Wiley Rein & Fielding

April 2004

The Executive Summary

Developments Affecting Professional Liability Insurers

Insurers Must Advance Defense Costs Under Unilaterally Rescinded D&O Policy

The United States District Court for the Eastern District of Pennsylvania, applying Pennsylvania law, has held that insurers are required to advance defense costs to directors and officers insured under a D&O policy issued to Adelphia Communications Corporation, which the insurers unilaterally rescinded, pending judicial determination of rescission and other coverage issues in an action stayed by a bankruptcy court. *Assoc. Elec. & Gas Ins. Servs., Ltd. v. Rigas*, 2004 WL 540451 (E.D. Pa. Mar. 17, 2004).

The insurers issued D&O policies to Adelphia. The primary policy provided that the insurer would "pay on behalf of the directors and officers any and all sums which they become legally obligated to pay as Ultimate Net Loss for which the Company has provided reimbursement by reason of any Wrongful Act." The policy defined Ultimate Net Loss as "the total Indemnity and Defense Cost with respect to each Wrongful Act to which the policy applies, provided that Ultimate Net Loss does not include any amount allocated pursuant to Condition (T), to Claims against persons other than directors and officers or to non-covered matters." Condition T provided for an allocation to the extent that a claim involved "both covered and non-covered matters." Additionally, the policy contained two relevant exclusions. The "Fraud Exclusion" barred coverage for a claim against a director or officer arising from the "dishonest, fraudulent, criminal or malicious act or omission of such Director or Officer if a final adjudication establishes that acts of active and deliberate dishonesty were committed or attempted with actual dishonest purpose and intent and were material to the cause of action so adjudicated." The "Prior Knowledge Exclusion" barred coverage for any claim "where at the inception of the Policy Period the Director and Officer had knowledge of a fact or circumstance which was likely to give rise to such Claim and which such Director and Officer failed to disclose or misrepresented in the application…."

continued on page 8

Rescission Limited to Individuals Who Made Knowing Misstatements in the Application

A federal district court, applying Alabama law, has interpreted the severability and representation clauses in D&O policies issued to HealthSouth Corporation to mean that the insurers "can only rescind the policy as to an insured person who personally made a knowing misrepresentation in the written application on which [the insurer] relied to issue the policy." *In re Health South Corp. Ins. Litig.*, No. CV-03-BE-1139-S (D. Ala. Mar. 16, 2004). The court also held that the fiduciary liability policies issued to HealthSouth precluded rescission "as to any insured who did not make any misstatement in the application with knowledge that the statement was untrue."

continued on page 10

Also in This Issue

Whether Insured Is Aware of Potential Claim Is Factual Question

A federal district court in New York, applying New York law, has held that whether an attorney insured under a legal malpractice policy had knowledge of a potential claim at the time that a court precluded him from using an expert at trial, because he failed to serve an expert report in a timely manner, is a factual question that could not be decided on summary judgment. *Cade & Saunders, P.C., et al. v. Chicago Ins. Co.,* 2004 WL 415225 (N.D.N.Y., Mar. 2, 2004).

The insurer issued annual claims-made policies to a lawyer. The policies' notice provision 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…as soon as practicable."

The insured attorney represented a plaintiff in a personal injury case in October 1998. The attorney became involved in the case at a relatively late stage and sought, at that point, to use a new expert witness at trial; however, the court precluded him from doing so because he did not file an expert report until the morning of trial. A different law firm then handled the trial, which resulted in a verdict for the defense. A subsequent appeal challenging the preclusion of the expert also failed. Three years later, in October 2001, the attorney received a letter advising him that his former client was contemplating a legal malpractice lawsuit. He promptly notified the insurer of the letter and the lawsuit that the former client subsequently filed against him. The insurer denied coverage on the grounds that notice was untimely since the attorney failed to provide notification of the potential claim when the court precluded use of the expert or shortly thereafter.

Coverage litigation ensued, and both parties moved for summary judgment. The insurer argued that notice was untimely since the attorney was on notice of the potential claim as soon as the trial court issued the order precluding use of the expert witness. The attorney argued that he did not have notice of the claim at that time because the preclusion order resulted from a "strategic choice," and because he had a "good faith" belief that a claim would not be filed because of his close relationship with the underlying plaintiff.

The court denied both motions for summary judgment. It first noted that it is "well-settled" that "[a]n insured must provide notice to the insurer upon discovery of facts and circumstances that would lead an objectively reasonable person to believe in the possibility of a claim." However, the court also explained that the determination of reasonableness is generally a factual issue. In light of the arguments and supporting evidence raised by both parties, the court found, "as have a number of other courts when faced with the same issue, that the issue of notice cannot be resolved on a summary judgment motion." ✦

Texas Law Applicable to Coverage Dispute

In an unpublished opinion, a Texas appellate court, applying Texas choice of law principles, held that Texas law applies to a coverage dispute based on "numerous Texas contacts." *Scottsdale Ins. Co., et al., v. Nat'l Emerg. Svcs., Inc.*, 2004 Tex. App. LEXIS 2307 (Tex. App. Mar. 11, 2004).

The insurer entered into negotiations to issue a policy to an Illinois corporation that had its principal place of business in California and did business in all 50 states, including Texas and Virginia. The parties became embroiled in litigation when the insurer canceled the policy after it had received the premium, but while the policy was still being underwritten. A key issue became the determination as to whether Texas or Virginia law applied.

The insurer argued that the parties had agreed to apply Virginia law because the insurance proposal identified the Virginia officer of the corporation as "the first Named Insured." The court rejected this argument, explaining that it "is far too slender a reed to support" the contention that the parties "intended" that Virginia law govern. The court reasoned that to hold that Virginia law governs, it would need to find "either an express or an implied choice of law provision," and there was none present.

The court then determined, applying Texas choice of law principles, that Texas law governs. The court noted that "the central location for the contract formation, negotiation, and cancellation was in Texas." The court also explained that the premium was paid in Texas and that most of the communications and actions concerning the policy were in Texas. Although the "first Named Insured" was located in Virginia, the corporation had offices located throughout the nation and did business in every state. ✦

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Four Suits Concerning Sale of Same Investments Are Separate Claims

A federal district court in Texas, applying Texas law, has determined that four lawsuits filed against a life insurance agent, insured under two E&O policies, concerning the same type of investment constituted separate claims because the agent's duty to each investor depended on their "unique circumstances." *Am. Auto. Ins. Co. v. Grimes*, 2004 WL 246989 (N.D. Tex. Feb. 10, 2004). The court also held that the underlying allegations involved "professional services," as defined in the policies.

An insurer issued a claims-made E&O policy to one insurance company for the period from February 1, 2001 to February 1, 2002, and a claims-made E&O policy to a second insurance company for the period from January 1, 2002 to January 1, 2003. Both policies provided coverage to the life insurance agent who was sued in the underlying litigation. The first policy contained a related claims provision stating that "[t]wo or more claims arising out of a single act, error, omission…or a series of related acts, errors, omissions…shall be treated as a single claim. All such claims, whenever made shall be considered first made during the policy period…in which the earliest claim arising out of such acts, errors, or omissions…was first made and reported." The first policy defined "professional services" to "mean those services necessary to the conduct of the insurance business of the named insured," including the "sale and/or servicing" of various products, including annuities, as well as "[p]roviding advice, consultation, [and] administration…in conjunction" with products the agent sold. The second policy defined "professional services" to include "recommendations regarding saving, investments, insurance, [and] anticipated retirement." The first policy also provided that coverage would be available only if "as of the effective date of this Policy, no named insured had knowledge of any act, error, omission…which could reasonably be expected to result in a claim."

The insured agent began offering non-insurance, non-annuity investments in customer-owned, coin-operated telephones (COCOTs) and allegedly advised his clients to redeem their annuities in order to invest in COCOTs. Four unrelated clients filed separate lawsuits at different times against the agent alleging negligent advice and negligent and fraudulent misrepresentations in connection with the COCOT investments. The insurer filed a declaratory judgment action to determine its obligations under the two policies.

The insurer argued that coverage was available only under the first policy, even though some of the lawsuits were filed during the second policy period, because the four suits were related claims since they all concerned the investments in COCOTs. The court disagreed, explaining that the agent "rendered separate services to each of [the claimants] in separate and distinct meetings, he owed each of them a separate duty, and each meeting required [the agent] to consider unique circumstances in determining how to advise them regarding their investments." It therefore held that the lawsuits filed and reported during the second policy fell within that policy's coverage.

The insurer also argued that coverage was unavailable because the advice concerning the COCOTs investments did not satisfy the policies' definitions of "professional services." The court rejected the argument, explaining that it "will construe those clauses liberally so as to include all services associated with a covered product from its initial sale to a customer through its eventual disposition, provided such services involve the specialized knowledge and training associated with the profession of an insurance agent and/or financial and investment consultant."

Finally, the court addressed the insurer's argument that coverage was unavailable because the agent had knowledge of the claims prior to the inception of the first policy. The court agreed with the insurer's position with respect to one of the claims because, although the plaintiff filed the suit after the inception of the policy, the underlying claimant's attorney had written a letter to the agent alleging fraudulent acts prior to the inception of the policy. The court rejected the agent's argument that the letter did not bar coverage for the allegations of negligence, which had not been raised in the letter, explaining that "the fraud claims involving the COCOTs and the negligence claims involving the annuities clearly arose from a series of related acts involving a single claimant."

The court held that the policies did not preclude coverage for the other claims because there was no evidence demonstrating that the agent had "actual, subjective knowledge [that the underlying plaintiffs] intended to bring claims, or had actually brought claims, against him." In so ruling, the court rejected the argument that the agent had knowledge of the potential claims since he possessed knowledge of his acts, as well as the fraud allegations by one claimant. The court reasoned that "[t]o exclude coverage for claims arising from those acts, simply because claims had been made by other persons regarding different acts, would be to interpret 'knowledge' and 'claim' so broadly as to deny the reasonable expectations of the parties." ✦

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D&O Policy Proceeds Are Not Property of Estate Where Indemnification Has Not Occurred

The United States Bankruptcy Court for the District of Delaware has held that when a D&O policy provides a debtor corporation with indemnification coverage, but that indemnification is uncertain or has not occurred, the proceeds are not property of a bankruptcy estate. *In re Allied Digital Tech. Corp.*, 2004 WL 504268 (Bankr. D. Del. Mar. 16, 2004).

The insurer issued a D&O policy that provided direct coverage to the individual directors and officers of the insured company, corporate reimbursement coverage to the company for amounts paid as indemnification to the directors and officers and entity coverage for securities claims. After the corporation filed for bankruptcy, the trustee filed an adversary proceeding against the corporation's directors and officers seeking $62 million in damages. The directors and officers sought an order allowing reimbursement of their defense costs under the D&O policy. The trustee objected on the grounds that proceeds of the policy were part of the bankruptcy estate, and that the automatic stay therefore barred distribution of these proceeds.

In rejecting the trustee's argument, the bankruptcy court explained that the general rule that a debtor's liability policy is property of the bankruptcy estate does not always apply with respect to policy proceeds. Instead, the court explained that in cases involving policy proceeds, courts look at the specific language of the policies

continued on page 9

I v. I Exclusion Bars Coverage for Former Directors' Suit

A federal district court in Florida, applying Florida law, has held that an insured v. insured exclusion in a D&O policy precluded coverage for a lawsuit brought against the corporation by two of its former directors. *See Powersports, Inc. v. Royal & SunAlliance Ins. Co.*, 2004 WL 415269 (S.D. Fla. Feb. 25, 2004).

An insurer issued a D&O policy to a company that contained an I v. I exclusion precluding coverage for "Loss resulting from any Claim made against any Insured Person, or with respect to Insuring Clause C, the Company…brought or maintained by or on behalf of the Company or any Insured Person in any capacity." The policy also contained an allocation clause that required the insurer and corporation to "fairly and reasonably allocate such amount between covered Loss and non-covered Loss" when the two are "jointly incurred."

Two former directors of the company, as well as a corporation they controlled, sued the corporation and its directors and officers, alleging tortious interference with a contract that the former directors had entered into with a third party to purchase stock of the company. The insurer denied coverage based on the I v. I exclusion, and coverage litigation ensued.

The court held that the I v. I exclusion barred coverage for the lawsuit. The court first noted that the parties agreed that the former directors were "Insured Persons" under the policy. The court then rejected the corporation's argument that because the former directors and the corporation they controlled asserted distinct claims, coverage was available as to the claim by the corporation controlled by the former directors. The court reasoned that "every single allegation of fact in the underlying pleadings and each count asserted in both Complaints" jointly referred to the former directors and their corporation and did not distinguish between their claims.

The court also rejected the corporation's argument that the allocation clause required the insurer to provide coverage for the claims by the company controlled by the former directors. The court reasoned that if it were to read the allocation clause as a grant of coverage for the corporation's claims, "it would read the I v. I clause out of the policy." Finally, the court rejected the corporation's argument that the I v. I exclusion was ambiguous, concluding that "[t]he plain language of the clause states that claims brought by insured persons are not covered." ✦

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Excess Insurer Did Not Act in Bad Faith by Disclaiming Coverage Based on a Professional Liability Exclusion

A Pennsylvania state trial court has determined that an excess insurer did not act in bad faith by disclaiming coverage based on a professional liability exclusion in a general liability insurance policy, even though the court disagreed with the insurer's determination that the exclusion was applicable. *Egger v. Gulf Ins. Co.*, 2004 WL 516687 (Pa. Ct. Com. Pl. Mar. 10, 2004).

The insurer issued an excess general liability policy to a company that provided security guard services. The underlying litigation arose after an employee died in an accident, and his estate alleged negligence on the part of the company in connection with his death. The excess insurer reserved its rights, contending that the claim "did not arise out of [the company's] security guard or investigative operation," but rather out of "the alleged negligent provision of emergency medical services." After the company was found liable in an amount that implicated the excess insurer's layer, it sought indemnification. The insurer denied coverage, and the company sued alleging breach of contract and bad faith. In a prior ruling, the court had found that the professional liability exclusion in the policy did not preclude coverage.

In this decision, the court held that the insurer did not act in bad faith by denying coverage. The court reasoned that the excess insurer had conducted an appropriate and reasonable investigation of the underlying action and clearly notified the company in a reservation of rights letter that it believed coverage was unavailable. The court also noted that, as an excess carrier, the insurer did not have an obligation to provide coverage until the primary policy had been exhausted. Accordingly, the court concluded that the claimant "failed to demonstrate by clear and convincing evidence that [the insurer] lacked a reasonable basis to deny coverage or that it handled the claim improperly or that it was motivated by self-interest or ill will." ✦

Insurer Must Provide Separate Counsel to Town Board Members

A New York appellate court has held that an insurer that issued a professional liability policy to a town has a duty to defend five former town board members where the underlying complaint contained a count for negligence even though the policy "clearly" excluded coverage for the other allegations in the complaint. *Murphy v. Nutmeg Ins. Co.*, 2004 WL 383485 (N.Y. App. Div. Mar. 1, 2004). The court also held that each board member was entitled to separate counsel since each had made a claim for contribution against the others, creating a potential conflict of interest.

The insurer issued a professional liability policy to a town. Although the appellate court did not quote the policy language in its opinion, it stated that the duty-to-defend policy "clearly excluded coverage for, among other things, dishonest, fraudulent, and criminal or malicious acts of the insured, as well as acts arising out of an insured's activities in a fiduciary capacity." The town brought the underlying action against five former members of the town board alleging RICO violations, breach of fiduciary duty and negligence based on their participation in the purchase of a building to house local police and court facilities.

The appellate court held that the insurer had a duty to defend the board members because the underlying complaint included a negligence count. The court noted that the insurer would not have a duty to defend if the only counts had been for RICO violations and breach of fiduciary duty. However, the court explained that the insurer had a duty to defend "as long as there remains a pending claim sounding in negligence, since the allegations set forth in that claim for relief fall squarely within the scope of the risks covered by the subject policy." The court also held that each of the board members is entitled to separate counsel "since each made a claim for contribution, and thus, the possibility of conflict exists." ✦

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Third Party Payments Do Not Constitute Loss Under Crime Policy

In an unreported decision, a Minnesota appellate court has held that settlement payments to reimburse a third party for losses caused by thefts perpetrated by the insured's employees did not constitute a loss under an excess crime loss indemnity policy. *Cargill, Inc. v. Nat'l Union Fire Ins. Co.*, 2004 WL 51671 (Minn. Ct. App. Jan. 13, 2004).

An insurer issued an excess crime loss indemnity policy to a company that marketed hybrid corn seed used to grow feed corn. The genetic code of hybrid seeds is known as germplasm. The germplasm of a particular hybrid seed is a trade secret, which may be patented and registered pursuant to the Plant Variety Protection Act.

The policy provided that the insurer will indemnify the insured for "[l]oss sustained by the Insured by reason of any claim first made against the Insured during the Policy Period directly caused by Theft or Forgery by any Employee of the Insured and for which loss the Insured is liable." The policy excluded coverage for "damages of any type, including but not limited to, punitive, exemplary, and the multiplied portion of multiplied damages, for which the Insured is legally liable, except direct compensatory damages…arising from a loss covered under this Policy; [and] indirect or consequential loss of any nature."

In June 1998, the insured sold its seed business. Pursuant to the sale agreement, the company warranted that as of the date of the sale it was unaware of any "pending or…threatened litigation or claim of infringement or misappropriation" regarding the transferred germplasm. The sale agreement also provided that the transferred germplasm was not subject to "any claim or potential claim of joint ownership by a third party." In October 1998, a competitor brought suit against the insured company alleging violations of the Lanham Act for falsely representing in its advertising that its seed corn was the result of its own research when the company had actually used a competitor's germplasm in cultivating its seeds. In February 1999, the competitor brought suit against the company that had purchased the insured's seed business. The suit sought to enjoin the purchaser from using the competitor's proprietary germplasm in its seed corn. The purchaser in turn informed the insured that the competitor's claims could potentially lead to a breach of contract action.

In June 1999, the insured settled with the purchaser. The purchaser agreed to release all potential breach of contract claims in exchange for $335 million. Of that amount $295 million was designated as a return of the price paid as consideration for the purchaser's loss of the use of the insured's germplasm. In May 2000, the insured entered into a settlement agreement with the competitor company pursuant to which the insured agreed to pay the competitor $100 million, $71 million of which represented royalties for past use of proprietary information.

The insured sought coverage from the insurer for defense and settlement costs. In June 2000, the insured submitted a proof of loss to the insurer detailing six different thefts of the competitor's germplasm by its employees. After the insurer denied coverage, litigation followed.

The appellate court held in favor of the insurer. First, the court noted that the crime loss policy in question was an excess policy that was triggered only after the primary insurer has paid the full amount of limits on the underlying policy. The court found that the insured has made no showing that the primary insurer had paid or agreed to pay the full amount of limits on the underlying policy.

The court went on to hold that even if the full limits of the underlying policy had been paid, the insured was not entitled to coverage under the policy. The court concluded that the language of the policy's insuring clause was a fidelity provision, providing coverage solely for the insured's direct losses caused by an employee's theft and not for the insured's liability to third parties caused by the employee's theft.

The court also held that the insured would not be entitled to coverage because the insured had not suffered a loss. The court pointed out that the term "loss," though not defined in the policy, requires a financial detriment. In this case, the settlement monies were for a partial return of the purchaser's price and royalties owed to the insured's competitor. The court concluded that

continued on page 7

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Third Party Payments

continued from page 6

these amounts were restitutionary in nature and therefore did not represent a financial detriment to the insured. Additionally, the court noted that the misappropriated germplasm was used by the insured for its financial benefit. The Court held that it could not find that an insured has suffered a loss when it "reimburses a third party for employee dishonesty carried out for the benefit of the insured."

The court also held that the insured was unable to prove that its losses were even caused by theft. The court determined that the injured competitor's claim for damages was based on the insured's improper use of proprietary information and not on an actual conversion of property. The court also held that the insured could not recover under the policy because of a policy exclusion denying coverage for "loss resulting from the accessing of any confidential information, including…trade secret information." ✦

Litigator Joins WRF's Expanding Insurance Practice

Wiley Rein & Fielding LLP is pleased to announce that **Jonathan M. Jacobs** has joined the firm's insurance and litigation practices as Of Counsel. His arrival further enhances the capabilities of one of the largest and most prominent insurance law practices in the United States. In the past several years, the practice has added almost a dozen members.

Mr. Jacobs will represent clients in professional liability matters and related litigation. In addition to extensive experience litigating a wide variety of disputes, including commercial, corporate, insurance and securities law matters, Mr. Jacobs conducts internal investigations for companies facing allegations of wrongdoing.

Mr. Jacobs received his J.D. from the University of Pennsylvania Law School and served as a Law Clerk for the Honorable Paul V. Niemeyer, U.S. District Court for the District of Maryland (now on the Court of Appeals for the Fourth Circuit). ✦

Jonathan M. Jacobs can be reached at 202.719.7464 or jjacobs@wrf.com.

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Insurers Must Advance Defense Costs

continued from page 1

Adelphia disclosed that its past financial statements contained false and misleading information. The company filed for bankruptcy in June 2002. Numerous suits were brought against the directors and officers of the company, who then sought the advancement of defense costs by the insurers. The insurers refused to advance defense costs, rescinded the D&O policies and advised the defendants that absent rescission there was no coverage under the D&O policies for the suits filed based on several exclusions in the policies. The insurers then filed a declaratory judgment action in the district court seeking a judicial determination concerning rescission and coverage. Thereafter, the bankruptcy court stayed the coverage litigation "in so far as it relates to the Carriers' request for rescission, any factual findings, and all deposition discovery." However, the bankruptcy court lifted the automatic stay to permit the directors and officers to seek access to up to $300,000 per insured for defense costs from the insurers.

The district court held that the insurers were required to advance defense costs. First, the court determined that the insurers could not refuse to advance defense costs based on their unilateral rescission of the policies. The court explained that it could not engage in fact finding to determine whether rescission was proper because of the stay issued by the bankruptcy court. The court further noted that "the black letter law of Pennsylvania supports the view that rescission is available to a defrauded party without a judicial determination if the party repudiates the contract and provides restitution," which, for an insurance contract, requires return of the premium. In this case, however, the court noted that the carriers had not returned the premiums and could no longer do so because of the bankruptcy stay. The court concluded that, under Pennsylvania law, a contract remains in full force and effect pending rescission and therefore the insurers would have to advance defense costs pending the outcome of the insurers' rescission claim.

The court concluded that, under Pennsylvania law, a contract remains in full force and effect pending rescission and therefore the insurers would have to advance defense costs pending the outcome of the insurers' rescission claim.

The court then addressed whether the policy provided for the advancement of defense costs. The court found that based on the "legally obligated to pay" language in the insuring clause of the policy, the insurers' duty to pay defense costs arose contemporaneously with the director's and officer's obligation to pay those costs. The court rejected the insurers' contention that the allocation clause of Condition T of the policy rendered the advancement of defense costs discretionary on the part of the insurers. The court noted that Condition T allowed for allocation only if a "claim…includes both covered and non-covered matters" and that, in the present case, the insurers had taken the position that all of the insureds' claims were not covered. Next, the court determined that the "Fraud Exclusion" was inapplicable because there had been no judicial determination that the directors and officers engaged in active fraud or deliberate dishonesty. However, the court noted that in the event that there was such a later judicial determination, the insureds would be required to reimburse the insurers for the defense costs advanced.

Finally, the court addressed the applicability of the "Prior Acts Exclusion." The court found that unlike the "Fraud Exclusion," the "Prior Acts Exclusion" did not on its face require a final adjudication to take effect. However, the court also noted that the exclusion did not state how a determination regarding whether the insured had knowledge of claims prior to the policy period should be made. The court found that the exclusion could "reasonably be read" to permit the insurer to determine whether the exclusion applies or to require a judicial determination that the exclusion applies. The court also indicated that it could not itself make findings of fact as to whether the "Prior Acts Exclusion" applied because of the bankruptcy stay. Accordingly, the court held that the exclusion was ambiguous and construed it in favor of the insureds. Moreover, the court again noted that the insurers would be entitled to reimbursement of defense costs if they ultimately prevailed on this defense. ✦

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Coverage Not Barred for Failure to Warn of Future Danger

The United States Court of Appeals for the Eighth Circuit, applying Missouri law, has held that a criminal acts exclusion in a professional liability policy issued to a psychologist does not preclude coverage for a lawsuit alleging that the psychologist failed to warn a child and the child's mother of the danger of continuing sexual abuse by the child's father. *Am. Home Assur. Co. v. Pope*, 360 F.3d 848 (8th Cir. 2004).

The insurer issued a professional liability policy to a psychologist, which contained an exclusion barring coverage for any "dishonest, criminal, fraudulent, or malicious act or omission." The underlying plaintiff sued the psychologist, alleging that he negligently failed to warn her and her mother of the future danger of sexual abuse by her father, who was a patient of the psychologist. The underlying plaintiff also alleged that the psychologist violated a Missouri law that makes the failure to report child abuse to state authorities a misdemeanor. The insurer filed a declaratory judgment action seeking a ruling that the criminal acts exclusion in the policy precluded coverage.

The Eight Circuit held that coverage was available. The court stated, without explanation, that the exclusion in the policy precluded coverage for the allegation that the psychologist violated Missouri law. The court determined, however, that the exclusion did not exclude coverage for the "common law duty to notify private individuals" of the risk of future harm. The court reasoned that the insurer "has not cited any Missouri statue or case law making criminal the failure to warn *the victim* of the possibility of future abuse." ✦

D&O Policy Proceeds

continued from page 4

and who is listed as an insured. The bankruptcy court identified four potential scenarios:

- First, in cases where a policy provides only direct coverage to directors and officers, the court stated that the proceeds are not property of the estate.
- Second, in cases where a policy provides only direct coverage to a debtor, the court concluded that the proceeds are property of the estate.
- Third, in cases where a policy provides direct coverage to the directors and officers, and direct or indemnification coverage to the debtor, the court explained that the proceeds are property of the estate "if depletion of the proceeds would have an adverse effect on the estate to the extent the policy actually protects the estate's other assets from diminution by providing indemnification coverage for a pending claim."
- Fourth, in cases where a policy provides the debtor with coverage, but the coverage "either has not occurred, is hypothetical, or speculative," the proceeds are not property of the estate.

The court concluded that the last scenario applied in this case. The court found that policy provided: (1) direct coverage to the individual defendants for "real" claims and defense costs and (2) indemnification coverage to the corporation for amounts paid to the directors and officers. However, such payments were "hypothetical" at this point since the company had not paid any defense costs. In addition, the trustee had not shown that any securities claims were viable, such that there would be direct coverage for the corporation. Therefore, the directors and officers were entitled to their bargained-for right to coverage for liability and defense costs. The court viewed the trustee as "no different than any third party plaintiff" since his concern was only that the payment of defense costs might affect his ability to recover under the D&O policy as a plaintiff rather than protecting a potential defendant.

Although it was not necessary to the outcome, the court further suggested that even if the proceeds of the policy were part of the bankruptcy estate, the automatic stay should be lifted because the directors and officers had shown that they would be unable to conduct a worthwhile defense of the trustee's claim absent funding from the policy. ✦

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Rescission Limited

continued from page 1

Various carriers issued primary and excess D&O policies and fiduciary liability policies to HealthSouth. Following an investigation by the United States Securities and Exchange Commission and the Department of Justice of fraud at the company, 11 officers and employees pled guilty to the charges brought by the government. Thereafter, securities, derivative and ERISA class action lawsuits were filed against the company and its directors and officers. Following tender of these claims, the insurers filed litigation to rescind the policies.

The primary D&O policy contained a "Representations and Severability Clause" with the following language:

> In granting coverage to any one of the Insureds, the Company has relied upon the declarations and statements in the written application for this coverage section and upon any declarations and statements in the original written application submitted to another insurer in respect of the prior coverage. All such declarations and statements are the basis of such coverage and shall be considered as incorporated in and constituting part of this coverage section.
>
> Such written application(s) for coverage shall be construed as a separate application for coverage by each of the Insured Persons. With respect to the declarations and statements contained in such written application(s) for coverage, no statement in the application or knowledge possessed by any Insured Person shall be imputed to any other Insured Person for the purpose of determining if coverage is available.

In addition, the fourth excess D&O policy provided:

> [I]t is hereby understood and agreed that this policy is issued in reliance upon statements made and materials furnished to the Insurer…including prior applications or requests, and all statements made and materials incorporated in the following specific documents… whether furnished directly to the Insurer or indirectly to the Insurer from public sources available to the Insurer.

The application to the fiduciary liability policy stated that "[t]he undersigned declares that the statements set forth herein are true to the best of his or her knowledge and belief." The policy further provided that "[n]o statement in the application or knowledge or information possessed by an Insured shall be imputed to any other Insured for the purpose of determining the availability of coverage hereunder."

The court first held that, under the primary D&O policy, rescission could be based only on mistatements or omissions in the written application. The court noted that Alabama law permits reliance on other materials; however, the court concluded that the primary policy narrowed the insurer's rights since it referenced only written materials. The court also held that the severability clause of the D&O policy limited rescission to knowing misrepresentations. The court explained that although the Alabama rescission statute allows rescission for innocent misstatements that are material or affect the insurer's decision to issue the policy, here the insurers waived the defense of innocent misrepresentation by including references to "knowledge" in the severability clause. The court then held that the severability clause "unambiguously provides that the rights of each insured as to coverage will be separately determined." Thus, knowledge of one insured could not be imputed to any other insured.

The court next addressed coverage under the excess policies. The court rejected the excess carriers' argument that they were not bound by the severability clause in the primary policy. The court reasoned that the excess policies followed form to the primary policy and none of the policies contained a different severability provision or even referenced severability. The court noted that the fourth excess carrier for one of the policy periods at issue had language in its policy stating that it would rely on materials beyond the application and enumerating those materials. The court therefore held that to the extent that individual insureds had knowledge of the falsity of any such materials, they could provide a basis for rescission to that excess carrier and the carriers higher up in the tower.

The court also considered the ability of the D&O carriers to rescind as to the company itself. The court noted that with respect to entity coverage for the company for securities violations, the primary policy modified the severability clause by providing that knowledge of any insured company could be "imputed" to the company. However, the court explained that the modification did not apply to the second insuring clause concerning coverage to the company for indemnification of individual insureds. The court concluded that since coverage to the company for indemnification "in essence is derivative of the individual insured's person's right to coverage," the carriers could not deny indemnification coverage except as to any individual insured who made knowing misrepresentations.

continued on page 11

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Business Enterprise Exclusion Does Not Bar Coverage

Applying Maine law, the United States Court of Appeals for the First Circuit has held that a business enterprise exclusion in a lawyer's professional liability policy does not bar coverage for a malpractice claim alleging that an insured lawyer improperly negotiated a book deal for a client in which all proceeds from the book sales were channeled into the client's corporation in which the lawyer's wife owned 25 percent of the shares. *Am. Guarantee & Liab. Ins. Co. v. Keiter*, 360 F.3d 13 (1st Cir. 2004).

The insurer issued a lawyer's professional liability policy that contained an exclusion for "any claim based upon or arising out of the work performed by the Insured, with or without compensation, with respect to any corporation, fund, trust, association, partnership, limited partnership, business enterprise or other venture…in which any Insured has any pecuniary or beneficial interest, irrespective of whether or not an attorney-client relationship exists, unless such entity is named in the Declarations." The exclusion stated that "[f]or purposes of this policy, ownership or shares in a corporation shall not be considered a 'pecuniary or beneficial interest' unless one Named Insured or members of the immediate family of the Named Insured own(s) 10 percent of the issued and outstanding shares of such corporation."

In the underlying action, a former client brought a malpractice suit against the insured attorney alleging, among other things, that the attorney breached his fiduciary duty to the client by negotiating a book contract on the client's behalf in a manner to benefit the attorney. Specifically, the client alleged that the attorney negotiated the contract to channel all proceeds into the client's corporation in which the lawyer's wife owned 25 percent of the shares. The insurer filed a declaratory judgment action seeking a ruling that it had no duty to defend or indemnify the lawyer based on the business enterprise exclusion.

The First Circuit initially noted that "[p]rofessional liability insurers generally do not wish to provide coverage for the business activities of insured lawyers," and therefore generally include a business enterprise exclusion in their policies. In this instance, however, the court concluded that the business enterprise exclusion did not unambiguously bar coverage. The court explained that, under the first sentence of the exclusion, the attorney had no pecuniary interest in the corporation since he did not own shares, though he might be deemed to have a beneficial interest in it through his wife's stock ownership. The court then turned to the second sentence of the exclusion and reasoned that it could be construed in two different ways, only one of which would preclude coverage. On one hand, the sentence could be read, as the insurer argued, to bar coverage whenever an immediate family member owns 10 percent of the outstanding shares of a corporation. Alternatively, the court reasoned that the second sentence could be read "as a carve out, not as definition." Under this approach, the exclusion would be triggered only by a determination that, under the first sentence of the exclusion, the insured has a "beneficial interest" in the business at issue. The court concluded that the second approach was preferable because "[t]his is the most literal reading of the two sentences. It also has the benefit of looking to state law definitions of property rights in the absence of an express definition of the term 'pecuniary or beneficial interest' in the Policy."

Applying this reading of the business enterprise exclusion, the court held that the exclusion did not apply and the insurer had a duty to defend the lawyer. The court explained that, under Maine law, a husband does not by virtue of marriage alone gain a beneficial interest in property owned by his wife absent divorce. Since there was no indication that the attorney and his wife were in a divorce situation, the husband had no beneficial interest in his wife's stock, and the exclusion did not apply. ✦

Rescission Limited

continued from page 10

Turning to the fiduciary liability policies, the court evaluated whether those insurers had the right to rescind. The court held that the primary policy plainly provided that no statement or knowledge by one insured could be imputed to any other insured. Thus, for the fiduciary insurer "to seek rescission against any insured, it must establish the knowledge of the specific insured as to any alleged misrepresentations based on what that insured knew." ✦

Contributors

Joseph A. Bailey III	202.719.4554	jbailey@wrf.com
Nicholas A. Bonarrigo*	202.719.7410	nbonarrigo@wrf.com
Mary E. Borja	202.719.4252	mborja@wrf.com
Thomas W. Brunner	202.719.7225	tbrunner@wrf.com
Deborah Chandler**	202.719.7414	dchandler@wrf.com
Jason P. Cronic	202.719.7175	jcronic@wrf.com
Paul A. Dame*	202.719.7415	pdame@wrf.com
Cara Tseng Duffield	202.719.7407	cduffield@wrf.com
Valerie E. Green	202.719.7516	vgreen@wrf.com
Paul J. Haase	202.719.3434	phaase@wrf.com
Dale E. Hausman	202.719.7005	dhausman@wrf.com
Jonathan M. Jacobs	202.719.7464	jjacobs@wrf.com
Kimberly M. Melvin	202.719.7403	kmelvin@wrf.com
Karalee C. Morell	202.719.7520	kmorell@wrf.com
Leslie A. Platt	202.719.3174	lplatt@wrf.com
Adam Rogers***	202.719.7422	arogers@wrf.com
Kenneth E. Ryan	202.719.7028	kryan@wrf.com
William E. Smith	202.719.7350	wsmith@wrf.com
Daniel J. Standish	202.719.7130	dstandish@wrf.com
Sandra Tvarian Stevens	202.719.3229	sstevens@wrf.com
David H. Topol	202.719.7214	dtopol@wrf.com
Jonathan S. Woodruff	202.719.7426	jwoodruff@wrf.com

* Member, Virginia Bar. District of Columbia Bar membership pending. Supervised by the principals of the firm.
** Member, Massachusetts Bar. District of Columbia Bar membership pending. Supervised by the principals of the firm.
*** Member, Florida Bar. District of Columbia Bar membership pending. Supervised by the principals of the firm.

1776 K Street NW ✦ Washington, DC 20006 ✦ (ph) 202.719.7000 ✦ (fax) 202.719.7049
7925 Jones Branch Drive ✦ Suite 6200 ✦ McLean, VA 22102 ✦ (ph) 703.905.2800 ✦ (fax) 703.905.2820

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