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Insurance Coverage Litigation Committee

HABITABILITY TORTS AND HOUSING DISCRIMINATION CLAIMS: PRIMARY AND UMBRELLA INSURANCE DISPUTES

By: Timothy M. Thornton[1]

Landlord tenant law and housing discrimination featured in a number of prominent news stories in 2015. The Supreme Court upheld application of "disparate impact" theory to the Fair Housing Act.[2] [3]

A. The Wrongful Entry, Eviction, Invasion Offense

The personal injury coverage of the commercial general liability (CGL) policy covers injury arising out of "the wrongful eviction from, wrongful entry into, or invasion of the right of private occupancy of a room, dwelling or premises that a person occupies, committed by or on behalf of its owner, landlord or lessor".

B. Interference with Possessory Interest In Property Only, or Also Enjoyment and Use of Property

Wrongful entry and wrongful eviction are traditional landlord tenant claims. But "invasion of the right of private occupancy" is not a legal term of art. How far beyond wrongful entry and wrongful eviction does it extend? Does it concern only interference with a

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2 Texas Dep't of Hous. & Cmty. Affairs v. Inclusive Communities Project, Inc., 135 S. Ct. 2507, 192 L. Ed. 2d 514 (2015).

3 Fair Housing Act (FHA), Civil Rights Act of 1968, § 801 et seq., 42 U.S.C.A. § 3601 et seq.

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LETTER FROM THE CHAIR

Dear TIPS Insurance Coverage Litigation Committee Members:

Welcome to the Spring 2016 TIPS ICLC Newsletter. Thanks to Jennifer Sacro and Teresa Milano, we have another great publication with content from our very successful 24th Annual Program in Phoenix.

The Spring 2016 edition includes four cutting-edge articles on insurance issues. We start with disputes arising from discrimination in housing, followed by an ever-evolving hot topic that for claims-made practitioners – the interrelated wrongful acts dilemma. We also address developments in errors and omissions/professional liability coverage and claims, and an insurance producer's role in coverage disputes. The article titles and authors are: (1) *Habitability Torts and Housing Discrimination Claims: Primary and Umbrella Insurance Disputes* by Timothy M. Thornton, (2) *The Impact of "Interrelated Wrongful Acts" On Insurance Coverage Under Claims Made Policies* by Joan M. Cotkin, (3) *You're a Professional – So Act Like One: Latest Developments in E&O Coverage and Claims* by Darin McMullen, and (4) *Double Agents, Order-Takers, and Special Advisors – The Producer's Intriguing Role in Coverage Disputes* by Damian Arguello. We send a special thanks to the authors for their contributions to this publication.

Don't forget, the ABA Annual Meeting will take place from August 4 to 7, 2016, in San Francisco. Make your plans now! Chair-Elect Chris Mosley and I hope to see you there and look forward to working with you going forward. To get involved and take advantage to of all of the great opportunities the ICLC offers, please connect with us on LinkedIn and check our website. And if you have any questions, please do not hesitate to contact us: Gary L. Gassman (ggassman@cozen.com) and Christopher Mosley (cmosley@shermanhoward.com). ⚖⚖

Best –

Gary L. Gassman
Chair, 2015-2016
TIPS Insurance Coverage Litigation Committee

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THE IMPACT OF "INTERRELATED WRONGFUL ACTS" ON INSURANCE COVERAGE UNDER CLAIMS MADE POLICIES

By: Joan M. Cotkin[1]

Introduction.

When a given event or a related set of events gives rise to multiple claims that are potentially covered by claims made liability insurance policies such as directors' and officers' ("D&O") policies, special problems arise in applying the policy deductibles, limits and trigger. The problems and solutions differ from what would be found in an "occurrence" liability insurance policy that covers "all sums" which the insured becomes obligated to pay. Some of the questions that arise are as follows:

(1) How many deductibles apply?

(2) How do the policy's "per claim" and aggregate limits apply?

(3) Where the claims arising out of an event or related events fall over multiple policy years, do all the of the claims trigger coverage? How many policies are triggered by the claims?

Policy Provisions.

Claims made policies often contain provisions to the effect that "more than one **Claim** involving the same **Wrongful Act** or **Interrelated Wrongful Acts** shall be deemed to constitute a single **Claim** and shall be deemed to have been made at the time the earliest **Claim** is made."

This provision attempts to address the difficulties that arise when a single event or "occurrence" or related set of events causes multiple claims and particularly where the multiple claims are scattered across multiple policies. First, the provision will typically mean that the deductible in the policy – which is usually written on a per claim basis – will apply only once regardless of the number of claims to the extent claims are subject to this provision.

Second, if an event happens and the first claim is made and reported during a particular policy, this provision will prevent subsequent claims from falling outside the scope of the first policy's coverage merely because they are reported much later.

Third, if the provision is coupled with a provision allowing an insured to report circumstances reasonably likely to give rise to a claim such that all claims related to that circumstance reported during the policy term are deemed to be reported at the same time the circumstance was reported and are deemed to be covered as part of that first policy regardless of how much later they are reported.

Fourth, the language provides policyholders with assurance that if they change to a different insurer and the new insurer has an exclusion for prior acts that claims arising out of prior acts will be covered under the first policy rather than not being covered at all. Typically, subsequent policies (even those written by the same insurer) may also use language defining interrelated wrongful acts to assign claims trailing in a second policy year to a prior policy year.

Difficult issues can arise occur when there is inadequate reporting of circumstances under a prior policy and enforcement of a prior acts exclusion under a subsequent policy. Also even where the two policies both provide full prior acts coverage and are issued by the same insurer, difficulties will emerge in defining the number of "claims" in which policies are triggered.

Some Case Law Interpreting "Interrelated Wrongful Acts".

In *Eureka Fed. Sav. & Loan Ass'n v. Am. Cas. Co. of Reading, Pa.*, 873 F.2d 229 (9th Cir. 1989), the critical question was "whether the losses in [the underlying] *Kidwell* [action] arose out of the same act (the loan policy) or [were] otherwise sufficiently interrelated to be considered a single loss. "The insurance policy at issue contained common language providing that "Claims based on or arising out of the same act, interrelated acts, or one or more series of similar acts, or one or more directors or officers shall be considered a single loss. . . ." *Id.* at 234. The underlying *Kidwell* action involved claims against five officers of the D&O policyholder for breach of fiduciary duty, negligence, mismanagement and waste in connection with losses on over 200 loan transactions.

Continued on page 14

1 Ms. Cotkin is a policyholder attorney at *Nossaman LLP* in Los Angeles, California. She has over three decades of legal experience, and serves as Chair of the Insurance Practice subgroup of Nossaman's Litigation practice group.

RECENT DEVELOPMENTS IN PROFESSIONAL LIABILITY INSURANCE COVERAGE

By: Darin J. McMullen[1]

The past year has seen a number of noteworthy decisions in the area of professional liability coverage. These rulings may have significant impact, both in areas of historical coverage dispute such as the duty to defend and notice requirements, and in emerging arenas such as coverage for cyber-related losses under professional liability coverage.

What Constitutes a "Claim"

Early in 2015, the U.S. Court of Appeals for the Eighth Circuit ruled that pre-litigation demands for a refund or reimbursement can constitute a "claim" and therefore must be reported to an insurance company in order for coverage to be triggered. In Philadelphia Consol. Holding Corp. v. LSI-Lowery Sys., Inc., 775 F.3d 1072 (8th Cir. 2015), the defendant LSI sold software to one of its customers. In March 2007 the customer raised complaints about the software's performance demanding a reimbursement of the purchase price in exchange for a resolution of its complaints. Also at that time, the customer threatened litigation, though it did not institute any action until December 2008. Following the December 2008 suit, LSI notified its insurance company of the litigation and requested defense and indemnification under a 2007-08 professional liability policy, as well as a subsequent 2008-09 policy with the same reporting requirement. While the 2007 policy defined a claim as a demand for money, the 2008 policy provided a significantly broader definition to include a demand for money or services. Both policies required notice of claims on a "claims-made and reported" basis.

Philadelphia Insurance Companies ("PIC") denied coverage and argued that LSI failed to promptly report the claim in the 2007-2008 period Litigation ensued, and the District Court and Eighth Circuit agreed with PIC with regard to the 2007-08 policy. Regarding the 2008-2009 policy, PIC argued that the customer's demands and complaints about the software in March 2007 constituted a "claim" that occurred prior to the 2008-2009 policy's date of inception. In response, LSI contended that the customer complaints were not "claims" because the customer never made a specific demand for money from LSI in March of 2007 and therefore, the negotiations at that time did not constitute a "claim."

The District Court and the Eighth Circuit rejected LSI's argument. The Eighth Circuit concluded that the customer's offer to resolve the dispute for a reimbursement of the purchase price was effectively a demand for money and therefore constituted a claim under the 2008-2009 policy. Because this willingness to settle was evinced in 2007 and before the inception of the 2008-2009 policy, the Court held that LSI was not entitled to coverage under that year's policy.

The fact pattern in LSI is hardly unique, as pre-litigation demands for refunds are commonplace in commercial relationships. Policyholders with similar policy reporting requirements and definitions of claim must be cognizant of when such commercial negotiations trigger a duty to report such "demands" to their insurance company.

Cyber-Related Losses Under Professional Liability Policies

A May 2015 ruling by a Utah Federal Court provides one of the first coverage decisions involving a cyber-related loss and whether coverage existed under a technology-based errors and omissions policy. In Travelers Prop. Cas. Co. of Am. v. Fed. Recovery Servs., Inc., 103 F. Supp. 3d 1297 (D. Utah 2015), the District Court ruled that the policyholder, Federal Recovery, was not entitled to a defense by Travelers under a "Cyber First" policy, because the allegations against the policyholder did not trigger the policy's negligence-based definition of a wrongful act.

Federal Recovery was in the business of processing, storing, transmitting and handling electronic data. One of Federal Recovery's clients, Global Fitness, hired Federal to process Global's gym members' membership fee payments. A dispute arose between Global Fitness

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DOUBLE AGENTS, ORDER-TAKERS, AND SPECIAL ADVISORS—THE PRODUCER'S INTRIGUING ROLE IN COVERAGE DISPUTES

By: Damian J. Arguello[1]

Significant Research and Content Contributed by Doug Richmond[2], *Aon Corporation*, Overland Park, KS

Insurance producers[3] play a central role in procuring and servicing the insurance policies in a coverage dispute, and thus are frequently ensnared in the coverage action. This article examines two common issues arising from the complex relationship between producers, policyholders, and insurers in coverage disputes.

Hypothetical

High-Falutin' Dude Ranch in Weed County, Colorado caters to tourists seeking to enjoy recreational cannabis. Devil-Horse runs a horseback riding operation at the ranch, renting space in High-Falutin's stables, providing its own horses to guests, and conducting the rides on ranch property. Devil-Horse agreed to indemnify High-Falutin' against claims arising from Devil-Horse's operations and to carry $5 million of "comprehensive general liability insurance" naming High-Falutin' as an additional insured.

Devil-Horse procured coverage through All-Risk Insurance Agency, whose website marketed All-Risk as "experts in Colorado's recreational marijuana industry." All-Risk had an agency agreement with ACME Casualty, which granted All-Risk $2 million binding authority. ProLiab provided professional liability insurance to All-Risk.

All-Risk issued binders to Devil-Horse for a $1 million primary CGL policy and a $4 million umbrella, both underwritten by ACME. The binders did not mention additional insured coverage or any exclusions. All-Risk then issued a certificate of insurance to High-Falutin' purporting to conform to High-Falutin's contractual requirements.

The policies ACME eventually issued did not include any additional insured coverage. Further, they excluded coverage "for claims arising out of the insured's knowing violation of any federal or state laws."

One day, several Silicon Valley executives staying at the ranch took a trail ride organized by Devil-Horse, during which they consumed cannabis edibles and fed them to the horses. One horse became paranoid and bolted, unhorsing several riders who sustained serious injuries and later sued Devil-Horse and High-Falutin'.

Devil-Horse promptly reported the suit to ACME, which declined coverage for High-Falutin' because it was not an additional insured and under the policy's illegal acts exclusion. High-Falutin' then sued Devil-Horse, All-Risk, and ACME.

Discussion

The hypothetical contains some outlandish facts but the basic scenario is common. As insurance policies become more complex and specialized, producers increasingly become a focus in coverage litigation. Yet, the legal relationships among producers, insurers, and policyholders are often confused by courts and even producers themselves, a situation muddled further by conflicting approaches taken by various federal and state courts. Below, we explore two issues affected by these relationships.

Issue One: Can High-Falutin' Rely on All-Risk's Certificate of Insurance?

Generally, certificates of insurance do not bind the insurer or alter coverage. In fact, the current ACORD form expressly states as much. *See* ACORD 25 (2014/01) (stating in part, "THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED

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3 This article uses the terms "producer," "intermediary," "broker," and "agent" interchangeably.

BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER."); *see also* § 6:37A, Certificates of insurance, 2 Insurance Claims and Disputes § 6:37A (6th ed.); *Westfield Ins. Co. v. FCL Builders, Inc.*, 407 Ill. App. 3d 730, 736, 948 N.E.2d 115, 120 (2011). Because of this language, most third parties allege negligent misrepresentation against a producer issuing an erroneous certificate.

The decisions addressing whether a third party can reasonably rely on erroneous certificates are mixed. *Compare Brown & Brown of Texas, Inc. v. Omni Metals, Inc.*, 317 S.W.3d 361, 396 (Tex. App. 2010) (reliance justified) with *TIG Ins. Co. v. Sedgwick James of Washington*, 184 F. Supp. 2d 591, 598 (S.D. Tex. 2001) *aff'd*, 276 F.3d 754 (5th Cir. 2002) (not justified). The answer may depend on whether the intermediary is the insurer's agent, the policyholder's agent, or both.

Because they rely on renewals driven by customer loyalty, independent agents in particular work to cultivate a relationship of trust by emphasizing their ability to place the policyholder's insurance with different insurers with whom they have relationships. Notwithstanding the fact that the independent agent is looking out for the policyholder's interests, if there is a written agency agreement with an insurer, the independent agent acting within the scope of its express authority likely will bind the insurer with his/her words or conduct. *Zannini v. Reliance Ins. Co. of Illinois*, 147 Ill. 2d 437, 451, 590 N.E.2d 457, 463 (1992). However, depending on the jurisdiction, despite the apparent legal relationship between the insurer and the independent agent, the agent may be held to represent the policyholder under the circumstances. *See, e.g., Jonathan Woodner Co. v. Aetna Ins. Co.*, 442 F.2d 754 (D.C. Cir. 1971) (applying D.C. law); *Markel Serv., Inc. v. National Farm Lines*, 426 F.2d 1123 (10th Cir. 1970) (applying Okla. Law).

In Colorado, where All-Risk is hypothetically located, an insurance "producer" may be deemed to be an agent of the insurer. *See* C.R.S. § 10-2-401(1) (producer who solicits applications "on behalf of an insurer shall be regarded as representing the insurer and not the insured . . . in any controversy . . ."). Recent case law further suggests that Colorado courts view intermediaries as indistinct from insurers. *See, e.g., DC-10 Entm't, LLC v. Manor Ins. Agency, Inc.*, 308 P.3d 1223, 1229 (Colo. App. 2013) (noting insured has "the same expectations of the insurance broker that he or she would have of the insurer"). Thus, there is a good chance that in the hypothetical, All-Risk will be held to be ACME's agent, though the possiblity that a court would find it is a dual agent cannot be excluded.

Issue Two: Can All-Risk's Counsel Ethically Advise All-Risk to Align with the Policyholder against ACME?

Caught between the policyholder and a possible indemnity claim by ACME (agency agreements often require the agency to indemnify the insurer for the agent's negligence) All-Risk needs to choose with which party to align, if any.

On the one hand, producers feel loyal to policyholders because they make their living from renewals, which requires establishing strong, long-term relationships with policyholders. Consequently, their first move when a coverage dispute arises frequently is to advocate on behalf of the policyholder.

On the other hand, often the most successful defense strategy is to align with the insurer and claim that the agency was a mere "order-taker" with limited duties to the policyholder. *See*, *e.g.*, *Bayly, Martin & Fay, Inc. v. Pete's Satire, Inc.*, 739 P.2d 239, 243 (Colo. 1987) (agent who agrees to obtain particular coverage has duty to obtain such coverage or notify of failure or inability to do so); *Kaercher v. Sater*, 155 P.3d 437, 441 (Colo. App. 2006) (noting general rule that absent special relationship with insured, agent has no duty to advise regarding policy provisions).

While this is a sensible defense given the principal/agent relationship with an insurer, many producers feel this approach betrays the customer they worked so hard to cultivate, and worry their reputation among other customers will suffer. In rural communities, or insular industries, this dilemma can be magnified.

In helping a producer formulate its defense strategy, counsel should be mindful of these competing considerations. For instance, ABA Model Rule of Professional Conduct 2.1 requires a lawyer to advise a client using professional judgment informed by considerations beyond the merits of the case, including "moral, economic, social and political factors, that may be relevant to the client's situation." Comment 2 to the Rule explains further, "Advice couched in narrow legal terms may be of little value to a client, especially where practical considerations, such as cost or effects on other people, are predominant. Purely technical legal advice, therefore, can sometimes be inadequate."

Thus, in the hypothetical, counsel should balance the competing long-term interests All-Ris has concerning a long-term, significant policyholder customer like High-Falutin' against duties to ACME, with whom it may have a significant book of business. Similarly, counsel should advise All-Risk about the conflicting loyalties to the two policyholder customers.

Additionally, as with any defense counsel retained by an insurance company to defend an insured, All-Risk's counsel in the hypothetical must also contend with the interests of the agent's professional liability insurer (here, ProLiab). That insurer's interest may be focused solely on legal issues in the case, and not on the agent's other long-term interests, for which the insurer does not bear the cost. In Colorado, ProLiab is not considered a client, and therefore the lawyer's duty is solely to All-Risk. *See* Colorado Bar Association Ethics Opinion 91. However, in other states, ProLiab may also be a client, whose interests the lawyer must consider. *Id*.

Ultimately, the ethical duties of the producer's defense counsel require it to understand the producer's business and sort out the competing interests beyond the merits of the case at hand.

Conclusion

The legal relationships insurance intermediaries have with insurers and policyholders are complex and contradictory, receiving differing treatment in different jurisdictions in decisions that are often fact-dependent. As insurance coverage becomes increasingly complicated and specialized, reliance on intermediaries, and their involvement in coverage litigation, are likely to increase. Thus, attorneys representing policyholders, insurers, and producers need to be mindful of these complexities to provide effective representation to their respective clients. ⚖⚖

HABITABILITY TORTS AND…

Continued from page 1

possessory interest in the property, or does it extend as well to *use and enjoyment* of the premises? Does it extend to constructive eviction or breach of the warranty of habitability?

The first case to address this issue was Beltway Management Co. v. Lexington-Landmark Ins. Co., 746 F.Supp. 1145 (D.D.C. 1990). A tenants' group sued the landlord, Beltway, for breach of common law and statutory[4] warranties of habitability.

The Landmark policy covered "wrongful entry or eviction or other invasion of the right of private occupancy".[5]

Beltway contended that "other invasion of the right of private occupancy" covered claims for violations of the warranty of *habitability*.[6] Landmark countered that this covered claims for interference with the *right of physical possession*.[7] It argued the coverage was "never intended to subsidize the insured's cost of doing business and/or repairing and maintaining rental properties."[8]

The court held that given (1) modern principles of landlord tenant law, which view a lease as more than a mere conveyance, and as a "distinct set of goods and services", (2) other case law interpreting the phrase to cover restrictive zoning decisions and discriminatory refusals to rent, and (3) the rule against treating contract terms as mere surplusage, the phrase must be interpreted to cover breach of the implied warranty of habitability.[9]

The court reasoned that if "other invasions" refer to invasions that are nearly identical to "wrongful entry or eviction" then at a minimum this must include constructive eviction.[10] Given the substantial similarity of constructive eviction to breach of the implied warranty of habitability, then the latter claim must also be covered.[11]

In Vermont Mut. Ins. Co. v. Parsons Hill Partnership, 188 Vt. 80, 1 A.3d 1016 (2010) the Court disagreed

4 The District of Columbia Housing Regulations, 5G DCR 2501, required repair and maintenance designed to make the premises or neighborhood safe and healthy.
5 Id., 746 F.Supp. at 1148.
6 Id., 746 F.Supp. at 1149-50.
7 Id., 746 F.Supp. at 1150.
8 Id., 746 F.Supp. at 1150.
9 Id., 746 F.Supp. at 1152-55.
10 Id., 746 F.Supp. at 1155.
11 Id., 746 F.Supp. at 1155.

with *Beltway;* it had failed to recognize the limitation of coverage to "offenses".[12]. It held that construing a breach of warranty as an "invasion" stretched the language of the policy beyond its plain and unambiguous meaning.

There, a state environmental agency advised a landlord that it had assigned a "No Drink" status to water in the apartments. The landlord did not notify the tenants nor try to remediate the condition. The tenants sued for breach of the common law warranty of habitability.[13] The court held that the tenants' claim did fall within the personal injury coverage.[14]

C. Coverage of Housing Discrimination under Wrongful Entry, Eviction or Invasion

A number of housing discrimination cases has considered this offense.[15] Some cases address whether there is an invasion of the right of private occupancy where a landlord refuses to rent to a prospective tenant, who does not have occupancy.[16] In Bernstein v. North East Ins. Co., 19 F.3d 1456, 1457 (D.C. Cir. 1994) the court found no coverage for such a claim as the plaintiff did not have possession.[17]

Other cases consider whether the landlord's intent vitiates coverage.[18] In Boston Housing Authority v. Atlanta Intl. Ins. Co., 781 F.Supp. 80 (D.Mass. 1992) the court concluded that the Authority acted intentionally, so that coverage was barred, including coverage for defense costs.[19]

D. Excess Umbrella Coverage

Lawsuits alleging both housing habitability torts and housing discrimination may involve both the CGL and the umbrella coverage.

Both cover "wrongful entry, wrongful eviction or other invasion of the right of private occupancy… ." The excess umbrella policy is excess on these claims.

The CGL does not cover discrimination, unless a broadening endorsement has been added. Many umbrella policies define personal injury to include "discrimination or humiliation". To this extent, the umbrella coverage is broader than the primary, and may apply. What does that mean as to defense and settlement?

Primary insurers may argue that the umbrella must be treated as another primary, and share in obligations to indemnify and defend. Umbrella insurers will assert that they do not contribute with the primaries because of policy language[20], the layered structure of an insurance program, and the expectations of the parties that the umbrella insurer should not share a duty to defend with a primary insurer[21].

Careful analysis is required. Do the same factual allegations support both claims? Are the habitability allegations incorporated into the claims for housing discrimination? Are there allegations that are covered only under the excess umbrella?

In *Federal Ins. Co. v. Steadfast Ins. Co., 209 Cal. App. 4th 668, 147 Cal. Rptr. 3d 363 (2012)* the Department of Justice sued the Sterling defendants for discrimination under the FHA[22]. The primary insurers covered "wrongful eviction," "wrongful entry," and "invasion of the right of private occupancy."[23] The excess umbrella insurer covered those claims and also specifically insured against claims for "discrimination, harassment or segregation based on a person's age, color, national origin, race, religion or sex".[24]

The DOJ alleged refusal to rent; maintenance of a hostile environment; providing inferior treatment; misrepresentation of the availability of units; and statements that expressed a preference for Korean-Americans and against others.[25] The DOJ asserted that the practices included entering apartments without notice and evicting tenants with children.[26]

12 Id., 188 Vt. at 92.

13 Id., 188 Vt. at 92.

14 Id., 188 Vt. at 90.

15 Powell v. Alemaz, Inc., 335 N.J.Super. 33, 760 A.2d 1141 (App.Div. 2000); Bernstein v. North East Ins. Co., 19 F.3d 1456 (D.C.Cir. 1994); State Farm Fire & Cas. Co. v. Westchester Investment (C.D. Cal. 1989) 721 F.Supp. 1165 (finding coverage for Fair Housing claims asserted by prospective tenant); Romano v. Gardner, 688 F. Supp. 489 (E.D.Wis. 1988) (claim of race discrimination in refusing to rent an apartment, court held that insurer had a duty to defend under other invasion of the right of occupancy offense).

16 Martin v. Brunzelle, 699 F.Supp. 167 (N.D.Ill.1988); Larson v. Continental Cas. Co., 377 N.W.2d 148 (S.D.1985)

17 Id., 19 F.3d at 1459.

18 *Boston Housing Authority v. Atlanta Intl. Ins. Co, 781 F.Supp. 80 (D.Mass. 1992).*

19 *Id., 781 F.Supp. at 82-83*.

20 Typical excess umbrella language states it will not defend "if any other insurer has a duty to defend."

21 They argue that primary insurers have been paid substantially higher premiums per dollar of coverage because it is anticipated and expected that the primary will also defend the insured.

22 FHA, 42 U.S.C. § 3601 et seq.

23 Id., 209 Cal.App.4th at 673-74.

24 Id., 209 Cal.App.4th at 674-75.

25 Id., 209 Cal.App.4th at 672.

26 Id.

The umbrella insurer argued that the claims fell within the primary coverage and those insurers must defend. The court disagreed, holding that Federal was the only insurer that covered discrimination claims, and that the DOJ action solely concerned housing discrimination.[27]

The government did not have a right of possession. "Even if a claim by a tenant or prospective tenant under 42 U.S.C. sections 3613 or 3614, subdivision (c) might potential covered by the [primary] policies, the claim by the United States is not. The United States had no right of occupancy."[28] The primary coverage did not apply. The umbrella covered discrimination, and so the umbrella insurer alone had the duty to defend.[29]

However, if individual actions were brought by the tenants, there would be coverage under the primary policies if there were allegations of wrongful entry, wrongful eviction or other invasion of the right of private occupancy

In United States v. Security Management Co., Inc., 96 F.3d 260 (7th Cir. 1996) (applying Wisconsin law) the court held that primary coverage for "wrongful eviction from, wrongful entry into, or invasion of the right of private occupancy … "[30] did not apply to testers or tenant associations in a lawsuit alleging FHA violations, as they did not have a right of occupancy.[31]

Primary bodily injury coverage did not apply as there were no allegations of bodily injury, meaning physical injury.[32] However the umbrella policy defined bodily injury to include mental anguish.[33] The court found potential for claims of mental anguish.[34]

E. Miscellaneous Issues

Date of loss is a significant issue. It is " hard … to determine precisely when, along such a continuum of time, a breach of the warranty of habitability occurs."[35]

Intent issues are also significant. Under the FHA, the courts recognize disparate treatment and disparate impact theories. Texas Dep't of Hous. & Cmty. Affairs v. Inclusive Communities Project, supra. Courts have traditionally found that disparate impact may be covered, but that disparate treatment is not. Solo Cup Co. v. Federal Ins. Co. (7th Cir. 1980) 619 F.2d 1178, 1187 (employment discrimination claims). Vicarious liability may also be insurable.[36]

Plaintiffs can recover attorney's fees under contract, statute[37] or a private attorney general theory. United States v. Security Management held that an attorneys' fees award under the FHA was not covered as "damages".[38] In California, attorneys' fees awards are made as part of the cost award. Cal.Code Civ.Proc. §1033.5. Courts have held that these "costs" then fall within the Supplementary Payments provision.[39] However, as of 2007 the CGL Supplementary Payments do *not* include such attorneys' fee awards as costs.

F. Conclusion

Insureds and primary insurers defending actions alleging both habitability violations and housing discrimination should analyze the possibility of coverage under excess umbrella insurance both for excess coverage when exposure may exceed the primary limits, and also umbrella coverage that may cover claims that are not covered by primary insurance. Excess umbrella insurers for their part must evaluate whether damages for claims of discrimination may overlap in whole or in part damages for claims covered under the primary insurance coverage for wrongful eviction, wrongful entry and invasion of the right of private occupancy. ⚖

27 Id., 209 Cal.App.4th at 679.

28 Id., 209 Cal.App.4th at 684.

29 Id., 209 Cal.App.4th at 685.

30 Id., 96 F.3d 264.

31 Id., 96 F.3d 264-66. The court also applied *ejusdem generis* in its analysis. It rejected the argument that the doctrine did not apply since there was no "catch-all" phrase (such as "*other* invasion of the right …"). *See* New Castle Cty., DE v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA, 243 F.3d 744, 752 (3d Cir. 2001) (noting question of whether *ejusdem generis* applies where the word "other" is removed from before the phrase invasion of the right of private occupancy).

32 Id., 96 F.3d 267.

33 Id., 96 F.3d 268.

34 Id.

35 Beltway v. Lexington-Landmark, supra,746 F.Supp. at 1156.

36 See New York Commissioner of Insurance Circular Letter No.6, *supra*.

37 Such as housing discrimination statutes and rent control / stabilization ordinances.

38 Id., 96 F.3d 269-70 (noting that the Fair Housing Act classified attorneys' fees as separate from costs, 42 U.S.C. §3613 (c)(2).

39 Prichard v. Liberty Mutual Ins. Co. (2000) 84 Cal.App.4th 890, 101 Cal.Rptr.2d 298.

THE IMPACT OF...

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Id. at 230-31. The Ninth Circuit held that "The mere existence of an aggressive loan policy is insufficient as a matter of law to transform disparate acts and omissions made by five directors in connection with issuance of loans to over 200 unrelated borrowers into a single loss." The court explained:

> The fact that all loan losses arguably originated from one loan policy does not require finding only one loss. In this case, there were numerous intervening business decisions that took place after the loan policy was initiated. They required the exercise of independent business judgment. . . . Thus, the decision to implement the aggressive loan policy did not cause the losses, rather it was the alleged negligence on the part of the *Kidwell* defendants in making or approving the individual transactions.

Eureka, 873 F.2d at 235.

At the other end of the spectrum, the California Supreme Court in *Bay Cities Paving & Grading, Inc. v. Lawyers' Mut. Ins. Co.*, 5 Cal. 4th 854, 855 P.2d 1263 (1993) faced the question of whether an attorney's failure to file a stop notice to protect the priority of his client's mechanic's lien and the attorney's subsequent failure to file a timely foreclosure action on that same lien were "related" acts constituting a single "claim" under the attorney's malpractice insurance. The court warned that not every conceivable logical relationship would lead to events to constitute a single claim. "At some point, a relationship between two claims, although perhaps 'logical' might be so attenuated or unusual that an objectively reasonable insured could not have expected they would be treated as a single claim under the policy." *Id.* at 867. The *Bay Cities* court found the two errors made by the attorneys sufficiently related to constitute a single claim because "[t]hey arose out of the same specific transaction, the collection of a single debt. They arose as to the same client. They were committed by the same attorney [… and they] resulted in the same injury, loss of the debt." *Id.*

The Ninth Circuit, in *Fin. Mgmt. Advisors, LLC v. Am. Int'l Specialty Lines Ins. Co.*, 506 F.3d 922 (9th Cir. 2007), faced a fact pattern somewhat in the middle of the spectrum between the *Eureka* and *Bay Cities* decisions. In that case, the policies provided that a claim brought in the second policy year that "arises out of the same or related wrongful acts" as a claim brought in the first policy year was treated as having been brought in the first policy year. The policyholders sought to trigger two separate policy years for two separate lawsuits brought by different investors who received financial advice from the same financial advisor. One of the two lawsuits, the *Sitricks* claim, exhausted the remaining available policy limits in the first policy year. The insurer then denied coverage for the second suit, the *Steinman* claim, asserting that it triggered only the first policy year. The Ninth Circuit disagreed:

> Sitricks and Steinman were unrelated investors with unique investment objectives. They were advised at separate meetings on separate dates, according to their unique financial positions. Indeed, the investment packages ultimately recommended to and chosen by each client were different – the Sitricks invested in several CBO funds as well as various equities, while Steinman invested only in CBO II.

Fin. Mgmt. Advisors, 506 F.3d at 925.

Some other selected cases interpreting "interrelated wrongful acts" in analogous circumstances are as follows:

In *KB Home v. St. Paul Mercury Ins. Co.*, 621 F. Supp. 2d 1271, 1272 (S.D. Fla. 2008),[2] the court applied California law to expressly reject an insurer's assertion that "the fact that all four complainants believed that the workplace culture was infused with sexual harassment is adequate under the policy to prove interrelatedness." Instead, the court found that under the EPLI policy at issue, one of the four claims was unrelated to the other three because it did not arise out of sexual harassment at the same event as the other three claims did.

In *Kilcher v. Cont'l Cas. Co.*, 747 F.3d 983 (8th Cir. 2014), members of an Indian tribe became eligible to share in gaming profits upon reaching the age in majority. These plaintiffs invested the gaming profits with Helen Dale who, over several years, advised them to purchase unnecessary life insurance policies with low yields, high fees, and high surrender costs. The insurance covering Dale provided that "[m]ore than one Claim involving the same Wrongful Act or interrelated Wrongful Acts shall

2 Affirmed sub nomine *KB Home v. The Travelers Ins. Co.*, 339 F. App'x 910 (11th Cir. 2009).

be considered one claim." "Interrelated wrongful acts" were defined as "any Wrongful Acts which are logically or causally connected by reason of any common fact, circumstance, situation, transaction or event."

The trial court ruled in favor of the plaintiffs but the Eighth Circuit, applying Minnesota law reversed. The court reasoned that it was not important how many allegedly wrongful acts there were but simply whether the "method" or "modus operandi" was sufficiently interrelated to each wrongful act. Since each wrongful act followed the same method for the same purpose – to oversell products to plaintiffs and retain high commissions – there was but a single claim for the purpose of the defendant Dale's insurance policies.

The cases are all, to some degree, shades of gray. As one commentator pointed out: "Driven to absurd extremes, an attorney could point to the fact that each claim arose from actions that occurred on the planet Earth between human beings. Conversely, an attorney arguing against relatedness should almost always be able to find some points of distinction." John Zulkey, *Related Acts Provision*, last visited May 24, 2016, http://www.hww-law.com/161E02/assets/files/Documents/Zulkey%20Related%20Acts.pdf.

The cases can be very fact specific and can also be result oriented. In some context, for example, where a policy is not renewed after an event that leads to a number of claims and an extended reporting option is not purchased, finding that the claims are in fact related may be crucial to finding any coverage at all. In contrast, where coverage has been renewed and where the first policy year has already been exhausted, finding that the claims are all related and constitute a single claim may make coverage in the second policy year unavailable. The consideration is fact specific and often depends upon whether "interrelated wrongful acts" is defined and the nature of that definition. The courts will look to whether there is a "causal" or "logical" relationship among the claims. Although I have not surveyed it, I suspect that the courts also look to the result to help guide the decision and that to some degree the decisions are result oriented.

Case Study.

A large bank fails. The failures spawn class action suits by investors and others in one policy year and trailing lawsuits by the bankruptcy trustee of the bank's holding company as well as by the FDIC in the following policy year. All of the suits name directors and/or officers. Although there is $80 million of D&O insurance in each policy year, the limits are subject to erosion by defense fees and there are over two dozen lawsuits. Moreover, total losses from the bank's failure exceeds several billion dollars. The lawsuits brought during the first policy year were primarily investor class actions focused on alleged misrepresentations about the profitability of the bank's core business, the creation of CDOs and MBS – bonds created for sale in the third party market through the origination of residential loans.

The bankruptcy trustee's suit was filed in policy year two and essentially claimed that those directors and officers who were directors and officers of the holding company had a responsibility not to invest additional amounts of its capital in the bank when it became apparent that the bank was failing and that in doing so – during the second policy term – they injured the holding company giving a cause of action to the trustee. The trustee also complained of many of the same decisions that the class actions investors complained of as well as other decisions all of which took place during the first policy year and the trustee did so in the context of a single lawsuit.

There is also another lawsuit brought by the SEC and which was a claim first made and reported in the second policy year and was against the bank's CEO. There was an argument that it arose out of the same or related set of facts as claims asserted in the first policy year. However, for those seeking to implicate the second policy year, it would be particularly difficult to argue that a claim such as this should relate back while others should not. Distinctions would have to be very carefully drawn.

FDIC filed suit against the bank CEO for decisions made during the first policy year relating to the continued production of residential mortgage loans and the continued creation of CDOs and MBSs after the market for resale have evaporated. FDIC admits that the first lawsuit is "related" to the investor lawsuits filed in policy year one even though it was filed later. FDIC files a separate suit not naming as defendants the bank's CEO, president or directors but instead naming only officers of a separate division ("HBD") within the bank who had loan approval authority and who allegedly caused $500 million in losses through their decisions on multimillion dollar homebuilder, land acquisition and land development loans which were mostly held for investment by the bank and which did not involve loans to individual residential homeowners.

HBD and the residential side of the bank had common executive leadership at the top but HBD operated fairly independently. HBD had its own loan policies and operated entirely in a different line of business – acquisition development and construction ("ADC") lending.

Eight different insurers provided a total of $80 million in each of the two policy years for a grand total coverage of $160 million. Most of the insurers in the two policy years were the same. Multiple claims arising out of "interrelated wrongful acts" were to be treated as a single claim and were deemed to have occurred and to implicate only the first policy where the earliest claim was first made and reported.

How much insurance collectively was available to all of the claimants? Which claimants could make a claim to coverage under which policies? ⚖⚖

RECENT DEVELOPMENTS IN…

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and Federal Recovery, and Global ultimately sued Federal Recovery alleging that Federal wrongfully refused to return account data to Global, including gym members' credit card and bank account information. Global's claims included counts of tortious interference, conversion, breach of contract, breach of the implied covenant of good faith, as well as promissory estoppel -- and did not expressly allege that Federal Recovery was negligent in any manner.

Federal tendered the claim to Travelers pursuant to a "Cyber First" insurance policy which included a "Technology Errors and Omissions Liability Form" obligating Travelers to:

> "pay those sums that [the policyholder] must pay as damages because of loss . . . caused by an 'error and omissions wrongful act.'"

The policy also obligated Travelers to provide Federal with a defense for such claims. The policy further defined an "errors and omissions wrongful act" as "any error, omission or negligent act." Federal Recovery sought indemnification and defense under the policy.

Travelers sued its policyholder to disclaim coverage, arguing that Global did not allege any damages arising out of any "error, omission or negligent act." Travelers argued that Global's allegations of wrongful refusal to turn over the customer data alleged, in essence, an intentional act and not an error or omission or negligent act, as the complaint did not specifically allege any negligence. Federal argued that although the allegations of the underlying complaint suggested an intent to withhold the data, Federal could nevertheless be potentially liable for erroneous or negligent acts. Therefore, such allegation had triggered coverage and Federal was entitled to a defense.

The Utah District Court took a narrow approach to the "eight corners" rule for determining the duty to defend. Looking only at the allegations in the complaint, the court found that there were no allegations sounding in negligence that triggered the Travelers policy. The court rejected Federal's argument as to the "potential" or "possible" liabilities which could attach for conduct that did not rise to the level of intent and saw no potential liability in negligence. Consequently, the court ruled that Travelers was not obligated to provide Federal with a defense.

Although the "wrongful acts" definition in the Travelers Cyber First policy may not have broad application to all professional liability policies, the approach taken by the court in Federal Recovery has resonance for disputes arising out of any definition of "wrongful acts" or "errors and omissions" that is defined by negligence. If courts take a narrow interpretive approach to the "eight corners" analysis as the Utah Federal Court did here, the duty to defend may only attach where the underlying plaintiff has expressly alleged negligence on the part of the policyholder. Conversely, other courts may focus on the potential for liability arising out of negligence and deem that the duty to defend is in fact triggered by such possibilities and potential liability. Choice of law and jurisdiction thus may ultimately determine whether coverage exists

Misrepresentation in Application Voids Coverage

In December 2015 the New Jersey Supreme Court ruled that where a misrepresentation of material fact was made by an applicant, a professional liability policy may be rescinded regardless of any impairment to a third party's ability to be made whole absent insurance proceeds. While the ruling DeMarco v. Stoddard, 223 N.J. 363, 125 A.3d 367 (2015), may seem axiomatic, the New Jersey High Court's 5-2 ruling signaled a departure from existing New Jersey law which refused to declare policies obtained by fraudulent misrepresentation as void because of the potential hardships a lack of insurance would visit upon the innocent third party plaintiffs.

In DeMarco, a podiatrist who practiced in both New Jersey and Rhode Island, misrepresented the percentage of his practice that occurred in Rhode Island in order to obtain more favorable rates from the Rhode Island Joint Underwriting Association (RIJUA). The

coverage procured from the misrepresentation allowed the podiatrist to comply with New Jersey's statutory requirement for medical malpractice coverage of $1 - $3 million in coverage. N.J.S.A. 45:5-5.3.

A New Jersey patient sued the podiatrist, Dr. Stoddard, for malpractice and ultimately joined RIJUA in the action to obtain a declaration of coverage. Dr. Stoddard's fraudulent representation in the application was recognized by both the trial court and the New Jersey Appellate Division. However, those courts held that the coverage was not to be rescinded because of the potential hardship it would place the third-party plaintiff in with regard to recovery absent insurance proceeds. The trial and appellate court arrived at this conclusion by looking to New Jersey's automobile insurance laws and jurisprudence, under which courts forbid the rescission of auto insurance due to a statutory mandate for coverage. Finding the medical malpractice statutory requirement analogous, the trial court and Appellate Division did not permit RIJUA to rescind its coverage despite Dr. Stoddard's clear misrepresentation in his application.

The New Jersey Supreme Court, on December 1, 2015, reversed and flatly rejected the lower courts' analogue to automobile insurance, holding that "reliance on that model . . . ignored New Jersey's longstanding rule that an insured professional cannot expect insurance coverage to respond to third-party claims when the professional liability insurance has been rescinded due to the misrepresentation of material fact in the application." Consequently, the Supreme Court ruled the RIJUA had no duty to defend or indemnify Dr. Stoddard in light of his material misrepresentation on his application for malpractice insurance.

Whether the DeMarco opinion signals a fundamental shift in New Jersey's law on rescission due to misrepresentation or is simply the result of professionals being held to a higher standard in their applications remains to be seen.

Rescission Does Not Extend to Innocent Co-Insureds

In contrast to the New Jersey Supreme Court's ruling in DeMarco, the U.S. Court of Appeals for the Fourth Circuit recently ruled that fraudulent conduct of one insured under a professional liability policy should not void coverage for innocent policyholders under the same policy. In Evanston Ins. Co. v. Agape Sr. Primary Care, Inc., No. 14-2268, 2016 WL 192748 (4th Cir. Jan. 15, 2016), the Fourth Circuit applied South Carolina's innocent co-insured doctrine and equitable considerations in determining that the innocent co-insureds should not be deprived of coverage.

Agape Senior Primary Care had purchased a professional liability insurance policy from Evanston in 2012. The Evanston policy provided coverage to Agape, as well as some of its doctors and nurse practitioners, including Dr. Floyd Cribbs and nurse practitioner Kezia Nixon. A third individual, Earnest Osei Addo, was also hired by Agape as a physician. However, Addo had fraudulently assumed the identity of Dr. Arthur Kennedy, which Agape was not aware of at the time of hire or the renewal of the Evanston policy. Addo treated more than 500 patients under Dr. Kennedy's identity, and, when his identity misappropriation was discovered, several patients treated by Addo filed lawsuits.

Evanston initially agreed to defend the lawsuits, which named Nixon and Cribbs, neither of whom knew of Addo's misappropriation of Dr. Kennedy's identity. Subsequently, however, Evanston filed a declaratory judgment seeking to void coverage for all other innocent insured employees of Agape – including Dr. Cribbs and Nixon – as a result of Addo's misrepresentations when applying for malpractice insurance.

In determining cross-motions for summary judgment, the District Court held that although the policy was void as to Addo as a result of his fraudulent misrepresentations, the policy would not be voided as to Agape and innocent co-insureds. The Fourth Circuit affirmed, looking to South Carolina law which, as a matter of equity, disfavors rescission. Moreover, the Panel applied well-established principles of insurance policy interpretation in stating that Evanston, as drafter of the policy and the application, could have "easily" and expressly drafted provisions limiting coverage "in the face of fraud by one discrete applicant." The Fourth Circuit further added that South Carolina statute "reinforces the view that the insured usually must exhibit some fault in order to support vitiation of an insurance policy. Although the Agape case was decided under South Carolina law, the equitable principles underlying the Fourth Circuit's ruling may have application in other jurisdictions.

As these recent cases demonstrate, the arena of professional liability insurance coverage is fluid and ever-evolving. Moreover, emerging risks and new insurance products will likely give rise to increased insurance coverage disputes. The Federal Recovery decision is merely the tip of what promises to be a large iceberg involving the intersection of cyber-related losses and professional liability insurance coverage. ⚖

2016-2017 TIPS CALENDAR

August 2016

4-7 **ABA Annual Meeting** **Westin St. Francis Hotel**
Contact: Felisha A. Stewart – 312/988-5672 **San Francisco, CA**
Speaker Contact: Donald Quarles – 312/988-5708

October 2016

19-23 **TIPS Fall Leadership Meeting** **Hotel Del Coronado**
Contact: Felisha Stewart – 312/988-5672 **Coronado, CA**

November 2016

3-4 **Aviation Litigation Committee Mtg** **Ritz-Carlton, Washington DC**
Contact: Donald Quarles – 312/988-5708 **Washington, DC**

9-11 **FSLC & FLA Fall Meeting** **Fairmont Chicago**
Contact: Donald Quarles – 312/988-5708 **Chicago, IL**

January 2017

19-21 **Fidelity & Surety Committee Midwinter Meeting** **Roosevelt Hotel**
Contact: Felisha A. Stewart – 312/988-5672 **New Orleans, LA**

February 2017

2-5 **ABA Midyear Meeting** **Miami, FL**
Contact: Felisha A. Stewart – 312/988-5672

April 2017

6-7 **Motor Vehicle Products Liability Program** **Arizona Biltmore Resort**
Contact: Donald Quarles – 312/988-5708 **& Spa Phoenix AZ**

7-8 **Toxic Torts & Environmental Law Midyear Mtg** **Arizona Biltmore**
Contact: Felisha Stewart – 312/988-5672 **Resort & Spa**
Phoenix, AZ

26-30 **TIPS Section Conference** **JW Marriott Chicago**
Contact: Felisha A. Stewart – 312/988-5672 **Chicago, IL**
Speaker Contact: Donald Quarles- 312/988-5708