Wiley Rein LLP

EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | September 2014

ALSO IN THIS ISSUE

Pennsylvania Federal Court Confirms that Settlements Returning Overdraft Fees Are Not "Damages"

The United States District Court for the Western District of Pennsylvania, applying Pennsylvania law, has rejected a motion to reconsider its June 24, 2014 decision that amounts a bank paid to customers in settlement of lawsuits seeking the return of allegedly improper overdraft protection fees constitute covered "Damages" under a bank's professional liability insurance policies. *PNC Financial Services Group, Inc. v. Houston Cas. Co.,* No. 13-cv-331 (W.D. Pa. June 24, 2014). Wiley Rein represents the excess insurer in the litigation.

The bank's customers filed class action litigation alleging that the bank improperly manipulated the order in which it processed customers' transactions in order to cause their accounts to be

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Insurer's Recoupment of Defense Expenses Includes Pre-Judgment Interest

A federal district court, applying Virginia law, has held that an insurer entitled to recoup defense expenses also was entitled to pre-judgment interest on its payments. *Protection Strategies, Inc. v. Starr Indemn. & Liab. Co.*, No. 1:13-CV-00763 (E.D. Va. Aug. 18, 2014). Wiley Rein LLP represents the insurer.

The insurer had advanced defense expenses for a government investigation against the insured company and its officers. After the officers pleaded guilty, the insurer moved for summary judgment based on dishonesty, profit, prior knowledge, and warranty exclusions. The court granted summary judgment and held that the insurer was entitled to recoup its defense payments. The insurer then sought pre-judgment interest on its defense payments accruing from the time it made each payment. While recognizing that the insured had raised *bona fide* arguments about coverage, the court concluded that prejudgment interest was necessary to make the insurer whole because the insureds' misrepresentations in the insurance application caused the insurer to advance defense costs to which the insureds were never entitled. ■

Insurer Is Not Estopped from Raising New Coverage Defenses When it Reserves its Right to Rely on Other Policy Terms

Applying Nebraska law, the Nebraska Supreme Court has held that an insurer is not estopped from raising new coverage defenses where it repeatedly reserves its right to rely on other policy terms, conditions, and exclusions, and does not assume the defense of the underlying lawsuit. *Breci v. St. Paul Mercury Ins. Co.*, 2014 WL 3686856 (Neb. July 25, 2014).

In June 2007, a federally chartered credit union that had been placed under conservatorship filed suit against its former directors, alleging that the directors had breached their fiduciary duties and caused the credit union to suffer loss. The former directors promptly sought coverage from the credit union's management liability insurer. In January 2008, the insurer sent a general reservation of rights letter that discussed certain definitions in the policy; stated that the insurer was continuing to investigate and evaluate coverage; and specifically reserved the insurer's right to rely upon other policy terms, conditions, and exclusions to disclaim coverage. In February 2009, the insurer sent the former directors a letter disclaiming defense and indemnity coverage for the underlying lawsuit based on the policy's insured versus insured exclusion.

In April 2009, the former directors filed a declaratory judgment action against the insurer, in which the credit union later intervened. On April 20, 2010, the trial court entered an order denying the insurer's motion for summary judgment and granting the directors' "motion for declaratory judgment" based on the court's conclusion the insured versus insured exclusion did not apply because the credit union was not an "insured" under the D&O coverage part of the policy. The insurer timely filed a motion to alter or amend the judgment.

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No Coverage For Bankruptcy Court Sanctions Motion Because of Untimely Notice and Motion Did Not Seek Award of "Damages"

Applying Indiana law, the United States District Court for the Northern District of Indiana has held that no coverage was available for a claim because the insured failed to give timely notice to the insurer and defended the claim before notifying the insurer. *Bowman, Heintz, Boscia & Vician, P.C. v. Valiant Ins. Co.*, 2014 WL 3818235 (N.D. Ind. Aug. 1, 2014). In addition, the court held that no coverage was available for the claim, which sought sanctions for violating a bankruptcy stay, because it did not seek amounts constituting "damages" under a lawyers malpractice policy.

A named partner of the insured law firm became embroiled in litigation with a golf community in Florida. After the golf community filed for bankruptcy, the named partner brought a class action lawsuit against the purported individual owner of the golf community for diversion of escrow funds, and the golf community's bankruptcy counsel sent a letter demanding dismissal of the case because it violated the bankruptcy stay. When the partner refused to dismiss the case, the golf community filed a motion with the bankruptcy court to enforce the automatic stay and seeking sanctions. Although it had not been served with the motion, the law firm hired counsel to oppose the motion and to appear at the hearing concerning the applicability of the stay to the litigation. The court granted the stay motion and set a hearing date on the request for sanctions. Ten days before the sanctions hearing and seven months after the letter from the golf community's counsel, the law firm tendered the sanctions motion to its legal malpractice insurer. The insurer denied coverage for the motion because it sought the award of

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Policies Afford No Coverage for Litigation Arising Out of Unreported Demand Letter

A California federal court has held that two consecutive claims-made-and-reported professional liability policies afford no coverage for litigation when the insured failed to provide notice of a prior related Claim. *Alterra Excess & Surplus Ins. Co. v. Gotama Building Engineers, Inc.*, 2014 WL 3866093 (C.D. Cal. July 24, 2014). The court also concluded that a warranty exclusion barred coverage for the litigation.

An insurer issued two professional liability policies to an engineering firm for the claims-made policy periods of June 1, 2012 to June 1, 2013 (the "2012 Policy") and June 1, 2013 to June 1, 2014 (the "2013 Policy"). In April 2013, the insured received a demand letter from an architecture firm concerning the insured's plumbing and mechanical design for a building. The demand letter stated that the insured was responsible for the cost of correcting certain design deficiencies and demanded that the engineering firm acknowledge responsibility and place its insurance carriers on notice of the claims. The insured did not report this demand letter. In addition, in May 2013, the engineering firm provided the insurer with a renewal application in which the insured responded "no" to a question asking whether an insured had "any knowledge or information of any act, error or omission which might reasonably be expected to give rise to a claim." The application provided that "if such knowledge or information exists any claim or action arising there from is excluded from this proposed coverage." In June 2013, the building filed a lawsuit against the architecture firm, and, in August 2013, the architecture firm filed a cross-claim against the insured based

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New Jersey Appellate Court Concludes Third Parties Have Standing to Bring Action Against E&O Insurer

In an unpublished opinion, a New Jersey appellate court has held that third-party claimants have standing to bring an action against an insolvent insured's E&O carriers, even in the absence of policy language providing that right. *Ferguson v. Travelers Indem. Co.*, 2014 WL 3798524 (N.J. App. Div. Aug. 4, 2014).

The carriers issued primary and excess E&O policies to an underwriting management company. An insurance company retained the insured to assist with the evaluation and implementation of a reinsurance program. The insured allegedly failed to recognize or disclose substantial flaws in the program and, as a result, the reinsurance program exposed the insurance company to significant risk. The insurance company ultimately was sold at a substantial loss. As part of the sale, the insurance company assigned its rights against third parties to the shareholders of the insurance company's parent entity. Following the assignment, the shareholders filed an action against the insured underwriting management company seeking damages as a result of the insured's evaluation and implementation of the reinsurance program. The action was uncontested, and the shareholders obtained a $92 million judgment against the insured.

The insured was insolvent and unable to satisfy the judgment and the shareholders sued the insured's E&O carriers in attempt to satisfy the judgment from policy proceeds. The carriers moved to dismiss, contending that the shareholders lacked standing to bring the action under New Jersey law. The trial court held in favor of the carriers, and the shareholders appealed.

The New Jersey appellate court reversed, concluding that the shareholders had standing. The court noted that, "[i]t appears well settled

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No Coverage Where Attorney Failed to Disclose Tolling Agreement With Client on Application for Insurance

The United States District Court for the Central District of California, applying California law, has held that, where an attorney enters into an agreement with his client to toll the applicable statute of limitations for a potential malpractice claim, the attorney's denial, in an insurance policy application, of awareness of circumstances that could result in a claim constitutes a material misrepresentation warranting denial of coverage. *Blum Collins LLP v. NCG Prof'l Risks, Ltd.*, No. CV 12-8996 FMO (CWx) (C.D. Cal. July 31, 2014).

While at a prior law firm, the insured attorney represented a client in a property dispute. In September 2007, the client and attorney dissolved their relationship through an agreement providing that "[the attorney] agree[d] to furnish [the underlying claimant] with time to evaluate her assertions [of malpractice] and her potential damages without filing an action during the time period her appeal rights are in place[,]" and suspending the applicable statute of limitations. The trial court in the property dispute entered judgment against the client in October 2007, and the judgment was affirmed on appeal in January 2009. In February 2009, a representative of the client emailed the attorney asserting that the attorney's malpractice caused the adverse judgment against the client.

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Award for Claim Based on Improper Attorney Billing Is Not "Loss," Does Not Involve "Professional Legal Services," and Is Barred by a Personal Profit/Advantage Exclusion

A Texas federal district court has granted summary judgment in favor of an insurer and held that there was no coverage for claims made against an insured law firm arising out of the firm's alleged improper deductions from its client's settlement distributions. *O'Quinn P.C. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 2014 WL 3543709 (S.D. Tex. July 17, 2014). The court held that: (1) an arbitration award did not constitute covered "Loss" under the policy since the relief sought was essentially restitutionary in nature; (2) coverage was not triggered because the suits alleged wrongdoing in connection with improper billing practices, and not "professional legal services"; and (3) the policy's personal profit/ advantage exclusion barred coverage.

During the early 1990s, a law firm began representing women in lawsuits against breast implant manufacturers. Due to the large number of similar suits, the breast implant cases were consolidated for pretrial proceedings. In mid-1993, the firm began deducting 1.5% out of the gross recovery of each client's award for their *pro rata* share of expenses common to all cases, which it referred to as "BI General Expenses." This deduction was not set forth in the terms of the firm's contingency fee contracts. In addition, the "BI General Expense" account reported a surplus, but money was never returned to any of the firm's clients until 2007.

In 1999, a group of former clients sued the firm and alleged that the deduction of the "BI General Expenses" was improper. Another similar suit was filed in 2001, but that case was later non-suited, and the plaintiffs joined the 1999 suit as class members. An arbitration panel issued a final award against the law firm and ordered it to repay the amounts deducted for "BI General Expenses" and to forfeit some of the fees it collected as a remedy for its breach of fiduciary duty. The award was confirmed by a state trial court, after which the law firm settled with the claimants. The law firm then sought coverage under two legal malpractice policies issued by a

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"Knowing and Willful" Violation of Unfair Business Practices Statute Triggers Dishonesty Exclusion

A federal district court, applying Massachusetts law, has held that damages awarded under Massachusetts Code Chapter 93A based on a finding of knowing and willful conduct constituted "malicious" acts triggering the liability policy's dishonesty exclusion. The court also concluded that the statutory attorneys' fees awarded under Chapter 93A are penal in nature and thus are not covered under a liability policy that excludes coverage for penalties.

The insurer issued a professional liability policy to an attorney. The policy's definition of "Damages" excluded coverage for criminal or civil fines, penalties (statutory or otherwise), fees or sanctions; punitive, exemplary or multiplied damages; and legal fees and costs paid to the insured. The policy excluded from coverage any claim based on an act or omission that was intentional, criminal, fraudulent, malicious or dishonest.

A former client sued the insured attorney after the attorney represented the client in the purchase of land that the attorney knew, but did not disclose, was a protected Indian burial site. The jury awarded the client $20,000 for the attorney's professional negligence and $397,000

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Montana Supreme Court Holds That Where Policy Is "Potentially Implicated," There Is No Need to Examine Terms of Policy and Underlying Complaint

Applying Montana law, the Montana Supreme Court has held that an insurer breached its duty to defend where the insurer was on notice that a policy was "potentially implicated" and "unjustifiably" refused to provide a defense. *Tidyman's Mgmt. Svcs. Inc. v. Davis,* 2014 WL 3778481 (Mont. Aug. 1, 2014). In so doing, the court declined to analyze coverage by examining the applicable D&O policy and the allegations in the underlying complaint. Also, the court reversed the trial court's entry of summary judgment concerning the reasonableness of the underlying $29 million stipulated settlement, holding that an evidentiary hearing was necessary on the reasonableness of the amount of the settlement but rejecting the insurer's argument that the hearing should address potential collusion among the parties to the settlement.

Employee shareholders brought an action in federal court against certain directors and officers of the insured company alleging Employee Retirement Income Security Act violations and breach of corporate fiduciary duties arising from a merger. The shareholders alleged that the directors and officers misrepresented the merit of the merger after receiving advice prior to the transaction that the company should be sold. After multiple settlements, and with only claims for breach of corporate duty against two directors remaining, the federal court dismissed the action. The shareholders then filed a state court action against the two remaining directors, adding the company, a Washington corporation created by the merger, as a plaintiff. Soon thereafter, the insurer, which had provided a defense in the federal court action under a D&O policy, sent a declination letter to the directors' counsel, stating that based on the policy's "Insured v. Insured" exclusion, "it appears that the [state court] Complaint . . . does not implicate the Policy."

The plaintiffs amended their complaint, adding the insurer as a defendant and seeking a declaratory judgment that the D&O policy provided coverage for the directors. After three attempts by counsel for the directors to clarify whether the insurer would continue to pay their defense costs, the insurer sent a second letter affirming its coverage denial and stating that "there is no longer any

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coverage for this matter" and that it was "not going to continue to pay the costs of defense." Before the insurer sent the second denial letter, it filed a motion to dismiss the amended complaint for lack of coverage. Subsequently, one of the insured directors filed a "stipulation resulting from the insurer's refusal to provide coverage" with the court. The stipulation, an identical version of which the other insured director filed a month later, provided for a settlement releasing the directors from personal liability for the damages sought in exchange for assigning all of their rights against the insurer to the plaintiffs. Three weeks after the first defendant filed his stipulation, the insurer sent a third letter to the insureds' counsel advising of "changes to [its] coverage position" and providing that it would advance defense costs subject to a reservation of rights. Ten days later and on the same day that the second director filed his stipulation, the plaintiffs moved for summary judgment, alleging that the insurer was liable for the stipulated settlement for breaching its duty to defend. The district court ultimately granted that motion and motions to approve the stipulations for entry of the $29 million judgment and declined to hold a hearing on the reasonableness of the stipulated settlement. In so doing, the court also rejected the insurer's collusion argument related to the settlement as speculative and, relying on an opinion and affidavit prepared as part of the previous federal court litigation, noted that the settlement amount was based on the estimated value of the company at the time of the merger.

On appeal, the court first considered the insurer's argument that Washington law should govern the contact dispute because Montana was only an anticipated place of performance of the contract. Applying the "most significant relationship" test set forth in *Mitchell v. State Farm Insurance Co.*, 68 P.3d 703 (Mont. 2003), instead of a "materially greater interest" test, which the court concluded would apply when an insurance contract contained a choice-of-law provision, the court affirmed the trial court's application of Montana law. The court reached that conclusion "because the contract did not contain a choice-of-law provision, Montana was an anticipated place of performance, and this action involved Montana workers who brought suit in Montana and a stipulated settlement in Montana."

Next, the court considered whether the trial court had erred in finding that the insurer had breached its duty to defend without analyzing coverage under the policy. The insurer disputed that the state and federal court actions were the "same" and argued that, in any event, the trial court was required to analyze coverage under the policy and based on the allegations in the complaint before finding a breach of a duty to defend. According to the Montana high court, however, "all that matters" for determining whether the duty to defend is triggered "is whether [the insurer] was on notice that the Policy was implicated." Because the insurer defended the insureds in the federal action, the court concluded that the insurer knew the policy was "potentially implicated." The court found that the fact that the insurer eventually reversed its coverage position "cemented" its recognition that the policy was implicated. Then, relying on the insurer's letter, which stated that coverage was "no longer" available and noting the insurer's failure promptly to respond to the insureds' communication attempts or to pay attorneys' fees, the court found that the insurer had declined to provide a defense. Finding both that the insurer was on notice that the policy was "potentially implicated" and failed to provide a defense, the court affirmed that the insurer breached its duty to defend. In reaching that conclusion, the court emphasized that the insurer should have continued providing a defense while reserving rights under the policy.

The court rejected the insurer's arguments that fact issues precluded finding a breach because the insurer effectively sought a coverage determination by filing the motion to dismiss and because the insureds were represented at all times. Instead, the court found a breach of the duty to defend because the insurer failed to advance defense costs while the motion was pending and failed to defend under a reservation of rights while awaiting a coverage determination. In declining to analyze coverage under the policy based on allegations in the complaint, the court explained that a Montana court must only analyze coverage before determining whether an insurer has breached its duty to defend when there "has been an 'unequivocal' demonstration that a claim is not within the policy coverage."

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Montana Supreme Court Holds That Where Policy Is "Potentially Implicated," There Is No Need to Examine Terms of Policy and Underlying Complaint *from page 6*

The court then considered the insurer's arguments that the trial court had erred in denying a hearing and discovery on reasonableness and collusion related to the stipulated settlement. Although the court rejected the insurer's argument that Montana law compelled the trial court to take the procedural step of conducting a reasonableness hearing, it agreed that the trial court's failure to consider certain facts presented by the insurer with respect to the reasonableness of the settlement was error. Specifically, the court pointed to the trial court's failure to consider issues with the valuation report, the lack of an identified buyer for the company at the time of the merger, the minimal discovery provided on the issue in relation to the substantial judgment, that the settlement was "magnitudes greater" than the settlements entered with other directors, and a separate valuation of the company for less than half the final judgment amount. Concluding that "further consideration is necessary to determine whether the $29 million stipulated settlement is reasonable," the court remanded the action to the trial court for a hearing on the reasonableness of the stipulated settlement.

Nevertheless, the court also found that the insurer had failed to demonstrate specific facts to necessitate a hearing on collusion. The court characterized the insurer's collusion argument as amounting only to the allegation that the directors and officers lacked any "incentive to minimize the settlement amount" and, as a result, that "the settlement was per se unreasonable because it was improperly collusive." In support of collusion, the insurer argued that the insureds stood to personally benefit from the large settlement, that the stipulated settlement amount was over seven times what the plaintiffs had previously offered to accept, and the timing of the stipulation—immediately following the coverage denial—was more than suspicious. The court, however, concluded that those facts did "not rise to the level of collusion" because the term required a "sort of agreement aimed at defrauding another or otherwise breaking the law" that the insurer had not shown. Because the court found that the settlement amount was based on a valuation conducted before the proceeding and that the insurer offered no evidence of the insureds' participation in determining that amount, it concluded that no material facts required further inquiry by the trial court on the collusion issue. The court also essentially dismissed the insurer's timing argument because it could not fault the insureds for acting quickly to protect their individual interests.

In a strongly-worded dissent, Justice McKinnon primarily took issue with the court's willingness to find a breach of the insurer's duty to defend without considering whether the complaint alleged facts which, if proven, would result in coverage under the applicable policy. The dissent asserted that the majority "effects a significant shift in our jurisprudence" by creating a "broad and nebulous" "potentially implicated" standard that "effectively moots any future need for analysis of the policy and the complaint." ■

New Jersey Appellate Court Concludes Third Parties Have Standing to Bring Action Against E&O Insurer *continued from page 4*

in New Jersey . . . that an injured plaintiff, having obtained a judgment against an insured tortfeasor which remains unsatisfied due to insolvency, 'stands in the shoes' of the insured with respect to the insurance policy and thus acquires standing to pursue an action against the insurer." In so finding, the court rejected the carriers' argument that N.J.S.A. 17:28-2, New Jersey's "direct action" statute, authorizes a third-party action against an insurer only in particular personal injury and property damage lawsuits. According to the court, "[s]imply because the statute mandates that those specifically identified types of policies contain a contractual provision establishing the right to a post-judgment action, it does not follow that no such right therefore exists in other, non-listed insurance policies." Accordingly, the court concluded that the shareholders had standing to bring the action against the E&O carriers. ■

No Coverage Where Attorney Failed to Disclose Tolling Agreement With Client on Application for Insurance *continued from page 4*

Meanwhile, in July 2008, after moving law firms, the attorney applied for professional liability coverage. On the application, the attorney answered "no" to the following question: "After enquiry, are any persons listed in Supplement 1 aware of any circumstances, allegations, tolling agreements or contentions as to any incident which may result in a claim being made against the Applicant or any of its past or present Owners [or] Partners . . . ?" Supplement 1 was not attached to the application.

The insurer subsequently issued a professional liability policy to the attorney's firm. In pertinent part, the policy excluded coverage for: (1) "any Claim arising out of any Assured's activities as a . . . partner, officer, director or employee of any . . . corporation, company or business other than that of the Named Assured"; (2) "any Claim made by or against or in connection with any business enterprise . . . which is owned by any Assured of which is directly or indirectly controlled, operated or managed by any Assured in a non-fiduciary capacity"; (3) "any Claim arising out of any acts, errors or omissions which took place prior to the effective date of this insurance, if any Assured on the effective date knew or could have reasonably foreseen that such acts, errors or omissions might be expected to be the basis of a Claim[.]"

The insured tendered the matter for coverage in March 2009. The insurer denied coverage for the claim citing, *inter alia*, "material misrepresentations and omissions in the [insureds'] policy application."

In the coverage litigation that followed, the court held that the attorney made a material misrepresentation in the insurance application, warranting a denial of coverage for the client's claim. In holding that the application misrepresentation was material, the court maintained that, when the signer of a policy application falsely represents that he or she did not know of any act by relevant parties that could give rise to a claim, such a false statement is deemed material as a matter of law.

The attorney disputed that there were misrepresentations on the application because, at the time of the application, he allegedly did not believe that any circumstances existed "which may result in a claim." The court concluded otherwise, holding that the phrase "assertions [of malpractice] and . . . potential damages" in the attorney-client tolling agreement "clearly" constituted notice to the attorney of a potential claim. The court also rejected insured's arguments that the insurer's failure to attach a listing of the firm's attorneys as "Supplement 1" to the application prevented the attorney from answering the question accurately and that the named insured law firm had no duty to disclose circumstances related to the tolling agreement because the attorney entered into the agreement while at his prior firm. In support, the court noted that the policy application asked for information pertaining to a claim that might arise against the applicant firm *or* "any of its past or present Owners [or] Partners."

The court also rejected the insured's argument that the insurer had waived its right to assert its coverage defenses. The court concluded that, where an insured files a breach of contract action before a carrier asserts an affirmative claim based on misrepresentations in an insurance application, the insurer can avoid coverage through cross-claims and affirmative defenses asserted in the insureds' suit, and it does not waive its rights simply by failing to file its own suit.

Finally, the court held that the policy's prior-knowledge exclusion and exclusions for "any Claim arising out of any Assured's activities as a . . . partner, officer, director or employee of any . . . corporation, company or business other than that of the Named Assured" and "any Claim made by or against or in connection with any business enterprise . . . which is owned by any Assured of which is directly or indirectly controlled, operated or managed by any Assured in a non-fiduciary capacity" independently precluded coverage. ■

Insurer Is Not Estopped from Raising New Coverage Defenses When It Reserves Its Right to Rely on Other Policy Terms *continued from page 2*

Separately, the credit union and the directors reached a settlement of the underlying action. On April 26, 2010, the directors filed a confession of judgment and assigned their rights against the insurer to the credit union. On May 5, 2010—while the insurer's motion to alter or amend the judgment was still pending—the insurer moved for leave to file an amended answer based on its position that the settlement raised new issues and new coverage defenses that were not previously known to the insurer. The trial court granted the motion for leave to amend and partially granted the motion to alter or amend the judgment, concluding that it had erred by granting judgment to the directors (but not by ruling that the insured versus insured exclusion did not apply).

In April 2012, the insurer filed a second motion for summary judgment that raised a number of coverage defenses, including that the underlying action constituted a claim that was first made prior to the policy period and that coverage was barred pursuant to the policy's regulatory exclusion. In September 2012, the trial court granted the insurer's second motion for summary judgment, holding that (1) the insurer was not estopped from raising additional coverage defenses in its amended answer; (2) the claim arose prior to the policy period; and (3) even if the claim had fallen within the policy period, the regulatory exclusion would bar coverage.

On appeal, the Nebraska Supreme Court rejected the credit union's argument that the insurer should have been estopped from raising new coverage defenses in its answer. The appellate court held that the doctrines of estoppel and "mending one's hold" did not apply because the insurer specifically reserved its rights to rely on other terms, conditions, and exclusions in the policy, both in its original answer and its initial reservation of rights letter—precluding a finding of detrimental reliance by the directors. Although the court recognized that the doctrine of estoppel can be used to "expand the scope of insurance coverage" where an insurer defends a claim without a reservation of rights agreement and the insured suffers some prejudice or harm, the court held that this "exception to the general estoppel rule" did not apply because the insurer never indicated to the directors that there was coverage for the credit union's lawsuit, nor did the insurer assume or control the directors' defense. The appellate court also held it was not an abuse of discretion to grant the insurer's motion to amend given that the settlement of the underlying action constituted a "newly discovered" development warranting leave to amend. ■

Policies Afford No Coverage for Litigation Arising Out of Unreported Demand Letter *continued from page 3*

on the claims in its demand letter. The insured provided notice of the cross-claim to the insurer in January 2014. The insurer maintained that late notice precluded coverage under the 2012 policy and the litigation was not first made during and was otherwise excluded under the 2013 policy by operation of the warranty exclusion.

As to the 2012 policy, the court agreed that the demand letter was a Claim because it was a "written demand for monetary damages, services or non-monetary relief" and that the insured therefore failed to provide timely notice of the Claim. As for the 2013 policy, the court concluded the insured should have disclosed the demand letter. Because the cross-claim was "the court-filed equivalent" of the demand letter, it arose from the demand letter and therefore was excluded by the warranty exclusion. In so holding, the court found that "arising from" meant that the exclusion applied to "all proceedings sharing common facts and circumstances.'' ■

No Coverage For Bankruptcy Court Sanctions Motion Because of Untimely Notice and Motion Did Not Seek Award of "Damages" *continued from page 2*

sanctions, which did not constitute "damages," as defined under the policy. The insurer later contended that the law firm provided untimely notice of the motion. The insured filed suit seeking coverage for the defense of the stay motion and indemnity for the amounts awarded for violation of the stay.

The court held that no coverage was available under the policy for the bankruptcy motion because the law firm failed to provide timely notice to the insurer. The policy required the insured to give notice "of the Insured's receipt of any notice, advice, or threat, whether written or verbal, that any person or organization intends to hold the Insured responsible for any alleged breach of duty." The court held that, at the earliest (seven months before notice), the law firm was aware of a "notice, advice, or threat" when it received the letter from the golf community's bankruptcy counsel and, at the latest (three months before notice), when the bankruptcy court granted the stay motion and set a hearing to determine whether sanctions would be awarded. So, notice was not timely provided.

Because the insurer proved that notice was not timely made, the burden shifted to the insured under Indiana law to prove that the insurer had not been prejudiced by the delayed notice. The court held that the law firm failed to offer evidence that the insurer was not prejudiced by the delayed notice. First, the court rejected the insured's argument that timely notice of previous litigation involving the golf community obviated the need for timely notice of the stay motion. The court held that the previous litigation was not related to the stay motion. Second, the court rejected the argument that the law firm was not required to provide notice because it did not know how the court would rule on the request to enforce the stay. It reasoned that the notice provisions are triggered by any threat that the insured be held liable—not simply threats of liability that the insured believes are credible. Finally, the court held that the law firm's defense of the bankruptcy motion nullified its notice under Indiana law because undertaking the defense denied the insurer of its right to investigate and defend the claim.

In addition, the court held that no coverage was available under the policy for the motion because the only relief sought—monetary sanctions for violating the bankruptcy stay—did not constitute "damages" under the policy. As defined in the policy, covered "damages" expressly did not include "sanctions." The court held that the insurer's duty to defend was never triggered because the bankruptcy motion sought to recover only amounts constituting sanctions for the law firm's willful violation of the bankruptcy stay. ■

Award for Claim Based on Improper Attorney Billing Is Not "Loss," Does Not Involve "Professional Legal Services," and Is Barred by a Personal Profit/Advantage Exclusion *continued from page 4*

single insurer: one that was in effect at the time of the 1999 suit, and another that was in place at the time of the 2001 suit.

The court granted summary judgment in the insurer's favor. First, the court ruled that the two lawsuits constituted a single "Claim" deemed first made in the earlier policy period pursuant to the "Interrelated Wrongful Acts" provision in the policies, reasoning that they involved the same factual allegations and arose from a common nexus of fact. It then held that coverage was unavailable for any of three reasons: First, the underlying award was not "Loss" under the policy since the underlying claims were essentially restitutionary in nature. The court rejected the law firm's argument that neither the plaintiffs, the arbitration award, nor the settlement used the term "restitution," opining that the gravamen of the claims was for reimbursement of amounts the firm had improperly deducted from its client's settlements. Second, the claims did not arise out of "professional legal services" but instead out of improper billing practices, which did not require specialized knowledge and skill inherent to lawyers. Finally, the claim arose out of the firm's "gaining profit or advantage to which it was not legally entitled" and was therefore barred under a policy exclusion. ■

"Knowing and Willful" Violation of Unfair Business Practices Statute Triggers Dishonesty Exclusion *continued from page 5*

in damages for the attorney's deceptive acts and practices under Chapter 93A, which amount was doubled to $794,000 based on a finding of willfulness on the part of the attorney. The court also awarded the client attorneys' fees.

The insurer argued that none of the client's recovery was covered under the policy, and coverage litigation ensued. The court in the coverage litigation held that, because the jury expressly found that the insured's conduct was willful and knowing, the insured's conduct was "malicious," thus triggering the policy's dishonesty exclusion. Accordingly, the actual damages awarded under Chapter 93A were not covered under the policy. The court also held that the policy excluded coverage for the multiplied damages under the punitive damages exception to the definition of "Damages." With respect to the statutory attorneys' fees, the court concluded that the fee award is a statutory penalty intended to deter misconduct and to punish wrongdoers and, therefore, the exception to the definition of "Damages" for penalties barred coverage for the attorneys' fees. Finally, the court held that the exception to the "Damages" definition for any return of fees paid to the insured barred coverage for the damages based on the attorney's professional negligence because that amount represented a return of the fees that the client had paid to the attorney. ■

Pennsylvania Federal Court Confirms that Settlements Returning Overdraft Fees Are Not "Damages" *continued from page 1*

overdrawn multiple times, thus maximizing the number of fees it could charge for "overdraft protection services." The bank settled the customer lawsuits, agreeing to pay over $90 million to customers who had been charged multiple overdraft fees. The bank sought coverage for the settlements under its professional liability policies. The policies afforded specified coverage for "Damages," defined to include "a judgment, award, surcharge or settlement as a result of a Claim" but not to include "fees, commissions or charges for Professional Services paid or payable to an Insured." The bank filed a declaratory judgment action seeking coverage for the settlements under the policies.

In its June 24, 2014 order, the District Court concluded that the portions of the overdraft litigation settlements paid to class members fall within the fee exception and are not covered. The bank sought reconsideration of the order, arguing that the fee exception was intended only to carve out fees that were paid to a plaintiff class member who happened to be an insured director, officer or employee of the bank. The court concluded that the policy language was not reasonably susceptible to this interpretation, noting that the policy defined "Insured" to include individuals acting in their insured capacity, but that the bank's new interpretation of the fee exception would involve individuals acting instead as customers of the bank.

The court further rejected the bank's argument that its order rendered the policies illusory. The court reasoned that the policies are illusory only if they would not pay benefits under any reasonably expected set of circumstances. Because the bank could face claims that did not seek the recovery of fees, the court concluded that that the policies were not illusory. The court also determined that its interpretation of the policies was appropriate as a question of law, dismissing the bank's contention that the court improperly decided a jury question by determining that bank's overdraft settlements implicated the fee exception.

Finally, the court refused to credit the bank's contention that, because the District Court judge reached a different interpretation of the policies' fee exception than the magistrate judge, the policy language was ambiguous. The court emphasized that its interpretation of the fee exception is "the only reasonable interpretation," and the provision therefore is not ambiguous. ■

Professional Liability Attorneys

Kimberly A. Ashmore	202.719.7326	kashmore@wileyrein.com
Matthew W. Beato	202.719.7518	mbeato@wileyrein.com
Mary E. Borja	202.719.4252	mborja@wileyrein.com
Edward R. Brown	202.719.7580	erbrown@wileyrein.com
Jason P. Cronic	202.719.7175	jcronic@wileyrein.com
Cara Tseng Duffield	202.719.7407	cduffield@wileyrein.com
Benjamin C. Eggert	202.719.7336	beggert@wileyrein.com
Ashley E. Eiler	202.719.7565	aeiler@wileyrein.com
Milad Emam	202.719.7509	memam@wileyrein.com
Michael J. Gridley	202.719.7189	mgridley@wileyrein.com
Dale E. Hausman	202.719.7005	dhausman@wileyrein.com
John E. Howell	202.719.7047	jhowell@wileyrein.com
Leland H. Jones, IV	202.719.7178	lhjones@wileyrein.com
Parker J. Lavin	202.719.7367	plavin@wileyrein.com
Charles C. Lemley	202.719.7354	clemley@wileyrein.com
Mary Catherine Martin	202.719.7161	mmartin@wileyrein.com
Kimberly M. Melvin	202.719.7403	kmelvin@wileyrein.com
Jason O'Brien	202.719.7464	jobrien@wileyrein.com
Leslie A. Platt	202.719.3174	lplatt@wileyrein.com
Marc E. Rindner	202.719.7486	mrindner@wileyrein.com
Kenneth E. Ryan	202.719.7028	kryan@wileyrein.com
Gary P. Seligman	202.719.3587	gseligman@wileyrein.com
Richard A. Simpson	202.719.7314	rsimpson@wileyrein.com
William E. Smith	202.719.7350	wsmith@wileyrein.com
Daniel J. Standish	202.719.7130	dstandish@wileyrein.com
Sandra Tvarian Stevens	202.719.3229	sstevens@wileyrein.com
Karen L. Toto	202.719.7152	ktoto@wileyrein.com
David H. Topol	202.719.7214	dtopol@wileyrein.com
Jennifer A. Williams	202.719.7566	jawilliams@wileyrein.com

Wiley Rein LLP Offices:
1776 K Street NW
Washington, DC 20006
202.719.7000

7925 Jones Branch Drive
McLean, VA 22102
703.905.2800