Wiley Rein & Fielding

March 2004

The Executive Summary

Developments Affecting Professional Liability Insurers

Single Lawsuit Constitutes Five Claims Under Policy

The Maryland Court of Appeals has held that, under a legal malpractice policy, a single lawsuit brought by five siblings alleging malpractice by the insured attorney in connection with a single personal injury lawsuit he brought on their behalf involved five separate claims under the policy. *Beale v. Am. Nat'l. Lawyers Ins. Reciprocal*, 2004 WL 306092 (Md. Feb. 19, 2004).

The insurer issued a lawyers professional liability policy, with a per claim limit of $1 million and an aggregate limit of $2 million. The policy stated that "[t]he Per claim Limit of Liability…is the limit of the Company's liability for all Damages arising out of the same, related or continuing Professional Services without regard to the number of claims made, demands, suits, proceedings, claimants, or Persons Insured involved."

Five siblings, who suffered bodily injury as a result of ingesting lead paint chips present in a rented house in Baltimore, MD retained the law firm to represent them in a personal injury action against their landlord. The attorney representing the siblings neglected the case, resulting in summary judgment in favor of the landlord based on lack of evidence. Thereafter, the siblings filed the underlying malpractice action against the attorney. The insurer maintained that the malpractice action constituted a single claim and offered the siblings the per claim limit of $1 million. After the siblings rejected the offer, demanding the aggregate limit, the insurer filed the instant declaratory judgment action.

The Court of Appeals held in favor of the siblings, reasoning that the underlying litigation involved five claims under the policy because the attorney had a separate duty as to each sibling, even if he was representing them in the same case. The court explained that "the parties' intentions are more accurately determined by recognizing, and giving effect to, the duty that an attorney owes to each client individually and separate and apart from that owed his or her other clients." The court opined that a separate result could have been reached as to each individual child in the original litigation based on, for example, variations in their lead paint exposure and the resulting injury. The court therefore concluded that "because of the individual differences in the children and the distinct and separate duty that the attorney owes to each…the rendering of professional services on behalf of one of the children is not the same professional service as, or even related to, the professional services rendered on behalf of the other children." ✦

Insurer Must Advance Defense Costs Despite Rescission of Policies

A New York trial court has held that an insurer that issued D&O and fiduciary liability policies to Tyco International Ltd. must advance defense costs to former CEO Dennis Kozlowski even though the insurer had rescinded the policies based on material misrepresentations and omissions made to the insurer in application. *Fed. Ins. Co. v. Tyco Int'l Ltd.* (N.Y. Sup. Ct. Mar. 5, 2004).

The insurer issued a series of D&O and fiduciary liability policies to Tyco from March 15, 1999 through March 15, 2003. The fiduciary policy required the insurer to defend the insureds in covered litigation; the D&O policy required the insurer to advance defense expenses for covered claims. Both policies contained a personal profit exclusion precluding coverage for loss "based upon, arising from, or in consequence of such [insured] having gained in fact any personal profit, remuneration or advantage to which such [insured] was not legally entitled."

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Attorneys Fees Constitute Monetary Judgment

In an unreported decision, an Ohio appellate court has held that attorneys fees awarded in an underlying lawsuit constitute a "monetary judgment" under an E&O policy issued to a township. *Sylvania Township Bd. of Tr. v. Twin City Fire Ins. Co.,* 2004 WL 226115 (Ohio Ct. App. Feb. 6, 2004).

The insurer issued an E&O policy to a township board of trustees. The policy provided that the insurer would "pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of errors or omissions injury to which this policy applies." The policy provided that "damages" means a "monetary judgment, award or settlement but does not include fines or penalties or damages for which insurance is prohibited by law applicable to the construction of this policy." The policy did not define the terms "monetary judgment," "fine" or "penalty."

In the underlying action, the court ordered the board of trustees to pay attorneys fees for violations of Ohio's Public Records Act and Sunshine Act. After the insurer took the position that attorneys fees are punitive in nature and denied coverage, this coverage litigation ensued.

The Ohio appellate court held that attorneys fees constituted damages under the policy. The court distinguished an earlier Ohio case that did not involve insurance coverage, which had held that attorneys fees are not "monetary damages" within the meaning of common law damages. In that case, the court had considered whether the court of common pleas or the court of claims had jurisdiction to award attorneys fees. By contrast, in the insurance context, the appellate court explained that a court must evaluate the contract language, not the common law concept of damages. Since the policy did not define "monetary judgment" or "penalties," the court applied the "common" meaning of these terms to find that attorneys fees qualify as a monetary judgment. The court also reasoned that the underlying award of attorneys fees was discretionary, not punitive. "Because this award was handled pursuant to statute, the attorneys fee award is regarded as part of costs. Therefore, the award of attorneys fees did not constitute a 'fine' or a 'penalty,' and as a result, none of the exceptions to the broad definition of 'damages' applied." ✦

Improper Billing Is Not a Professional Service

A New Jersey appellate court has held that two insurers who issued medical malpractice policies had no duty to defend a claim for reimbursement of improperly billed sums because billing is a commercial service, not a professional service, under a professional liability policy. *Hampton Med. Group, P.A. v. Princeton Ins. Co.*, 2004 WL 169810 (N.J. Super. Ct. App. Div. Jan. 29, 2004).

Two different insurance companies issued similar physician's professional liability policies to two medical groups. Both policies afforded coverage for injuries arising out of "the rendering of or failure to render…professional services" associated with a "medical incident." One of the policies defined "medical incident" as "any act or failure to act in the furnishing of professional medical…services." The other policy defined "medical incident" as "a single act or omission or a series of related acts or omissions in the rendering of or failure to render professional services to any one person." The second policy defined "professional services" as "services requiring specialized knowledge and mental skill in the practice of the profession described in the declarations…."

The insureds both contracted with hospitals to provide psychiatric physician services. In the underlying litigation, a health insurance provider sued the medical groups for reimbursement of improperly billed sums, alleging fraud, intentional misrepresentation, negligent misrepresentation and unjust enrichment. The complaint did not allege injury to patients, but rather that the medical groups extended treatment in order to trigger coverage or bill for services not rendered. The insurers denied coverage for these claims and this coverage litigation followed.

The court held that the "claim for reimbursement cannot fairly be characterized as a claim for damages arising out of a physician's rendering or failure to render professional services. Nor do we consider its claim for reimbursement to represent a medical incident." Specifically, the court distinguished between commercial and professional activities. Here, the court reasoned, the allegations of over billing "related entirely to plaintiffs' commercial activities running their business enterprises and did not involve a medical incident." Accordingly, the court found that there was no coverage under the policy. The court distinguished this case from a case involving allegations of patient injury. According to the court, a claim alleging that a patient did not receive the appropriate standard of care would qualify as a professional incident and would be covered by the policies. ✦

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Single Limit Applies, Claims Are Related and Insurer May Advance Under Mutual Fund Policy Despite Receivership Order

A federal district court in Texas, applying Texas law, has granted a motion for summary judgment filed by an insurer immediately after the insurer initiated a suit seeking a declaratory judgment as to a number of coverage issues. *Exec. Risk Indem., Inc. v. Integral Equity, L.P., et al.*, 2004 WL 438936 (N.D. Tex. Mar. 10, 2004). The court held, *inter alia*, that the insureds and underlying claimants were not entitled to discovery on the coverage issues under Rule 56(f) because:

- the policy was unambiguous,
- the claims made against insureds were "related" such that only one $5 million limit of liability per "claim" applied,
- the advancement of defense expenses depletes the limit of liability and
- the insurer was authorized to advance defense costs to the insureds notwithstanding that some of them were in receivership under Texas law.

Wiley Rein & Fielding LLP represented the insurer in the case.

The insurer issued an insurance policy that provided specified coverage to mutual funds and one of its officers. The policy contained a $5 million per claim limit and a $25 million aggregate limit. The policy defined "claim" as "any civil proceeding in a court of law or equity." It defined "related claims" as "all Claims for Wrongful Acts based on, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving the same or related facts, circumstances, situations, transactions or events," and provided that related claims would be treated as a single claim. The policy stated that "the Underwriter will, upon written request, pay on a current basis Defense Expenses for which this Policy provides coverage," and that "Defense Expenses will be part of and not in addition to the Underwriter's limit of liability, and payment of Defense Expenses by the Underwriter will reduce and may exhaust its limit of liability."

A lawsuit was filed in Texas state court against the insureds alleging mismanagement in connection with money that

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Class Action Plaintiffs Not Permitted to Intervene in Coverage Action

A federal district court in Alabama has held that class action plaintiffs were not entitled to intervene in a declaratory judgment action brought by insurers of the defendants seeking to rescind policies issued to the defendants because the class action plaintiffs did not have a legally protectable interest in the insurance dispute and because the interests of the plaintiffs were adequately represented by the policyholder defendants. *In re HealthSouth Corp. Ins. Litig.*, 2004 WL 231427 (N.D. Ala. Feb. 3, 2004).

The insurers had issued crime loss indemnity policies and fiduciary liability policies to the policyholders who were sued in an underlying ERISA class action alleging that they had breached fiduciary duties they owed to a health plan. The insurers filed this action against the policyholders, seeking a declaration that the policies were void *ab initio* due to fraud and misrepresentations in the underwriting process. The class action plaintiffs filed a motion to intervene in the rescission proceeding, asserting that they were entitled to intervene as of right or requesting that they be granted permissive intervention.

The court first considered the class action plaintiffs' motion to intervene as of right. The court held that the plaintiffs were not entitled to intervene because they did not have a protectable interest in the property or the transaction that was the subject of the rescission. Instead, the court concluded that the class action plaintiffs had only a contingent interest in the subject of the insurance dispute because no judgment had been obtained against the policyholders. The court also reasoned that the class action plaintiffs' interests were adequately represented by the policyholders. The court explained that the claimants and the policyholders had identical interests with respect to the insurers, which was to ensure that the policies were not rescinded and that the policies were available to provide coverage for any losses that may be covered.

The court also held that the class action plaintiffs should not be granted permissive intervention, reasoning that the would-be intervenors' claims and defenses did not have common questions of law or fact with the insurance dispute. The court explained that the underlying plaintiffs' federal ERISA allegations were unrelated to the insurers' state law allegations concerning misrepresentations in the insurance underwriting process. In addition, the court noted that, even if common questions existed, it was appropriate to deny permissive intervention in order to avoid unduly complicating and delaying the insurance dispute. ✦

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No Duty to Defend Dentist Accused of Sexual Assault

A United States District Court in Kansas has held that an insurer did not owe a duty to defend or indemnify a dentist accused of sexually assaulting his assistant while purporting to be providing medical treatment. *Wisdom v. Saint Paul Fire & Marine Ins. Co.*, 2004 WL 290976 (D. Kan. Jan. 23, 2004).

The dentist hired an assistant and told her that he wanted to train her to aid him in treating Temporomandibular Joint (TMJ) Syndrome, a painful facial condition in the joints of the lower jaw. During the training, aware that the assistant herself suffered from TMJ, the dentist asked the assistant to sit in the dental chair so that he could demonstrate the TMJ treatment using electrodes and massage. While in the chair, the dentist asked the assistant to remove her clothes as part of the treatment, and then proceeded to sexually assault her.

The assistant sued the dentist alleging battery and outrage. The policy stated that the insurer will "defend any suit brought against any protected person for covered claims, even if the suit is groundless or fraudulent." The policy also provided that "[the insured] is protected against claims that result from: Professional services that you provided or should have provided." The insurer declined to defend and filed a declaratory judgment action, seeking a determination that it owed no duty to defend or indemnify under the policy.

The court granted the insurer's motion for summary judgment. The court concluded that, given the facts, a duty to defend could only be predicated on a finding that the dentist was providing treatment or related training for TMJ pain as a professional service. The court found, however, that a "good faith analysis" of the facts revealed that the assistant's allegations were based on the dentist's intentional plan to sexually arouse himself, rather than on negligent professional treatment. Accordingly, the principal allegations of the assistant's complaint did not involve the practice of dentistry or any other professional service. ✦

No Federal Question Jurisdiction for Suit Seeking Coverage for Liability Under Section 16(b)

In an unreported decision, a federal district court for the Western District of Washington granted a motion to remand, holding that there is no federal question jurisdiction for a lawsuit seeking indemnification from insurers for a claim for Section 16(b) liability under the Securities Exchange Act of 1934. *Jain v. Clarendon Am. Co.,* No. C03-2842P (W.D. Wash. Jan. 9, 2004).

A former CEO and his wife sought coverage from their directors and officers liability insurance carriers and indemnification from the corporate insured (Infospace, Inc.) after a court had found them liable for approximately $200 million allegedly gained in prohibited short-swing trading in violation of Section 16(b) of the Exchange Act. The insurers denied coverage, *inter alia,* because federal law bars indemnification for Section 16(b) liability and Infospace refused to indemnify them. Thereafter, the CEO and his wife filed suit in state court, alleging breach of contract, breach of the duty of good faith and fair dealing, breach of fiduciary duties and intentional interference with contract relations. Infospace removed the suit to the Western District of Washington, arguing that the CEO's and his wife's claims implicated and depended on a substantial federal question—whether indemnity is available for Section 16(b) liability.

The district court rejected Infospace's position, reasoning that the "argument is properly characterized as a defense based on a federal question" and therefore could not provide a basis for removal. Although Infospace could use the prohibition under Section 16(b) against indemnification as a defense to the claims, the court held that Infospace could not rely on such a defense to justify removal because any grounds for removal must appear on the face of the complaint.

In granting the insureds' motion for remand, the court rejected Infospace's argument that the federal court had jurisdiction because the insureds' claims are necessarily federal in character and the insureds' right to relief depends on resolution of a substantial, disputed federal question. The court reasoned that the insureds were not seeking to challenge their federal Section 16(b) liability, but rather, alleging that the insurers had breached their obligations in violation of state law by not insuring that liability. The court concluded "that insurance or indemnification coverage and indemnification are not the same."

The court also rejected the arguments that resolution of the allegations depended on the resolution of a substantial, disputed federal question that was a necessary element of the insureds' state law claims. The court found that the insureds' allegations rested on state contract or tort law. The court also explained that the insureds did not need to prove that their contract was valid to bring a breach of contract claim. ✦

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City's Liability Policies Provide Civil Rights Violations Coverage

In a lengthy opinion addressing a myriad of coverage issues, the United States District Court for the Eastern District of Michigan, applying Michigan law, has held that insurers that issued professional liability policies to a city had certain obligations to provide a defense and indemnity for underlying litigation alleging due process and equal protection violations, as well as defamation and slander. *City of Sterling Heights, et al. v. United Nat'l. Ins. Co., et al.,* 2004 WL 252091 (E.D. Mich. Feb. 11, 2004).

In the underlying litigation, the operators of an amphitheater filed state and federal lawsuits against the insured city and its city manager. These lawsuits alleged that city officials harassed the operators and conspired to violate their due process rights by revoking a special land use permit. The complaints alleged, among other things, substantive and procedural due process violations, equal protection violations, business libel and slander and breach of express and implied contract. The city filed the instant declaratory judgment action against three insurers that issued its primary and excess liability coverage.

Employment Practices Liability

The first insurer had issued two primary and excess claims-made, public officials and employment practices liability policies to the city, including one policy effective from September 2000 to September 2001, and another policy effective from September 2001 to September 2002. The district court first addressed the insurer's argument that coverage was unavailable because the township made the decision to revoke the permits after the policies had expired. The court rejected this argument, reasoning that the complaints alleged numerous violations of the underlying plaintiffs' civil rights that occurred prior to the policies' expirations based on threats to revoke the license. The court also held that coverage was available only under the first policy period because that was when the city first gave notice of circumstances that might give rise to the claim.

The court also rejected the insurer's argument that the libel, slander and defamation allegations asserted against the city and its manager were not included in the policy definition of "employment wrongful acts" under the employment practices liability policy. The definition of "employment wrongful act(s)" included "actions involving…defamation…libel, slander…or other employment-related practices." The policy also stated that "Employment Wrongful Act(s) does not include any Public Official Wrongful Act(s)." The court held that the claim by the non-employee, underlying plaintiff could constitute an "employment wrongful act." The court also rejected the insurer's argument that the policy covered only "employment-related conduct" with respect to employees of the Township, reasoning that "[t]his argument ignores the fact that, in the underlying State Action, it is alleged that [the city manager] committed the slander, libel and/or defamation while employed as the City's Manager."

The court next rejected the insurer's contention that there was no coverage for the plaintiffs' equal protection allegations because its policy excluded coverage for damage "arising out of the willful violation" of state or federal statutes. Although the court acknowledged that the underlying plaintiffs would have to prove that the city committed an "intentional retaliation" in order to prevail, the court held that it was not clear such proof would necessarily lead to the conclusion that the city's conduct was a "willful violation" of civil rights.

Finally, the court rejected the insurer's argument that most of the underlying plaintiffs' damages came under the exclusion for "damage to or destruction of any property including diminution of value or loss of use." The court found that Michigan case law supported the policyholder's position that the economic damages sought by the underlying plaintiffs were covered, as they were a result of constitutional harms, not the destruction of tangible property.

Errors and Omissions Liability

A second insurer had issued a claims-made, public entity general liability policy, which contained commercial general liability, public officials errors and omissions liability and umbrella coverage. The district court denied the second insurer's motion for summary judgment in its entirety. The court first held that the insurer was not entitled to summary judgment on the grounds that the "known-loss doctrine" negated the duty to indemnify because the city was aware of the underlying conduct at issue when it purchased the policy. The court reasoned that under Michigan law, the known-loss doctrine involves a "subjective component"— the insured's awareness of an immediate threat of injury—which "typically precludes summary judgment." Here, the city and the city manager had presented evidence refuting that "at the time the policy was purchased [they] either knew or were aware of the threat of litigation…that did not take place until after the policy was purchased."

The court also rejected the insurer's argument that the "knowledge of wrongful acts" exclusion in its policy precluded coverage for damages arising out of the federal action. That exclusion precluded coverage "if the insured had knowledge of circumstances which could reasonably be expected to give rise to a claim." The court agreed with the insureds that some of the facts alleged in the federal action were as a result of "wrongful acts" committed during the insurer's policy period and therefore were not known at the inception of the policy. ✦

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District Court Finds No Coverage Based on Prior Acts Exclusion

A federal District Court in Massachusetts has held that the prior acts exclusion in a D&O policy precluded coverage for a complaint alleging misrepresentations in connection with the sale of franchises because the allegations were related wrongful acts to the same or similar misrepresentations made in connection with the sale of franchises by the same insured to the same underlying plaintiffs prior to the policy period. *Gateway Group Advantage, Inc. v. Am. Int'l Specialty Lines Ins. Co.*, 2003 U.S. Dist. Lexis 24178 (D. Mass. Dec. 4, 2003).

On December 18, 1999, an insurer issued a D&O policy to a company that sold franchises to operate kiosks in retail stores. The policy contained a prior acts exclusion, which stated "This policy only provides coverage for Loss arising from Claims which allege Wrongful Acts occurring on or after December 18, 1998 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." The policy defined "wrongful act" as "any breach of duty, neglect, error, misstatement, misleading statement, omission or act by the Insureds in their respective capacities…[or] by reason of their status as directors, officers, or Employees of the Company." The policy defined "related wrongful acts" as "wrongful acts which are the same, related or continuous, or wrongful acts which arise from a common nucleus of facts. Claims can allege related wrongful acts regardless of whether such Claims involve the same or different claimants, Insureds or legal causes of action."

On December 16, 1998, the underlying plaintiff executed a license agreement to operate an Illinois franchise. In March 1999, the same underlying plaintiff exercised an option to purchase additional franchises in Missouri. The plaintiff operated the Illinois and Missouri franchises until 2000, when the franshisor ceased its operations.

On August 9, 2000, the underlying plaintiff brought suit in Illinois against the franchisor, seeking damages based on the plaintiff's detrimental reliance on misrepresentations related to the Illinois franchise. On February 22, 2002, the underlying plaintiff filed a separate suit in Massachusetts that related only to the Missouri franchise. The Massachusetts suit tracked the allegations made in the earlier suit concerning the Illinois franchise. The insurer denied coverage for the Massachusetts suit on the ground that the acts complained of in the Massachusetts suit were related wrongful acts to the acts alleged in the Illinois suit, which predated the policy period.

The court granted the insurer's motion for summary judgment based on the language of the exclusion. In doing so, the court rejected the company's argument that the allegations in the Illinois suit could not serve as the basis for a related wrongful act because the Illinois suit did not allege negligence and therefore was not a wrongful act. The court noted that the Illinois suit was based on claims of negligent misrepresentation. Further, the court held that the wrongful act language in the policy at issue covered misstatements and other acts that "go beyond mere oversight." Additionally, the court could find no explanation for why the conduct alleged in the Missouri suit constituted a wrongful act while the conduct alleged in the Illinois suit did not, when the allegations in both suits were essentially identical.

The court next held that the acts complained of in the Massachusetts suit involved related wrongful acts to the acts at issue in the Illinois suit. The court reasoned that the insureds could not point to any misrepresentations that were made specifically concerning the Missouri franchise that were not also made concerning the Illinois franchise. Therefore, because the misrepresentations complained of in connection with the Missouri franchise were substantially the same as the misrepresentations complained of in connection with the Illinois franchise, the allegations in both suits were related wrongful acts. Additionally, the court noted that even if the acts complained of in the two suits were not the same, they were related in that the insureds engaged in "a single course of conduct designed to promote investment" and that any and all misrepresentations arose from that course of conduct. The court held that regardless of whether the misrepresentations underlying both suits were the same or related, the result was the same—the policy afforded no coverage because of the prior acts exclusion.

Finally, the court rejected the argument that the insurer had a duty to defend because the defense based on the prior acts exclusion was not apparent from the face of the Massachusetts complaint read in isolation. The court found that the insurer could rely on the allegations made in the Illinois suit when making its decision on whether or not to defend the Massachusetts suit. Relying on the facts presented in the Illinois suit, the court found that the insurer could have reasonably concluded that no aspect of the Massachusetts claims fell within the scope of coverage. ✦

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Pollution Exclusion Bars Coverage for Securities and Derivative Actions

Applying Texas law, the United States Court of Appeals for the Fifth Circuit has held that an absolute pollution exclusion in a D&O policy barred coverage for securities and derivative litigation alleging that the company and its directors and officers concealed information from the public concerning the company's illegal waste disposal activities. *Nat'l Union Fire Ins. Co. v. U.S. Liquids, Inc.*, 2004 WL 304084 (5th Cir. Feb. 17, 2004).

The coverage dispute arose from a consolidated securities action and shareholder derivative suit filed against a company that provided waste management services and its directors and officers. The underlying litigation alleged that the company acquired numerous waste management businesses "without regard to or disclosure of these companies' improper waste disposal practices." The complaints alleged that after the FBI investigated and shut down part of one of the company's plants, the company's concealment of illegal waste disposal practices came to light and the price of the company's stock tumbled.

The company previously had purchased a D&O policy that included a "Securities Plus II" endorsement providing coverage for securities claims, including those "based upon or attributable to, in part or in whole, the purchase or sale, or offer or solicitation of an offer to purchase or sell, any securities" of the company, and any class or derivative claims "alleging any Wrongful Act of an Insured." The policy also included an absolute pollution exclusion precluding coverage for loss arising from a claim "alleging, arising out of, based upon, attributable to, or in any way involving, directly or indirectly: (1) the actual, alleged or threatened discharge, dispersal, release or escape of pollutants; or (2) any direction or request to test for, monitor, clean up…or neutralize pollutants…." The exclusion also included, but was not limited to, claims "alleging damage to the Company or its security holders." The policy specified that the definition of "claim" included "securities claim." Finally, the policy provided for the advancement of defense costs prior to the final disposition of a suit, and specifically stated that "the Insurer does not…assume any duty to defend."

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Single Limit Applies, Claims Are Related and Insurer May Advance Under Mutual Fund Policy

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the underlying plaintiff had invested in the mutual funds. Subsequently, some of the defendant's mutual funds were placed into receivership under Texas law. The insurer then filed the instant declaratory judgment action against the insureds, the receiver and the underlying plaintiff seeking court approval to advance defense expenses to the insureds and seeking a ruling concerning certain other coverage issues that were in dispute. Immediately thereafter, the insurer filed a motion for summary judgment as to all issues in its complaint.

The receiver and the underlying plaintiff argued that the motion for summary judgment was premature because they should be given an opportunity to take discovery first concerning negotiation of the policy. The court rejected this argument, noting that "[t]he only contested issues in this case relate to the interpretation of certain provisions in the Policy." The court explained that, under Texas law, discovery is permitted only if the policy is ambiguous, which is a matter of law, and that "parol evidence is not admissible for the purpose of creating an ambiguity." The court then addressed each of the disputed issues and held that the policy language unambiguously supported the insurer's position.

The court agreed with the insurer that a single $5 million limit was applicable to the underlying litigation and rejected the receiver's and underlying plaintiff's argument that multiple limits were available because the underlying litigation alleged multiple causes of action and named multiple insureds as defendants. As an initial matter, the court held that multiple causes of action in a single lawsuit could constitute multiple claims. However, the court agreed with the insurer that all of the causes of action should be treated as a single claim "under the broad definition of Related Claims given in the Policy." The court explained that all of the causes of action were based on the same inducement to the same underlying plaintiff to invest in the same funds or on continuing misrepresentations concerning those funds.

The court next held that the advancement of defense expenses would deplete the limits of liability in the policy. The court rejected the underlying plaintiff's argument to the contrary based on the unambiguous language in the policy.

Finally, the court held that the insurer could advance defense expenses notwithstanding the fact that two of the insured funds were in receivership. The court reasoned that the mutual funds in receivership "have no cognizable interest, in and of themselves, in the proceeds" of the policy. Instead, "any proceeds from the Policy—whether they are first paid to the Insured or not—are owed not to the Insured but to successful third-party claimants against the Insured, as well as to the Insured's attorneys defending against those claims." ✦

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Policy Proceeds Property of Estate When D&Os Assign Their Rights to Debtor

A federal district bankruptcy court has held that the proceeds of a D&O liability insurance policy are property of the debtor's estate when specifically assigned to the trustee by the directors and officers, and where the debtor had an interest in the policy because it potentially afforded entity coverage for a securities claim pending against the debtor. *In re Eastwind Group, Inc.*, 2004 Bankr. LEXIS 25 (Bankr. E.D. Pa. Jan. 14, 2004). In upholding the settlement agreements that resolved the claims between and among the trustee, directors and officers and insurer, the court also held the agreements precluded a third party from pursuing collection from the insurer.

The case arose from a third party's challenge to a series of settlement agreements between the trustee, the debtor's directors and officers and the insurer. In return for $550,000 from the insurer and the directors' and officers' release of any claims against the insurer, the agreements released the debtor's claims against the directors and officers and the insurer arising from the allegedly improper transfer of one of the debtor's assets. The third party, which had filed a claim against the debtor and its directors and officers alleging securities violations, objected to the settlement on grounds that the policy proceeds were not part of the estate and that the trustee had not demonstrated that the settlement was in the estate's best interests. The policy included entity coverage for securities claims. The policy's payment provision required that "[i]n the event of Loss," the insurer first must pay covered non-indemnifiable loss, and then, with respect to the policy's remaining limits of liability, must pay or withhold payment "at the written request of the chief executive officer of the Named Corporation."

Surveying the conflicting precedents on whether policy proceeds are property of a bankruptcy estate, the court held that "[r]egardless of which methodology this court were to choose," the proceeds were property of the estate. The court first reasoned that the trustee, as successor to the debtor, had an interest in the proceeds because the policy included entity coverage for securities claims, and the third party was alleging violations of the same by both the debtor and its directors and officers. Moreover, the court emphasized that the directors and officers had agreed with the trustee to assign their interests in the policy in exchange for the release of the trustee's claims. Stating that "[t]he significance of that fact cannot be overstated," the court held that the proceeds now belonged to the trustee, and distinguished contrary precedents on grounds that the directors and officers in those cases had not agreed with the trustee concerning the disposition of the policy proceeds.

The court rejected the third party's argument that the policy's priority of payment provision prevented the policy proceeds from becoming property of the estate because non-indemnifiable claims against the directors and officers took absolute priority over the debtor's rights to payment for indemnification or direct claims. The court reasoned that the debtor had indemnified the directors and officers, and that there were "no non-indemnifiable losses to speak of."

Next, the court held that the third party was enjoined by the settlement from pursuing any collection rights against the insurer. The court reasoned that the third party "has no rights against [the insurer] whatsoever because the proceeds have been assigned by the [directors and officers] to the Trustee," and stated that the third party still could sue the directors and officers, but could not expect to recover any policy proceeds.

Finally, the court rejected the third party's argument that the trustee had failed to demonstrate that the settlement should be approved. The court reasoned that, although the trustee's motion was silent as to the estimated value of the released claims, the trustee "had testified as to what the case was worth and why, as well as the cost of getting to that point." Moreover, the court noted that the trustee had admitted that its claim against the insurer had weaknesses. Specifically, the trustee stated that the claim was brought after the expiration of the claims-made policy, and an exclusion for deliberate fraudulent acts potentially applied. In addition, the trustee expressed doubt that its claim against the directors and officers would result in a "meaningful recovery" because the actual value of the asset that the directors and officers allegedly improperly transferred was unclear. In light of the likely difficulties in collection from the directors and officers, the complexity of the litigation and the interest of the creditors, the court held that the trustee had carried its burden of proving that the settlement agreements were in the best interests of the estate. ✦

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Insurer Must Advance Defense Costs Despite Rescission of Policies

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Subsequently, Tyco officers and directors were named as defendants in numerous lawsuits alleging liability for misstatements about the company's finances, misrepresentations in SEC filings and the misappropriation of hundreds of millions of dollars though improper bonuses and interest-free loans. Kozlowski sought coverage for the ERISA litigation, the securities litigation and a criminal indictment. Many of the plaintiffs' allegations were confirmed in Form 8-K filed by the company on September 8, 2002, which disclosed that Kozlowski and other officials had misappropriated more than $700 million in Tyco funds. The 8-K also stated that "[d]uring at least the five years prior to June 3, 2002, Tyco's three top corporate officers—its CEO, it CFO and its Chief Corporate Counsel—engaged in a pattern of improper and illegal conduct by which they enriched themselves at the expense of [Tyco] with no colorable benefit to [Tyco] and concealed their conduct from the Board and its relevant committees."

On February 13, 2003, subsequent to Tyco filing the Form 8-K, the insurer wrote a letter to Tyco that tendered the premium and notified the company that it was rescinding the policy then in effect "based upon material misrepresentations and omissions in the information that [the insurer] relied upon in issuing and extending the Policy." The letter noted that the underwriters had relied on various SEC filings that the company now conceded were inaccurate. The same day it sent the letter, the insurer filed a declaratory judgment action against Kozlowski, Tyco and 14 other defendants. It subsequently amended the complaint to drop its claims except as to Kozlowski and three other defendants. Kozlowski filed a motion for a declaration that the insurer had a duty to defend and advance defense costs under the policies, notwithstanding the rescission.

The trial court agreed with Kozlowski, concluding, with little explanation, that "until [the insurer's] rescission claims are litigated in its favor and the Policies are declared void *ab initio*, they remain in effect and bind the parties." While noting that there was little law on this issue in New York, the court pointed to decisions from other jurisdictions. The court did note that if the insurer were to prevail in its lawsuit and obtain a declaration that the policies were void *ab initio*, it "may" be able to recover the defense costs it had previously reimbursed.

The court also held that the insurer was required to defend Kozlowski or reimburse his defense costs for each of the matters notwithstanding the personal profit exclusion. The court reasoned that each of the matters contained at least some allegations of wrongful acts that were not based on allegations of personal profit. ✦

Pollution Exclusion Bars Coverage for Securities and Derivative Actions

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The court first rejected the company's argument that the securities endorsement and pollution exclusion were ambiguous as applied to the securities and derivative litigation. The court concluded that the "the terms of the Policy's pollution exclusion were clear and neither patently nor latently ambiguous." Next, the court held that the pollution exclusion precluded coverage for the securities action and the derivative suit. The court reasoned that the "arising out of" language in the pollution exclusion required a "but for" causal relationship, and that this standard governed "the broadly worded pollution exclusion." In so doing, the court rejected the company's argument that the Texas Supreme Court had rejected the "but for" test in *King v. Dallas Fire Insurance Co*., 85 S.W.3d 185 (Tex. 2002). The court distinguished *King* on the grounds that it was "limited to the situation where a policy contains an 'occurrence' requirement that must be triggered before an employer can be covered for an employee's intentional actions." Because "the losses described in the factual allegations of the securities and derivative suits bore more than an incidental relationship to the broad polluting conduct excluded in the Policy and that 'but for' such illegal activities those underlying claims would not exist," the court concluded that the pollution exclusion barred coverage for the securities and derivative suits.

Finally, the court determined that the insurer had no duty to advance defense costs to the company for the litigation because the pollution exclusion precluded coverage. The court reasoned that the insurer had no obligation to make any payment for loss arising from an uncovered claim and that the policy provided that loss included defense costs. ✦

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Professional Services Exclusion in General Liability Policies Bars Coverage

The Wisconsin Supreme Court has held that the professional services exclusion in excess general liability policies issued to a general contractor precluded coverage for allegations of faulty advice by a soils engineer who was covered under the policies at issue. *Am. Family Mut. Ins. Co. v. Am. Girl, Inc.*, 2004 WL 42252 (Wis. Jan. 9, 2004).

The insured general contractor hired a soils engineer as a subcontractor to provide advice on site preparation for a construction project. As a result of allegedly inadequate advice by the subcontractor, the building that the insured erected on the site settled and was eventually torn down. The excess general liability policies at issue, which also covered the subcontractor, precluded coverage for "any liability arising out of the rendering of or failure to render professional services in the conduct of your business or profession." The Wisconsin Supreme Court reasoned that this language therefore barred coverage for liability allegedly arising from the subcontractor's professional services. In so holding, the Court distinguished a decision in which a Wisconsin appellate court had refused to apply a professional services exclusion to a homebuilder on the grounds that it was not possible to distinguish between the design and manufacturing components of the homebuilder's activities. Here, by contrast, the Court reasoned all of the alleged liability was a result of the provision of professional soil engineering services. ✦

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