Wiley Rein & Fielding

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The Executive Summary

Developments Affecting Professional Liability Insurers

Federal Court In Texas Holds No Breach of *Stowers* Duty; Prejudgment Interest Is "Damages"

The United States District Court for the Northern District of Texas, applying Texas law, has held that an insurer that issued a malpractice policy to a podiatrist and then refused to accept a settlement offer within settlement limits was not liable for extra-contractual damages after the trial court in the underlying action awarded a judgment of more than double the policy limits. *Gulf Ins. Co., et al., v. Jones, et al.*, 2003 WL 22208551 (N.D. Tex. Sept. 24, 2003). The court also held that prejudgment interest is considered to be "damages" and that the insurer therefore had no contractual duty to pay for prejudgment interest once the policy limits were expended. Finally, the court held that the insurer had not violated the Texas Deceptive Trade Practices Act.

The insurer had issued a professional liability policy to the podiatrist that provided coverage "for damages which you become legally obligated to pay...." The policy contained an "Additional Benefits" provision that provided coverage for amounts beyond the policy's limits for, among other things, "all costs of defending a suit, including interest on that part of any judgment that does not exceed the limit of your coverage." The policy also contained a provision giving the insurer "the right to investigate, to negotiate and to settle any suit or claim if we think that it is appropriate."

The coverage action arose after a medical malpractice claim was filed against the podiatrist. The insurer defended the podiatrist in the malpractice action, and, during the course of the litigation, rejected an offer to settle the lawsuit for policy limits. At the time the settlement offer was made, the podiatrist was informed of the offer and stated that he did not want to settle the case. The suit subsequently ended in a verdict against the podiatrist for over twice the policy limits, plus prejudgment and post-judgment interest. The insurer paid policy limits as well as post-judgment interest on that amount. The podiatrist assigned his rights against the insurer to the underlying plaintiff, who then sought to recover the entire amount of the judgment from the podiatrist.

The district court held that the insurer had no extra-contractual liability for refusing to accept the settlement demand, rejecting the argument that the insurer had violated its obligations under *Stowers Furniture Co. v. American Indemnity Co.*, 15 S.W.2d 544 (Texas Comm'n App. 1929). The court reasoned that, although the first two elements of *Stowers* had been met because the claim was within the scope of coverage and the underlying plaintiff had made a demand within the policy limits, the third element of *Stowers* necessary to establish extra-contractual liability had not been satisfied. That prong of the *Stowers* test requires that "the terms of the demand are such that an ordinarily prudent insurer would accept it, considering the likelihood and degree of the insured's potential exposure to the excess judgment." The court rejected the podiatrist's argument that the insurer's claims adjuster had failed to identify the weaknesses in the podiatrist's defenses.

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Also In This Issue

Sexual Misconduct Exclusion Bars Coverage for Sexual Harassment by Chiropractor

In an unpublished opinion, the United States Court of Appeals for the Tenth Circuit has held that a sexual misconduct exclusion in a professional liability policy issued to a chiropractor barred coverage under the policy for sexual harassment. *Nat'l Chiropractic Mut. Ins. Co. v. Kancilia*, 2003 WL 22273338 (10th Cir. Oct. 3, 2003).

The insurer issued a professional liability policy to a chiropractor. The policy provided coverage for amounts that "the insured shall become legally obligated to pay as damages because of injury caused by accident arising out of the rendering of or failure to render to a patient" those professional services "usually and customarily furnished by Chiropractors." The policy excluded coverage for "injury resulting in whole or in part from…sexual impropriety; sexual intimacy, or assault." The policy also excluded coverage for "punitive or exemplary damages, fines, penalties imposed by law, or matters uninsurable under law pursuant to which this policy is construed."

Two former patients of the chiropractor, one of whom was also an employee, filed suit against the chiropractor alleging sexual misconduct on his part. After a jury trial, the court in the underlying action found the chiropractor liable for the torts of negligence, invasion of privacy and outrageous conduct. The court awarded economic damages, non-economic damages and punitive damages. After the chiropractor sought coverage under the insurance policy for damages awarded at trial, the insurer filed a declaratory judgment action, contending that coverage for the judgment was excluded under the policy.

The Tenth Circuit agreed with the insurer. The court initially noted that the only potential coverage issue was with respect to economic damages because the policy "expressly exclude[s] coverage for any of the non-economic or punitive damages awarded in the underlying action." The court held that no coverage was available for economic damages because the policy provided coverage only for "accidents," and the allegations against the chiropractor were based on intentional conduct. The court also noted that the policy explicitly excluded coverage for sexual assault or impropriety. The court rejected the assertion that coverage was available because the underlying plaintiffs had also alleged that the chiropractor failed to diagnose or treat them properly, reasoning that the state trial court case had focused exclusively on the chiropractor's inappropriate sexual conduct.

The Tenth Circuit also rejected the argument by the underlying claimants that they were entitled to a separate evidentiary hearing in the coverage action to afford them the right to present additional evidence to establish coverage. The court held that the availability of coverage could appropriately be determined based on "the language of the policies at issue and the evidence presented in the underlying trial." ✦

No Coverage for Claim Filed After Cancellation of Claims-Made Policy

In an unreported decision, an Ohio appellate court, applying Ohio law, has held that a claims-made professional liability policy did not afford coverage for a claim that was filed after the policyholder cancelled the policy and received a pro-rated premium refund. *Dial v. Ostrander, et al.*, 2003 WL 22227987 (Ohio Ct. App. Sept. 23, 2003).

The Insurer issued a claims-made professional liability policy that provided coverage to the policyholder company and a psychologist employed by the company. The policy period at inception was June 28, 2001 to June 28, 2002. On March 29, 2002, however, the company cancelled the policy, the parties added an endorsement to the policy that cancelled the policy effective March 29, 2002, and the insurer issued a prorated premium refund. Subsequently, on May 17, 2002, a lawsuit was filed against the psychologist. The insurer denied coverage and litigation ensued.

The Ohio appellate court ruled in favor of the insurer, holding that the policy unambiguously precluded coverage. In doing so, the court rejected the argument that the policy was ambiguous because the claim was made within the stated policy period when the policy was issued, and the policy did not provide that the policy period would change in the event of cancellation. The court reasoned that such an interpretation was unreasonable because the primary purpose of an insurance contract is to afford coverage in return for compensation. Consequently, since the policyholder had cancelled the policy and the insurer had issued a prorated premium refund, the insurer had no obligation to cover a claim made after the date of cancellation. The court also held that even though the insurer had received notice of the claim within the extended reporting period, the policy did not afford coverage because the claim had been made outside of the policy period. ✦

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Insurer Has Duty to Defend Title Company Against Allegations of Excessive Fees for Closing Costs

A federal district court, applying Minnesota law, has held that an insurer has a duty to defend a title company insured under an E&O policy against a consumer class action lawsuit alleging that the title company referred certain services to third-party vendors and then marked-up the charges without disclosing to its clients its relationship with the vendors or the markups. *Pac. Ins. Co. v. Burnet Title, Inc.*, 2003 WL 22283355 (D. Minn. Sept. 24, 2003).

The insurer issued an E&O policy to a real estate title company. The policy provided coverage for "a negligent act, error or omission in the rendering of or failure to render 'professional services.'" The policy defined professional services as "services performed or advice given in the Insured's capacity as Title Agent, Title Abstractor and Escrow Agent." "Damages" was defined as "the monetary portion of any judgments, awards or settlements which an insured becomes legally obligated to pay [but Damages does not include] the return or reimbursement of fees for 'professional services.'"

In the underlying action, a class of former customers of the title company filed suit against the company, alleging that the company violated the Real Estate Settlement Protection Act (RESPA) by fraudulently inflating the bills of third-party vendors, such as couriers, without disclosing the relationship with the vendors or the markups. Plaintiffs sought injunctive and declaratory relief, actual damages, prejudgment interest, penalties, treble damages, attorneys' fees, costs, expenses and other remedies. After the insurer declined to continue funding defense of the underlying litigation, coverage litigation ensued.

The district court rejected the insurer's argument that coverage was unavailable because the underlying complaint simply alleged improper billing, which does not constitute "professional services." The court cited with approval case law relied on by the insurer to support the contention that "even tasks performed by professionals are not considered 'professional services' if they are ordinary activities that can be performed by those lacking the relevant training and expertise." *See Med. Records Assocs. V. Am. Surplus Lines Ins. Co.*, 142 F.3d 512, 514 (1st Cir. 1998). However, in this case, the court reasoned that the allegations of the underlying plaintiffs involved improper disclosure of referrals, which were "closer to the core" of the services being provided by the broker. Thus, "[o]n the 'professional continuum,' the Court finds that making referrals is close enough to the 'professional' end of the spectrum to be included in the E&O policy."

The court also rejected the insurer's argument that, because each of the counts of the underlying complaint included "intent" language, the insurer was not obligated to defend the title company under the E&O policy since the policy provided coverage only for negligence claims. The court reasoned that the "fundamental nature" of the title company's alleged misconduct included both intentional and negligent acts, that RESPA violations do not require "intent," and that when complaints do not distinguish between intentional and negligent misrepresentations, Minnesota courts have held that it is reasonable to assume that both are alleged.

Finally, the district court addressed which portion of the damages sought by the underlying plaintiffs was covered under the Policy. The court concluded "that the return of overcharged fees is not the type of 'damages' that triggers coverage under the policy." It also held that the trebling of those fees was excluded because the trebling "is clearly a penalty." The court, however, rejected the insurer's argument that the attorneys' fees sought by underlying plaintiffs did not constitute damages because they are part of costs. The court reasoned that RESPA authorizes courts to award to the prevailing party "the court costs of the action together with reasonable attorneys fees." 12 U.S.C. § 2607(d)(5). According to the district court, this language makes attorneys' fees distinct from costs. ✦

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Court Upholds Application of Retroactive Date In Claims-Made Policy

A federal district court in Louisiana, applying Louisiana law, has held that a claims-made professional liability policy did not afford coverage for a claim made during the policy period where the claim arose out of conduct occurring prior to the retroactive date and the policy excluded coverage for such conduct. *Malmay v. Sherman*, 2003 WL 22077786 (E.D. La. Sept. 8, 2003).

The insurer issued a professional liability policy to a lawyer. The policy was a claims-made policy with a policy period of October 17, 2001 to October 17, 2002. The policy contained a Retroactive Date of October 17, 2001, and it stated that coverage was available for "Claims first made against any Insured during the Policy Period and reported to the Company in writing during the Policy Period or within 60 days thereafter, by reason of any Wrongful Act occurring on or after the Retroactive Date." It further stated that "Claims arising from any Wrongful Act… occurring prior to [the Retroactive Date] are not covered by this Policy."

On May 16, 2002, the lawyer informed the insurer of a malpractice claim against him. The claim arose from the lawyer's failure to file his client's personal injury claim by January 2, 2001, the last day within the applicable statute of limitations. The insurer denied coverage because the wrongful act giving rise to the claim occurred on January 2, 2001, when the lawyer allowed the statute of limitations to run, which was prior to the Retroactive Date of the policy.

In the coverage litigation, the lawyer argued that because the policy was labeled on the declarations page as a "claims-made" policy, it necessarily provided coverage for all claims made during the policy period, regardless of the date of the acts giving rise to the claim. The district court rejected that argument, and held for the insurer. The court reasoned that the notice on the declarations page that the coverage was claims-made simply imposed one limitation on coverage. "That such claims are excluded from coverage by virtue of the Policy being a 'claims-made' policy does not necessarily mean that all claims made within the policy period are *included* within the scope of coverage." The court therefore concluded that the retroactive date in the policy "operates as an independent and additional limitation on coverage." ✦

No Coverage for Directors and Officers of Insured Entity Where Conduct "Inextricably Intertwined" with Conduct on Behalf of Non-Insured Entity

In an unreported decision, a federal district court in Pennsylvania, applying Pennsylvania law, has determined that no coverage is available for directors and officers of an insured company where the alleged conduct was "inextricably intertwined" with their conduct as directors and officers of an entity that was not insured. *Continental Cas. Co. v. Adams*, 2003 WL 22162379 (M.D. Pa. Sept. 12, 2003).

The insurer issued a health care executive liability insurance policy to a non-profit corporation. The policy contained an outside directorship exclusion that barred coverage for "any loss in connection with any claim…involving any actual or alleged conduct by the individual insureds in the discharge of their duties as directors, officers, trustees, employees or volunteers of any entity other than the [insured] Entity...." The directors and officers also worked for an uninsured for-profit corporation.

One of the employees of the non-profit corporation, who later served as the chief financial officer of the for-profit corporation, was alleged to have been involved in a check-kiting scheme. According to the underlying complaint, the scheme involved writing checks from the for-profit corporation's account and depositing the checks in the non-profit corporation's account, only to draw on the account to write a check to deposit back in the for-profit corporation's account. Neither of the accounts had sufficient funds, and the officer treated these transactions as inter-company loans. The underlying complaint also alleged that had the other insured officers read the daily or monthly reports of the non-profit, insured corporation, the scheme would have failed. The complaint further alleged that the directors and officers acted negligently in their capacities as directors and officers of the for-profit, uninsured corporation and thereby "facilitated the scheme."

The district court held that no coverage was available under the policy. Emphasizing the language of the outside directorship exclusion, the court first noted that the scheme "could only be effectuated by actions taken by individual insureds in the discharge of their duties as directors and officers of both the insured entity and the uninsured

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Under New Jersey Law, "Reasonable Expectations" of the Parties May Operate to Void Policy Language

A federal district court in Minnesota, applying New Jersey law, has held that the reasonable expectations of the insured may operate to void policy provisions governing the assignment of a claim to a particular policy period. *See St. Paul Mercury Ins. Co. v. JBA Int'l, Inc.*, 2003 WL 22272120 (D. Minn. Sept. 30, 2003). The court also made rulings on motions for summary judgment concerning the alleged bad faith refusal to settle on the part of the insurer.

Beginning on June 30, 1997, the insurer issued three consecutive one-year errors and omissions policies to a computer software company. The policies provided coverage for "claims or suits for covered loss…first made or brought while this agreement is in effect." The policies contained a retroactive date of October 31, 1994. The policies further provided that the insurer would deem a claim to be first made or brought on the earliest of the following dates: the date the insured received written notice of suit; the date the insured provided a notice of potential claim stemming from its error; or the date the insured could reasonably foresee that a claim or suit would be brought. The policies also contained an excess insurance clause stating that "[w]hen this agreement is excess insurance, we'll have no duty to defend any claim or suit that any other insurer has a duty to defend. However we'll defend a claim or suit for covered loss if the other insurers won't."

The company sought coverage from the insurer for three lawsuits. The first lawsuit was brought against the company in December 1997. The insurer deemed the claim to have first been made prior to June 30, 1997 and denied coverage. A second lawsuit was brought against the company in June 1999. After investigation, the insurer deemed the claim to have first been made in the 1997-1998 policy period and denied coverage because the applicable limits for that policy period had been exhausted. A third lawsuit was brought after the third policy had expired, during the extended reporting period, and the insurer refused to contribute to a settlement within the deductible of the policy being provided by a second insurer. The company sued the insurer, contesting the insurer's determinations as to when the first two claims had first been made and alleging a bad faith refusal to settle in connection with the second and third lawsuits. The insurer moved for summary judgment on a number of issues.

The district court denied the insurer's motion for summary judgment that its determination as to when the claims were made was correct. Although the court agreed that the language of the policy unambiguously supported the insurer's position and although the court rejected the company's argument that the insurer had made misrepresentations that estopped it from denying coverage, the court held that the company had raised an issue of fact as to whether applicable policy terms were inconsistent with its reasonable expectations in light of the October 31, 1994 retroactive date. The court based its holding on a decision by the New Jersey Supreme Court finding that the absence of retroactive coverage in a claims-made policy does not comport with the reasonable expectations of a policyholder. *See Sparks v. St. Paul Ins. Co.*, 495 A.2d 406 (N.J. 1985). The district court reasoned that because the policy defined "Claim" to preclude coverage for a claim or suit that was resonably forseeable prior to the inception of the policy, "the policy's definition of when a claim is first made effectively eliminates retroactive coverage." However, the court also declined to rule at the summary judgment stage of the case whether the elimination of retroactive coverage was reasonable and expected when the company purchased the policy. The court also rejected the insurer's argument that the fact that the company purchased the policy through a broker precluded reliance on the reasonable expectations defense, explaining that such an argument would hold sway only if the policy was "actually negotiated or jointly drafted."

The district court granted the insurer's motion for summary judgment as to violations of the New Jersey Consumer Fraud Act in connection with the negotiation of the initial policy based on alleged misrepresentations concerning the scope of coverage. The court explained that the Consumer Fraud Act allows a plaintiff to recover "any ascertainable loss of money." Here, since the insurer had paid out the entire limits under the first policy and there was no allegation concerning misrepresentations about the amount of coverage available under that Policy, the court concluded that there was no ascertainable loss.

The court also made rulings on the insurer's motion for summary judgment with respect to the bad faith claims made by the company based on the insurer's failure to settle the second and third lawsuits. The company alleged that at two points in time the insurer had failed to settle the second lawsuit. The court declined to rule on the argument with respect to the first opportunity to settle, reasoning that it could not determine on the existing record whether the refusal to settle "was thoroughly honest, intelligent, and objective." With respect to the second opportunity to settle that case,

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Notice to Insurer and Payment to Broker Sufficient to Exercise Right to Extended Reporting Period

A Louisiana appellate court has determined that a policyholder timely exercised its option to extend the reporting period under a professional liability policy when it gave notice to the insurer and submitted payment of the additional premium to the broker. *Postlethwaite & Netterville, APAC v. Royal Indem. Co.*, 2003 WL 22220170 (La. Ct. App. Sept. 26, 2003).

The insurer issued a claims-made policy to an accounting firm with a policy period "from 9/15/00 to 9/15/01 At 12:01 a.m. Standard Time." The policy gave the accounting firm an option to purchase an Extended Reporting Period (ERP) endorsement, which extended the reporting period through September 15, 2002. The ERP endorsement stated that the policyholder "could exercise its right to the ERP by: (1) requesting it within sixty days of the end of the policy period; (2) having paid all premiums due for the policy at the time of the request; and (3) promptly paying when due the additional premium for the endorsement."

A month after the expiration of the initial policy, a bank sued the accounting firm for damages arising out of audit services in connection with defaulted loans. The accounting firm gave the insurer notice of the claim. On November 14, 2001, the accounting firm notified the insurer that it was exercising its option to extend the reporting period and submitted a check to the broker for the original policy. On the same day, the policyholder tendered the claim a second time and requested a defense.

The appellate court held that the insured had satisfied the first prong of the ERP provision by requesting the coverage within sixty days after the expiration of the policy period. It rejected the insurer's argument that the sixty-day period to request the ERP had expired at 12:01 a.m. on November 14, relying on a Louisiana statute providing that "[w]hen the term for performance of an obligation is not marked by a specific date but is rather a period of time, the term begins to run on the day after the contract is made, or on the day after the occurrence of the event that marks the beginning of the term, and it includes the last day of the period." The court reasoned that since the sixty-day period in the ERP endorsement did not specify a particular time on the sixtieth day, the period ran though the entire day on November 14.

The court also rejected the insurer's argument that the accounting firm had failed to fulfill the third prong of ERP provision because it paid the additional premium to the broker, who the insurer argued was not its authorized agent. The court noted that the broker had previously accepted premium payments for the insurer. The court further observed that the policyholder had been doing business with the broker for approximately twenty years, and the policyholder believed that the broker was the insurer's agent. ✦

Under New Jersey Law, "Reasonable Expectations" of the Parties May Operate to Void Policy Language

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the court noted that it came after the insurer had placed that claim in the 1997-1998 policy period at a point when coverage was exhausted. Accordingly, since the refusal to settle was based on a denial of coverage, the court reasoned that the refusal should be evaluated based on whether the insurer's decision to deny coverage was "fairly debatable," which the court held that it was. The court therefore granted the insurer summary judgment with respect to the second opportunity to settle.

The court also granted the insurer's motion for summary judgment concerning its refusal to settle the third case, which settled within the deductible of a second insurer's policy. The court rejected the company's argument that the amount not paid by the other insurer should have been funded, reasoning that the plain language of the other insurance clause supported the insurer's conclusion that it had no obligation to pay the deductible of another insurer's policy. ✦

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Federal Court In Texas Holds No Breach of *Stowers* Duty; Prejudgment Interest Is "Damages"

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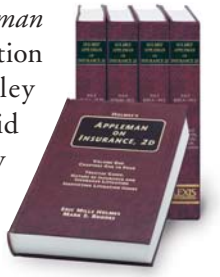
The court explained that the record reflected that the claims adjuster was aware of all of the evidence. In addition, the podiatrist had testified that the claims in the lawsuit were defensible. The court noted that the insurer's decision not to settle did not arise from an erroneous belief that it needed the podiatrist's assent to do so, but rather from its independent belief that the suit was not worth policy limits. The court next rejected as speculative the podiatrist's argument that he might have settled if the attorney chosen by the insurer had been more experienced and had convinced him to settle. In addition, the court noted that even if the attorney was at fault, "an insurer is not vicariously responsible for the conduct of an independent attorney it selects to defend an insured." The court also rejected the argument that the insurer had breached a contractual obligation to settle, reasoning that the policy provision giving the insurer "the right to investigate, to negotiate and to settle any suit or claim if we think that it is appropriate" did not create a duty to settle, but only a right to do so.

The district court next held that the insurer had not breached the contract by failing to pay for prejudgment interest in excess of the policy limits. The court held that prejudgment interest unambiguously was covered as "damages" under the policy's insuring clause and not as "interest" under the Additional Benefits provision of the policy, because "[p]rejudgment interest falls within the common-law meaning of damages." By contrast, the court reasoned that post-judgment interest "is not an element of the measure of damages," and thus falls under the Additional Benefits provision. In doing so, the court distinguished *Embrey v. Royal Insurance Co.*, 22 S.W.3d 414 (Tex. 2000), which contained dicta referencing a 1984 state insurance bulletin that the policyholder maintained required the insurer to provide coverage for prejudgment interest exceeding the policy limits. The court reasoned that even if the bulletin still applied, "it cannot supplant that whole body of law which defines prejudgment interest as part of damages." Furthermore, the court noted that any such required coverage would derive only from an amendment to the policy providing such coverage, and no evidence of such an amendment existed. Since the insurer had already paid the policy limits, the court held that the insurer did not breach the policy by failing to pay for prejudgment interest.

The court also held that the insurer did not breach the policy by failing to reimburse the policyholder for time that the policyholder spent assisting in his defense. The court reasoned that although the policy provided coverage for those costs, the podiatrist had not submitted a claim for them. In doing so, the court rejected the podiatrist's argument that the insurer had a duty to inform him of this policy benefit, noting that each party is obligated to read the policy.

Finally, the court held that the insurer had not violated the Texas Insurance Code and Deceptive Trade Practices Act by failing to settle the suit and by not paying prejudgment interest or reimbursing the policyholder for time spent assisting with the defense. Noting that the Texas Supreme Court had adopted the *Stowers* standard in determining the liability standard under the Deceptive Trade Practices Act for insurers that allegedly failed to make reasonable attempts to settle a claim, the court held that its conclusion that the insurer had no liability under *Stowers* required a similar result under the Deceptive Trade Practices Act. Similarly, the court held because the insurer had already paid the policy limits and the podiatrist had not submitted a claim for the time spent assisting with the defense, no other grounds for statutory liability existed. In so holding, the court dismissed the podiatrist's additional allegation that the insurer had misrepresented that prejudgment interest was covered, reasoning that such an allegation was unsupported by the evidence. ✦

WRF Attorney Authors "Professional Liability Chapter" In Holmes' Appleman on Insurance



For the first time, *Holmes' Appleman on Insurance, 2d*, includes a section on professional liability. Wiley Rein & Fielding attorney David H. Topol authored the recently released chapter. Mr. Topol is Of Counsel in the Insurance and Appellate Practices. He represents insurance carriers in connection with a variety of professional liability policies, including banking, mutual fund, investment adviser, directors and officers liability policies.

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No Coverage for Directors and Officers of Insured Entity Where Conduct "Inextricably Intertwined" with Conduct on Behalf of Non-Insured Entity

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entity." The court further observed that the underlying complaint alleged that the negligent conduct of the individuals in their capacities as directors and officers of the for-profit company facilitated the check-kiting scheme. Therefore, the court determined that the allegations in the underlying complaint "plainly show [the directors and officers] acting simultaneously in dual capacities: as officers and directors of both the insured and uninsured corporations." Because the complaint did not distinguish upon which company's behalf the negligent conduct was undertaken, the court concluded that the "negligence claims plainly have the requisite nexus to the activities of [the directors and officers] on behalf of [the for-profit, uninsured corporation] to fall within the scope" of the outside directorship exclusion. The court explained that "an otherwise covered claim of negligence of a named insured is excluded where that claim is closely connected to the named insured's activities as an agent of an entity other than the named insured." Since the claims against the directors and officers were "inextricably intertwined with their actions" on behalf of the uninsured corporation, the court determined that the exclusion applied to bar coverage for the underlying litigation. ✦

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