Wiley Rein LLP

EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | May 2015

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Georgia Supreme Court Unanimously Holds That Insured Cannot Sue Insurer for Amounts Paid to Settle Claim Without Insurer's Consent

The Supreme Court of Georgia has held unanimously that an insured's complaint against its insurer seeking coverage for amounts paid to settle an underlying lawsuit and alleging bad faith was properly dismissed because the insured settled the underlying lawsuit without its insurer's consent. *Piedmont Office Realty Trust, Inc. v. XL Spec. Ins. Co.*, No. S15Q0418 (Ga. Apr. 20, 2015). Wiley Rein represented the insurer.

The insured, a real estate investment trust, exhausted the limits of a primary D&O policy and incurred another $4 million under its excess policy while defending an underlying securities action. The insured prevailed on summary judgment, but the securities claimants appealed, and the insured sought consent from the excess insurer to settle the case for the $6 million remaining under its policy. Based largely on the insured's counsel's analysis of the potential exposure, the excess insurer agreed to contribute $1 million toward settlement. Without obtaining the insurer's consent, the insured entered into a $4.9 million settlement agreement, which was later approved by the district court.

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Insurer Entitled To Recoup Settlement Payment Made in Underlying Action

A Pennsylvania federal court has held that an insurer was entitled to reimbursement of a settlement payment paid on behalf of its insured where the insurer reserved its rights to deny coverage and entered into a reasonable settlement. *Am. Western Home Ins. Co. v. Donnelly Distribution, Inc.*, No. 14-797 (E.D. Pa. Feb. 6, 2015).

An insured was sued in a tort action arising out of a slip and fall accident. The insurer defended the insured subject to a reservation of rights and filed a coverage lawsuit seeking a declaration that it was not obligated to defend or indemnify the insured. The insured settled the underlying lawsuit for an amount within the limits of the policy, which the insurer paid. The United States Court of Appeals for the Third Circuit held in the coverage action that the insurer had no duty to defend or indemnify the insured. The insurer then filed a lawsuit against the insured seeking reimbursement of the amount it paid to settle the underlying litigation.

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Insurer's Recoupment Claim Still Alive After Appellate Court Rejects Dismissal Based on Waiver

The United States Court of Appeals for the Eleventh Circuit, applying Georgia law, has reversed the dismissal of an insurer's complaint for recoupment of amounts it paid to settle a claim against its insured, holding that the district court erred in relying on factual conclusions that did not flow inevitably from the insurer's complaint in determining that the insurer's lawsuit was barred by waiver and the insurer's voluntary payment. *Twin City Fire Ins. Co. v. Hartman Simons & Wood LLP*, 2015 WL 1651628 (11th Cir. April 15, 2015).

The insured, a law firm, was hired by a bank to draft documents for a real estate transaction. The bank alleged that, due to an attorney drafting error, a party to the transaction was erroneously released of all of its financial obligations to the bank, costing the bank $60 million. The bank demanded indemnification from the insured, and the insured tendered the matter to its insurer. Approximately three years later, the bank made a $10 million time-limited settlement demand on the insured, which the insured demanded the insurer accept.

After the insured rejected the insurer's request for an allocation of the settlement amount between covered and non-covered amounts, the insurer agreed to pay the entire settlement subject to a full reservation of its rights. Shortly before making the settlement payment, the insurer filed a coverage action asserting claims for allocation and recoupment of settlement amounts paid.

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Prejudice Irrelevant to Late Notice Where Timely Notice Is Condition Precedent

Applying Minnesota law, the Court of Appeals of Minnesota has held that, where timely notice is a condition precedent for coverage under a claims-made-and-reported policy, an insurer need not demonstrate actual prejudice to disclaim coverage. *Michaels v. First USA Title, LLC*, 2015 WL 1514018 (Minn. Ct. App. Apr. 6, 2015).

The appellate court also determined that, where an insurer was given no opportunity to investigate an underlying claim and participate in the insured's defense and there was a large judgment against the insured, the insurer suffered actual prejudice in any event. The court also held that an insured's notice of wrongful acts that could result in a claim, along with notice of a prior suit, did not constitute adequate notice of a later-filed suit.

The insured's claims-made-and-reported E&O policy, which provided coverage from March 29, 2007 to March 29, 2008, required—as a condition precedent to coverage—that the insured give the insurer written notice "as soon as practicable of any claim made against the [i]nsured." In addition, the policy's "special reporting clause" provided, in relevant part:

> If during the Policy Period . . . the Insured shall become aware of any occurrence which may reasonably be expected to give rise to a claim against the Insured for a Wrongful Act which occurs on or after March 29, 2002 and prior to the end of the Policy Period, and provided the Insured gives written notice to the Company during the Policy Period . . . of the nature of the occurrence and specifics of the possible Wrongful Act, any claim which is

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Federal District Court Concludes No Coverage for Untimely Claim

In an unpublished decision applying Louisiana law, a federal court has held that matters not timely reported under claims-made-and-reported D&O liability policies do not implicate coverage. *XL Spec. Ins. Co. v. Bollinger Shipyards, Inc.*, 2015 WL 853993 (E.D. La. Feb. 26, 2015).

The insurers each issued a D&O policy to the insured, a ship building company, with one-year policy periods. The policies provided coverage for claims first made during the policy period of each respective policy and reported by January 30, 2007 and July 30, 2009, respectively. The insured asserted that the United States "first made" claims against it under the False Claims Act on two separate occasions—the first being a "preserve evidence" letter and the second being a tolling agreement—and, as a result, each claim implicated one of the policies. The insurers denied coverage for both claims on the basis that they were not timely reported and the insured initiated coverage litigation.

In granting the insurers' motion for summary judgment, the court determined that there was no evidence that the insured gave notice of any claim to any insurer prior to July 28, 2011. Therefore, according to the court, neither policy was implicated. In doing so, the court observed that "the purpose of the reporting requirement . . . is to define the scope of coverage . . . by providing a certain date after which an insurer knows it is no longer liable under the policy." The court disagreed with the insured's argument that, because its coverage had been continually renewed, its policies had effectively "merged into one" single policy for purposes of notice. The court explained that each policy is separate and not an extension of the previous policy. Additionally, the court determined that the policies' continuity date did not alter the relevant policy periods, but instead applied only to define the scope of a particular exclusion. ■

No Coverage Under Claims-Made-and-Reported Policies for Claims Not Timely Reported

In an unpublished decision applying Kentucky law, a federal court has held that a matter not timely reported under one of a series of consecutive claims-made-and-reported policies does not implicate coverage. *C.A. Jones Mgmt. Group, LLC, v. Scottsdale Indem. Co.*, No. 5:13-cv-173 (W.D. Ky. Mar. 25, 2015).

The insurer issued consecutive D&O liability policies to the insured for several one-year periods. The policies provided coverage for claims first made during the policy period of each respective policy. Each policy's notification provision required that notice of a claim be given within 60 days following the end of the policy period in which the claim was made. The insured sought coverage for a claim of which it gave the insurer notice more than 60 days after the expiration of the policy period in which the claim was made. The insurer denied coverage on the basis that the claim was not reported during the policy period in which it was made or the applicable grace period.

Relying on an unpublished opinion of an intermediate Kentucky appellate court, the court initially determined that the insured timely reported the claims because, according to the court, the renewal of the relevant policy resulted in seamless coverage for the insured. The insurer then filed a motion for reconsideration. In granting the insurer's motion for reconsideration, the court determined that applying the Kentucky appellate court's reasoning would result in "manifest injustice" because it would "generat[e] a long and unbargained-for tail of liability exposure, the avoidance of which forms the conceptual framework for claims-based coverage in the first place." The court concluded that the Kentucky Supreme Court more likely would follow the dissenting opinion of the intermediate appellate court opinion, and therefore held that the insured must satisfy the reporting requirements of the applicable policy notwithstanding that it purchased several consecutive claims-made policies. ■

Insurer Need Not Demonstrate Prejudice to Disclaim Coverage for Late Notice under Excess Claims-Made Policy

The United States District Court for the Eastern District of Kentucky has held that, where an excess claims-made policy requires—as conditions precedent to coverage—notice of a claim within 90 days of the policy's expiration and within 30 days of notice to a primary carrier, an insurer need not demonstrate prejudice to disclaim coverage. *Ashland Hosp. Corp., d/b/a King's Daughters Med. Ctr. v. RLI Ins. Co.*, Civil Action No. 13-143-DLB-EBA (E.D. Ky. Mar. 17, 2015).

On December 30, 2011, the insured provided notice to its primary D&O carrier for the October 1, 2010 to October 1, 2011 policy period of a United States Department of Justice investigation that had commenced on July 25, 2011. The insured first gave its excess D&O carrier for that policy period notice of the investigation on June 29, 2012. The excess policy generally followed form to the primary policy, which provided that "[a]s a condition precedent to any to payment in respect of any Claim . . . [the insured] must give [the insurer] written notice of such Claim, with full details, as soon as practicable after it is received . . . [i]n no event may notice be provided more than ninety (90) days after expiration . . . of the Policy Period." The excess policy separately provided that "[t]he Insureds shall, as a condition precedent to exercising their rights under th[e] Policy, give the Insurer written notice of any of the following events as soon as practicable, but in no event later than thirty (30) days after such event[,]" including, in pertinent part, "any notice by the Insured under any Underlying Insurance[.]" The excess carrier disclaimed coverage for the investigation, stating that the insured's notice was untimely.

In the coverage litigation that followed, the United States District Court for the Eastern District of Kentucky held that, in first providing the excess carrier notice over 90 days after its excess policy's expiration and over 30 days after first providing the primary carrier with notice, the

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Insurer Owes No Duty to Defend "Related Claim" Where Suit is Based on Same Course of Discriminatory Conduct Alleged in Prior Litigation

Applying New York law, a federal district court has held that an insurer owed no duty to defend a policyholder, finding that a claim arising from allegations of "longstanding discriminatory animus" was related to a prior claim based on a "sufficient factual nexus" between the lawsuits brought thirteen years apart. *Darwin Nat'l Assurance Co. v. Westport Ins. Corp.*, 2015 WL 1475887 (E.D.N.Y. Mar. 13, 2015). In addition, the court determined that coverage also was excluded under the "claims-made" policy's "prior or pending litigation" provision.

In 1996, a Catholic diocese brought an action alleging that a village violated its rights to use a property for religious purposes by denying its application to develop a cemetery. The diocese prevailed but brought a subsequent action against the insured municipality in 2009, generally alleging that the village continued to discriminate against it by taking measures that prevented the diocese from developing the property. The insured tendered the defense of the 2009 action to two insurers under separate "claims-made" Public Officials and Employees Liability policies. The insurers, the first of which had defended the village in the 1996 action, agreed to share in advancing defense costs. The second insurer filed the present declaratory judgment action, asserting that the 2009 action did not constitute a claim "first made" during the policy period and that the policy's "prior or pending litigation exclusion" precluded coverage.

On the parties' motions for summary judgment, the court first determined that, although a "claim" should be construed as a cause of action, rather than a lawsuit, the causes of action alleged in the 2009 action were related to those of the 1996 action because they shared a "sufficient factual nexus." Noting the "broad construction"

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California Court Holds Claims by Separate Investors in the Same Ponzi Scheme All Barred by Application Exclusion

A California appellate court has held that the application exclusion of a broker-dealer's professional liability policy barred coverage for claims by customers who invested in the same Ponzi scheme involved in a previous claim. *Crown Capital Securities, L.P. v. Endurance Am. Spec. Ins. Co.*, 2015 WL 1607164 (Cal. App. Ct. Apr. 10, 2015).

The broker-dealer received a claim by a customer alleging that the broker-dealer had failed properly to investigate investments in a real estate firm that had filed for bankruptcy and was alleged to have been running a Ponzi scheme. The broker-dealer later submitted an application for professional liability insurance that asked if any claims had been made against the entity. The broker-dealer answered "yes" and submitted a loss run from its prior insurer containing the claim by the customer. The application also asked if the applicant was aware of any fact, circumstance, situation, or accident that may result in a claim. The insured answered "no." The application contained an "application exclusion" barring coverage for "any claim or lawsuit . . . arising from any fact, circumstance, act, error or omission disclosed or required to be disclosed in response" to those questions. After the policy was issued, three additional claims were made by customers of the insured broker-dealer who invested in the same real estate firm. The insured sought coverage under the professional liability policy, contending that each of these claims involved a separate investment that did not "arise out of" the prior investment in the real estate firm that was at issue in the initial claim. The insurer denied coverage pursuant to the terms of the application exclusion, and coverage litigation ensued.

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No Duty to Defend Where Insured Received Demand Prior to Policy's Inception

Applying California law, the United States Court of Appeals for the Ninth Circuit has held that an insurer does not have a duty to defend a claim against a real estate company where the company first received a demand from the claimant five months before the policy's inception. *Carlson v. Century Surety Co.*, 2015 WL 1434943 (9th Cir. Mar. 31, 2015). The court also determined that the judgment entered against the insured in the underlying proceeding pursuant to a settlement with the claimants was unreasonable.

A couple brought a claim against a real estate company over a failed residential real estate transaction. The couple sent a demand letter and then filed suit. The real estate company tendered the claim to its insurer, but the insurer denied coverage after discovering that the demand letter was sent over five months before the policy incepted. The couple and the real estate company subsequently agreed to settle. In connection with the settlement, the couple filed an amended complaint increasing the asserted damages from $65,000 to $3 million and made the settlement contingent on receipt of declarations from the real estate company denying that it had received notice of the couple's demand before the policy's inception. The real estate company assigned its rights to the couple, who then brought suit against the insurer.

The trial court held that the insurer had breached its duty to defend, but the appellate court reversed. According to the appellate court, the insured company's file contained the couple's pre-policy demand letter, and the couple had no evidence to support its argument that the company may not have received the letter until over five months after it was sent. As such, the court held that the insured company had notice of the claim before the policy's inception, and therefore the insurer had no duty to defend.

The court also held that, even if the insurer owed a duty to defend, the couple would be barred from recovering under the policy because no reasonable juror could conclude that the settlement between the company and the couple was not fraudulent. The court found that the couple's amended demand and its requirements for certain declarations designed to trigger coverage under the policy were clear signs of a fraudulent settlement agreement. ■

Indiana High Court Holds Settlement of Managed Care Organization Multi-District Litigation Is Covered Under E&O Policies

The Indiana Supreme Court, applying Indiana law, has held that the settlement of a multi-district litigation, which alleged that the insured managed care organization had engaged in a scheme of systematically failing to pay claims by medical providers in full and in a timely manner, fell within the insuring agreement of the organization's E&O policy because the insured's losses resulted from alleged wrongful acts that occurred solely in the rendering or failure to render professional services. *WellPoint, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 2015 WL 1849523 (Ind. Apr. 22, 2015).

The insured managed care organization was named in various lawsuits alleging that the organization had engaged in an improper, unfair, and deceptive scheme designed to systematically deny, delay, and diminish payments due to doctors for rendering covered, medically-necessary services. Plaintiffs brought two lawsuits in Connecticut state court asserting claims for breach of contract, breach of the duty of good faith and fair dealing, violation of the Connecticut Unfair Trade Practices Act and Unfair Insurance Practices Act, negligent misrepresentation, and unjust enrichment. Plaintiffs in three lawsuits in Florida asserted claims under the Racketeer Influenced and Corrupt Organizations Act (RICO), including conspiracy and aiding and abetting, and claims for breach of contract and violations of prompt-pay statutes.

The actions were all consolidated in a federal multi-district litigation in the United States District Court for the Southern District of Florida. The claims alleging breach of contract, unjust enrichment, and violations of state prompt-pay statutes were subsequently dismissed or dropped. In July 2005, the managed care organization settled the multi-district litigation but denied any wrongdoing or liability.

The managed care organization, which was self-insured for its primary and excess layers

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Invasion of Privacy Exclusion Blocks Basketball Team's Shot at D&O Coverage for TCPA Claims

The United States District Court for the Central District of California has held that an invasion of privacy exclusion in a D&O policy barred coverage for a claim alleging violations of the Telephone Consumer Protection Act (TCPA). *Los Angeles Lakers, Inc. v. Federal Ins. Co.*, No. 2:14-cv-07743-DMG-SH (C.D. Cal. Apr. 17, 2015).

The insured, a professional basketball organization, was sued for violations of the TCPA after it sent text messages to numerous individuals. The policyholder tendered the suit under its D&O policy, but the insurer denied coverage on the basis that the policy barred coverage for any claim "based upon, arising from, or in consequence of … invasion of privacy …." After disputing the denial, the policyholder filed a coverage action against the insurer, arguing that the underlying suit alleged only economic injuries and did not seek damages for the violation of privacy interests.

Ruling on the insurer's motion to dismiss, the court held that the invasion of privacy exclusion barred coverage for the underlying suit. First, the court noted that "violations of the TCPA are rooted in a violation of an individual's privacy interests," and it recognized that courts have "universal[ly] interpret[ed] TCPA claims as implicit invasion-of-privacy claims." Based on that conclusion, and "because the [p]olicy specifically exclude[d] claims arising from invasions of privacy," the court ruled that the exclusion applied. The court also noted that its conclusion was bolstered by the broad prefatory language of the exclusion. Finally, the court recognized that a number of other decisions, including *LAC Basketball Club Inc. v. Federal Insurance Co.*, No. CV 14-00113 GAF FFMX, 2014 WL 1623704 (C.D. Cal. Feb. 14, 2014), and *Resource Bank v. Progressive Casualty Insurance Co.*, 503 F. Supp. 2d 789, 797 (E.D. Va. 2007), had applied invasion of privacy exclusions in D&O policies for claims involving alleged TCPA violations. ■

Insurer Has Duty to Defend under Claims-Made Policy Where Insured Potentially Received Notice of the Claim During the Policy Period

The United States District Court for the Eastern District of Texas, applying Texas law, has held that an insurer had a duty to defend its insured where the underlying complaint contained allegations sufficient to support the position that the insured *potentially* received pre-suit notice during the claims-made policy period, notwithstanding that the insured was not served with the complaint until after the policy period had expired. *Corinth Investors Holdings, LLC v. Evanston Ins. Co.*, 2015 WL 1321616 (E.D. Tex. 2015).

An insured medical center held a claims-made insurance policy for the policy period of January 1, 2012 to January 1, 2013 (the 2012-2013 Policy) and a claims-made insurance policy with another insurer for the policy period of January 1, 2013 to January 1, 2014 (the 2013-2014 Policy).

On January 2, 2013, the insured was served with notice of a suit filed by a former patient. The insured reported the lawsuit under both the 2012-2013 Policy and the 2013-2014 Policy. Both carriers denied coverage, each arguing that the claim was not first made during its respective policy period.

The insured sought a declaratory judgment that the 2013-2014 insurer had a duty to defend the insured in the underlying litigation, to which the court agreed. The two insurers then filed cross-motions for summary judgment seeking a declaration as to whether the 2012-2013 insurer had a duty to defend the claim. The 2012-2013 insurer argued that it had no duty to defend because the complaint in the underlying litigation did not specifically allege that the insured received notice of the claim during the 2012-2013 Policy period, and also because the court had already ruled that the 2013-2014 insurer had a duty to defend. The 2013-2014 insurer argued that the pleadings established that the insured potentially had received notice of the claim during the earlier 2012-2013 Policy period.

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Insurer Has No Duty to Defend When Insured Fails to Give Adequate Notice During Policy Period

An Illinois appellate court has held that an insurer had no duty to defend its insured law firm in two underlying lawsuits because the insured failed to comply with the notice condition of the policy where it gave only cursory notice of potential claims the day before the policy expired. *Ill. State Bar Ass'n Mut. Ins. Co. v. Beeler Law, P.C.*, 2015 WL 1407310 (Ill. App. Ct. Mar. 25, 2015). In so holding, the court concluded that adequate and timely notice was a "requirement" and "condition precedent" to insurance coverage, and "general notice" thus failed to trigger the insurer's duty to defend.

The insured law firm purchased a legal malpractice insurance policy from the insurer that required the insured to give written notice of any claim "as soon as practicable" and within the policy period. The policy further required the notice to include specific information, including details about the alleged wrongful conduct and the circumstances giving rise to the claim. One day before the policy expired, the insured emailed the insurer to report three potential claims, identifying only the potential claimants by name and advising that more details would follow. The insured failed to provide any additional information until several months later, after the policy expired, when it was sued in underlying litigation and it forwarded the complaints to the insurer. In response to the law firm's request for a defense, the insurer brought the present coverage action, seeking a declaration that it did not have a duty to defend the insured in the underlying suits. On the parties' cross-motions for summary judgment, the trial court granted the insurer's motion, concluding that the insured failed to satisfy the policy's notice requirements.

The Illinois appellate court affirmed the grant of summary judgment in favor of the insurer, holding that it was

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Unserved *Qui Tam* Complaint Does Not Satisfy "Claim First Made" Requirement of Claims-Made Policy

A federal district court in California has ruled that an unserved *qui tam* complaint was a "Claim" but that it did not trigger coverage because, without service, the complaint was not "first made" during the operative policy period. *Braden Partners, LP v. Twin City Fire Ins. Co.*, No. 14-cv-01689-JST (N.D. Cal. Apr. 3, 2015).

Following an initial investigation by the Department of Justice, the insured was notified of a pending *qui tam* lawsuit against it, which alleged violations of the Federal and California False Claims Acts. The insured reported the suit to its insurer, which denied coverage on several grounds.

In the litigation that followed, the court found that the complaint against the insured constituted a "claim" within the meaning of the policy. The court, however, further found that the policy did not respond to that claim because it was not a claim first made during the claims-made period of the policy. In this regard, the court noted that the policy provided that a claim would "be deemed to have been made … on the date that a summons or similar document is first served …." According to the court, because the *qui tam* complaint was not served on the insured, it was not "first made" against the insured. ■

Coverage Barred under "Known Risk" Exclusion Where Applicant for Insurance "On Notice" of Potential Malpractice Claim

Applying District of Columbia law, the United States Court of Appeals for the District of Columbia Circuit affirmed summary judgment in favor of an insurer based on a claims-made policy's "known risk" exclusion where a law firm was on notice of, but failed to disclose, a potential malpractice claim in its application for insurance. *Chicago Ins. Co. v. Paulson & Nace, PLLC*, 2015 WL 1782273 (D.C. Cir. Apr. 21, 2015). In addition, the court affirmed that the insurer had not waived its right to deny coverage because it invoked the exclusion when it gained actual knowledge of the alleged malpractice.

In 2006, a law firm filed two medical malpractice complaints on behalf of a girl who was paralyzed during surgery. The first, timely complaint was dismissed based on a captioning error, and in June 2007, the same Virginia state court dismissed the second complaint with prejudice on statute of limitations grounds. One month later and while a state court appeal was pending, the firm applied for and obtained a claims-made professional liability insurance policy. In the application, the firm's sole member stated that there were no "circumstances which may result in a claim being made against his firm." The law firm advised the insurer of the incident in May 2009, but it represented that the potential malpractice had occurred in 2008. Two years later, during its investigation of the claim, the insurer discovered the caption error and soon after reserved its rights to deny coverage under the policy's known risk exclusion. After the claimant prevailed in her legal malpractice action against the firm, the insurer brought a declaratory judgment action and was granted summary judgment that coverage was barred based on the exclusion.

In affirming the district court decision in its entirety, the Court of Appeals first determined that a reasonable attorney under the circumstances would have been on notice of the potential malpractice claim at the time the firm applied for coverage. In finding "no triable question" with respect to whether the firm had a duty to inform the insurer of the caption error, the court rejected the firm's argument that it expected the error to be corrected on appeal as irrelevant. The court also affirmed that expert testimony was unnecessary, finding that the attorney's lack of care was so "obvious" that that a lay juror could find negligence as a matter of "common knowledge."

Next, the court rejected arguments that the insurer had either forfeited or waived its right to deny coverage. In particular, the court declined to adopt the firm's position that the insurer forfeited its right to deny coverage by failing to comply with a Virginia statute requiring claimant notification of any disclaimer, affirming that District of Columbia

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Georgia Supreme Court Unanimously Holds That Insured Cannot Sue Insurer for Amounts Paid to Settle Claim Without Insurer's Consent *continued from page 1*

The insured then sued its insurer in federal district court for breach of contract and bad faith, seeking coverage for the full settlement amount plus statutory interest. The insured claimed, among other things, that the insurer's consent to the settlement was not required because the insurer withheld its consent unreasonably and in bad faith. Rejecting that argument, the district court granted the insurer's motion to dismiss. The insured appealed.

On questions certified by the United States Court of Appeals for the Eleventh Circuit, the Georgia Supreme Court first discussed the case of *Trinity Outdoor, LLC v. Central Mutual Insurance Co.*, 285 Ga. 583, 279 S.E.2d 10 (Ga. 2009), which also involved an insured's unilateral settlement without its insurer's consent. Ultimately, with respect to the present action, the court summarized its conclusion that the insured's complaint was properly dismissed:

> [T]he plain language of the insurance policy does not allow the insured to settle a claim without the insurer's written consent. It also provides that the insurer shall only be liable for a loss which the insured is "legally obligated to pay." Finally, the policy contains a "no action" clause which stipulates that the insurer may not be sued unless, as a condition precedent, the insured complies with all of the terms of the policy and the amount of the insured's obligation to pay is determined by a judgment against the insured after a trial or a written agreement between the claimant, the insured, and the insurer. In light of these unambiguous policy provisions, we hold that [the insured] is precluded from pursuing this action against [the insurer] because [the insurer] did not consent to the settlement and [the insured] failed to fulfill the contractually agreed upon condition precedent.

The court also rejected the insured's argument that the "consent to settle" provision did not apply because the insurer "unreasonably withheld" its consent to the settlement, in violation of a policy provision stating that the insurer's consent "shall not be unreasonably withheld." The court rejected the assertion that that phrase distinguished the policy here from the policy in *Trinity Outdoor*, concluding that the very same duty was implied in *Trinity Outdoor* but did not dictate a different result. The court also rejected the argument that the insurer waived the consent requirement by denying coverage for the settlement, concluding that the insurer did not "wholly abandon" its insured but rather funded the insured's defense in the underlying action.

In addition, the court rejected the insured's argument that the district court's approval of the settlement agreement created a "legal obligation to pay." The court stated that the insured "could not settle the underlying lawsuit without [the insurer's] consent —in breach of its insurance contract—and then, after breaching the contract, claim that the district court's approval of the settlement imposed upon [the insurer] a distinct legal obligation to pay the settlement." ■

California Court Holds Claims by Separate Investors in the Same Ponzi Scheme All Barred by Application Exclusion
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The California appellate court rejected the insured's argument and held that coverage was precluded by the application exclusion contained in the policy. In so holding, the court concluded that the insured was aware, prior to the submission of its application for insurance, that (1) the real estate firm had declared bankruptcy and allegedly had been operating a Ponzi scheme; (2) an initial claim had been made by an investor of the real estate firm; and (3) its broker-dealers had sold other investments in the real estate firm to their customers. The court therefore reasoned that the insured was aware of facts and circumstances that might result in claims being made against it for any investment in the real estate firm. Accordingly, the application exclusion barred coverage for the subsequent claims, even though the later claims asserted causes of action other than the failure to exercise due diligence alleged in the initial claim. The court held that the claims concerned facts and circumstances of which the insured was aware prior to submitting the application because they "concerned the purchase of [real estate firm] investments" by the insured's customers. ■

Insurer Need Not Demonstrate Prejudice to Disclaim Coverage for Late Notice under Excess Claims-Made Policy

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insured gave late notice and failed to satisfy conditions precedent to coverage. The court rejected the insured's arguments that one of the notice provisions was ambiguous because the provision did not appear on either the first page of the primary policy or in the insuring clauses and had been deleted from the renewal version of the excess policy. In addition, the court rejected the insured's contention that the excess policy did not follow form to the underlying policy's notice provisions because the excess policy had supplemental reporting requirements. Moreover, the court rejected the insured's argument that, pursuant to the excess policy's provision requiring notice within 30 days of specified events, it was only required to give notice of one event rather than all of them.

In finding that the insured failed to comply with the excess policy's notice requirements, the court held that the excess carrier did not have to show prejudice in order to deny coverage for late notice under a claims-made-and-reported policy. The court distinguished the excess policy from the occurrence-based policy at issue in *Jones v. Bituminous Casualty Corporation*, 821 S.W.2d 798 (Ky. 1991), which adopted a notice-prejudice rule, on four bases: (1) the excess policy was not a contract of adhesion; (2) unlike the policy in *Jones*, the excess policy provided a "definite time" when notice was due; (3) unlike the insured in *Jones*, the excess carrier's insured was not statutorily obligated to purchase its policy; and (4) applying a notice-prejudice rule to a claims-made policy would result in a windfall for the insured. ■

Insurer Owes No Duty to Defend "Related Claim" Where Suit is Based on Same Course of Discriminatory Conduct Alleged in Prior Litigation

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given to the unambiguous terms "based upon," "arising out of" and "in any way involving" in the policy's definition of "related claim," the court reasoned that the claims were related largely because the lawsuits involved the same property, the same types of complaints, and "virtually the same parties." The court concluded that under either "arising out of," which requires a causal connection, or "in any way involving," which requires only "some kind of connection or relationship," the claims were related based on its finding that, in the 2009 action, the diocese alleged a "consistent course of discriminatory conduct" and a "longstanding discriminatory animus" that resulted in both the initial denial of the diocese's application and the subsequent measures taken by the insured to avoid the consequences of the state court ruling. In reaching that result, the court rejected the village's argument that the claims were unrelated because some causes of action in the 2009 action were based on allegations of abuse unrelated to the earlier lawsuit, finding instead that the complaint alleged that the village took those actions "as part of a long-standing campaign" to block development that dated back to the 1996 action.

Applying similar reasoning, the court further held that the policy's "prior or pending litigation" exclusion, which excluded from coverage defense expenses "from any Claim based on, arising out of . . . or in any way involving . . . any fact, circumstance, situation, transaction, event, or Wrongful Act . . . underlying or alleged in any . . . litigation . . . brought prior to the Inception Date," negated the insurer's duty to defend. Because the diocese generally alleged that the campaign to block its application for development stemmed from the village's animus, the court found that the 2009 action alleged causes of action that arose out of or in any way involved facts "underlying or alleged" in the 1996 action.

The court also held that the first insurer had a duty to defend in the 2009 action. In so doing, the court rejected the argument that the dismissal of certain causes of action as time-barred severed any connection between the two suits. The court concluded that the argument ignored the fact that the standard for establishing a duty to defend, which is a question of contract interpretation, is different from the standard for finding a continuing violation for statute of limitations purposes, which must be based on the accrual date of certain claims. ■

Insurer's Recoupment Claim Still Alive After Appellate Court Rejects Dismissal Based on Waiver

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The insured moved to dismiss the insurer's complaint for failure to state a claim, arguing that the insurer failed to reserve its right to seek allocation and recoupment properly and therefore waived it, that the insurer's settlement with the bank was a "voluntary payment," and that the insurer had no contractual right to seek allocation and recoupment of the settlement payment. The district court agreed that the insurer waived its allocation and recoupment claims by failing to reserve its rights properly, and dismissed the insurer's complaint.

On appeal, the Eleventh Circuit disagreed, reversing the district court's dismissal. The appellate court first took issue with the district court's reliance on the insured's claims that the insurer did nothing to reserve its rights between the three years from when it was notified of the bank's claim to when the bank made the settlement demand. The court stated that the complaint included no factual allegations regarding what might have occurred in those three years and that the district court's determination that the insurer was "dilatory" during those three years rested on inferences only. The court explained that the insurer was under no obligation to anticipate the insured's affirmative waiver defense and include factual allegations responsive to that defense. According to the court, the complaint's silence "did not give the district court license to assume that [the insurer] had failed to take certain actions during that period." The court also found that, by concluding the insurer was "dilatory," the district court implicitly found that the insurer's conduct had prejudiced the insured, which is "quintessentially a question of fact" that should not have been reached in evaluating the complaint on a motion to dismiss.

The court found that the district court made similar errors in concluding that the insurer's claim was barred pursuant to the voluntary payment doctrine. The court explained that the district court could not properly have made the factual finding that the insurer "was aware of all the material facts relating to its coverage defense at the time it made the payment to the [b]ank" by looking solely at the complaint. The court added that, although the district court properly noted that Georgia law recognizes exceptions to the voluntary payment doctrine for payments made under "urgent and immediate" necessity, the district court improperly put the onus on the insurer to establish the applicability of the exception at the motion to dismiss phase, where the sole question should have been whether it was plain from the face of the complaint that the exception could *not* be invoked. ■

Insurer Entitled To Recoup Settlement Payment Made in Underlying Action

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The court granted summary judgment to the insurer, holding that it was entitled to recoup the settlement payment. The insurer argued that it was entitled to reimbursement based on an unjust enrichment theory, while the insured argued that the settlement was a voluntary payment that could not be recouped. The insured also noted that the policy at issue did not explicitly allow for recoupment of a settlement payment.

In determining that the insurer was entitled to reimbursement of the settlement payment, the court looked to the factors announced in *Axis Specialty Insurance Co. v. The Brickman Group, Ltd.*, 756 F. Supp. 2d 644 (E.D. Pa. 2010). These factors are (1) whether the insurer made the payment based upon a mistake of law; (2) whether the insured was on notice at the time of payment that the obligation to pay was disputed; (3) whether the insurer made the payment primarily to protect its own interest; and (4) whether permitting reimbursement under the circumstances would upset the "delicate incentive structure inherent in the insurer/insured relationship." According to the court, all of these factors pointed towards allowing reimbursement. Here, the insurer did not make the payment based on a mistake of law; the insurer reserved its rights at the time of the settlement; the settlement benefited the insured by capping costs at a low amount; and the decision to settle was a reasonable one, so the incentive structure would not be upset. Finally, the court noted that the Third Circuit was aware of the settlement when it held that the insured had no duty to indemnify, and its decision therefore probably contemplated that the insured would be entitled to reimbursement. ■

Prejudice Irrelevant to Late Notice Where Timely Notice Is Condition Precedent

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> subsequently made against the Insured arising out of such Wrongful Act shall, for the purposes of this policy, be treated as a claim made during the currency hereof.

Pursuant to this provision, and during the policy period, the insured provided the insurer with written notice of wrongful acts that occurred in June and July 2006 and of a subsequent lawsuit. However, the insured did not provide the insurer with notice of a 2010 lawsuit which culminated in a judgment against the insured totaling nearly $850,000. Seeking to access insurance proceeds of the expired policy, the underlying claimants from the 2010 lawsuit sought leave to file a supplemental complaint against the insurer. The trial court denied leave on the grounds that there was no coverage under the policy.

On appeal, the Court of Appeals of Minnesota affirmed the trial court's ruling, holding that, because timely notice was a condition precedent to coverage and the insured did not provide notice of the 2010 lawsuit, the policy at issue did not afford coverage for that lawsuit. According to the court, the policy's special reporting provision did not negate the insured's obligation to notify the insurer of claims "as soon as practicable" merely because it converted the policy from a claims-made policy to an occurrence-based policy with respect to claims arising out of reported wrongful acts. The court also rejected the underlying claimants' argument that the insurer had to show actual prejudice to disclaim coverage for late notice, noting that the insurer's policy expressly made timely notice a condition precedent for coverage. According to the court, even if the insurer had to show actual prejudice, because the insured gave the insurer no opportunity to investigate the underlying claim or participate in its defense and suffered a large judgment, coverage would not attach under the policy.

The court also rejected the underlying claimants' argument that the insurer's denial of coverage violated the Minnesota Unfair Claims Practices Act, holding that the statute did not permit private causes of action. ■

Coverage Barred under "Known Risk" Exclusion Where Applicant for Insurance "On Notice" of Potential Malpractice

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law applied and adding that, in any event, Virginia courts have clearly held that the statute may not be enforced by a policyholder against an insurer.

The court also rejected the law firm's waiver defense. In so doing, the court found that the insurer did not gain "constructive knowledge" of the procedural error when it first obtained documents that contained dates of the underlying medical malpractice proceedings. Instead, the court concluded that the insurer had no duty "during the preliminary stages of the claim process to sift and verify the information provided by" the firm. Lacking a genuine question as to the insurer's "actual knowledge" of the error and finding no reason that knowledge should be imputed to the insurer, the court affirmed summary judgment. ■

Insurer Has Duty to Defend under Claims-Made Policy Where Insured Potentially Recevied Notice of the Claim During the Policy Period

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The court held that there was a duty to defend under the 2012-2013 Policy. In reaching this conclusion, the court rejected the argument that the underlying complaint had to allege specifically that the insured had received notice of the claim during the 2012-2013 Policy period in order to trigger defense obligations under that policy. The court explained that, to the contrary, the allegation in the complaint that the claimant had sent "pre-suit notice" to the insured was sufficient to support that the insured *potentially* received notice of the claim during the 2012-2013 Policy period and, accordingly, the 2012-2013 carrier had a duty to defend the insured. The court also rejected the argument that its conclusion that the 2013-2014 insurer had a duty to defend negated any defense obligation on the part of the 2012-2013 carrier. The court explained that the analysis as to the carriers' defense obligations were to be completed separately, and each was to be resolved in favor of the insured. ■

Indiana High Court Holds Settlement of Managed Care Organization Multi-District Litigation Is Covered under E&O Policies

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of E&O coverage, sought coverage from its E&O reinsurers. The excess reinsurers denied coverage for the settlement and defense costs, and the managed care organization filed this coverage action. The trial court granted summary judgment in favor of the reinsurers, and the intermediate court of appeals affirmed.

On appeal, the Indiana Supreme Court considered three principal contentions of the reinsurers as to why the settlement was not covered. First, the reinsurers argued that the settlement did not fall within the terms of the policy's insuring agreement, which covered "Loss of the Insured resulting from any Claim or Claims … against the Insured … for any Wrongful Act of the Insured … but only if such Wrongful Act … occurs solely in the rendering or failure to render Professional Services." The reinsurers argued that the managed care organization's conduct at issue was not committed solely in the performance of professional services. The policy defined "professional services" as "services rendered or required to be rendered solely in the conduct of the Insured's claims handling or adjustments." The court held that the unambiguous language of the policy covered any claims resulting not only from the managed care organization's actions adjusting and paying reimbursement claims from health care providers but also its failure to do so.

Second, the reinsurers also argued that Indiana public policy precludes insurance coverage for an insured's intentional wrongdoing or its ordinary business obligations, and therefore the settlement fell within an exclusion from the definition of loss for matters deemed uninsurable by law. The court rejected this argument, finding no declared Indiana public policy that would preclude the managed care organization's recovery because the relief it sought was contractual or restitutionary in character. Moreover, the court found that the policy covered intentional conduct because it defined "wrongful act" to include acts "wrongfully attempted," and "attempt" necessarily involves intentional behavior.

Third, the court considered the reinsurers' argument that coverage for the settlement was precluded by the policy's dishonest or fraudulent acts exclusion. The exclusion contained an exception for claims "seeking both compensatory and punitive damages based upon or arising out of allegations of both fraud and bad faith in the rendering of or failure to render Professional Services." The court concluded that issues of fact regarding the application of the exclusion prevented summary judgment for the reinsurers. Nonetheless, having already determined that the claim resulted from the managed care organization's performance of or failure to perform professional services and finding that the settled claims alleged bad faith against the managed care organization, the court held that the settlement fell within the exception to the exclusion and was therefore covered by the policy. ■

Insurer Has No Duty to Defend When Insured Fails to Give Adequate Notice During Policy Period

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"undisputed that [the insured] failed to comply with the notice requirements." According to the court, the insured's purported notice by email during the policy period was "deficient" under the terms of the notice condition, and the insurer did not receive "actual notice" of the claims asserted against the law firm until the insured tendered the first underlying complaint to the insurer, after the policy period had expired.

The court also concluded that the notice condition was a "requirement" and a "condition precedent" to insurance coverage, rather than a "mere promise," so the insured's "general notice" of potential claims failed to trigger the insurer's duty to defend under the terms of the policy's insuring agreement. The court grounded its conclusion on the clear and unambiguous language of the notice condition. The court also noted that the policyholders were sophisticated "in commerce and insurance matters" and thus "should have had a clear understanding of their contractual obligations and reporting requirements under the Policy." It was also "clear" to the court from the policy language that the notice condition "was intended to be a condition precedent, not a mere promise," and "Illinois case law is clear that courts do enforce notice requirements." ■

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