This article summarizes certain significant opinions impacting policyholder rights to coverage under directors and officers (“D&O”) and errors and omissions (“E&O”) policies during the period from January 2014 through June 2014. During this period, courts have issued opinions on many issues that are frequently litigated by policyholders and their insurers. For example, several courts limited insurer defenses based on vague extra-contractual, public policy arguments that any settlement that is labeled as “disgorgement” or “restitution” should not be covered. Courts also have considered and/or rejected arguments by insurers that certain conduct exclusions are triggered by something other than a final adjudication in the underlying proceeding for which coverage is being sought, such as “findings” by regulators that are not admitted. Several courts addressed and/or limited an insurer’s ability to deny coverage for alleged late notice, with some courts applying a prejudice requirement in the context of claims-made policies. Courts also grappled with issues of whether certain “Claims” alleged Wrongful Acts related to “Professional Services” and/or whether two or more “Claims” alleged “interrelated” Wrongful Acts. Of course, all of the cases discussed herein were decided upon the specific policy language and underlying facts at issue.

Definition of Loss/Coverage for Settlement Payments Labeled as “Disgorgement”

Insurers routinely attempt to deny coverage for any payments that could arguably be labeled as “disgorgement” or “restitution,” on the grounds that such payments are “uninsurable” as a matter of law. In many cases, however, insurers have just focused on the “label” used in the settlement, without considering the specific remedy at issue and/or whether a relevant state has in fact adopted the broad “public policy” bars to coverage that the insurers espouse. Past case law addressing this issue has been mixed, but several recent opinions have cut back materially on this defense.

Going back to 2013, in J.P. Morgan Securities, Inc. v. Vigilant Insurance Co., the New York Court of Appeals rejected an insurer’s motion to dismiss a claim by Bear Stearns seeking coverage for a settlement payment made pursuant to a settlement agreement with the Securities and Exchange Commission (“SEC”) that was labeled as “disgorgement” in the settlement papers. In reversing the Appellate Division, the Court of Appeals concluded that the “disgorgement” label was not controlling, agreeing with Bear Stearns’ position that the “payment, although labeled disgorgement by the SEC, did not actually represent disgorgement of its own profits,” but rather represented the improper profits acquired by third-party hedge fund customers. Further, the Court of Appeals stated that New York had recognized only two narrow public policy exceptions to coverage, namely punitive damages and conduct “with the intent to cause injury.”

Under this approach, courts should reject any insurer “disgorgement” defense based merely on the label used in the underlying settlement and should require insurers to meet their burden of proof (as with any defense) on a case-by-case basis based on the specific circumstances concerning the payment at issue and the specific “public policy” (if any) in the relevant state at issue. In other words, courts should not permit insurers to cite “public policy” that does not exist.

In 2014, there have been several opinions that similarly rejected broad and vague insurer “disgorgement” defenses. For example, in William Beaumont Hospital v. Federal Insurance Co., the policyholder (Beaumont) sought coverage for the settlement of an antitrust class action filed by nurses alleging a conspiracy among various hospitals to suppress wages and seeking to recover unlawfully retained wages. The insurer denied coverage “arguing that the settlement constituted disgorgement and was not considered a Loss under the Policy and thus was uninsurable.” The Sixth Circuit rejected the insurer’s defenses for various reasons. In part, the...
Beaumont court held that the term “disgorgement” was limited in scope, meaning “to give up illicit or ill-gotten gains.” As such, the disgorgement defense potentially only applies when the policyholder illicitly “acquires” something (not when the policyholder illicitly “retains” something). The Beaumont court reasoned:

This is not mere semantics. Retaining or withholding differs from obtaining or acquiring. The hospital could not have taken money from the nurses because it was never in their hands in the first places. While the hospital’s alleged actions are still illicit, there is no way for the hospital to give up its ill-gotten gains if they were never obtained from the nurses. Therefore, the damages Beaumont paid in settlement of the claim does not constitute disgorgement.\(^5\)

Based on this distinction, the Beaumont court rejected the insurer’s reliance on the often-cited Level 3 decision, noting that this case and its progeny “all involve wrongfully acquiring something,” not illicitly “retaining” something.\(^6\) The Beaumont court also referred to the underlying settlement documents, which “confirmed” that the nurses were seeking “purely compensatory damages” (e.g., what the nurses would have been paid “if not for the violation”).\(^7\)

Finally, the Beaumont court rejected the insurer’s broad public policy defense that “no one should benefit from his own wrongdoing.” Rather, the Beaumont court held that “Federal has not identified any cases in the Sixth Circuit holding that disgorgement is not insurable” and that the “public policy” cases cited by the insurer were limited to claims involving “intentional tortious or criminal acts.”\(^8\)

Similarly, in U.S. Bank National Association et al. v. Indian Harbor Insurance Co. et al.,\(^9\) a federal district court in Minnesota, applying Delaware law, denied certain insurers’ motions for judgment on the pleadings, in which the insurers had argued that a “restitutionary” settlement payment was “insurable” as a matter of law. In the underlying litigation, U.S. Bank was sued in a series of class action lawsuits in which the claimants alleged that the bank charged improper overdraft fees, and that the bank misrepresented its overdraft fee policy to its customers. The claimants asserted various common law and statutory claims, seeking return of the excess overdraft fees. U.S. Bank settled the class action lawsuits in 2013 for $55 million.

U.S. Bank then sought coverage from its professional liability insurers for defense costs, as well as for the amounts paid in settlement. The insurers denied coverage. In denying coverage, the insurers relied in part on the definition of “Loss,” which excluded matters “uninsurable under the law pursuant to which this Policy is construed” (referred to by the court as the “Uninsurability Provision”).

Ultimately, the U.S. Bank court held that “at this stage of the proceeding [a motion to dismiss on the pleadings], the Insurers have not clearly established as a matter of law that . . . the Uninsurability Provision . . . prevents the settlement from being a covered loss under the insurance policies.”\(^10\) In denying the motions, the court stated as follows: “The Insurers have failed to cite, and the Court cannot locate, any Delaware authority deeming restitution uninsurable. Delaware courts have scrutinized public-policy bars against insurance coverage in similar contexts, only to conclude that public policy did not prohibit coverage.”\(^11\)

Notably, the U.S. Bank court also relied on the illgotten gains exclusion in the policy, which potentially barred coverage for certain profits to which the policyholder was not legally entitled, but only if a “final adjudication” in the underlying action established that the policyholder had received such profits. The court held that this “final adjudication” standard “shows not merely that the parties contemplated the possibility of coverage for restitution, but that they agreed coverage would exist unless the restitution was imposed by a final adjudication.”\(^12\)

For additional new authority, see:

- **Cornerstone Title & Escrow, Inc. v. Evanston Insurance Co.**,\(^13\) in which the Sixth Circuit rejected an insurer’s defense based on the “profit exclusion,” holding that this exclusion applied only if the policyholder both “collected” and “retained” the sums at issue. The Sixth Circuit also rejected the insurer’s reliance on the “restitution” label in the underlying settlement, stating that there are many cases where a “defendant who enjoyed no personal gain could still be ordered to pay restitution . . . .” as part of a settlement.

- **Peerless Insurance Co. v. Pennsylvania Cyber Charter School**,\(^14\) in which a Pennsylvania federal court rejected an E&O insurer’s defense that the claimed “loss”—which related to the policyholder charter school’s alleged improper collection of student fees from school districts -- was uninsurable as a matter of public policy. The court also rejected various arguments based on exclusions. With respect to the “public policy” defense, the court held that “courts have not uniformly precluded the possibility of a ‘loss’ when restitutionary claims are asserted.” Rather, the court reasoned that “only in the ‘clearest cases’ could an alleged public policy be the basis of a judicial decision” resulting in a loss of coverage. In rejecting the insurer’s public policy defense, the court noted that the insurer had not shown that the payments at issue were “facially unlawful” (a “necessary premise” of any public policy defense) or that the policyholder would receive a “windfall” if it obtained coverage.
Certain policies define the term “Loss” to exclude “penalties.” Courts have adopted different interpretation of this exclusionary language in the past. For example, certain courts have focused solely on the “label,” holding that such language bars coverage for anything labeled as a “penalty” in a statute governing an underlying claim. In contrast, other courts have looked beyond the label to determine whether the payment at issue is designed by statute to compensate the underlying plaintiff, rather than punish the policyholder (and, therefore, should be covered).

This issue has frequently arisen in recent years in the context of claims seeking coverage for alleged violations of the Telephone Consumer Protection Act (“TCPA”). Although case law is mixed, certain courts have concluded that liabilities under the TCPA are, in fact, remedial in nature (designed to compensate the underlying plaintiffs) and have rejected insurer arguments that such payments are uninsurable penalties or punitive damages. In so doing, courts have rejected the insurer’s focus on the “label” used in the underlying statute, but rather have considered the “statute as a whole” and the “reason for the law, the problems sought to be remedied, and the purposes to be achieved.”

In 2014, a Louisiana appellate court applied this caseby-case analysis in rejecting an insurer’s argument that statutory damages under a different act were not covered. In Williams v. SIF Consultants of Louisiana, Inc., the court held that damages awarded under Louisiana’s Preferred Provider Organization Act constituted statutory damages, rather than fines or penalties and, therefore, were not excluded under a preferred provider organization’s (“PPO”) E&O policies. The insurers argued that PPO damages were punitive in nature and fell within the carve-out for “fines, penalties, taxes, and punitive, exemplary or multiplied damages” in the policies’ definition of covered “Loss.”

Although the court recognized that the definition of “Loss” “clearly excludes” certain fines and penalties, it concluded that “[i]t is equally clear that the policy does not exclude statutory damages.” Noting that the state PPO statute subjects a violator to “damages” but does not include any language regarding “penalties,” the court rejected the insurers’ arguments that the policies excluded coverage for the amounts awarded against the PPO policyholder.

**What Triggers a Fraud Exclusion (e.g., Settlements, Plea Agreements, SEC Findings, etc.?)?**

Insurers and policyholders frequently debate whether certain settlements or “findings” by regulators trigger the so-called “conduct” exclusion in policies for certain types of “fraud” or other intentional misconduct. Of course, this issue necessarily will be impacted by the specific exclusion at issue, including whether the “fraud” exclusion is triggered only by a “final adjudication,” when the barred conduct “in fact” occurred, or when such conduct is merely “alleged.”

Several recent cases highlight this evolving coverage issue. First, this issue has been addressed in the evolving Vigilant matter. By way of background, back in 2011, the insurers argued to the Appellate Division that “findings” in Administrative Orders or similar filings alleging that a policyholder engaged in fraudulent conduct would result in a loss of coverage, even though such “findings” were neither admitted nor denied. With no analysis and ignoring the plain language of the exclusion at issue (which applied only upon a “final adjudication”), the Appellate Division agreed with the insurer, finding that—even though the SEC order did not specifically state that the funds were obtained improperly and that Bear Stearns settled without admitting liability—when “read as a whole,” the SEC order and other documents related to the SEC investigation were “not reasonably susceptible to any interpretation other than that Bear Stearns knowingly and intentionally facilitated illegal late trading . . . and that the relief provisions of the SEC Order required disgorgement of funds gained through that illegal activity.”

As discussed above, the Court of Appeals reversed and denied the insurers’ motion to dismiss, remanding to the trial court for further proceedings. On remand, the trial court in 2014 rejected the insurers’ defense based on fraud exclusion given the terms of the settlement, namely that Bear Stearns did not admit the SEC Staff’s “findings.” In so holding, the court held that the settlement agreements did not qualify as a “judgment or other final adjudication of wrongdoing” as required by the exclusion. The trial court reasoned that “[t]o infer, as the Insurers urge, that the term ‘final adjudication’ encompasses settlement of an administrative order, is to expand its reasonable interpretation beyond what is permitted under New York Law. . . . Insofar as this Court concludes that the Administrative Orders do not trigger the Dishonest Acts Exclusion, Insurers cannot now be permitted to rewrite [the ‘final adjudication’] contractual language out of the Policies.”

In contrast, in Protection Strategies, Inc. v. Starr Indemnity & Liability Co., the United States District Court for the Eastern District of Virginia found that guilty pleas entered against four executives triggered certain policy exclusions, including a fraud exclusion, under a D&O coverage part. The policy at issue excluded any “Loss . . . arising out of . . . any deliberate fraudulent act or any willful violation of law by an Insured if a final judgment or adjudication establishes that such act or violation occurred.” The court held that the plea agreements “clearly established” the facts necessary to trigger the exclusion.
court found that a guilty verdict for fraudulent misrepresentation against a bank employee triggered a D&O policy exclusion, which applied to any Claim merely “based upon . . . any fraudulent, dishonest, or criminal acts” (although the court found coverage under a fidelity bond issued by the same insurer). The court held that a special verdict entered against the bank employee triggered this exclusion (which did not even require a “final adjudication”).

**Insurer Must Show Prejudice Following Late Notice, Even Under Claims-Made Policies**

Late notice is a common defense raised by insurers when attempting to deny coverage. With respect to many types of policies, courts often reject such defenses unless the insurer proves not only that notice was late, but also that the insurer was materially prejudiced by the late notice. In contrast, given unique features of claims-made D&O and E&O policies, insurers typically argue that they are not required to prove prejudice in order to prevail on late-notice defenses. Although not consistent across all jurisdictions, several recent opinions have rejected that insurer position and have required insurers to prove prejudice in order to prevail on a late-notice defense under claims-made policies.

Certain courts have held that state statutes that require insurers to prove prejudice on late-notice defenses apply to claims-made policies. For example, in *Navigators Specialty Insurance Co. v. Medical Benefits Administrators of Maryland, Inc.*, the court addressed a claim potentially involving two consecutive claims-made-and-reported policies issued by the same insurer. The court addressed several issues, including when the “Claim” was first made and what policy was triggered. As one alternative, the insurer argued that the Claim was first made during the first policy period, but that no notice had been given during that period. To the extent the court found that the Claim had first been made during the first policy period, the policyholder acknowledged that it did not give notice during that policy period, but argued that the insurer “was not prejudiced by late notice.” The court stated that the dispute about whether a showing of prejudice is necessary turns on whether a Maryland statute applies to claims-made-and-reported policies. After an extensive review of the statute and prior case law, the court held that the statute applied and that, therefore, the insurer must show actual prejudice in order to avoid coverage.

Thus, policyholders should consider potentially relevant statutes when responding to “late notice” defenses.

Other courts have recently rejected insurer late-notice defenses under claims-made policies on other grounds, even in the absence of a state notice-prejudice statute. For example, in *Sirius XM Radio, Inc. v. XL Specialty Insurance Co., et al.*, the Appellate Division rejected an insurer’s late-notice defense under a D&O claims-made policy. A policyholder gave timely notice for one claim, but allegedly gave untimely notice for three other claims that were potentially “related” to the first claim. The court held that the D&O insurer’s policy notice requirements were ambiguous with regard to whether its requirement that an insured provide notice of “any” claim pertained to claims that may be “related” under the policy’s provision for “interrelated wrongful acts.” Further, the court held that even assuming that the insured did have to notify the insurer of every interrelated claim as soon as practicable, the “documentary evidence fails to resolve all factual issues as a matter of law.”

Other recent opinions, however, have not required insurers to prove prejudice in the context of claims-made policies. For example, in *Templo Fuente De Vida Corp., et al. v. National Union Fire Insurance Co. of Pittsburgh, Pennsylvania*, a New Jersey appellate court affirmed a trial court’s entry of summary judgment in favor of the insurer because the policyholder did not provide notice of the claim under a claims-made policy “as soon as practicable.” In denying coverage, the court strictly enforced the notice requirement where notice was given during the policy period but not until six months after the policyholder received notice of the claim. The court also rejected the policyholder’s argument that an insurer must show that it was prejudiced by the late notice. In so doing, the court distinguished between occurrence-based policies (where an insurer must show prejudice) and claims-made policies, reasoning that “requiring a [claims-made] insurer to make such a showing would constitute ‘an unbargained for expansion of coverage.’”

**The Definition of “Professional Services” and/or “Professional Services” Exclusions**

Several courts have recently addressed disputes related to whether an underlying claim alleged Wrongful Acts with respect to the provision of “Professional Services.” Such disputes have arisen in various contexts, such as disputes on whether an E&O policy affording coverage for “Professional Services” has been triggered or, in contrast, whether a “Professional Services” exclusion in a D&O policy operates to bar coverage.

For example, in *Hilco Trading, LLC, et al. v. Liberty Surplus Insurance Corporation, et al.*, an Illinois appellate court determined whether appraisals prepared by one insured for another insured constituted “professional services” under a professional liability policy sufficient to trigger a duty to defend, when the definition of “professional services” included “services . . . provided by the insured to a third party for a monetary fee.” In that case, two insured appraisal companies provided appraisals to a sister finance company, which relied on the appraisals to make loans. The finance company (also an insured) borrowed money from banks to fund the loans, but before agreeing to loan money to the finance company, the banks required the appraisals provided by the appraisal companies to
show that the loans were fully secured. Facing financial trouble, the finance company was unable to repay the banks, which sued the finance company and the appraisal firms for providing inaccurate and exaggerated appraisals.

The appraisal companies provided notice of the bank lawsuits to their insurer, which denied coverage on the basis that there were no allegations in the underlying lawsuits that the appraisal companies provided professional services to a “third party” as required by the definition of “professional services.” The insurer argued that the services were provided by the appraisal companies only to the insured finance company, rather than the third-party bank, citing, in part, contracts that stated that the appraisals were provided solely for the use of the insured finance company.

The appraisal companies filed a coverage action, but the trial court agreed with the insurer and granted summary judgment in its favor. On appeal, the appellate court reversed, finding that the appraisal companies’ professional services were provided to a “third party” within the meaning of the policy, at least for purposes of triggering a duty to defend. The court noted that the appraisal companies not only prepared and forwarded the appraisals to the finance company knowing that they would be provided to a third-party bank, but that they also provided express written consent to the bank to use their appraisals. Therefore, the court held that the appraisal companies’ actions were sufficient to trigger the duty to defend.

Conversely, in Carlyle Investment Management, L.L.C. v. ACE American Insurance Co., the Superior Court of the District of Columbia held that a unique professional services exclusion barred coverage for the specific claim at issue. The policy at issue generally covered “Professional Services Claims” and included a detailed, multi-part definition of “Professional Services.” The policy also included an exclusion for Claims related to the provision of “Professional Services” to one entity, Carlyle Capital Corporation (“CCC”). When a Claim arose relating to services provided to CCC, the policyholder argued that this exclusion should be construed narrowly, as it was arguably “intended to exclude only claims arising from professional services in the nature of those provided by lawyers and accountants.” The insurer countered that the policyholder “bargained for the broadest possible coverage for losses attributable to their provision of Professional Services to any Fund, Organization, or Portfolio Entity, and they are stuck with that definition of Professional Services” with respect to the unique exclusion at issue. The court ruled for the insurer, discounting the policyholder’s arguments about “whether or not the words mean something else in the insurance industry outside the context of this particular contract,” given the specific definitions in the policy at issue.

Several other recent decisions varied in their findings of coverage, based upon the underlying allegations at issue and whether they constituted the rendering of (or failure to render) professional services:

- In Rob Levine & Associates Ltd. v. Travelers Casualty and Surety Co., a federal district court held that a “Legal Services Exclusion” in a law firm’s D&O policy did not bar coverage for false advertising claims brought against the law firm and its attorneys. Two clients filed a class action lawsuit for false advertising against the law firm. The firm provided notice under its D&O policy, but the insurer denied coverage on the basis of the policy’s “Legal Services Exclusion,” which precluded coverage for any “Claim based upon . . . any Wrongful Act related to the rendering of, or failure to render, professional services.” The court granted the law firm’s motion for summary judgment, finding that the false advertising claim related to advertising, not the provision of legal services. Because the firm’s advertisements were made to the general public prior to legal services being performed, the court found that they did not involve the “rendering” of legal services.

- In LCS Corrections Services, Inc. v. Lexington Insurance Co., a federal district court, applying Texas law, held that a professional services exclusion barred coverage for a lawsuit filed by a prisoner who died in the insured’s custody, allegedly due to medical malpractice and civil rights violations, such as denying to provide the inmate’s prescribed medications. The court found that the allegations in the underlying civil rights claim implicated the “failure to render professional services,” rather than providing a “global administrative decision,” as suggested by the policyholder.

- In Bennett v. U.S. Liability Insurance Group, an Oregon district court held that inappropriate billing actions did not constitute covered “professional services” under a business liability insurance policy. When a policyholder was sued for improper billing and fee collection practices, the insurer denied coverage on the basis that the allegations did not involve “Wrongful Acts” as defined by the policy, which covered only the rendering of “Professional Services.” Because the conduct at issue did not involve “services rendered to others for a fee solely in the conduct of the insured’s profession,” the court found that the claims at issue were not covered.

- In Municipal Revenue Services, Inc. v. Houston Casualty Co., a federal district court in Pennsylvania held that alleged misappropriation of confidential information to obtain a law firm’s business could arise out of an insureds’ professional services and was potentially covered by a professional liability policy. The insurer refused to defend and moved to dismiss the coverage action due to the policy’s definition of “Professional Services,” which included only “the performance of providing a Tax preparation and/or Bookkeeping Services and/or providing Tax Lien Services, for others for a fee.” The court rejected the
insurer’s argument, denying the motion and finding that the claimant’s misappropriation allegations could plausibly involve conduct rendered in the course of the insureds’ professional work.

**Burden of Proof of Interrelated Wrongful Acts**

Courts have recognized that case law addressing the issue of whether two or more Claims are “related” is at best unpredictable and at worst irreconcilable. In many cases, one insurer will argue that a Claim filed in its period is “related” to a Claim filed during an earlier period when another insurer issued coverage, and the first insurer will argue that the Claim is not “related.” In some cases, insurers will argue for a broad interpretation of “related” (when they want to avoid per claim limits) and in other cases may argue for a narrow interpretation (when a separate retention applies to claims that are not “related”).

There were many opinions in early 2014 addressing such disputes, which are often fact specific. For purposes of this article, the focus is on one opinion that highlighted a fundamental legal issue related to interrelated acts, namely, the burden of proof.

In *Borough of Moosic v. Darwin National Assurance Co.*, the Third Circuit applied Pennsylvania law in holding that an insurer bears the burden of proof to showing claims are related when the insurer attempts to deny coverage on the basis that a claim is related to an earlier claim made prior to the inception of the professional liability policy at issue. The underlying dispute in Moosic involved lawsuits filed by two property owners against a town, which alleged that town officials interfered with the property owners’ First Amendment and due process rights. The town provided notice under its professional liability policy, but the insurer denied coverage on the basis that the claim was related to prior mandamus claims made by the property owners that pre-dated the inception of the policy. The policy defined “Related Claim” as “all claims for Wrongful Acts based upon, arising out of, resulting from, or in any way involving the same or related facts, circumstances, situations, transactions or events or the same or related series of facts circumstances, situations, transactions or events, whether related logically, casually or in any other way.”

The town filed a demand for declaratory relief, which was dismissed by the district court on the basis that the recent civil rights claims related to the prior mandamus claims and, therefore, should be treated as a claim made prior to the inception of the policy. On appeal, the Third Circuit reversed and remanded to the trial court, finding that the trial court applied the incorrect burden by requiring that the insured prove that the civil rights suit and the mandamus suit were not Related Claims. The court reasoned that “because the Related Claims provision limits coverage, we find that it is an exclusion” and that the insurer “bears the burden of proving” that the exclusion applied. The court held that the fact the Related Claims provision “appears in the section entitled ‘Conditions,’ rather than the section entitled ‘Exclusions,’” was not “determinative . . . . Other courts have found that the location of a provision within an insurance policy does not determine whether it is a condition or exclusion.”

**Waiver of Coverage Defenses Following Insurer Breaching Duty to Defend**

In *K2 Investment Group, LLC v. American Guarantee & Liability Insurance Co.*, the New York Court of Appeals reversed itself and held that, under New York law, a liability insurer who breaches its duty to defend in declining to provide coverage “is not barred from relying on policy exclusions as a defense to [the] lawsuit.” This highly unusual decision reversed the Court of Appeals’ own 2013 ruling in *K2*, which held that “when a liability insurer has breached its duty to defend its insured, the insurer may not later rely on policy exclusions to escape its duty to indemnify the insured for a judgment against him.”

Notwithstanding the reversal in *K2*, certain other states continue to apply the “estoppel” rule, namely that an insurer is estopped from raising a coverage exclusion following a breach of its duty to defend.

**Endnotes**

3.  Id. at 497.
4.  Id. at 499 (quoting Webster’s Third New International Dictionary (1993)).
5.  Id.
6.  Id.
7.  Id. at 500.
8.  Id. at 501 (emphasis added).
10.  Id. at *5.
11.  Id. at *3.
12.  Id.
15. See, e.g., Mortenson v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa., 249 F.3d 667, 672 (7th Cir. 2001) (concluding that for the purposes of interpreting a D&O insurance policy, “a penalty is a penalty is a penalty”).

16. See, e.g., Columbia Cas. Co. v. HIAR Holding, L.L.C., 411 S.W.3d 258, 267-68 (Mo. 2013) (rejecting insurer argument that award under TCPA was not “damages” as that term was used in a general liability policy, concluding that TCPA statutory damages are “remedial” rather than “punitive” in nature and are not an uninsurable “penalty”); Standard Mutual Insurance Co. v. Lay, 989 N.E.2d 591, 599 (Ill. 2013) (holding that TCPA is a “remedial and not a punitive statute” and that payments thereunder were designed as “liquidated damages” to address “compensable” injuries to fax recipients).

17. See Lay, 989 N.E.2d at 598.


20. Id.


22. Id.


37. Id. at 97-98.


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