Wiley Rein LLP

EXECUTIVE SUMMARY

Legal Developments Affecting Professional Liability Insurers | December 2016

Excess Insurer's Unambiguous Consent-to-Settlement Provision Bars Coverage

The United States Court of Appeals for the Sixth Circuit, applying Michigan law, has held that a policy provision requiring an excess insurer's written consent before entering into a settlement was not ambiguous and therefore barred coverage under the excess policy. *Stryker v. National Union Fire Ins.,* 2016 WL 6818853 (6th Cir. Nov. 18, 2016).

The insured, a manufacturer of biomedical devices, was sued for personal injuries by individual claimants. In a separate suit, another company sought indemnification from the insured. The insured settled the individual claims against it and was ultimately found liable to the other company. After the insured's primary insurer denied coverage for the claims, a court issued a declaratory judgment that the primary insurer was obligated to provide coverage. The primary insurer thus paid out the indemnification amount owed to the other company, thereby exhausting its limits and leaving unpaid the settlements with the individual claimants. Thereafter, the insured filed a supplemental complaint against its excess insurer to recover the remaining amount it paid to settle the individual actions. The excess insurer disputed its coverage obligation because the insured had failed to obtain its written consent at the time the insured settled, as required under the excess policy's definition of "ultimate net loss." The trial court granted summary judgment in favor of the insured, concluding that the excess carrier's policy language was ambiguous.

On appeal, the court reversed and determined that the policy language was not ambiguous because a reasonable person would know that the policy required the excess insurer's written consent for any and all settlements. Because the insured did not satisfy the consent requirement, its direct settlements with the individual claimants did not constitute "ultimate net loss" under the excess policy and were therefore not covered. The court rejected the insured's argument that the term "claims" encompassed liability for settlements made without consent, so long as the compromise originally occurred

continued on page 2

ALSO IN THIS ISSUE

Excess Insurer's Unambiguous Consent-to-Settlement Provision Bars Coverage

continued from page 1

below the excess insurer's layer. The court explained that the policy itself defined the term "claim" only in two ways: liability established either by "adjudication" or by "compromise with the written consent" of the excess insurer.

Further, the court rejected the insured's argument that the excess insurer had violated the implied covenant of good faith and fair dealing because the timeliness of the insured's request for consent was not a valid basis for refusing consent under the policy. The court determined there was no basis for such an argument because the policy language did not allow for the excess insurer to give retroactive consent for the settlements. Finally, the court rejected the insured's contention that the excess insurer waived its rights under the "consent to settle" provision because it denied liability and wrongfully refused to defend. Rather, the court found that the primary insurer's wrongful denial could not be imputed to the excess insurer simply because the excess insurer's policy followed form. The court determined that the excess insurer's policies contained provisions that were unique from the primary insurer's policy, and as such, the primary insurer's denial did not automatically release the insured from the excess insurer's "consent to settle" requirement. ■

Insured's Settlement Without Regard to Reasonableness Rendered Consent Judgment Unenforceable Against Insurer that Breached Duty to Defend

The United States Court of Appeals for the Eleventh Circuit, applying Florida law, has held that an insurer's breach of the duty to defend did not render it liable for a consent judgment where the insured did not consider the reasonableness of the settlement amount. *Sidman v. Travelers Cas. & Sur.*, 2016 WL 6803034 (11th Cir. Nov. 17, 2016).

The insured, a homeowners' association, was sued by a resident. The homeowner prevailed and, under a state statute, was entitled to attorneys' fees. The insurer denied coverage for the fee claim, however, and the insured entered into a consent judgment with the claimant. In later proceedings, the court determined that the insurer breached its duty to defend and indemnify the insured in connection with the fee claim. After a bench trial, however, the court ruled that the insurer was not bound by the settlement because the settlement was neither reasonable in amount nor negotiated in good faith. The claimant appealed.

On appeal, the court affirmed. First, the court noted that an insurer that breaches its duty to defend is liable for a settlement entered into by its insured unless the agreement is obtained through "fraud or collusion." The court rejected the claimant's argument that the insurer knew about and acquiesced to the settlement – and thus waived its objections based on fraud or collusion – noting that there was "no such rule in Florida law." Second, the court ruled that the evidence supported the district court's refusal to bind the insurer to the settlement. The court noted that the evidence supported the trial court's finding that the insured agreed to settle the claim for any amount in exchange for the claimant's agreement not to execute the judgment against it. According to the court, that evidence was sufficient to find that the settlement agreement was negotiated in bad faith, thus eliminating the need to consider whether the settlement was reasonable in amount. The court also rejected the claimant's argument that the settlement was not collusive as a matter of law because the claimant and insured never agreed to share the settlement proceeds, concluding instead that although such an agreement would be sufficient to establish collusiveness, it was not necessary to find collusion. ■

Sixth Circuit Enforces 24-Month Contractual Limitations Period In Bond; Employee's Knowledge Bars Coverage for Company Under E&O Policy

The United States Court of Appeals for the Sixth Circuit, applying Michigan law, has held that an insured securities broker-dealer's failure to bring legal proceedings within the 24-month period specified by its financial institution fidelity bond precluded coverage for losses resulting from an employee's embezzlement scheme. *Hantz Fin. Servs., Inc. v. Am. Int'l Specialty Lines Ins. Co.*, 2016 WL 6609544 (6th Cir. Nov. 9, 2016). The court also held that the insured's errors and omissions policy did not respond because the wrongful acts by the employee were "committed with knowledge that [they were wrongful acts]."

The employee's embezzlement came to light in March 2008. By May 2008, the company determined that the employee had embezzled more than $2.6 million from twenty-two clients. Although the company ended up settling nearly all of the claims asserted against it by the affected clients, one couple's claim proceeded to a FINRA arbitration, with an award entered in their favor in June 2010. The state circuit court entered judgment confirming the award on December 17, 2010, and the court of appeals affirmed the judgment on January 24, 2012.

While working to settle and litigate the affected clients' claims, the broker-dealer sought coverage under both its bond and its E&O policy. To this end, the insured provided the bond insurer with a sworn proof of loss in May 2008. Over the following two and a half years, the insurer and broker-dealer traded communications, with the insurer requesting information for its investigation and the insured responding to those requests and updating the insurer on the status of the claim. The insurer ultimately denied coverage under the bond in March 2011, and the broker-dealer brought suit against the insurer on March 18, 2013. The broker-dealer also brought suit against its E&O insurer, which had likewise denied coverage.

With respect to the bond, the Sixth Circuit affirmed the entry of judgment in favor of the insurer on the grounds that the bond prohibits the insured from bringing a legal proceeding against the insurer to recover its losses "after the expiration of 24 months from the date of … final judgment or settlement." In reaching this conclusion, the court rejected the insured's argument that the time for filing suit did not begin to run until the underlying judgment was affirmed on January 24, 2012. According to the court, under Michigan law, a "final judgment" refers to a trial court's order ending the litigation at that level, and not when all appeals are exhausted. The court also rejected the insured's contention that the insurer had waived the limitations period by conducting a lengthy investigation of coverage and by raising certain potential grounds for denial, while at the same time failing to advise the insured that it would enforce the limitations period. The court found that "the insurer's failure to specify which defenses it would assert does not constitute a waiver of those defenses by any stretch."

As to the E&O policy, the court concluded that coverage was barred by the policy's "Wrongful Acts Exclusion," which precluded coverage for losses in connection with "any actual or alleged Wrongful Act committed with knowledge that it was a Wrongful Act." The parties conceded that the broker knowingly stole client funds, but the broker-dealer argued that it nonetheless was entitled to coverage because only the employee, and not the company, had knowledge of the wrongdoing. The court, however, found the insured's reading of the provision "strained" and held that the employee's knowledge precluded coverage for both the company and the employee, who were both insureds under the policy. ■

Bank's Failure to Submit Proof of Loss Precludes FDIC's Claim as Receiver Under Crime Bond

The Court of Appeals for the Tenth Circuit, applying Colorado law, has held that an insurer's denial of coverage to the Federal Deposit Insurance Corporation (FDIC), standing in the shoes of an insured as receiver, does not violate public policy where the insured's rights under a policy have not vested. *FDIC v. Kan. Bankers Sur. Co.,* 2016 WL 6440367 (10th Cir. Nov. 1, 2016). The court also held that the FDIC forfeited two arguments related to policy interpretation on appeal.

A bank was insured under a financial institution crime bond. The bond contained two pertinent provisions: (1) if the insurer elected not to defend the bank against a lawsuit for covered loss, the bank's deadline for submitting a proof of loss would be extended until six months after settlement or adjudication of such lawsuit, and (2) because the bond terminated upon the taking over of the bank by a receiver, a proof of loss was required to be submitted to the insurer prior to the takeover of the bank by a receiver in order for the receiver to obtain coverage under the bond.

The bank was sued in early 2009 by a borrower for alleged misconduct by the bank in connection with a $50 million loan. The insurer declined to defend the bank. Prior to the bank sending the insurer a proof of loss, a bank commissioner closed the bank and appointed the FDIC as receiver. After settling the borrower's claim, the FDIC sought coverage under the bond, which the insurer refused based on the bond's proof of loss provision. The FDIC filed suit. A district court ruled in favor of the insurer, holding that because the bank did not complete a proof of loss before the FDIC's takeover, the FDIC could not recover under the bond. The FDIC appealed, raising three arguments.

The appeals court affirmed, holding that the FDIC had forfeited two of its arguments – that the bond language was non-standard and that the bank had substantially complied with the proof of loss requirement – by failing to raise them before the district court. As to the third argument, the FDIC argued that the district court's interpretation of the proof of loss condition violates public policy because it restricts the exercise of the bank's rights held by the FDIC. The FDIC relied on *FDIC v. St. Paul Companies*, 634 F. Supp. 2d 1213 (D. Colo. 2008), where a court held that the FDIC's takeover did not terminate coverage because the insured need only have discovered the loss prior to the takeover. The FDIC argued that, similarly, the insured bank had discovered the loss prior to the FDIC's takeover and so the FDIC had the right to enforce coverage.

The court first noted that both federal and Colorado law expressly permit insurance provisions to limit the broad powers of receivers, like the FDIC. Second, the court held that, even standing in the bank's shoes, the FDIC had no right to enforce coverage. In particular, unlike *St. Paul Companies* where the bond contained no express language requiring a proof of loss, the proof of loss provision here required strict compliance as a condition precedent to coverage. Because the bank did not submit a proof of loss in accordance with the provision, the bank never acquired the right to coverage and, therefore, neither did the FDIC. ■

Eleventh Circuit Finds Claims to be Related Even Though They Are Based on Different Legal Theories

Applying Tennessee law, a federal appellate court has held that pre-policy demands and later-made claims were related notwithstanding the fact that the demands and claims may have relied on different legal theories. *Direct Gen. Ins. Co. v. Indian Harbor Ins. Co.*, 2016 WL 5437062 (11th Cir. Sept. 29, 2016).

The insured, a Tennessee insurer that issues automobile policies in Florida providing personal injury protection, sought coverage under its primary and excess liability insurance policies for numerous demands and lawsuits regarding the insured's payment of personal injury protection benefits under a Florida statute. Pursuant to that statute, the insured reimbursed medical providers using a "fee schedule method" of calculation. During the relevant policy period, the insured provided notice of a class action complaint alleging that the insured underpaid personal injury protection benefits, which subsequently was amended to assert that the insured's use of the "fee schedule method" was unlawful. Several years later, the insured provided notice of 70,000 additional claims that it asserted related to the claims first made during the earlier policy period. The insured also identified additional demands it received prior to the inception of the relevant policy, but the insured asserted that the pre-policy demands were not "claims" for "wrongful acts." The insured argued that the pre-policy demands were not related to the later claims because they did not assert that the insured improperly used the "fee schedule method" to calculate benefits.

The policies issued by the excess carriers provided coverage on a "claims-made" basis. The policies defined "Related Claims" as "all Claims for Wrongful Acts based on or directly or indirectly arising out of or resulting from the same or related . . . series of facts, circumstances, situations, transactions or events." The excess carriers took the position that all of the claims and pre-policy demands were related such that they constituted a single claim made prior to the inception of the excess policies.

In affirming the lower court's decision granting the excess carriers' motion for summary judgment, the appellate court rejected the insured's theory that the pre-policy demands did not rely on the same legal theory as the claims made during the policy period and, therefore were not related. Rather, the appellate court explained that the policy's definition of "Related Claims" did not require the same legal theory and pointed to other direct links between the pre-policy demands and the claims made during the policy period in support of its decision, including that the same claimant that asserted a pre-policy demand later filed suit during the policy period.

The appellate court also disagreed with the insured's argument that relating the pre-policy demands with the later-made claims rendered the definition of "Related Claims" limitless and coverage illusory because the insured itself applied the definition to relate 70,000 claims. ■

Professional Services Exclusion Bars Coverage for False Claims Act Suit Against Online Education Servicer

The United States District Court for the Northern District of California, applying California law, has held that a professional services exclusion bars coverage under a directors and officers liability policy for an online education program servicer against an action under the False Claims Act, holding that the False Claims Act allegations at issue arose out of the professional services provided by the insured. *HotChalk, Inc. v. Scottsdale Ins. Co.*, 2016 WL 6818760 (N.D. Cal. Nov. 15, 2016).

The insured education servicer assists universities creating or expanding online degree programs. A set of plaintiffs filed a *qui tam* action against the insured under the federal False Claims Act, alleging violations of Title IV of the Higher Education Act, which prohibits institutions receiving education grants from providing commissions or bonuses to admissions or financial aid employees for generating additional enrollments or student loans. The court noted in its opinion that the Act's legislative history shows Congress desired to regulate the services provided by third parties like the insured to protect student borrowers and the government's financial interests. The *qui tam* plaintiffs alleged that the insured provided illegal compensation to student recruiters while it falsely certified compliance with Title IV. The insured settled the *qui tam* suit with the plaintiffs and United States government and then sought coverage from its D&O insurer, which filed a motion for judgment on the pleadings that the professional services exclusion in the policy barred coverage for the underlying *qui tam* action.

The court granted the insurer's motion, holding that the policy's professional services exclusion, which bars coverage for any claim "arising out of . . . the rendering or failing to render professional services," applied. The court noted that the policy did not define the term professional services, but the insured conceded that providing support for universities seeking to add or grow online education programs constituted professional services. The insured argued, however, that the Title IV dispute "related strictly to its employee compensation system" and the exclusion thus did not apply. The court disagreed, finding that the underlying suit could only be maintained because the insured provided professional education services that made the Title IV requirements applicable at the outset. Furthermore, the court reaffirmed that the phrase "arising out of" as used in a policy exclusion is broad and requires only a minimal factual relationship "between the excluded activity and the action underlying the lawsuit." In light of this, the court held that no coverage exists where, as here, the causal connection is "tight," concluding that absent those professional services, the insured would not have been subject to the underlying suit in the first instance ■

Suit for Reimbursement of Beauty School Expenses Under California Labor Law Triggers Duty to Defend Despite Wage and Hour Exclusion

The United States District Court for the Southern District of California, applying California law, has held that an employment practices liability policy's wage and hour exclusion does not apply to a claim for reimbursement of reasonable business expenses under the California Labor Code. *Hanover Ins. Co. v. Poway Acad. of Hair Design, Inc.,* 2016 WL 6698936 (S.D. Cal. Nov. 14, 2016).

The insureds, two beauty academies, were sued by a student for payments for her work in one of the academy's teaching salons. The student's complaint alleged six claims against the insureds under the California Labor Code (CLC), including a claim for reimbursement of reasonable business expenses under CLC § 2802. In particular, the student sought reimbursement for a "kit" of beauty tools and educational materials that the academy required her to purchase in order to work at the salon.

The two beauty academies had employment practices liability insurance policies that contained a wage and hour exclusion for claims for loss arising out of a violation of any state law "that governs wage, hour and payroll policies and practices." The insurer denied coverage and instituted coverage litigation. The insureds admitted that five of six of the student's claims fell under the exclusion but argued that the student's claim under CLC § 2802 for reimbursement of expenses was not excluded, triggering the insurer's duty to defend the entire lawsuit.

The court denied the insurer's motion for summary judgment, holding that CLC § 2802 is not a wage and hour law. The court found that CLC § 2802 has broader purposes than a typical wage and hour statute, such as providing employee indemnification for third-party suits. The court also reasoned that the kit at issue included educational materials, and reimbursement for such materials would not necessarily be compensation. While the court acknowledged that at least one other case characterized a similar claim as one for reimbursement of wages, the court opined that it is unclear whether CLC § 2802 is a wage and hour claim under California law, and so the insurer had to defend the insured's suit.

The court also denied the insurer's claim for reimbursement of defense costs for the non-covered claims. While the court acknowledged the insurer's right to recoupment, the court found that the insurer had not proven, by a preponderance of the evidence, that the defense costs it sought were allocated solely to the non-covered claims. ■

“Other Insurance” Clause Does Not Create Right to Equitable Contribution Against Excess Policy

The United States District Court for the District of Arizona, applying Arizona law, has held that the “other insurance” clauses in two policies are not “mutually repugnant” to enable the primary insurer to receive equitable contribution from an excess insurer where the “other insurance” clause in the primary policy stated that the clause does not apply if the other policy is written to apply as excess insurance. *Admiral Ins. Co. v. Community Ins. Group SPC Ltd.,* 2016 WL 6873345 (D. Ariz. Nov. 22, 2016).

The insured physician was sued for medical negligence. The physician maintained his own professional liability policy and was also insured by a policy maintained by the clinic that employed him. The physician sought coverage under his own professional liability policy for the lawsuit. After settling the lawsuit against the physician, the physician’s insurer filed an action against the clinic’s insurer, seeking equitable contribution for the defense and settlement payments it made on behalf of the physician.

The physician’s insurer asserted that both policies provided coverage for the physician as primary policies and therefore it was entitled to equitable contribution from the clinic’s insurer. The clinic’s insurer asserted that its policy provided only excess coverage for the physician, and accordingly, it was not required to contribute toward payments made on behalf of the physician because the amounts paid did not exceed the limit of liability of the physician’s policy.

The court granted summary judgment for the clinic’s insurer, holding that the clinic’s policy provided only excess coverage. The court determined that the clinic’s policy provided only excess coverage for employees who maintained their own insurance based on the policy’s “other insurance” clause, which stated that if any employee maintained another policy covering the insured loss, the clinic policy would be excess over the employee’s own policy. The court rejected the argument by the physician’s insurer that because its policy also contained an “other insurance” clause, the two clauses were “mutually repugnant” and therefore under Arizona law both insurers would be treated as primary insurers. The court concluded that although the “other insurance” clause in the physician’s policy made it an excess policy in some cases, the clause clearly stated that “[t]his condition does not apply to ‘other insurance’ that is written to apply in excess of the limits provided by this policy.” ■

Embezzling Payroll Service Providers Were "Employees" of Insured, Triggering Crime Coverage

A federal district court in North Carolina has granted an insured's motion for summary judgment, holding that it was entitled to coverage under its crime policy for embezzlement by its payroll service provider because the payroll service provider constituted an "employee" under the terms of the policy. *Colony Tire Corp. v. Federal Ins. Co.,* 2016 WL 6683590 (E.D.N.C. Nov. 14, 2016).

The insured, an automotive parts and service retailer, retained a service provider to handle its payroll and taxes beginning in 2002. In 2014, the insured discovered that the service provider's two founders, sole owners, and managers had embezzled from clients, including the insured. The insured sought coverage under a commercial crime coverage part for nearly $500,000 in loss due to the embezzlement. The insurer denied coverage, and the insured sought a declaratory judgment that its loss was covered by the policy.

The court held that the service providers' founders were "employees" under the policy, triggering coverage under the employee theft insuring clause, because "employee" was defined to include "any contractual independent contractor." The policy specified that a "contractual independent contractor" must be (1) a natural person; (2) while in the regular service of an organization in the ordinary course of such organization's business; (3) pursuant to a written contract for services between such organization and either the natural person or any other entity acting on behalf of the natural person.

The insurer argued that the individuals who had embezzled the funds from the insured were not "contractual independent contractors" because, in forming its contract with the insured, the service provider entity was not "acting on behalf of" the individuals. The insurer contended that under North Carolina law, a corporation could only act through its agents, and not on behalf of them. The court held that, while it is true that a corporation may only act through its agents, it does not follow that a corporation cannot also act on their behalf, noting that the policy language defining contractual independent contractors clearly contemplates that an entity may act on behalf of an individual. The court concluded that, because the individuals who had embezzled were "contractual independent contractors" and therefore "employees" under the policy, the policy applied to the embezzlement claim. ■

Subjective Standard Applies to Rescission of E&O Policy Based on Response to Application Question

The United States District Court for the Southern District of Ohio, applying California law, has held that an errors and omissions insurer is not entitled to rescission of its policy based on an alleged misrepresentation by the insured on the application for the policy. *Maxum Indem. Co. v. Nat'l Condo & Apartment Ins. Grp.*, 2016 WL 6628490 (S.D. Ohio Nov. 9, 2016). In so holding, the court applied a subjective standard to the question of the insured's knowledge because the language of the application did not specifically indicate that an objective standard applied.

The insured wholesale insurance broker had entered into a business relationship whereby it issued quotes and binders for property insurance coverage to a retail insurance broker, which the retail broker then issued to its own clients. Although the quotes and binders issued by the wholesale broker listed two

continued on page 10

Subjective Standard Applies to Rescission of E&O Policy Based on Response to Application Question *continued from page 9*

insurance carriers, those companies had never issued or approved the policies. Upon learning of their lack of valid insurance, some of the property owners filed suit against the retail broker, which in turn filed third-party claims and cross-claims against the wholesale broker. The wholesale broker sought coverage for the retail broker's claims under its E&O policy.

The E&O carrier filed a declaratory judgment action to rescind the policy or alternatively for a declaration that the policy's prior knowledge exclusion barred coverage. It pointed to a cease-and-desist letter sent to the wholesale broker by one of the purported insurance carriers prior to the application date. The E&O insurer also pointed to several additional communications received by the wholesale broker before the policy incepted, including a cease-and-desist letter by the other purported insurance carrier and a letter from the Illinois Department of Insurance advising that the wholesale broker had issued binders that may not constitute legally valid insurance.

The district court granted summary judgment in favor of the insurer on the prior knowledge exclusion, which barred coverage for any claim arising out of or resulting from any wrongful act or related information of which the insured had knowledge prior to the policy inception date and which may result in a claim. However, the U.S. Court of Appeals for the Sixth Circuit reversed and held that the policy covered the claims by the retail broker as a matter of law because a subjective standard governed the application of the exclusion, and the communications at issue did not give the wholesale broker knowledge of a wrongful act that may result in a claim.

On remand, the insurer moved for summary judgment on its entitlement to rescind the policy based on the wholesale broker's failure to disclose the communications in response to an application question which asked if the applicant had "any knowledge of any potential errors or omissions claims." The court held that the application question regarding potential claims had the same meaning as the prior knowledge exclusion. Because the Sixth Circuit had already held as a matter of law that the communications at issue did not implicate the exclusion, the court held the insurer likewise could not rescind based on the application response.

The insurer argued that an objective standard should apply to the question of rescission—i.e., that it need only show that an objectively reasonable person would consider the communications to be potential claims—even though a subjective standard governed the applicability of the exclusion. The court rejected this argument because the application did not contain any language indicating that an objective standard would apply, and California law requires that ambiguities in insurance policies and applications be construed in favor of coverage.

The court concluded that the insurer breached the policy by refusing to defend or indemnify the wholesale broker. The court further held that the retail broker, as a judgment creditor of the wholesale broker, was a third-party beneficiary under the policy and had standing to recover against the insurer. ■

Under Errors and Omissions Policy, No Duty to Defend Suit Alleging Only Intentional Misconduct

The Court of Appeals of Indiana, applying Indiana law, has held that an insurer had no duty to defend its insured against a complaint alleging only intentional misconduct where the policy covered only negligent acts, errors and omissions. *Mt. Vernon Fire Ins. Co. v. Louis Jancetic,* 2016 WL 6584268 (Ind. Ct. App. Nov. 4, 2016). The court further held that the insurer had not engaged in any conduct that would estop it from denying coverage.

The insured, a real estate agency, assisted in the sale of a property. After the sale, the buyer sued the seller and the insured alleging that they knowingly failed to disclose a mold problem with the property at the time of the sale. The insured tendered the complaint to its insurer under an errors and omissions policy, which, pursuant to its terms and conditions, covered negligent acts, errors, or omissions. The policy also excluded coverage for any claim "arising out of . . . any actual or alleged . . . dishonest, fraudulent, criminal or malicious act or omission or deliberate misrepresentation committed by, at the direction of, or with the knowledge of any Insured." The insurer immediately denied coverage, and the insured did not dispute the denial.

After settling with the seller, the buyer pursued its claim against the insured real estate agency and obtained a judgment against the insured. The buyer then sought to recover the amount of the judgment from the insurer under the policy. The trial court denied the insurer's motion for summary judgment and ultimately entered judgment against the insurer.

On appeal, the court reversed, concluding that the policy clearly and unambiguously excluded coverage for intentional misrepresentations. In so holding, the court noted that the insured's policy covered only negligent acts, errors or omissions, and the buyer's sole claim against the insured was for intentional misconduct. Thus, the buyer could not meet his initial burden of showing that the claim fell within the scope of the policy's coverage. The court also concluded that, because the insurer denied coverage from the start and had no further involvement in the case until the buyer sought recovery under the policy directly, it had not engaged in conduct that would estop it from denying coverage. The court reversed and remanded to the trial court with instructions to enter summary judgment in the insurer's favor. ■

Misappropriation of Funds Exclusion Precludes Coverage for Accounting Firm's Erroneous Transfer of Client Funds to Third-Party Fraudsters

A federal district court in Connecticut has granted an insurer's motion to dismiss a breach of contract claim by an accounting firm, holding that the firm's professional liability policy's exclusion for theft, misappropriation, commingling, or conversion of funds precluded coverage for a claim against the insured for completing fraudulently requested transfers of funds. *Accounting Resources, Inc. v. Hiscox, Inc.*, 2016 WL 5844465 (D. Conn. Sept. 30, 2016). The court rejected the insured's argument that the exclusion applied only to misappropriation or conversion by the insured or its employees.

The insured accounting firm provided bookkeeping and accounting services for a client, including paying the client's vendors on its behalf. A third party compromised the client's email server and sent fraudulent email requests for vendor payments to the insured. The insured completed the transactions, wiring more than $500,000 to bank accounts presumably controlled by the third party. After the loss was discovered, the client blamed the insured, and the insured sought coverage under its professional liability policy. The insurer denied

continued on page 12

Misappropriation of Funds Exclusion Precludes Coverage for Accounting Firm's Erroneous Transfer of Client Funds to Third-Party Fraudsters *continued from page 11*

coverage based on a policy exclusion barring coverage for "any damages or claim expenses, for any claim . . . based upon or arising out of the actual or alleged theft, misappropriation, commingling, or conversion of any funds, monies, assets, or property." The insured then filed an action against the insurer for breach of contract.

The court held that the exclusion was unambiguous and precluded coverage for the claim. The insured argued that the exclusion barred coverage only for theft, misappropriation, commingling, or conversion of funds by the accounting firm or its employees, and not for the negligence of the insured in contributing to or failing to prevent those acts by others. The court concluded, however, that the exclusion contained no limitation regarding who must engage in the theft, misappropriation, commingling, or conversion and, as a result, the exclusion applied regardless of who engaged in those acts. According to the court, the fact that other exclusions (e.g., the intentional acts exclusion) did specify to whose acts the exclusion applied supported its conclusion, because the parties plausibly could have drafted a similar limitation on the theft of funds exclusion. The court also noted that the exclusion's lead-in language, which included "arising out of," contemplated even an indirect causal connection, which would include wrongful conduct by third parties that goes undetected and unexposed by the insured. The court therefore granted the insurer's motion to dismiss. ■

No Coverage for Claims Arising Out of Attorney's Theft of Client Funds Before Policy Period

The United States District Court for the Middle District of Tennessee, applying Tennessee law, has held that an insurer had no duty to defend or indemnify an insured attorney for claims arising out of his theft from his clients' estates because the attorney had knowledge of the theft and could reasonably foresee a claim before the inception of the policy, and the claims were all related. *Hanover Ins. Co. v. Clemmons,* 2016 WL 5724213 (M.D. Tenn. Sept. 30, 2016).

The insured attorney had pleaded guilty to stealing from the estates of several of his clients and had been sentenced to prison and disbarred. The attorney had been appointed by the probate court as conservator over the property of two individuals and later the administrator of the estate of one of the individuals. After the attorney had failed to file proper accountings of the estates, the probate court removed him from his role. The successor conservator filed suit against the attorney, alleging that the attorney breached his fiduciary duty to each estate by failing to account for assets and by misappropriating and converting estate funds for his own use. The attorney's professional liability insurer filed a coverage action for a declaration that it had no obligation under its policy with respect to the claims against the attorney. Subsequently, the successor conservator amended his complaints against the attorney to add professional negligence claims based on the attorney's failure to obtain a surety bond in the amount required by Tennessee statute.

The insurer's policy provided coverage only for claims for which the insured attorney "had no knowledge of facts which could have reasonably caused [him] to foresee a claim, or any knowledge of the claim, prior to the effective date of the policy." In responding to the insurer's motion for summary judgment, the successor conservator did not dispute that coverage was unavailable for the misappropriation and conversion claims against the attorney because, having stolen from his clients' estates, the attorney could have reasonably foreseen these claims. The court agreed, applying a mixed subjective-objective test and finding that the attorney had knowledge that the policy would not provide coverage for his

continued on page 13

No Coverage for Claims Arising Out of Attorney's Theft of Client Funds Before Policy Period

continued from page 12

theft. The court also held that the claims were not covered because they related directly or indirectly to: (1) admitted fraudulent, dishonest, and criminal acts; (2) personal profit from estates; and (3) conversion, misappropriation, and intentional or illegal use of estate funds, all of which were excluded from coverage.

With respect to the negligence claims, the successor conservator argued that a reasonable attorney could not foresee a claim resulting from obtaining surety bonds in an amount lower than required by statute because the probate court had approved the bonds. The court rejected this theory, concluding that the negligence claims were excluded as related to the conversion and misappropriation claims. The court held that the prior knowledge exclusion also barred coverage for the negligence claims because the attorney "knew the 'nature of the injury' he had inflicted on his clients and that he would likely be subjected to lawsuits as a result, even if he did not correctly anticipate the precise nature of the claims that injured parties would raise." Likewise, the three exclusions also barred coverage for the negligence claims. In so ruling, the court rejected the successor conservator's argument that the concurrent cause doctrine warranted coverage for the negligence claims, emphasizing that the policy's exclusions had broad lead-in language for claims "based upon, arising out of, or related directly or indirectly" to the excluded conduct. ■

No Action Clause Does Not Bar Insured's Duty to Defend/Bad Faith Claims Against Insurer

The United States District Court for the Western District of Oklahoma has held that, under Oklahoma law, a policy's "no action" clause does not apply to an insured's breach of contract claims against its insurer premised on a breach of the duty to defend the underlying claim. *Wilbanks Securities Inc. v. Scottsdale Ins. Co.,* 2016 U.S. Dist. LEXIS 144761 (W.D. Okla. Oct. 19, 2016). In so holding, the court explained that the "no action" clause "is a provision that applies to the claims of third parties" and specifically those claims "seeking recovery of settlements or judgments and not declaratory judgments regarding the duty to defend."

The insured, a financial services firm, sought coverage from its insurer under its financial services professional liability policy after the Financial Industry Regulatory Authority (FINRA) and former clients instituted arbitration proceedings against it and certain of its officers. The insurer concluded it had no duty to defend or indemnify the insured. The insured responded by filing a declaratory judgment action against the insurer, seeking a declaration that the insurer had a duty to defend the ongoing arbitration, as well as asserting claims for breach of contract and bad faith.

The insurer moved to dismiss, arguing that the declaratory relief sought and claim for breach of contract failed because the insured could not satisfy the condition precedent of the policy contained in the "no action" clause. The "no action" clause provided, in relevant part, that "[n]o suit or other action may be brought against [the insurer] unless . . . . the obligation of the insured to pay 'damages' has been finally determined either by judgment against the insured after actual trial or arbitration or by written agreement signed by the insured, claimant and [the insurer]."

The court rejected this argument and denied the insurer's motion to dismiss. According to the court, the cases relied on by the insurer where Oklahoma

continued on page 14

No Action Clause Does Not Bar Insured's Duty to Defend/Bad Faith Claims Against Insurer

continued from page 13

courts had concluded that the insured could not recover under the policy due to the "no action" clause were inapposite as they did not involve the duty to defend and instead involved direct actions by third parties or situations where the insurer was never asked to provide a defense. Instead, the court relied on the United States Court of Appeals for the Tenth Circuit's decision in *Paul Holt Drilling, Inc. v. Liberty Mutual Ins. Co.,* 664 F.2d 252 (10th Cir. 1981), which determined that Oklahoma courts would hold that the "no action" clause is intended to apply only to claims made by third parties and held that an insured's breach of contract claim premised on breach of the duty to defend accrues at the time the defense is denied by the insurer.

Applying the *Paul Holt* decision, the court concluded that the cause of action regarding the insurer's duty to defend accrued at the time the insurer refused to provide its insured with a defense to the arbitration and that the "no action" clause did not constitute a condition precedent to the insured's claim. According to the court, "to give effect to the no action clause would eliminate in its entirety any obligation by [the insurer] to fulfill its duty to defend until such time as the insured has failed to prevail in the underlying action." ■

Professional Liability Attorneys

Kimberly A. Ashmore	202.719.7326	kashmore@wileyrein.com
Matthew W. Beato	202.719.7518	mbeato@wileyrein.com
Mary E. Borja	202.719.4252	mborja@wileyrein.com
Edward R. Brown	202.719.7580	erbrown@wileyrein.com
Ashley L. Criss*	202.719.3565	acriss@wileyrein.com
Jason P. Cronic	202.719.7175	jcronic@wileyrein.com
K. Stewart Day*	202.719.3566	kday@wileyrein.com
Cara Tseng Duffield	202.719.7407	cduffield@wileyrein.com
Benjamin C. Eggert	202.719.7336	beggert@wileyrein.com
Ashley E. Eiler	202.719.7565	aeiler@wileyrein.com
Jessica N. Gallinaro	202.719.4189	jgallinaro@wileyrein.com
Michael J. Gridley	202.719.7189	mgridley@wileyrein.com
Emily S. Hart	202.719.4190	ehart@wileyrein.com
John E. Howell	202.719.7047	jhowell@wileyrein.com
Leland H. Jones, IV	202.719.7178	lhjones@wileyrein.com
Parker J. Lavin	202.719.7367	plavin@wileyrein.com
Charles C. Lemley	202.719.7354	clemley@wileyrein.com
Jessica C. Lim	202.719.3749	jlim@wileyrein.com
Kimberly M. Melvin	202.719.7403	kmelvin@wileyrein.com
Alexander H. Merritt*	202.719.3571	amerritt@wileyrein.com
Laura Lee Miller	202.719.4196	lmiller@wileyrein.com
Jason O'Brien	202.719.7464	jobrien@wileyrein.com
Leslie A. Platt	202.719.3174	lplatt@wileyrein.com
Nicole Audet Richardson	202.719.3746	nrichardson@wileyrein.com
Marc E. Rindner	202.719.7486	mrindner@wileyrein.com
Kenneth E. Ryan	202.719.7028	kryan@wileyrein.com
Gary P. Seligman	202.719.3587	gseligman@wileyrein.com
Richard A. Simpson	202.719.7314	rsimpson@wileyrein.com
William E. Smith	202.719.7350	wsmith@wileyrein.com
Daniel J. Standish	202.719.7130	dstandish@wileyrein.com
Margaret D. Thomas	202.719.4198	mthomas@wileyrein.com
David H. Topol	202.719.7214	dtopol@wileyrein.com
Karen L. Toto	202.719.7152	ktoto@wileyrein.com
Jennifer A. Williams	202.719.7566	jawilliams@wileyrein.com
Bonnie Thompson Wise	202.719.3763	bwise@wileyrein.com

*District of Columbia Bar pending, supervised by principals of the firm.