Wiley Rein & Fielding

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The Executive Summary

Developments Affecting Professional Liability Insurers

$70 Million Disgorgement Paid to SEC and NASDR by CSFB Is Not "Loss" Under E&O Policy

A state trial court in New York has held that a $70 million payment by Credit Suisse First Boston Corporation (CSFB) as disgorgement to settle a lawsuit by the U.S. Securities and Exchange Commission (SEC) and an investigation by the NASD Regulation, Inc. (NASDR) is not a "loss" under CSFB's E&O policy. *Vigilant Ins. Co. v. Credit Suisse First Boston Corp.*, No. 600854/02 (N.Y. Sup. Ct. July 8, 2003).

CSFB purchased an E&O policy providing coverage "for any actual or alleged Wrongful Act arising from the rendering of, or the failure to render, services to any client, customer or other person or entity." The policy defined "loss" as "all damages, awards, judgments, settlements, costs and Defense Costs, and shall include, without limitation, pre-judgment interest, post-judgment interest, equitable relief, punitive or exemplary damages, treble or other multiplied damages and the legal expenses of any plaintiff or claimant if the Insured(s) is legally liable for such expenses."

The SEC brought a lawsuit against CSFB, alleging that CSFB had unlawfully coerced customers into paying a portion of their profits to CSFB when they "flipped" CSFB-underwritten IPO stock. ("Flipping" refers to purchasing shares in an IPO and then selling the shares in the immediate aftermarket to realize a profit.) CSFB subsequently entered into a settlement with the SEC and NASDR pursuant to which it agreed, among other things, to "pay $70 million, representing disgorgement of monies obtained improperly by CSFB as a result of the conduct alleged in the Complaint." After CSFB sought coverage for the $70 million under its E&O policy, the insurer initiated coverage litigation.

The New York trial court held that CSFB could not recover the $70 million from its insurer because "[s]uch a result would defeat the purpose of the disgorgement provision" in the settlement agreement. The court explained that the purpose of disgorgement is to deprive a party of ill-gotten gains and to deter unlawful conduct and that these objectives would be undermined if CSFB were able to recoup the money it disgorged from its insurers.

The trial court rejected CSFB's argument that the settlement agreement provided an insufficient basis to conclude that it had engaged in wrongdoing. The court noted that the settlement agreement expressly linked the disgorgement to allegations of wrongdoing set forth in the complaint. Accordingly, it reasoned that the settlement is "essentially the same" as a final adjudication.

The trial court also rejected CSFB's argument that it should not be barred from recovering the $70 million from the insurers because CSFB was not returning any money to its customers. The court explained that the purpose of the disgorgement was not to compensate CSFB's customers. Rather, "[t]he purpose is to deprive CSFB of money that it obtained unjustly and to deter similar conduct in the future. To permit CSFB to recoup the disgorged money through its insurance carrier would undermine that goal." ✦

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Illinois District Court Affirms Bankruptcy Court's Injunction of Nationwide Securities Class Action

A federal district court in Illinois has affirmed a bankruptcy court's order temporarily enjoining a shareholder securities class action lawsuit against a bankrupt company's directors and officers pursuant to Section 105(a) of the Bankruptcy Code pending the completion of competing litigation filed by the bankruptcy trustee against the same defendants. *Megliola v. Maxwell*, 293 B.R. 443 (N.D. Ill. 2003). The court held that the class action litigation affected the amount and allocation of property among creditors because the class action plaintiffs and the trustee were both seeking to recover the same pool of limited assets—the proceeds of the debtor's D&O policy.

Prior to the debtor filing for bankruptcy, shareholders filed a class action lawsuit against the company and its directors and officers, alleging violations of federal securities laws. After the company filed for bankruptcy, the bankruptcy trustee filed an adversary proceeding against the directors and officers, alleging breaches of state law fiduciary duties owed to the debtor and its creditors. Both suits potentially implicated the debtor's $50 million D&O liability program. After filing suit against the directors and officers, the bankruptcy trustee initiated an adversary proceeding against the shareholders, seeking to enjoin them from pursuing their litigation and seeking to recover under the debtor's D&O policies.

The bankruptcy court enjoined the class action litigation under Section 105(a) of the Bankruptcy Code, which provides that the "court may issue any order, process, or judgment that is necessary or appropriate to carry out the provisions of this title." The court reasoned that the litigation was sufficiently related to the trustee's administration of the estate because the shareholders' suit could potentially reduce the amount of D&O insurance proceeds that the trustee would be able to recover in his adversary proceeding against the directors and officers. The shareholders appealed, arguing that the bankruptcy court did not have the authority to "block adjudication of a nationwide class

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Sexual Harassment and Discrimination Claims Barred by Employment-Related and I v. I Exclusions

A federal district court, applying Minnesota law, has held that a D&O insurer has no duty to defend an officer of a company who was sued for sexual harassment and discrimination because the claim was barred under both the employment-related and I v. I exclusions of the policy. *Miller v. ACE USA*, 261 F. Supp. 2d 1130 (D. Minn. 2003). The court also held that, because the insurer had no duty to defend, the policyholder could not bring an action against the insurer for breach of good faith and fair dealing or breach of fiduciary duty.

The insurer issued a D&O policy to a company. The policy contained an employment-related exclusion that barred coverage in connection with any claim "based upon, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving any employment-related matters brought by or on behalf of a director, officer, or employee." The policy also excluded coverage for any claim "for actual or alleged libel, slander, defamation, bodily injury, sickness, disease, death, false imprisonment, assault, battery, mental anguish, emotional distress, [or] invasion of privacy." Finally, the policy contained an I v. I exclusion, barring coverage for any claims "by, on behalf [of], or at the direction of any of the Insureds." "Insureds" was defined to include employees.

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Letter Demanding that Board Remedy Corporate Waste Constitutes "Demand for Monetary Damages"

In an unreported decision, a New Jersey trial court has held that a shareholder's letter to a company, alleging corporate waste and demanding that the board "recover excessive compensation" and void a trust, constituted a "claim" under a D&O policy where that term was defined to include "a written demand for monetary damages." *Ames Rubber Corp. v. Fed. Ins. Co.*, No. SSX-L-253-02 (N.J. Super. Ct., Law Div. June 20, 2003).

The insurer issued a claims-made D&O policy in 1999 to two companies controlled by three families. The policy defined "claim" to include "a written demand for monetary damages." The policy also contained an I v. I exclusion that applied to claims "brought by or on behalf of any or all members" of the controlling families. The same insurer provided coverage in subsequent years, although the policy issued in later years did not contain an I v. I exclusion. The policy issued in 2002 contained language stating that "Related Claims will be treated as a single claim made when the earliest of such Related Claims is first made."

In 1999, one of the family members wrote a letter to counsel for the companies alleging instances of misconduct and self-dealing by the directors and officers of the company. The letter stated that the author "expected" the board of directors of the company to take necessary steps "to recover the excessive compensation paid to" one of the officers and to void funds placed in a "Rabbi Trust," which had been created to fund retirement obligations of certain officers of the company. Subsequently, in 2002, members of one of the families filed suit against the companies, enumerating the same allegations contained in the 1999 letter. The insurer denied coverage, contending that the suit was a "related claim" to the 1999 letter and therefore coverage was barred under the I v. I exclusion in the 1999 policy. The policyholders argued that the 1999 letter did not constitute a claim because there was no "written demand for monetary damages." Coverage litigation ensued.

The trial court ruled in favor of the insurer, holding that the 1999 letter constituted a "written demand for monetary damages." It reasoned that the New Jersey Supreme Court has held that the term "damages" should be "accorded its plain, non-technical meaning." *See Morton Int'l v. General Acc. Ins.*, 134 N.J. 1, 25 (1993). The court noted that, under this standard, "damages" encompasses both legal and equitable relief since the "average businessman" would not differentiate between the two types of relief. Accordingly, the court concluded that the 1999 letter demanded monetary damages since the letter stated that the author "expected" the companies to take certain actions in response to the "business torts" of misconduct and self-dealing set forth in the letter. Because the lawsuit was deemed to constitute part of the same "Claim" as the 1999 letter and thus fell within the 1999 policy, the I v. I exclusion barred coverage. ✦

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Allegations of Fraudulent Transfer Excluded Under "Knowingly Wrongful Acts" and "Unlawful Profit" Exclusions in Legal Malpractice Policy

In an unreported decision, a federal district court, applying New York law, has held that an insurer was not obligated to defend or indemnify a law firm that was sued for aiding and abetting a company's directors in breaching their fiduciary duties and for fraudulently transferring certain shares of stock to itself because the allegations fell within the "knowingly wrongful acts" and "unlawful profit" exclusions in the firm's legal malpractice policy. *Steadfast Ins. Co. v. Strook Strook & Lavan LLP*, 2003 WL 21243020 (S.D.N.Y. May 28, 2003).

A law firm purchased a claims-made professional liability policy. The policy barred claims "based on, arising out of or resulting from in fact: (1) any malicious, knowingly wrongful, or criminal act, error, omission, or breach of duty…; or (3) the gaining by any Insured…of any profit, gain or advantage to which such Insured or person was not legally entitled."

A committee of unsecured creditors for a bankrupt company, which had been represented by the law firm in earlier transactions, commenced a bankruptcy proceeding against the law firm. The creditors alleged that the law firm "conspired with and aided and abetted" the company's directors to breach their fiduciary duties to the creditors in connection with a distribution of certain common stock. The creditors also alleged that the law firm fraudulently transferred certain shares of stock to itself. After the creditors and law firm settled the dispute, the law firm and the insurer entered into coverage litigation.

The district court held, based on a comparison between the allegations in the underlying complaint and the terms of the policy, that no coverage was available. The court reasoned that the allegations that the law firm aided and abetted and conspired to breach a fiduciary duty required proof of actual knowledge and that they therefore fell squarely within the "knowingly wrongful acts" exclusion. The court determined that the allegations relating to the law firm's transfer of shares to itself alleged that the law firm received an unlawful advantage based on those transfers and therefore fell wholly within the "unlawful profit, gain, or advantage" exclusion. The court also rejected the law firm's argument that the insurer had waived its coverage defenses by failing to timely disclaim coverage, noting that the insurer "reserved its right to disclaim coverage by issuing two reservation of rights letters notifying [the law firm] about its potential denial of coverage on the identical bases asserted in this litigation." ✦

Embezzlement Is Not Act in Capacity as President; Other Exclusions Also Bar Coverage

In an unpublished decision, a California appellate court has held that the former president of a company was not entitled to coverage under a D&O policy in connection with a lawsuit alleging that he embezzled money because the embezzlement was not an act in his "capacity as an officer or director" of the company. *Kronemyer v. Philadelphia Indemn. Ins. Co.*, 2003 WL 21213243 (Cal. Ct. App. May 27, 2003). The court also held that the exclusion for employment-related acts and the I v. I exclusion barred coverage for allegations that the former president was negligent in performing his duties.

The insurer issued a D&O policy to a film company. The policy provided coverage for claims seeking relief for "wrongful acts." The policy defined "wrongful acts" as any "actual or alleged error, misstatement, misleading statement, act, omission, neglect, or breach of duty committed by an Insured…in [his] capacity as a director or officer." The policy contained an employment practices exclusion barring coverage for "[l]oss in connection with any Claim arising out of, based upon or attributable to any actual or alleged breach of a written or oral employment contract or employment-related defamation." The policy also contained an I v. I exclusion that barred coverage for any claim "brought or maintained by or on behalf of the Company or an Insured in any capacity." The I v. I exclusion contained an exception for "a Claim in the form of a cross claim, third party claim or other claim for contribution or indemnity by an Insured which is part of or directly results from a Claim which is not otherwise excluded by the terms of the Policy."

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No Coverage Under Claims-Made Policy Where Policyholder Received Written Notice of a Potential Claim Prior to Inception of Policy

In an unreported decision, an Ohio appellate court held that a radiologist was not entitled to coverage under a claims-made medical malpractice policy because he had received written notice of the potential claim prior to the inception of the policy. *Kentucky Medical Ins. v. Jones*, 2003 WL 21453941 (Ohio App. June 24, 2003).

The insurer issued a claims-made medical professional liability policy to a radiologist and her employer. The policy provided coverage for claims "made against you and reported to us for the first time during the policy period." The policy defined claim to include "the receipt by you of express notification of an intention to investigate a potential legal action against you or of an intention to hold you responsible for damages." The policy also addressed when a claim is made, providing that "[a] claim is considered to be made on the first date you receive notice of a legal action against you or the date of your receipt of express notification of an intention to investigate a potential legal action against you or to hold you responsible for damages."

Prior to the inception date of the policy, the radiologist received a letter from a former patient stating that he was investigating a potential legal action. The radiologist disclosed the letter in her application for insurance. A few years later, the patient died and his wife brought a wrongful death action against the radiologist. The insurer disclaimed coverage on grounds that the claim was not first made during the policy period. Coverage litigation ensued.

The court held that the policy barred coverage because the claim had been made prior to the inception of the policy. The court rejected the radiologist's argument that the use of the term "first" in the provision governing when a claim is made modified only information about a legal action, and not notice of an intention to investigate a potential legal action, reasoning that such an approach was inconsistent with the usual and ordinary meaning of the language in the policy provision. The court also rejected the argument that the wrongful death action was a distinct claim from the medical malpractice claim. The court reasoned that the policy drew no such distinction, and that "the receipt of notification of a potential action relating to defendants' rendering of professional medical services includes all potential damages that could result from the malpractice, and certainly would encompass complications resulting in death." The court further noted that while Ohio courts have held that a wrongful death action constitutes a separate, independent cause of action from one for medical malpractice, those cases do not address whether the two causes of action are separate "claims" for purposes of insurance coverage. ✦

Embezzlement Is Not Act in Capacity as President; Other Exclusions Also Bar Coverage

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A former president of the company filed a lawsuit against the company, which then filed a cross complaint alleging that the former president had embezzled money, converted other company assets, and negligently performed his duties. The insurer denied coverage, and litigation ensued.

The appellate court held that no coverage was available for the allegations of embezzlement and conversion because those allegations did not involve "Wrongful Acts." The court explained that "[a]n officer does not act in his capacity as such when he engages in misconduct for his individual benefit to the injury of his employer."

The appellate court held, without elaboration, that the allegations of negligent performance of duties were excluded under the employment practices exclusion. It also held that the I v. I exclusion barred coverage for these allegations. The court rejected the president's arguments that the exception in the I v. I exclusion for contribution or indemnity claims applied, reasoning that the corporation did not seek relief for indemnity or contribution, did not allege that the president was responsible for a liability the corporation satisfied, and did not plead that the president was responsible or mandated to satisfy such a liability. ✦

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Overbilling Does Not Constitute "Printing Services" Under Printers E&O Policy

A federal district court in Missouri, applying Missouri law, has held that allegations that a printing company, insured under a printers E&O policy, overbilled for services did not involve "printing services." *Jerome Group, Inc. v. Cincinnati Ins. Co.*, No. 4:01CV0479 TCM (E.D. Mo. May 9, 2003).

The insurer issued an E&O printers policy to a printing company. The policy provided coverage for "sums that the insured becomes legally obligated to pay as damages caused by any negligent act, error or omission of the insured or any other person for whose acts the insured is legally liable arising out of the rendering or failing to render 'printing services.'"

The printing company entered into a contract to scan and index medical records for storage on CD-ROMs. Because the company did not have the capability to perform the work in-house, it contracted with a third-party to do the actual work. The party that had purchased the printing services subsequently performed an audit and found that it had been overbilled for the scanning and indexing. After the policyholder and the company that purchased the services entered into a settlement, the policyholder initiated litigation seeking coverage under its E&O policy.

The district court held that coverage was unavailable under the policy. The court noted that it could not find any authority in Missouri or the Eighth Circuit defining the term "professional services," and it adopted the reasoning of the First Circuit in *Medical Records Associates Inc. v. American Empire Surplus Lines Insurance Co.*, 142 F.3d 512, 513 (1st Cir. 1998). In that case, the First Circuit had explained that professional services "embrace[] those activities that distinguish a particular occupation from other occupations evidenced by the need for specialized learning or training and from the ordinary activities of life and business." The district court explained that, even if the scanning and indexing required special expertise, the act of billing for those services did not, and the underlying dispute involved only billing issues. The court reasoned that this point was reinforced by the fact that a third party, rather than the policyholder company, had performed the printing services. Thus, "[t]his billing is an effect of [the third party's] services and is not the printing services themselves." ✦

Texas District Court Holds that Fortuity Doctrine Applies Regardless of Actual Knowledge of Underlying Loss and Potential Liability

In a case involving commercial liability policies, a federal district court in Texas, applying Texas law, has held that the fortuity doctrine bars coverage where the insureds knew they were engaged in activities for which they could possibly be found liable, regardless of whether they had actual knowledge of the underlying loss and potential liability. *RLI Insurance Co. v. Maxxon Southwest, Inc.*, 2003 WL 21283878 (N.D. Tex. April 22, 2003).

The case arose after an insurer brought a declaratory judgment action seeking a declaration that it did not owe a duty of defense or indemnity under two commercial liability policies in connection with a civil suit alleging that the policyholder engaged in a conspiracy to violate federal antitrust laws. The insurer argued that the activities at issue constitute a "loss-in-progress" because the underlying complaint alleged that the conduct at issue predated the inception of the policy by at least four years.

The district court ruled in favor of the insurer, explaining that the fortuity doctrine precludes insurance coverage "where the insured is, or should be, aware of an ongoing progressive loss or known loss at the time the policy is purchased." The court also noted that "Texas courts have long recognized the doctrine as an inherent requirement of all risk insurance policies and as a standard component of Texas insurance law." In so ruling, the district court rejected the policyholder's argument that the doctrine should not apply because the underlying complaint did not allege knowledge of loss by the underlying plaintiff or that a lawsuit would be brought. The court explained: "The key factor in determining coverage under the fortuity doctrine is not, as defendants contend, whether the insureds had actual knowledge of the underlying loss, but rather if they knew at the inception that they were engaging in activities for which they could possibly be found liable." Since there was no dispute that the policyholder knew it was engaged in the potentially actionable conduct at issue in the underlying complaint, the court held that the fortuity doctrine barred coverage. ✦

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Coverage for Embezzlement by Employee of Policyholder Barred Under I v. I and Conversion Exclusions

A federal district court in Louisiana held that a policyholder, insured under a claims-made real estate licensee policy, is not entitled to coverage for losses resulting from embezzlement by an employee because the loss is excluded under both the I v. I and conversion exclusions in the policy. *See PNA, L.L.C v. Interstate Ins. Group*, 2003 WL 21488120 (E.D. La. June 20, 2003).

The insurer issued a real estate licensee policy to a company providing real estate services. The policy contained an exclusion for "conversion, misappropriation, commingling, or defalcation of funds or other property." The policy also contained an I v. I exclusion, barring coverage for "[a]ny 'claim' made by an insured under the policy against any other insured."

An employee of the real estate company embezzled money from the company, which then sought to recover the money from its insurer. The insurer denied coverage, and litigation ensued.

The court agreed with the insurer that the I v. I exclusion barred coverage. It reasoned that even if the employee who embezzled under the policy was not an insured, the claim was being asserted by the principals of the company who were insureds.

The court also held that the exclusion for conversion "unambiguously barred coverage." The policyholder argued that the exclusion was ambiguous or otherwise unenforceable because another exclusion in the policy, which barred coverage for dishonest, fraudulent, or criminal acts, contained an exception for "innocent insureds." The court rejected the argument, explaining that the insurer had simply decided to include an exception to one exclusion, but not the other. ✦

Physician's Excessive Charges for Prescription Drugs to Patients Constitute "Professional Services"

In an unpublished opinion, the U.S. Court of Appeals for the Fourth Circuit, applying North Carolina law, has held that a weight-loss center that was sued for overcharging patients for prescription drugs was entitled to a defense by its professional liability insurer because the allegations involved "professional services." *Continental Cas. Co. v. Physicians Weight Loss Centers of Am., et al.*, 2003 WL 1689530 (4th Cir. Mar. 31, 2003). The court also held that the exclusion for the "return of fees" did not bar coverage because the damages sought were based on inflated prices for goods, not services.

The insurer issued a professional liability policy to a weight-loss center. The policy provided "coverage against professional liability claims brought against [the insured] resulting from professional services provided by [the insured]." The policy further defined "professional services" as "those health care or medical services [the insured] normally provide[s] as a [weight loss program center]." The policy also contained an exclusion barring coverage for "fines, penalties, the return or withdrawal of fees or governmental payments."

A patient who had been treated at the weight-loss center filed a class-action lawsuit against the center. The complaint alleged that the weight-loss center required the patient to purchase drugs from the center at more than twice the price for which they were sold at a pharmacy, and that the treating physician, employed by the weight-loss center, refused to give her a prescription to fill at the pharmacy because he was barred from doing so by the center. The complaint alleged various state statutory violations, intentional interference with fiduciary duty and fraud.

The Fourth Circuit held that the acts alleged in the underlying claim constituted "professional services." In doing so, the court stated that the insurer mischaracterized the claim as a "mere dispute over pricing." Instead, the court determined that the underlying complaint involved the dispensation of a prescription and the breach of the physician's fiduciary duties, which were indisputably "professional services."

The court also rejected the insurer's argument that the exclusion for "fines, penalties, the return or withdrawal of fees or governmental payments" precluded coverage. The court first reasoned that the term "return of fees" applied to charges for professional services, rather than to payments for goods. Because the underlying claims sought "damages based on the inflated purchase price of a good, not a service," the court held that the exclusion was inapplicable. In addition, the court noted that the "context" of the exclusion suggested that it applies only to fees paid to the government. ✦

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Coverage Available Under Medical Liability Policy in Texas for Punitive Damages

A Texas appellate court has held that, in the absence of guidance from the state legislature or the Texas Supreme Court, insurance policies may provide coverage for punitive damages. *Westchester Fire Ins. Co. v. Admiral Ins. Co.*, 2003 WL 21475423 (Tex. App. June 26, 2003).

A nursing home purchased an occurrence-based primary policy of professional medical liability insurance with a limit of $1 million per occurrence and an excess policy with a limit of $10 million per occurrence. The primary policy defined occurrence as "an accident…which results in bodily injury…neither expected nor intended from the standpoint of the Insured."

The nursing home was sued by a patient and found to have been grossly negligent in its treatment of the patient. The underlying court held that the patient was entitled to compensatory damages, plus prejudgment interest; mental anguish damages; and treble damages, attorney's fees, and prejudgment interest under the Texas Deceptive Trade Practices Act (DTPA). The amount of compensatory damages exceeded the primary carrier's policy limits. Before the court could hold a hearing on punitive damages, the case settled with the primary carrier tendering its limits and the excess carrier contributing the remainder. The excess carrier then brought an equitable subrogation claim against the primary carrier, alleging that the primary carrier failed to settle the underlying insurance claim within its policy limits.

The excess carrier argued that the primary carrier improperly settled for punitive damages, which it contended are uninsurable as a matter of law. The appellate court disagreed. It noted that neither the Texas legislature nor the Texas Supreme Court have addressed the public policy implications of permitting insurance for punitive damages. In the absence of such direction, the court declined to hold that insurance coverage for punitive damages was void as against public policy.

The excess carrier also argued that the punitive damage component of the settlement was not covered under the language of the policy because the underlying court had found the nursing home to have been grossly negligent, and, thus, the injuries were "expected" or "intended." The court rejected that argument, reasoning "it is possible for a person to know that an act or omission is likely to cause serious harm, but not to anticipate it or to consider it probable that harm will likely occur." The court further noted that the policy did not contain an exclusion for grossly negligent behavior.

The court did hold, however, that damages based on the DTPA were not covered under the policy because the underlying trial court had based DTPA liability on a finding that the nursing home "intentionally" deceived the patient and its acts and omissions were "knowing." Since knowing is defined under the DTPA as "actual awareness," the court concluded that the DTPA violations were based on "expected" or "intended" acts or omissions. ✦

Bad Faith Action Can Proceed Against Medical Malpractice Insurer Even Without Initiation of Malpractice Suit Against Insured Doctor

In an unpublished decision, a Massachusetts district court, applying Massachusetts law, has held that a bad faith lawsuit may be brought against a medical malpractice insurer for failure to "effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear" even if the insured physician has not been sued for malpractice. *Rurak v. Med. Prof'l. Mut. Ins. Co.*, 2003 WL 21212721 (D. Mass. May 19, 2003).

The insured physician treated a patient who subsequently suffered a heart attack as a result of negligent medical treatment. The insurer, which had issued a medical malpractice policy to the physician, received four expert reports including one it procured, as well as a second by an expert the insurer had retained as its own expert in other cases, all of which indicated that the physician's "liability was reasonably clear." Although the injured patient never initiated a medical malpractice suit against the radiologist, he made a claim to the insurer. The patient subsequently filed suit against the insurer, alleging that the insurer had "stonewalled" by refusing to make a settlement offer or attempt to resolve the suit.

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Interview of Policyholder Under "Cooperation Clause" Does Not Require Disqualification of Interviewing Attorney in Rescission Litigation

A federal district court in Texas, applying Texas law, has held that an attorney representing an insurance carrier who interviewed an insured director of a company, pursuant to the "cooperation clause" of the D&O policy issued to the company, was not disqualified from representing the carrier in subsequent litigation to rescind the policy. *Great Am. Ins. Co. v. Christopher*, 2003 WL 21414676 (N.D. Tex. June 13, 2003).

The insurer issued a D&O policy to a company. The policy contained a cooperation clause requiring the policyholder to "provide the Insurer with all information and particulars it may reasonably request in order to reach a decision as to its consent to incur costs of the defense."

After the company filed for bankruptcy and shareholder lawsuits followed, the company sought indemnification under the policy. The insurer's outside counsel told the directors that the carrier would not accept coverage until it had an opportunity to interview one of the directors. During the interview, the attorney told the director that the information discussed "would not be disseminated to third parties." After the interview, the insurer began to advance defense expenses pursuant to an agreement in which the carrier reserved all of its rights. Subsequently, the insurer determined that material misrepresentations had been made in the application for the policy, and it instituted litigation to rescind the policy. One of the directors moved to disqualify the insurer's counsel on the grounds that the same law firm had conducted the interview prior to agreeing to advance.

The district court denied the motion to disqualify. It first rejected the argument that a *de facto* attorney-client relationship existed between the insurer's counsel and the director as a result of the interview and the limited disclosure of confidential information. The court reasoned that disclosure of confidential information, while relevant to the creation of an attorney-client relationship, is not sufficient by itself. Instead, the court said inquiry must be made into "the facts and circumstances as a whole." Here, since separate counsel represented the director at all times, and the director's attorney even negotiated the contours of the interview, the court reasoned that there was no attorney-client relationship. The court suggested that the relationship was much more like an information exchange under a joint defense agreement.

The court also rejected the argument that, because the insurer's outside counsel received confidential information, it owed the company's director a fiduciary duty. The court first noted that the counsel was using the information on behalf of the same client he had been representing at all times—the insurer—and that the situation was therefore distinguishable from cases in which an attorney uses information on behalf of another client. The court also explained that "Texas law is clear that an assumed duty to preserve confidences does not preclude an attorney and client from acting in their own best interests, even to the point of using information disclosed by others in ways that conflicts with the others' interests." Finally, while the court noted that the promise by counsel not to disclose the information created a reasonable expectation that the information would not be used in subsequent representation of a third party, the director "could not expect loyalty" from the insurer's counsel at "the expense" of the insurer. ✦

No Duty to Defend Lawyer Sued in Capacity as President of Manufacturing Company

In an unreported decision, a New York appellate court has held that an insurer had no duty to defend a law firm under a legal malpractice policy in a lawsuit alleging that a lawyer in the policyholder firm engaged in unlawful conduct in his capacity as president of a manufacturing company. *Seskin & Sassone, P.C. v. Liberty Int'l Underwriters*, 2003 WL 21508492 (N.Y. App. June 30, 2003).

The insurer issued a legal malpractice policy to a law firm. The policy excluded coverage for "any claim arising out of your services and/or capacity as an officer, director, partner, trustee, manager, operator, or employee of any organization other than the named insured." In an underlying action, the law firm was sued because one of its partners allegedly engaged in a fraudulent scheme concerning a retail development project in Nevada while acting in his capacity as the president of a corporation that manufactures medical equipment. The underlying complaint did not allege that the lawyer provided legal services. The court therefore concluded that "the allegations fall wholly within the policy exclusion." ✦

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No Coverage Under Claims-Made Policy for Previously Reported Potential Claim

A New York appellate court held that no coverage was available under a claims-made legal malpractice policy for a lawsuit arising out of actions occurring prior to the inception date of the policy and as to which a prior insurer had been notified. *Rosenbaum v. Chicago Ins. Co.*, 2003 WL 21294008 (N.Y. App. June 5, 2003). The court reached this result based on an exclusion in the policy barring coverage where the policyholder gave notice to a prior insurer of alleged negligence that could give rise to a claim. In so ruling, the court rejected the policyholder's argument that the "New York Amendatory Endorsement" required a different result. The court explained that the endorsement, "which makes the policy applicable to claims made and reported to Chicago during the policy period, any subsequent renewal thereof, or during any applicable Extending Reporting period simply amends the main policy form's coverage clause to add the term any subsequent renewal thereof, thereby clarifying that coverage will not be lost merely because a claim is made during one policy period but reported during the subsequent renewal period. Plaintiff's broader interpretation of this endorsement provision is manifestly unreasonable, since it would negate all of the main policy form's conditions to, and exclusions from, coverage." ✦

Insurer has a Duty to Defend Against Federal Trade Commission Investigation Even Absent Claim for Damages

In an unpublished decision, a trial court in Maine has held that an insurer has a duty to defend an insured non-profit corporation in an investigation by the Federal Trade Commission (FTC) even though the investigation notice did not contain a claim for damages. *Maine Health Alliance v. Med. Mut. Ins. Co.*, 2003 WL 21387158 (Me. Super. Ct. May 20, 2003).

The insurer issued a professional liability policy to a non-profit corporation that provided healthcare services. The claims-made policy obligated the insurer to "pay on behalf of the INSUREDS all LOSS for which the INSUREDS shall be legally obligated to pay as a result of any CLAIM or CLAIMS made against any INSURED due to a WRONGFUL ACT" and to defend "any CLAIM against the INSUREDS seeking damages for LOSS, even if any of the allegations are groundless, false or fraudulent." The Policy defined a claim as "any demand made upon an INSURED for damages, whether formal or informal, written or oral, or any occurrence which the INSURED believes may subsequently give rise to a CLAIM as a result of a WRONGFUL ACT." The Policy defined loss as "any amount including CLAIMS EXPENSE, in excess of the applicable retention and not exceeding the Limit of Liability, which [the Plaintiff is] legally obligated to pay or which the [Plaintiff] shall be required or permitted by law to pay for any CLAIM or CLAIMS made against them for WRONGFUL ACTS." Claims expense was defined to include "legal fees and all other fees or costs incurred in the defense of any covered CLAIM including post-judgment interest and expenses for investigation, adjustment and appeal."

The FTC sent the non-profit corporation a formal notice that it was conducting a non-public investigation into certain contractual relationships of the company. The company sought coverage under the policy, contending that the investigation could give rise to a claim for damages. The insurer denied a defense, arguing that the FTC investigation was not a claim for damages. Coverage litigation ensued.

The court held in favor of the non-profit corporation. It first concluded that the FTC investigation constituted a claim under the policy language because evidence in the record established that the plaintiff "believed" that the investigation could give rise to a claim. The court then held that the corporation had suffered a "loss" because it incurred a "Claims Expense"—legal fees—in defending against the FTC investigation. The court explained that "[a]lthough the Policy's definition section and description of coverage is clear, when read along the 'duty to defend' clause, the Policy is reasonably susceptible of multiple interpretations and therefore ambiguous." The court further noted that the insurer could have employed more precise language in defining terms so as to differentiate between actual claims for damages and occurrences that could potentially give rise to claims in the future. ✦

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Insurer Liable for Negligent Monitoring of Defense, Under Duty to Defend Policy, Prior to Withdrawal of Defense

The Supreme Judicial Court of Massachusetts has held that an insurer is liable for damages resulting from negligence by the insurer in monitoring the underlying defense, under a duty to defend policy, during the period of time before the insurer withdrew a defense of the claim. *Sullivan v. Utica Mut. Ins. Co.*, 788 N.E.2d 522 (Mass. 2003).

The insurer issued a duty to defend E&O policy to a company that provided risk management and insurance agency services. The policy contained an exclusion for any claims relating to the payment of premiums.

The policyholder company was sued in connection with its role in securing certain insurance coverage for the underlying plaintiff. The complaint contained allegations relating to premiums, as well as claims for negligence. The insurer agreed to provide a defense, subject to a reservation of rights, and it hired an attorney to defend the company in the underlying action. The underlying plaintiff subsequently amended its complaint, removing all claims for negligence. Since the amended complaint contained only allegations relating to the payment of premiums, the insurer withdrew its defense. The policyholder company sued the insurer, alleging, among other things, breach of contract and negligence for failing to employ competent counsel and to supervise counsel. The trial court granted summary judgment to the insurer on all issues, except negligence. After a trial on the negligence claim, the jury awarded the company $607,000 for out-of-pocket expenses, including legal fees, and $500,000 for lost profits.

The Massachusetts high court held that the insurer was entitled to withdraw its defense once the underlying complaint was amended to remove any covered claims. The court also held that the insurers could not be found liable for breach of contract for its conduct prior to withdrawing the defense because it fulfilled its contractual obligation by hiring an attorney. The court explained, however, that the insurer could be found liable for negligence if it breached its "duty of reasonable performance" in providing a defense.

The Massachusetts high court explained that, on the record, a jury could reasonably have found the insurer to have been negligent. The court noted that the insurer's claim representatives had "testified that as long an insurance company is providing the defense, it has an obligation to make sure that the defense is adequate." The court concluded that, based on testimony about how the underlying defense attorney was handling the case, including "discovery problems," a reasonable inference could be drawn that the insurer had failed to satisfy this duty of care, articulated by its own claims representative, in providing a defense.

The court held, however, that the insurer could not be held to be vicariously liable for the negligence of the underlying defense attorney. It reasoned that the attorney "was subject to a professional duty to attend to the interests of his client…and not to allow [the insurer's] financial underwriting of the expense to infringe on his duty of competent representation."

With respect to damages, the court held that the insurer was responsible for additional legal fees incurred only to the extent that those fees (i) were incurred prior to the insurer's withdrawal, and (ii) resulted from the insurer's negligent handling of the matter. The court noted that it is a "long-standing rule" in Massachusetts that lost profits are not available as damages, except in cases involving personal injury or property damage. However, since the insurer had not made the argument in this case, the court held that it was waived and the policyholder company was therefore entitled to recover lost profits. ✦

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Insurer Did Not Waive Ability to Rescind by Accepting Premiums

A federal district court, applying New York law, held that where an application for a legal malpractice policy failed to disclose the existence of 28 potential claims, as well as the fact that the prospective insured was being investigated by a state disciplinary committee, the application contained material misrepresentations justifying rescission. *Chicago Ins. Co. v. Kreitzer & Vogelman*, 2003 WL 21262077 (S.D.N.Y. June 2, 2003). The court also held that the insurer did not waive its right to rescind by accepting premiums for tail coverage after learning of some, but not all, of the facts that ultimately led it to sue for rescission.

An insurer brought this action, seeking a declaration that it properly rescinded two policies that it had issued to a New York law firm. After hearing evidence, the court made several findings of fact, including that although the law firm had identified in its application for coverage five claims pending against it, it had failed to disclose 28 potential claims and it did not answer a question concerning pending disciplinary proceedings, even though the state disciplinary committee was investigating the policyholder's managing partner. On the following year's renewal application, the policyholder again failed to report the disciplinary proceedings and approximately 30 potential claims. The court also found that the law firm had later informed the insurer of the managing partner's suspension resulting from the disciplinary proceedings. Aware of the suspension and of 10 claims that had been pending against the policyholder, the insurer nevertheless accepted premiums for an endorsement granting tail coverage. In the six months that followed, the insurer received notice of the additional claims, investigated the claims, and explored a potential rescission action. The insurer ultimately rescinded the policies and the accompanying tail coverage, and tendered all premiums.

In light of these findings of fact, the court first concluded that the policyholder's misrepresentations and omissions were material and justified rescission of the policies. The court reasoned that the insurer had successfully proved that if it had known about the disciplinary proceedings and additional claims, it either would have issued the policies under different terms and premiums or would not have even issued the policies.

The court also held that the insurer had not waived its ability to rescind the policies by accepting payments for tail coverage even after it learned of some of the omissions. The court reasoned that the insurer's knowledge of the managing partner's suspension from the practice of law and the presence of 10 claims against the policyholder "was not sufficient knowledge of the grounds for rescission such that [the insurer] waived its rights to rescind" when it accepted premiums for tail coverage. The court rejected the policyholder's argument that the insurer's failure to investigate the blank answer on the renewal application constituted a waiver, reasoning that an insurer does not have a duty to investigate or verify information supplied by a policyholder. Moreover, the insurer's six-month investigation into whether grounds for rescission existed also did not cause a waiver, as case law and public policy "support[] the allowance of such a reasonable investigation."

The court also rejected the policyholder's argument that the insurer was estopped from rescinding the policies because the policyholder had detrimentally relied on the insurer's acceptance of premiums by not acquiring tail coverage from the prior insurer. The court explained that the argument failed because the policyholder would not have been able to obtain tail coverage from its prior insurer at the relevant time in light of the additional claims. ✦

Bad Faith Action Can Proceed Against Medical Malpractice Insurer

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The district court rejected the insurer's motion to dismiss on the grounds that a bad faith claim cannot proceed before a determination of liability against the physician. The court explained that the Massachusetts Unfair Claims Settlement Practices Act requires an insurance company to "effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear." It also noted that the Supreme Judicial Court of Massachusetts had previously held that successful litigation of an underlying claim is not a prerequisite to bringing a claim for bad faith insurance practices. *See Clegg v. Butler*, 424 Mass. 413, 419, 676 N.E.2d 1134 (1997). Accordingly, the court held that the action could proceed. ✦

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Title Insurance Company's Failure to Disclose Injunction Against It Is Material Misrepresentation Allowing E&O Insurer to Rescind Policy

The U.S. Court of Appeals for the Seventh Circuit, applying Illinois law, has held that an insurer that issued an E&O policy to a title insurance and escrow issuing agent company was entitled to rescind the policy where the policyholder failed to disclose in its application that an Illinois court had entered a permanent injunction barring it from preparing deeds or other legal documents. *TIG Ins. Co. v. Reliable Research Co.*, 2003 WL 21488139 (7th Cir. June 30, 2003).

The insurer issued an E&O policy to a title insurance and escrow issuing agent company. The application, which was incorporated into the policy, asked the title insurance company to disclose every claim or suit filed against it in the past 10 years. The policy stated that "[i]f any Insured under this policy, or any of your authorized representatives, conceals or misrepresents any material fact or circumstance concerning the insurance, this policy will be void." In answering a question in the application concerning prior claims, the title insurance company did not disclose that four years earlier an Illinois Circuit Court had issued a permanent injunction enjoining it from "preparing Deeds or other legal documents relating to the transfer of real estate" and requiring it to "cease and desist the unlawful practice of law." After issuance of the policy, the title insurance company submitted claims for two lawsuits to the insurer. Those underlying lawsuits included allegations that the title insurance company had violated the permanent injunction, which therefore alerted the insurer, for the first time, to the existence of the injunction. The insurer subsequently sued for rescission and moved for summary judgment, which the district court granted.

The Seventh Circuit affirmed. The court held that, under Illinois law, an insurer may rescind a policy if the application contains a misrepresentation that was made with an intent to deceive or that was material. The court explained that "Illinois courts frame the materiality question in terms of whether 'reasonably careful and intelligent persons would regard the facts as stated to substantially increase the chances of the event insured against, so as to cause a rejection of the application.'"

The Seventh Circuit rejected each of the title insurance company's arguments as to why the failure to disclose the injunction was not material. First, the court rejected the argument that the injunction applied to the "unauthorized practice of law," but the policy merely insured against "faulty title work." The court explained that the argument conflicted with the company's application for insurance and that it was also inconsistent with the terms of the policy, which applied broadly to "Professional Services." The court also rejected the company's argument that the record did not support summary judgment because the insurer's underwriter had testified that, but for the injunction, the company was a "clean risk," thereby undermining the argument that this single additional disclosure would have been material. The court explained that "[i]t is perfectly reasonable to conclude that the nine-year old claim that resulted in no loss to [the title insurance company] or its E&O carrier would not be considered significant, but that disclosure of a permanent injunction barring [the title insurance company] from engaging in the unauthorized practice of law would." Finally, the court rejected the title insurance company's argument that summary judgment was inappropriate in light of the strong policy preference in Illinois to send materiality questions to the jury, reasoning that there was no factual question that the failure to disclose the permanent injunction was material. ✦

The court explained that "[i]t is perfectly reasonable to conclude that the nine-year old claim that resulted in no loss to [the title insurance company] or its E&O carrier would not be considered significant, but that disclosure of a permanent injunction barring [the title insurance company] from engaging in the unauthorized practice of law would."

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U.S. District Court Holds that Parties Can Voluntarily Reform Insurance Contract

A federal district court, applying Illinois law, has held that parties to an insurance contract can voluntarily reform the contract where a mutual mistake exists in drafting the policy. *St. Paul Mercury Ins. Co. v. Foster*, 2003 WL 21469149 (C.D. Ill. June 26, 2003). In its ruling, the court also addressed a number of other coverage issues, including the known loss doctrine, what constitutes insurable loss, application of the personal profit exclusion, and whether a written request for information constitutes notice.

The insurer issued a claims-made policy to a marketing firm that included a variety of coverages, including coverage for fiduciary liability. The insurer issued a policy that did not include the firm's Employee Stock Owners Plan (ESOP) on the list of ERISA plans insured and that contained an exclusion barring coverage for the ESOP. According to the district court, subsequent communications between the insurer and the firm confirmed that the insurer had intended to provide coverage for the ESOP, and that the ESOP had been excluded from coverage as a result of a mutual mistake by the parties. The insurer communicated to the firm that it had made a mistake, that it intended to provide coverage for the ESOP, and that it would find a way to accomplish the necessary technical corrections to the policy. Before the policy was formally changed, however, the firm and its directors and officers were sued in connection with a loss of value of stocks owned by the ESOP. The insurer subsequently initiated coverage litigation.

The court held that the parties had voluntarily reformed the policy to provide coverage for the ESOP. The court explained that reformation is available where there has been a meeting of the minds between contracting parties and when the agreement is reduced to writing "some agreed upon provision was omitted or one not agreed upon was inserted either through mutual mistake or through mistake by one party and fraud by another." The court also held that it does not require a court's equitable power to reform a contract and that parties can do so voluntarily. In fact, the court explained "that permitting and enforcing voluntary reformations by private parties is good policy in the abstract, as it encourages parties to contracts to correct their own mistakes without resorting to costly litigation." The court held that, based on the facts at issue, the parties had voluntarily reformed the contract, and the insurer could not change its mind now that it faced a potential liability.

The court also rejected the insurer's argument that the "known loss doctrine" barred reformation because the firm had begun to seek reformation after it had received a notice of potential litigation involving the ESOP. The court explained that the insurer had determined that the parties intended to include the ESOP in the policy from the very inception of the policy and at that time the firm did not have notice of the potential claim.

The insurer argued that it was also entitled to deny coverage because the underlying complaint sought restitution, which is uninsurable as a matter of public policy. The district court rejected that argument as a basis for denying coverage at this stage of the litigation because restitution was not the only form of relief potentially available to plaintiffs at trial.

The court also rejected as premature the insurer's argument that the personal profit exclusion barred coverage because the exclusion required a showing that the insured "in fact" gained such profits. The court reasoned the "[a]s such a finding is inextricably intertwined with a genuine issue of material fact requiring resolution at trial in the underlying case, the Court cannot make resolve [sic] this question on summary judgment prior to the resolution of the underlying litigation."

The district court rejected the insurer's argument that it had not received notice "as soon as practicable" because, while it had been informed of the lawsuit in a timely manner, it had not previously been informed of letters that had been sent three months earlier to the firm requesting a copy of the plan, discussing the decline in value of the shares and asserting a need for further information to "adequately protect" the interests of the underlying plaintiffs. The district court held that "mere" requests for information, "even if they allude to the possibility of a lawsuit," do not constitute a demand for services. The court also explained that the approach advocated by the insurer would be "bad public policy" because "[i]t would create uncertainty in every policy containing this notice requirement, as well as result in a flood of notices of 'claims' based on requests for information or efforts at intimidation by attorneys that may never materialize into demands against any insurance policies." ✦

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Illinois District Court Affirms Bankruptcy Court's Injunction

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action lawsuit, brought by non-creditors against non-debtors," under Section 105(a).

The district court upheld the injunction under Section 105(a), reasoning that the class action litigation would affect the bankruptcy estate or the allocation of property among creditors because the trustee and the class action plaintiffs were competing for the same limited amount of insurance proceeds. Relying on the decision in *Fisher v. Apostolou*, 155 F.3d 876, 882 (7th Cir. 1998), the district court explained that a bankruptcy court may temporarily enjoin litigation that is "related to" a bankruptcy case or a trustee's work on behalf of an estate, including actions between third parties that "have an effect on the bankruptcy estate." The class action litigation was sufficiently "related to" the bankruptcy at issue, the district court opined, because "the dispute 'affects the amount of property for distribution [i.e., the debtor's estate] or the allocation of property among creditors.'" In so holding, the court rejected the shareholders' attempts to distinguish *Fisher* on the grounds that the plaintiffs in that case were creditors of the debtor, determining that there is no factual distinction between litigation brought by shareholders and creditors. ✦

Sexual Harassment and Discrimination Claims Barred by Employment-Related and I v. I Exclusions

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A former employee of the policyholder company sued the company and its CFO, alleging a pattern of sexual advances and harassment, followed by discriminatory and retaliatory treatment. After the insurer denied coverage, the CFO initiated coverage litigation.

The court initially rejected the CFO's argument that coverage was available, irrespective of the employment-related exclusion, because a single factual allegation in the complaint alleged that certain assets of the company had been transferred to another entity in an effort to devalue the worth of the company, which arguably implicated a shareholder cause of action. The court explained that the single allegation, which was not tied to any cause of action, could not create coverage "[w]ith no relation to those counts actually enumerated, assuming some type of securities action based on this sole reference to stock devaluation would create a claim [the underlying plaintiff] has not expressly alleged and for which she has provided no basis or explanation, and would unreasonably construe and enlarge what is on its face an employment discrimination and sexual harassment lawsuit."

The district court held that the employment-related exclusion barred coverage for most of the counts in the complaint and that the exclusion barring coverage for assault, battery, and emotional distress barred coverage for the remaining counts. In so ruling, the court rejected the argument that the exclusion should not apply to claims by former employees. The court reasoned that the language of the exclusion was "expansive" and not limited to current employees. It also noted that the company could have, but did not, purchase Employment Practices Liability coverage, which generally covers claims by former employees. Finally, the court reasoned that "[d]enying coverage for claims by employees who sue while still employed with the company, while providing it for those brought by employees who have resigned or been fired, would draw an artificial and impractical distinction that would greatly hinder the purpose of exempting employment-related suits from D&O coverage."

The court also held that the I v. I exclusion applied since the policy language was "explicit and unambiguous." The court rejected the CFO's argument that the I v. I exclusion should apply only to those employees acting as "the functional equivalent" of directors and officers, reasoning that such a distinction did not exist in the policy.

Finally, the court rejected the CFO's argument that the insurer could be liable for breach of the duty of good faith and fair dealing or breach of fiduciary duty. The court explained that since the insurer had no duty to defend, it could not be liable for a breach of good faith and fair dealing. Similarly, because a breach of fiduciary duty requires a fiduciary obligation, which can only exist after the insurer assumes defense of the insured, that allegation against the insurer had no merit. ✦

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Speaker's Corner

September 24, 2003
"Ensuring Protection for D&O Coverage in Corporate Bankruptcies"
Daniel J. Standish, *Panelist*
Institute for International Research's D&O Liability Conference
Crowne Plaza United Nations
New York, NY

December 9, 2003
"Corporate Bankruptcy and Its Impact on D&O Policies"
Daniel J. Standish, *Panelist*
The American Conference Institute's Directors and Officers Liability Conference
New York, NY

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