Wiley Rein & Fielding

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The Executive Summary

Developments Affecting Professional Liability Insurers

Claims Against Debtor's Former Officers Brought by Litigation Trustee Barred By Insured v. Insured Exclusion

A Virginia Bankruptcy Court has held that an insured v. insured exclusion bars coverage for claims against the debtor's former officers made by a litigation trustee handling a trust to whom a debtor-in-possession assigned its claims against its former directors and officers. *Terry v. Federal Ins. Co., et al., (In re R.J. Reynolds-Patrick County Mem. Hosp., Inc.*) (Bankr. W.D. Va. Aug. 15, 2003).

As a part of its reorganization plan, the debtor-in-possession created a trust, to which it assigned all of its claims against its former directors and officers, and designated a trustee to manage the trust. Following confirmation of the plan, the trustee filed an adversary proceeding against two former officers of the debtor. Thereafter, the trustee notified the debtor's D&O insurer of the claim. The insurer denied coverage based on the insured v. insured exclusion, which barred coverage for all claims "brought or maintained by or on behalf of any Insured," including derivative claims brought or maintained with "the solicitation, assistance or participation" of an insured. Coverage litigation followed.

The bankruptcy court held that the insured v. insured exclusion barred coverage for the trustee's claims for two reasons. First, the court held that the claims were "brought by or on behalf of" the debtor because the trustee brought the claims as contractual assignee of the debtor. The court reasoned that the debtor voluntarily assigned its claims against its former officers through the reorganization plan and as such the trustee stood in the shoes of the debtor in suing the former officers. Moreover, the court determined that a debtor could not assign a claim to a third party to circumvent an exclusion in its D&O policy.

In rejecting the trustee's arguments, the court distinguished recent cases, such as *In re Molten Metal Technology, Inc.*, 271 B.R. 711 (Bankr. D. Mass. 2002), and *In re County Seat Stores*, 280 B.R. 319 (Bankr. S.D.N.Y. 2002), that have held that an insured v. insured exclusion does not apply to claims brought by chapter 11 trustees. The court reasoned that in those other cases, the appointment of the chapter 11 trustee and accompanying assignment of claims was involuntary and was not done for the purpose of avoiding the application of the insured v. insured exclusion. Here, by contrast, a debtor-in-possession outside the control of a trustee voluntarily assigned the claims. The court also reasoned that a chapter 11 trustee and a pre-petition debtor or debtor-in-possession are distinct entities as the former is appointed by the court and is a statutory creation. In contrast, the trustee in the instant case was merely an assignee of a debtor-in-possession whose rights arose by virtue of the provisions of the reorganization plan. The court opined that where a debtor voluntarily assigns its claims to a third party, there is a potential for collusion between the debtor and its directors and officers, a result insurers attempt to avoid by including an insured v. insured exclusion in their policies.

Second, the bankruptcy court also held that the insured v. insured exclusion applied because the trustee's claims were brought or maintained with "the solicitation, assistance or participation" of the debtor. The court reasoned that even if the trustee was acting as the agent of the creditors and not the assignee of the debtor, there would be no coverage under the exclusion because the debtor, through the reorganization plan: (1) "solicited" the action against the former officers by creating "a legal entity to sue on behalf of the creditors" and (2) "assisted" in the prosecution of the action by voluntarily assigning the claims to the trustee. ✦

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Proceeds of Adelphia's D&O Policies Are Not Property of the Bankruptcy Estate; Rescission Action Not Subject to Automatic Stay

A federal district court in New York has held that the proceeds of Adelphia's D&O policies are not property of its bankruptcy estate and thus the automatic stay does not apply to enjoin litigation brought by several of Adelphia's D&O insurers to rescind the policies. *In re Adelphia Communications Corp.*, 2003 WL 22005944 (S.D.N.Y. Aug. 20, 2003). The district court, however, remanded the action to the bankruptcy court to determine whether the rescission action should be stayed under Section 105 of the Bankruptcy Code, which grants the bankruptcy court broad equitable powers.

In March and June 2002, Adelphia and its affiliate filed voluntary petitions for relief under chapter 11. Subsequently, the United States Department of Justice brought criminal charges against five Adelphia directors for conspiracy and securities fraud, the Securities and Exchange Commission sued Adelphia and five directors seeking disgorgement of ill-gotten gains and civil penalties, and shareholders filed several lawsuits against Adelphia and its directors and officers alleging securities fraud.

In September 2002, several Adelphia directors and officers requested relief from the automatic stay to permit payment or advancement of defense costs under Adelphia's D&O policies. Thereafter, the insurers sought to rescind the policies and brought a declaratory judgment action against the Adelphia directors and officers. At the same time, the insurers moved for relief from the automatic stay "to the extent necessary" to name Adelphia and its affiliate as additional defendants in the declaratory judgment action. In response, Adelphia filed an adversary proceeding against the insurers seeking to enjoin the further prosecution of the coverage litigation based on either the automatic stay or the bankruptcy court's equitable powers under Section 105 of the Bankruptcy Code.

The bankruptcy court denied the insurers' motions for relief from the automatic stay to pursue coverage litigation against Adelphia and held that the automatic stay applied to the insurers' pending coverage litigation against Adelphia's directors and officers. The bankruptcy court, however, did grant relief from the automatic stay to five Adelphia 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

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Kansas Supreme Court Holds That Limited Retroactive Coverage in Excess Limits Endorsement Does Not Violate Public Policy

The Kansas Supreme Court has held that limited retroactive coverage in an excess limits endorsement added on to a claims-made medical malpractice policy did not violate Kansas law or public policy. *Marshall v. Kan. Med. Mut. Ins. Co.*, 2003 WL 21673754 (Kan. July 18, 2003). The court also held that the policy language at issue was not ambiguous.

The insurer had provided claims-made medical malpractice coverage to a physician since 1989. The policy provided coverage of $200,000 per claim, with an aggregate limit of $600,000. In 1997, the physician delivered a baby with irreversible brain damage. In October 1998, the attorney representing the baby's parents requested medical records from the physician. In December 1998, after receiving the request for the medical records, the physician applied for an excess limits endorsement to the policy with coverage of $1 million per claim and $1 million in the aggregate. The endorsement stated that coverage would "be available only for claims first made against the named insured during the policy period and occurring subsequent to the excess limits retroactive date, as set forth in the Declarations page and Excess Limits Endorsement." That retroactive date was January 1, 1999. In August 1999, the baby's parents sued the doctor, and litigation ultimately ensued over whether the excess limits endorsement was applicable.

The Kansas Supreme Court held that the policy did not afford coverage. The court initially rejected the physician's argument that the lack of retroactive coverage was prohibited by a Kansas statute requiring doctors to maintain coverage of at least $200,000 per claim and $600,000 annual aggregate and requiring that "[s]uch policy shall provide as a minimum coverage for claims made during the term of such policy or during the prior term of such policy." The physician had argued that the bar on retroactive coverage limited the extent to which the policy provided claims-made coverage because coverage would not be available for most claims that would likely be made during the policy period. The court reasoned that although the statute required basic coverage—that is, "minimum coverage"—to be claims-made, it did not require "any and all" coverage to be claims-made.

The Kansas Supreme Court next held that the limited retroactive coverage did not violate public policy and, in fact, that public policy considerations weighed in favor of the limited coverage. The court reasoned that public policy supports freedom to contract and that without this freedom, "it is likely that insurance companies might refuse to assume additional risk on behalf of health care providers." The physician asserted that he did not have freedom to contract because no one from the insurer spoke to him about the policy, but the court rejected that argument, noting that the physician had a copy of the policy and an opportunity to review it. According to the court, "[a] party to a contract has a duty to learn the contents of a written contract before signing it." The court also reasoned that the goal of preventing fraud supported the result because it makes "excess liability insurance available at a reasonable cost." Although there was no indication in the record of "an overt attempt to defraud" the insurer, the timing of the physician's purchase of the endorsement demonstrated the possibility of fraud.

The Kansas Supreme Court also held that endorsement was not ambiguous. The court rejected the physician's argument that ambiguity was created by having different retroactive dates for the primary and the excess coverage. ✦

Cost of Repurchasing Securities That Were Unlawfully Sold Is Not "Loss" or "Damages"

The United States Court of Appeals for the First Circuit, applying Maine law, has held that costs that a securities broker-dealer incurred to repurchase unlawfully sold securities do not constitute "Loss" or "Damages" under an E&O policy issued to the broker-dealer. *New Life Brokerages Serv., Inc. v. Cal-Surance Assoc., Inc.*, 2003 WL 21448838 (1st Cir. June 24, 2003).

The Securities Division of Maine's Bureau of Banking (Securities Division) investigated a broker-dealer for engaging in the unlawful practice of "selling away," which involved the sale of securities that were not registered or approved for sale by the broker-dealer. The Securities Division sought to revoke the broker-dealer's license and

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Illinois Appellate Court Applies Breach of Fiduciary Duty and Intentional Fraud Exclusions

An Illinois appellate court has held that an insurer had no duty to defend public officials, insured under a public officials E&O policy, where the underlying complaint alleged only breach of fiduciary duty and intentional fraud, which were expressly excluded in the policy. *Twin City Fire Ins. Co. v. Somer*, 2003 WL 21706831 (Ill. App. Ct. July 23, 2003).

The insurer issued a public officials E&O policy to a township. The policy contained exclusions for "[l]iability arising out of a dishonest, fraudulent, criminal or malicious act or omission of any insured" as well as "[l]iability arising out of any insured's activities in a fiduciary capacity or as a trustee or in any similar activity."

Taxpayers in the township filed a lawsuit against two supervisors of the township and the township's attorney, alleging that the three officials entered into a conspiracy whereby the township sold certain property to the attorney without following proper procedures. The attorney then allegedly entered into "sham transactions" to assign the properties to the township temporarily in order to waive the outstanding property taxes before the property was returned to the attorney. The insurer refused to provide a defense, citing a number of policy provisions. After the insured officials prevailed in the underlying lawsuit, they brought an action against the insurer.

The Illinois appellate court held that the insurer properly denied coverage. The court explained that, in evaluating coverage, the underlying complaint "must be read as a whole in order to assess its true nature." Although the complaint contained five counts, some of which went to relief (*e.g.*, a count for an accounting and restitution of the unpaid property taxes), the court explained that "the underlying complaint essentially states two causes of action, breach of fiduciary duty and intentional fraud." Since the policy expressly excluded both of those causes of action, coverage was unavailable. The court reasoned that the fact that the complaint contained counts seeking various forms of relief was irrelevant because "all of the factual allegations of the complaint are premised upon only one theory of recovery, that of intentional fraud and a conspiracy to commit fraud." ✦

Insurer Has Duty to Defend Attorney Where Notice of One of Four Allegations in Complaint Was Untimely

In an unreported decision, a federal district court, applying New York law, has held that an insurer has a duty to defend an insured under a claims-made legal malpractice policy where notice of one of the four allegations in the complaint was untimely because the insurer had received timely notice of the other allegations. *Fein v. Chicago Ins. Co.*, 2003 WL 21688239 (S.D.N.Y. July 18, 2003).

The insurer issued a claims-made legal malpractice policy to an attorney. The policy required notification to the insured "[u]pon the Insured becoming aware of any negligent act, error, omission, or Personal Injury in the rendering of or failure to render Professional Services which could reasonably be expected to be the basis of a Claim covered hereby."

The underlying plaintiff had retained the attorney in 1995 to represent its interests in connection with a default judgment that had previously been entered against it in a slip and fall case as well as in a declaratory judgment action filed against it and its insurer seeking to collect on the default judgment. The attorney did not move to vacate the default judgment until late 1999, more than four and a half years after he had been retained. The underlying plaintiff subsequently hired new counsel and settled the slip and fall case. The underlying plaintiff alleged that the attorney had failed to vacate the default judgment in a timely fashion. The complaint also alleged that the attorney had failed to pursue vigorously a cross claim for coverage against the underlying plaintiff's insurer, failed to file a notice of claim in the 1998 rehabilitation proceeding involving the underlying plaintiff's insurer, and failed to advise the underlying plaintiff of his rights against his insurance broker.

The district court initially noted that, under New York law, an insured's failure to comply with a notice provision in an insurance policy is generally a complete defense regardless of prejudice. In addition, "[f]ailure to give timely notice of a claim may be excused if the insured either had no knowledge of the occurrence or reasonably believed that he was not liable."

The court held that the attorney had not provided timely notice of the allegation that he had failed to move to vacate the default judgment because "an objectively reasonable person would have concluded by 1999, when [the attorney] filed the motion to vacate the default that [the attorney's] actions could

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Insurer Had Duty to Defend, But Not to Indemnify, Dentist for Sexual Misconduct Claim

In an unreported decision, a California court has held that an insurer had a duty to defend, but not to indemnify, a dentist who was sued for sexually molesting a patient where the underlying complaint alleged that dental assistants in the practice were negligent in failing to report the acts of the dentist. *Marie Y. v. Gen. Star Indem. Co.*, 2003 WL 21694551 (Cal. Ct. App. July 22, 2003).

The insurer issued a professional liability policy to a dentist. The policy provided coverage for "dental incidents," which was defined as "any act, error, omission, or mistake in the rendering of or failure to render services in the profession of dentistry by an insured or any person for whose acts or omissions an insured is legally responsible." The policy defined the "profession of dentistry" to include "services performed in the practice of the profession of dentistry as defined in the business and the professional codes of the state where you practice." The policy contained an exclusion "for liability for any damages arising out of a dental incident which is also a willful violation of a statute, ordinance or regulation imposing criminal penalties; however, (1) we will defend any civil suit against the insured seeking amounts which would be covered if this exclusion did not apply."

The dentist was sued by a patient who alleged that the dentist inappropriately touched her while she was under the influence of nitrous oxide. At that time, the insured agreed to provide a defense, subject to a reservation of rights. Subsequently, the dentist entered a plea of *nolo contendere* to two counts of misdemeanor sexual battery and served a year in jail. At that point, the insurer withdrew its defense in light of the plea of *nolo contendere.* The state dental board also conducted a hearing, and it revoked the dentist's license. The patient then amended her complaint to add, among other things, allegations that two chair-side assistants failed to stop the dentist or to report the incident. The amended complaint alleged that the dentist could be liable for the actions of the assistants as the "captain of the ship" or under the doctrine of *respondeat superior.* The insurer continued to deny a defense. The underlying trial court ultimately entered a judgment against the dentist for $1.03 million, and the dentist assigned his rights against the insurer in exchange for a covenant not to sue.

With respect to the patient's original complaint, the California appellate court held that the insurer had no duty to defend or indemnify. The court reasoned that the sexual misconduct did not involve "the rendering of or failure to render services in the profession of dentistry." The court noted that the policy provided coverage for the "profession of dentistry," and the relevant business code expressly excluded sexual misconduct from the definition of dentistry. The court further reasoned that coverage was barred by a state statute stating that "[a]n insurer is not liable for a loss caused by the willful act of the insured; but he is not exonerated by the negligence of the insured, or of the insured's agents or others." Since the California Supreme Court had previously held that sexual molestation is a "willful act," coverage was therefore barred by statute.

With respect to the allegations in the amended complaint concerning the conduct of the chair-side assistants, the court held that the statutory bar on indemnity for willful acts applied to the claim. The court reasoned that "it would violate the public policy underlying [the statute] (which is to discourage willful torts) to create coverage for [the dentist] based on the assistants' conduct, because their 'negligence' was inextricably intertwined with [the dentist's] intentional wrongdoing." But the court also held that the statutory bar did not apply to the duty to defend since public policy concerns did not bar a defense for willful torts. The court therefore turned to the question whether the alleged failure of the assistants constituted a "dental incident" under the policy's exclusion, thereby obligating the insurer to provide a defense. The court held that it did because "the only evidence on this regard is to the effect that the failure of a dental assistant to report sexual misconduct constitutes a breach of the dental assistant's duty of care toward a patient."

The court held that the only damages available were the reasonable attorneys' fees and costs incurred in defending the action. The court rejected the dentist's argument that the court should award the entire underlying judgment because the insurer had breached its obligation to defend, reasoning that to do so "would contravene the strong policies" in the statute barring indemnification in these circumstances. ✦

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Federal District Court Holds Prior Acts Exclusion Inapplicable; Invokes Related Claims Exclusion

A federal district court, applying Florida law, has held that insurer could not deny coverage based on the prior acts exclusion in its policy. *Pro Net Global Ass'n v. U.S. Liab. Ins. Co.*, No. 3:02-CV-369-J-32TEM (M.D. Fla. June 4, 2003). The court also held that a second insurer properly denied coverage for two lawsuits involving "the same or substantially the same facts, circumstances, and situations" as a third lawsuit initiated prior to the inception of coverage.

Two insurers had issued consecutive claims-made policies to a company. The underlying litigation involved three lawsuits filed against the policyholder company by distributors of Amway promotional materials who alleged that the company engaged in various schemes to disrupt the chain of distribution and sponsorship with Amway's business. The same lawyer filed each of the lawsuits, and each complaint contained similar factual allegations and overlapping causes of action. The first lawsuit was filed during the first insurer's policy period. The later two lawsuits were filed during the second insurer's policy period. Coverage litigation ensued involving the company and two of its insurers.

The first insurer had issued a policy containing an exclusion for "any Claim based upon or arising out of any Wrongful Act or circumstance likely to give rise to a Claim of which any insured had knowledge, or otherwise had a reasonable basis to anticipate might result in a Claim, prior to the [beginning of the coverage period]." The policy defined "Claim" to include "any written notice received by any Insured that any person or entity intends to hold such Insured responsible for a Wrongful Act." Although the first suit was filed during the first insurer's policy period, the insurer sought to deny coverage by pointing to two facts that it asserted provided notice to the company of potential litigation prior to the inception of coverage and therefore barred coverage. First, the underlying complaint alleged that the company's standard membership agreements contained arbitration clauses, which the insurer contended was done to prevent potential litigation and indicated that the company anticipated litigation. Second, the insurer pointed to a lawsuit involving some of the company's principals that preceded the formation of the company and that was voluntarily dismissed by the person initiating the lawsuit who later became a member of the company, which the insurer also argued gave the company reason to anticipate litigation. The court rejected the insurer's arguments that these two facts constituted knowledge of a potential claim. The court reasoned that neither fact presented "a conclusive basis upon which to find" that any of the company's principals had "knowledge, or otherwise had a reasonable basis to anticipate" the three lawsuits that were filed.

The second insurer provided coverage after the first lawsuit had been filed, but prior to initiation of the later two lawsuits. The policy excluded coverage for claims "based upon, arising out of, or attributable to any demand, suit or proceeding pending, or order, decree or judgment entered against the Company or any Insured Person on or prior to the [institution of the policy], or the same or substantially the same fact, circumstances or situation underlying or alleged therein." The policy also excluded claims "based upon, arising out of, or attributable to any fact, circumstance or situation which has been the subject of any written notice given under any policy of which this policy is a renewal or replacement." The court held that "[b]ased upon the allegations in the three underlying lawsuits and the unambiguous pending claim exclusion in the [insurer's] policy, it seems plain" that the insurer owed no coverage. ✦

Billing for Legal Services Does Not Constitute "Professional Services"

A Massachusetts appellate court has held that a legal malpractice policy did not provide coverage for an underlying judgment requiring an attorney to repay amounts that were improperly billed to a client because "the billing function of a lawyer is not a professional service." *Reliance Nat'l. Ins. Co. v. Sears, Roebuck & Co.*, 2003 WL 21742250 (Mass. App. Ct. July 30, 2003).

The insurer provided coverage to an attorney for claims arising "out of the rendering or failure to render professional services for others in the insured's capacity as a lawyer." In an underlying lawsuit, the attorney was found liable to one of his clients for approximately $950,000 in fees that the court found the attorney was not entitled to receive. The appellate court held that the attorney was not entitled to coverage for that amount because billing is not a professional service. The court explained that "[b]illing for legal services does not draw on special learning acquired through rigorous intellectual training.... The billing function is largely ministerial." ✦

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Law Firm and Three Attorneys Entitled to Independent Counsel of Their Own Choosing in Legal Malpractice Case

In an unreported decision, a New York state trial court has held that a law firm and three of its attorneys insured under a duty-to-defend legal malpractice policy were entitled to independent counsel in an underlying action for legal malpractice because of potential conflicts among them. *Rosenberg & Estis, P.C., et al. v. Chicago Ins. Co.*, 2003 WL 21665680 (N.Y. Sup. Ct. July 11, 2003). The court also held that, because of disputed coverage issues, the attorneys were entitled to choose their own counsel.

The insurer issued a duty-to-defend legal malpractice policy to a law firm. The policy provided that "[u]pon the Insured becoming aware of any negligent act, error, omission or Personal Injury in the rendering of or failure to render Professional Services which could reasonably be expected to be the basis of a Claim covered hereby, written notice shall be given by the Insured, or its representative to the Company together with the fullest information obtainable as soon as practicable."

In October 2000, the law firm provided notice to the insurer of a potential claim arising out of alleged misconduct by one of its attorneys of which it had just become aware. In March 2001, after that matter had been resolved, the law firm notified the insurer that it had uncovered further acts of misconduct by the same attorney from 1997 and 1998 that could give rise to a claim. In December 2001, the law firm and three of its attorneys were sued as a result of the purported misconduct. The insurer denied coverage, contending that the law firm had not provided timely notice of the potential claim because (1) the attorney whose misconduct was at issue had knowledge of the misconduct in 1997 and that knowledge could be imputed to the entire firm, and (2) in any event, the law firm should have uncovered the misconduct by timely reviewing the attorney's files after receiving notification in October 2000 of the first potential claim. Coverage litigation ensued.

The trial court held that both arguments raised by the insurer involved issues of fact that precluded summary judgment. The court explained that the attorney's knowledge of his misconduct could not necessarily be imputed to the entire firm, reasoning that "[i]t can be assumed that a 'bad actor' does not advise his partners or employers of his bad acts, until they are otherwise uncovered." In particular, the court noted that the law firm appeared to be "large" and to have "many" attorneys, and reasoned that "[t]he matter would be different if it related to a single practitioner or possibly to a very small and well integrated firm." The court also held that the issue whether the firm acted diligently and reasonably in reviewing the attorney's files was an issue of fact that could not be resolved on summary judgment and that the insurer was therefore obligated to continue providing a defense pending further resolution of the coverage issues.

The trial court granted the motion of the law firm that it and the individual attorney defendants (none of whom was the lawyer who engaged in the alleged malpractice) were entitled to independent counsel of their own choosing. The court explained that the insureds were entitled to choose their own counsel because "[a] conflict of interest requiring the retention of independent counsel arises where the question of insurance coverage is intertwined with the question of liability." Here, the court found a conflict because the obligation of the insurer to indemnify might turn on proof of whether the law firm adequately supervised the attorney who engaged in the purported misconduct. The court also held that the law firm and individual attorneys were entitled to separate counsel because "there may be a conflict of interest" among them.

Finally, the court granted the insurer's motion to dismiss the counts in the law firm's complaint for statutory and common law bad faith based on the insurer's alleged violation of New York law concerning "unfair claim settlement practices." The court initially noted that the statute at issue did not create a private cause of action. In addition, it held that the allegations did not state a cause of action because the law firm failed to charge, as is required by statute, conduct that is "consumer oriented." The court reasoned that, while the complaint alleged an impact on the public, the law firm "is a large law firm, which commenced this action to protect its interests under a specific insurance policy…. "[T]here is no allegation that the plaintiff was of disparate bargaining power with defendant when the insurance policy was issued." ✦

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Two Alleged Breaches of Professional Obligations by Accountant Held to Be Separate Claims

In an unreported decision involving an accountant insured under a claims-made professional liability policy, a California appellate court has held that two lawsuits brought against the accountant alleging that he breached his professional and fiduciary obligations to a client in connection with the client's retention of an investment advisor and the client's retention of a surgeon were not related, even though the insurer argued that both lawsuits alleged that the accountant failed to disclose that the individuals retained by the client had financial interests in the client's sports agent. *Pope v. Chicago Ins. Co.*, 2003 WL 21640888 (Cal. Ct. App. July 14, 2003).

The insurer issued consecutive claims-made professional liability policies to an accountant in 1998 and 1999. The policies each contained a limit of $2 million per claim, with an aggregate limit of $4 million. The policies provided that "[a]ll Claims arising out of the same or related act, [or] omission…shall be considered a single Claim for the purpose of this insurance and shall be subject to the same limit of liability."

The accountant provided services to a sports agent. He subsequently entered into a fiduciary relationship with a professional baseball player who used that sports agent. In 1998, the baseball player sued the accountant, alleging that the sports agent had referred him to an investment advisor who had converted and misappropriated funds. The player alleged that the accountant was liable for the losses because the accountant had failed to inform the player of the fact that the investment advisor was also an investor in the sports agent or of the fact that there were business irregularities and accounting discrepancies in the accounting methods used by the investment advisor. The insurer accepted a defense of the 1998 suit under the 1998 policy.

In 1999, the baseball player sued the accountant alleging that the sports agent had referred him to a surgeon to treat a sports injury. According to the player, the accountant failed to inform him that the surgeon was an investor in the sports agent and, had the player known of the conflict of interest, he would have engaged in additional investigation into the surgeon's qualifications. The player alleged that negligence by the surgeon resulted in a premature end to his playing career. The insurer took the position that the 1999 suit was a related claim to the 1998 suit and therefore subject to a single per claim limit. Coverage litigation followed.

The appellate court applied the framework for addressing related claims set out by the California Supreme Court in *Bay Cities Paving & Grading, Inc. v. Lawyers' Mutual Insurance Co.*, 5 Cal. 4th 854 (1993). The first part of that framework requires a determination whether the allegations involve separate injuries. The court concluded that here the player had asserted two claims against the accountant because he "alleged two distinct species of injury, one being the loss of funds caused by [the investment advisor's] malfeasance and the other being the physical injury caused by the [surgeon's] medical malpractice. These injuries occurred at different times and were attributable to different malefactors."

The appellate court then addressed the second component of the *Bay Cities* framework: whether, even if the claims are distinct, they should be deemed related under the related-claims language of the policy. The court explained that in *Bay Cities*, while the California Supreme Court had rejected the argument that the term "related" was *per se* ambiguous, it had noted that "[a]t some point, of course, a logical connection may be too tenuous reasonably to be called a relationship, and the rule of restrictive reading of broad language would come into play." The appellate court therefore explained that, "[u]nder the *Bay Cities* approach, we must resolve whether the term 'related' is ambiguous in the context of this policy and the circumstances of this case." The court concluded that in this case the two claims were too attenuated to be considered related because, among other things, they involved distinct injuries, the injuries occurred at different times and they resulted from different "efficient" causes (medical malpractice vs. financial malfeasance). The court also noted that there were differences in the alleged knowledge and failures to disclose by the accountant in the two cases. The court concluded that, although the claims "may at some level of abstraction be characterized as involving the same or related conduct by [the accountant], we do not interpret *Bay Cities* as permitting the amalgamation of distinct claims into a single claim where the actionable conduct by the insured is distinct in time, character and impact, and shares only broad and generic similarities." ✦

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Binder Provided Coverage Subject to "Related Wrongful Acts" Exclusion, Even Though Binder Did Not Mention "Related Acts" Exclusion

The United States Court of Appeals for the Fifth Circuit has held that a binder excluding "all prior acts prior to policy inception date" excluded coverage "for related wrongful acts," even though the binder did not mention related wrongful acts, because the ordinary form of the contemplated policy contained such an exclusion. *Med. Care Am., Inc. v. Nat'l Union Fire Ins. Co.*, 2003 WL 21788994 (5th Cir. Aug. 5, 2003).

The insured was a company formed as a result of the merger of two other companies. In anticipation of the merger, the company procured D&O coverage from the insurer. The temporary conditional binder issued to the new company provided that the policy would exclude "all prior acts prior to policy inception date." When the policy issued, that provision was embodied in an endorsement providing that "this policy only provides coverage for Loss arising from claims for alleged Wrongful Acts occurring on or after September 9, 1992 and prior to the end of the Policy Period and otherwise covered by this policy. Loss(es) arising out of the same or related Wrongful Act(s) shall be deemed to arise from the first such same or related Wrongful Act."

Between the time when the binder issued and the policy issued, and after the merger date of September 9, 1992, a shareholder suit was filed against the company and its directors and officers alleging misrepresentations prior to the merger. The lawsuit ultimately settled for $60 million; however, the insurer denied coverage based on the exclusion for related wrongful acts, contending that the alleged misrepresentations predated the merger.

The Fifth Circuit held that the insurer was entitled to deny coverage. It noted "that under Texas law an insurance binder provides coverage according to the terms and provisions of the ordinary form of the contemplated policy." The court held that the trial court had properly ruled in favor of the insurer at the close of evidence because "the evidence and inferences point so strongly and overwhelmingly in favor of a finding that [the insurer's] standard prior acts endorsement normally or ordinarily used in its D&O liability policies contained related acts language."

The Fifth Circuit also rejected the argument that the insurer was estopped from relying on the prior acts exclusion because that language was not in the binder. The court first noted that there was no evidence that the insurer had "misrepresented or concealed" coverage terms. Furthermore, under Texas law, to make an argument based on estoppel, the policyholder would need to show that it exercised due diligence to ascertain the truth of the matters at issue and that it lacked the means or had been prevented from doing so. The court held that no such showing had been made here.

Finally, the Fifth Circuit held that the trial court had properly granted the insurer's motion for summary judgment as to the bad faith claims against it. The court concluded that "the evidence overwhelmingly shows that there was a bona fide coverage dispute, which [the insurer] subsequently won." ✦

Cost of Repurchasing Securities That Were Unlawfully Sold Is Not "Loss" or "Damages"

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conditioned any agreement not to revoke the license on the broker-dealer repurchasing a substantial number of the unlawfully sold securities. The broker-dealer's E&O insurer refused to provide coverage for the repurchase of the securities, and the broker-dealer then sued its insurance broker for failing to procure coverage for liability resulting from selling away.

The First Circuit held in favor of the insurance broker, reasoning that because the cost of repurchasing securities was not "loss" or "damages" under Maine law, the insurance broker would not have been able to procure coverage from any insurer. The First Circuit based its conclusion on a prior decision by the Supreme Judicial Court of Maine in which that court had held that "damages" in an insurance policy did not include expenses that an insured incurred in eradicating pollution damages because such costs are "remedial." *Patrons Oxford Mut. Ins. Co. v. Marios*," 573 A.2d 16 (Me. 1990). Like the equitable remedial costs in *Marios*, the First Circuit explained, "the broker-dealer's equitable remedial buy-back costs, insisted on by the Securities Division, are distinguishable from any actual direct damages that [the broker-dealer] would have been obligated to pay its customers." ✦

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Wisconsin Court Applies Intentional Acts Exclusion, Rejects Application of Bodily Injury and Pollution Exclusions

A Wisconsin appellate court has held that an exclusion for intentional acts precluded coverage for certain claims made against a real estate broker insured under an E&O policy but that the exclusion, as well as exclusions for bodily injury and pollution, did not bar coverage for other claims against the broker. *Droegkamp v. American S. Ins. Co.*, 2003 WL 21749514 (Wis. Ct. App. July 30, 2003).

The insurer issued an errors and omissions policy to a real estate broker. The policy contained exclusions for claims arising out of (1) any "dishonest, fraudulent, criminal or malicious act or omission or deliberate misrepresentation," (2) bodily injury and (3) pollution. The broker was sued in connection with the sale of a residence. The complaint included causes of action for intentional misrepresentation, fraudulent misrepresentation, strict liability misrepresentation and negligence. The complaint sought relief for, among other things, the cost of repairs, compensation for the diminished value of the property, personal injury and "mold problems."

The court held that the policy excluded coverage for the counts for intentional and fraudulent misrepresentation because they involved intentional acts. The court held, however, that the remaining counts were not excluded under any of the exclusions in the policy. It first reasoned that the allegations involving strict liability misrepresentation and negligence "can be established without proof of deliberate conduct" and therefore were not excluded as intentional acts. The court reasoned that the personal injury exclusion did not bar coverage because the complaint sought pecuniary damages, which were not excluded. Finally, the court held that the pollution exclusion did not bar coverage because "the mold language in the complaint appears only in the request for relief, not in the substantive portion of the complaint; thus it is not properly considered a substantive allegation." The court also stated that "there is some support for the argument that mold does not constitute pollution." ✦

Policy Issued to Law Firm Void as to Two Partners Engaged in Conduct Not Disclosed in Application and as to the Firm, But Not as to "Innocent" Partner

The New Jersey Supreme Court has held that an insurer that had issued a legal malpractice policy to a three-person law firm was entitled to rescind coverage as to the managing partner who had engaged in conduct not disclosed in the application he signed, as to a second partner engaged in the same conduct and to the firm as an entity, but that the insurer could not rescind coverage as to the lone partner without knowledge of the falsity of the representations. *First Am. Title Ins. Co. v. Lawson*, 2003 WL 21666583 (N.J. July 17, 2003). The court based its decision on various public policy considerations and did not identify the existence of a severability clause.

In obtaining legal malpractice coverage for the three-person law firm, the managing partner signed a warranty statement that he was "not aware of any circumstances or any allegations of contentions as to any incident, which may result in a claim being made against the firm or any of its…partners." In fact, the partner knew those statements were false because he was engaged in the unauthorized practice of law by acting as a closing attorney in a state where he was not authorized to do so and, in concert with a second partner, by misappropriating client funds. The insurer sued to rescind the policy.

The court held that the insurer had "the clear right to rescind the [managing partner's] coverage in the face of his blatant and direct misrepresentations." It also held the insurer could rescind coverage as to the second partner, who was involved in misappropriating client funds because he "knew or should have known that the forms submitted to the carrier contained false or misleading information."

The court also held that the carrier could rescind the policy as to the firm as an entity. The court reasoned that "[p]ermitting the firm's coverage to survive [the managing partner's] defalcations would, in essence, condone the use of a partnership entity as a subterfuge for fraudulent conduct." In so holding, the court emphasized the role of the managing partner in the misrepresentations and noted that "[t]his is not a case in which a lone attorney

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Excess Insurer Has No Obligation to Share in Cost of Defense

The United States Court of Appeals for the First Circuit has held that an excess insurer has no obligation to reimburse a primary insurer for its *pro rata* share of costs in defending a law firm insured by both carriers. *Lexington Ins. Co. v. General Accident Ins. Co.*, 338 F.3d 42 (1st Cir. 2003).

A primary insurer issued a professional liability policy to a law firm with a limit of liability of $10 million. Four additional insurers issued excess policies. The policy issued by one of the excess carriers provided that it would insure the law firm "in accordance with the applicable insuring agreements, terms, conditions and exclusions of the Underlying Policy…except as regards the premium, the obligations to investigate and defend and for costs and expenses incident to the same."

The primary insurer incurred $5.5 million in legal fees and expenses, which it sought to allocate *pro rata* among the various excess carriers. The First Circuit held that the excess carrier had no obligation to contribute to defense costs because its excess policy unambiguously provided that it had no obligation to do so. The court also held that the plain language of the policy undermined other arguments made by the primary carrier, including that it was entitled to reimbursement under the doctrine of equitable contribution, reasoning that the doctrine cannot "override explicit, unambiguous policy language." ✦

Policy Issued to Law Firm Void as to Two Partners Engaged in Conduct Not Disclosed in Application and as to the Firm, But Not as to "Innocent" Partner

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in a multi-person firm knowingly had supplied the managing partner with false information that the partner merely forwarded to the carrier without knowledge of its falsity."

The court held, however, that the carrier could not rescind coverage as to the third partner. The court noted that the third partner did not engage in the relevant conduct, had no knowledge of the conduct and, in fact, generally worked out of a separate office. The court therefore characterized him as an "innocent" partner. The court also reasoned that if coverage were denied as to that attorney, he would have no coverage for unrelated acts of malpractice that might have occurred and that result "could leave members of the public, whom [that partner] represented throughout that period, unprotected even though the insured himself committed no fraud. In our view, that harsh and sweeping result would be contrary to the public interest." In particular, the court noted that denying coverage to that attorney would be inconsistent with the requirement in the Rules of Court that attorneys maintain malpractice insurance. ✦

Insurer Has Duty to Defend Attorney Where Notice of One of Four Allegations in Complaint Was Untimely

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give rise to potential liability." Since the attorney did not provide notification to the insurer in 1999, the court held he had failed to comply with the notice requirements of the policy.

However, the court also held that, with respect to the other allegations against the attorney, "a reasonable person would not have been aware of the potential for malpractice liability before the suit was actually filed." The district court explained in a conclusory manner why the particular facts at issue did not give rise to an expectation of a claim for malpractice. Among other things, the court noted that the attorney had not been retained to provide services in connection with the rehabilitation proceeding or to pursue a potential malpractice claim against the insurance broker. The court also noted that since the lawsuit against the underlying plaintiff already named the underlying plaintiff's insurer, a cross claim against that insurer would have been duplicative. The court concluded that because the attorney had provided timely notice of the lawsuit, which included three allegations as to which the attorney would not have expected a malpractice claim to result, the insurer was required to defend and indemnify the attorney. ✦

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Proceeds of Adelphia's D&O Policies Are Not Property of the Bankruptcy Estate

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court determined that the D&O policies, which provided Adelphia entity coverage for securities claims, and their proceeds were property of the bankruptcy estate.

The district court vacated the bankruptcy court decision, holding that the D&O policy proceeds are not property of the bankruptcy estate. The court reasoned that although the D&O policies provided entity coverage, the debtors did not have a "cognizable equitable and legal" property interest in the policies at this juncture because: (1) the debtors had not made or contemplated making any payments for which they would be entitled to indemnification coverage, and (2) no claims for entity coverage were pending. Instead, the court characterized the debtors' interest as "akin to a car owner with collision coverage claiming he has the right to proceeds from his policy simply because there is a prospective possibility that his car will collide with another tomorrow, or a living person having a death benefit policy, and claiming his beneficiaries have a property interest in the proceeds even though he remains alive."

Having determined that the automatic stay did not apply to the rescission action, the court remanded the case to the bankruptcy court to determine whether the litigation should be stayed under Section 105 of the Bankruptcy Code. That provision has been construed in some circumstances to enjoin suits against third parties that might impede the reorganization process. ✦

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