Wiley Rein LLP

EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | December 2015

ALSO IN THIS ISSUE

Pennsylvania Notice-Prejudice Rule Does Not Apply to Claims-Made Policies

The Superior Court of Pennsylvania has reaffirmed that the Pennsylvania notice-prejudice rule does not apply to claims-made policies. *Reifer v. Westport Ins. Co.*, 2015 WL 7354650 (Pa. Super. Ct. Nov. 20, 2015).

In the underlying legal malpractice case, a former client filed a writ of summons against her former attorney. The attorney did not report the writ to his professional liability insurer. Nine months later, the former client filed a complaint against the attorney. The attorney gave notice of the complaint to his insurer outside of the policy period and the 60-day extended reporting period. The insurer denied coverage based on untimely notice. The policy's insuring agreement stated the insurer would provide specified coverage as a result of a claim "first made against [the insured] during the POLICY PERIOD and reported to [the insurer] in writing during the POLICY PERIOD or within sixty (60) days thereafter[.]"

The former client and the attorney settled the malpractice suit, and the attorney assigned his rights under the policy to the former client. The former client filed a declaratory judgment action against the insurer to enforce coverage under the policy.

continued on page 6

Insured Cannot "Fill the Gap" Between Primary Insurer's Settlement Payment and Underlying Limit

The United States Court of Appeals for the Fifth Circuit, applying Texas law, has held that an excess insurer had no obligation to make any payments when a policyholder settled its claims against a primary insurer for less than the underlying limit, even if the policyholder paid the difference to "fill the gap" between the primary insurer's payment and the underlying limit. *Martin Res. Mgmt. Corp. v. AXIS Ins. Co.*, 2015 WL 6166661 (5th Cir. Oct. 21, 2015). In so holding, the court held that only the primary insurer can pay the full amount of the underlying limits in order to exhaust the underlying policy and trigger the excess policy.

The insured purchased a primary insurance policy and two excess insurance policies, each with a liability limit of $10 million. The excess coverage applied only after the underlying policy had been "exhausted by actual payment." After settling the underlying stock-dilution litigation, the insured

continued on page 7

Insurer Obligated to Produce Underwriting Files Relating to Policies Issued to Other Policyholders

The United States District Court for the Western District of Pennsylvania ruled that, under federal rules of civil procedure regarding discovery, an insurer is obligated to produce in coverage litigation underwriting files relating to policies issued to other policyholders. *H. J. Heinz Co. v. Starr Surplus Lines Ins. Co.*, 2015 WL 5781295 (W.D. Pa. Oct. 1, 2015).

The insured, a food manufacturer, brought a declaratory judgment action against its insurer seeking coverage under a product contamination policy in connection with a recall of baby food that the insured had produced. In discovery, the policyholder sought underwriting files relating to similar insurance policies issued to other policyholders. The insurer objected to the request on the grounds that (1) the request was "overly broad, unduly burdensome, and not reasonably calculated to lead to the discovery of admissible evidence," and (2) the requested documents contained confidential third-party information. The policyholder agreed to narrow its request to specific documents from the underwriting files, including: each policyholder's application, the loss history page, pages identifying "subjectives" required of the policyholder, the premium charged, and any analysis the insurer conducted in deciding to issue the policy or set the premium. The request also stated that the insurer could redact confidential information, such as the name of the policyholder.

When the parties were unable to resolve the discovery dispute, the policyholder filed a motion to compel, which the court granted. In

continued on page 7

Insurer Failed to Show Claims Were Not Interrelated; Not Entitled to Summary Judgment for Suit Seeking Disgorgement

A Texas intermediate court of appeals has held that an insurer was not entitled to summary judgment where the insurer contended that a claim brought by a bankruptcy plan agent (i) did not allege a wrongful act, and (ii) was not made within the policy period because it did not relate back to claims made during the policy period. *Burks v. XL Spec. Ins. Co.*, 2014 WL 6949610 (Tex. App. Nov. 10, 2015).

The policyholder, a former CFO of a company reorganized under Chapter 11, was sued by the plan agent to recover property that the company had transferred to him. The D&O insurer denied coverage for the plan agent's claim, asserting that the claim did not allege a wrongful act and sought only disgorgement, which was not covered "loss" under the policy. The CFO then settled the claim with the plan agent and sued the insurer. The trial court granted—without specifying the grounds—the insurer's motion for summary judgment, which asserted that the claim was made after the policy period because it was not related to prior claims within the policy period, and that the insurer had no duty to advance defense costs or to indemnify the policyholder for the settlement because the claim sought only disgorgement.

The appellate court held that the insurer was not entitled to summary judgment on the claim-made issue because a question of fact existed as to whether the plan agent's claim was interrelated with prior shareholder derivative claims made during the policy period. The court rejected the insurer's contention that the "eight corners rule" precluded the court from considering the complaints in the prior shareholder derivative suits in determining whether the insurer had a duty to advance defense expenses. The court also rejected the insurer's argument that the plan agent's claim did not allege a "wrongful act" under the policy, reasoning that the plan agent alleged various acts and omissions—the receipt of money, stock and benefits and the failure to give the company something of reasonably equivalent value—which fell within the broad definition of "any . . . alleged act, error, or omission . . . by any Insured Person while acting in his or her capacity as an . . . Insured Person of the Company."

The court also held that the exclusion for loss arising from profit or remuneration to which the insured is not legally entitled did not negate the duty to defend because that exclusion specifically

continued on page 7

Third Circuit Holds That "Renewal" Policy Must Have "The Same, Or Nearly The Same, Terms" As Original Policy

The United States Court of Appeals for the Third Circuit, applying Pennsylvania law, has held that, in order "for a contract to be considered a renewal, it must contain the same, or nearly the same, terms as the original contract." *Indian Harbor Ins. Co. v. F&M Equip., Ltd.*, 2015 WL 5973384 (3d. Cir. Oct. 15, 2015).

The insurer issued a Pollution and Remediation Legal Liability Policy to the insured, which provided $10 million in specified pollution liability coverage over a 10-year coverage period for 12 specific sites. The policy included an endorsement providing that the insurer "shall not cancel nor non-renew" the policy except in five circumstances not at issue here. The policy was amended during the coverage period to increase the limit of liability to $14 million for an additional premium.

At the end of the 10-year policy term, the insurer requested a renewal application from the insured, and the insured then requested that the insurer provide it with proposed premiums and terms. The insurer proposed a policy with a one-year policy period, limit of $5 million, and which omitted coverage for one of the 12 sites covered under the prior policy. The insured objected to the proposed terms and litigation ensued. The district court ruled in favor of the insurer, holding that the insurer satisfied its obligation to renew the policy by offering a new policy and giving notice of its intent to change certain policy terms and conditions.

On appeal, the Third Circuit vacated the district court's ruling and ordered that summary judgment be entered in favor of the insured. In so holding, the court first acknowledged that a "renewal contract need not contain identical terms to the original." The court then addressed the pivotal issue of how similar the new contract must be and whether the insurer here satisfied that standard.

continued on page 8

Action by Tennessee Attorney General Deemed to Pre-Date Claims-Made Policy Period Because Related to Earlier-Filed Customer Complaints

A Tennessee federal court has held that a claims-made D&O policy does not afford coverage for a lawsuit brought by the Tennessee Attorney General because the suit involved wrongful acts that were related to customer complaints filed against the insured prior to the policy period. *Hale v. Travelers Cas. & Sur. Co. of Am.*, 2015 WL 6737904 (M.D. Tenn. Nov. 4, 2015). Alternatively, the court held that coverage was barred because the insured made material misrepresentations in its application for the policy.

The insured, a provider of hormone replacement therapy, did not dispute that prior to the inception date of the policy at issue numerous customer complaints had been filed against it with the Better Business Bureau and the Tennessee Department of Commerce and Insurance, it had received refund demand letters from customers, a customer had filed a complaint in state court, and a local news channel had conducted an investigation into the customer complaints. During the policy period, the Tennessee Attorney General filed a lawsuit against the insured containing "virtually identical" allegations to the customer complaints and accompanied by affidavits of disgruntled customers. The insurer denied coverage on the grounds that the Attorney General lawsuit and the customer complaints involved "related wrongful acts," which the policy defined as wrongful acts having as "a common nexus, or [] causally connected by reason of, any fact, circumstance, situation, event or decision." The policy provided that all claims for related wrongful acts were considered a single claim deemed made at the time of the first such claim.

The court held that the plain language of the policy dictated that the Attorney General lawsuit alleged "related wrongful acts" to those alleged in the customer complaints, and accordingly held that the Attorney General lawsuit was a claim first made before the policy period. The court rejected the insured's argument that the

continued on page 10

Failure to Provide Notice of Related Suit and Exclusion for Insufficiency of Escrow Funds Preclude Coverage for Title and Escrow Company

An Oklahoma federal district court has held that an insurer properly denied coverage for a lawsuit because notice to the insurer of an earlier suit seeking temporary injunctive relief did not also qualify as notice of the later suit involving the same conduct and seeking damages. *Thames v. Evanston Ins. Co.*, 2015 WL 7272214 (N.D. Okla. Nov. 17, 2015). As an alternative basis for its decision, the court applied an exclusion for claims arising out of the "insufficiency in the amount of escrow funds" notwithstanding that the underlying claim also alleged that non-excluded events contributed to the loss.

A customer retained an insured title and escrow company to provide closing and escrow services for a real estate purchase. The first closing date could not be met, and closing was initially delayed, because the company never prepared certain documents. Later, the company informed the customer that the funds in his account were insufficient to cover the purchase price. Shortly thereafter, the customer sued the company and its sole officer and director, seeking temporary injunctive relief in connection with the funds in his escrow account. The company and its director noticed the claim under the company's professional liability policy, and their attorney advised the insurer of the possibility that the director "misallocated or stole the escrow funds." The insurer denied coverage for that claim. Subsequently, in a separate action, the customer initiated a second lawsuit against the insureds, but notice of that lawsuit was never provided to the insurer. The insureds eventually negotiated a confessed judgment against the claimant, who in turn brought suit to garnish the insurer's policy.

Following a bench trial, the court entered judgment in favor of the insurer. First, the court ruled that the insureds' failure to provide notice of the second lawsuit precluded coverage. In so doing, the court rejected the customer's argument that notice of the initial action for injunctive relief served as notice of the later suit because the two matters arose out of the same or similar facts, and because the insurer could have

continued on page 11

Managed Care E&O Policy Covers Suit Alleging Unfair Competition by Competitors

A California federal court has held that a managed care organization E&O policy provided coverage for a suit alleging unfair competition, and was not limited to coverage for suits brought by the insured's customers or clients. *EYEXAM of Cal., Inc. v. Allied World Surplus Lines Ins. Co.*, 2015 WL 7015414 (N.D. Cal. Nov. 12, 2015).

An eyeglasses retailer contracted with an optometry practice to co-locate their businesses in the same outlets. Competitors of the retailer and the optometrists brought suit against both entities, alleging violations of Cal. Bus. & Prof. Code § 17200 *et seq.*, California's Unfair Competition Law (UCL). The competitors argued that the retailer and the optometrists violated California statutes that, *inter alia*, generally require optometrists to be independent of retailers of eyeglasses. Pursuant to the UCL, the competitors sought injunctive relief and attorneys' fees and costs.

Both the retailer and the practice were insured under the same "Managed Care Organization" E&O policy. That policy provided specified coverage for "Claims" for "Wrongful Acts," which was in turn defined to include the performance of "Managed Care Activities." "Managed Care Activities" was a multi-pronged definition, which included "advertising, marketing, selling, or enrollment for health care or workers' compensation plans"; "evaluating, selecting, credentialing, contracting with or performing peer review of any provider of Medical Services"; and "services or activities performed in the administration or management of health care workers' compensation plans," among other services. In addition, "Claim" was defined to mean "any written notice . . . that a person or entity intends to hold an Insured responsible for a Wrongful Act." The insurer denied coverage,

continued on page 9

No Coverage for Claims Arising from Failure to Appeal Adverse Decision

Applying Massachusetts law, a Massachusetts federal court has held that no coverage was available under two claims-made policies because the insured knew before policy inception that a client would bring a claim when the insured failed to perfect an appeal of an adverse zoning decision. *Gandor v. Torus Nat'l Ins. Co.*, 2015 WL 6043621 (D. Mass. Oct. 15, 2015). In addition, the court held that a former client's suit for failure properly to insure a former associate did not allege a professional service because it involved the running of a business rather than the practice of law.

A former firm client filed two lawsuits against the insured law firm partner and associate stemming from the associate's failure to perfect properly an appeal of an adverse zoning decision. Before the inception of the first claims-made policy, the associate handling the appeal wrote a memo to the partner in which he described a "fatal error" he made when representing the client and his notification to the client of the "mistake." The partner then wrote to the client, asserting that the firm did not commit malpractice and requesting a release from the client in exchange for refunding previously paid legal fees. In policy year one, the client filed suit against the associate and the firm for legal malpractice which was settled for an assignment of the insureds' rights under the policy. In policy year two, the claimant filed suit against the partner for failing to purchase appropriate legal malpractice insurance for the former associate. The claimant settled the second suit in exchange for an assignment of the partner's rights under the second policy.

The court held that no coverage was available for the first suit because the insured had prior knowledge that a claim could be made before the inception of the first claims-made policy. The policy precluded coverage for claims if, at the effective date, the insured "could have reasonably foreseen that such wrongful act might be expected to be the basis of a claim." The court held that, before the inception of the policy, the insureds could have reasonably foreseen a claim because the associate admitted to the partner that he made a "fatal error" in the representation and the partner offered to refund fees in exchange for a release because the client "was making a claim of malpractice."

continued on page 9

Attorney Cannot Wait on Outcome of Appeal to Report Dismissal of Client's Claim Due to Malpractice

An Indiana appellate court has held that an insured attorney knew or reasonably should have known a potential malpractice claim could be made at the time he renewed his malpractice policy even though an intermediate appellate court had reversed an order that dismissed his client's claim due to the attorney's alleged negligence in responding to discovery. *The Bar Plan Mut'l Ins. Co. v. Likes Law Office, LLC*, 2015 WL 6023075 (Ind. Ct. App. Oct. 15, 1995). The court also held that the trial court abused its discretion by permitting expert testimony that made ultimate legal conclusions prefaced only by a reference to unspecified "custom and practice of the professional liability insurance and underwriting industry."

The insured attorney repeatedly failed to respond to interrogatories directed to his client, the plaintiff, in a personal injury case. After the client was compelled to respond, the defendant moved for dismissal of the client's case as a sanction for submitting false and misleading answers to the interrogatories and deliberately concealing evidence. The attorney did not respond to the motion, and the trial court dismissed the case in March 2010. In March 2011, an intermediate appellate court reversed the dismissal, and the personal injury defendant appealed to the state supreme court in April 2011. The supreme court reversed, dismissing the client's case on January 18, 2012, and the client filed a legal malpractice claim against the insured attorney.

The attorney's professional liability insurer denied coverage because the attorney's legal malpractice policy excluded coverage for claims against an

continued on page 10

Second Circuit Affirms Applicability of Lower Limit on Liability Pursuant to Endorsement; No Bad Faith Claim

Applying New York law, the United States Court of Appeals for the Second Circuit has held that a claim against a broker-dealer was subject to a $1 million limit on liability, rejecting the insured's argument that the claim was subject to a $7.5 million limit. *Catlin Spec. Ins. Co. v. QA3 Fin. Corp.*, 2015 WL 6684207 (2d Cir. Nov. 3, 2015). The court also held that the insurer's failure to settle within the higher limit was not in bad faith because the insurer had an arguable basis for denying coverage above the $1 million limit.

Clients of the broker-dealer brought suit in connection with losses sustained on investments. The broker-dealer was issued a professional liability insurance policy that included an endorsement providing that claims relating to certain investments were subject to a $1 million limit rather than the $7.5 million limit reflected on the declarations page.

The broker-dealer's insurer brought a declaratory judgment action to determine whether a $1 million limit or a $7.5 million limit applied to the claim. The policyholder counterclaimed for breach of contract and bad faith. The trial court dismissed the bad faith claim but held that the policy was ambiguous with regard to the applicable limit of liability. After a jury trial, in which both parties presented evidence of the endorsement's intended meaning, the jury ruled in favor the insurer, and the court subsequently denied the insured's motion for a new trial based on erroneous jury instructions.

The Second Circuit affirmed, rejecting the insured's arguments that the jury instructions were erroneous. First, the court held that the district court did not err in refusing to explicitly instruct the jury on *contra proferentem* because, assuming that was applicable, the jury understood the essence of the rule. Second, the court held that the district court did not err in refusing to instruct the jury that the insurer had to meet the heighted burden applicable when an insurer seeks to invoke an exclusion. In fact, such an instruction would have been improper because, under New York law, a limitation of liability is not an exclusion.

The court also held that the insured's bad faith claim was properly dismissed. Under New York law, an insurer is not in bad faith when there is an arguable basis for denying coverage. In this case, the insurer refused to settle based on its interpretation of the endorsement, which a jury later concluded was correct. Therefore, the insurer had an arguable basis for denying coverage. ■

Pennsylvania Notice-Prejudice Rule Does Not Apply to Claims-Made Policies *continued from page 1*

The insurer sought dismissal of the declaratory judgment action because the underlying malpractice claim was not reported during the policy period or the 60-day extended reporting period as required under the policy. The trial court agreed with the insurer's arguments, dismissing the declaratory judgment action.

The Superior Court of Pennsylvania affirmed the trial court's dismissal. The appellate court found that the attorney had failed to give timely notice to the insurer as required by the clear and unambiguous language of the policy and therefore the insurer was not required to provide coverage. Citing Pennsylvania authority, the court refused to extend to claims-made policies the Pennsylvania notice-prejudice rule applied to occurrence policies, which requires an insurer to demonstrate prejudice resulting from the insured's breach of a notice requirement. The court also declined to find that the policy reporting requirement violated the Pennsylvania Supreme Court's Rule of Professional Conduct requiring attorneys to inform new clients on the status of the attorney's professional liability insurance or that late notice provisions in claims-made policies violate public policy as unreasonable forfeitures. ■

Insurer Failed to Show Claims Were Not Interrelated; Not Entitled to Summary Judgment for Suit Seeking Disgorgement *continued from page 2*

applied only to loss other than defense expenses and applied only as determined by a final determination in the underlying action. The court further held that, even if disgorgement was uninsurable under Texas law, the insurer did not establish that the policy precluded the advancement of defense expenses incurred defending a claim for disgorgement.

The court further held that the insurer was not entitled to summary judgment regarding its duty to indemnify the policyholder for the settlement, which the insurer contended represented only uninsurable disgorgement or restitution. The court held that, while an insurer may have no duty to indemnify an insured for a *judgment* for disgorgement or restitution, a fact issue existed about whether the entire settlement represented disgorgement because the record (which included only a stipulation of dismissal, not the actual settlement) did not show any admission of wrongdoing, and the plan agent sought amounts other than restitution and disgorgement, specifically, a "money judgment" and attorneys' fees. ■

Insured Cannot "Fill the Gap" Between Primary Insurer's Settlement Payment and Underlying Limit *continued from page 1*

settled its claim for coverage with the primary insurer for payment of $6 million of its $10 million limit. The insured then sought payment from the excess insurer. The excess insurer moved for summary judgment that its policy was not triggered because the insured did not exhaust the primary policy. After the magistrate judge granted summary judgment in favor of the excess insurer, the insured appealed, arguing that it could pay the difference to "fill the gap" between the underlying limit and the below-limit settlement to exhaust the primary policy.

The Fifth Circuit affirmed, holding that the excess policy unambiguously required the primary insurer to pay the full amount of the underlying limits in order to trigger the excess policy. The court explained that the excess policy stated that its policy was triggered only after "all applicable Underlying Insurance … had been exhausted by actual payment under such Underlying Insurance." The court ruled that such language was unambiguous, and it would be unreasonable to construe the provision to allow exhaustion when the primary insurer settled below its liability limit. The court also determined that because payment must be made "under such Underlying Insurance," only the primary insurer could make payment. Thus, the policyholder's own payments—purportedly to make up the difference between the underlying liability limit and the below-limit settlement—did not constitute "actual payment." The excess policy also defined "Underlying Insurance" to specifically mean the primary policy with a liability limit of $10 million. As such, the court found that the word "all" made it clear that a settlement did not exhaust the underlying policy if it was for less than the $10 million limit of liability. ■

Insurer Obligated to Produce Underwriting Files Relating to Policies Issued to Other Policyholders *continued from page 2*

so doing, the court concluded that the request was narrowly tailored and appropriate in light of the amount in dispute between the parties. Additionally, the court ruled that the request was appropriately limited in scope because it was confined to a specific set of policies, involving comparable insured companies, which were issued over a specific time period. Finally, the court rejected the insurer's argument that the request was inappropriate due to the private nature of insurance policies, reasoning that the request allowed for safeguards to protect private information, such as redaction. ■

Policy Roundtable: Building Assurance in Cyber Insurance

Stakeholder Roles and Responsibilities

Wiley Rein is collaborating with McBee Strategic to host a roundtable discussion on January 20, 2016, on the state of the cyber insurance industry and factors that influence growth of this complex market. The roundtable will be moderated by Greg Garcia, leader of McBee's Cybersecurity Practice. For additional details, click here.

The event, beginning at 10 a.m., will be divided into two panel discussions and will end with a networking lunch. The roundtable will engage industry executives and senior policymakers to identify key business and policy drivers of the cyber insurance market and propose breakthroughs that could accelerate the growth of the industry.

Greg will be joined at the event by senior state and federal government officials, as well as representatives from both the insurance and financial sectors. Panelists include:

Tom Finan, Senior Cybersecurity Strategist and Counsel, U.S. Department of Homeland Security;
Matt McCabe, Senior Advisory Specialist for FINPRO/Errors & Omissions, Marsh USA's Cyber Division;
Kevin McKechnie, Executive Director, American Bankers Association;
Michael Newman, Senior Policy Analyst, Federal Insurance Office, U.S. Department of the Treasury;
Dan Standish, Chair, Insurance Practice, Wiley Rein LLP;
John Soughan, Head of Proposition Management & Development, Zurich Financial Services; and
Stephen Viña, Minority Chief Counsel for Homeland Security, Senate Committee on Homeland Security and Governmental Affairs.

The event is complimentary, but space is limited.
For more information, contact Matt Huisman at mhuisman@wileyrein.com or 202.719.3103.

Third Circuit Holds That "Renewal" Policy Must Have "The Same, Or Nearly The Same, Terms" As Original Policy *continued from page 3*

The court noted that, "[r]egardless of the particular degree of similarity required, [the insurer's] position cannot be what the parties intended. There is no difference between what [the insurer] proposes and what it had every right to do without a prior promise to renew. If any new offer counts as a renewal, the promise of a renewal is illusory." The court continued, stating that "a renewal need not be identical to the original. But to hold that it can be any modification at all would not give effect to the parties' intentions." Relying on *McCuen v. American Casualty Co. of Reading, Pa.*, 946 F.2d 1401 (8th Cir. 1991), the court held that "renewal requires continuation of coverage on the same, or nearly the same, terms as the policy being renewed."

Applying this standard, the court found that the insurer here "did not offer a contract that is either the same or nearly the same as the Policy, [and therefore] it breached its promise to offer a renewal extension of coverage." Specifically, the court held that, while a "reasonable change in price should not alone render a new contract a nonrenewal," where "[t]he length of coverage is different, the amount of coverage is different, and the scope of coverage is different," the new contract is not a renewal. ■

Managed Care E&O Policy Covers Suit Alleging Unfair Competition by Competitors

continued from page 4

arguing that the underlying suits were not "Claims" and were not for "Wrongful Acts."

In the ensuing coverage action, the court denied the insurer's motion to dismiss. The court rejected the insurer's argument that the underlying suits were not "Claims." The insurer argued that a "Claim" must be filed by a customer or client of the insured. The court disagreed, reasoning that the terms of the policy specifically stated that a "Claim" included notices "that a *person or entity* intends to hold an Insured responsible for a Wrongful Act," and therefore "Claims" were not limited to claims brought by healthcare providers or plan members.

The court also rejected the insurer's argument that the underlying suits did not allege "Wrongful Acts." The court noted that the underlying suits included allegations that the insureds interfered with the professional judgment of the doctors who worked at the optometry practice. According to the court, these acts fell within a prong of the definition of "Managed Care Activities" that provided specified coverage for "evaluating, selecting, credentialing, contracting with or performing peer review of any provider of Medical Services." In addition, the court observed that the underlying suits alleged that the optometrists improperly promoted the services of the retailer of eyeglasses, which the court held fell within a provision of the definition of "Managed Care Activities" that provided specified coverage for "advertising, marketing, selling, or enrollment for health care or workers' compensation plans."

The insurer asserted that providing coverage for the underlying suits alleging unfair competition would be inconsistent with the purpose of the policy, which the insurer argued was designed to provide coverage for errors and omissions in the rendering of services to the insureds' clients or customers. The court noted that nothing in the policy permitted the court to ignore the "clear and explicit" language of the policy, regardless of the purported purpose of the policy. The insurer also cited to *Bank of the West v. Superior Ct.*, 2 Cal. 4th 1254, 1264 (1992), for the "principle" that insurance policies did not provide coverage for claims brought under California's UCL. The court rejected this notion, noting that *Bank of the West* relied on particular wording present in CGL policies that was not present in this E&O policy. The underlying complaints sought injunctive relief and not disgorgement, and the court did not discuss *Bank of the West*'s additional holdings that the only monetary relief available under the UCL is disgorgement and is uninsurable under California law. ■

No Coverage for Claims Arising from Failure to Appeal Adverse Decision

continued from page 5

The court also held that no coverage was available for the second lawsuit made in policy year two for two reasons. First, the court held that the second lawsuit was deemed made during the first policy because it was "related" to the first lawsuit made during policy year one. The two lawsuits were related because the wrongful conduct—namely, mistakes in appealing the zoning decision—were "identical" in both lawsuits. No coverage was available under the first policy for the second lawsuit because the insureds had prior knowledge that the client might bring a claim. Second, even if the second lawsuit was not related to the first lawsuit, the court held that the second lawsuit was not covered because it did not involve the provision of professional services. In the second lawsuit, the claimant alleged that the partner was liable because he failed to obtain appropriate legal malpractice insurance for the associate, which was "not the result of rigorous intellectual training" and pertained "to the running of a business rather than the practice of law."

Finally, the court held that, because there was no coverage under the two policies for the two claims, the insurer did not commit bad faith in violation of Section 93A of the Massachusetts code. ■

Attorney Cannot Wait on Outcome of Appeal to Report Dismissal of Client's Claim Due to Malpractice *continued from page 5*

Insured who, before the policy's December 1, 2011 effective date, knew or should reasonably have known of any circumstance, act, or omission that might reasonably be expected to be the basis of that Claim. The insurer also concluded that the application for the policy and the preceding policy had asked whether the attorney or his firm had "knowledge of any incident, circumstance, act or omission which may give rise to a claim" and that the responses were "no."

The attorney argued that as of November 2011 he had no knowledge of any such incident, circumstance, act, or omission because the appellate court had reversed the trial court's dismissal of his client's case. The attorney contended that he had no such knowledge until the supreme court reversed, during the policy period under which he sought coverage. The court agreed with the insurer, concluding that the attorney's "omission to timely and correctly respond to interrogatories and the trial court's subsequent dismissal of the cause could reasonably be expected to trigger a malpractice claim." Although, at the time of the appellate reversal in favor of his client, the attorney "could reasonably affirm that he had no reason to believe any of his acts or omissions 'may result in a claim for malpractice[,] . . . all that changed" when the underlying defendant appealed to the state supreme court. Accordingly, the court concluded that any reasonable attorney would realize that his client might pursue a malpractice claim should the supreme court affirm the trial court's dismissal of his client's case. Therefore, the court concluded, he should have disclosed these facts on his application for renewal, and his failure to timely notify the insurer precluded coverage.

The court also reversed the trial court's admission of expert testimony from a professional liability insurance industry expert who opined, among other things, that "[b]ased on the custom and practice of the professional liability insurance and underwriting industry, there was no act or incident as of the date of the insurance application for the 2011 Policy which reasonably would give rise to a potential claim against Likes as a result of the Opinion of the [c]ourt of [a]ppeals." The court noted that the expert's affidavit did not "clarify what these customs actually are or identify his sources therefor" but instead touched immediately upon the legal issues the court was called to answer. According to the court, "[a] mere generalized statement of 'based on the custom and practice of the professional liability insurance and underwriting industry' without any further clarification does not lift these paragraphs from the impermissible realm of legal conclusion into valid expert opinion." The court therefore determined that these portions of the affidavit should not have been admitted. ■

Action by Tennessee Attorney General Deemed to Pre-Date Claims-Made Policy Period Because Related to Earlier-Filed Customer Complaints *continued from page 3*

customer complaints were meritless, frivolous, and represented only a small percentage of its customers because the policy did not require more than one alleged wrongful act or that an allegation be meritorious. The court also rejected the insured's objections that the customer complaints were hearsay because it considered them not for the truth of the matter asserted but as evidence that the complaints were filed and to determine whether the allegations in them had a common nexus or causal connection with the Attorney General lawsuit.

In the alternative, the court found that the insured had made material misrepresentations on its policy application. The application asked whether there had been any demands against the insured in the past five years, whether or not they would be covered under the policy. The court found that the insured was aware at the time it responded "no" on the application that it had received the customer complaints and demands for refunds. Similarly, the insured falsely responded "no" to a question asking whether it had knowledge of any fact, circumstance, or situation that could reasonably give rise to a claim against the insured. Because the application stated that coverage would be unavailable for any matter that constituted a claim under the policy and that was required to be disclosed on the application, the court held that coverage was barred for the Attorney General lawsuit. ■

Failure to Provide Notice of Related Suit and Exclusion for Insufficiency of Escrow Funds Preclude Coverage for Title and Escrow Company *continued from page 4*

discovered the second lawsuit had it conducted a reasonable investigation. Instead, the court noted that the policy's reporting provision required notice of "*every* demand, notice, summons or other process," which did not occur here. The court also rejected the customer's argument that providing notice would have been "useless," given the insurer's coverage position, ruling instead that "proper claim reporting and notice of every suit is a condition precedent to coverage under the policy."

As an alternative basis for its decision, the court applied an exclusion for claims "based upon or arising out of any conversion, misappropriation, commingling, defalcation, theft, disappearance, [or] insufficiency in the amount of escrow funds…." As a threshold matter, the court ruled that the phrase "arising out of" necessitated a broad reading, requiring only "but-for" causation, in that it only requires "some causal connection between the excluded events listed" and the loss. Here, the court noted that but for the insufficiency in the amount of escrow funds, the transaction would have closed and the customer would not have initiated suit. The court also ruled that the judgment arose from the misappropriation of the escrow funds, and thus that an alternative prong of the exclusion applied, noting the evidence before the court in support of that conclusion. Finally, the court rejected the customer's argument against application of the exclusion because he would have never had a claim had the insureds not initially failed to prepare the necessary closing documents. Instead, the court observed that there would have been no claim had it not been for the insufficiency of escrow funds, and under those facts (and the "but for" test applicable to "arising out of" language), the exclusion plainly applied. ■

SPEECHES/UPCOMING EVENTS

2016 Insurance Law Symposium: The New Face of Insurance Litigation

LAURA A. FOGGAN, Speaker

• **ALI Restatement of the Law of Liability Insurance**

JAN. 22, 2016 | NEWTON, MA

ACI's ERISA Litigation Conference

KIMBERLY M. MELVIN, Speaker

• **Fiduciary Insurance and Claims: Perspectives from Underwriting, Claims, Organization and Coverage Counsel**

MARCH 1-2, 2016 | CHICAGO, IL

ABA's 2016 Insurance Coverage Litigation Committee CLE Seminar

MARY E. BORJA, Speaker

• **Battling for the Forum: Strategies Employed by Insurers and Policyholders to Secure and Protect the Most Advantageous Forum for Their Coverage Disputes**

MARCH 4, 2016 | TUCSON, AZ

AGRIP's 2016 Governance and Leadership Conference

BENJAMIN C. EGGERT, Speaker

• **Navigating Signage Regulation**

MARCH 6-9, 2016 | NASHVILLE, TN

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
Jason P. Cronic	202.719.7175	jcronic@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
Michael J. Gridley	202.719.7189	mgridley@wileyrein.com
Dale E. Hausman	202.719.7005	dhausman@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
Mary Catherine Martin	202.719.7161	mmartin@wileyrein.com
Kimberly M. Melvin	202.719.7403	kmelvin@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
Frederick H. Schutt	202.719.7502	fschutt@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
Karen L. Toto	202.719.7152	ktoto@wileyrein.com
David H. Topol	202.719.7214	dtopol@wileyrein.com
Jennifer A. Williams	202.719.7566	jawilliams@wileyrein.com
Bonnie Thompson Wise	202.719.3763	bwise@wileyrein.com