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EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | November 2015

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A Breach of Contract is not a "Negligent Act"

An Illinois federal court has held that an underlying complaint alleging breach of contract did not allege injury arising out of "any negligent act, error or omission" necessary to trigger employee benefits liability coverage, citing the "well-recognized line of demarcation between negligent acts and breaches of contract." *Hartford Cas. Ins. Co. v. Karlin, Fleisher & Falkenberg, LLC*, 2015 WL 5766110 (N.D. Ill. Sept. 30, 2015).

A former employee of a law firm sued the firm for breach of contract and violations of the Illinois Wage Payment and Collection Act (IWPCA). The complaint generally alleged that the law firm was required to pay the former employee for his accrued vacation and sick leave when he left the firm, but that the firm did not do so. The law firm held an employee benefits liability policy that provided specified coverage for "employee benefits injury," which was defined to mean "injury that arises out of any negligent act, error or omission in the 'administration' of your 'employee benefits program.'" The insurer denied coverage on several grounds, including that a breach of contract is not a "negligent act" as that term is used in insurance policies.

In the ensuing coverage litigation, the court granted the insurer's motion for summary judgment, holding that the insurer owed no duty to defend or indemnify against the underlying complaint.

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Tenth Circuit Holds that Implied Duty to Investigate and Initiate Settlement Negotiations Does Not Extend to Excess Insurer

The United States Court of Appeals for the Tenth Circuit has held that while a primary insurer may owe its insured a duty to initiate settlement discussions under Oklahoma law, that duty does not extend to an excess insurer prior to exhaustion of the underlying coverage. *SRM, Inc. v. Great Am. Ins. Co.*, No. 5:11-CV-01090-F (10th Cir. Aug. 25, 2015).

After a train collided with a dump truck, killing the truck driver and causing the train to derail, three train workers sued the trucking company and its primary auto liability insurer, as well as the railroad. The railroad and the trucking company then asserted cross claims against

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Coverage for DOJ Investigation Not Barred Because No Way to Determine Whether There Was Substantial Overlap with Earlier Lawsuits

A federal court in California has held that an investigation did not relate back to earlier lawsuits against the insured, nor was coverage barred by the policy's prior or pending litigation exclusion, because the investigation was "shrouded in secrecy," and it was therefore impossible to determine whether the investigation or allegations arose out of or were based upon the prior litigation. *Millennium Labs., Inc. v. Allied World Ins. Co.*, 2015 WL 5772653 (S.D. Cal. Sept. 30, 2015). The court further held that the policy's regulatory claim sublimit did not apply because the investigation involved allegations of other wrongful acts.

The insured medical diagnostics laboratory was served with several subpoenas by the U.S. Department of Justice (DOJ) regarding a wide variety of potential health care offenses, including allegations that the insured had violated HIPAA and had conspired with health care providers to submit false or fraudulent claims to federal health care programs for reimbursement. An attorney for the DOJ also sent a letter stating that the agency was conducting a joint criminal and civil investigation of the insured company and its officers. The insured submitted the subpoenas for coverage under its D&O policy. Before the

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Coverage Barred by Prior Litigation Exclusion, Regardless of Insured's Actual or Reasonable Belief About Pre-Policy Demand Letter

A federal court in Florida has held that a prior or pending litigation exclusion in a claims-made policy applied where, prior to the inception of the policy, a member of the insured limited liability company sent a letter to another member demanding distributions and threatening to file a lawsuit. *U.S. Liab. Ins. Co. v. Kelley Ventures, LLC*, 2015 WL 5827903 (S.D. Fla. Sept. 30, 2015). The court granted the insurer's motion for summary judgment even though there was a material dispute of fact as to whether the member subjectively and/or reasonably believed that a claim had been made against the insured LLC prior to the policy period.

When applying for a corporate D&O liability insurance policy, a member owning 50 percent of the insured venture limited liability company (insured member) answered "no" to the question whether any person or entity was aware of any fact that might result in a claim against the insured or any of its officers or directors. Prior to filing the application, however, the member who owned the other half of the insured LLC (claimant member) sent several letters demanding equal distributions from the LLC and threatening to file a lawsuit. The claimant member subsequently filed the underlying lawsuit against the LLC and the insured member during the policy period.

The insurer denied coverage and filed a lawsuit seeking (1) rescission of the policy due to a material misstatement on the application, or, in the alternative, (2) a declaratory judgment that several provisions in the policy, including a prior or pending litigation exclusion, barred coverage.

On the insurer's motion for summary judgment, the court held that coverage was barred by a prior or pending litigation exclusion, which barred coverage for any "pending or prior … claim [or] demand … of which an Insured had written notice before the inception … of th[e] Policy." According to the court, the claimant member's letters made detailed demands for distributions from the LLC prior to the policy period, and the exclusion thus applied regardless of whether the insured member subjectively or reasonably believed that the nature of the claims had changed over time.

As a separate and independent reason for granting summary judgment, the court also held that a "Percentage Shareholder Exclusion" for claims brought by an owner of more than 10 percent of the LLC's shares applied to bar coverage. In so holding, the court rejected the argument that the exclusion did not apply to the claimant member because he allegedly brought

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Claim Asserting Innocence in Alleged Copyright Infringement "Arises Out of" Copyright Infringement and Triggers Exclusion

Applying Massachusetts law, the United States District Court for the District of Massachusetts has held that a policy exclusion for injury "arising out of" copyright infringement bars coverage for a lawsuit alleging that the claimant infringed the insured's software copyrights, even in the absence of a claim for infringement by the insured. *PTC, Inc. v. Charter Oak Fire Ins. Co.*, 2015 WL 5005796 (D. Mass. Aug. 21, 2015).

A software company's licensee filed suit, alleging that the company had engaged in the unauthorized monitoring and use of the licensee's confidential electronic information and made false accusations regarding copyright infringement. In response, the insured company filed a counterclaim alleging copyright infringement. The company sought coverage for the licensee's claim under a general liability policy that provided coverage for the company's "personal and advertising injury." The insurer denied coverage pursuant to an exclusion for "personal injury . . . arising out of any actual or alleged infringement or violation of . . . copyright [laws]." The company filed suit against the insurer, arguing that the exclusion did not apply because the licensee's complaint did not allege copyright infringement by the company.

The court sided with the insurer, holding that the exclusion barred coverage for the licensee's claim. According to the court, the "arising out of" language in the exclusion was sufficiently broad to include personal injury arising out of alleged infringement by a third party, rather than the insured. The court found that the licensee's allegations about the company's copyright-related scheme were within the language of the exclusion, despite the absence of a claim against the company for copyright infringement. ■

Exclusions Bar Coverage Under Employee Benefits Liability Policy for Claims Arising From Alleged Underfunding of Pension Plan

The United States District Court for the District of Minnesota, applying Minnesota law, has held that certain policy exclusions apply to bar coverage under an employee benefits liability policy for claims arising from the insured's alleged underfunding of its employees' pension plan (Plan) and failure to disclose information regarding the funding of the Plan and payment of projected benefits. *Publishing House of the Evangelical Lutheran Church in America v. Hartford Fire Ins. Co.*, 2015 WL 5472730 (D. Minn. Sept. 16, 2015).

The insured, a nonprofit corporation, sought coverage under the employee benefits liability coverage in its general liability policy for the underlying litigation brought by a class of participants and beneficiaries in the Plan. The employee benefits liability insurer denied a duty to defend. After settling the underlying litigation, the insured filed a declaratory judgment action seeking a declaration that the insurer had a duty to defend and indemnify.

In granting the insurer's motion for summary judgment, the court first held that the underlying complaint triggered the insuring agreement of the employee benefits liability coverage, which provided coverage for "damages" that the insured was obligated to pay because of "injury that arises out of any negligent act, error or omission in the 'administration' of your 'employee benefits programs.'" The court held that, while the allegations in the underlying complaint did "not use negligence or negligence-like language, they also [did] not allege that the conduct was intentional and [did] not foreclose the possibility of negligence," and thus, "the allegations raise[d] an arguable possibility of negligence." The court also held that the allegations concerned the "administration" of the Plan in that the allegations "involve[d] non-discretionary acts, such as the handling of Plan-related communications and the calculation of projected benefits."

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Missouri Appeals Court Affirms That Insolvency Exclusion Bars Indemnity Coverage for Refusal to Pay

The Missouri Court of Appeals has affirmed summary judgment in favor of an insurer, holding that a policy's insolvency exclusion barred indemnity coverage where facts established in the underlying arbitration established that the claim involved the refusal to pay benefits to the insured's client by two investment trusts that the insured had recommended as investment vehicles to the client. *Arch Ins. Co. v. Sunset Fin. Servs., Inc.*, 2015 WL 5704506 (Mo. Ct. App. Sept. 29, 2015).

The insurer issued an E&O insurance policy that contained an exclusion which provided that the policy did not apply to any claim "based upon, arising out of or in any way involving insolvency, receivership, conservatorship, liquidation, bankruptcy, inability or refusal to pay of any organization, entity or vehicle of any kind . . . in which [the insured] has placed or recommended to be placed the funds of a client or account" (Insolvency Exclusion).

The policyholder advised a client to invest in multiple Real Estate Investment Trusts (REITs) to supplement his disability income. After two of the REITs suspended distributions and limited shareholders' ability to redeem their investments, the client initiated arbitration proceedings against the insured. The insurer defended the policyholder subject to a full reservation of rights. After the arbitrator issued an award against the policyholder in favor of the client, the insurer filed a lawsuit seeking a declaratory judgment that it owed no duty to indemnify the insured based on the application of the policy's Insolvency Exclusion. The trial court granted summary judgment to the insurer, concluding that the Insolvency Exclusion barred coverage because the REIT's suspension of payments to the client gave rise to the client's claim against the insured.

On appeal, the insured argued that the Insolvency Exclusion was inapplicable because the client had not specifically alleged in the arbitration complaint that the REITs were unable or refused to pay, but had accused the insured of recommending

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Insurer Breaches Duty to Defend by Interpleading Limit

A California federal district court has held that an insurer did not properly interplead its remaining policy limits because the amount subject to competing claims was less than the total amount interpled. *Doublevision Entm't, LLC v. Navigators Spec. Ins. Co.*, 2015 WL 5821414 (N.D. Cal. Oct. 6, 2015). Further, because interpleading the remaining policy limits caused the carrier to cease funding defense of an underlying claim, the court determined that the insured had breached its duty to defend.

The insureds, an escrow company and its principal, were sued by a number of customers for mishandled escrows. They tendered those suits under a "wasting limits" E&O policy, which began to pay for their defense. While the litigation was pending, other customers filed administrative complaints with the California Department of Corporations, which conducted an investigation and ultimately found a shortage of nearly $200,000 in the company's accounts. The Department of Corporations later moved to appoint a receiver to liquidate and wind up the business, and the order on that motion granted the receiver the authority to receive "any insurance proceeds which may provide coverage for the shortage in any escrow accounts."

The E&O policy stated that the insurer was "not obligated … to continue to defend any claim after the applicable limit of liability has been exhausted by the payment of damages or claim expenses … or after the [insurer] has deposited the remaining available limit of liability into a court of competent jurisdiction …." Realizing that the various claims were likely to exhaust its policy limit, the insurer first attempted to tender the policy limits to the insureds, but it received a letter from an enforcement attorney at the Department of Corporations informing the insurer that doing so might violate the order appointing a receiver of the insured company, inasmuch as the shortage of nearly $200,000 had not yet been satisfied.

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Reimbursement of Defense Costs at Panel Rate Does Not Constitute Irreparable Harm for Preliminary Injunctive Relief

The United States District Court for the Southern District of New York court has held that an insurer's reimbursement of only a portion of the full amount of defense costs sought by an insured under a duty to advance policy does not constitute irreparable harm for purposes of preliminary injunctive relief. *Stuckey v. Nat'l Union Fire Ins. Co. of Pittsburgh*, 2015 WL 5547441 (S.D.N.Y. Sept. 17, 2015). The court also found that the insured was not entitled to injunctive relief allowing him unlimited settlement authority because the insurance policy provided that the insurer had the right to associate with the insured in settlement discussions and to consent to settlements.

In the underlying case, an employee of a university brought causes of action for sexual harassment and assault and battery against her supervisor, a former dean, as well as against the university. The university tendered a notice of claim to its insurer under a Manuscript NFP Individual and Organization Insurance Policy. The insurer reserved its rights to deny coverage. The individual insured, unaware of the policy and the possibility of coverage, retained his own defense counsel and paid the cost of defense for over three years until the insurer contacted the individual insured's defense counsel seeking copies of invoices. The insurer, after an invoice review, concluded that several categories of fees were not covered, that the individual insured was being indemnified by the university, and that he was therefore not entitled to immediate reimbursement of defense costs.

The individual insured sought a preliminary injunction against the insurer to have all of his prior and future defense costs reimbursed and either to force the insurer to start settlement negotiations with the claimant in the underlying sexual harassment case or to allow the individual insured to engage in settlement discussions on his own. After the individual insured brought the coverage litigation, the insurer agreed to reimburse a portion of past defense costs and to advance defense costs going forward, but only up to the hourly billing rate for panel defense counsel. The insurer also took the position that other amounts incurred by the insured's defense counsel were not reimbursable.

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Insurer's Suit for Declaration that Multiple Claims Constitute a Single Claim Must Await Resolution of Insured's Liability

A federal district court in Alabama has dismissed as "premature and unripe" an insurer's suit for a declaration that multiple claims against its insured pharmacist constituted a single claim because the pharmacist's liability in each case had not yet been established. *Am. Cas. Co. of Reading, Pa. v. Allen*, 2015 WL 5693598 (N.D. Ala. Sept. 29, 2015).

Numerous individuals allegedly were exposed to a deadly blood infection, which was believed to have originated from medication that was compounded by a single pharmacy. Multiple lawsuits by exposed patients or, in the cases of those who died from the infection, by their survivors against the pharmacy followed.

The pharmacist was insured under a healthcare providers' professional liability insurance policy, which provided for a single limit of liability of $1 million and an aggregate limit of liability for all claims of $3 million. Under the terms of the policy, "related claims" against an insured were considered a single claim, subject to the single claim limit of liability of $1 million. The Policy defined "related claims" to mean all claims arising out of a single act, error or omission or arising out of acts, errors or omissions that are logically or causally connected by any common, fact, circumstance, situation or decision.

The insurer filed suit against the insured, seeking a declaration that the multiple claims against the pharmacist constituted a single claim under the policy such that only the $1 million single claim limit of liability applied. In bringing the action and opposing the insured's motion to dismiss, the insurer argued that, in order to fulfill its contractual

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Policies Do Not Provide Coverage for Claim Stemming from Pre-Continuity Date Subpoena and Acts of Subsidiary Prior to Acquisition by Insured

A Louisiana intermediate court of appeals has affirmed a district court's holding that the insurance policies at issue covered only those wrongful acts that occurred after the dates the policies were issued and that a letter from the U.S. Department of Labor stating that it was conducting an investigation and attaching a subpoena constituted a "claim" that was required to be reported during the policy period in which it was made. *Bilyeu v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 2015 WL 5714557 (La. Ct. App. Sept. 30, 2015).

The plaintiffs were trustees and shareholders in their company's employee stock ownership plans. They approved, as trustees on behalf of the plan, the sale of their shares to the plan in three transactions, the last of which was in July 2004. After an acquisition, the company's new owners purchased claims-made-and-reported fiduciary liability and D&O liability policies beginning in July 2005. The company also purchased excess coverage on the fiduciary policy beginning in October 2006 and on the D&O policy beginning in December 2007.

The plaintiffs received a letter from the Department of Labor in September 2007 stating that it was conducting an investigation and attaching a subpoena seeking documents related to the company and the plans. The Department asked the plaintiffs to sign tolling agreements in April 2008, four months after the end of the 2006-07 policy period. After the plaintiffs tendered the claim, the primary and excess insurers denied coverage. The plaintiffs then filed a declaratory judgment action against both insurers, and the district court granted summary judgment for the insurers.

The court of appeals affirmed. The court held that a provision in the fiduciary policy barring coverage for wrongful acts committed or allegedly committed by an insured before the time that insured became an insured and before a sponsor

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Contractual Liability Exclusion Bars Coverage for Negligence Claim

The United States Court of Appeals for the Eleventh Circuit has held that coverage was precluded for a negligence claim because the claim arose out of the insured's contractual liability and was thus barred by the contractual liability exclusion contained in the D&O policy. *Bond Safeguard Ins. Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, 2015 WL 5781002 (11th Cir. Oct. 5, 2015). In so holding, the court held that there was a sufficient causal connection between the negligence claim and the insured's contractual liability to enforce the unambiguous terms of the exclusion.

The insured, a real estate development company, was issued a directors, officers, and private company liability insurance policy by the insurer. The policy contained a contractual liability exclusion precluding coverage for "Loss in connection with a Claim made against an Insured . . . alleging, arising out of, based upon or attributable to any actual or alleged contractual liability of the Company or any other Insured under any express contract or agreement." In 2008, the insured halted work on various improvement projects covered by bonds, and a surety was forced to pay to settle the bonds. The surety brought suit against the insured, alleging breach of contract and negligence. The insured ultimately settled with the surety by assigning its rights under the D&O policy to the surety. The surety amended its complaint to include only one count of negligence and demanded indemnification from the insurer. The insurer denied coverage pursuant to the terms of the contractual liability exclusion. The district court ruled in favor of the insurer, holding that the language of the contractual liability exclusion was unambiguously broad and precluded coverage for the negligence claim.

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each other. In addition to its primary insurer, the trucking company notified its excess insurers of the claim. The excess insurer proceeded to monitor the case for potential exposure under its umbrella policy.

A year into the primary insurer's defense of the trucking company and without a settlement offer from the claimants, the trucking company demanded that its primary insurer and the excess insurer tender their liability policy limits of $1 million and $5 million, respectively, to settle the case. The primary carrier responded that it was prepared to offer its limit to the railroad to settle that claim or tender its limit to the trucking company and the excess carrier for their use in negotiating a settlement with the railroad and/or other claimants. The excess carrier, however, declined and instead "urged an aggressive defense." After losing its cross-claim and what it believed to be its best defense on pre-trial motions, the trucking company renewed its demand of policy limits to settle. The excess insurer again declined that request, contending that it required additional discovery to properly evaluate the claims.

The parties subsequently agreed to mediation. At the time, defense counsel for the trucking company estimated the insured's potential exposure to be between $4 million and $7 million. The excess insurer estimated economic damages at approximately $8 million, but believed that a likely jury award would be between $2 million and $4.65 million. The claimants initially demanded $20 million at the mediation, but later agreed to settle for $6.5 million. The settlement was funded by $1 million from the primary carrier and $5 million from the excess insurer. The trucking company paid the remaining $500,000.

The trucking company then brought suit against the excess insurer, contending that the excess insurer breached the parties' insurance contract and the implied covenant of good faith and fair dealing by failing proactively to investigate the claims, failing to initiate settlement negotiations and forcing the trucking company to pay $500,000 out-of-pocket to settle. On appeal from the entry of summary judgment in favor of the insurer, the Tenth Circuit explained that while Oklahoma law makes clear the implied duty of a primary insurer to "initiate settlement negotiations" if "an insured's liability is clear and injuries of a claimant are so severe that a judgment in excess of policy limits is likely," Oklahoma courts have yet to decide how this duty applies to an excess insurer whose contractual duties to its insured are not triggered until the primary insurer's policy limits have been exhausted. The court then proceeded to predict how the Oklahoma Supreme Court would decide the question. In doing so, the court focused on the language of the contract and concluded that the excess policy was unambiguous in providing that the excess insurer's contractual duties to investigate, settle or defend claims against its insured did not kick in until the primary insurer exhausted its policy limits by actually paying claims. In this regard, the court found that exhaustion did not occur here until both insurers simultaneously paid their respective limits at settlement. In other words, according to the court, at the same time the excess insurer's contractual duties to the trucking company took effect, those duties were fully discharged by paying its policy limits towards settlement.

In upholding the judgment in favor of the insurer, the court rejected the trucking company's efforts to "sidestep the policy it agreed to" by suggesting that the duty of good faith and fair dealing is an implied duty, independent of the policy language, applied equally to all insurers. Instead, the court explained that excess insurers have "a reasonable economic expectation," and it would be inappropriate for a court "to alter [those] obligations and economic expectations, which are rooted in the unambiguous terms of its contract with [its insured]." The court noted, however, that a key factor in its conclusion was that the claimants made no settlement offers or demands until the mediation, nor did the primary insurer negotiate a settlement that the excess insurer refused to join; rather, the demand came from the insured's separately retained counsel. ■

A Breach of Contract is not a "Negligent Act" *continued from page 1*

The court noted the "well-recognized line of demarcation between negligent acts and breaches of contract," concluding that a breach of contract does not sound in negligence. Additionally, the court determined that an "intentional policy determination, including the establishing of a vacation or sick pay policy, is not a negligent act."

The complaint alleged a cause of action for violation of the IWPCA, which the insured argued sounded in negligence and therefore triggered a duty to defend. The court agreed that "[a] violation of the IWPCA need not involve an intentional act." However, the court nonetheless held that "even the IWCPA sounds in contract, not in negligence," the defendants' decision not to follow their alleged policy of paying accrued sick leave was not a "negligent act." ■

Coverage for DOJ Investigation Not Barred Because No Way to Determine Whether There Was Substantial Overlap with Earlier Lawsuits *continued from page 2*

inception of the policy, the insured had been named as a defendant in several *qui tam* and private lawsuits alleging that it had encouraged health care providers to submit false or fraudulent claims to health insurers and had provided unlawful kickbacks.

In this coverage action, the court first considered whether the DOJ investigation constituted a claim under the policy. The policy's definition of claim included a formal civil or criminal investigation of any insured person commenced by the issuance of a subpoena. The court found that the DOJ investigation fell within this definition, even though the subpoenas were issued to the insured entity, because the DOJ's letter explained that the investigation included the insured's officers.

The insurer argued that there was no coverage for the DOJ investigation because it was "related" to the earlier competitor and *qui tam* actions, which were pending prior to the inception of the policy, and therefore was not a claim first made during the policy period. Although the court acknowledged that there might be similar allegations in the DOJ investigation and the earlier lawsuits, it found no evidence that the investigation arose out of, resulted from, or was in consequence of the same or related facts, circumstances, situations, transactions or events as the lawsuits, as required by the policy's "related claims" definition.

Likewise, the court found that the policy's prior or pending litigation exclusion, which excluded coverage for any claim alleging or derived from the same or essentially the same facts, or the same or related wrongful acts, as alleged in litigation pending prior to the policy period, did not bar coverage. The court concluded there was no way to determine whether there was substantial overlap between the earlier lawsuits and the DOJ investigation sufficient to trigger the exclusion because the investigation was "shrouded in secrecy" and included broad, non-specific allegations. Nor was the fact that the DOJ had requested copies of documents filed in the prior lawsuits dispositive.

Finally, the insurer argued that the policy's $100,000 sublimit for regulatory claims should apply. The court recognized that an argument could be made that the DOJ subpoenas were a claim for regulatory wrongful acts, as defined by the policy, including the insured's alleged fraudulent activities in connection with federal health care programs. However, the court found that the DOJ's letter expanded the claim to include more, including breaches of duty, misstatements or misleading statements, and violations of HIPAA, which fell within the policy's company claims coverage or HIPAA claims coverage. Accordingly, the court held that the insurer was liable for the policy's full $5 million limit of liability. ■

Coverage Barred by Prior Litigation Exclusion, Regardless of Insured's Actual or Reasonable Belief About Pre-Policy Demand Letter *continued from page 2*

the suit as a tenant against his landlord, rather than as a member against its LLC.

The court found a material dispute of fact remained as to whether the insured member subjectively or reasonably believed that the claimant member was asserting a potential claim against the LLC prior to the policy period. The court therefore declined to rescind the insurance policy as a matter of law because the insured member might have subjectively believed there was not a claim against the LLC when completing the application for insurance. For the same reason, the court also denied the insurer's motion for summary judgment on the issue whether coverage was precluded by the "Full Prior Acts Coverage Provision," which stated that coverage would not apply to claims based on wrongful acts prior to the inception of the policy that the "persons signing the Application had knowledge, or otherwise had a reasonable basis to anticipate." ■

Exclusions Bar Coverage Under Employee Benefits Liability Policy for Claims Arising From Alleged Underfunding of Pension Plan *continued from page 3*

Despite concluding that the underlying complaint triggered the employee benefits liability coverage, the court ultimately held that coverage was barred by two exclusions in the policy. The court first held that an exclusion barring coverage for the "failure of any investment or saving program to perform as represented by an insured" applied to preclude coverage based on the "allegations seek[ing] liability based on the fact that the Plan did not turn out to be as secure as [the insured] claimed and did not produce the benefits projected by [the insured]."

The court next held that coverage was barred by an exclusion precluding coverage for claims for "[t]he failure of any insured to: (1) [p]erform any obligation; [or] (2) [f]ulfill any guarantee; with respect to . . . [t]he payment of benefits under any 'employee benefits program' . . . [or t]he providing, handling or investing of funds relating to any of these." The court recognized that "[t]he first two phrases of [the exclusion] are satisfied because the underlying complaint alleges that [the insured's] failure to disclose was a failure to perform a fiduciary duty" and that a "fiduciary duty is an obligation." The court next ruled that the "allegations seeking liability for [the insured's] failure to disclose information regarding contributions, funding, and the payment of benefits fall within the operative language of [the exclusion]." ■

Missouri Appeals Court Affirms That Insolvency Exclusion Bars Indemnity Coverage for Refusal to Pay *continued from page 4*

unsuitable investments, which allegation did not trigger the exclusion.

The appellate court rejected the insured's argument, holding that, for purposes of the duty to indemnify, the court was not limited to considering only the allegations in the client's arbitration complaint, but could consider the arbitration proceeding in its entirety. The court further concluded that, based on the Insolvency Exclusion's expansive, "in any way involving" lead-in language, the provision does "not require proof of a causal connection" between the refusal to pay and the underlying claim.

Applying the exclusion to the circumstances presented, the court held that Insolvency Exclusion barred coverage because the facts, as established at the arbitration, clearly indicated that the client's claims "were based upon, arose out of, or at least 'involved' the REITs' refusal to pay." In so holding, the court noted that its decision was aligned with "most jurisdictions," which reject the argument that the claimant specifically must allege insolvency or a refusal to pay in order to trigger the Insolvency Exclusion. ■

Reimbursement of Defense Costs at Panel Rate Does Not Constitute Irreparable Harm for Preliminary Injunctive Relief *continued from page 5*

The court denied the plaintiff's motion for a preliminary injunction. The court acknowledged that courts applying New York law have held that irreparable harm could result from a complete failure to advance defense costs. The court held, however, that there was no irreparable harm under the circumstances because the plaintiff was already receiving partial payment. The court also found that the individual insured was not entitled to injunctive relief giving him unlimited settlement authority under the terms of the university's insurance policy, which expressly allowed the insurer to associate with the insured in settlement discussions and to consent to any ultimate settlement. ■

Insurer Breaches Duty to Defend by Interpleading Limit
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The insurer then filed a complaint for interpleader and deposited the balance of the policy limit, or nearly $500,000, into the registry of the court. The insurer did not name any of the private claimants as parties to the interpleader suit, however, and it instead named only the company insured and the Department of Corporations. (An amended complaint later added the individual insured and the receiver as defendants.) In the interim, the insurer ceased payment of fees for the insureds' defense counsel, and their counsel withdrew shortly before trial was scheduled to commence.

The private suits were later settled with the interpleader funds, with the exception of one case. In that case, the plaintiff prevailed against the insureds, obtaining a judgment in excess of the insureds' policy limit. The plaintiff subsequently took an assignment of the insureds' claims against their insurer and brought suit against the insurer based on its alleged breach of the duty to defend. Pursuant to a Rule 50 motion, the trial court held that the insurer breached its duty to defend by interpleading the full policy limit (and ceasing to defend the insureds) rather than simply interpleading the nearly $200,000 at issue between the insureds and the Department of Corporations. The court later entered judgment against the insurer.

The insurer subsequently moved for judgment as a matter of law in its favor, asserting that the insureds had no claim against it to assign. The court rejected that motion, concluding that the prior ruling properly held that the insurer breached the duty to defend. In so ruling, the court stated that the policy "should be read as erasing the duty to defend only to the actual extent that conflicting claims are pending (and identified in the interpleader complaint)." Here, the court noted, the conflicting claims identified in the complaint—those asserted by the receiver and the Department of Corporations—were less than $200,000, so it was an error for the insurer to deposit the policy limit (which totaled close to $500,000 by that time) with the court. The court ruled that the insurer breached its duty to defend by failing "to keep the oxygen flowing" to the insured in the form of defense costs in connection with the other claims. The court also rejected the insurer's argument that it later "cured" defects associated with its failure to name the private claimants in its interpleader action, noting that the insurer's initial breach "left its insurers gasping for air for months, through the start" of the trial that ultimately led to the excess judgment against it. As such, the court determined that the insurer had not properly exhausted its policy limit, and thus that it breached its duty to defend by refusing to pay additional defense expenses after it had improperly impleaded its policy limit in the interpleader action. ■

Insurer's Suit for Declaration that Multiple Claims Constitute a Single Claim Must Await Resolution of Insured's Liability *continued from page 5*

duties with regard to settlement, the insurer needed to know whether to evaluate its potential exposure in terms of whether the $1 million or $3 million limit of liability applied.

The court rejected the insurer's position, first finding that the insurer's purported inability to negotiate a settlement of the underlying claims based on its lack of a court order that the underlying claims are, or are not, related does not constitute a legal and concrete injury. The court pointed out that the insurer could in fact consider its "potential" exposure of $3 million in settlement negotiations without the declaratory judgment action, adding that the United States Court of Appeals for the Eleventh Circuit has noted that "advisory relief is unavailable through the declaratory judgment procedure" when an insurer seeks "a hypothetical advisory opinion to assist it in its ongoing settlement negotiations."

Next, the court held that even if there was an injury to address, the issue of whether the claims against the pharmacist were related was not ripe for resolution. In this regard, the court rejected the insurer's argument that the relatedness issue could be determined by the pleadings alone, pointing out that although the bare allegations of the complaints may trigger the duty to defend, the duty to indemnify does not arise out of the duty to defend, and therefore must be analyzed separately. Further, the court explained that whether claims are related for the purposes of determining policy limits requires a finding of the proximate cause of the insured's liability for each claimant's injury. According to the court, under Alabama law, claims that are based on the same cause are "related," but if the cause of injury is not the same for each, the claims are not related. ■

Contractual Liability Exclusion Bars Coverage for Negligence Claim *continued from page 6*

The Eleventh Circuit affirmed, holding that coverage for the negligence claim was precluded by the terms of the contractual liability exclusion contained in the D&O policy. In so holding, the appellate court noted that, while Florida courts had not interpreted the precise language of this exclusion, Florida courts interpret the term "arising out of" to require a causal connection or relationship that is more than a mere coincidence. Accordingly, the court concluded that "the alleged negligence and misrepresentations, which form the basis of the tort claim, had a clear nexus to the development contracts, and the tort claim is inextricably intertwined with the circumstances surrounding the development contracts." The court also noted that "resolution of the tort claim requires consideration of the losses and duties under the development contracts." The court rejected the surety's argument that its claim was pled in tort, finding that the plain language of the contractual liability exclusion did not limit its applicability to losses in connection with only claims pled in contract. ■

Policies Do Not Provide Coverage for Claim Stemming from Pre-Continuity Date Subpoena and Acts of Subsidiary Prior to Acquisition by Insured *continued from page 6*

organization became a sponsor organization applied because the claim arose from wrongful acts allegedly committed before the plaintiffs' company was acquired. The court also held that an ERISA exclusion in the D&O policy barred coverage, as did an exclusion for administrative proceedings or regulatory investigations pending before the continuity date where the insured had notice of the investigation or proceeding. The continuity date of the 2007-08 policy was in December 2007, after the Department of Labor letters and subpoenas.

The court further held that the subpoena constituted a claim under the fiduciary policy, which defined claim to include "any fact-finding investigation by the U.S. Department of Labor." Because the claim was made in September 2007, during the 2006-07 policy period, but not reported until four months after that policy expired, it was also not a claim made and reported during a single policy period. ■

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