Wiley Rein LLP

EXECUTIVE SUMMARY

Legal Developments Affecting Professional Liability Insurers | April 2017

Judgment Creditor Not Entitled to Policy Proceeds Where Insured Defaulted Without Insurer's Consent

The United States District Court for the Southern District of New York, applying New York law, has held that two judgment creditors of an insured were not entitled to insurance policy proceeds where the insured had breached the terms of the policy by allowing a default judgment to be entered against it. *XL Specialty Ins. Co., v. Lakian,* 2017 WL 1063451 (S.D.N.Y. March 20, 2017). The court further held that the insurer had not waived its policy defenses by writing a letter to the broker informing it of the insured's duty to defend the action or by filing an interpleader action without naming the judgment creditors. The court also concluded that a third judgment creditor for an insured person had no rights to the policy because it had no claim under the policy at the time the interpleader action was filed, and because the policy was not property of the insured person. Wiley Rein represents the insurer.

A professional liability insurer filed an interpleader action against two insured persons and a law firm retained by the

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Insured-Versus-Insured Exclusion Bars Coverage for Claim Against Former Director That Insured Assigned to Its Fidelity Insurer

The Texas Supreme Court has held that the insured-versus-insured exclusion in a D&O policy precludes coverage for a claim asserted by the insured's fidelity insurer, under an assignment of rights from the insured, against a former director of the insured. The court reversed the holding of the intermediate court of appeals and reinstated the trial court's entry of summary judgment for the D&O insurer on the basis that it owed no duty to defend the former director. *Great American Ins. Co. v. Primo,* 2017 WL 749890 (Tex. Feb. 24, 2017).

The insured condominium association filed a claim with its fidelity insurer after a director wrote two checks to himself

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Court Finds Late Notice of Claim Prejudiced Insurer

The United States District Court for the District of Connecticut has held that an insured's untimely notice of a claim precluded coverage under a claims-made policy because it prejudiced the insurer as required by Connecticut law. *Zahoruiko v. Fed. Ins. Co.,* 2017 WL 776645 (D. Conn. Feb. 28, 2017).

The insured, an officer of a technology company, executed a note for a line of credit. A third party purchased the note a few years later and sued the insured for defaulting on it. The parties settled the matter by executing a new, second note. Several years later, the insured allegedly missed loan payments on the second note, so the parties entered into a forbearance agreement. The agreement delayed payments and waived some of the insured's future defenses in the case of default. Two years later, the third party sued on the second note. After two additional years, the court granted summary judgment in favor of the third party.

The insured had two directors and officers claims-made policies. The insured notified its insurer for the first time of both lawsuits ten days after it learned that the third party intended to move for summary judgment. The insurer denied coverage, and the insured filed suit.

The court found no coverage for the first lawsuit because the demand letter preceding the suit was made during a lapse between the two policies. As to the second lawsuit, the court held that a related claims provision and a prior litigation exclusion did not apply because the lawsuits involved two separate notes. The court did conclude, however, that the insured's notice of the claim was untimely, and as required by Connecticut law, prejudiced the insurer.

As to untimeliness, according to the court the insurer "offered undisputed evidence" that the insured did not notify it of the lawsuits until "ten days after learning that [the third party] intended to move for summary judgment, sixteen months after being served the [second lawsuit] complaint, 20 months after receiving a demand letter, and three years and nine months after signing a forbearance agreement with [the third party]."

The court also held that the insured's tardiness materially prejudiced the insurer. In particular, the court held that the insured waived defenses in its forbearance agreement years prior to the lawsuit and incurred litigation costs without the participation of the insurer. By doing so, the court held that the insured failed to comply with the policy's requirements and also hampered the insurer's ability to negotiate "better repayment terms or from settling the lawsuit before the defense costs were incurred." ■

Court Upholds Eroding Defense Expense Provision; ERISA Exclusion Bars Coverage for Constitutional and Statutory Civil Rights Claims

The United States Court of Appeals for the Fifth Circuit, applying Mississippi law, has held that policies providing that defense costs erode policy limits are enforceable as written and do not offend public policy. *Federal Ins. Co. v. Singing River Health Sys.*, 2017 WL 816235 (5th Cir. Mar. 1, 2017). The court further held that the policy's Employee Benefits Law Exclusion barred coverage for a broad set of claims including those based on the federal and state constitutions and statutes.

The insured health system purchased a health care portfolio policy containing both an executive and employee liability coverage part and a fiduciary liability coverage part. The policy provided that "loss will be reduced, and may be exhausted by defense costs unless otherwise specified." The policy's employment practices liability coverage part also contained an Employee Benefits Law Exclusion barring coverage for any claim "for any actual or alleged violation of the responsibilities, obligations or duties imposed by any federal, state, or local statutory law or common law . . . that governs any employee benefit arrangement program."

A number of underlying lawsuits were brought against the insured alleging that it underfunded its retirement plan and trust. The suits alleged beaches of contract and fiduciary duty, as well as violations of the Mississippi and United States constitutions and 42 U.S.C. § 1983. The insurer defended the insured under a reservation of rights. The insurer then filed an action seeking a declaration that defense costs were included in the limit of liability and that no coverage existed under the EPL coverage part due to the Employee Benefits Law Exclusion. The insured counterclaimed and sought continued payment of defense costs without regard to policy limits.

The parties cross-moved for summary judgment, and the trial judge granted the insurer's motion in part and denied the insured's motion in full. Both parties appealed.

On appeal, the Fifth Circuit recognized that defense costs erode the limit of liability under the plain language of the policy. The court noted that the policy stated in multiple places that defense costs erode policy limits. The insured argued that the term "defense costs" was defined in reference to "loss," which only included amounts the insured became "legally obligated to pay." Accordingly, the insured argued, amounts advanced by the insurer cannot be defense costs because the insurer rather than the insured is obligated to pay them. The Court rejected this argument, opining that the only reasonable interpretation of this language is that it encompasses defense costs that, but for the insurance policy, would be the insured's legal obligation.

The court further held that the Employee Benefit Law Exclusion barred coverage for claims not only under ERISA and related laws but also based on federal and state constitutions and statutes, including § 1983 claims. The court noted that the language of the exclusion is "broad." The panel found that the term "govern" means laws that create obligations with which employee benefits plans must comply. The exclusion could not be limited to laws solely governing employee benefit plans because the provision stated it includes but is not limited to laws like ERISA and COBRA. Because the federal and state constitutions and the federal civil rights statute create obligations with which every employee benefit plan must comply, claims alleging that the plan violated those obligations fell within the scope of the exclusion. ■

No Crime Coverage for Social Engineering Fraud

The United States Court of Appeals for the Ninth Circuit, applying California law, has held that a crime policy did not afford coverage for a loss caused by an insured's initiation of wire transfers based on fraudulent email instructions. *Taylor & Lieberman v. Federal Ins. Co.*, 2017 WL 929211 (9th Cir. Mar. 9, 2017).

The insured, an accounting firm, received several emails from a client's email address with instructions for transferring client funds. Believing the instructions to be genuine, the insured initiated the transfers. The insured subsequently learned that a third party had gained access to the client's email address and sent the payment instructions as part of a fraudulent scheme. It then sought coverage for the loss under its crime policy, but the insurer denied coverage and coverage litigation ensued. The district court granted summary judgment in favor of the insurer after concluding, as a threshold matter, that the insured could not show a "direct loss" because there were intervening causes between the initial fraudulent emails and the resulting loss. (For the district court opinion, see *here*.)

On appeal, without addressing the "direct loss" issue, the court affirmed the decision on alternative grounds.

First, the court determined that the loss did not result "from Forgery or alteration of a Financial Instrument by a Third Party." The insured had contended that the words "financial instrument" only limited coverage for an alteration, and that a covered Forgery need not be of a financial instrument. The court disagreed, holding that "under a natural reading of the policy, forgery coverage only extends to forgery of a financial instrument."

Second, the court rejected the insured's argument that the computer fraud coverage applied because the emails constituted an unauthorized "entry into" its computer system or "introduction of instructions" that "propogate[d] themselves" through the insured's computer system. The court reasoned that unwanted emails, without more, could not be considered an "unauthorized entry" into the recipient's computer system. In addition, "under a common sense reading of the policy," the court found that the fraudulent emails were "not the type of instructions that the policy was designed to cover, like the introduction of malicious computer code." The court found the computer fraud coverage to be inapplicable on those grounds.

Third, the court ruled that the insured was not entitled to coverage for the "fraudulent written, electronic, telegraphic, cable, teletype or telephone instructions issued to a financial institution directing such institution to transfer, pay or deliver Money or Securities from any account maintained by an Insured Organization at such Institution, without an Insured Organization's knowledge or consent." The court reasoned that, because the insured requested the wire transfers, the transfers were made with both its "knowledge" and "consent." The court also ruled that the coverage did not apply for the independent reason that the insured accounting firm was not a "financial institution." ■

No Coverage for Consultant's Theft Under Company's Crime or Property Policies

Applying Indiana law, the United States Court of Appeals for the Seventh Circuit has held that neither a company's crime policy nor its commercial property policy provided coverage for theft of company property by a consultant who worked for the company. *Telamon Corp. v. Charter Oak Fire Ins. Co.,* 2017 WL 942656 (7th Cir. Mar. 9, 2017).

A telecommunications company hired an individual to work as the company's Vice President of Major Accounts for six years by way of a series of consulting services agreements between the telecommunications company and the individual's solo consulting company. The individual had primary responsibility for removal of old telecommunications equipment and resale of the equipment to salvagers. In reselling the equipment, however, she pocketed the profits.

The company sought coverage for the theft under its crime insurance policy, which covered theft by "an Employee," and defined "Employee" as "any natural person . . . who is leased to the Insured under a written agreement between the Insured and a labor leasing firm, while that person is subject to the Insured's direction and control and performing services for the Insured." In the coverage litigation following the insurer's denial of coverage, the court held that the individual was not an "Employee" because her services were governed by a written agreement between the insured and her own consulting firm, which was not a firm in the business of leasing labor, but instead was merely her own vehicle for providing her services. Accordingly, the court held that no coverage was available for the theft under the crime policy.

The company also sought coverage under its commercial property policy, which covered risks of direct physical loss. The policy contained an exclusion for any "dishonest or criminal act by . . . employees (including leased employees), directors, trustees, authorized representatives or anyone (other than a carrier for hire or bailee) to whom you entrust the property for any purpose." The court held that the individual was an "authorized representative" of the company because she was the senior-most person with authority over certain of the company's facilities and she was entrusted with the property that she stole. Therefore, the court held that the exclusion was triggered and no coverage was available for the theft under the property policy. ■

Prior Acts Exclusion Bars Coverage for Suits Alleging Wrongful Conduct Spanning Prior Acts Date

A Maryland intermediate appellate court has affirmed summary judgment in favor of an insurer, holding that a Prior Acts Exclusion applied to bar coverage for two antitrust lawsuits where the suits alleged that the insured conspired to raise prices beginning as early as 2002 and the Prior Acts Exclusion barred coverage for "Interrelated Wrongful Acts, committed, attempted, or allegedly committed or attempted in whole or in part prior to May 15, 2007." *Cristal USA Inc. v. XL Specialty Ins. Co.,* 2017 WL 727795 (Md. Ct. Spec. App. Feb. 24, 2017). The court also held that a coverage determination by the primary insurer does not bind an excess follow-form insurer, and that the excess insurer had no duty to defend the action.

The insured, a producer of titanium dioxide, purchased a Private Company Directors, Officers and Employees Liability Policy covering the period from May 16, 2009 to May 16, 2010 and an excess policy for the same period that followed form. In 2010, two antitrust class actions were filed against the insured alleging that the insured conspired to artificially raise the price of titanium dioxide beginning as early as March 2002. The insured sought coverage under its primary and excess policies. The primary insurer initially denied coverage under the Prior Acts Exclusion, but then changed its position and provided its full limit. The excess insurer denied coverage, citing the Prior Acts Exclusion, which bars coverage "for Loss on account of any Claim made against any Insured based upon, arising out of or attributable to Wrongful acts, including Interrelated Wrongful Acts, committed, attempted or allegedly committed or attempted in whole or in part prior to May 15, 2007 for [insured's parent company] and its Subsidiaries." The insured brought a declaratory judgment action against the excess insurer. The trial court granted summary judgment in favor of the excess insurer, and the insured appealed.

On appeal, the insured argued that the lower court had incorrectly interpreted the Prior Acts Exclusion and that the excess insurer had a duty to defend the underlying action. More specifically, the insured contended that the May 15, 2007 date, which was the date that the insured's parent company had acquired the insured, only applied to acts "for the benefit of" the parent company and its subsidiaries. The court rejected this argument, holding that the exclusion "can only reasonably be interpreted to exclude coverage for wrongful acts committed by [the parent company] and its subsidiaries, including Appellant, prior to May 15, 2007."

The court also held that "a follow form insurer is not automatically bound by the coverage determinations of the primary policy insurer." Finally, the court noted that "Interrelated Wrongful Acts" language had not been analyzed by any Maryland court in the exclusion context. Nonetheless the court held that the exclusion barred coverage because the complaints alleged Wrongful Acts that occurred as early as 2002, and that even if they also alleged acts occurring after May 15, 2007, "the 'in whole or in part' and Interrelated Wrongful Acts language contained in the exclusion precludes coverage for the entire action where it is clear that all of the actions alleged are related to the same conspiracy claim." ■

Deceptive Business Practices Exclusion Does Not Bar Coverage for Kickback Suit

The United States District Court for the Northern District of California has held that a deceptive practices exclusion contained in an errors and omissions policy issued to a real estate brokerage did not bar coverage for a suit alleging the brokerage engaged in a kickback scheme with a vendor because two causes of action asserted did not necessarily require a finding of deception or fraud. *Hanover Ins. Co. v. Paul M. Zagaris, Inc.,* 2017 WL 713146 (N.D. Cal. Feb. 23, 2017).

The insured, a real estate brokerage company, was sued by a group of California residents who alleged that the company was receiving secret kickbacks through the sale of natural-hazard disclosure reports that the brokerage firm purchased from a shell corporation for half the price the brokerage company then charged the consumer. The putative class action alleged that the shell corporation then shared that profit with the brokerage firm, who never disclosed that interest to its clients, allegedly in breach of its fiduciary duties. The complaint also asserted claims for violation of California's Unfair Competition Law, constructive fraud, unjust enrichment, and civil conspiracy.

After agreeing to defend the brokerage company, subject to a reservation of rights, the professional liability insurer filed a declaratory judgment action seeking a ruling that it had no duty to defend, as well as the reimbursement of attorney's fees and costs paid to defend the underlying suit. On the parties' cross-motions for summary judgment, the insurer contended that the exclusion precluding coverage for claims that "arise out of . . . deceptive business practices" applied to the action in its entirety, eliminating the insurer's duty to defend. The brokerage company argued that certain allegations of the underlying action did not necessarily fall within the exclusion.

The court determined that the key question was whether the causes of action for breach of fiduciary duty and constructive fraud "arise out of . . . deceptive business practices" such that the exclusion applied to the entire underlying suit. The court rejected the insurer's reliance on *Vandenberg v. Superior Court,* 21 Cal. 4th 815 (1999), for the contention that the action as a whole arose out of deceptive business practices, opining that the *Vanderberg* case did not stand for such a sweeping a proposition. The court pointed out that the count for breach of fiduciary duty may constitute negligence or fraud, depending on the circumstances of the case, and that the constructive fraud count can be comprised of not otherwise fraudulent conduct such as an omission. According to the court, it is possible that the brokerage firm could be found to have breached its fiduciary duties by failing to disclose its interest in the sale of the reports, or engaged in constructive fraud via the same omission, independent of any alleged deception. In other words, the insurer could not meet its burden to show "through conclusive evidence, that the exclusion applies in all possible worlds." The court granted the brokerage company's motion for summary judgment, leaving the insurer responsible for continuing the defense of its insured. ■

Initial Inquiry Letter from Office of Disciplinary Counsel Constitutes "Disciplinary Proceeding," Triggering Notice Obligation

A Louisiana appellate court, applying Louisiana law, has held that an initial inquiry letter from the Louisiana Attorney Disciplinary Board, Office of the Disciplinary Counsel received by a lawyer constituted a "Disciplinary Proceeding" under a lawyer's professional liability policy, triggering an insured's notice obligations under the policy. *Trelles v. Continental Cas. Co.,* 2017 WL 658249 (La. Ct. App. Feb. 17, 2017). The court held that the insured was not entitled to coverage because notice of the disciplinary action was not provided during the policy period.

On October 28, 2010, the insured lawyer received an initial inquiry letter from the Office of Disciplinary Counsel advising him that a complaint of professional misconduct had been made against him. On May 26, 2012, the lawyer received a formal notice of charges. At that time, he reported the matter to his insurer under his 2012-2013 professional liability policy. The policy provided coverage for "Disciplinary Proceeding[s]" first received by the insured and reported to the insurer during the policy period. The policy defined "Disciplinary Proceeding" as "any pending matter, including an initial inquiry, before a state or federal licensing board or a peer review committee to investigate charges alleging a violation of any rule of professional conduct in the performance of legal services." The insurer denied coverage on the grounds that the "Disciplinary Proceeding" began prior to the inception of the policy period when the lawyer received the initial inquiry letter. The lawyer initiated this coverage litigation, and, on cross-motions for summary judgment, the trial court granted the insurer's motion, finding that the initial inquiry letter was notice of a "disciplinary proceeding" as defined by the policy.

The appellate court affirmed the decision. The appellate court found no merit to the lawyer's argument that the initial inquiry letter was not a "Disciplinary Proceeding" because the Office of the Disciplinary Counsel is not "a state . . . licensing board" or "a peer review committee," finding this interpretation of the policy language to be "unreasonable or strained." According to the court, the definition of "Disciplinary Proceeding" unambiguously encompassed the initial inquiry from the Office of the Disciplinary Counsel. Therefore, the court affirmed the trial court's decision that coverage was precluded because the insured failed to provide timely notice when he received the initial inquiry letter in 2010. ■

Insurer Must Pay Defense Expenses in Appeal of Fraud Conviction

The California Court of Appeal has held that an exclusion requiring repayment to the insurer upon a "final determination" of the insured's culpability applies only after the insured's direct appeals have been exhausted, and therefore the insurer was obligated to pay the insured's litigation expenses in an appeal of the underlying litigation. *Stein v. AXIS Ins. Co.,* 2017 WL 914623 (Cal. Ct. App. Mar. 8, 2017).

The insured, an officer of a medical device company, was convicted of securities fraud in federal court. He tendered his appeal of that conviction to one of the company's insurers. However, the policy included an exclusion for any claim involving willful misconduct, which was triggered by "a final adjudication adverse to [the] Insured Person in the underlying action . . . establishing that the Insured Person" committed willful misconduct. The exclusion also provided that "[i]f it is finally determined that [the exclusion] applies," the insured would be obligated to repay the insurer any defense expenses paid on his or her behalf. The insurer denied coverage because it considered the conviction to be a "final determination" of the officer's willful misconduct for purposes of the exclusion.

The officer sued the insurer, alleging that it had defrauded him and breached the policy by failing to pay his litigation expenses on appeal of the conviction. After finding that the willful misconduct exclusion precluded coverage because the insured's criminal conviction was "final under federal law until it is reversed," the trial court sustained the insurer's demurrer without leave to amend and dismissed the case. The officer appealed.

The Court of Appeal reversed and held that the insurer was obligated under the policy language to cover the insured's defense expenses incurred as a result of an appeal from a civil or criminal proceeding, even if a trial court determined that the insured was guilty of or liable for fraud. The court specifically pointed to the willful misconduct exclusion, noting that, while it barred coverage for losses brought about by fraud or criminal acts, the exclusion did not apply to defense expenses. The court rejected the insurer's argument that, under federal law, a trial court judgment is deemed to be a final adjudication until reversed on appeal. In rejecting that argument, the court noted that nothing in the policy indicated that the parties intended the phrase "final adjudication" to carry the same meaning as in federal law. The court also noted that an appellate court can render an adjudication with greater finality than a trial court. Finally, the court explained that the policy only provides one trigger for the exclusion: a final adjudication. Thus, the court concluded that, any trial court judgment against the officer would not trigger the exclusion so long as the judgment could be appealed. ■

Court Finds Insurer Not Bound by $1 Million Consent Judgment

The Supreme Court of Appeals of West Virginia has held that a consent judgment did not bind a general liability insurer because the insurer was not a party to the lawsuit and did not expressly agree to the judgment. *Penn-America Ins. Co. v. Osborne,* 2017 WL 878716 (W. Va. March 1, 2017).

The claimant, a logger, injured his leg in a timbering accident. He filed suit against his employer and two other parties – the owner of the land and a timber-lessee. The employer's general liability insurer denied coverage for the lawsuit. The two other parties notified the employer that it had a contractual duty to defend them in the suit, but the employer never notified its insurer of the parties' request for a defense.

The claimant entered into a pre-trial consent judgment with the landowner and timber-lessee without notice to the insurer. The parties agreed to a $1 million judgment for the claimant (the policy limit) that the claimant would not seek to collect from the two settling parties, and to an assignment of the parties' claims against the insurer to the claimant. The claimant dismissed the suit against the two parties and filed suit against the insurer. The trial court entered summary judgment in the claimant's favor, finding the insurer bound by the consent judgment.

The appeals court reversed, holding that as a matter of law, the insurer was not bound by the consent judgment because it was not a party to the lawsuit and did not expressly agree to it. The court also held that the parties' assignment of claims was void as a matter of public policy. The court found that the parties had falsely stipulated that the landowner and timber-lessee faced the risk of personal liability for a potential verdict, because in fact their lawsuit was covered by another insurance policy. Moreover, the parties based their determination of the claimant's injuries on the $1 million policy limit. Finally, the insurer had no knowledge of settlement negotiations or the ability to participate. Highlighting these facts as evidence of possible fraud and collusion, the court held that the settlement agreement impermissibly resulted in "a $1 million windfall for [the claimant's] injured leg with [the insurer's] money." ■

Insurer Had Duty to Defend Where at Least One Allegation "Possibly" Constituted a Wrongful Act

The United States District Court for the District of Connecticut, applying Connecticut law, has granted summary judgment in favor of an insured, holding that an underlying complaint alleged at least one act that could "possibly" fall within the policy's definition of "wrongful acts," triggering a duty to defend. *Fernandez v. Zurich Am. Ins. Co.,* 2017 WL 923910 (D. Conn. March 8, 2017).

The insurer issued a professional liability policy to a company that provided staffing and recruiting services. The insurer denied coverage for an action against the insured, alleging that the insured improperly solicited employees from a competitor, on the grounds that the complaint did not allege a "wrongful act" within the meaning of the policy. The policy defined "wrongful act" to include "[a]ny actual or alleged act, error or omission, misstatement, or misleading statement in the course of providing 'staffing services.'" In the coverage action that followed, the insured moved for summary judgment on its breach of duty to defend and breach of contract claims.

The court determined that the complaint alleged some acts that "at least 'possibly' constituted 'wrongful acts'" under the policy. The court pointed to allegations that the insured placed at least one temporary employee from the underlying plaintiff in a job with one of the insured's customers and placed advertisements on job search websites. Because the phrase "in the course of" means "during and as part of the specified activity," the court reasoned that these allegations describe acts that were done "in the course of" providing staffing services to the insured's clients as required by the policy." The court rejected the insurer's argument that "in the course of" required a causal nexus between the injuries alleged and the staffing services provided. The court concluded that because there was at least one allegation possibly within the scope of coverage, the insurer owed a duty to defend and was liable for breach of contract. ■

Federal Liability Risk Retention Act Preempts Maryland's Notice-Prejudice Statute for Non-Chartered Risk Retention Group

A Maryland federal court has held that the federal Liability Risk Retention Act (LRRA) preempts Md. Ins. Code § 19-110, Maryland's notice prejudice statute, in circumstances where Maryland law otherwise would govern a contract issued by a non-chartered insurer. *Mora v. Lancet Indem. Risk Retention Grp., Inc.,* 2017 WL 818718 (D. Md. Mar. 1, 2017).

A patient received care from a doctor for heart-related issues. The patient later died of a sudden cardiac event. The patient's widow and children filed suit against the doctor, who was insured under a claims-made-and-reported medical malpractice policy issued by a risk retention group based in Nevada. The doctor failed to respond and did not participate in the defense of the suit. Although the patient's family put the doctor's insurer on notice of the suit, the insurer declined to provide a defense, contending that it could not meaningfully defend without the participation of the doctor. The court entered a default judgment against the doctor.

In the ensuing coverage litigation, the insurer asserted that coverage for the suit was barred because (a) the insured did not provide notice during the policy period and (b) the insurer was prejudiced by the insured's failure to participate in the defense of the litigation. The insurer further contended that the LRRA preempted Maryland's notice-prejudice statute such that it was not required to demonstrate that it was prejudiced by the insured's failure to provide notice during the policy period.

As the court noted, under the LRRA only the chartering state can "regulate the formation and every day operations of a risk retention group," and the insurer here was chartered in Nevada. The court concluded that Maryland's notice-prejudice statute, Md. Ins. Code § 19-110, regulated the "operations" of insurers and thus it was preempted by the LRRA. The court rejected the claimants' assertion that the LRAA's preemption exception for any "law governing the interpretation of insurance contracts" applied. The court reasoned that this exception was inapplicable because "Section 19-110 does not assist in interpreting existing terms of an insurance contract, but imposes an additional burden on the insurer before it may disclaim coverage based on a lack of notice or cooperation, despite what the particular insurance policy says." As the policy was a claims-made-and-reported policy, the court held that notice was required during the policy period and that the insurer need not show prejudice. However, resolving an issue of first impression, the court held that the third-party notice provided by the plaintiffs in the lawsuit, which occurred during the policy period, was sufficient. Accordingly, the court denied the insurer's motion for summary judgment on this basis.

The court also held that disputed issues of material fact remained as to whether the insured breached the cooperation clause. The text of the cooperation clause specifically required a showing of "prejudice." Among other things, the court noted that it could not "determine on this record whether a defense expert at the underlying malpractice trial could have provided a reasonable and admissible standard of care or causation opinion in the insured-doctor's absence." ■

Loss Caused by Fraudulent Exploitation of Coding Error Does Not Implicate Computer Fraud Coverage

A Georgia federal district court has held that a fraudulent scheme using telephones to exploit a computer coding vulnerability in the insured's system that ultimately led to a loss was not covered under a computer fraud provision in a commercial crime policy. *Incomm Holdings, Inc. v. Great Am. Ins. Co.,* 2017 WL 1021749 (N.D. Ga. Mar. 16, 2017).

The insured managed a prepaid card program. As part of the program, cardholders would load funds onto prepaid cards issued by banks. To load funds, the cardholders called a designated telephone number and inputted certain information. As a result of the coding error in the insured's computer system, cardholders were able to call into the system from multiple phones at the same time and make multiple loads, which enabled them to access more funds than they purchased. Before the insured fixed the coding error, cardholders made approximately $10.3 million in unauthorized redemptions. As required by contract, the insured paid that amount to the issuing bank.

The insured sought coverage under a computer fraud provision in its commercial crime policy, which afforded coverage for "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 of that property from inside the premises or banking premises: a. to a person (other than a messenger) outside those premises; or b. to a place outside those premises." The insurer denied coverage, and coverage litigation ensued.

The district court granted summary judgment in favor of the insurer, holding that the loss did not fall within the scope of the crime policy's coverage.

First, the court ruled that the loss was not caused by the "use[] of a computer." The court noted that each cardholder used a phone – which is not a "computer" – to make fraudulent redemptions. The court also rejected the notion that the cardholders "used" the insured's computer system, observing that "[l]awyerly arguments for expanding coverage to include losses involving a computer engaged at any point in the causal chain – between the perpetrators' conduct and the loss – unreasonably strain the ordinary understanding of 'computer fraud' and 'use of a[] computer.'"

As an alternate basis for its ruling, the court determined that the incident did not involve the "loss of … money … resulting directly from" computer fraud. The court reasoned that the "loss" at issue was not the insured's payment to the issuing bank, but instead occurred when the payments were made to merchants from the cardholder funds. As such, the court ruled that the "loss" was not caused "directly" by the fraudulent customer loads, but instead the loss was caused "directly" by the insured's decision to transfer funds to the bank, as required by its contract. ■

insureds because the insurer was faced with competing demands in excess of remaining policy limits. Several other law firms retained by the insureds and three judgment creditors were permitted to intervene. The demands arose from two underlying suits, brought by investors against the named insured investment fund and its officers, alleging fraudulent inducement, breach of fiduciary duty, and misuse of the invested funds.

Two judgment creditor investors, who had obtained a default judgment against the investment fund in an underlying action, sought summary judgment that they were entitled to the interpleaded funds. The insurer had determined that the judgment creditors were not entitled to coverage because the investment fund, which had allowed a default judgment to be entered against it, had breached the policy by failing to fulfill its duty to defend the claim and by admitting liability without the insurer's consent. The court rejected the judgment creditors' argument that the insurer had a duty to take action to avoid the default, because the policy imposed no duty to defend on the insurer and instead imposed an explicit duty to defend on the insured. The court also held that the fund's default was tantamount to an admission of liability, in violation of the policy provision requiring the insured to seek consent prior to settling or admitting liability. The court also concluded that the insurer had not waived its defenses by sending a letter to the insured's broker informing it of the motion for default and the insured's duty to defend, because the letter had explicitly reserved all of the insurer's rights. The court further determined that the insurer's filing of the interpleader action without pleading the lack of coverage for the named insured also did not constitute waiver, as the insurer had attached the policy and interpleaded as defendants all persons or entities who had, to date, sought coverage under the policy, which the insured investment fund and its judgment creditors had not done. As a result, the court concluded, the judgment creditors were not entitled to coverage.

Another investment fund also intervened, as a judgment creditor of one of the insured persons arising from a separate underlying action. The court noted that the intervening fund had no claim under the policy at the time the interpleader action was filed because it did not yet have a judgment against the insured person. The court concluded that, because courts determine the rights of interpleader parties on the basis of the facts extant at the time the action was commenced, the fund's claim was barred. The fund also could not attach the insured person's interest in the interpleaded policy proceeds because the insured person was not entitled to recover any portion of the interpleaded funds, and therefore any benefits to him under the policy were not his property.

Finally, the court determined that, because it had dismissed the judgment creditors, the remaining interpleader defendants were entitled to disbursement of the interpleaded funds as agreed among them. ■

for just over $100,000 shortly before resigning. The fidelity insurer paid the claim in exchange for a written assignment of all of the insured's rights and claims against the former director for the loss. When the fidelity insurer sued the former director to recover the funds, the director demanded that the insured's D&O insurer provide a defense. After the fidelity insurer nonsuited its claims against the director, the director sued the D&O insurer to recover the defense costs and attorneys' fees he incurred in the suit brought by the fidelity insurer. The D&O insurer moved for summary judgment, arguing that the former director had already collected his defense costs through indemnification and arguing that the insured-versus-insured exclusion in the D&O policy precluded coverage. The trial court granted the D&O insurer's motion for summary judgment based on the insured-versus-insured exclusion, but the intermediate court of appeals reversed.

Reversing the intermediate court of appeals, the Texas Supreme Court held that the suit by the fidelity insurer fell within the plain language of the insured-versus-insured exclusion. The exclusion in the D&O policy provided that no coverage was available for "any Claim made against any Insured by, or for the benefit of, or at the behest of [the insured] or . . . any person or entity which succeeds to the interest of [the insured]." The Supreme Court held that the intermediate court of appeals erred in applying a narrow definition of the term "successor" from a corporate transactions context to determine whether the fidelity insurer "succeed[ed] to the interest of the insured." According to the court, that specialized use of the term "successor" is distinct from its use in the context of the insured-versus-insured exclusion and from its plain meaning, noting that this was in accord with the holdings of other courts. The Supreme Court also noted that the holding of the intermediate court of appeals would make collusive suits more likely, because an insured could simply assign its claim to a third party to avoid the exclusion in the policy. For these reasons, the court reversed, and rendered judgment for the D&O insurer. ■

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