Wiley Rein & Fielding

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The Executive Summary

Developments Affecting Professional Liability Insurers

Fiduciary Policy Does Not Cover Amounts Paid to Establish and Fund Employee Accounts

The United States Court of Appeals for the First Circuit, applying Massachusetts law, has held that "loss" or "liability" under an ERISA fiduciary policy does not include amounts paid belatedly by a policyholder to establish and fund profit-sharing accounts for eligible employees under the company's profit sharing plan. *Pacific Ins. Co., Ltd. v. Eaton Vance Mgmt.*, 369 F.3d 584 (1st Cir. 2004).

The insurer issued an ERISA fiduciary policy to the company. The policy provided coverage for "[l]oss or liability incurred by the Insured, from any claim made against the Insured during the Endorsement Period, by reason of any actual or alleged failure to discharge his or its duties or to act prudently within the meaning of the Employee Retirement Income Security Act of 1974."

The company learned that it had mistakenly failed to create and fund the accounts of a number of employees eligible for the company's profit-sharing plan. It ultimately paid more than $850,000, including interest, to fund the accounts. Four months after learning of the mistake and six weeks after acknowledging its obligation to fund the additional employees' accounts, the company notified the insurer of the payments. Coverage litigation ensued.

The First Circuit held that the policy did not cover the contributions. It explained that the insurer could only be held liable under the policy if the company "incurred a (1) 'loss or liability' (2) 'by reason of' (3) 'any actual or alleged failure to discharge…its duties or to act prudently within the meaning of…ERISA…or by reason of any actual or alleged breach of fiduciary responsibility within the meaning of [ERISA].'" The court rejected the company's contention that the term "by reason of" is ambiguous and should be construed against the insurer. Instead, the court explained that "'by reason of' means 'because of,' and thus necessitates an analysis at least approximating a 'but for' causation test." Applying this standard to the facts of the case, the court explained that "the relevant liability for which [the company] seeks recovery from its insurer is *not* one for breach of fiduciary duty relative to the belatedly funded employee accounts; rather, [the company] seeks reimbursement for amounts it paid—principal and interest—in satisfaction of its Plan-created obligation to establish and fund those accounts to the level they would have attained had [the company] initially complied with the Plan."

The court also rejected the company's argument that the asserted breach of fiduciary duty was a concurrent cause of the obligation, reasoning that the underlying obligation to fund the Plan existed regardless of whether the policyholder fulfilled its fiduciary duties. The court concluded that "[i]t makes no sense to permit a dereliction of duty to transform an uninsured liability into an insured event." ■

In This Issue

I v. I Exclusion Inapplicable to Action by Debtor-in-Possession

A federal bankruptcy court in Illinois, applying Illinois law, has held that the I v. I exclusion in a D&O policy does not bar coverage for an action by a debtor-in-possession against the former CEO of the insured company. *In re HA 2003, Inc.*, 2004 WL 1354244 (Bankr. N.D. Ill. June 9, 2004). The court also held that an excess carrier could not maintain that its consent was required for a settlement if it was denying coverage under the policy.

Various insurers issued primary and excess D&O policies to a company that later filed for bankruptcy under chapter 11. The primary policy, to which the excess policies followed form, contained an I v. I exclusion, which stated that "'the Company shall not be liable for Loss on account of any Claim made against any Insured Person…brought or maintained by or on behalf of any Insured.'" The primary policy also contained an endorsement that created an exception to the I v. I exclusion for "'a claim (whether or not brought in the name of, on behalf of, or in the right of the Insured Organization) brought by or on behalf of a bankruptcy trustee, magistrate or any other person appointed by a bankruptcy court or judge, or authorized under applicable law to act on behalf of a debtor or brought by or on behalf of any creditor of the Insured Organization.'"

> **The court held that the insurer "may not deny coverage and still maintain control over the settlement...."**

The company, as a debtor-in-possession, sued its former CEO for breach of fiduciary duty and corporate waste. All but one of the insurers settled with the company. The remaining excess insurer maintained that there was no coverage under the policy by virtue of the I v. I exclusion.

The bankruptcy court disagreed with the excess insurer, holding that the company, "as debtor-in-possession, [fell] squarely under the language of [the] Endorsement" to the I v. I exclusion. The court rejected the insurer's argument that the definition of a "person" in the endorsement did not apply to the company, reasoning that "person" was not defined in any of the policies. The court also noted that elsewhere in the policy, the term "person" was clearly limited to a human being. The court therefore concluded that the language in the endorsement "makes it clear that this term includes organizations because organizations are authorized under applicable law to act on behalf of a debtor." The insurer next argued that the endorsement could not be read to apply to actions by a debtor-in-possession because it did not specifically mention a debtor-in-possession. Disagreeing with the insurer, the court stated that if the insurer "did not intend for [the endorsement] to apply to debtors-in-possession, who are clearly authorized to act on behalf of the debtor under the Bankruptcy Code, the insurer[] should have specifically excluded them."

The court did reject the contention by the debtor-in-possession that coverage was also available because the claim was brought "by or on behalf of any creditor" since any recovery would be distributed to creditors under the reorganization plan. The court explained that the claim was one that only the company could bring, and the exception to the I v. I exclusion would not apply even if the creditors would ultimately benefit if the company prevailed.

The court next addressed whether the insurer could withhold its consent to the company's settlement even though it had denied coverage under the policy. The court held that the insurer "may not deny coverage and still maintain control over the settlement…." In so ruling, the court followed the rule outlined in *Commonwealth Edison Co. v. Nat. Union Fire Ins. Co.*, 752 N.E.2d 555 (Ill. App. Ct. 2001), in which the court held that "an insurer that defended while reserving its right to contest coverage lost the right to consent to a settlement." The insurer contended that this case and others were inapposite because there was no duty to defend under the policy at issue. The court reasoned, however, that the insurer "has done more than reserve its right to contest coverage; it has flat-out denied coverage and i[s] litigating that issue to judgment in this case."

Finally, the company sought a determination that the underlying settlement was reasonable. The court dismissed the claim as non-justiciable because the settlement agreement had not yet been signed. ■

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Delayed Notice Absolves Insurer

In an unreported decision, a federal district court in Pennsylvania, applying Pennsylvania law, has held that a 16-month delay in notifying an insurer of a claim absolves the insurer of its duty to indemnify because the policyholder knew or should have known earlier that the complaint filed against it constituted a claim under the policy. *Philadelphia Indem. Ins. Co. v. Fed. Ins. Co.*, 2004 WL 1170525 (E.D. Pa. 2004).

The policyholder, an insurance company, was insured by a reinsurer under a professional liability policy. The policy provided coverage for "Loss which the Insureds shall become legally obligated to pay as a result of any Claim first made against the Insureds…arising out of any Wrongful Act committed by the Insureds or any person for whose acts the Insureds are legally liable." The policy defined claim as "a civil proceeding commenced by the service of a complaint or similar pleading." The policy also provided that the policyholder must provide "written notice as soon as practicable…of any Claim made against the Insured(s) for a Wrongful Act, of which the Insured's General Counsel or equivalent officer first becomes aware of such Claim."

One of the insurance company's insureds submitted a claim under a D&O policy. The insurance company denied the claim, and the policyholders filed suit alleging bad faith. The insurance company retained outside defense counsel, who identified the underlying coverage litigation as a "bad faith" suit on each invoice. However, the insurance company delayed notifying the reinsurer of the claim against it for 16 months. After the underlying bad-faith litigation settled, the reinsurer offered to pay only a portion of the settlement amount, contending that the case could have settled for a lower amount had it been timely notified of the claim. Coverage litigation ensued.

In determining whether the reinsurer had a duty to indemnify, the court focused on the issue of whether service of the complaint on the insurance company's president and chief operating officer triggered the notice provision of the policy. The court first rejected the insurance company's argument that the notice provision was ambiguous because the insurance company did not have a general counsel. The court noted that the insurance company admitted that it authorized its vice president of claims to notify the reinsurer in the event of a claim, and it therefore concluded that the notice provision

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Coverage Barred for Claim Arising Before Policy Period

A federal district court in New York, applying New York law, has held that a claims-made policy precludes coverage for a lawsuit based on a transaction where, prior to the inception of the policy, one of the plaintiffs in the underlying litigation had sent a letter to the policyholder making the same allegations concerning a similar transaction. *Seneca Ins. Co. v. Kemper Ins. Co.*, 2004 WL 1145830 (S.D.N.Y. May 21, 2004). The court reasoned that the lawsuit and letter were claims arising from "Interrelated Wrongful Acts" and therefore constituted a single claim that arose before the inception of the policy.

The policyholder, an equestrian trade association, purchased a liability insurance policy from one insurer with a policy period of July 18, 2000 to July 18, 2001, and then purchased a second policy from a different insurer with a policy period of August 31, 2001 through August 31, 2002. The first policy precluded coverage for claims alleging antitrust violations and provided that "the Insured shall be reimbursed for all amounts which would have been collectable under this policy if such allegations are not subsequently proven." The second policy provided coverage on a claims-made basis and defined "Claim" to include "a written demand against any Insured for monetary damages or other relief." The same policy provided that "[a]ll Claims arising from the same Wrongful Act and all Interrelated Wrongful Acts shall be deemed one Claim, and such Claim shall be deemed to be first made on the earlier date that…any of the Claims were first made against an Insured under this Policy or any prior policy." The policy defined "Interrelated Wrongful Acts" as "any and all Wrongful Acts that have as a common nexus any fact, circumstance, situation, event, transaction, cause or series of causally or logically connected facts, circumstances, situations, events, or causes." The second policy also contained a prior notice exclusion precluding coverage for claims "based upon, arising from, or attributable to: (a) any Wrongful Act… which has been the subject of any written notice given under any other policy, providing such policy would have provided coverage but for the exhaustion or diminution of its limits of liability; or (b) any Wrongful Act whenever occurring, which, together with a Wrongful Act described in (a) above, constitute Interrelated Wrongful Acts."

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Promissory Note Contingent on Insurance Recovery May Be "Loss"

The United States District Court for the Northern District of Illinois, applying Illinois and Delaware law, has held that a company's promissory note, which potentially obligates it to reimburse its corporate parent for the settlement of shareholder class action lawsuits, could amount to a covered "loss" under its D&O policy even though the company is not obligated to pay money under the terms of the underlying settlement agreement. *Genesis Ins. Co. v. FTD.COM, Inc.*, 2004 WL 1199984 (N.D. Ill. June 1, 2004).

The insurer issued a D&O policy to a floral company. The policy provided that, among other things, the insurer will pay "on behalf of [the company]:" (1) "Loss which [the company] is required to indemnify, or which [the company] may legally indemnify, the Directors or Officers, arising from Claims first made during the Policy…Period;" and (2) "Loss arising from Securities Claims first made against [the company] during the Policy…Period." The policy defined "Loss" to include: (1) "any amounts which the Directors or Officers are legally obligated to pay;" (2) "such amounts which [the company] is required to indemnify the Directors or Officers, or such amounts which [the company] may legally indemnify the Directors or Officers" and (3) "any amounts which [the company] is legally obligated to pay for Securities Claims made against [the company]."

The majority of the floral company's shares were owned by another company, and a minority of its shares were publicly traded. The parent of the company that owned a majority of the floral company's shares acquired a 100 percent interest in the floral company by buying out the interests of the minority public shareholders. After the transaction was complete, the public shareholders of the floral company filed a class action lawsuit against the floral company, the majority shareholder and the parent of the majority shareholder alleging that inadequate consideration had been paid for the floral company's stock. In August 2003, the lawsuit settled. Under the terms of the settlement agreement, the shareholders received $10.7 million worth of stock of the parent company. Meanwhile, in October 2003, two months after the class action settlement agreement was signed, but before the court approved it, the floral company executed a promissory note to the parent company for repayment of the settlement amount. The note provided that the insured floral company would reimburse the parent for the $10.7 million settlement payment unless it is "determined pursuant to the Insurance Litigation that the liability of [the floral company] pursuant to the [Shareholder] Litigation is for an amount less than the Settlement Amount." In that case, the floral company would only have to repay the lower amount. Coverage litigation ensued and the insurer filed a motion for judgment on the pleadings, arguing that it had no duty to indemnify the company because the company was not "legally obligated" to pay under the underlying settlement agreement and therefore it had not suffered a covered "Loss."

Initially, the court found that, by itself, the settlement agreement did not legally obligate the floral company to pay any amount. According to the terms of the agreement, the parent company issued $10.7 million in shares "at its sole expense" and incurred all costs, taxes and fees associated with the payment. The agreement also provided that if the parent failed to deliver the shares, counsel for the plaintiff shareholders could either terminate the settlement or force the parent to consent to specific performance. The court determined that, under Delaware law, these provisions clearly indicated that the parent was the only entity legally obligated to pay under the settlement agreement. Moreover, the court was not persuaded by the floral company's reliance on the fact that the parent paid "on behalf of all Defendants," explaining that this language "does not, by itself, create a legal obligation for [the floral company] or any other party to pay any amounts due under the Settlement Agreement to the Shareholder Plaintiffs."

Notwithstanding this conclusion, however, the court held that, under Illinois law, viewing all inferences in favor of the floral company, the promissory note could be considered a valid apportionment of money paid under the settlement agreement such that it "could constitute a legal obligation to pay for a claim made for a wrongful act, *i.e.,* a 'Loss' under the Policy." The court first rejected the insurer's argument that the provision in the promissory note limiting the floral company's repayment to the amount of liability determined in the insurance coverage litigation obligated it to pay only up to its liability under the settlement agreement, which was zero. Instead, the court concluded that the provision applies to the amount of the floral company's liability pursuant to the "Securities Litigation," not the settlement agreement. The court also rejected the insurer's assertion that the promissory note only created a conditional obligation, which required a finding of liability in the insurance litigation. In the court's opinion, the promissory

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Single Limit of Liability for Physicians with Same Patient

The Texas Court of Appeals has held that a lawsuit brought against two doctors, covered under the same policy, for their treatment of the same patient constitutes one "loss event" for purposes of determining policy limits. *Columbia Cas. Co., v. CP Nat'l, Inc.*, 2004 WL 1171877 (Tex. App. May 27, 2004).

The insurer issued a professional liability policy to a physician practice management company in which both doctors practiced. Two physicians in the practice were sued after they allegedly made separate errors interpreting and following up on the same chest x-ray, which they reviewed at separate times. The policy provided for a $1 million dollar limit per loss event and defined the per loss event limit to apply to "all insureds for all damages to all persons for injuries to one patient." The court held that the language in this provision clearly and unambiguously limited coverage to one limit since only one patient was involved in the underlying case.

The practice management company argued that language in another provision of the policy, which provided that "the limit of liability stated for 'each claim' is the limit of our liability for all injury or damage arising out of, or in connection with, the same or related medical incident," supported its argument that two loss events occurred because the doctors' actions were not causally related to one another since the physicians made separate errors. The court noted that the meaning of "related" was an issue of first impression in Texas and, using the term's "plain, ordinary, and general accepted meaning," it defined "related" as "having a logical or causal connection." The court held that since the medical incidents "involved the same patient, at the same facility, during the same period of time, with regard to the same x-ray, with the same result," all of the alleged acts of malpractice were related medical incidents under the plain meaning of the policy language. Thus, only one policy limit applied. ■

Court Applies Securities Exclusion to Coverage under E & O Policy

In an unreported decision, a California appellate court has held that a securities exclusion in an E&O policy did not bar coverage for lawsuits alleging that an insurance agent was liable for investment advice provided in connection with unregistered securities. *Susman v. Fireman's Fund Ins. Cos.*, 2004 WL 1178773 (Cal. Ct. App. May 28, 2004). However, the court held that coverage was unavailable because the policy's insuring agreement did not provide coverage for investment advice.

The policyholder was an insurance agent who sold homeowners insurance, life insurance and other insurance products. The agent was covered under a group E&O policy, procured through a managing insurance company. The policy provided coverage for damages based on "any act, error or omission of the *Insured*, or any person for whose acts the *Insured* is legally liable, in rendering or failing to render *Professional Services* for others in the conduct of the *Named Insured*'s profession as a licensed Insurance Agent…but only while soliciting, servicing, placing or binding business on behalf of a carrier other than [the managing company] providing that the Agent has been authorized by the [managing company] to broker such business." The policy also contained a number of exclusions, including one barring coverage for "[a]ny claim arising out of the sale or servicing of *Securities*; however this exclusion shall not apply to variable life insurance, variable annuity products or mutual funds approved for sale by [the managing insurance company] and/or its subsidiaries and affiliates."

In the underlying action, the agent was solicited for an investment opportunity in a communications company. The managing insurance company learned of this investment and directed the agent to provide information regarding the investment opportunity to his clients. During this time, unbeknown to the agent, the state of Arizona issued a cease and desist order against the communications company, whose securities were not registered. Later, investors attempting to redeem their shares found that the communications company lacked the funds to repurchase the shares. The company was placed into receivership in Arizona. A group of investors brought suit against the agent alleging breach of contract, fraud, negligence, unfair trade practices and securities violations, contending that the agent "marketed, sold or otherwise promoted the sale of unregistered securities." The agent tendered defense of the underlying actions to his E&O insurer. After the insurer declined to defend, the agent sued.

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Prior Notice by Bank of Lawsuit Precludes Coverage

In an unreported decision, the United States District Court for the Western District of Wisconsin, applying Wisconsin law, has held that the prior notice exclusion in a bank's D&O policy precluded coverage for a claim asserted solely against the bank, even though the D&O policy in effect when the bank provided precautionary notice did not provide entity coverage. *Bancinsure, Inc. v. The Park Bank*, No. 03-C-397-C (W.D. Wis. May 13, 2004).

The insurer issued consecutive, one-year, claims-made D&O policies to the bank, effective July 1, 2000 to July 1, 2001 (the 2000 policy) and July 1, 2001 to July 1, 2002 (the 2001 policy). The 2000 policy named as "Insured Persons…all persons who were, now are or shall be the directors and officers of the Company." The 2000 policy did not provide entity coverage. The 2000 policy also provided that if "any Insured Person or the Company" became aware of circumstances that might "give rise to any Claim against any Insured Person for a specific alleged Wrongful Act" during the policy period and provides written notice to the insurer no later than 30 days after the expiration of the policy, the actual claim against the "Insured Person" would be treated as having been made during the policy period.

Originally, the 2001 policy contained the same provisions as the 2000 policy. In September 2001, however, the insurer added an errors and omissions endorsement to the 2001 policy, retroactively effective to July 1, 2001. The endorsement replaced the phrase "Insured Person" with "Insured" in the underlying policy and defined "Insured" to include the bank, its parent company and their "employees acting within the scope of their employment." The 2001 policy also excluded coverage for "Loss in connection with any Claim made against the [Insured]…arising out of…(1) any Wrongful Act or any fact, circumstance or situation that has been the subject of notice under any policy of insurance in effect prior to the Inception Date of this Policy."

In April 2001, another bank alerted the policyholder bank to a possible check kite fraud involving both banks. The policyholder bank provided notice of the possible fraud to the insurer in May 2001. In July 2001, the second bank sued the policyholder bank for conversion of funds and breach of contract, but it did not name any of the bank's directors or officers in the suit. That same month, the bank gave notice of the suit to the second insurer, which denied coverage based on the receipt of notice during the prior policy period. The bank settled the underlying lawsuit in December 2002 and filed a claim with the second insurer under the 2001 policy for approximately $550,000, representing the amount of the settlement and defense costs.

The court held that the insurer had properly denied coverage because the bank had provided notice of the fraud, which led to the claim against the bank and the eventual settlement in May 2001, prior to the inception of the 2001 policy. The bank argued that because the 2000 policy covered only the bank's directors and officers and did not provide entity coverage, the notice provided by the bank in May 2001 was not notice of a "Claim against any Insured Person," and therefore the prior notice exclusion in the 2001 policy did not apply to bar coverage. The defendant questioned why the bank would have to give notice under "someone else's insurance policy" (*i.e*, the 2000 policy insuring its directors and officers). The court rejected the bank's argument as "creative" but "not a reasonable interpretation" of the policy. The court noted that the insurer was not arguing that the bank was required to give notice under the 2000 policy, but rather that it had, in fact, given notice under its 2000 policy in a failed "attempt to persuade plaintiff to provide coverage" and now is bound by that notice under the terms and exclusions of the 2001 policy. According to the court, it is "undisputed" that the bank is an "insured" under the 2001 policy and that the policy "excludes claims made against insureds if notice [of the facts or circumstances leading to the claim] has been given previously under any prior policy." ■

Promissory Note

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note created a "present obligation" of $10.7 million with a "contingent reduction" if the floral company is not found fully liable in the insurance litigation. The court explained that whether or not this reduction would apply is presently undetermined and would depend on an "allocation determination," so the floral company still "could prove a set of facts that would demonstrate it suffered a covered 'Loss' under the Policy." The court therefore denied the insurer's motion for judgment on the pleadings. ■

Court Applies Exclusions for Diminution in Property Value, Abuse of Process and Malicious Prosecution

In an unreported decision, the United States District Court for the Eastern District of Pennsylvania, applying Pennsylvania law, has held that exclusions in a public officials policy barred coverage for claims brought by real estate owners against a township and its public officials alleging interference with contract, abuse of process and wrongful use of civil proceedings. *Gen. Star Nat'l Ins. Co. v. Palmer Township*, 2004 WL 1175729 (E.D. Pa. May 27, 2004).

The insurer issued a public officials and employment practices liability insurance policy that provided coverage to the township and its officials. The policy contained exclusions providing that "[t]his insurance does not apply to any CLAIM made against the insured: (d) for any damage arising from bodily injury, sickness, disease, or death of any person, or for damages to or destruction of any property including diminution of value or loss of use…(e) [f]or false arrest, false imprisonment, libel, slander, defamation, invasion of privacy, wrongful eviction, assault, battery, malicious prosecution, or abuse of process by any insured."

In the underlying action, a group of real estate owners brought suit in a state trial court against the township and certain of its publicly elected officials, alleging that the owners were improperly denied the right to develop and use their real estate in the manner in which they desired. The insurer initially undertook the defense of the officials. The trial court later dismissed six of the nine counts brought against the defendants, leaving only counts alleging: (1) interference with prospective and current contractual relations concerning the real estate, (2) abuse of process and (3) wrongful use of civil proceedings. After the dismissal of the six counts, the insurer filed a declaratory judgment action, contending that since the policy specifically excluded coverage for the remaining counts in the complaint it had no duty to defend or indemnify.

The district court granted the insurer's motion for summary judgment. The court first determined that there was no ambiguity in the language of the exclusions at issue and that it would therefore give effect to their plain meaning. Addressing the interference with contract count, the court found that coverage was excluded for this count since it stated a claim for the diminution in value of the plaintiffs' contract rights and real property. Turning its attention to the abuse of process count, the court agreed with the insurer that this claim was expressly barred by the language of the policy, which excluded coverage for claims for abuse of process. In so finding, the court rejected the officials' argument that the abuse of process exclusion was inapplicable because the abuse of process count alleged "malicious use of process," which was not the same as "abuse of process." The court found that "such a distinction can only be made in a hypertechnical analysis by attorneys who could find ambiguity in any term." Finally, the court found that the "malicious prosecution" exclusion barred coverage for the count alleging "wrongful use of civil proceedings," noting that the only difference between the two types of allegations is that the former is a common law claim while the latter is statutory. The court also cited Pennsylvania precedent holding that "insurance policies which provide[] coverage for claims of malicious prosecution cover[] claims for wrongful use of civil proceedings." ■

Delayed Notice

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was triggered once that employee became aware of the complaint. The court found that even if he did not read the complaint, the officer "was familiar" with the underlying litigation, and the notice provisions of the policy therefore applied. The court explained that the vice president of claims was aware of the litigation based on the fact that the company "den[ied] coverage in the underlying [litigation] matter just five months earlier, coupled with the seriousness of a suit for coverage, and his actual receipt of the…complaint." The court also noted that the captions in the bad faith complaint were bolded, so that "even a cursory review of the complaint would have revealed the causes of action" alleged. As such, the court held that the officer "knew or should have known of the likelihood" that the complaint constituted a claim under the company's reinsurance policy. The court also rejected the insurance company's promissory estoppel argument based on the reinsurer's reservation of rights letter, finding no promise or detrimental reliance. ■

Coverage Barred

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On July 6, 2001, during the first policy period, the association received a letter from an attorney representing a horse show organizer, which asserted that the association's refusal to grant official recognition to a certain horse show on grounds of "mileage conflicts" constituted a restraint of competition in violation of antitrust laws. The letter, which stated that the organizer had "sustained actual direct damages," requested a meeting to seek resolution of the matter and stated that the attorney would proceed on the organizer's behalf if the meeting did not take place. The association submitted the letter to the first insurer, which disclaimed coverage on the grounds that the policy did not cover antitrust violations but agreed to defend under a reservation of rights. In July 2002, the same attorney informed the association by letter that he intended to file a complaint alleging antitrust violations on behalf of the same horse show organizer and an additional party to whose horse shows the association purportedly had refused to grant official recognition because of mileage conflicts. The two plaintiffs filed their suit in August 2002, and the second insurer rejected the association's claim for coverage. The first insurer subsequently sued the second insurer, alleging that the latter breached its duty to defend.

The court held that the second insurer properly denied coverage because the August 2002 lawsuit and the July 2001 letter constituted a single claim made prior to the inception of the second policy since both the letter and the lawsuit arose from "Interrelated Wrongful Acts." The court first reasoned that the July 2001 letter was a "claim" under the policy and applicable case law. The court explained that although the letter did not demand a specific amount of monetary damages or other relief, it alleged damages and requested a meeting whose purpose impliedly was to seek damages or relief.

The court next determined that the lawsuit and the letter "arose from, at minimum, Interrelated Wrongful Acts" because they shared a common factual nexus, including attempts to gain official recognition for horse shows, which the association had rejected on the basis of the mileage rule. The court also noted that the attorney who wrote the July 2001 letter also drafted the July 2002 letter and the complaint in the lawsuit. The court rejected the first insurer's argument that the two claims did not arise from "Interrelated Wrongful Acts" because the suit and the letter involved separate applications to the association for separate shows, which the association had denied in separate decisions. The court reasoned that the definition of Interrelated Wrongful Acts did not impose such a requirement; rather it required only a sufficient factual nexus. Consequently, the court held that the lawsuit and July 2001 letter constituted a single claim that arose before the second insurer's policy period and granted the second insurer's motion to dismiss.

However, the court did reject the second insurer's argument that the prior notice exclusion also justified dismissal. The court reasoned that the second insurer could not carry its burden of proving that the first policy provided coverage for the August 2002 lawsuit. The court noted that the actual extent of coverage under the first policy was disputed because of the antitrust exclusion and the first insurer's decision to defend under a reservation of rights, and that the first insurer's complaint was "not deficient on this point such that it must be dismissed." ■

Securities Exclusion

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The appellate court first rejected the insurer's argument that the securities exclusion barred coverage, holding that it could not find, as a matter of law, that the securities exclusion was applicable. The court explained that an insured could reasonably expect that the "sale or servicing" of securities, as used in the exclusion, did not include providing investment advice or information regarding securities offered by others as the agent did in this case.

However, the court held that the policy did not afford coverage because even if the securities exclusion was inapplicable, coverage must first be implicated before a duty to defend may be imposed. The court concluded that the policy provided no basis for coverage because the underlying allegations did not establish that the plaintiff was "soliciting, servicing, placing or binding business on behalf of a carrier other than [the managing company]." According to the court, the use of the terms "binding" and "carrier" in the policy "made it clear that it applies to insurance. It cannot reasonably be interpreted to include providing investment advice or promoting investment opportunities in a corporation." The court therefore affirmed the trial court's grant of a demurrer in favor of the insurer. ■

Other Decisions of Note

No Duty to Defend Employee Sued Outside Scope of Duties for Insured

In an unreported decision, a New York appellate court has held that an insurer had no duty to defend a physical therapist in a malpractice action because the therapist was not sued "while acting within the scope" of his duties as an employee of the insured entity. *Rescott v. Am. Cas. Co. of Reading, Pennsylvania*, 2004 WL 1328404 (N.Y. App. Div. June 14, 2004). The court explained that the employee worked for two different physical therapy providers and that, although he was insured in his capacity as an employee of the first entity, the underlying complaint named him as a defendant solely in his capacity as a therapist for the second, uninsured entity. ■

Insurer Cannot Appeal Settlement in Case Where It Was Not Required to Pay

The United States Court of Appeals for the Third Circuit has held that an insurer lacked standing to appeal a district court's approval of an underlying settlement where the settlement did not require the insurer to make any payment. *IPSCO Steel (AL.), Inc. v. Blaine Const. Co.*, 2004 WL 1277959 (3rd Cir. June 10, 2004). The insurer issued a professional liability policy for a construction project that required it to pay money only after any project-specific policies were exhausted. The settlement agreement approved by the trial court required payment only from the project-specific insurer, but it also "capped" the potential exposure policy at an amount below the policy limits. The professional liability insurer sought to challenge the settlement, arguing that it was aggrieved because it was more likely to face exposure as a result of a second underlying suit in light of the cap on the project-specific insurer's policy. The Third Circuit held that the insurer was not aggrieved for purposes of standing because it was "at least two steps removed from any real effect" since there would first have to be a finding that the insured was liable and that the policy afforded coverage. The court also noted that even if the insurer had standing, its argument would fail because a district court generally has no obligation to evaluate the fairness and reasonableness of settlements of non-class action lawsuits. ■

"In Any Way Involving" Language Precludes Coverage

A Texas intermediate appellate court has held that an exclusion in an E&O policy issued to an insurance broker for any claim "arising out of…or in any way involving…[p]lacement of risk or an insurance or reinsurance contract…with any insurance company… that is not rated B+ or higher by A.M. Best…and… becomes bankrupt" precluded coverage for lawsuits brought against the broker after it placed coverage with an insufficiently-rated insurer that became insolvent. *Greenwood Ins. Group, Inc. v. U.S. Liab. Ins. Co.*, 2004 WL 1351413 (Tex. Ct. App. June 17, 2004). The broker argued that the insolvency exclusion did not preclude coverage because the insolvent insurer's policy would have precluded coverage for the lawsuit brought against the broker's client irrespective of the insurer's insolvency and because the lawsuits against the broker contained misrepresentation claims that were "unrelated to, and independent of," the underlying insurer's insolvency. The court rejected the broker's arguments, stating that the "broadly-worded [insolvency exclusion] excludes, not only claims 'arising out of' [the underlying insurer's] bankruptcy, but also claims 'in any way involving' [the underlying insurer's] bankruptcy." The court reasoned that the underlying insurer's insolvency "set into motion a chain of events" that led to the suits against the broker, and that the insolvent insurer never denied coverage because of an exclusion but rather failed to pay because of its insolvency. ■

Voided Transfer Coverage for Auto Dealer

A Florida appellate court has held that a "Title Errors and Omissions Liability Endorsement" to a commercial lines policy issued to an auto dealership did not provide coverage for a lawsuit by a bankruptcy trustee to set aside the transfer of five automobiles that had been fraudulently purchased by employees of the bankrupt company, with the company's funds, but titled to themselves or their friends. *Pompano Motor Co. v. Chrysler Ins. Co.*, 2004 WL 1335811 (Fla. Dist. Ct. App. June 16, 2004).

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Other Decisions of Note

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Under the endorsement, coverage was available only if the auto dealer was sued because of negligence and the purchaser, the lienholder or legal owner filed suit "for damages because of the error or omission title or omission in the title registration." The court reasoned that coverage for the $50,000 settlement of the lawsuit was unavailable in this case because the bankruptcy trustee, which stood in the shoes of the company, was neither the lienholder nor the legal owner of the cars, which were owned by individuals. In addition, the court held that coverage was unavailable because there was no negligence on the part of the auto dealer since it had no duty "to look behind the transactions and conduct quasi-criminal investigations" into the details of each transaction. ■

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