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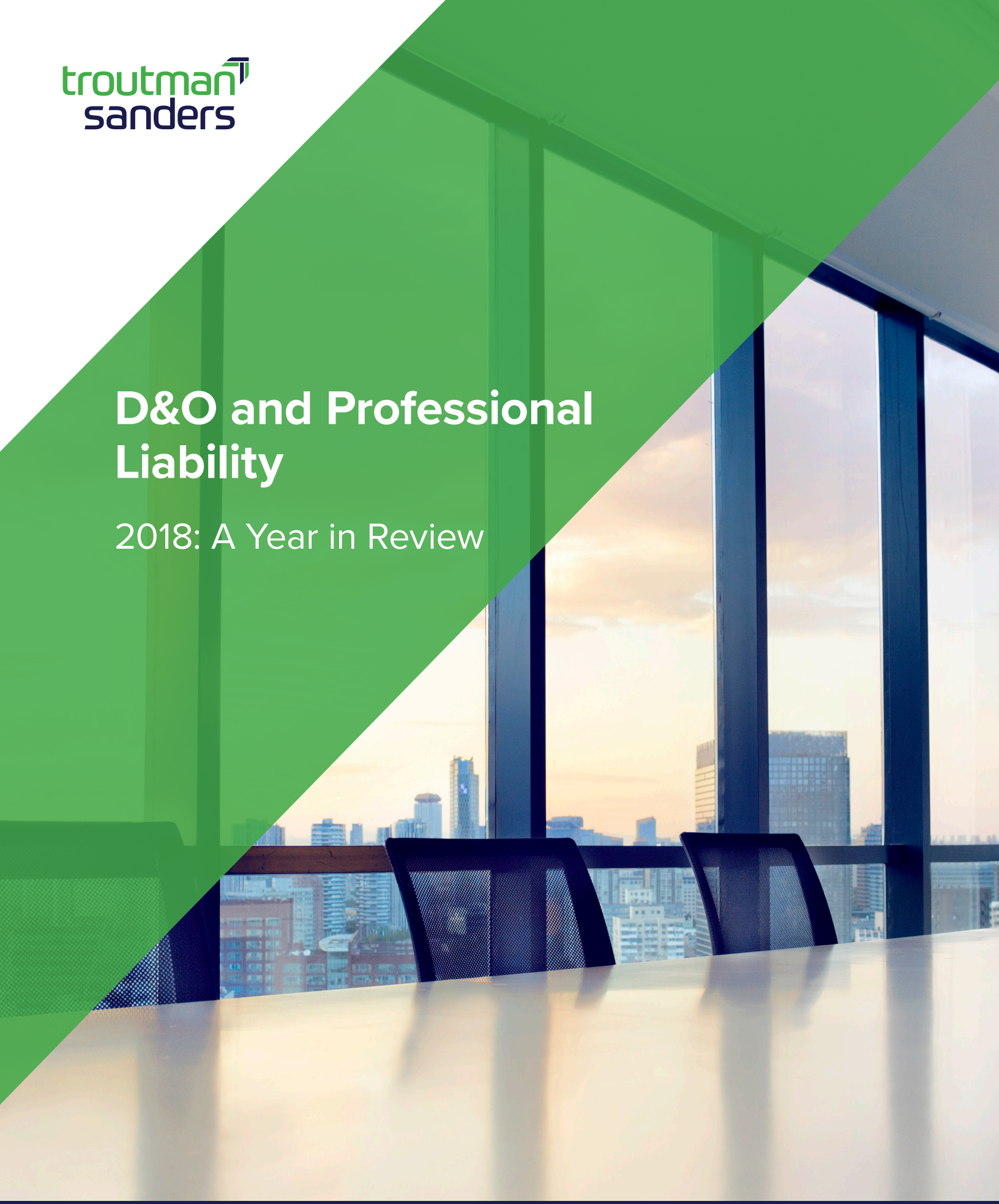
D&O and Professional Liability

2018: A Year in Review



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2018: A Year in Review

2018 once again saw a breadth of court decisions addressing a wide variety of directors and officers and professional liability insurance coverage issues. Twenty federal courts of appeals, four state supreme courts, and dozens of other courts applying the law of 35 states issued notable decisions in this arena. We focused on topics we believe will continue to be important in the directors and officers and professional liability insurance field, and hope you find the following selection of cases to be informative and helpful. (Please note the cases are organized within each topic alphabetically by the state law applied).

In this issue

Notice

US HF Cellular Commc'ns, LLC v. Scottsdale Ins. Co., No. 2:17-CV-261, 2018 WL 2938388 (S.D. Ohio June 12, 2018)

Under California law, reporting requirements were required to be strictly enforced, even though a policy had been renewed. The insurer issued directors and officers liability policies that provided claims-made-and reported coverage, which required the insured to give written notice of any claim as soon as practicable, but in no event later than 60 days after the end of the policy period. The insured reported the lawsuit as a claim during the renewal policy period, four months after the 60-day reporting deadline. The insurer denied coverage on the basis of late notice, and the court granted summary judgment in favor of the insurer.

Nat'l Cas. Co. v. Fulton Cty., Ga., No. 1:16-CV-679-WSD, 2018 WL 1523089 (N.D. Ga. Mar. 28, 2018)

Loss runs provided to an underwriter were deemed not to provide sufficient notice of claims or potential claims to the insurer. The insurer issued claims-made employment practices liability coverage. Multiple employment cases were filed against the insured. The insured sought coverage and argued that the loss runs provided to the underwriter during the underwriting and renewal process constituted proper notice. The court concluded these notices were deficient because, *inter alia*, they did not properly apprise the insurer of the facts of the claims that would enable it to participate in their defense. The

court also found that subsequent notice given by correspondence to the insurer, provided between 11 and 24 months after the underlying cases were filed, were untimely as a matter of law.

S.W. Disabilities Servs. and Support v. ProAssurance Specialty Ins. Co., Inc., 2018 IL App (1st) 171670

Use of the term "occurrence" in an insuring agreement was held insufficient to transform a clearly designated claims-made policy into an occurrence-based policy. The insured purchased a claims-made-and-reported general liability policy that provided coverage for damages caused by an occurrence first reported during the policy period. The insured first reported its claim to the insurer months after cancellation of the policy. The insurer denied coverage based on the insured's failure to provide notice during the policy period. The insured alleged that the policy should be treated as an occurrence-based policy, and argued that the use of the term "occurrence" in the insuring agreement rendered the policy ambiguous. The Appellate Court of Illinois rejected this argument, finding that the policy was not susceptible to more than one reasonable interpretation due to the bold, capitalized provisions throughout that identified the policy as a claims-made policy.

Med. Protective Co. of Fort Wayne Ind. v. Am. Int'l Specialty Lines Ins. Co., No. 1:13 CV 357, 2018 WL 1257238 (N.D. Ind. Mar. 9, 2018), *aff'd in part, rev'd in part and remanded,* 911 F.3d 438 (7th Cir. 2018)

Use of the term "occurrence" in a reporting clause endorsement did not transform a claims-made policy into an occurrence-based policy. The insurer issued a claims-made policy providing professional liability coverage. The policy included an exclusion for wrongful acts occurring prior to the inception date of the first policy period where the insured knew or could have reasonably foreseen the wrongful act could lead to a claim. The policy also included a reporting clause endorsement that extended coverage to claims made after the policy period if notice was provided of an occurrence that may reasonably be expected to give rise to a claim. The insurer denied coverage for the claim on the basis that it was first made against the insured before the policy incepted. The insured argued that the reporting endorsement transformed the policy into an occurrence-based policy and that the occurrence occurred during the policy period. Applying Indiana law, the Seventh Circuit rejected the insured's arguments, relying on the explicit language in the policy identifying it as a "claims-made policy."

First Horizon Nat'l Corp. v. Hous. Cas. Co., 742 F. App'x 905 (6th Cir. 2018), *reh'g denied* (Aug. 3, 2018)

Under Tennessee law, notice of circumstances of a potential claim was deemed insufficient to preserve coverage when an actual claim had been made but was not disclosed at the time of the notice. The insured purchased professional liability coverage under a claims-made policy. The policy allowed claims made after the policy period to relate back to notice of circumstances provided during the policy period. The insured became the target of a federal investigation and received a settlement demand from the DOJ. The insured provided the insurer with a notice of circumstances of the investigation that stated that it might potentially result in a claim but failed to disclose that the DOJ had already made an actual settlement demand. After the policy period ended, the insured sought coverage for its settlement related to the investigation, contending that the claim related back to the notice of circumstances or, in the alternative, that the notice of circumstances was a notice of an actual claim. The court rejected both arguments, concluding that the notice of circumstances given during the policy period did not provide sufficient notice to preserve the claim or serve as an actual notice of claim.

Gateway Residences at Exch., LLC v. Ill. Union Ins. Co., No. 1:17-CV-629, 2018 WL 1629107 (E.D. Va. Apr. 3, 2018)

The insured's failure to report a claim under a claims-made-and-reported policy is not a breach of the policy, but rather a non-occurrence of a condition precedent to coverage. The insured reported a claim under a claims-made-and-

reported professional liability policy after the policy had expired. The insurer denied coverage because it did not receive notice of the claim during the policy period. The insured argued that the insurer was precluded from raising untimely notice as a defense to coverage, relying on a Virginia law that requires an insurer to notify a claimant within 45 days of discovery of a breach of policy terms. The court determined that the Virginia law did not apply because the insurer did not assert a violation of the policy. The court found that the insured's failure to report the claim was a non-occurrence of a condition precedent to coverage and therefore, the insurer was not obligated to provide coverage.

Grigg v. Aarrowcast, Inc., 2018 WI App 17

A claims-made policy that required the reporting of claims "as soon as practicable" was held to be governed by Wisconsin's notice-prejudice statute. The insurer issued claims-made directors and officers liability coverage and denied coverage for the underlying action on multiple grounds, including late notice. The trial court granted summary judgment in favor of the insurer, and the insured appealed asserting that the insurer could not demonstrate it was prejudiced by the late notice. The Wisconsin Court of Appeals concluded that where notice is merely required "as soon as practicable" and coverage is not conditioned upon notice during the policy period, Wisconsin's notice-prejudice rule applies. The Wisconsin Court of Appeals reversed and remanded for further proceedings.

Related Claims

Northrop Grumman Corp. v. AXIS Reinsurance Co., No. 1:17-CV-01738, 2018 WL 5314918 (D. Del. Oct. 26, 2018)

Under California law, two class-action lawsuits by participants and beneficiaries of an employer retirement plan against the employer's investment and administrative committees were deemed related claims under the employer's fiduciary liability policies, and therefore triggered coverage under a single policy period. There was a 16-month gap between the end of one class period and the beginning of the other, and because ERISA imposes personal liability, judgment in the two actions, if imposed, could be against completely different individuals. However, the court found that the two actions alleged "the same specific behaviors," that the insured had paid excessive administrative fees to the employer and third-party service providers. The court thus determined the claims were sufficiently related because they concerned "[t]he existence of that continuing course of allegedly illegal conduct."

Health First, Inc. v. Capitol Specialty Ins. Corp., No. 17-11181, 2018 WL 4025461 (11th Cir. Aug. 22, 2018)

Under Florida law, multiple claims alleging a continuing pattern of anticompetitive behavior by the insured health-care network were related under professional liability policies that stated all claims "related logically, causally or in any other way" would be deemed to arise whenever the first related claim was made. The insurer successfully asserted that the underlying complaints similarly alleged that the insured "used its monopolistic power to coerce doctors to admit patients exclusively to Health First facilities." Because the insured failed to offer contrary evidence, the insurer was permitted to argue relatedness based solely on the underlying complaints. The court agreed with the insurer that the claims related back to the date that the first such claim was made, which predated the policy period, and thus were not covered under the policy.

Certain Underwriters at Lloyd's of London v. Fed. Deposit Ins. Corp. for Omni Nat'l Bank, 723 F. App'x 764 (11th Cir. 2018)

The Eleventh Circuit, applying Georgia law, affirmed the district court's ruling that a directors and officers liability policy provided coverage to the insured bank, finding that the retroactive exclusion for prior or "interrelated wrongful acts" did not apply. From 2005 to 2007, prior to the 2008 policy period, the bank engaged in various unsound lending practices which triggered regulatory investigations. During the 2008 housing

crisis, the bank foreclosed on various properties and instituted a plan to invest and renovate the properties rather than selling them "as-is" at the time of foreclosure. After the bank's rating was changed in 2008 to indicate it was "failing or would fail imminently," the bank improperly continued its plan to invest in the subject properties. The FDIC sought to recover for the $12.6 million in wrongful investments made by the bank in 2008. The court rejected the insurer's argument that FDIC's claim to recover the wrongful investments related back to the bank's unsound lending practices, stating that the "continuing investments into the . . . properties were not 'interrelated wrongful acts' under the policy but rather were independent wrongful acts that occurred during the policy period." Accordingly, the court found that the policy covered the bank's wrongful investments made in 2008.

Lloyd's Syndicate 3624 v. Biological Res. Ctr. of Ill., LLC, 341 F. Supp. 841 (N.D. Ill. 2018)

Several lawsuits alleging mishandling and/or sale of human remains against an insured non-transplant anatomical donation business were related as a single claim under a professional liability and general liability policy. Generally, the complaints each alleged that the insured induced the plaintiffs (or their decedents) to agree to donate the decedents' remains for medical or scientific uses, but instead sold, mishandled, and/or desecrated the remains. The insurance policy stated that all claims "based upon or arising out of any and all continuous, repeated or related Wrongful Acts or Accidents committed or allegedly committed by one or more of the Insureds shall be considered a single Claim." The court found that even though the insured had sold "different decedents' body parts at different times," and "executed different gifting agreements with different witnesses under different circumstances," the claims were not unrelated. Instead, the court held that, "in any meaningful sense of the word," the claims were "related" because they alleged a single course of conduct by the insured.

Great Am. Ins. Co. v. State Parkway Condo. Ass'n, No. 17-CV-3083, 2018 WL 4333623 (N.D. Ill. Sept. 11, 2018)

The court granted the directors and officers liability insurer's motion for summary judgment that multiple claims regarding alleged disability discrimination, made over the course of multiple policy periods, related back to a single policy period. The insured's claims concerned (1) two complaints that the claimant filed with the state human rights department alleging failure to accommodate and discrimination based on his hearing disability; (2) a countercomplaint that the claimant filed in court against the insured alleging discrimination, retaliation, and harassment in connection with his hearing disability; and (3) a separate lawsuit that the claimant filed in federal court against the insured regarding failure to accommodate and discrimination based on his hearing condition. The court determined that the claims related back to the earlier policy period because they all arose from, were based on, or related to the insured's allegedly discriminatory and retaliatory conduct against the claimant for his hearing disability.

Twin City Fire Ins. Co. v. Permatron Corp., No. 15 C 10252, 2018 WL 1565599 (N.D. Ill. Mar. 30, 2018)

An insured's failure to timely notify its employment practices liability insurer of an "initial" claim barred coverage for subsequent related claims. The policies stated that the claim date for "Interrelated Wrongful Acts" occurs when "any of such Claims was first made, regardless of whether such date is before or during the Policy Period." The insured failed to provide notice of its employee's original discrimination claim with the EEOC. However, the insured timely notified the insurer of subsequent claims by the same employee for wrongful conduct and retaliation. The court determined that the subsequent retaliation and wrongful conduct claims were sufficiently related to the initial claim for discrimination because they shared "a common nexus of fact" and arose from "a single event," which was the insured's termination of the employee. Therefore, all such claims related back to the initial discrimination claim, which had

not been timely reported, and the insurer was not legally obligated to provide coverage for any of the claims.

Billeaudeau v. Opelousas Gen. Hosp. Auth., 243 So. 3d 133 (La. App. 2018), *reh'g denied* (June 13, 2018), *writ denied*, 253 So. 3d 1298 (Oct. 15, 2018)

An insured's claim under a directors and officers liability policy did not relate back to its prior reported claim under a medical malpractice professional liability policy because the policies were not "successor" policies. Though the prior medical malpractice claim was "based on the same facts which now form the basis of" the subsequent negligent credentialing claim against the insured, the court found that the present directors and officers liability policy was not a successor policy to the prior medical malpractice professional liability policy because they "provide different coverages for different purposes." Accordingly, the court held that the negligent credentialing claim did not relate back to the prior medical malpractice claim.

Freedom Specialty Ins. Co. v Platinum Mgmt. (NY), LLC, No. 652505/2017, 2018 WL 4334216 (N.Y. Sup. Ct. Sept. 10, 2018)

An insurer could not show for purposes of its motion for summary judgment that a prosecution by the SEC against the insured regarding a Ponzi-like scheme (the "Ponzi Prosecution") was sufficiently related to a prior SEC investigation and prosecution against the insured's founder regarding bribery (the "Bribery Prosecution") to exclude coverage for the Ponzi Prosecution under an excess directors and officers liability policy. The insurer asserted that the Ponzi Prosecution related to the investigation in the Bribery Prosecution because the funds from the alleged bribery "helped defendants continue their Ponzi-like Scheme by providing funds to satisfy redemption requests." However, the court determined that for the insured to succeed on a motion for summary judgment in alleging a nexus with a "fact, circumstance, situation, transaction or event underlying . . . [a prior] *investigation*," the insured must at minimum prove that (a) there existed an investigation before the policy's inception date, (b) there was a common "fact, circumstance, situation, transaction or event" between that investigation and the Ponzi Prosecution, and (c) such common "fact, circumstance, situation, transaction or event" was one that was "underlying" the prior investigation, "under a strict and narrow interpretation of that term." The court found that the insurer failed to meet its burden, denied the insurer's motion for summary judgment, and granted the insured's counter-motion for summary judgment, holding that the Ponzi Prosecution was covered under the policy.

Cushman & Wakefield, Inc. v. Ill. Nat'l Ins. Co., No. 14 C 8725, 2018 WL 1898339 (N.D. Ill. Apr. 20, 2018)

Under New York law, multiple claims brought in different policy periods, which were made by different claimants, were deemed related where the losses resulted from a valuation method used by the insured real estate company which overvalued the property. Although the real estate professional liability policy did not define "related wrongful acts" for purposes of determining whether the multiple claims were related as a single claim, the court applied New York's factual-nexus test, under which claims are related if they "arise from common facts and [ ] the logically connected facts and circumstances demonstrate a factual nexus among the Claims." Under the factual-nexus test, the court determined that the claims were related. Even though each appraisal was a different work product, providing a unique valuation analysis and conclusion by a different employee, they were each produced using the same allegedly misleading method.

Stewart Eng'g, Inc. v. Cont'l Cas. Co., No. 18-1386, 2018 WL 5832805 (4th Cir. Nov. 7, 2018)

Under North Carolina law, claims regarding two pedestrian bridges that collapsed within 24 hours of each other were sufficiently related to constitute a single claim, and subject to a single limit of liability, under a professional liability and

pollution incident policy. The policy stated that all related claims would be considered a single claim subject to a single limit of liability to the extent such claims arose out of "a single wrongful act; [or] . . . multiple wrongful acts that are logically or causally connected by *any* common fact, situation, event, transaction, advice, or decision." The court determined that the claims concerning the bridge collapses were "logically or casually connected by any common fact" because the collapses were caused by the same design flaw and because a miscommunication between the project manager and the project engineer responsible for both bridges led to the failure to detect and correct the common design flaw.

Miami-Luken, Inc. v. Navigators Ins. Co., No. 1:16-CV-876, 2018 WL 3424448 (S.D. Ohio July 11, 2018)

The court granted an insurer's motion for summary judgment that a directors and officers liability policy did not provide coverage to the insured-pharmaceutical company for the defense of an order to show cause issued by the Drug Enforcement Agency ("DEA"). In applying for coverage, the insured disclosed that it had been named in a lawsuit by the State of West Virginia based on allegations that the insured was one of the "major distributers of controlled substances that contributed to the prescription drug abuse epidemic in West Virginia" The policy contained a Specific Litigation Exclusion that excluded coverage for all loss, including costs of defense in connection with any claim "based upon, arising out of, relating to, directly or indirectly resulting from, or in consequence of, or in any way involving" the prior West Virginia action. The court determined that the DEA's subsequent order to show cause – based on the insured's purported failure to maintain effective controls regarding controlled substances it had distributed to customers, including in "southern West Virginia" – was related to the prior West Virginia action because the two claims concerned the "same *or* similar. . . facts, circumstances, *or* allegations."

Morden v. XL Specialty Ins. Co., 903 F.3d 1145 (10th Cir. 2018)

Under Utah law, claims by client investors of the insured registered investment advisor and by the SEC were "related" claims under a financial services professional liability policy, such that they constituted a single claim first made prior to the policy period. Before the policy period, the SEC sent notices to the insured indicating it would be opening an investigation into the insured's investment advising services, after which investigation the SEC issued a cease and desist order. Subsequently, during the policy period, client investors of the insured filed a lawsuit alleging federal and state law claims that tracked the allegations in a prior SEC cease and desist order, including with respect to investments that the insured had made in a company that the SEC order did not address. The insurer successfully asserted that the subsequent action by the client investors related back to the SEC claims because they concerned allegations of "a practice – a scheme – of defrauding investors over a period of several years by means of 'related' misconduct." Therefore, the appellate court reversed the lower court's dismissal of the insurer's counterclaim, remanded the case with instructions to grant summary judgment on such counterclaim, and affirmed summary judgment against the party seeking coverage under an assignment of rights.

Prior Knowledge / Known Loss / Rescission

ALPS Prop. & Cas. Ins. Co. v. Merdes & Merdes, P.C., No. 4:14-CV-00002, 2018 WL 1278422 (D. Alaska Mar. 12, 2018)

The court held that, in the coverage litigation, the insured was collaterally estopped and thus bound by a finding made in the underlying litigation that the insured had knowledge of a potential claim by a certain time for purposes of computing prejudgment interest. The insurer issued errors and omissions coverage to a law firm that provided coverage for claims if "at the effective date of [the] policy, no Insured knew or reasonably should have known or foreseen that [an] act, error, omission or personal injury might be the basis of a claim."

In 1995, a law firm brought suit against a former client to recover unpaid fees. The trial court ruled in favor of the law firm, and the client ultimately paid the law firm amounts due. After the Alaska Supreme Court reversed the trial court's decision, the law firm refused to return what the client had paid pursuant to the judgment. In 2013, the client filed a lawsuit of its own, seeking recovery of the amounts retained by the law firm. An Alaska trial court entered judgment against the law firm and awarded prejudgment interest that ran from July 2010, the date the law firm was aware of a possible claim. The Alaska Supreme Court affirmed this ruling. In the subsequent coverage litigation, the court granted summary judgment to the insurer. The court held that because the law firm was a party to the 2013 lawsuit and the court in that matter decided that the law firm was aware that a claim "may be brought" in 2010, all elements of collateral estoppel were met and the court was bound by the Alaska Supreme Court's decision. Thus, because the law firm "reasonably should have known or foreseen that the act, error, omission or personal injury might be the basis of a claim," the insurer had no duty to defend or indemnify the law firm in the underlying action.

W. World Ins. Co. v. Prof'l Collection Consultants, 721 F. App'x 621 (9th Cir. 2018)

The Ninth Circuit, applying California law, affirmed the trial court's grant of summary judgment in favor of an insurer, finding that the insurer could rescind a directors and officers liability policy based upon a material misrepresentation in the application. The policy covered, *inter alia*, claims arising from a civil, regulatory, criminal, or administrative investigation or proceeding against the insured. About six months before the insured completed its renewal application, the FBI executed a search warrant at the insured's offices, subpoenaed a number of the insured's employees, and demanded the production of several thousand documents. Despite the investigation, the insured answered in the negative when asked on its application whether it knew of any circumstances that might lead to a claim. Though the insured maintained that the investigation had been completed by the time it filed the renewal application, the insurer argued that the policy was void *ab initio* because it would not have issued the policy had it known of the investigation. The court agreed with the insurer that the insured's failure to disclose the FBI investigation was material, thus permitting the insurer to rescind the policy.

Med. Protective Co. v. Am. Int'l Specialty Lines Ins. Co., 911 F.3d 438 (7th Cir. 2018)

The Seventh Circuit, applying Indiana law, revived a coverage suit regarding whether a professional liability insurer must cover an insured's settlement in a wrongful death claim, finding that factual questions remained as to whether the insurer's refusal to settle a claim triggered a prior knowledge exclusion. A family brought a wrongful death suit against a physician. Twice during litigation, the family offered to settle the case for $200,000, the physician's policy limit. The physician's malpractice insurer rejected both offers. Following a verdict against the physician, the physician's malpractice insurer paid the family the amount the physician was individually liable under the applicable statutory cap, and the family then sued the malpractice insurer for bad faith for the remainder of the verdict. The family and the malpractice insurer ultimately settled for a confidential amount over $5 million. The malpractice insurer, which purchased a $5 million errors and omissions policy during the wrongful death litigation, sought coverage under that policy to pay for the confidential settlement. The errors and omissions carrier denied coverage based on the policy's prior knowledge exclusion, which barred coverage for any claim arising out of a "Wrongful Act" occurring before the inception of the policy that the insurer "knew or should have reasonably foreseen… could lead to a claim or suit." "Wrongful Acts" were defined as "any breach of duty, neglect, error, misstatement, misleading statement, omission or other act done or wrongfully attempted." The Seventh Circuit held that mere allegations of wrongful conduct are insufficient to trigger the prior knowledge exclusion. Furthermore, the insurer had the burden of proving that a Wrongful Act had actually occurred, *i.e.*, of showing that the malpractice insurer had improperly failed to settle the family's claims within the physician's policy limits when

it had the opportunity to do so. Therefore, the Seventh Circuit concluded that a genuine issue of material fact remained and remanded the case.

Madison Mechanical, Inc., et al. v. Twin City Ins. Co., No. GLR-17-1357, 2018 WL 1583519 (D. Md. Mar. 30, 2018)

The court granted summary judgment in favor of the insurer, finding that the insurer had no duty to defend or indemnify its insureds under a directors, officers, and entity liability policy where the insureds had knowledge of a potential claim prior to submitting a mid-term application to add an additional entity as an insured under the policy. More than a month prior to submitting the mid-term application, the insureds received a letter from a former shareholder putting the insureds "on notice of [their] potential litigation liability . . . both on a corporate and personal level" due to alleged improper actions related to the formation of a new corporate entity. The insureds failed to disclose the existence of the letter on the mid-term application, which contained a prior knowledge exclusion that precluded coverage for any claim based on, arising from, or in any way relating to errors, misstatements, misleading statements, acts, omissions, neglect, breaches of duty, or other matters that the insureds knew of, but did not disclose, prior to the inception of coverage for the new entity. More than five months after coverage incepted for the new entity, the insureds were sued by the former shareholder based on the allegations set forth in the letter. The court found that the exclusion in the application was specifically made a part of the policy, and agreed with the insurer that the letter from the former shareholder put the insureds on notice of acts that could give rise to a claim prior to the inception of coverage for the new entity.

Alterra Excess & Surplus Co. v. Excel Title Agency, 742 F. App'x 968 (6th Cir. 2018)

The Sixth Circuit, applying Michigan law, held that an insured was barred from coverage because it had prior knowledge of a potential claim. The insured title company acted as an escrow agent in a client's real estate investment scheme. When the scheme collapsed, several investors sought remuneration from the insured and the client. In one email, an investor advised that if the insured did not return the investor's funds by a particular date, the investor would "begin to proceed with all civil and criminal action, both state and federal[.]" Eight months after receipt of that email, the insured completed an application for a professional liability policy, where it answered "no" to a question regarding its knowledge of "any circumstances, acts, errors or omissions that could result in a professional liability claim against" it. When the investor later sued the insured and the insured sought coverage for the claim, the insurer denied coverage based on the prior knowledge exclusion. In the coverage litigation, the appellate court held that the clear threat of litigation in the investor's email made the investor's lawsuit foreseeable. The court rejected the insured's argument that a claim was not foreseeable because the email merely threatened litigation because even though the investor might not file a suit, the potential for one was still foreseeable. Accordingly, the court held that no coverage was available for the investor's claim based on the policy's prior knowledge exclusion.

ALPS Prop. & Cas. Ins. Co. v. McLean & McLean, PLLP, 2018 MT 190, *reh'g denied* (Sept. 18, 2018)

The Supreme Court of Montana held that a Montana statute allowing insurers to prevent recovery under an insurance policy in certain circumstances, including when an insured misrepresents or omits information on an application, does not provide a right to rescind the policy *ab initio.* The court also held that an innocent insured had a reasonable expectation of retaining his attorney malpractice insurance and continuing to have the option to purchase an extended reporting period endorsement based on policy provisions and his lack of culpability. A father-and-son law firm was insured under successive claims-made policies. Each year, on the renewal application, in response to the question of whether the insured was aware of circumstances that could reasonably be expected to be the basis of a claim, the father would answer "no" on behalf of himself individually and the firm, and the son would answer "no" on behalf of himself individually. Without the son's knowledge, the father regularly

withdrew funds from client trust accounts for his own use. Once the son discovered this, he reported the matter to the Office of Disciplinary Counsel and the firm's insurer. Shortly thereafter, clients began making claims against the firm and the attorneys arising out of the father's conduct. The insurer sent the firm and attorneys a notice that it was cancelling the policy for nonpayment of premium. The son did not dispute that the policy had been properly cancelled but claimed that he met the policy's definition of an "innocent insured" and requested extended coverage for himself under an extended reporting period endorsement. However, the insurer advised that it was rescinding the policy from the date of inception, asserting the insureds had made material misrepresentations in the applications. In a subsequent declaratory judgment suit, the trial court granted summary judgment to the insurer, holding that it properly rescinded the policy from inception. The Supreme Court reversed, holding that the relevant statute does not provide insurers the right to rescind a policy from inception based on material misstatements in an application. The court also held that, because the policy was not properly rescinded, the son had a reasonable expectation of retaining attorney malpractice insurance and keeping the option to purchase an extended reporting period endorsement based on the policy's "innocent insured" provision.

Medchoice Retention Grp., Inc. v. Rand, 344 F. Supp. 3d 1184 (D. Nev. 2018)

The court granted summary judgment in favor of the insurer, finding that the insurer was entitled to rescind the professional liability policy at issue based on the insured's material misrepresentations in the application. The insured, a physician, answered "no" to questions on his insurance application inquiring about potentially compensable events or bad outcomes related to patient care, claims or potential claims in which he might be become involved, and any incidents in the previous four years that might reasonably lead to a claim against him. At the time the insured submitted the application, he in fact had knowledge of numerous instances wherein he prescribed opioids to his patients without a legitimate medical purpose and outside the scope of his professional practice. The insured's knowledge was evidenced by his statements in a guilty plea in a criminal action related to the death of one of the patients to which he illegitimately prescribed opioids. Based on the insured's statements in the guilty plea, the insurer sought to rescind the policy due to the insured's misrepresentations in the application. The court agreed that the insured's misrepresentations were material, and accordingly granted the insurer's motion for summary judgment on rescission.

Ironshore Indem., Inc. v. Pappas & Wolf, LLC, No. A-0959-16T1, 2018 WL 2012009 (N.J. Super. Ct. App. Div. May 1, 2018)

The appellate court affirmed the trial court's grant of summary judgment in favor of the insurer, holding that the insurer was entitled to deny coverage under a professional liability insurance policy where the insured made a material misrepresentation in its renewal application. The insured attorney failed to disclose that, prior to submitting the application, a client for which the attorney had served as in-house counsel and for which the attorney's firm served as outside counsel was sued for securities-related fraud. The attorney's deposition testimony revealed that, more than eight months before submitting the renewal application, he was concerned that a claim might be asserted against him in connection with the securities fraud action. The court held that the attorney's failure to disclose that a claim might be asserted against him in connection with the securities fraud action constituted a material misrepresentation that justified the insurer's denial of coverage.

Aztec Abstract & Title Ins., Inc. v. Maxum Specialty Grp., 302 F. Supp. 3d 1274 (D.N.M. 2018)

The court granted summary judgment in favor of the insurer, finding that the insurer had no duty to defend or indemnify its insured under a professional liability policy where the insured had knowledge of a wrongful act that might result in a claim prior to the policy's inception. More than a year before submitting its policy application, the insured, a title insurance agent, knew of an alleged

error in the legal descriptions in the mortgage documents for two properties on which it had issued title insurance policies. The insured also knew that the alleged errors in legal descriptions could result in the loss of collateral. When the insured later submitted a claim to the insurer related to the alleged error in legal description, the insurer denied coverage because, among other reasons, the insured knew of a wrongful act that might give rise to a claim more than a year before submitting its application and thus coverage was barred by the policy's Prior Knowledge Exclusion. The court agreed with the insurer, holding that no reasonable jury could find that the exclusion did not apply to bar coverage. The court also rejected the insured's argument that the exclusion applied only to prior demands for money or potential claims that had been determined to be "valid."

Patriarch Partners, LLC v. AXIS Ins. Co., No. 17-3022, 2018 WL 6431024 (2d Cir. Dec. 6, 2018)

The Second Circuit, applying New York law, held that a warranty executed before the inception of a directors and officers liability policy barred coverage for an SEC action because the insured knew of the SEC's investigation before the warranty was signed. The insured, an equity firm, was investigated by the SEC. The SEC interviewed two of the insured's former executives and issued a formal order of investigation. The insured's founder, who also served as the insured's sole officer and director, did not know of the formal order of investigation, but the insured's outside counsel did. After the SEC inquiries, the insured purchased excess directors and officers coverage and executed a warranty, representing that "neither the undersigned nor any other director or officer … is aware of any facts or circumstances that would reasonably be expected to result in a Claim[.]" After the warranty was signed, the SEC initiated a civil enforcement action. The insured tendered the matter to its excess carrier, which denied coverage because the SEC investigation commenced before the policy period. In the coverage action, the Second Circuit held that the warranty barred coverage for the SEC proceeding because the contacts between the insured and SEC before the warranty was signed signaled a potential claim. Also, the court held that the insured's outside counsel knew of the formal investigation before the warranty was executed and that its knowledge was imputed to the insured.

Travelers Cas. & Sur. Co. of Am. v. Gold, Scollar, Moshan, PLLC, No. 14cv10106, 2018 WL 1508573 (S.D.N.Y. Mar. 14, 2018)

The court granted summary judgment in favor of the insurer, finding that it was entitled to rescind the professional liability policy at issue due to a material misrepresentation in the application. The insureds, a law firm and its attorneys, applied for renewal of their policy. A question on the renewal application asked if any member of the firm had knowledge of any incident, act, error, or omission that could be the basis of a claim, to which the insureds responded "no." In fact, a partner at the firm had been misappropriating client funds for at least 10 months prior to the submission of the renewal application. When the firm and its attorneys were sued based on the partner's misappropriation of client funds, the insurer denied coverage and ultimately rescinded the policy based on the misrepresentation in the application. The court held that the insureds clearly made a misrepresentation and that said misrepresentation was material, and accordingly ordered that the policy at issue was void *ab initio*. Of note, the court also held that, although there was no direct evidence the individual who signed the application knew of or took part in the partner's misconduct, the individual who signed the application was also a member of the firm, and thus authorized to speak on its behalf in submitting the application.

Cushman & Wakefield, Inc. v. Ill. Nat'l Ins. Co., No. 14 C 8725, 2018 WL 1898339 (N.D. Ill. Apr. 20, 2018)

The court, applying New York law, denied an insurer's motion for summary judgment, finding that the professional liability policy's prior knowledge exclusion did not apply to bar coverage because the insurer could not establish that the insured subjectively knew that a wrongful act occurred prior to the policy's inception date and that a

reasonable person with knowledge of the relevant facts might expect those facts to be the basis for a claim. The insured, a real estate services firm, faced a number of lawsuits related to its use of a total net value methodology in conducting real estate appraisals. The lawsuits alleged, in essence, that the insured's appraisal methodology was inherently misleading and that such misleading appraisals were part of a larger scheme to inflate loans issued in connection with the properties the insured appraised. The insurer issued four consecutive first-layer excess policies that followed form to primary policies with prior knowledge exclusions that barred coverage for claims arising from any wrongful act committed prior to the policy period if any insured knew of such claim or wrongful act prior to the policy's inception date. The lawsuits against the insureds spanned each of the four policy periods. The court held that, despite evidence showing that the insured's appraisers had concerns regarding the total net value appraisal method's potential to produce misleading results, the insurer could not conclusively establish that, prior to the policies' inception, the insured knew that issuing such appraisals was inherently misleading. The court also held that mere knowledge of some consequences of an act does not provide a reasonable basis for an insured to conclude that a claim will be asserted against it based on that act.

Wesco Ins. Co. v. Layton, 725 F. App'x 289 (5th Cir. 2018)

The Fifth Circuit, applying Texas law, affirmed the trial court's grant of summary judgment in favor of an insurer, holding that the insurer had no duty to defend or indemnify its insured under a professional liability policy where the insured knew of a claim asserted against it prior to the policy's inception. The initial petition in the underlying action, filed more than six months prior to the policy's inception, alleged that the insured attorney breached his fiduciary duties to the underlying plaintiffs in connection with two investment transactions. The insured submitted the initial petition in the underlying action to the insurer for coverage two months after the policy incepted, but the insurer denied coverage because the initial petition was not a claim first made during the policy period. A few weeks later, the underlying plaintiffs amended their initial petition to include a negligence cause of action and added the insured's law firm, which was also an insured under the policy. The insured submitted the amended petition for coverage, but the insurer again denied and subsequently sought a declaration of no coverage under the policy. The district court found that even if the amended petition was a claim first made during the policy period, coverage was barred by the fortuity doctrine because the insured knew or should have known that his conduct would likely expose him to liability when he bought the policy. The appellate court agreed, holding that the fortuity doctrine precluded any defense or indemnity coverage for the insured because the initial petition put the insured on notice that a loss had occurred prior to the policy's inception.

APLS Prop. & Cas. Ins. Co. v. Turkaly, No. 2:16-cv-10064, 2018 WL 385195 (S.D. W. Va. Jan. 11, 2018)

The court granted in part and denied in part the insurer's motion for summary judgment, finding that the insurer was entitled to rescind the professional liability policy at issue based on the insured's material misrepresentation in its renewal application. The insured, an attorney, answered "no" to a question regarding his awareness of any fact, circumstance, act, error, or omission that could reasonably be expected to the be the basis for a claim. However, more than a month prior to submitting his renewal application, a copy of a complaint filed against him by his brother relating to the insured's administration of a certain will was mailed to the insured's post office box. Further, after submitting his renewal application but prior to policy issuance, the insured was personally served with his brother's complaint, but still represented to the insurer that no changes needed to be made to the answers provided on the application. The insured then submitted his brother's complaint to the insurer for coverage. The insurer defended under a reservation of rights, but ultimately rescinded the policy when it learned that the insured knew of his brother's complaint prior to submitting his renewal application. The court agreed that the insurer was entitled to rescind the policy *ab initio* based on the insured's material

misrepresentation and granted summary judgment to that effect. However, the court denied the insurer's motion for summary judgment insofar as the insurer sought reimbursement of defense costs expended under the policy because the policy, being void *ab initio*, could not form the basis of liability for either the insurer or the insured.

Admiral Ins. Co. v. Fisher, No. 17-0671, 2018 WL 2688182 (W. Va. June 5, 2018)

The West Virginia Supreme Court of Appeals reversed a grant of summary judgment, reinstating a lawsuit that sought to rescind a doctor's professional liability policy on the grounds that the insured made material misrepresentations when applying for the policy. Between late 2010 and early 2011, federal law enforcement officers executed a search warrant on the doctor to investigate drug overdose deaths, and a state licensing panel began investigating the doctor for alleged misconduct. In June 2011, the doctor submitted an application for an errors and omissions policy. Although the doctor did affirm in the application that he was unaware of "any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit," he answered "yes" to a question asking whether he was being "investigated by any licensing or regulatory agency." In the application, the doctor provided some additional information concerning the state licensing investigation, but not the law enforcement investigation. The insurer issued the policy. During the policy period, the doctor was sued for wrongful death relating to drug overdoses. The insurer agreed to defend the doctor but filed a crossclaim seeking a declaration that the policy was void *ab initio* for material misrepresentations. The trial court granted summary judgment to the insured on the rescission claim, holding that the insurer "improperly engaged in post-claim underwriting when it denied coverage despite having the relevant information at its disposal at the time of application." The Supreme Court of Appeals reversed, noting that during the application process, the doctor stated that he was aware of no facts or circumstances "which may result in a malpractice claim or suit" and disclosed only limited facts concerning the state investigation. At the same time, the doctor was aware of several patient overdose deaths, including that of a patient with whom he had a sexual relationship. The court therefore reversed and directed the trial court to consider on remand whether the insurer waived its right to challenge the misrepresentations based on a failure to conduct a reasonable inquiry in response to the answers on the application.

Prior Acts / Prior Notice / Prior & Pending Litigation

Jayhawk Private Equity Fund II LP v. Liberty Ins. Underwriters, Inc., No. 2:17-cv-05523-GW-RAO (C.D. Cal. June 7, 2018)

The court granted an insurer's motion to dismiss based on the policy's prior acts exclusion. The prior acts exclusion in the directors and officers liability policy excluded coverage for any claims "based upon, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving any act, error, omission, misstatement, misleading statement, neglect, breach of duty, Wrongful Act, Company Wrongful Act or Employment Wrongful Act committed or allegedly committed prior to [the policy's inception date]." The court agreed with the insurer that the exclusion applied because the insured's alleged conduct occurred prior to the policy's inception date. Even though the insured's alleged conduct also occurred after the policy's inception date, the exclusion operated to exclude the entirety of the underlying claim.

Landmark Am. Ins. Co. v. Navigators Ins. Co., No. 18-cv-05504-CRB, 2018 WL 6591620 (N.D. Cal. Dec. 14, 2018)

The court granted an insurer's motion for judgment on the pleadings because the directors and officers liability policy's "Specific Circumstances" endorsement and prior notice exclusion barred coverage for a lawsuit brought by a bankruptcy trustee against the insured's former directors and officers. The court first reasoned that the policy's "Specific Circumstances" exclusion, which referenced a prior state agency's report

and investigation regarding the insured's financial ability to provide the services it offered to consumers, contained very similar allegations as those contained in the bankruptcy trustee's suit. Second, the court reasoned that the insurer's prior notice exclusion applied to exclude coverage of the bankruptcy trustee's suit because the insured had noticed the state agency's report and investigation to its prior insurance carrier.

EMSI Acquisition, Inc. v. RSUI Indem. Co., 306 F. Supp. 3d 647 (D. Del. 2018)

The court agreed with the insurer that a prior acts exclusion in a directors and officers liability policy barred coverage for claims arising out of misconduct that took place prior to the date contained in the exclusion. The court granted the insurer's motion for judgment on the pleadings because all of the wrongful acts at issue in the underlying action, which included alleged breaches of certain warranties contained in a stock purchase agreement, took place prior to the date contained in the exclusion. As a result, the unambiguous exclusion barred coverage.

Smith v. Travelers Cas. & Sur. Co. of Am., No. 18-80189-CIV, 2018 WL 4208340 (S.D. Fla. June 14, 2018)

A prior acts exclusion in a directors and officers liability policy applied because the allegations in the underlying lawsuit pre-dated the policy's prior acts date by several years. The insured argued that the exclusion does not preclude coverage because the underlying action alleged wrongful acts that also occurred after the inception of the policy, but the court rejected that interpretation and found the alleged wrongful acts that occurred during the policy period were not "distinct and separate" from those occurring before the prior acts date. As a result, the court granted the insurer's motion to dismiss the complaint for declaratory relief and breach of contract.

Emmis Commc'ns Corp. v. Ill. Nat'l Ins. Co., 323 F. Supp. 3d 1012 (S.D. Ind. 2018)

A directors and officers liability policy's "Specific Investigation/Claim/Litigation/Event or Act" exclusion did not bar coverage of a shareholder suit because the insurer failed to satisfy its burden that each part of the exclusion applied to the claim. In part, the exclusion provided that there would be no coverage for any matters that were noticed to a different insurance company. Finding that the exclusion was ambiguous, the court reasoned that the exclusion could mean that there would be no coverage for any claim that was reported to the other insurer "at any time," or any claims that had been reported to the other insurer at the time the policy went into effect.

Freedom Specialty Ins. Co. v. Platinum Mgmt (NY), LLC, No. 652505/2017, 2018 WL 4334216 (N.Y. Sup. Ct. Sept. 10, 2018)

An insurer could not establish that coverage for an SEC proceeding was barred by a prior or pending litigation exclusion in a directors and officers liability policy because the insurer could not meet the court's "strict standard" demonstrating commonality of the underlying actions. The court reasoned that the insurer could not demonstrate that there was a "common fact, circumstance, situation, transaction, or event" between the prior investigation by the SEC and the present SEC action against the insureds.

Dishonesty & Personal Profit Exclusions

Office Depot, Inc. v. AIG Specialty Ins. Co., 722 F. App'x 745 (9th Cir. 2018)

The Ninth Circuit found that the district court erred in holding that California Insurance Code section 533 precluded insurance coverage for claims brought under the California False Claims Act ("CFCA") as a matter of law. Section 533 bars indemnification of "willful" wrongful conduct. However, the CFCA requires only "reckless[ness]" regarding the truth or falsity of the information in the claim, and does not require "[p]roof of specific intent to defraud." Therefore, CFCA claims do not necessarily involve the "willful" conduct required for preclusion under Section 533. The Ninth Circuit also stated that Section 533 operates as an exclusionary clause, and the insurer has

the burden to demonstrate that the claim is uninsurable, which the insurer had failed to do.

Ill. State Bar Ass'n Mut. Ins. Co. v. Leighton Legal Grp., LLC, 2018 IL App (4th) 170548

The insurer issued a professional liability policy that excluded intentional, dishonest, and fraudulent conduct. The insurer filed a motion for judgment on the pleadings, asserting that it did not have a duty to defend because the underlying complaint alleged intentional misconduct. The underlying complaint alleged that the insured (an attorney) "willfully refused" to distribute trust corpus "in order to perpetuate their self-compensation scheme," "[w]ilfully" misinformed plaintiffs that they were not entitled to trust corpus, "willfully" committed a serious breach of trust by failing to fulfill his fiduciary duty, and engaged in bad faith. The district court denied the motion, but the Appellate Court of Illinois reversed and remanded, finding that the allegations of intentional conduct could not have been the result of mere professional negligence and thus were excluded from coverage.

Restitution, Disgorgement & Damages

Axis Reinsurance Co. v. Northrop Grumman Corp., No. 2:17-CV-8660 (C.D. Cal Nov. 16, 2018)

In an unpublished, partially sealed decision, the court ruled that an excess insurer could recoup payments made to cover an insured's ERISA suit settlement, finding that the settlement constituted uninsurable disgorgement under California law. In doing so, the court found that although the settlement did not specifically use the word "disgorgement," the language of the agreement made clear that it was instructing the insured "to disgorge its ill-gotten gains." The court rejected the insured's argument that California's rule against insuring disgorgements did not apply because there was no order or final adjudication, finding that the rule must be followed "where a governmental agency identifies violations in a thorough and timely investigation but, nonetheless, enters into a settlement of those violations rather than expend precious resources litigating for a final resolution."

J.P. Morgan Secs. Inc. v. Vigilant Ins. Co., 166 A.D.3d 1, 84 N.Y.S.3d 436 (N.Y. App. Div. 2018)

The court, citing the U.S. Supreme Court's decision in *Kokesh v. Securities and Exchange Commission*, found that an insured's disgorgement payment to the SEC for improper profits it earned for its clients was uninsurable as a matter of public policy. In doing so, the court reversed a trial court's grant of judgment to the insured, finding that the fact that the disgorgement payment represented sums that the insured earned for its clients, not itself, was irrelevant to the question of insurability. The court found that the *Kokesh* decision established that "disgorgement is a penalty, whether it is linked to the wrongdoer's gains or gains that went to others." As such, the court ruled that all SEC disgorgements are uninsurable as a matter of New York public policy.

In re TIAA-CREF Ins. Appeals, 192 A.3d 554 (Del. 2018), *reargument denied* (Aug. 23, 2018)

The Delaware Supreme Court, applying New York law, found that class action settlement payments made by the insured as payment of Transactional Fund Expense gains did not involve uninsurable disgorgements as a matter of public policy because there was no evidence the payments were linked to funds the insured improperly acquired.

Insured Capacity

Goggin v. Nat'l Union Fire Ins. Co. of Pittsburgh, No. N17C-10-083 PRW CCLD, 2018 WL 6266195 (Del. Super. Ct. Nov. 30, 2018)

The insurer issued a directors and officers liability policy to a coal company. After filing for bankruptcy, the company filed suit against former directors, alleging breach of fiduciary duties and self-dealing. The underlying complaint alleged that the plaintiffs were also directors of a

competing business and were operating under a conflict of interest. The court applied a "but for" test to the policy exclusion for claims "alleging, arising out of, based upon or attributable to any actual or alleged act or omission of an Individual Insured serving in any capacity, other than as an Executive or Employee of a Company, or as an Outside Entity Executive of an Outside Entity," and concluded that no coverage was owed to the former directors because the underlying allegations arose out of their capacity as directors of the competing company.

Maui Land & Pineapple Co., Inc. v. Liberty Ins. Underwriters Inc., No. 16-00271 DKW-KJM, 2018 WL 1613777 (D. Haw. Apr. 3, 2018)

A directors and officers liability insurer had a duty to advance defense costs to an individual insured who was sued in his capacity as a senior executive officer of the insured development firm and as a director of a co-defendant organization that allegedly exerted undue influence and control over a luxury condominium development that was built by the insured development firm. The insurer had denied coverage on grounds that the underlying claims did not implicate the individual in his capacity as an executive of the insured development firm. The court disagreed with the insurer and concluded that the allegations raised the potential for coverage under the policy, triggering the insurer's duty to advance defense costs.

Fodera v. Arbella Prot. Ins. Co., 2018 Mass. App. Div. 1 (Dist. Ct. 2018)

A directors and officers liability insurer owed a duty to defend to the former trustee/developer of a condominium development in an action filed by the current trustees of that development. The current trustees alleged that the former trustee and other entities he partially owned defectively constructed the condominium development. The policy provided coverage for former trustees for a negligent "wrongful act," as described in the policy, if the trustees were "acting solely in their capacity as such." Even though the complaint alleged that the former trustee acted as a "developer/trustee," the insurer had a duty to defend the former trustee against those claims that were perhaps otherwise excluded.

Sec. Nat'l Ins. Co. v. H.O.M.E., Inc., 312 F. Supp. 3d 777 (D.N.D. 2018)

The insurer issued a directors and officers liability policy to a closely held corporation held by four siblings. One of the siblings, a lawyer, served as the president of the corporation. He executed stock purchase agreements with the other siblings and advised them on the legal aspects of the agreements and attempted to exercise the options. After the president filed suit to enforce the agreement, the siblings filed a counterclaim alleging various business torts and breaches of fiduciary duty. The president sought coverage under the corporation's policy. The court concluded that the insurer owed no duty to defend the president because the allegations in the siblings' counterclaims were related to the president's legal advice in preparing the stock purchase agreements, and not his role as president of the corporation. Even if the insurer had a duty to defend, the claim would fall within the insured versus insured exclusion of the policy.

Westport Ins. Corp. v. Hippo Fleming & Pertile Law Offices, No. 3:15-CV-251, 2018 WL 4705780 (W.D. Pa. Oct. 1, 2018)

An insurer had no duty under a professional liability policy to defend the insured law firm or attorney in an action by a former client who alleged that the firm used information from its representation of him to develop real estate through other corporate entities owned by one of the partners to the benefit of the firm. The Outside Business Exclusion of the policy barred coverage for any claim arising from an insured attorney's work "as an officer, partner, director, [or] manager … of any company … other than the named insured." The underlying allegations implicated the partner and firm's activities in connection with the development of real estate, not the practice of law for the firm. The court granted summary judgment to the insurer after finding that the Outside Business Exclusion applied to all counts in the underlying action as a matter of law.

Insured v. Insured Exclusion

YS Garments v. Cont'l Cas. Co., No. CV17-3345 SJO (JEMX,), 2018 WL 3830178 (C.D. Cal. July 13, 2018)

The court held that an exception for claims made by an employee in a directors and officers policy's insured v. insured exclusion applied to an action by one co-founder a company against the other co-founder. The plaintiff alleged that the partners agreed to take 50 percent interest in the company, but the defendant issued 100 percent of the stock to himself when he registered the corporation. The defendant sought to buy out the plaintiff, who then stopped showing up to work and demanded 50 percent ownership of the company or $50 million. The court found that the employee exception created a duty to defend because there was evidence the plaintiff received a W-2 and it was unclear whether the plaintiff was an executive, since there was no evidence he had been elected to serve as a director or officer. The court interpreted the exclusion against the insurer and denied the insurer's motion for summary judgment.

EMSI Acquisition, Inc. v. RSUI Indem. Co., 306 F. Supp. 3d 647 (D. Del. 2018)

The court held that a major shareholder exclusion ("MSE") in a directors and officers liability policy was ambiguous and construed it in favor of coverage. The policy was issued to Company A, which entered into a stock purchase agreement through which it became wholly owned by Company B. Soon after, Company B made a claim against Company A's former directors, which assigned their coverage claims to Company B. The MSE excluded coverage for "Loss arising out of . . . any Claim brought by . . . [an] entity that owns . . . five percent or more of the outstanding stock of the Insured Organization." Coverage for Company A therefore turned on whether the MSE contained a temporal element. Company B argued that the MSE only applied to shareholders who owned shares when the policy was issued or when a wrongful act occurred, and thus did not preclude coverage for its claims because it was not a shareholder until after the policy incepted and the alleged misconduct of Company A's former directors occurred. The insurer countered that the MSE applied to shareholders who owned shares when the claim was made. The court concluded that the MSE was ambiguous because it did not contain temporal language and both the insurer and insured offered a reasonable interpretation.

Certain Underwriters at Lloyd's, London v. Pope, No. 2016-CA-001028-MR, 2018 WL 1224679 (Ky. Ct. App. Mar. 9, 2018)

In a split decision, the Kentucky Court of Appeals held that an insured v. insured exclusion applied to claims by a rehabilitator of funds against a school board that created the funds and appointed its trustees, but affirmed the lower court's finding that the exclusion did not apply to claims against the trustees. A Kentucky school board created an insurance trust to maintain insurance funds and appointed a board of trustees to manage the funds. The commissioner of insurance appointed itself and an individual as rehabilitators because of the funds' financial situation, and then sued the school board and trustees. Those entities had procured a trustees errors and omissions and directors and officers liability insurance for association with self-insurance funds policy, which contained an insured v. insured exclusion for claims brought by a trust or entity against another trust or entity. Based on its statutory definition, the court found the rehabilitators stepped into the shoes of the funds, which were insured under the policy, and thus their claims against the school board, an insured entity, were precluded. However, the board of trustees of the fund was not an entity insured under the policy; therefore, the exclusion did not preclude coverage for the rehabilitators' claims against it.

Governo v. Allied World Ins. Co., 335 F. Supp. 3d 125 (D. Mass. 2018)

The court held that an insurer had a duty to defend a counterclaim brought by departing attorneys against their former firm based on the allegations in the firm's complaint. The firm brought seven claims against the departing partners for conduct that occurred after they left the firm. The lawyers professional liability policy excluded coverage

for any claim brought by any insured. The policy's definition of insured included two exceptions, one for when an attorney has left the firm and the other tying the definition to when the attorney is performing services on behalf of the firm. Although two claims brought by the departing partners concerned their time at the firm, the final claim was for a declaratory judgment that the law firm's allegations of post-firm conduct were false. The court found the two exceptions to the exclusion applied because the departing attorneys were being sued – and thus countersued – for conduct after they left the firm and not for work on behalf of the firm.

Sec. Nat'l Ins. Co. v. H.O.M.E., Inc., 312 F. Supp. 3d 777 (D.N.D. 2018)

The court held that a directors and officers liability policy's exclusion for suits brought by "any insured person in any capacity" precluded coverage in an underlying family business dispute, which had its origins in a stock transfer agreement, whereby the insured company's founder transferred his shares to his four children. One of the siblings, an attorney who later served as the President and Director of the company, sued the other three inheritors to enforce a provision in the stock purchase agreement that allowed him to exercise a call option and buy his siblings' shares, after he and his law firm rendered them legal advice encouraging them to sign the agreement. His three siblings answered with nine counterclaims. As the first court to interpret an insured v. insured exclusion under North Dakota law, the court concluded the language was not ambiguous, and that it precluded coverage for the counterclaims brought by the siblings. The court agreed with the insurer that "preventing coverage for family disputes is particularly appropriate in cases dealing with 'closely-held family businesses.'"

In re Palmaz Sci., Inc., No. 16-50552-CAG, 2018 WL 3343597 (Bankr. W.D. Tex. June 4, 2018)

The court held that the exception in a directors and officers policy's exclusion for direct shareholder claims applied to a litigation trustee who was assigned those claims, even though he was also an insured under the policy. The exclusion precluded coverage for any claim by a security holder, except when the claim is brought by a security holder independent of and without the involvement of any other insured. In finding the exception applied to the trustee, the court rejected the insurers' arguments that the exclusion applied because the trustee was bringing claims as a security holder and that would render the exception meaningless, that the exception did not apply because the trustee was an assignee and not an actual shareholder, and that the exception did not apply because the claims themselves did not depend on the trustee's involvement but rather were assigned to him.

Contractual Liability

Perniciaro v. McInnis, 255 So. 3d 1223 (La. Ct. App. 2018)

The court held that a contractual liability exclusion in a directors and officers liability policy barred coverage for an insured's alleged tortious conduct on the basis that the torts would not have occurred "but for" the insured's alleged breach of contract. The insured, a parish, contracted with a vendor for information technology services. The vendor alleged that the parish council wrongfully terminated the contract in favor of a different service provider and that council members defamed the vendor by discussing the dispute to the press. The vendor filed suit against the parish government, asserting claims of breach of contract, defamation, and general allegations of "[a]ny and all other negligent and/or intentional acts[.]" The insured's liability carrier denied coverage partly on the basis that the policy excluded coverage for breach of contract, defamation, and mental anguish. The district court agreed. The appellate court applied a "but for" test, holding that the contract exclusion barred coverage for the lawsuit, reasoning that "[t]he negligent and intentional torts alleged by Plaintiffs stem from the contract [between the vendor and insured]. These alleged claims would not have occurred but for the breach of contract by the Parish, and the claims are not separate and distinct from the breach of contract."

Mau v. Twin City Fire Ins. Co., 910 F.3d 388 (8th Cir. 2018)

The Eighth Circuit, applying North Dakota law, affirmed the trial court's summary judgment ruling in favor of an insurer, holding that a directors and officers liability policy did not cover a company for breach of a noncompetition covenant in an asset purchase agreement. The selling company sold its assets to a separately owned and operated entity, the buying company, through an asset purchase agreement executed by the selling company, which included a noncompetition covenant. After the agreement was signed, two affiliates of the selling company – which were not parties to the asset purchase agreement – entered into a transaction. The buying company sued the selling company and its owner for breach of contract, fraud, and civil conspiracy on the grounds that the transaction violated the noncompetition covenant. The selling company was insured under a policy issued to its parent company. The selling company sought a defense from the insurer, but the insurer declined to defend. In the coverage litigation, the Eighth Circuit ruled that summary judgment in favor of the insurer was proper. The court held that the insurer had no duty to defend the selling company because the claims asserted against it would not exist in the absence of the asset purchase agreement, and therefore the policy's breach of contract exclusion applied.

Spec's Family Partners, Ltd. v. Hanover Ins. Co., 739 F. App'x 233 (5th Cir. 2018)

The Fifth Circuit, applying Texas law, held that a breach of contract exclusion did not bar coverage for a demand received by an insured retailer from its credit card processor for indemnification and other relief arising from a payment card breach. After an insured retailer's credit card network was hacked, certain issuing banks demanded payment from the insured's card processor, which in turn demanded reimbursement from the insured. The processor sent demand letters to the insured, noting the insured's non-compliance with industry standards and demanding that the insured take steps to confirm its security compliance. The letters also referred to the insured's contractual indemnification obligations and requested other unspecified amounts. The insured's directors and officers insurer agreed to fund the insured's defense under a reservation of rights. In the coverage litigation, the district court granted the insurer's motion for judgment on the pleadings, holding that the processor's claim against the retailer was barred by a breach of contract exclusion. On appeal, the court reversed, ruling that the pleadings did not "unequivocally show" that the breach of contract exclusion applied. The court reasoned that the demand letters implicated liability outside of the contract. For example, the demand letters included reference to the insured's non-compliance with industry standards and made separate demands for relief from the contractual indemnification demand. For that reason, the court reversed the ruling in favor of the insurer, holding that the breach of contract exclusion did not bar the duty to defend.

Conifer Health Sols., LLC v. QBE Specialty Ins. Co., No. 4:17-CV-00664, 2018 WL 4620613 (E.D. Tex. Sept. 26, 2018)

The court held that a contract exclusion in an errors and omissions policy barred coverage for breach of a contract to provide health management services. The insured, a health management service provider, was sued by a client for breach of contract, breach of express warranty, unjust enrichment, and gross negligence/willful and wanton misconduct. The client later amended its complaint, omitting all causes of action other than breach of contract. The insured tendered the claim to its errors and omissions insurer, which denied coverage based on several policy exclusions. In the coverage litigation, the court ruled in favor of the insurer on summary judgment, holding that the policy's contract exclusion barred coverage. The insured argued that the exclusion did not apply because the claim did not allege that it was a party to the contract, and that its status as an assignee was legally distinct from that of a party to the contract. The court rejected this argument, holding that because there was a valid assignment and an assignee generally stands in the shoes of the assignor, the insured was a party to the contract. In considering the insured's argument that the term "party" rendered the exclusion ambiguous, the court concluded that the insured had not

demonstrated that the provision was susceptible to more than one reasonable interpretation and that a plain reading of the exclusion did not present any ambiguity. The insured also argued that the claim alleged wrongful acts that were independent of the contract at issue and that some alleged wrongdoing took place prior to the assignment of the contract. The court rejected these arguments, holding that the allegations were nonetheless in connection with the contract and fell within the scope of the exclusion. The court also found that the insured failed to establish that without the contract in place, it would be liable for the other allegations.

Mt. Hawley Ins. Co. v. Slay Eng'g, Tex. Multi-Chem, & Huser Constr. Co., Inc., 335 F. Supp. 3d 874 (W.D. Tex. 2018)

The court held that a breach of contract exclusion in a commercial general liability policy did not bar the insurer's duty to defend the insured in a construction defect lawsuit. The insured, a construction company, contracted with a city to build a sports complex. After the complex was built, the city sued the insured, alleging construction defects and asserting claims for breach of contract and negligence. The insurer denied coverage based on the policy's breach of contract exclusion and sued the insured for a declaration that it owed no duty to defend. The court held that the insurer had a duty to defend because the city's allegations left open the possibility that the property damage in question could have occurred even if the construction company had not breached its contract or engaged in negligent conduct. Because the insurer failed to demonstrate that the alleged breach of contract was a "but for" cause of the property damage, the breach of contract exclusion did not apply.

Crum & Forster Specialty Ins. Co. v. GHD Inc., 325 F. Supp. 3d 917 (E.D. Wis. 2018)

The court held that a contract exclusion in a multi-line liability policy barred coverage for an action solely alleging breach of contract. The insured, a designer and producer of anaerobic digest systems, was sued for breach of contract based on an alleged design failure. Although the relevant errors and omissions policy contained a breach of contract exclusion, the insured tendered the claim. The insurer then sought a declaratory judgment that it had no obligation to defend or indemnify due to the breach of contract exclusion. In response, the insured stipulated that coverage was barred by the exclusion but argued that because every contract contains a common-law duty to perform "with care, skill, reasonable expedience and faithfulness," any professional errors or omissions claim must "arise out of" a breach of contract, and thus, coverage could never exist. The insured argued that because illusory coverage is contrary to Wisconsin public policy, the court should reform the contract by removing the contract exclusion. The court rejected the insured's argument, holding that there were professional duties beyond strictly contractual obligations, including duties to third parties or the "world at large." The court also noted that, even if the contract exclusion did render coverage illusory, it would not be eliminated altogether. Instead, the policy could be reformed to exclude liability for breach of contract but not liability to third parties who were not parties to the contract. Therefore, the court held that the insurer had no duty to defend or indemnify the insured.

Professional Services

Cases Addressing Policies Providing Coverage for Professional Services

Evanston Ins. Co. v. Law Offices of Michael P. Medved, P.C., 890 F.3d 1195 (10th Cir. 2018)

The Tenth Circuit, applying Colorado law, held that an insurer had no duty to defend its insured under a lawyer's professional liability policy because the insured's actions did not constitute "professional services." The insured foreclosure attorney was sued by a group of property owners and was provided a draft complaint by the Colorado Attorney General's Office, both of which alleged overbilling. In granting the insurer's motion for summary judgment, the district court held that the insurer had no duty to defend because the only allegations were of overbilling, which did not constitute "professional services," defined in the policy as "those services performed by the 'Insured' for others . . . as a lawyer . . . ." The

insured claimed that the firm's billings were an integral part of its professional services because the billings provided lenders and investors with the documentation required for reimbursement of attorney's fees. The court disagreed, finding that the only alleged "wrongful act" was improper overbilling, not that the insured impacted the rights of lenders and investors to reimbursement

Med. Protective Co. v. Fabricius, No. 15 cv 6917, 2018 WL 2561009 (N.D. Ill. June 4, 2018)

The insured had been sued in an action seeking to rescind its sale of its dental practice based on allegations the insured fraudulently misrepresented key aspects of the size and nature of his practice and breached the sale agreement. The insurer asserted it had no duty to defend or indemnify the insured under its professional services policy because the underlying lawsuit was not a "claim" based on "professional services" rendered "in the practice of the Insured's profession" as those terms were defined in the policies. The court found that, although the allegations in the underlying suit were "claims" under the policy, they were unrelated to the policy's definition of "professional services," which were defined as the "rendering of … dental … services to a patient and the provision of medical examinations, opinions, or consultations regarding a person's medical condition within the Insured's practice as a licensed health care provider …" Accordingly, the court found that the matter at issue was fundamentally a contract dispute arising from the sale of the insured's dental practice, and granted the insurer's motion for summary judgment.

Arzadi v. Evanston Ins. Co., No. 2:17-CV-5470-SDW-CLW, 2018 WL 747379 (D.N.J. Feb. 7, 2018)

The insured attorney was alleged to have engaged in a fraudulent scheme to defraud a non-party insurance company. The professional liability policy provided coverage for "any act … by the Insured in rendering … Professional Legal Services for others." The policy further defined "Professional Legal Services" as "services rendered by an Insured as a lawyer … provided that such services are connected with and incidental to the Insured's profession as a lawyer and are performed by or on behalf of the Named Insured or any Predecessor Firm …" The underlying suit contained allegations that the insured's fraudulent activities included advising clients how to proceed with their personal injury claims, which the court found fell squarely within the policy's definition of "Professional Legal Services." Accordingly, the court granted the insured's motion for summary judgment.

Ill. Union Ins. Co. v. U.S. Bus Charter & Limo Inc., 291 F. Supp. 3d 286 (E.D.N.Y. 2018)

The insured was sued in a class action complaint for alleged violations of the Telephone Consumer Protection Act ("TCPA") concerning text messages promoting bus transportation and travel accommodations. The insured's miscellaneous professional liability policy covered "Professional Services," defined to include "performance of professional services as a bus charter broker for others for a fee" and "Travel Agency Operations," defined to include "services necessary or incidental to the conduct of a travel agency business including the procurement or attempted procurement . . . of travel , lodging, or guided tour accommodations." In ruling on cross motions for summary judgment, the court found that the policy unambiguously covered the TCPA violations under both the "as a broker" and "Travel Agency Operation" provisions because the messages included "deals," "rentals," and specified prices. The court rejected the insurer's argument that there should be no coverage because the insured was advertising for itself and that no fee was charged until a transaction was complete, finding that the bus rental advertisements related to parts of the bundle of services the insured provided, and that the services were nevertheless still offered for a fee.

Affinity Living Grp., LLC v. StarStone Specialty Ins. Co., No. 1:18-CV-35, 2018 WL 4854650 (M.D.N.C. Oct. 5, 2018)

The insured nursing home owner and managing entity were sued on grounds that they acted

in concert to submit false claims for Medicare reimbursements for services not actually provided to residents of their homes. The underlying complaint also alleged that the facilities were unable to provide "personal care services" necessary to meet the assessed needs of residents. The insurer denied coverage for the suit under an umbrella policy that provided coverage for damages resulting from a "medical incident," which included the insured's "professional services," defined as "the healthcare services or the treatment of a patient" including medical, dental, and counseling services. In resulting coverage litigation, the court granted the insurer's motion for judgment on the pleadings, finding that billing was not a health care service or treatment of a patient constituting "professional services." The court also found that although the complaint alleged that the insured delivered deficient personal care services to its residents, it sought damages based on allegedly fraudulent billing, which constituted an "intervening cause" that severed any connection between the medical incidents alleged and the injuries to government for which the complaint sought recovery.

Beattie v. McCoy, 2018-Ohio-2535

The insured, a self-described "sex addict" who nonetheless practiced internal medicine from 1993 until October 2012, had his license suspended for having an affair with a patient. During the period of the affair, the insured had a professional liability policy which provided coverage for claims arising from professional services involving "allegation of injury … because of professional services provided or which should have been provided or that result from an incident which causes bodily injury." The policy defined "professional services" as "medical, surgical, dental, imaging, mental or other health care professional service or treatments … (and the) provision of drugs, health care supplies or appliances." In 2016, the patient with whom the insured had the affair sued him, alleging that his sexual behavior constituted medical malpractice, and seeking a declaration that the insurer was required to indemnify the insured because he damaged her while performing a professional service. The trial court found that the insurer had no obligation to indemnify the insured. The appellate court affirmed, finding that, even as her general internist physician, the insured's conduct in failing to refrain from sex or failing to rebuke the patient's sexual advances was not "inextricably related" to the professional services the insured had been rendering to his patient.

PACO Assurance Co., Inc. v. Hanson, No. C17-0649RSL, 2018 WL 1071656 (W.D. Wash. Feb. 27, 2018).

The insured chiropractor was sued based on the alleged submission of misleading, false, and/or fraudulent bills in order to obtain Personal Injury Protection payments from his patients' auto insurance policies. The complaint also alleged that the insured used a predetermined treatment plan that was not designed to appropriately examine, diagnose, and provide medically necessary services to patients, and that the insured over-treated patients. The chiropractic professional liability policy at issue provided coverage for damages resulting from a "malpractice incident," which included an act, error or omission in the insured's "professional services," defined as services "within the scope of practice of a chiropractor." In the ensuing declaratory relief action, the court denied the insurer's motion for summary judgment, holding that the complaint's allegations would require plaintiff to prove that the insured's treatment plan was not only consistent, but also that it fell below the standard of care, and thus necessarily involved alleged errors or omissions in the services provided by a chiropractor that triggered coverage under the policy.

Cases Addressing Professional Services Exclusions

HotChalk, Inc. v. Scottsdale Ins. Co., No. 16-17287, 736 F. App'x 646 (9th Cir. 2018)

The insured, which provided technology and support services to universities seeking to establish or expand their online education programs, was sued in a False Claims Act ("FCA") action alleging it caused false claims to be submitted to the Department of Education ("DOE") in connection with students' claims for financial aid. The Ninth Circuit, applying California law, affirmed

the district court's holding that a professional services exclusion in a directors and officer liability policy barred coverage for the insured's settlement of the FCA suit. The exclusion precluded coverage for claims "alleging, based upon, arising out of, attributable to, directly or indirectly resulting from, in consequence of, or in any way involving the rendering or failing to render professional services." The Ninth Circuit agreed that the claims at issue in the FCA suit clearly arose out of the insured's professional services because its alleged liability derived from the fact that its professional services caused ineligible students and ineligible universities to submit claims for federal financial aid to the DOE.

W. World Ins. Co. v. Nonprofits Ins. All. of Cal., 295 F. Supp. 3d 1071 (N.D. Cal. 2018)

The insured Scientology-based substance abuse and addiction treatment facility was sued in lawsuits alleging that its employees provided alcohol to patients, which led to the patients entering into sexual relationships with staff members and overdosing on heroin. The insurer denied coverage pursuant to a professional services exclusion in its commercial general liability policy, which precluded coverage for claims arising out of the "rendering of or failure to render any professional service." Although the policy did not define "professional service," the insurer argued the term has accepted meaning in California courts: services "arising out of a vocation, calling, occupation, or employment involving specialized knowledge, labor, or skill, and the labor or skill involved is predominantly mental or intellectual, rather than physical or manual." The insurer argued that the provision of alcohol to patients was a departure from treatment protocols and thus a "failure to render professional services" such that the exclusion applied. The court disagreed, holding that the patients were injured by non-professional conduct outside the scope of treatment, and thus the exclusion did not apply to bar coverage.

Ohio Sec. Ins. Co. v. Premier Pain Specialists, LLC, No. 17 C 5937, 2018 WL 3474537 (N.D. Ill. July 19, 2018)

An insurer sought a declaratory judgment that it had no duty to defend or indemnify its insureds for an underlying negligence action, in which plaintiff alleged she was injured after a procedure at the insureds' facility. The plaintiff alleged the insured "failed to keep a recovery room in a safe condition so as to prevent a fall" and "maintained faulty equipment in the room" as a result of "faulty design," among other claims. The court assumed, without deciding, that the insured demonstrated that the underlying claims fell within the policy coverage. However, the court also found that coverage was precluded under the "garden variety" professional services exclusion. The court found that when "taken as a whole," the claims of environmental negligence arose directly from an injury caused by the insureds' failure to properly render a professional service in a medical context, which requires "specialized knowledge" that included creating a "reasonably safe" recovery room.

Beazley Ins. Co., Inc. v. ACE Am. Ins. Co., 880 F.3d 64 (2d. Cir. 2018)

This matter arose from the insured NASDAQ public stock exchange's Initial Public Offering of Facebook, Inc. A variety of technical difficulties resulted in improperly executed trades, which subsequently lead to retail investors filing a consolidated securities class action asserting fraud claims against the exchange. In the coverage action, the Second Circuit, applying New York law, affirmed the district court's holding that coverage was precluded under a directors and officers liability policy's professional services exclusion. Although the policy did not define "professional services," the court held the exclusion was broadly worded and that plaintiffs' losses were directly related to the exchange's failure to properly execute the purchase and sale orders and deliver timely confirmations, which "go to the heart of NASDAQ's provision of professional services."

Independent Counsel

Bull v. Federated Mut. Ins. Co., 338 F. Supp. 3d 958 (E.D. Ark. 2018)

The court, in recognizing that the Arkansas Supreme Court had not yet directly addressed whether an insured has the right to independent counsel, found that the insured did not have a right to independent counsel under the circumstances, where the insured presented no evidence that appointed counsel's defense was inadequate or that counsel acted contrary to the insured's interests. The court also found it relevant that the policy did not contain any promises to provide independent counsel and the insurer's reservation of rights letter advised the insured that it had the right to retain separate counsel to associate in the defense of the underlying action at its own expense.

Centex Homes v. St. Paul Fire & Marine Ins. Co., 19 Cal. App. 5th 789 (2018)

The court affirmed the trial court's grant of summary judgment in favor of the insurer, finding that the insured was unable to establish a legally sufficient conflict of interest to warrant independent counsel. California Civil Code Section 2860 and California case law provide that the insured has a right to obtain independent counsel paid for by the insurer whenever their competing interests create an ethical conflict for counsel. The insured filed an action against its insurer, arguing that it was entitled to independent counsel whenever a possible conflict may arise, but the court disagreed, explaining that the insured is only entitled to independent counsel whenever there is an actual, not possible conflict. The court also disagreed with the insured's argument that there was an actual conflict of interest because defense counsel retained by the insurer could control the outcome of the coverage issue, finding that the insured only provided legal conclusions and no facts to support this argument.

Pac. Intercultural Exch. v. Scottsdale Ins. Co., No. D071478, 2018 WL 4500674 (Cal. Ct. App. Sept. 20, 2018)

The court affirmed summary judgment entered in favor of the insurer, rejecting the insured's argument that it was entitled to recover fees and costs incurred by its general counsel as the insured's purported independent counsel. The court rejected the insured's argument that the insurer's settlement negotiations undertaken in connection with the underlying action against the insured revealed a conflict, finding that the fact that the insured disagreed with the insurer's proposed settlement terms did not create a conflict where the insurance policy gave the insurer the exclusive right to control settlement.

Bean Prods. Inc. v. Scottsdale Ins. Co., 2018 IL App (1st) 170421-U

The court affirmed summary judgment in favor of the insurer, holding that an insured was not entitled to independent counsel and finding that the insurer's reservation of rights based on the lack of coverage for punitive damages and general reservation of rights did not create an actual conflict of interest. The court also found that the insured could not recover the fees and costs incurred by its independent counsel, because fees were incurred without the insurer's consent and in violation of the policy's no-voluntary payments provision.

Johnson v. W. Bend Mut. Ins. Co., No. A17-1957, 2018 WL 6596270 (Minn. Ct. App. Dec. 17, 2018)

The court, in explaining the general rule under Minnesota law that insurance coverage cannot be enlarged by estoppel, refused to estop an insurer from challenging coverage on the basis of its failure to provide independent counsel.

Grain Dealers Mut. Ins. Co. v. Cooley, 734 F. App'x 223 (5th Cir. 2018)

The Fifth Circuit, applying Mississippi law, explained that, where an insurer defends under a reservation of rights, the insurer has a special obligation to provide the insured with an opportunity to select independent counsel. The Fifth Circuit held that the insurer was estopped from denying coverage because the insurer failed to advise the insured of its right to retain

independent counsel and the insured established that it was prejudiced by the insurer's failure to provide independent counsel.

Siltronic Corp. v. Emp'rs Ins. Co. of Wausau, No. 3:11-cv-1493-YY, 2018 WL 406044 (D. Or. Jan. 3, 2018)

Under Oregon law, pursuant to Oregon Revised Statutes 465.483, unlike most other jurisdictions, a *per se* conflict of interest exists between the insurer and the insured, triggering the right to independent counsel, when an insurer defends an environmental claim under a reservation of rights or there is potential for the environmental claim to exceed policy limits. At issue was whether "independent counsel" refers to co-counsel who defends the underlying suit with the insurer's defense counsel (*Cumis* counsel), or defense counsel who represents both the insurer and the insured but who operates independently of the insurer and is directed and controlled by the insured (independent defense counsel). Although both comport with Oregon's code of ethics, the court found that in this particular case, the insurer had to provide *Cumis* counsel because it was not able to provide independent defense counsel

Advancement of Defense Costs

AR Capital, LLC v. XL Specialty Ins. Co., No. N16C-04-154 WCC CCLD, 2018 WL 6601184 (Del. Super. Ct. Dec. 12, 2018)

An investment company purchased a directors and officers primary policy and several follow-form excess policies. The investment company entered into an agreement with a management company concerning the company's investments and operations. The management company sought defense costs from the policies after the investment company's internal audit revealed reporting irregularities that led to various shareholder lawsuits and an SEC investigation. The court found that there was coverage for the management company. The court then partially granted the management company's summary judgment motion for advancement of the company's defense costs under the policies as follows: 1) there was coverage for the class action lawsuit brought by plaintiffs who purchased the investment company's securities; 2) there was coverage for the various opt-out litigations alleging fraudulent and misleading conduct that led to financial losses of the plaintiffs in those actions; 3) the SEC's order of investigation was covered; and 4) the management company failed to establish that it was entitled to defense costs for the investment company's own internal audit on the grounds that the insured did not establish that it was a covered claim under the policy.

Verizon Commc'ns Inc. v. Ill. Ins. Co., No. N14C-06-048 WCC CCLD, 2018 WL 2317821 (Del. Super. Ct. May 16, 2018)

The court granted the plaintiffs' motion for entry of final judgment and prejudgment interest. In a prior order, the court had determined that the underlying action fell within the definition of a "securities claim" of the executive and organizational liability policies at issue. All but one of the excess insurers opposed the motion on grounds that there were pending issues pertaining to defense costs. At the time of the motion, the insurers had not reimbursed any of the defense costs. The court ruled that its prior order required the insurers to pay defense costs and the insurers could litigate the question of reasonableness after payment was made. The court noted that the only reason given by the insurers for their initial denial of coverage was that the claim was not a "securities claim" under the terms of the policies. The court further found that the policies required the insurers to pay defense costs even if there was a dispute about the final amount. The insurers had not challenged any of the invoices submitted for payment. After the final amount was paid, any costs that should not have been covered would be repaid to the insurers.

Woodspring Hotels LLC, v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA, No. N17C-09-274 EMD CCLD, 2018 WL 2085197 (Del. Super. Ct. May 2, 2018)

A company and its employee sought summary judgment that its directors and officers liability policy provided a duty to advance defense

costs for a claim brought by the employee's prior employer alleging that she appropriated electronic information to her new company. Under Delaware law, there was a duty to defend the entire underlying litigation if any claim asserted in the pleadings was entitled to a defense under the policy. The insurer argued that the employee's defense was excluded as a claim arising out of her acts "other than as an Executive or Employee of the Company." The court disagreed and found that the underlying claim alleged that the employee's conduct occurred while she was employed by the insured company and there was a duty to defend the entirety of the underlying claim against the employee. The insurer argued that the claims against the insured company were excluded based on a misappropriation of trade secrets policy exclusion. The court disagreed and found that one of the counts in the underlying complaint did not explicitly refer to trade secrets and therefore could arise in relation to a covered claim. The company was entitled to a complete defense.

Maui Land & Pineapple Co., Inc., v. Liberty Ins. Underwriters Inc., No. 16-00271 DKW-KJM, 2018 WL 1613777 (D. Haw. Apr. 3, 2018)

A lawsuit was brought against a real estate development company and one of its officers, among others. The officer was also a representative on a condominium board and the underlying complaint made allegations against the condominium board. The officer was insured by an executive advantage insurance policy. In the ensuing coverage action, the insurer and the real estate development company (which had an indemnification agreement with its officer) cross-moved for summary judgment. The insurer declined to advance defense costs to the company and its officer on grounds that the officer had not been sued in his capacity as an officer of the insured company. Instead, the insurer argued that the underlying claims were alleged against the officer in his capacity as a member of the condominium board. The court found that the underlying allegations were not clear. Applying a "potentiality standard" for triggering the duty to advance defense costs under Ninth Circuit precedent, the court found in favor of coverage.

Sec. Nat'l Ins. Co. v. H.O.M.E., Inc., 312 F. Supp. 3d 777 (D.N.D. 2018)

The court granted summary judgment to the insurer declaring that there was no obligation under a directors and officers policy to pay any costs or losses resulting from the legal defense of the insured company's president for unrelated counterclaims brought against him by his three siblings. The court found that the losses at issue did not arise solely from the president's actions as a director or officer of the company and there was no "possibility of coverage" to construe in favor of the president. In addition, the court found that the claims brought by the president's three siblings were excluded from coverage by the insured v. insured exclusion because it was undisputed that one of the president's siblings was a director of the company and an "insured person" under the policy at all relevant times. The court found that the exclusion also precluded coverage for the two non-insured siblings' counterclaims because all of the counterclaims were filed jointly and were indistinguishable.

Sec. & Exch. Comm'n v. Faulkner, No. 3:16-CV-1735-D, 2018 WL 2761850 (N.D. Tex. June 6, 2018)

Individual defendants who were charged with violations of the Securities and Exchange Act sought the continued advancement of defense costs under a directors and officers policy after the policy was at least partially included within an order freezing assets of the company to which the policy was issued. The company was also charged with SEC violations stemming from a scheme to defraud investors. The receiver for the company's estate opposed the motion. There was no dispute that the individual defendants qualified as "Insured Persons" under the policy and that they had been reimbursed by the insurer for their defense costs prior to the order establishing the asset freeze. The court balanced the harm of withholding defense costs from the individual defendants and their immediate need against the potential future harm to the receivership estate if such funds were released and found in favor of the individual defendants.

Allocation

Sec. Nat'l Ins. Co. v. H.O.M.E., Inc., 312 F. Supp. 3d 777 (D.N.D. 2018)

The court held that a directors and officers liability policy's allocation clause did not apply even though only one of three claimants was an insured. The underlying claims arose from a family business dispute, which had its origins in a stock transfer agreement, whereby the insured company's founder transferred his shares to his four children. One of the siblings, an attorney who later served as the president and director of the company, sued the other three inheritors to enforce a provision in the stock purchase agreement that allowed him to exercise a call option and buy his siblings' shares, after he and his law firm rendered them legal advice encouraging them to sign the agreement. His three siblings answered with nine counterclaims, but only one of the siblings was also an insured under the policy as a director of the company. The court concluded the claims were precluded by the policy's insured v. insured exclusion, but the solo sibling argued the allocation provision should apply to create coverage for the two non-insured siblings' claims. The court denied that request because the policy's allocation clause only applied to claims against both insured and uninsured persons/entities (covered and uncovered claims). In other words, the clause could limit coverage, not increase it.

Sec. & Exch. Comm'n v. Faulkner, No. 3:16-CV-1735-D, 2018 WL 2761850 (N.D. Tex. June 6, 2018)

The court declined to disturb an insurer's allocation of proceeds from a directors and officers liability insurance policy. In an earlier proceeding, the court determined when it granted the SEC's request against insured executives that they would face real and immediate harm without access to the policy proceeds. The insurer then began paying their claims, but when the policy was almost depleted, received notice from a different insured director of his covered claims. The insurer decided to allocate proceeds to the claimants pro rata moving forward, and the insured director requested that the court reallocate the proceeds in a more equitable manner. The court declined to do so because the request was too attenuated from the underlying securities fraud issues. The court further noted there were factual assertions that cautioned against applying its equitable power; specifically, that the director waited many years before seeking coverage and not immediately moving the court for relief.

Recoupment

AR Capital, LLC v. XL Specialty Ins. Co., No. CVN16C04154WCCCLD, 2018 WL 6601184 (Del. Super. Ct. Dec. 12, 2018)

Under a directors and officers policy, the court held that the insurer had a duty to advance defense costs until there was a determination of no coverage under the policy. The court noted that the insured would be obligated to repay defense costs if there was a subsequent determination of no coverage.

Phila. Indem. Ins. Co. v. Stazac Mgmt., Inc., No. 3:16-CV-369-J-34MCR, 2018 WL 2445816 (M.D. Fla. May 31, 2018)

The insurer was entitled to reimbursement of defense costs under a professional liability policy where it had expressly reserved the right to recoup any fees and costs paid if there was no coverage and where the policy expressly provided that the insurer was entitled to reimbursement of amounts paid to defend and/or settle a claim if it was determined by final judgment or agreement that no coverage is afforded.

Cushman & Wakefield, Inc. v. Ill. Nat'l Ins. Co., No. 14 C 8725, 2018 WL 1898339 (N.D. Ill. Apr. 20, 2018)

The insurers' counter-claims for recoupment of defense costs and settlement payments under real estate professional liability policies were denied where the court determined that there was coverage under the policies. However, the insurer was entitled to recover amounts that had been paid in excess of the limit of liability (due to a determination of related claims) where the policy

expressly provided that the insured would be liable to the insurer for any amounts paid in excess of the policy limits.

MedChoice Retention Grp., Inc v. Rand, 344 F. Supp. 3d 1184 (D. Nev. 2018)

Where a professional liability policy was rescinded, the insurer was entitled to summary judgment on a cause of action for a declaration that it was entitled to reimbursement of defense costs paid under the policy.

ALPS Prop. & Cas. Ins. Co. v. Farthing, No. 2:17CV391, 2018 WL 4927366 (E.D. Va. Sept. 26, 2018)

Where a lawyers professional liability policy expressly allowed for reimbursement of defense fees for non-covered claims and the insurer defended under a reservation of rights, the insurer was permitted to recover defense costs. The court ordered further briefing on the amount of defense fees allocated to non-covered claims.

ALPS Prop. & Cas. Ins. Co. v. Turkaly, No. 2:16-CV-10064, 2018 WL 385195 (S.D. W. Va. Jan. 11, 2018)

Where a lawyers professional liability policy was rescinded and void *ab initio*, the insurer was not permitted to recover defense costs paid under the policy.

Consent

Lynch & Kennedy Dry Goods, Inc. v. Am. Fire & Cas. Co., No. 1:17-CV-00006 JWS, 2018 WL 264208 (D. Alaska Jan. 2, 2018)

The court found that a business liability policy's voluntary payment provision, which provided that "[n]o insured will, except at that insured's own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without [the insurer's] consent," precluded coverage for pre-tender attorneys' fees and costs an insured incurred in successfully defending a criminal matter. The court found that, although the insurer would need to show it suffered prejudice in connection with its late notice defense – which the court declined to decide – the insurer was not required to show prejudice to rely on the policy's voluntary payment obligation, which the insured violated.

Piveg, Inc. v. Gen. Star Indem. Co., 710 F. App'x 776 (9th Cir. 2018)

The Ninth Circuit, applying California law, affirmed the lower court's ruling that a commercial general liability policy's no-voluntary payment provision excluded coverage to the extent the insured "voluntarily ma[de] a payment, assume[d] any obligation, or incur[red] any expense" to resolve third-party claims without the insurer's consent. Although there was evidence indicating that the insured and the claimant may have finalized the payment terms after the insurer denied coverage, the Ninth Circuit found this inconsequential because explicit payment terms are unnecessary to form a contract. The Ninth Circuit also noted that the statute of frauds did not render the insured's agreement to pay the claimant unenforceable because the emails between them sufficiently memorialized their agreement.

Amco Ins. Co. v. Morfe, No. 17-55383, 2018 WL 4520952 (9th Cir. Sept. 20, 2018)

The Ninth Circuit, applying California law, affirmed the lower court's ruling that coverage for an underlying settlement was not afforded under a liability policy because the insureds breached the policy's no-voluntary payments provision by settling the underlying action without the insurer's consent after tendering their defense to the insurer but before receiving a coverage determination. The claimant argued, among other things, that the "no voluntary payments" provision was unenforceable on the basis that the insurer breached its duty to provide an immediate defense by not rendering a coverage determination in the 12-week period from the time of tender until when the settlement agreement was executed. In rejecting this argument, the Ninth Circuit noted that the evidentiary record showed that the insurer's

investigation of coverage was still ongoing at the time the insured settled the underlying action.

Ranburn Corp. v. Argonaut Ins. Co., No. 4:16-CV-00088, 2018 WL 1523210 (N.D. Ind. Mar. 28, 2018)

The court held that primary and excess policies' voluntary payments provisions, which provided that "no insured will, except at its own cost, voluntarily assume any obligation or incur any expense without the Insurers' consent," precluded coverage for fees the insured incurred to retain an environmental consultant to assist in the defense of an underlying claim. The court found that because the insured voluntarily chose to engage the environmental consultant, despite the insurers' warning that the environmental consultant's fees would not be covered, the fees were excluded by the policies' voluntary payments provisions.

Union Ins. Co. v. Travelers Indem. Co. of Conn., No. 3:09-CV-283 HTW-LRA, 2018 WL 4689149 (S.D. Miss. Sept. 29, 2018)

In a contribution action between two insurers regarding payments they made in connection with a $1.75 million settlement of an underlying action on behalf of their mutual insured, the court held that the insured's alleged breach of the consent-to-settle provision in a liability policy issued by the defendant insurer was not a defense to plaintiff insurer's contribution claim. The defendant insurer argued that because it notified the insured and the plaintiff insurer prior to settlement that it only agreed to contribute $485,700 toward the underlying settlement, the consent-to-settle provision in its policy operated to preclude the plaintiff insurer from recovering any amount above what it consented to pay. The district court found that, because it appeared from the record that the defendant insurer had a full opportunity to participate in the settlement negotiations and its assessment of the settlement value diverged too greatly from all other parties for them to come to an agreement, a Mississippi court would decide that a breach of the consent-to-settle clause, if there was a breach, was excused because of the exigent circumstances. The district court further found that if the defendant insurer really thought it could escape liability because of the failure of the insured to obtain consent, it would have refused to pay any amount toward the settlement, or would seek contribution from its insured, which the defendant insurer had not done.

Contact

Richard J. Pratt
Partner, Insurance
Washington, D.C.
202.662.2077
richard.pratt@troutman.com

Editor

Brandon D. Almond
Counsel, Insurance
Washington, D.C.
202.274.2864
brandon.almond@troutman.com

Co-Editor

Jenni K. Katzer
Associate, Insurance
Orange County
949.622.2791
jenni.katzer@troutman.com

Insurance and Reinsurance Group Members

Atlanta
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Samuel Hyams*
Jenni K. Katzer*
Kevin F. Kieffer
Samrah Mahmoud
Terrence R. McInnis
Binh Duong Pham*
Robert M. Pozin
Ross Smith
Dustin H. Thai*
Ryan C. Tuley

San Diego
Christina Ding*
Tara L. Goodwin*
Jordan K. Jeffery*
Louise M. McCabe
Carrie E. Paulsen

San Francisco
Michael Cassata*
Michael Huggins*
Jennifer Mathis

Washington, D.C.
Brandon D. Almond*
Anthony J. Biraglia*
Charles T. Blair
Michael T. Carolan
Jonathan A. Constine
Leslie Davis
Darren W. Dwyer*
James Geiser*
Charles A. Jones
Thomas J. Kinney*
Stacey L. McGraw
William C. O'Neill
Richard J. Pratt
Jordan M. Rubinstein
Olaf Wilson*

*Contributors