Wiley Rein & Fielding

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The Executive Summary

Developments Affecting Professional Liability Insurers

Adelphia D&O Policies Are Property of Bankruptcy Estate; Coverage Litigation Against Directors and Officers Stayed

A New York bankruptcy court recently denied several D&O insurers' motions for relief from the automatic stay to pursue coverage litigation against Adelphia Communications Corp. (ACC) and Adelphia Business Solutions, Inc. (ABIZ). *Adelphia Comm. Corp., et al. v. Associated Elec. & Gas Ins. Servs. Ltd., et al. (In re Adelphia Comm. Corp.)*, Nos. 02-41729, 02-03282 & 02-11389, 2002 WL 31557175 (Bankr. S.D.N.Y. Nov. 15, 2002). The court also stayed the insurers' pending coverage litigation against ACC's directors and officers. The bankruptcy court, however, did grant relief from the automatic stay to five ACC directors to make a claim for payment or advancement of up to $300,000 per insured for defense costs. As a predicate for its holdings, the bankruptcy court determined that the D&O policies at issue, which provided entity coverage for securities claims to ACC and ABIZ, and their proceeds were property of the bankruptcy estate.

In March and June 2002, ABIZ and ACC, respectively, filed voluntary petitions for relief under chapter 11. Each entity continues to operate its businesses as a debtor in possession. Subsequently, in July 2002, the U.S. Department of Justice brought criminal proceedings against five Adelphia directors for conspiracy and securities fraud. The Securities & Exchange Commission also instituted a civil action against ACC and five directors seeking disgorgement of ill-gotten gains and civil penalties. Several civil lawsuits have also been filed against ACC and its directors and officers for securities fraud. In September 2002, several directors and officers of ACC requested relief from the automatic stay to permit payment or advancement of defense costs under ACC's and ABIZ's D&O policies. Thereafter, the insurers sought to rescind the policies based on fraud as to the directors and officers of ACC and ABIZ and brought a declaratory action against them. At the same time, the insurers filed a motion in the bankruptcy proceedings seeking relief from the automatic stay "to the extent necessary" to name ACC and ABIZ as additional defendants in the declaratory action. In response, ACC filed an adversary proceeding against the insurers seeking to enjoin the further prosecution of the coverage litigation pursuant to the automatic stay or, in the alternative, pursuant to the bankruptcy court's equitable powers under Section 105(a) of the bankruptcy code.

As an initial matter, the court concluded that under the circumstances of this case the automatic stay did apply to the insurance proceeds and relief from the stay was required to draw down on these proceeds. The court first noted that the policies themselves were property of the estate. Accordingly, the court denied the insurers' request for relief from the stay, reasoning that if the insurers were successful, "the policies they issued would come to an end and would from the perspective of the two chapter 11 estates be destroyed." The court also held that the automatic stay applied to the directors' request for access to the proceeds of the insurance policies. Although the court recognized that other jurisdictions have held that the proceeds of a D&O policy are not property of a bankruptcy estate, relying on *In re Cybermedica, Inc.*, 280 B.R. 12 (Bankr. D. Mass. 2002), the court found that the proceeds of the instant policies were property of ACC's and ABIZ's bankruptcy estates. The court reasoned that the corporations had a "material interest" in the proceeds of the D&O policies for their "own economic exposure" and that the estate is worth more with the D&O policies because the policies provided reimbursement and entity coverage to ACC and ABIZ. Moreover, the court focused on the fact that the maintenance of D&O insurance is essential to ACC's and ABIZ's attempt to reorganize because if the insurance was exhausted, then ACC's and ABIZ's ability to retain and attract directors and officers would be significantly impaired.

Having decided this threshold issue, the bankruptcy court refused the insurers' request to lift the automatic stay and held that the coverage litigation, including litigation against only the

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See page 2 for an index of articles, including articles on the I v. I exclusion, cooperation clause and coverage for subpoenas.

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Adelphia D&O Policies Are Property of Bankruptcy Estate

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directors and officers, is stayed, subject to reconsideration at the conclusion of the criminal proceedings. The court found that the issues in the coverage action are largely duplicative of those in the criminal prosecution. Thus, allowing the coverage litigation to proceed could potentially prejudice ACC and ABIZ because of the possibility that the directors being prosecuted might invoke their Fifth Amendment rights and that there could be questions of issue preclusion. Moreover, the court reasoned that the coverage litigation, along with all pending civil litigation, would likely be stayed on motion of the U.S. Attorney. Balancing all the relevant factors, the court determined that the prejudice to ACC and ABIZ outweighed the directors' need to litigate their entitlement to defense costs and the insurers' attempt to rescind their policies. The court did recognize, however, that "the insurers may not be criticized for failing to make payments on the D&O policies here after they have attempted, in good faith, to litigate their duty to do so."

The court, however, did grant relief to the five ACC directors to seek payment or advancement of $300,000 in defense costs per insured. Relying on *Ochs v. Lipson (In re First Central Financial Corp.)*, 238 B.R. 9 (Bankr. E.D.N.Y. 1999), the court reasoned that "at its core," a D&O policy is a "safeguard of officer and director interests and not a vehicle for corporate protection" even where the policy provides for entity coverage. Nonetheless, the court only granted relief to the five directors to seek $300,000 in defense costs per insured to preserve the proceeds of the policies for the potentially conflicting claims of coverage by the directors, the outside directors, ACC and ABIZ. ✦

For more information, please contact one of WRF's Professional Liability Attorneys at 202.719.7130

Coverage for Securities Claim Brought by Former Director Barred by I v. I Exclusion

A federal court in Florida has held that there is no D&O insurance coverage for a securities class action brought by a former director based on the insured v. insured exclusion. *Sphinx Int'l, Inc. v. Nat'l Union Fire Ins. Co.*, No. 6:01-CV-1462, 2002 WL 31319742 (M.D. Fla. Sept. 10, 2002). The court held, *inter alia*, that the lack of collusion between the underlying litigants did not foreclose the application of the exclusion.

A former director of the insured entity brought a securities class action against the insured entity and several of its directors. Thereafter, the former director solicited and recruited other shareholders to join in the litigation. The insureds sought coverage for the securities class action under a directors and officers liability policy. The insurer denied coverage based on the I v. I exclusion, which barred coverage for claims against insureds brought:

> By or at the behest of the COMPANY, or any affiliate of the company or any DIRECTOR or OFFICER, or by any security holder of the COMPANY, whether directly or derivatively, unless such CLAIM is instigated and continued totally independent of, and totally without the solicitation of, or assistance of, or active participation of, or intervention of any DIRECTOR or OFFICER or the COMPANY.

In response, the insureds filed coverage litigation.

The court rejected several arguments of the insureds in holding that the I v. I exclusion barred coverage for the securities class action. First, the insureds claimed that the exclusion did not apply because the former director who initiated the securities litigation was not a "duly" elected or appointed director and thus did not fall within the definition of "Director." Apparently, the former director had only held the position for a short period of time before the insured entity discovered that the former director was subject to a covenant not to compete and had misrepresented his experience and expertise. Defining "duly" as "properly, regularly, and according to law," the insureds maintained that the director was not "duly" appointed because his appointment was not according to law. The court rejected the insureds' construction as constrained and unreasonable, and instead held that a director is "duly" appointed if he is appointed "through regular and proper channels of corporate governance." The court also noted that the insureds had listed the former director as a former director in its applications for insurance. Accordingly, the court found that it was improper for the insureds "to keep the positive benefit under the [policies] of naming [the former director], but now want to avoid the negative implications of this designation."

The court also rejected the insureds' argument that the insurer must prove collusion to invoke the I v. I exclusion. In so holding, the court adopted in part the reasoning of Judge Posner in *Level 3 Communications, Inc. v. Federal Insurance Co.*, 168 F.3d 956 (7th Cir. 1999). The court observed that, like Judge Posner, it would not replace the contractual language of the I v. I exclusion with the rationale for the I v. I exclusion to create a standard that the exclusion only applies where the underlying action is collusive: "the original rationale underlying a legal or contractual norm does not provide a legal straightjacket." The court, however, did not adopt Judge Posner's holding in *Level 3* that coverage was barred only as to the portion of the settlement that was received by the former director. Noting that, unlike in *Level 3*, the former director initiated the securities litigation in this case, the court found that the I v. I exclusion covers the claims of all the plaintiffs in the securities litigation and not just those of the former director. The court also noted that, unlike the exclusion at issue in *Level 3*, the exclusion in this case barred coverage for any claim made at the instigation of, or with the assistance or participation of, any director or officer. Because the director in this action instigated, assisted and participated in the securities class action, the I v. I exclusion barred coverage for the entire securities class action settlement.

The court also rejected the insureds' contention that in determining coverage for defense expenses, the insurer can only look to the allegations of the underlying complaint. Under this view, the insurer had a duty to advance defense costs because the underlying complaint did not allege that the former director was a former director. This argument was rejected by the court because, unlike the cases on which the insureds relied, the policy in this case did not contain a duty to defend. The court also found that the insureds' argument that they had a reasonable expectation of coverage for the underlying litigation was without merit since Florida had rejected the reasonable expectations doctrine. Lastly, the language of the I v. I exclusion was found unambiguous. The court reasoned that although the insureds may think the application of the exclusion in this case "is unfair or unreasonable," the language of the exclusion was clear when they negotiated the policies and "they could have attempted to negotiate more favorable terms." Moreover, according to the court, the language of the I v. I exclusion does not "swallow up" the remainder of the policy because the exclusion would not apply to shareholder or derivative suits brought without the assistance of a director or officer. ✦

For more information, please contact one of WRF's Professional Liability Attorneys at 202.719.7130

"In Fact" Language Does Not Require Judicial Determination of Illegal Profiteering

The Seventh Circuit recently concluded that coverage for an action by a former client against a law firm seeking to recover payments for legal services under a void contract is barred by the personal profit exclusion contained in the law firm's professional liability policy. *Brown & Lacounte, L.L.P. v. Westport Ins. Corp*., No. 02-1425, 2002 U.S. App. LEXIS 21241 (7th Cir. Oct. 10, 2002). In so holding, the court found that the professional liability insurer was not required to prove the law firm's illegal profiteering as a prerequisite to denying coverage under the personal profit exclusion, which contained an "in fact" requirement.

An Indian tribe sued a law firm seeking the return of payments it made under a void legal services contract. The tribe maintained that legal services contract was void because the law firm failed to obtain the U.S. Secretary of the Interior's approval for the contract. The law firm sought coverage and a defense under its professional liability policy for the tribe's action, and the insurer denied coverage based on the personal profit exclusion. The exclusion provided that there was no coverage for claims "based upon, arising out of, attributable to, or directly or indirectly resulting from…any insured having gained in fact any personal profit or advantage to which he or she was not legally entitled." Coverage litigation ensued.

The Seventh Circuit found that the tribe's allegations against the law firm "comprise just the sort of claim barred by the policy's personal profit exclusion." In so holding, the court rejected the law firm's argument that the personal profit exclusion applies only to individual insured lawyers of the firm and not the firm itself because the exclusion refers to personal profit or advantage "to which *he or she* was not legally entitled." The court reasoned that because the term "insured" includes the law firm, "the most natural and reasonable interpretation" of the personal profit exclusion is that the law firm is included with the meaning of "any insured."

The court also rejected the law firm's argument that the insurer could not invoke the exclusion to deny coverage without first litigating the underlying allegations and proving that the law firm illegally profited. The court first reasoned that the law firm's interpretation would render the exclusion meaningless because the insurer "could never use it to exclude a claim until it defended the underlying action." Second, the court observed that policy interpretation involves questions of law and not fact. Therefore, the court found that there is no reason why it could not decide the application of the personal profit exclusion before the underlying allegations were proved. In so holding, the court distinguished *Alstrin v. St. Paul Mercury Ins. Co*., 179 F. Supp. 2d 376 (D. Del. 2002), and similar cases holding that mere allegations of receiving illegal profits were insufficient to trigger the personal profit exclusion. The court reasoned that those cases purportedly focused on whether there was "sufficient evidence in the underlying complaint to show the profits received were illegal." Because the allegations in the Indian tribe's complaint "unequivocally" allege that the law firm reaped an illegal profit, the court found that the exclusion barred coverage. ✦

Insurer Estopped From Raising Defense Unsuccessfully Litigated in Prior Case

The U.S. Court of Appeals for the Second Circuit, applying New York law, has held that an insurer is collaterally estopped from arguing that an exclusion in a legal malpractice policy precludes coverage where, in prior litigation against a different insured, a court ruled against the insurer on the same issue. *Fuchsberg & Fuchsberg, et al. v. Galizia, et al*., No. 01-7654 (2d Cir. Aug. 1, 2002).

The insured was a law firm that was sued for malpractice as a result of its failure to prosecute a claim. The law firm sought a defense and indemnification from its legal malpractice insurer pursuant to a "tail" coverage provision that afforded coverage that occurred after the effective date of the circumstances prior policy but prior to the effective date of the current policy. Tail coverage was available, however, only if, before the policy's effective date, "the Named Insured, any partner, shareholder [or] employee…had no reasonable basis to believe that the Insured had breached a fiduciary duty or to foresee that [a] Claim would be made against the Insured." The insurer denied coverage, arguing that an associate at the law firm who had handled the case had a "reasonable basis" to foresee the claim. Coverage litigation ensued.

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For more information, please contact one of WRF's Professional Liability Attorneys at 202.719.7130

Estate Representative Breaches D&O Policy Cooperation Clause

A federal district court in Kansas has held that the representative of a bankrupt entity breached the cooperation clause of a D&O policy by colluding with plaintiffs in a securities fraud action and filing an answer that admitted liability for all of plaintiffs' claims. *Youell, et al. v. Cynthia Grimes, et al.*, No. 02-2207-JWL (D. Kan. Aug. 19, 2002).

In August 1997, a state court action was filed against Stoico Restaurant Group (SRG) and its directors and officers alleging securities fraud in connection with an initial public offering. SRG tendered the defense of the action to its directors and officers liability insurer, and the insurer accepted the claim under a reservation of rights. The insurer consented to defense counsel, who ultimately negotiated a $410,000 settlement of the securities suit. Before the settlement was finalized, however, SRG filed for reorganization under chapter 11 and counsel sought approval of the settlement by the bankruptcy court.

While the motion to approve the settlement was still pending, the bankruptcy court appointed a designated representative of SRG's estate (the "Representative"). Thereafter, the Representative withdrew the pending motion, and her counsel called plaintiffs in the securities suit informing them that SRG's files contained "every smoking gun memo imaginable." The Representative's counsel then sent plaintiffs a letter reporting that "$410,000 is not an adequate amount to settle all claims" and that it "appears that an award could exceed $2 million." The Representative also informed plaintiffs that SRG's documents supported their securities fraud claims. Moreover, the Representative filed an answer in the securities suit admitting liability for the claims. After filing the answer, she agreed to settle the securities suit for $1.7 million, and sought the insurer's consent for the settlement. The insurer denied coverage for the settlement based on the Representative's breach of the cooperation clause, finding the settlement to be the result of collusion between the Representative and plaintiffs. After denying coverage, the insurer brought an action seeking a declaration that it was not liable for the settlement.

In granting the insurer's motion for summary judgment, the court determined that the cooperation clause in the D&O policy unambiguously provided that SRG could not take any action to increase the insurer's exposure under the policy. The court found that the following conduct of the Representative violated the cooperation clause: (1) withdrawing the motion to approve the settlement; (2) informing plaintiffs that their claims were viable and supported by SRG's documents; (3) filing an answer in the securities suit admitting liability; and (4) agreeing to settle the securities suit for $1.7 million. These acts, according to the court, "dramatically increased" the insurer's exposure and demonstrated the exact type of collusion that the cooperation clause is intended to eliminate. The court also found that the Representative's breach of the cooperation clause substantially prejudiced the insurer because the $1.7 settlement was more than three times the original agreement with the plaintiff and the admission of liability foreclosed the insurer from "effectively defending" the claims in the securities suit.

The court also determined that the fact that the Representative had a right to pursue claims against SRG's directors and officers for potential wrongdoing did not relieve the Representative of her obligation to cooperate under the policy. Rather, the Representative should have considered "whether the action would breach the insurance contract covering such wrongdoing" and weighed that consideration against the potential benefit of pursuing the claims. ✦

Insurer Estopped From Raising Defense Unsuccessfully Litigated In Prior Case

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The court held that the insurer was collaterally estopped from arguing that the "reasonable basis" provision precluded coverage as a result of prior litigation by the same insurer concerning the application of the same policy provision in a case with very similar facts. In the prior litigation, the insurer had unsuccessfully raised the same "reasonable basis" argument in an effort to deny coverage to a law firm that had been sued for malpractice after one of its associates had failed to file a personal injury action before the statute of limitations had run.

The Second Circuit reasoned that although the prior decision did not expressly address the proper interpretation of the "reasonable basis" provision, the decision had preclusive effect because the scope of the provision was "by necessary implication…contained in that which [was] explicitly decided." Since the insurer had clearly raised the "reasonable basis" provision in the prior litigation and the court in that case had ruled that the insurer was obligated to indemnify, the court had necessarily rejected the application of the provision under these circumstances. Accordingly, the insurer was barred from relitigating that issue in this case. ✦

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Aggregated Damages in a Class Action Suit Found Inconsistent with the PSLRA

In a case of first impression, a Pennsylvania federal court determined that class action damages based on a trading model that aggregated damages was not an acceptable method for assessing damages under the Private Securities Litigation Reform Act (PSLRA). *Robert K. Bell, et al., v. Fore Systems, Inc. et al.*, No. 97-1265 (W.D. Pa. August 2, 2002). The court has certified its order for interlocutory appeal to the Third Circuit.

The ruling on appropriate methodology for calculating damages resulted from defendants' motion in limine to exclude testimony from plaintiffs' expert witness on damages in a securities fraud class action. That witness used a damages model that calculated "aggregate damages" by multiplying the estimated number of damaged shares by the estimated artificial inflation for each day of the class period. The defendants argued that combined damages were inconsistent with the PSLRA, which mandated an individual damages limitation for each plaintiff.

"The court held that...the fact finder must determine the purchase price actually paid and sale price actually received by that plaintiff...."

The court agreed with the defendants. The applicable section of the PSLRA provides a limitation of damages whereby an "award of damages to the plaintiff shall not exceed the difference between the purchase or sale price paid or received…and the mean trading price of that security during the 90-day period beginning on the date on which the information correcting the misstatement or omission that is the basis for the action is disseminated to the market." The statute also contains a provision to establish damages for individuals who sell their shares during the 90-day "look back" period. The court noted that the text in this section of the PSLRA refers to the limitation as to each "plaintiff" rather than the "class." The court held that to apply properly the statutory mandate that a plaintiff's damages not exceed the damages limitation formula, the fact finder must determine the purchase price actually paid and sale price actually received by that plaintiff and the mean trading price of the security for the ninety-day "look back" period after the correcting information was disseminated to the market. Thus, the court concluded that "the [l]imitation on [d]amages cannot be imposed on the class as a whole, but must be applied to the circumstances of each plaintiff."

Based on this ruling, the court bifurcated the case into two phases: a class action phase and a plaintiff-specific phase. This first phase would resolve "whether each defendant (1) made a misstatement or omission of a material fact; (2) with scienter; (3) in connection with the purchase or sale of a security." The court also included in this phase the issues of whether the class members purchased securities in an open market that was affected by the misrepresentation and the tentative amount of damages per share based on the amount of inflation per share for several time segments. The court reserved for the second phase resolution of any remaining, plaintiff-specific issues, including whether the plaintiff purchased shares during the class period, whether the defendants can rebut any "fraud on the market" presumptions, and the actual damages calculation for each individual plaintiff based on the actual purchase and sale data and the "look back" period. The court stated that it anticipated that "[f]or the vast majority of the plaintiffs…Phase II proceedings will not be necessary."

The court acknowledged inefficiencies in individual determinations of damages as well as bifurcation and recognized that an appellate court may deem aggregate class damages acceptable. The court also acknowledged that its interpretation of the PSLRA "is at odds with current litigation practices" and "forthrightly admits that its proposed bifurcation of issues is based on practicalities rather than precedent." The court therefore certified its order for interlocutory appeal *sua sponte*. ✦

For more information, please contact one of WRF's Professional Liability Attorneys at 202.719.7130

No Coverage for Corporation's Defense Costs and Fees Under D&O Policy

The U.S. Court of Appeals for the Sixth Circuit, applying Ohio law, held that an insurer was not obligated to cover defense costs charged by a corporation's lawyers under a D&O policy that did not provide entity coverage where the corporation's officers retained separate defense counsel. *Telxon Corp. v. Federal Ins. Co.*, 309 F.3d 386 (6th Cir. 2002). A company and two of its officers were sued in 1992 in a class action securities lawsuit. The two officers each retained separate counsel. The applicable D&O policy provided that the insurer would "pay on behalf of each Insured Persons all Loss for which the Insured Person is not indemnified by [the company] and which the Insured Person becomes legally obligated to pay…." An Insured Person was defined in the policy as "[a]ny person who has been, now is, or shall become a duly elected director, or a duly elected or appointed officer of [the company]." The insurer provided coverage for all defense costs of the officers, but denied coverage for the defense costs incurred by the company. Coverage litigation followed.

The court ruled in favor of the insurer, reasoning that on the record it was clear that the company's lawyers were representing the company and not the officers. Accordingly, the officers were never "legally obligated to pay" the company's lawyers. The court also rejected the company's argument that it should apply the "reasonably related" rule and allow payment of the company's defense costs because they were "reasonably related" to the defense of the claims against the officers. The court noted that the Ohio Supreme court has not yet addressed the "reasonably related" rule, but concluded that the rule would not be applicable in these circumstances because the policy language was unambiguous. ✦

Wiley Rein & Fielding Expands Insurance Practice

Wiley Rein & Fielding LLP is pleased to announce the continued expansion of its pre-eminent 40-lawyer Insurance Practice with the addition of two experienced attorneys, William E. Smith and David H. Topol, who join the firm as Of Counsel.

William E. Smith rejoins the firm following a three-year period as Associate Litigation Counsel at WorldCom's Washington office, where he handled domestic and international commercial litigation, consumer class actions, and government contract litigation. At WRF, he will concentrate his practice on representing clients in complex civil litigation matters. Prior to working at WorldCom, Mr. Smith was an associate with WRF for six years and gained significant experience representing insurance carriers in coverage actions. Mr. Smith graduated *magna cum laude* from the University of Michigan Law School.

David H. Topol joins the firm with more than ten years of legal and management consultant experience. He most recently worked with McKinsey & Co. providing strategic counsel to major corporations. From 1997 to 2001, Mr. Topol served as a trial attorney in the Environmental Enforcement Section of the U.S. Department of Justice. In 1999, he received the Attorney General's award for outstanding contributions by a new employee. Mr. Topol's practice will focus on matters related to directors and officers liability insurance. After graduating from Yale Law School, where he was Executive Editor of *The Yale Law Journal,* Mr. Topol served as a law clerk for Judge A. Raymond Randolph in the U.S. Court of Appeals for the D.C. Circuit.

According to Thomas W. Brunner, head of the firm's Insurance Practice, "The addition of Bill and David increases the firm's capacity to represent some of the top insurers in the nation. Our goal is to continually recruit attorneys that offer our clients extraordinary legal services." ✦

For more information, please contact one of WRF's Professional Liability Attorneys at 202.719.7130

No Coverage for Breach of Express Contract

A federal district court, applying Pennsylvania law, has held that an insurer was not obligated to defend its insured under an E&O policy for the insured's breach of an express contract. *Miziker Entm't Group, Ltd., et al. v. Clarendon Nat'l Ins. Co. et al.*, No. 01-3219, 2002 U.S. Dist. LEXIS 19391 (E.D. Pa. Oct. 1, 2002).

The insured, an entertainment company, contracted with the Delaware River Port Authority to produce a "sound and light" show on the Delaware River to celebrate the new millennium. The show was cancelled when subcontractors hired by the entertainment company failed to build proper barges to support the show. The Port Authority then sued the entertainment company, alleging breach of contract, breach of the implied covenant of good faith and fair dealing and negligence. The insurer initially agreed, under a reservation of rights, to undertake the investigation and defense of the claims against the entertainment company, and provided the company with defense counsel rates, requested that the company file an answer to the complaint and provided the insured "General Litigation Guidelines." Three days after providing this information, however, the insurer informed the company that insurance coverage was not available because the underlying claim involved the breach of an express contract. The entertainment company subsequently instituted a coverage action, relying on a policy provision obligating the insurer to pay damages for claims against the insured for "[b]reach of contract limited to those which are implied in fact or in law, resulting from the alleged submission of program, musical or literary material used by the Insured in the Insured Production; committed… by the Insured… in connection with the creation, production, distribution, exhibition, broadcasting, advertising or publicizing the Insured Production." The entertainment company argued that its contracts with the subcontractors were implied in law and in fact for the Port Authority's benefit.

The court, in rejecting the company's argument, first noted that the intent of the relevant provision was to insure against unauthorized uses of another's intellectual property in the entertainment field. The court distinguished such intellectual property violations from the present case, noting that the allegations against the entertainment company did not involve the unauthorized use of "program, musical or literary material," but instead concerned allegations against the insured for breach of an express contract.

The court also held that, in any event, there was no implied contract. The court summarily rejected the argument

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First Circuit Holds No Coverage for Complying with Subpoena

A federal appellate court, applying Massachusetts law, has held that a nonprofit organization liability policy does not cover costs incurred by an insured to comply with an investigative subpoena. *Center for Blood Research, Inc. v. Coregis Ins. Co.*, 305 F.3d 38 (1st Cir. Sept. 30, 2002).

The U.S. Attorney for the District of Massachusetts served an investigative subpoena on the Center for Blood Research, Inc. (Center). The Center sought a defense from its insurer to comply with the subpoena under a nonprofit organization liability policy, but the insurer denied coverage. After complying with the subpoena, the Center sued the insurer, seeking recovery of its expenses, statutory damages and attorneys fees under the policy's nonmonetary claims endorsement. That endorsement provided that the insurer "shall have the right and duty to defend, including the selection of counsel, any Claim against the INSURED(s) alleging, based upon or arising out of claims, demands or actions solely for relief or redress in any form other than monetary damages." "Claim" was further defined as "any judicial or administrative proceeding in which any INSURED(s) may be subjected to a binding adjudication of liability for damages or other relief."

The First Circuit held that the policy did not provide coverage for the Center's costs of complying with the subpoena because the subpoena was not a "Claim" under the policy. The court reasoned that the subpoena allowed the government to gather information and investigate; it did not subject the insured to "a binding adjudication of liability." While the court recognized that a civil or criminal proceeding could have resulted from the investigation, it pointed out that "there could not have been a binding adjudication of liability for damages or any other relief" as part of the investigation. That binding adjudication would have to be pursued in a different forum.

The court also considered whether the enforcement provisions in the subpoena justified considering the subpoena a "Claim" under the policy. That provision in the subpoena referenced the statutory authority of the government to institute court proceedings to ensure compliance with the subpoena and to punish those failing to comply. The court concluded that the enforcement provision in the subpoena did not create a "Claim" under the policy because an enforcement proceeding is instituted separately from the attorney general's investigation and is held before a judge. The court did not, however, foreclose the argument that an enforcement proceeding might constitute a "Claim" under the policy, but it noted that there had been no enforcement proceeding in this case. ✦

For more information, please contact one of WRF's Professional Liability Attorneys at 202.719.7130

Blanket Policies Provide Coverage in Excess of Limits of Project-Specific Policy

The U.S. Court of Appeals for the Fifth Circuit, applying Louisiana law, recently denied the motion to stay of Reliance Insurance Company (In Liquidation) (Reliance) and held that, under Louisiana law, an insurer's blanket policy provides coverage only for losses in excess of the limits of a project-specific policy. *Holden, etc. et al., v. Connex-Metalna Mgmt. Consulting GMBH, etc. et al.*, 302 F.3d 358 (5th Cir. 2002).

Three insurers had provided coverage to a rail marine terminal company. Reliance provided a project-specific policy, and the other two insurers provided blanket property policies that provided coverage for the same property. The insurers disputed allocation of liability for losses suffered by the terminal company following the collapse of a crane during construction of a cargo terminal. The lower court ruled that a settlement with the insured should be divided among the three insurers in proportion to their respective policy limits.

Reliance moved to stay the appeal in deference to a Pennsylvania state court orders placing it in rehabilitation and later liquidation. The court first addressed the motion to stay and held that *Burford* abstention did not divest the court of jurisdiction over the case. The court reasoned that the appeal involved no decisive issue of state law nor did it implicate any federalism concerns. Further, the court reasoned that its resolution of the appeal would not substantially interfere in the administration of the insurer's assets by state authorities since the state court handling the rehabilitation could "very well preclude enforcement of any judgment" against the insurer.

Addressing the allocation issue, the court held that, under Louisiana law, when an insured has purchased a blanket property policy that covers the same property as a policy purchased specifically for a well-defined project, the blanket policy provides coverage only for losses in excess of the limits of the project-specific policy. The court reasoned that it would be "redundant to purchase a project-specific policy that simply duplicates the coverage of the broader blanket policy." Thus, the court found here that the builder's risk policy purchased specifically for the construction project at issue provided primary coverage for the loss, and the general blanket property policies functioned merely as "excess" policies. The court noted that the decision was based on a Louisiana court of appeals ruling, which represents the minority viewed on this issue, and that the Louisiana Supreme Court has not addressed the issue. Accordingly, the Fifth Circuit specifically did not extend its "Erie guess to predict how the Louisiana Supreme Court might resolve coverage issues between general and specific policies in other contexts." ✦

Plaintiff's Subpoena of Insurance Applications from Non-Party Insurers Quashed

A federal district court, applying Illinois law, recently granted several insurers' motions to quash subpoenas for depositions and accompanying requests for documents concerning insurance applications in a securities fraud suit. *In re Anicom Inc. Sec. Litig.,* No. 00C 4391, 2002 WL 31496212 (N.D. Ill. Nov. 8, 2002).

The State of Wisconsin Investment Board (SWIB) brought a class action against the insureds alleging securities fraud and issued subpoenas for depositions and accompanying requests for documents to various insurers who had issued D&O policies to the insureds. The subpoenas and document requests concerned applications for insurance and correspondence between the insureds and their insurers. The insurers moved to quash the subpoenas. While the insurers did not dispute that they were required to supply the insurance policies, they argued that the other materials requested were not relevant to SWIB's securities claims. The court agreed and quashed the discovery requests.

The court also rejected SWIB's argument that the information was discoverable because the insurers have asserted that $10 million of the $25 million dollar insurance program was not available due to misrepresentations in the insurance applications and that this assertion had impacted settlement discussions between the parties. The court reasoned that "while SWIB may want the additional $10 million dollars to be available and may want to know the specifics of why such amount was not available, this material was not relevant to its claims against [the insureds] for securities fraud." ✦

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Dismissal and Subsequent Refiling of Action Does Not Alter Trigger Date for Claims-Made Policy

A Missouri court of appeals has held that when a lawsuit is dismissed without prejudice for failure to prosecute and subsequently refiled, the trigger of coverage under a claims-made policy is based on the date of the filing of the original suit. *Northern, et al. v. Physicians Defense Association*, 2002 Mo. App. LEXIS 1905 (Mo. Ct. App. Sept. 16, 2002).

In May 1995, plaintiff in the underlying action was born with brain damages and suffered other birth complications. In January 1997, a medical malpractice action was filed on his behalf against the insureds, a doctor and a clinic. That action was dismissed for failure to prosecute in June 1999, but was refiled in August 1999. In July 2000, a consent judgment was entered in favor of plaintiff for $14.4 million. Under the terms of a settlement agreement, the plaintiff agreed to enforce the judgment only against the insurance carriers. Thereafter, the plaintiff, standing in the shoes of the insureds, sought coverage from two professional liability insurers under consecutive claims-made policies. The first insurer provided coverage for claims made during the policy period from January 1, 1997 through December 31, 1997, with a retroactive date to cover medical occurrences after January 1, 1995. The second insurer provided coverage for claims made during the policy period from June 1, 1997 (the date the insureds canceled the first policy) through June 1, 2000, with a retroactive date to cover medical incidents occurring after May 1995. In its application for the second policy, the hospital informed the second insurer of the May 1995 incident and the January 1997 lawsuit. The plaintiff argued that the first policy applied because the refiled lawsuit constituted the same cause of action the first insurer received notice of during the policy period. The plaintiff further contended that the second policy also covered the claim because its notification of the newly refiled lawsuit to the second insurer occurred during the policy period. The court agreed with the plaintiff that the first policy applied but rejected the insureds' argument as to the second policy.

The court initially noted that, had the case not been dismissed, it was indisputable that the first policy applied because the alleged wrongful act, the subsequent January 1997 lawsuit and the insured's notice to its insurer all occurred during the first policy period. Although the court acknowledged that a voluntary dismissal of a claim renders the initial claim void, it reasoned that the dismissal had no impact because "a claims made policy is triggered when the claim is made to the insurer." Thus, because the refiled suit related back to when the original claim was made, the court determined that the first policy was triggered.

The court applied the same rationale to the second policy and concluded that the second policy did not provide coverage. The second policy provided that "[a]ll claims arising out of the same medical incident will be considered as having been made at the time the first report was made." In its application, the insureds had referenced the May 1995 incident and its notice of the claim to the first insurer. The court, relying on an Eighth Circuit case applying Missouri law in which the court held that coverage "a claims made policy is triggered when a claim is first made, but not every time a claim is made," (*Berry v. St. Paul Fire & Marine Ins. Co.*, 70 F.3d 981 (8th Cir. 1995)), held that the second claims-made policy was not triggered because the initial claim was made before policy inception of the policy. ✦

No Coverage for Breach of Express Contract

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that there was an implied contract as to an affiliate of the entertainment company that was not a party to the contract with the Port Authority because the affiliate was not a named insured under the policy. The court further rejected the argument that the entertainment company's contracts with the subcontractors were implied in law and fact for the Port Authority's benefit, reasoning that an implied contract cannot exist where an express contract exists on the same subject. The court also held that the entertainment company did not have a reasonable expectation of coverage for its activities in creating the show, reiterating that Pennsylvania law rejects an insured's reasonable expectations argument where policy terms are clear and unambiguous. Finally, the court concluded that the insurer was not estopped from denying a duty to defend based on the insurer's initial claims-handling actions, which included a letter detailing attorney rates and requesting that the insured file an answer. The court reasoned that the company had failed to offer any evidence of detrimental reliance on the insurer's initial position. ✦

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No Imputation Under Prior Knowledge Provision

A Massachusetts bankruptcy court has held that a prior acts provision in a lawyer's professional liability policy does not preclude coverage "arising from an employee's undisclosed and undiscoverable knowledge of his or her wrongdoing." *Am. Guar. & Liability Ins. Co. v. Perrone (In re Perrone)*, Nos. 97-46312-JBR & 97-04324-JBR, 2002 WL 31386029 (Bankr. D. Mass. Oct. 18, 2002).

The insured was an attorney and issuing agent for a title insurance company. In an application for malpractice insurance, the attorney represented that he was not aware of any facts or circumstances that might give rise to a claim under the proposed insurance. Unbeknownst to the insured, one of his employees had been engaging in a scheme to defraud clients by diverting funds intended to pay off mortgages and using the funds for the employee's personal benefit. The employee's long-standing scheme to defraud was not exposed until after the policy was issued. Thereafter, the insurer denied coverage based on, *inter alia*, a prior knowledge provision. Coverage litigation followed.

The insurer argued that the malpractice policy provided coverage for claims made during the policy period for pre-policy errors or omissions only when "[t]he Named Insured, any partner, [or] *employee*...had no reasonable basis to believe that the Insured had breached a professional duty or to foresee that a claim would be made against the Insured." The insurer argued that the prior knowledge provision applied because the employee who had engaged in the fraudulent scheme had a "reasonable basis to believe that the insured had breached a professional duty or to foresee that a claim would be made against the insured."

The court rejected the insurer's argument. As an initial matter, the court held that because the prior knowledge provision was contained in the coverage grant, the attorney had the duty to prove that the prior knowledge exception to coverage did not apply. In holding that the provision did not apply, the court observed that the purpose behind the provision is to ensure that the loss covered by the policy is fortuitous and not a known loss. Because the insured was not aware of the employee's fraudulent scheme, the court reasoned that the loss in question was not a known loss and that the prior knowledge provision was not implicated. Moreover, the court reasoned that it was "inconceivable" that the employee would have disclosed her fraudulent conduct to the insured even if he had asked her whether she had a reasonable belief that a malpractice claim would occur prior to completing the application. The court, therefore, refused to impute the employee's knowledge to the insured. The court concluded, despite the plain language of the policy provision, that "the prior acts provision does not preclude coverage arising from an employee's undisclosed and undiscoverable knowledge of his or her own wrongdoing." ✦

Bankruptcy Court Authorizes Interim Payment of Limited Expert Costs to Directors and Officers

A Massachusetts bankruptcy court has denied an insurer's summary judgment motion, which sought assurance that it was not prohibited from paying the defense costs of the former officers and directors of a debtor in the process of liquidating, but granted its motion for leave to make an interim payment of expert costs to the officers and directors under their D&O policy. *In re Boston Regional Medical Center, Inc.*, No. 99-10860, 2002 Bankr. LEXIS 866 (Bankr. D. Mass. April 2, 2002).

A medical center filed for bankruptcy under chapter 11. Subsequently, the bankruptcy court confirmed a Joint Liquidating Plan of Reorganization pursuant to which all property of the bankruptcy estate was revested in the debtor and was to be liquidated for benefit of the creditors. As part of the liquidation, the unsecured creditors sued some of the medical center's officers, directors and trustees for acts they committed in their official capacities. In defending those suits, the officers, directors and trustees incurred defense costs that they contended were covered by a D&O policy with a policy limit of $20 million. The insurer was willing to provide coverage, and brought this adversary proceeding, seeking a declaration from the court that by providing coverage, "it would not be violating (a) a property interest of the [d]ebtor in the proceeds and (b) injunctions (contained in the [reorganization] plan and in the order confirming it), including the automatic stay."

The medical center argued that the aggregate claims for coverage exceeded the policy limit and, thus, payment of the officers' and directors' defense costs could potentially deplete the medical center's property interests by reducing the amount available to pay potential claims for indemnification. The insurer contended that the debtor has no interest in the proceeds because the defense costs that the insurer sought to pay were among the claims for which the officers and directors would seek indemnification coverage. Thus,

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Insured Must Prove That Claim Falls Within Coverage Grant To Trigger Duty to Defend

New York's highest court has held, *inter alia*, that the bodily and personal injury and the professional services exclusions in a D&O policy bar coverage for a doctor's claim against a hospital under 42 U.S.C. § 1983. The court also found that the hospital failed to meet its burden of proving that the doctor's tortious interference claim fell within the D&O policy's coverage grant. *Town of Massena v. Healthcare Underwriters Mut. Ins. Co., et al.,* No. 89, 2002 N.Y. LEXIS 2879 (N.Y. Sept. 17, 2002).

The insured, a hospital, had been sued by a doctor under 42 U.S.C. § 1983. The doctor's complaint alleged that in retaliation for his exercise of free speech, the hospital had engaged in a campaign of harassment to harm his medical reputation and to disparage him to patients. The doctor also alleged defamation and tortious interference with business relations and contract. The hospital tendered the claim to its D&O insurer under an Executive Liability and Indemnification Policy as well as to a professional liability insurer. The D&O insurer denied coverage for the doctor's claim based on a bodily and personal injury and a professional services exclusion. Thereafter, the hospital sued the insurers claiming they had a duty to defend the hospital.

The court held that the D&O insurer did not owe a duty to defend. The court reasoned that exclusions for loss arising out of "bodily injury, libel, slander, defamation of character" as well as resulting from the performance of "professional services" necessarily precluded coverage for all but the doctor's tortious interference claim, which was based on the alleged failure of three of the hospital's doctors to make referrals to the suing doctor. The insurer argued that there was no coverage for the tortious interference claim because the hospital employees' conduct occurred outside of their "insured capacity" or fell within the professional services exclusion. The court held that "[o]nce the insurance company asserted the exclusion, the [hospital] had the burden of showing that the conduct alleged was covered." The court concluded that the hospital had not made this showing and noted that the doctor's complaint did not allege that the three doctors' conduct had occurred while they were acting in their "insured capacity."

The court held that the professional liability insurer owed no duty to defend because of the broad exclusions contained in its policy. These exclusions precluded coverage for claims resulting from "any willful, fraudulent or malicious civil act," "defamation, libel, slander" and similar torts and interference with contract or prospective business advantage. ✦

Insured Must Show Prejudice from Insurer's Unreasonable Delay in Disclaiming Coverage

In an unpublished decision, the Second Circuit, applying New York law, recently held that an eight-month delay in disclaiming coverage for a valid reason is unreasonable as a matter of law, but that the insurer would not be required to provide indemnification and a defense absent a showing of prejudice. *Adams v. Chicago Ins. Co.*, No. 02-7179, 2002 WL 31398801 (2d Cir. Oct. 23, 2002).

The insurer issued a professional liability policy to the insured, an attorney. After the attorney received notification of a potential malpractice lawsuit, he informed his insurer. The insurer accepted notice of the claim under a reservation of rights, noting that the claim may not have been timely reported. The insurer then engaged in negotiations in attempts to settle the malpractice claim, although there is a dispute about how vigorously it did so. After unsuccessful communications between the insurer and the injured party, the client filed a malpractice suit against the attorney. Two weeks later, the insurer disclaimed coverage based on the untimely notice of the claim. The attorney did not dispute that the insurer had a valid coverage defense based on untimely notice. He argued, however, that the insurer was estopped claiming coverage based on its eight-month delay.

The appellate court held that the eight-month delay in asserting the late notice defense was "unreasonable as a matter of law," but remanded because the district court failed to determine whether the lawyer had been prejudiced as a result of the insurer's delay, a requisite component to establishing estoppel. The court stated that prejudice could be presumed where an insurer assumes control of the defense from the insured without reserving its rights to later assert policy defenses. Where the insurer has reserved its rights, however, the court said actual prejudice must be demonstrated. The court remanded to the district court to determine whether the lawyer had actually been prejudiced based on, among other things, the attorney's assertion that he was forced to spend time litigating issues that might have been forwarded to ADR as well as that the insurer failed to settle while there was a "residue of good will" among the parties. ✦

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Duty to Defend Arises Even If Professional Services Are Tainted with Fraud

A federal district court in New York recently held that, under New York law, an insurer had a duty to defend a law firm under a claims-made professional liability policy against allegations of fraudulent professional services. *Admiral Ins. Co. v. Weitz & Luxenberg, P.C.*, No. 02-2195(RWS), 2002 WL 31409450 (S.D.N.Y. Oct. 24, 2002).

The insured, a law firm, was sued in the underlying litigation based on facts that are not set out clearly in the opinion. The insurer provided coverage to the law firm until a series of motions to dismiss and amendments to the complaint narrowed the allegations against the law firm to tortious interference with economic advantage, tortious interference with contract, breach of contract and common law fraud. At that point, the insurer withdrew its defense, arguing that the remaining allegations, which involved "acts of extortion, backdating of documents and the like," did not involve "professional services" and were not performed by the lawyers "solely" in their capacity as lawyers. Coverage litigation followed, and the court held that the insurer had a duty to defend.

The policy defined "Professional Services" as services "rendered by [the law firm] solely as a lawyer, mediator, arbitrator or notary public for others." The policy also contained an exclusion providing that the insurer was not required to indemnify the insured for any "dishonest, fraudulent, criminal, or malicious act," but required the insurer to provide a defense for such claims.

The court reasoned that the definition of "Professional Services" did not explicitly exclude criminal, fraudulent or dishonest acts and that, construing the definition in favor of the law firm, a duty to defend existed even though the insurer would not be required to indemnify such acts. The court also rejected in part the insurer's argument that the lawyers did not perform the alleged acts "solely" as attorneys because their actions were merely "setting the stage" for non-attorney acts. The court agreed with the insurer with respect to allegations of extortionate threats and witness tampering, which it held were too far removed from performing professional services to qualify for coverage. The court reasoned, however, that allegations involving misdating pleadings, negotiating settlements and providing advice about whether to file suit despite a settlement were not "ancillary to fraud." The court concluded that "the fact that the services are alleged to be tainted with fraud does not render them not Professional Services when construing the policy in favor of the policyholder." The court further held that because the insurer had to defend against several of the allegations in the complaint, it had to defend against the entire complaint. The court also noted that, to the extent the plaintiff in the underlying lawsuit obtained restitution, no indemnification would be required because under New York law, "damages" does not include a claim for restitution of money wrongfully obtained by the insured. ✦

Nature of Claim, Not Identity of Claimant, Controls Whether Later-Filed Action Is Related to Prior Lawsuits

A federal district court, applying Texas law, has held that an insurer can deny coverage for a lawsuit that was a "related claim" to prior lawsuits, even though some of the plaintiffs in the most recent lawsuit had not been parties to the prior litigation. *Tri Core Inc., et al., v. Northland Ins. Co., et al.*, No. 3-01-CV-1431-BD, 2002 WL 31548754 (N.D. Tex. Nov. 12, 2002).

The insureds sold employee benefits plans to small businesses, and were sued for allegedly making misleading representations about the plans. Upon being sued, the insureds sought coverage under a claims-made E&O policy. The insurer denied coverage, claiming that the lawsuit was related to two prior lawsuits filed against the insureds prior to the effective date of the policy. Under the applicable policy, no coverage existed for claims or suits for which the insured had knowledge of before the inception date of the policy nor for "[a]ny claim or suit for damages in any way related to any litigation which commenced prior to the [e]ffective [d]ate of [the] policy." Coverage litigation ensued, and the court found in favor of the insurer.

The court noted that the claims asserted in the later-filed litigation at issue arose out of "wrongful acts" committed prior to the effective date of the policy that were known to

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Nature of Claim, Not Identity of Claimant, Controls Whether Later-Filed Action is Related to Prior Lawsuits

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policyholders as of the inception date of the policy. The court further noted that a comparison of the pleadings in the two prior lawsuits that were filed prior to the effective date of the policy with the complaint filed in the underlying litigation led "to the inescapable conclusion that all three cases were 'related'…Not only [were] the factual allegations and legal theories in all three cases substantially the same, but the…plaintiffs [in the prior cases] were also named as plaintiffs" in the current underlying litigation at issue." In so holding, the court rejected the insureds' argument that the policy excluded coverage only for related claims asserted by the same parties, and since the current underlying litigation included additional plaintiffs who were not part of the prior lawsuits, claims made by the new plaintiffs should be covered. The court reasoned that "it is the nature of the claim, not the identity of the claimant," that controlled as to whether prior lawsuits were related to the current underlying suit. "It is immaterial whether the claim is made or the suit is filed by a prior plaintiff or new party…the policy excludes coverage for *'all claims* involving the same wrongful act or wrongful acts which are logically or causally connected by reason of *any* common fact, circumstance, situation, transaction, event or decision.'" ✦

Bankruptcy Court Authorizes Interim Payment of Limited Expert Costs to Directors and Officers

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according to the insurer, payment of those costs directly to the officers and directors would reduce the debtor's indemnification obligations. The court disagreed with the insurer, reasoning that the medical center might ultimately not be found liable to indemnify the directors and officers for that money paid by in the insurer, in which case payment by the insurers from a limited pool of money would be to the center's detriment.

In addition to seeking summary judgment, the insurer also moved for an order authorizing it to pay between $500,000 and $600,000 for officers' and defendants' expert costs in the underlying action. The officers and directors claimed that an advancement of the proceeds was immediately needed to secure the services of the experts in time to meet discovery deadlines in the underlying action. The medical center opposed the action, arguing again that the disbursement of the proceeds would diminish the amount of the proceeds available to it.

The court decided to evaluate the motion using the standards for a preliminary injunction, and held that the "proposed payments for expert costs may be made without (apparently) violating" the automatic stay or the injunctions and the order under the reorganization plan. The court first noted that the insurer would be likely to prevail in defending its payments because the "[c]ourt is likely to hold that, upon distribution to the proceeds up to the policy limit, [the insurer] would have no further obligation to any insured, regardless of whether the proceeds have been equitably distributed among the various insureds." It then reasoned that neither the automatic stay nor the plan injunction precluded the payment of the proceeds. The "automatic stay enjoins acts against 'property of the estate,' but here the property at issue—[the debtor's] right as an insured to a *pro rata* share of the policy proceeds—has been revested by the plan in the debtor and no longer belongs to the bankruptcy estate." Finally, the court noted that because the officers and directors needed the insurance proceeds to procure the services of experts for an effective defense in the underlying action, irreparable harm to the officers and directors from their failure to secure expert testimony outweighed the harm to the debtor from the minimal reduction of the insurance proceeds. In weighing the relative irreparable harm, the court pointed to the small amount of money being paid relative to the size of the policy limits.

The court limited its holding, however, stating that "[a]though the [c]ourt has determined that [the insurer] is likely to prevail on those issues, [it] cannot provide final assurance that the payment (1) may be applied in full to the policy limit and (2) will not give rise to a claim in favor of [the debtor] for breach of obligations under the policy…[since] the [c]ourt cannot provide final assurance on an interim motion, before full consideration of the evidence and the law." Thus, the court noted that it "will not 'authorize' the payment in this sense but will grant [the insurer the] leave to make the payment." ✦

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Contra Proferentem Rule Creates Broad Coverage for Claims Alleging Investment Counseling

A New York federal court, applying New York law, has held that an E&O policy provided coverage for claims alleging "investment counseling" even though the insured was not in fact acting as an "investment counselor." *Morgan Stanley Group, Inc. et al. v. New England Insurance Co. et al.*, 222 F. Supp. 2d 381 (S.D.N.Y. 2002).

The insurers issued an "Investment Counselors Errors and Omissions and Fiduciary Liability Insurance" policy to Morgan Stanley Group, Inc. (Morgan Stanley). The policy provided coverage for "Loss which the Insured shall become legally obligated to pay, from any claim made against the Insured during the Policy Period, by reason of any actual or alleged negligent act, error or omission committed in the scope of the Insured's duties as investment counselors." Two banks purchased participation interests in a loan transaction promoted by Morgan Stanley. When material misrepresentations by the loan seller emerged and the investment failed, the banks filed lawsuits against Morgan Stanley, alleging that it provided false information on the investment. Morgan Stanley then sought coverage for the suits under its E&O policy, and the insurer denied coverage because Morgan Stanley was not acting as an "investment counselor." The insured filed suit.

In an earlier decision in the litigation, the Second Circuit had held that Morgan Stanley was not acting as an "investment counselor" in the transaction at issue. However, the appeals court held that Morgan Stanley might nevertheless be entitled to coverage for a claim by one of the banks because the complaint "alleged" that Morgan Stanley acted as an "investment counselor," even if it did not in fact do so. The insurer argued that "alleged" modifies "act, error or omission" and that coverage is therefore available only for alleged acts, errors or omissions while Morgan Stanley was acting as an investment counselor. Morgan Stanley argued that "alleged" modifies the entire provision and therefore provides coverage where a claim alleges that Morgan Stanley was acting as an "investment counselor" even if it is not in fact playing that role.

Finding the policy language ambiguous, the court looked at extrinsic evidence to determine the parties' intent. The court concluded that the extrinsic evidence offered by the parties (including testimony from Morgan Stanley that its risk manager obtained the insurance to "cover losses that might arise from allegations or actually giving negligent advice to clients," letters offered by Morgan Stanley in which the insurer stated "Morgan Stanley is not alleged [in the…complaint] to have acted as an investment advisor or investment counselor" and testimony from the insurer's underwriter that the words "actual or alleged" were not intended to obviate the requirement that the acts occur in the insured's capacity as an investment counselor) failed to resolve the policy's ambiguity. The court therefore applied the *contra proferentem* rule, construing the policy in favor of the insured as including coverage for claims alleging "investment counseling." ✦

Financial Gain Exclusion Bars Coverage for E&O Claim; Insurer May Be Estopped From Asserting Exclusion

The Fifth Circuit, applying Mississippi law, recently held that the financial gain exclusion in an E&O policy barred coverage for an improper assessment of tax. *Twin City Fire Ins. Co. v. City of Madison, MS.*, No. 01-60378 (5th Cir. Oct. 28, 2002). The court also held, however, that the insurer might be estopped from denying liability based on the exclusion because of its delay in asserting the exclusion and its failure to provide independent counsel.

Several housing developers brought a lawsuit against the insured, a city in Mississippi, claiming that it improperly assessed fees in connection with building permit applications. The city tendered the defense of the action to its E&O carrier and the carrier defended the city in the underlying action under a reservation of rights. Thereafter, the city settled the claims for $250,000. The insurer agreed to pay the settlement amount subject to a reservation of its rights to seek reimbursement of the payments based on the financial gain exclusion, which barred coverage for "[l]iability arising out of any insured obtaining remuneration or financial gain to which such insured was not legally entitled." The insurer brought a declaratory judgment action. The city filed a counterclaim maintaining that the E&O policy provided coverage by estoppel based on the insurer's improper claims handling and breach of the duty to defend and third party claims against the insurer's claims adjusters based on bad faith claims handling.

The Fifth Circuit held that the fee assessed by the city was an unauthorized tax and thus constituted "an illegal 'financial

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No Coverage for Legal Malpractice Action Under Prior Acts and Knowledge Exclusion

A federal district court, applying Pennsylvania law, denied coverage under claims-made professional liability policies for a legal malpractice action because, under an objective standard, the insureds knew or could have reasonably foreseen that prior circumstances might be the basis of a legal malpractice claim against them. *Westport Ins. Corp. v. Mirsky*, No. 00-4367, 2002 U.S. Dist. LEXIS 16967 (E.D. Pa. Sept. 10, 2002).

Beginning in 1995, lawyer one purchased successive one-year claims-made professional liability policies from the insurer. Beginning in 1995, lawyer two purchased successive one-year claims-made professional liability policies from the same insurer that included an endorsement that defined lawyer one as an independent contractor who was deemed an "Insured" under lawyer two's policy. Both policies excluded coverage for acts occurring prior to the inception date of the policy if the Insured "knew or could have reasonably foreseen that such act, error, omission, circumstance or PERSONAL INJURY might be the basis of a claim." Both lawyers sought coverage from the insurer after they were sued for legal malpractice in December 1999. The legal malpractice suit arose from the handling of a medical malpractice suit by the two lawyers that was dismissed in September 1998 because of the lawyers' failure to comply with discovery orders by the court. The insurer disclaimed coverage based on the prior knowledge exclusion because the lawyers did not report the claim until November 1999 and brought an action for declaratory judgment.

The court ruled in favor of the insurer. It initially noted that "[r]enewal of 'claims made' policies does not create a single policy period for purposes of reporting." Accordingly, the relevant policy was the policy issued in 1999. The court then applied an objective, "reasonable person" standard to determine whether the lawyers had prior knowledge of the likelihood of a claim. It concluded that, under that standard, the lawyers would have realized in September 1998, when the court in the underlying action dismissed the case because of the lawyers' conduct, that they had committed an act, error, or omission that might be the basis of a claim. The court concluded that no coverage was available under lawyer one's policy because the malpractice occurred prior to the 1999 policy and the lawyer could reasonably have foreseen the claim prior to the policy since he had handled the case and had knowledge of the dismissal. The court also concluded that no coverage was available under lawyer two's policy because (1) lawyer one, who had knowledge of the foreseeable claim prior to the 1999 policy was acting as an independent contractor for lawyer two and therefore was as an "Insured" under lawyer two's policy, and (2) even if lawyer one had not been acting as an independent contractor, lawyer two also had personal knowledge of the potential claim because he was also involved in the underlying case. ✦

Financial Gain Exclusion Bars Coverage for E&O Claim; Insurer May Be Estopped From Asserting Exclusion

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gain'" within in the meaning of the financial gain exclusion. Therefore, the court found that there was no coverage for the underlying action under the E&O policy.

The city maintained that a conflict of interest existed based on the insurer's reservation of rights since the application of the financial gain exclusion depended on the outcome of the underlying litigation for which the insurer provided a defense—if the city lost in the underlying action, there would be no coverage under the financial gain exclusion. Moreover, the city argued that the insurer did not timely notify the city of the conflict and its right to select independent counsel, and that it did not separate its claims handling from its coverage analysis. The court initially noted that in the duty to defend context, estoppel could create coverage where an exclusion would otherwise apply. The court found that questions of fact existed regarding whether the insurer's coverage letters provided the city with adequate notice of the insurer's position that any damages awarded to the plaintiff in the underlying litigation would not be covered under the E&O policy, the potential conflict of interest and the city's right to retain independent counsel. Moreover, the court also noted that the insurer might have breached the duty to defend by continuing to defend the city despite the potential conflict of interest and failing to provide independent counsel. The court further held that questions of fact existed regarding whether the insurer's claims handling constituted bad faith. ✦

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Duty to Defend Under Fiduciary Responsibility Policy Includes Claims Unrelated to ERISA

A federal appeals court, applying California law, recently held that an insurer had a broad duty to defend a pension trust fund under a claims-made fiduciary responsibility insurance policy for fiduciary claims that were unrelated to ERISA. *Pension Trust Fund for Operating Eng'rs. v. Fed. Ins. Co.,* Nos. 00-17055 & 00 – 17223, 2002 U.S. App. LEXIS 20712 (9th Cir. Oct. 1, 2002).

A pension trust fund was sued, *inter alia*, for breach of fiduciary duties in connection with real estate investments that it had made in a country club. The pension trust fund sought coverage under a policy provision that provided coverage for a "breach of fiduciary duty," which the policy defined as "the violation of any of the responsibilities, obligations or duties imposed upon fiduciaries by the Employee Retirement Income Security Act of 1974 or amendments thereto or by the common or statutory law of the United States of America or of any state or other jurisdiction therein."

The Ninth Circuit rejected the insurer's argument that there was no coverage for non-ERISA claims, reasoning that the literal language of the policy provided coverage for claims alleging violations of common law, Federal law or state law, which necessarily included breaches of fiduciary duty. The court also rejected the insurer's argument that it did not have a duty to defend because the policy term requiring a defense for claims "as a result of any actual or alleged breach of fiduciary duty," required a narrow causal connection between the alleged breach and the damages prompting the claim. Noting that while causal connection is a significant issue in first party insurance disputes, it is not a critical issue for third-party duty to defend cases, the court explained that "California courts have repeatedly found that remote facts buried within causes of action that may potentially give rise to coverage are sufficient to invoke the defense duty." Thus, the potential that a claim might allege covered conduct, is sufficient to create a duty to defend. Finally, the Ninth Circuit rejected the insurer's argument that it was relieved of the duty to defend because of late notice. The court held that because the policy at issue was not a "claims-made-and-reported" policy, the notice prejudice rule applied, and it remanded to the trial court to determine whether the insurer was prejudiced by the pension trust fund's delay in providing notice. ✦

Insurer Not Liable for Breach of Contract for Deciding to Stop Writing Coverage

A Louisiana federal district court, applying Louisiana law, has held that an insurer who decided to cease writing medical malpractice insurance policies did not breach its contract with plaintiffs. *Drs. Bethea, et al. v. St. Paul Guardian Ins. Co., et al.*, No. 02-14444 Sec. K(4), 2002 U.S. Dist. LEXIS 16723 (E.D. La. Sept. 4, 2002).

The insurer decided to cease writing medical malpractice insurance policies and informed its insureds that it would not extend its free reporting endorsements. In response, several physicians filed a lawsuit against the insurer, alleging that the insurer breached its contract with them and the putative class of insureds they represented. In support of their breach of contract action, the policyholders introduced a letter from the insurer, which provided that physicians who have been insured with the insurer "continuously for five years as a specifically-named individual with separate limits before retirement" would qualify for a free optional reporting endorsement at retirement. The physicians argued that they and their related entities had been continuously insured by the insurer and that their right to the free reporting endorsement has vested before the insurer's "unilateral" determination to cease writing coverage. Thus, they claimed that the insurer had breached their insurance contracts.

The trial court granted the insurer's motion to dismiss the breach of contract claim. The court first pointed to the endorsement at issue, which stated that "[t]his agreement may end because one of us chooses to cancel it," and concluded that under the terms of the policy, there was no agreement that the insurer would indefinitely continue to write medical malpractice insurance in Louisiana. The court also held that the letter introduced by the physicians could not have provided coverage because it was not incorporated into the insurance policy itself, and under a Louisiana statute, "[n]o agreement in conflict with, modifying or extending the coverage of any contract of insurance shall be valid unless it is in writing and physically made part of the policy or other written evidence of insurance, or it is incorporated in the policy."

Shortly before the court ruled on the motion to dismiss the breach of contract claim, the physician policyholders amended their complaint to plead in the alternative a claim for detrimental reliance or equitable estoppel based on the conduct of the insurer. That claim was not before the court, but it noted that those claims, "which seem to hit at the heartland of the dispute," remain viable. ✦

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No Attorneys Fees to Insured for Coverage Litigation

In an unpublished decision, a federal court of appeals has held that, under New York law, an insurer who has not acted in bad faith is not liable for the insured's attorneys' fees in a coverage action, and need not provide coverage for legal expenses incurred in the underlying litigation after the insured rejected a settlement. *Cowan v. Codelia*, No. 02-6035, 2002 WL 31478922 (2d Cir. Nov. 1, 2002).

This coverage litigation arose after a professional corporation was sued and requested coverage from its professional liability carrier. The insurer initially denied coverage, and the professional corporation sued for coverage. After the court held that the insurer had a duty to defend, the insurer provided a defense until the underlying case settled. Thereafter, the parties litigated whether the insurer was liable for the settlement and whether the law firm was entitled to its attorney's fees in the coverage litigation.

The court held that the law firm was not entitled to fees because it could not make "a showing of such bad faith in [the insurer's] denying coverage that no reasonable carrier would, under the given facts, be expected to assert it." The court found no such bad faith, noting that the insurer's arguments in support of no coverage had merit and been given serious consideration. The court next held that it was appropriate for the trial court to impose a cut-off date and cap for the professional corporation's recovery based on its rejection of a settlement in the underlying case. The court rejected the law firm's argument that it has no duty to consent to the settlement under the policy because the insurer's initial refusal to defend excused the law firm's obligations under the policy. The court reasoned that even though the insurer had initially disclaimed coverage, the policy's provisions governing the insured's duty to cooperate and the consent-to-settle clause still governed because the insurer had subsequently complied with the district court's order to defend the case. Finally, the court held that the professional corporation could recover only the reasonable value of legal services rendered in defense of the underlying litigation prior to the cut-off date, and that the lower court properly used the lodestar method as an aid in, rather than as the exclusive basis for, rendering its decision as to what fees were "reasonable." ✦

No Coverage for Trustees of Non-Profit Who Could Not Be Personally Liable

A Wisconsin appellate court has held that an insurer that issued a D&O policy to a synagogue did not have a duty to defend two trustees of the synagogue because the underlying complaint did not seek to hold the officers personally liable for damages. *Green v. Heritage Mut. Ins. Co.*, No. 01-2778, 2002 WL 31455720 (Wis. Ct. App. Nov. 5, 2002).

The underlying action had been filed against a synagogue, its board and two of the trustees in connection with the sale of property. The synagogue notified its insurer of the action and requested that it provide a defense, but the insurer refused. After the action was dismissed as to all defendants, the trustees sued the insurer, seeking recovery of their defense costs.

The insurer argued that it was not required to provide a defense because the underlying complaint did not allege a claim as to which the trustees could suffer a "loss." The policy defined "loss" as "any amount which an insured person is legally obligated to pay or which the named insured may be required or permitted by law to pay as indemnity to an insured person for a claim or claims made against an insured person for wrongful acts."

The appellate court agreed with the insurer. It reasoned that "not all claims made against a trustee fall within the policy definition of 'loss.' Only those claims which result in the trustees' personally being held liable are insured." Under the facts alleged in the complaint, the court concluded that while the synagogue could have been found liable, the trustees could not have been found liable for any loss. To begin with, the allegations against the trustees were based on the trustees' acting as agents for the synagogue, and under Wisconsin law, an agent generally cannot be held personally liable for the actions of a disclosed principal. Furthermore, the complaint sought only injunctive relief from the synagogue and did not seek any damages from the trustees personally. Accordingly, the court concluded that since there was not an alleged "loss," there was no coverage or duty to defend. ✦

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Receipt of Letter About Potential Claim by Clerical Employee Did Not Constitute Knowledge by Law Firm

A Nebraska federal court has held that receipt by a law firm's clerical employee of a letter advising of a potentially missed statute of limitations did not constitute sufficient knowledge on the part of the law firm to require it to notify its insurer of a potential claim. *Peterson & Peterson Law Offices, P.C., v. TIG Ins. Co.,* No. 8:01CV308, 2002 WL 31413808 (D. Neb. Oct. 28, 2002).

The insurer issued a claims-made lawyers professional liability policy to a law firm. The policy provided coverage for acts prior to the inception date of the policy if "neither the Insured, nor any partner, shareholder, or the Insured's management committee knew or should have known that a wrongful act, error or omission or Personal Injury had occurred or had a reasonable basis to foresee that a claim would be made against an Insured."

On April 27, 2000, an attorney representing a former client sent a letter to the law firm that raised the possibility of a missed statute of limitations and asked that its malpractice carrier be notified. While the letter was stamped by the office manager for the law firm as having been received, it was apparently routed directly to the closed file in the matter. Nine months later, after the policy had become effective, the law firm was sued for malpractice. The insurer denied coverage and sought to rescind the policy, arguing that because the law firm had received the April 27 letter, it had failed to notify the insurer of a foreseeable claim under the terms of the policy.

The court rejected the insurer's arguments. The court reasoned that there was no evidence that "any partner, shareholder, or the law firm's management committee" was aware of the letter or knew of the potential claim before the renewal of its policy because the partner in the law firm to whom the letter was addressed provided undisputed testimony that he did not receive a copy of the letter. In so holding, the court rejected the law firm's argument that the office manger's status as an employee made her an agent of the law firm and therefore her receipt of the letter should be imputed to the law firm. The court found this argument unpersuasive and stated that "[a]lthough the appropriate business practice would be to have your office staff disperse mail…that apparently did not happen in this case. Malpractice insurance is designed in part to protect against this type of negligence. To hold otherwise would vitiate coverage for the insured."

The court also denied the insurer's claim for rescission. It stated that to obtain rescission based on the application, the insurer would need to show that the misrepresentation in the application either (1) deceived the insurer to its injury, or (2) contributed to the loss. The court found no evidence supporting either of these grounds. ✦

Ninth Circuit Holds No Coverage for False Claims Act Violations

The U.S. Court of Appeals for the Ninth Circuit recently held that, under California law, an action under the False Claims Act (FCA) was not covered under a professional liability policy. *Horizon West, Inc. v. St. Paul Fire & Marine Ins. Co.*, 2002 U.S. App. LEXIS 18380 (9th Cir. Sept. 3, 2002).

The insureds, a group of nursing home operators, had been sued for allegedly submitting false Medicare and Medicaid claims and allegedly misrepresenting the quality of care at their facilities. The nursing home operators tendered the defense to the insurer, which was refused on the grounds that the policy did not cover FCA claims.

The nursing home operators argued that they were entitled to a defense because the policy required the insurer to compensate third parties for "injury or death resulting from…the providing or failure to provide professional services" and the complaint alleged an economic injury to the U.S.. In a short opinion, the court rejected the argument, reasoning that the "FCA injury does not 'result from' [the nursing home operators'] failure to provide professional services, but from its submission of allegedly fraudulent bills and its alleged misrepresentation of care standards." Thus, the provision of, or failure to provide, services was "merely conduct underlying the FCA claim," not the basis for the FCA claim itself. The court also rejected the argument that the submission of Medicare and Medicaid bills was a "professional service" under the policy, finding that the billing was an "effect of the service provided," and not itself a service. ✦

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E&O Policy Exclusion Barred Coverage for Claims Made by State Agency

A federal district court in Maine, applying Maine law, has held that seven errors and omission insurance policy forms would not provide coverage for the cost of repurchasing unregistered securities pursuant to a state securities agency's order because exclusions in each of the policies barred coverage for claims made by state agencies. *New Life Brokerage Servs., Inc. v. Cal-Surance Assoc., Inc.,* no. 01-172-B-C, 2002 WL 31059287 (D. Maine Sept. 16, 2002).

A securities broker-dealer in Maine was investigated by the Maine Securities Division for selling unrestricted securities ("selling away"). The Securities Division required the broker-dealer to surrender its license unless it would repurchase a substantial quantity of the unregistered securities. Because the broker-dealer's E&O policy did not cover "selling away," it surrendered its license. The broker-dealer then brought suit against its insurance broker for failing to design and obtain appropriate insurance coverage. The broker-dealer alleged that the insurance broker could have obtained insurance coverage for "selling away." The insurance broker moved for summary judgment on the ground that no policy that existed at the time it obtained the E&O insurance would have provided coverage for a claim brought by a state agency for "selling away."

The court examined seven policy forms available before the broker-dealer engaged in "selling away" to determine if the policies would have covered such a claim. The court noted that each policy contained an unambiguous exclusion for actions by a state agency, and therefore concluded that coverage would not have been available under any of the policies. The court rejected the broker-dealer's argument that the repurchase of securities would have been covered as "damages" under the policies because the money would have been "passed through" to the consumers who purchased the securities. The court reasoned that the factual record did not show that the purchasers of the unregistered securities had been injured by their purchase, and therefore, the Securities Division claim could well include costs beyond what the broker-dealer would have been liable for in damages. Indeed, the court noted that there had not been any claims by individuals who had purchased securities. Accordingly, the court ruled that because the policy forms providing coverage for "selling away" would not have helped the broker-dealer in these circumstances, it had no claims against its insurance broker. ✦

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