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The Executive Summary

Developments Affecting Professional Liability Insurers

Seventh Circuit Holds No Duty to Defend Where Complaint Alleges Only Intentional Conduct

The U.S. Court of Appeals for the Seventh Circuit, applying Illinois law, has held that an insurer that issued a travel agents' professional liability policy to a car rental company has no duty to defend a complaint alleging that the company intentionally overcharged customers, even though the underlying plaintiffs could have—but did not—allege negligent conduct. *Conn. Indem. Co. v. DER Travel Serv.,* No. 02-3302, 2003 WL 2010723 (7th Cir. May 2, 2003).

The insurer issued a professional liability policy to a car rental company. The policy provided coverage for "[a]ny negligent act, error, or omission" of the agency. It excluded coverage for "liability arising out of any act, error, or omission which is willfully dishonest, fraudulent, or malicious, or in willful violation of any penal or criminal statute or ordinance, and is committed (or omitted) by or with the knowledge or consent of the 'insured.'"

The car rental company was named as a defendant in a class action lawsuit alleging that the company overcharged consumers on car rentals in European countries by improperly applying the value added tax (VAT) to booking fees they charged consumers, even though the VAT was not applicable to such fees. The complaint alleged that the company violated the Consumer Fraud Act through "deceptive pricing and other deceptive acts" which were "intentionally and willfully effected in disregard of law." The insurer denied coverage based on the exclusion for intentional acts, and litigation ensued.

The Seventh Circuit ruled in favor of the insurer. It noted initially that the policy provides coverage only for negligent acts. The court then reviewed the relevant allegations in the complaint and concluded "[a] review of these paragraphs reveals not a hint of negligent conduct alleged. The complaint lucidly sets forth that [the company] purposefully engaged in a scheme to deceive consumers."

The court rejected the company's argument that the underlying plaintiffs could have asserted a negligence claim under the Consumer Fraud Act, reasoning that they did not do.

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Sixth Circuit Holds E&O Policy Exclusions for Specific Conduct Apply Even if Conduct Was Negligent

The U.S. Court of Appeals for the Sixth Circuit, applying Michigan law, has held that exclusions in an E&O policy that barred coverage for, among other things, claims arising out of breach of contract, commingling funds and embezzlement, applied notwithstanding the policyholder's argument that the conduct at issue resulted from negligence and was not intentional. *Northland Ins. Co. v. Stewart Title & Guar. Co.*, No. 01-1729, 2003 WL 1950030 (6th Cir. Apr. 25, 2003).

The insurer issued a policy to a title and escrow agent company and its directors. The policy required the insurer to "pay those sums that the insured becomes legally obligated to pay as damages because of a negligent act, error or omission in the rendering of or failure to render professional services as a

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"Eight Corners Rule" Prohibits Consideration of Extrinsic Facts; Prior Knowledge Exclusion Not Yet Applicable

A federal district court, applying Texas law, has held that the "eight corners rule" bars the introduction of extrinsic evidence when determining whether the duty to defend has been triggered under a legal malpractice policy, unless such evidence pertains to a fundamental coverage issue, such as whether a policy exists or whether a named insured or specified piece of insured property has been specifically excluded from coverage. *Westport Ins. Corp. v. Atchley, Russell, Waldrop & Hlavinka, L.L.P.,* No. 5:01 CV 280, 2003 WL 1889004 (E.D. Tex. Apr. 10, 2003). In the opinion, the court also summarized the standard for applying the "prior knowledge" exclusion and determined that it would be premature to decide whether the insurer was obligated to indemnify the policyholder.

The insurer issued a claims-made legal malpractice policy to a law firm that contained a prior knowledge exclusion. The exclusion stated that the policy did not apply to claims "based upon, arising out of, attributable to, or directly or indirectly resulting from...any act, error, omission [or] circumstance...occurring prior to the effective date of this POLICY if any INSURED at the effective date knew or could have reasonably foreseen that such act, error, omission [or] circumstance...might be the basis of a CLAIM."

The law firm was sued for legal malpractice in connection with representation of a client before the IRS. The complaint contained allegations of breach of fiduciary duties, breach of contract, negligence and violations of the Deceptive Trade Practices Act. The law firm tendered the complaint to the insurer, which refused to defend or indemnify. The insurer filed a declaratory judgment action seeking a declaration that it had no duty to indemnify or defend based on the prior knowledge exclusion. The insurer subsequently filed a motion for summary judgment and the parties submitted a joint stipulation of facts in connection with the motion.

The court first discussed at length the scope of the prior knowledge exclusion. It concluded that the prior knowledge exclusion bars coverage in three situations:

> (1) When the insured has subjective knowledge of an impending claim; (2) when facts subjectively known to the insured would lead a reasonable attorney to conclude that a grossly flagrant or glaring breach of duty occurred; or (3) where facts subjectively known to the insured would lead a reasonable attorney to conclude that at least some breach of duty occurred *and* where those same facts also indicate that the client is dissatisfied to a point that would lead a reasonable attorney to conclude that the client likely would file a claim.

In reaching this conclusion, the court rejected the insurer's argument that the exclusion should apply whenever a reasonable attorney, examining the facts known by the insured, would conclude that a professional duty had been breached. The court explained that "[s]o long as the attorney was conscious, the insurer's approach would exclude coverage for any error that occurred prior to the beginning of the policy period, which period is invariably for only one year. This is because the 'reasonable attorney' would recognize most, if not all, instances in which any duty had been breached, even if many attorneys would not be aware that a breach had occurred."

The court then discussed at length whether it should consider a joint stipulation of facts by the parties in deciding the motion for summary judgment. The court concluded that the "eight corners rule," which generally prevents the court from considering documents beyond the complaint and insurance policy, should be applied strictly, and exceptions should be permitted only "in very limited circumstances" in which "'fundamental' policy coverage questions are resolved by 'readily determined facts.'" The court explained that "fundamental policy questions" in which extrinsic facts could be considered include: "(1) whether a person has been excluded by name or description from *any* coverage; (2) whether the property has been expressly excluded from any coverage; and (3) whether the policy exists." Moreover, a "determination of these 'fundamental coverage issues' must be able to be made by a *readily determined fact* that does not engage the truth or falsity of the allegations in the underlying petition." Absent such "fundamental coverage facts," extrinsic evidence should not be considered. Here, because the parties offered no extrinsic evidence concerning such fundamental coverage issues, the court refused to consider any evidence outside of the policy and the underlying complaint.

On the basis of those two documents, the court found that the exclusion was not triggered because nothing in the complaint alleged that any of the firm's attorneys had subjective knowledge that a claim would be filed against them before the inception of the policy period, and nothing in the complaint suggested that "any of the highlighted wrongs were so blatant that any lawyer would expect to see a claim because of them." Thus, the court found that the exclusion did not preclude the insurer's duty to defend. Moreover, the court noted that, even if the exclusion barred coverage for claims based on acts that occurred before the policy period, the duty to defend would still be triggered because the complaint alleged breaches of duties owed by the

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Claims-Made E&O Policy Provides Coverage for Loss Caused by Continuous Exposure to Harmful Conditions Prior to Retroactive Date

A Washington appellate court has held that a claims-made policy provided coverage for loss caused by continuous or repeated exposure to harmful conditions that existed prior to and after the policy's retroactive date. *State of Wash. v. Zurich Specialties London, Ltd.*, No. 50211-5-I, 2003 WL 1824966 (Wash. Ct. App. Apr. 7, 2003). The court also held that the loss could not be allocated based on the number of negligent acts occurring before and after the retroactive date because, under Washington law, a court may not allocate loss unless allocation is expressly provided for in the policy or the court can devise a rational allocation scheme.

In 1999, a disabled woman sued the State of Washington for injuries sustained between 1984 and 1997 that she alleged were caused by her husband, who was her state-appointed caregiver. After settling the case for $8.8 million, the state brought a declaratory judgment action against its E&O insurer. The insurer had issued a claims-made policy that had a retroactive date of July 1, 1990 and had a $5 million deductible. According to the terms of the policy, coverage existed for "that amount of the Ultimate Net Loss which the Insured shall be obligated to pay by reason of the liability...assumed by the Insured under...[an] agreement, for damages on account of Personal Injuries resulting from each Loss." "Loss" was defined as "an accident, or offense, including continuous or repeated exposure to the same general harmful conditions, or a breach of professional duty, which took place on or after the retroactive date."

The appellate court rejected the insurer's argument that the policy did not provide coverage because the husband was appointed as a caregiver prior to the retroactive date and that any breach of duty must therefore have occurred prior to that date. The court noted that the state annually renewed the husband's appointment as caregiver and that it had received warnings of abuse and neglect after the retroactive date. Therefore, the court explained, the husband "remained in that position due to ongoing negligence by the State that extended well into the policy period." The court concluded, based on the insuring agreement and definition of "loss," that "this language provides coverage not just for harms commencing after the retroactive date, but also for continuous or repeated exposure to preexisting harmful conditions, as long as the repeated exposure takes place after the retroactive date. Further, the policy clearly provides coverage for personal injuries resulting from any breach of professional duty that takes place after the retroactive date."

The appellate court also rejected the insurer's argument that the loss should have been allocated based on the number of negligent acts that occurred before and after the retroactive date. The court explained that Washington courts do not allocate loss based solely on the number of years during which a policy was in effect and that allocation is improper unless the policy expressly provides for allocation or the court can devise a rational allocation scheme. Reasoning that an allocation based on the timing of negligent acts would not be rational because there was no causal connection between the specific acts and injuries alleged, the court rejected the insurer's argument that the retroactive date was an express allocation scheme based on the timing of the alleged negligent acts.

The court also rejected the insurer's argument that the trial court erred by considering an email message the insurer had sent to the state in which it took the position that 50% of the injury occurred prior to the retroactive date and invited the State to discuss the matter further. The court explained that the email was not an "offer of compromise" because the "statement that only half of the claim was covered was not an offer of compromise but an outright denial of indemnity." The court also explained that the email was admissible because "the parties were not engaged in negotiations or preparing for litigation at the time [the insurer] made the statements." ✦

Seventh Circuit Holds No Duty to Defend Where Complaint Alleges Only Intentional Conduct

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The court explained, "it is the actual complaint, not some hypothetical version, that must be considered."

Finally, the court acknowledged the "well-settled doctrine" that a complaint must be construed in favor of the insured. The court concluded, however, in this case that there was "no evidence that the [ ] complaint alleged [that the company] acted in a negligent fashion. Phrases such as 'mislead and conceal,' 'scheme or device,' and 'intentionally and willfully' are the paradigm of intentional conduct and the antithesis of negligent actions." ✦

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No Coverage for Foreseeable Legal Malpractice Claim Based on Prior Knowledge Exclusion

A federal district court, applying Pennsylvania law, has held that the prior acts exclusion in a claims-made legal malpractice policy barred coverage for a malpractice claim against an attorney that arose out of conduct before the policy period that the attorney had a basis to believe constituted legal malpractice. *Mirarchi v. Westport Ins. Corp.*, No. 99-44331, 2003 WL 1918975 (E.D. Pa. Apr. 21, 2003). The court also held that the policyholder's subjective beliefs as to whether a suit would be brought or has merit were irrelevant to an analysis of whether the claim was foreseeable.

On August 10, 1998, an attorney purchased a claims-made professional liability insurance policy. In the application, the attorney stated that he was unaware of "any circumstance, act, error, omission or personal injury which might be expected to be the basis of a legal malpractice claim or suit that has not previously been reported to the firm's insurance carrier." On March 4, 1999, during the policy period, the attorney was sued for professional malpractice for services rendered between 1994 and 1996 on behalf of an estate. The complaint alleged that the attorney had improperly caused the estate, rather than a beneficiary, to assume responsibility for the payment of certain mortgages and taxes. The insurer denied coverage based on a provision in the policy that excluded coverage for "[a]ny act, error, or omission or PERSONAL INJURY occurring prior to the effective date of this POLICY if any INSURED at the effective date knew or could have reasonably foreseen that such act, error, omission, circumstance or PERSONAL INJURY might be the basis of a CLAIM." The insurer relied on a deposition of the attorney that was taken on June 2, 1998 in a lawsuit between the estate and the beneficiaries in which the attorney stated that he was aware of "an act, error, omission or circumstance" that triggered the exclusion provision.

The district court ruled in favor of the insurer and concluded that the malpractice claim was "reasonably foreseeable." Since the Pennsylvania Supreme Court had not directly addressed the meaning of the phrase "reasonably foreseeable" in the context of a professional liability insurance policy, the district court relied on a two-step analysis used by the Third Circuit:

> First, it must be shown that the insured knew of certain facts. Second, in order to determine whether the knowledge actually possessed by the insured was sufficient to create a "basis to believe," it must be determined that a reasonable lawyer in possession of

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Property Damage Exclusion in E&O Policy Does Not Apply to Reprinting of Mailing to Correct Errors

A Texas appellate court has held that the property damage exclusion in an E&O policy issued to a printing company did not bar coverage for costs that the printing company incurred to reprint a mailing because the original printing contained erroneous information. *Venture Encoding Serv., Inc., v. Atl. Mut. Ins. Co.*, No. 2-02-020-CV, 2003 WL 2004361 (Tex. App. May 1, 2003).

The case arose when an insurer denied coverage to a printing company for the costs of reprinting a mailing because the original mailing contained erroneous information. The policy provided coverage for "sums that the insured becomes legally obligated to pay as damages arising out of any negligent act, error or omission committed by...the insured in the course of providing or failing to provide 'printing services.'" The policy excluded coverage for "costs or damages incurred for the correction, or repair or replacement of 'property damage' to...'Your product' arising out of such products, or any part of such products." However, the exclusion contained an exception for "damages incurred due to the withdrawal or inspection of such products or work because of any known or suspected defects or deficiency therein." The policy defined "property damage" as "[p]hysical injury to tangible properly, including all resulting loss of use of that property; or...[l]oss of use of tangible property that is not physically injured."

The court held that the exclusion for property damage did not apply because the misprinting did not constitute "property damage." The court reasoned that an "[e]rror in information is intangible property not tangible property," and "[d]amage to intangible property constitutes economic loss, not property damage."

The court also rejected the insurer's argument that coverage was unavailable because the policyholder had not been "legally obligated to pay" for correcting the mistake in printing services. The court reasoned that several contractual provisions in the policyholder's contract to complete the mailing required the policyholder to cover all expenses for corrective actions or negligent performance, and that the policyholder was thus contractually bound to pay for the reprinting. ✦

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Written Notice of Wrongful Acts Not Required Where Insurer Was Aware of Acts; Later Suit Related Back to Prior Litigation

A New York appellate court has held that a policyholder was not required, under a claims-made policy, to provide specific written notice of wrongful acts giving rise to a claim where the insurer already knew of the acts and had been involved in trying to settle the litigation arising out of the acts. *Greenburgh Eleven Union Free Sch. Dist. v Nat'l Union Fire Ins. Co.*, 2003 WL 1754020 (N.Y. App. Div., Apr. 3, 2003).

Two insurers issued consecutive, claims-made E&O policies to a school district. During the policy period when the first insurer was providing coverage, certain "disturbances" occurred at the school. As a result of the "disturbances," the school district took disciplinary action against some of the teachers and staff. The teachers and staff, through their union, then commenced a proceeding before the Public Employee Relations Board (PERB I), and the employees instituted a proceeding in federal court (Greenburgh I). The school district subsequently initiated proceedings against additional teachers and staff, and the union instituted a new proceeding before the PERB (PERB II). At that point, the first insurer's policy was discontinued, and the second insurer began providing coverage. Shortly thereafter, the teachers involved in PERB II filed suit in federal court (Greenburgh II). Both insurers disclaimed coverage for Greenburgh II, and coverage litigation ensued.

The first insurer denied coverage on the ground that it had not received written notice of the wrongful acts giving rise to the Greenburgh II claim. The court rejected the argument. It initially noted that notice requirements are to be liberally construed in favor of the insured. It then explained that while the insurer had not been given specific written notice of the disciplinary actions that formed the basis of the Greenburgh II claims, "the record overwhelmingly supports the conclusion that [the insurer] was intimately involved in seeking a global settlement of all disputes with the Teachers' Union through the time of PERB I, Greenburgh I and PERB II." The court further noted that the insurer's claims director had testified that he was aware of the disciplinary proceedings during the policy period.

The court agreed that the second insurer properly disclaimed coverage on the ground that the Greenburgh II action was not a claim first made during its policy period. The policy provided that a claim was first made at the time of the first claim arising out of the same wrongful act "or logically or causally connected wrongful acts." Since all of the disciplinary acts by the school district arose out of the same disturbances that gave rise to Greenburgh I, the court concluded that they were "logically or causally connected," and therefore Greenburgh II was made outside of the second insurer's policy period. ✦

No Coverage For Foreseeable Legal Malpractice Claim Based on Prior Knowledge Exclusion

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> such facts would have had a basis to believe that the insured had breached a professional duty. That the insured denies recognizing such a basis on grounds of ignorance of the law, oversight, psychological difficulties, or other personal reasons is immaterial.

Selko v. Home Ins. Co., 139 F.3d 146, 152 (3d Cir. 1998).

Applying the test here, the court first concluded that the attorney was aware of a number of critical facts, including that a lawsuit had arisen over the payment of the mortgage, that one of the parties blamed him for what had happened and that "he did not comply with Pennsylvania law" in his handling of the matter. The court then determined that a reasonable attorney knowing these facts that the attorney possessed would have had a basis to believe that he had breached a professional duty.

The court rejected the attorney's argument that the suit against him was not foreseeable because he had been acting at his client's direction and therefore had a subjective belief that his client would not sue him. The court explained that his "subjective belief" was irrelevant to the Third Circuit's "objective analysis." The court also rejected the attorney's argument that a claim was not foreseeable because he believed that any claim against him would be barred by the statute of limitations. Relying on the Third Circuit decision in *Coregis Insurance Co. v. Baratta & Fenerty, Ltd.*, 264 F.3d 302, 307 (3d Cir. 2001), the court explained that "a subjective belief that a malpractice action would not have merit, or a belief that the statute of limitations may have run, is not sufficient to avoid application of the exclusion." ✦

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"Loss" or "Liability" Under ERISA Fiduciary Policy Includes Amounts Paid to Establish and Fund Employee Accounts

The Massachusetts federal court, applying Massachusetts law, held that "loss" or "liability" under an ERISA fiduciary policy includes amounts paid by a policyholder company to establish and fund profit-sharing accounts for eligible employees originally left out of the company's plan. *Pacific Ins. Co., Ltd. v. Eaton Vance Mgmt.*, No. 00-11128-JLT, 2003 WL 1989584 (D. Mass. Apr. 30, 2003). The court also held that the insurer was required to reimburse the company for pre-tender costs and prejudgment interest.

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

The company determined that it had mistakenly failed to fund the accounts of a number of employees eligible for profit-sharing. It ultimately paid more than $850,000, including interest, to fund the accounts. Four months after learning of the mistake and six weeks after acknowledging its obligation to fund the additional employees' accounts, the company notified the insurer. Coverage litigation ensued. In an earlier stage of the case, the court had determined that the policy afforded coverage for the company's claim. In this decision, the court addressed damages.

The court first held that the company was entitled to reimbursement for the costs it incurred to establish and fund the accounts for its employees. The insurer argued that the company did not incur a "loss" because the company should have funded the employees' accounts from the outset. Disagreeing, the court explained that the policy afforded coverage for "loss" or "liability" that the company incurs from claims made against it because of "an actual or alleged breach of fiduciary responsibility." The court noted that in an earlier stage of this case, it had found that the company breached its fiduciary duty to its employees when it failed to establish and fund the plan accounts and that the breach was covered by the policy.

Next, the court determined that the company was entitled to the reimbursment of pre-tender costs. The insurer argued that it was not required to reimburse the company for these costs

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title agent, abstractor, escrow agent and notary public." The policy excluded coverage for, among other things: (1) "Contractual Liability – Any damages for liability of other which the insured has assumed under any oral or written contract or agreement;" (2) "Criminal Acts – Any damages arising out of dishonest, fraudulent, criminal or malicious act or omission by or on behalf of or at the direction of any insured;" and (3) "Handling of Funds – Any damages arising out of the commingling, conversion, misappropriation of defalcation of funds or other property."

A third party sued the title and escrow agent and three of its directors for breach of an underwriting agreement, breach of fiduciary duty, breach of the state insurance code, embezzlement, and the conversion and commingling of funds based on the allegation that the policyholder's escrow account was missing approximately $300,000. The insurer filed a declaratory judgment action seeking a determination that it had no duty to defend or indemnify.

The Sixth Circuit rejected the company's argument that it was entitled to coverage because any liability resulted from negligent conduct, concluding that the insurer had no obligation under the policy because the "damages alleged in the [underlying complaint] resulted from conduct that was excluded by the contract." The court initially noted, with respect to the exclusions, that "[t]he policy contains no language limiting these exclusions to intentional acts; rather, the exclusions are for damage resulting from specific kinds of conduct without regard to whether that conduct was intentional or negligent." Thus, the court determined that the breach of contract was "expressly excluded by the contractual liability exclusion." With respect to the embezzlement count, the court noted that embezzlement was not specifically excluded, but reasoned that embezzlement requires intentional conduct, and the policy provided coverage only for negligent acts. The court reasoned that the "Handling of Funds" exclusion clearly applied to the conversion and commingling of funds allegations and therefore barred coverage for those allegations. The court explained that "even if the insureds acted without knowledge of the dishonest, fraudulent, criminal or malicious nature of the act or omission, the damages, regardless of *mens rea*, would still be excluded from coverage if these damages resulted from one of the other listed exclusions." ✦

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Controlled Enterprise Exclusion in Lawyers Policy Inapplicable

A federal magistrate judge, applying Maine law, has issued a recommended decision holding that the controlled enterprise exclusion in a lawyer's malpractice policy does not apply to allegations that the attorney engaged in conduct intended to benefit an enterprise in which the lawyer had an interest because the actions by the lawyer were on behalf of a client and therefore were not "based upon or arising out of" work performed on behalf of the controlled enterprise. *Am. Guar. & Liab. Ins. Co. v. Keiter*, No. 02-123-P-C, 2003 WL 1889053 (D. Maine, Apr. 16, 2003).

An insurer issued a malpractice policy to an attorney. The policy contained a controlled enterprise exclusion applicable "to any claim based upon or arising out of the work performed by the Insured, with or without compensation, with respect to any corporation, fund, trust, association, partnership, limited partnership, business enterprise or other venture, be it charitable or otherwise, of any kind or nature in which any Insured has any pecuniary or beneficial interest, irrespective of whether or not an attorney-client relationship exists, unless such entity is named in the Declarations."

The lawyer provided legal advice to an individual in connection with the formation of a corporation in exchange for 25% of the stock in the corporation. The lawyer also advised the individual in connection with a book contract. The individual and the corporation subsequently sued the lawyer for malpractice. One count in the complaint alleged that the lawyer breached his fiduciary duties by recommending that all of the book royalties go to the corporation (in which he had an interest), rather than the standard industry approach in which 80% of the royalties would have gone to the author. The other counts in the complaint alleged various theories of "professional negligence." The insurer filed a lawsuit seeking a declaratory judgment that it had no duty to defend. It then filed a motion for summary judgment, and the magistrate judge recommended that the motion by the insurer be denied.

With respect to the count concerning the book royalties, the magistrate judge reasoned that, according to the allegations in the complaint, the lawyer did not undertake the book negotiations for the corporation. Instead, "he undertook the negotiation for the [the individual client] as an individual and breached his duty to [the individual client] as his individual client by arranging for all of the proceeds to go to [the corporation] in which [the lawyer] had a beneficial or pecuniary interest, rather than to [the individual client]." Accordingly, the magistrate judge reasoned that the alleged liability was not "based upon or [did not] aris[e] out of" work performed "with respect to" the corporation.

As to the remaining counts, the magistrate judge concluded that the insurer had relied on extrinsic facts and not simply on the allegations in the complaint. Since those facts were in dispute, the court concluded that summary judgment was inappropriate. ✦

"Eight Corners Rule" Prohibits Consideration of Extrinsic Facts

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law firm to its clients both before and after the inception of the policy period.

The court also held that it was premature to decide whether the insurer had a duty to indemnify until after the resolution of the underlying litigation. The court noted that it had "found no Texas case in which the Court announced that...the duty to defend was triggered, and simultaneously decided that the duty to indemnify could not arise for lack of coverage." The court explained that Texas law allowed the insurer to avoid the duty to defend in only two situations: (1) where "'fundamental coverage facts' that may be readily determined by extrinsic evidence preclude both duties from arising," and (2) where "the suit against the insured, by its own allegations, proves that no coverage exists." Because the court did not find the presence of either of those circumstances, the court refused to allow the insurer "to achieve in this action prematurely what it would be denied in state courts under state law." Further, the court explained that even if it found the issue to be a procedural one allowing for the application of federal law, the court would exercise its discretion and not grant relief as to the duty to indemnify because some of the issues it would address could overlap with those issues to be decided in the underlying litigation. The court did not want to interfere with the underlying litigation. ✦

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"Loss" or "Liability" under ERISA Fiduciary Policy

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because the company breached the notice provision of the policy. The court explained that, under Massachusetts law, an insurer "must prove both that the notice provision was in fact breached and that the breach resulted in prejudice to its position." The insurer contended that it did not need to show prejudice because the purpose of the rule requiring an insurer to show prejudice is to prevent a policyholder from experiencing total forfeiture of coverage, but where, as here, the insurer had already paid post-tender costs, the company would not suffer such a forfeiture. The company argued that because it was delegated the duty to defend, a showing of prejudice was required to justify releasing the insurer of its requirement to reimburse the company for litigation expenses. Agreeing with the company, the court explained that "where the insurer has a duty to defend the insured, there is an inherent prejudice when an insured makes decisions that impact the defense. Essentially, it is unfair to force the insurer, who might have made different choices, to pay for the defense prior to notification of a claim. This concern, however, is not present where the policy specifically absolves the insurer of any duty to defend." The court therefore concluded "absent a showing of prejudice, an insurance company is not absolved of its obligation to pay litigation costs merely because of an insured's failure to timely notify the insurance company of the claim." The court noted that it had already determined that the insurer suffered no prejudice in its earlier ruling, so the company was entitled to reimbursement for pre-tender costs.

The court also found that the company was entitled to prejudgment interest, reasoning that the company had not attempted to prolong the proceedings to obtain a larger damage award and that it would have had the benefit of these sums had the insurer not wrongfully refused to pay. ✦

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