013-14 policy period was triggered. The court explained that the letter's intent was to notify the insured that the injured individual was represented by counsel and to request that the policyholder preserve relevant records pertaining to the accident. The court observed that the letter did not demand damages, reference an attorney's lien or a claim or advise that a suit was imminent. The court also reasoned that, even if the insured regarding the litigation hold letter as a demand, it failed to take steps under the notice provisions of the 2012 policy in accordance with that belief, because the policyholder did not notify the insurer of the letter when it was received. ■

Insufficient Notice of Potential Claim Held to Bar Coverage

The United States District Court for the Southern District of New York, applying Pennsylvania law, has held that an insured's failure to provide sufficient notice of a potential claim during the policy period precluded coverage under its claims-made policy. *University of Pittsburgh v. Lexington Ins. Co.,* 2016 WL 4991622 (S.D.N.Y. Sept. 16, 2016).

The insured, an architectural firm, submitted a "notice of occurrence/claim" on the last day of the policy period of its claims-made insurance policy. The notice failed to provide certain information required by the policy's notice of potential claim provision, such as an "indication of the actual or alleged breach of any professional duty" or "a description of the professional services rendered which may result in a claim," and merely stated that the insured had been advised by its client, a university, that "this project is experiencing problems and delays in its early stages." When the insured did not provide any further information upon request, the insurer denied coverage on the grounds that the notice was insufficient.

The university ultimately sued the firm and, under an assignment of rights, instituted coverage proceedings against the insurer. In an earlier opinion, the court denied the university's motion for partial summary judgment, holding that the architectural firm's "perfunctory," "non-specific" notice was deficient because it did not provide the information required by the plain terms of the policy. At the court's invitation, the insurer then filed a motion for summary judgment seeking dismissal of the university's complaint.

The court granted the insurer's motion for summary judgment, holding that the university could not recover under the policy because the insured failed to provide sufficient notice of the potential claim before the policy expired. In so holding, the court disagreed with the university that the insured's failure to comply with the notice provisions of the policy should be excused because its compliance was "substantial." The court also rejected the university's argument that it should be entitled to recover under the policy because precluding coverage would create a "Catch-22" of no coverage under either the earlier policy or the subsequent policy. The court stated that the university's claims for coverage under the two policies involve different coverage and different facts. Further, the court opined that the insured was aware of the risks inherent in purchasing a claims-made policy and, if it wanted to avoid these risks, it could have purchased occurrence coverage. However, in this case, the court concluded that the insured's failure to comply with the claims-made policy's notice provisions precluded coverage under the policy. ■

No Coverage Available for Lawsuit Served on Insured after End of Extended Reporting Period

The Philadelphia County Court of Common Pleas, applying Pennsylvania law, has granted summary judgment in favor of an insurer, holding that coverage under a claims-made-and-reported policy is unavailable where an insured is not served with the lawsuit during the policy period or extended reporting period. *Wolf v. Liberty Ins. Underwriters, Inc.,* 2016 Phila. Ct. Com. Pl. LEXIS 359 (Phila. Ct. Com. Pl. Oct. 11, 2016).

The insured, an attorney, was sued for malpractice. The complaint was filed on December 22, 2014, but was not served on the insured until February 27, 2015. The insured sought coverage under his lawyer's professional liability policy, which expired on December 1, 2014 and included an automatic 60-day extended reporting period that ran through January 30, 2015. The insurer denied coverage for the malpractice suit because, while the lawsuit was filed during the policy's extended reporting period, the insured did not receive service of the lawsuit – and therefore the claim was not first made – until after the extended reporting period had expired. The insured filed a suit against the insurer seeking coverage, and the parties filed cross-motions for summary judgment.

The court granted the insurer's motion for summary judgment and denied the insured's motion, finding that coverage was unavailable for the lawsuit. The court determined that under the terms of the policy, which defined "claim" as "a demand received by [the insured]," the lawsuit did not become a "claim" until the insured received service of the writ of summons. The court noted that the insured probably would have received service during the extended reporting period had it been served correctly, but the claimant had erroneously attempted service at the insured's former address. However, the court stated that it could not "ignore the clear language of the Policy, nor circumvent the stipulated fact that [the insured] received a re-issued writ of summons beyond the Automatic Extended Reporting Period." ■

Absent Prejudice, Untimely Notice Does Not Preclude Coverage if Notice Provided During Renewal Policy Period

The Delaware Superior Court, applying Delaware law, has held that an insured's failure to provide timely notice of a claim during the applicable claims-made policy period does not preclude coverage when the insured renews the policy and provides notice of the claim during the renewal policy period, unless the insurer can prove prejudice as a result of the untimely notice. *Medical Depot, Inc. v. RSUI Indem. Co.,* 2016 WL 5539879 (Del. Super. Ct. Sept. 29, 2016).

The insured, a medical device company, received a demand letter on June 18, 2013, which threatened a class action lawsuit against the company if it did not bring itself into compliance with California law. In the letter, the claimant demanded that the company notify all customers who had purchased an allegedly defective product of their right to request a reasonable remedy, and suggested that an appropriate remedy might be to provide full refunds to those customers. The claimant subsequently filed a class action complaint against the insured on March 27, 2014. The insured was not served with the initial complaint; however, it was aware that the complaint had been filed. On June 12, 2014, the claimant filed an amended complaint, which was served on the insured on September 2, 2014.

The insured held two consecutive claims-made D&O policies with the same insurer, which covered the periods from June 15, 2013 to June 15, 2014 and June 15, 2014 to June 15, 2015. The policies defined "Claim" to mean, in relevant part, a "written demand for monetary relief" or a "civil proceeding for monetary relief which is commenced by Service of a complaint or similar pleading." The policies included a "New York Regulation 121 Disclosure Supplement," which defined "Claims-made relationship" to mean the time between the first policy issued to the insured and the expiration of the last policy issued to the insured "where there has been no gap in coverage."

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Absent Prejudice, Untimely Notice Does Not Preclude Coverage if Notice Provided During Renewal Policy Period *continued from page 10*

The supplement also stated that coverage is provided "only if the claim . . . is first made against the insured and reported to us in writing during the policy period, any subsequent renewal and any applicable discovery period." The policies also included a notice provision, which stated, in relevant part, that, as a condition precedent to coverage, the Insured must give written notice of the claim to the insurer "as soon as practicable after such Claim is first made," but no later than thirty days "after either the expiration date or any earlier cancellation date of this policy.

The insured first provided notice of the underlying action to the D&O insurer on September 9, 2014, during the renewal policy period. The insurer denied coverage on the grounds that the insured had failed to provide timely notice.

On cross-motions for summary judgment, the court determined that the Claim was first made during the 2013-2014 Policy Period, when the initial complaint was filed. The court explained that, although the complaint was not served on the insured, it constituted a claim because it was a demand for monetary relief of which the insured was aware. The court rejected the argument that the initial demand letter constituted a claim, noting that it contained no demand for money.

Based on the court's conclusion that the claim was first made during the initial policy period, the court found that the insured did not comply with the policies' notice provision as it failed to provide notice of the initial complaint "as soon as practicable" or within 30 days of the first policy's expiration date. However, the court went on to hold that, because the first policy was renewed, and because of the continuous claims-made nature of the insurer's relationship with the insurer as reflected in the New York Regulation 121 Disclosure supplement to the policies, the claim fell within the two-year period of claims-made insurance coverage provided by the consecutive policies. As such, the court held that the insurer must demonstrate prejudice in order to deny coverage on the grounds of late notice. As neither party had addressed prejudice in their respective summary judgment motions, the court did not grant either party's motion in its entirety. ■

"Reasonable Expectations" Doctrine Inapplicable Due to Unambiguous Effective and Retroactive Dates

The United States District Court for the Eastern District of Pennsylvania has held that a lawyer was not entitled to insurance coverage because he could not reasonably expect that his malpractice policy would provide coverage for acts occurring three months prior to the effective and retroactive date of the policy. *Downey v. First Indemnity Ins.,* 2016 WL 6033426 (E.D. Pa. Oct. 14, 2016).

After starting his own firm, the insured submitted an application for a new professional liability policy. The insured's policy with his prior carrier expired on August 18, 2007. Although the insured allegedly requested malpractice coverage that did not leave any gaps between his prior policy and the start date of his new policy, his application requested that coverage be effective as of October 1, 2007. The insurer issued a claims-made policy with an effective date and retroactive date of October 1, 2007. A complaint was later filed against the insured alleging that he had committed malpractice on July 5, 2007. The insurer denied coverage and the insured sued, alleging that he had been orally promised that there would be no gaps in coverage.

The court held that the insured was not entitled to coverage for the claim because the policy afforded coverage only for claims for wrongful acts occurring on or after October 1, 2007. The court also held that the "reasonable expectations" doctrine did not apply. The court noted that the insured, a lawyer, was not the type of unsophisticated consumer whom the reasonable expectations doctrine was designed to protect. The court also concluded that the insured had received precisely the coverage that he had requested, highlighting the insured's application and the insurer's quote, and thus determined that no reasonable fact finder could conclude that the insured possessed a reasonable expectation of coverage for acts occurring prior to October 1, 2007. ■

Coverage Not Illusory Where Coverage is Unavailable for Claims Failing to Satisfy a Claims-Made-and-Reported Policy's Requirements

The United States District Court for the Southern District of Indiana has held that coverage under a claims-made-and-reported policy is not illusory where coverage is unavailable for claims that do not satisfy the policy's claims-made, reporting, and retroactive date requirements. *Sunshine v. Gen. Star Nat'l Ins. Co.,* 2016 WL 5371848 (S.D. Ind. Sept. 26, 2016).

The insured, a real estate appraisal service, was sued for alleged misrepresentations and inaccuracies in a real estate appraisal. The insured maintained errors and omissions policies from two insurers and sought coverage for the lawsuit under both policies. The appraisal was performed by the insured during the policy period of one insurer, and the claim was first made during the policy period of the second insurer. The insurers denied coverage because the claim was either not made during the policy period or the underlying wrongful act occurred before the later policy's retroactive date. The insured filed a suit against the insurers for breach of contract, or alternatively, that coverage under the policies was illusory.

The court granted the insurers' motions to dismiss the insured's claims. The court dismissed the insured's breach of contract claim because the insured failed to satisfy the policies' requirements that (1) the alleged wrongful act occur after the retroactive date; (2) the claim be made during the policy period; and (3) the claim be reported during the policy period. Because the insured failed to plead a breach of contract claim, the court also dismissed the insured's bad faith and deception claims against the insurers. In addition, the court held that coverage under the policies was not illusory, and that the retroactive dates limiting coverage to wrongful acts two or three years before the start of the policy periods was reasonable. ■

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