Wiley Rein & Fielding

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The Executive Summary

Developments Affecting Professional Liability Insurers

Third-Party Claimant Lacks Standing to Sue D&O Insurer

A federal district court, applying California law, has held that a third-party claimant lacks standing to sue a D&O insurer to collect a default judgment, rejecting arguments that the third party has the right to do so (1) under a California insurance statute or, alternatively, (2) as an intended third-party beneficiary to the insurance contract. *GDF Int'l, S.A. v. Assoc. Elec. & Gas Ins. Servs. Ltd.*, No. C 02-02916 CRB, 2003 WL 926790 (N.D. Cal. Mar. 4, 2003).

A third party sued the policyholder company and three of its directors for securities fraud based on allegations that the company's directors had made false statements regarding the company's preferred stock. After voluntarily dismissing the directors, the third party received a $10 million default judgment against the company and then filed a direct action against the insurer under California Insurance Code Section 11580 to collect on the judgment, or in the alternative, as an intended third-party beneficiary to the insurance contract.

The court rejected the third party's argument that it had standing to sue under Section 11580, which enables a judgment creditor, in certain situations, to bring a direct action against a liability insurer when the insured is bankrupt or insolvent. Among other requirements, the judgment creditor must have "obtained a judgment for bodily injury, death, or property damage." The court reasoned that a judgment for securities fraud was not a judgment for bodily injury, death or property damage. The court noted that the third-party creditor had not provided any support for its theory "that a decline in the value of intangible property is a form of 'property damage' within the meaning of the statute."

The court also rejected the third party's argument that it had standing as an intended third-party beneficiary to the insurance contract. The court first noted that "[a]s a general rule, absent an assignment of rights or final judgment involving Section 11580, a third party claimant may not bring a direct action against an insurance company on an insurance contract because the insurer owes a duty only to the insured." The court reasoned that language in the insurance policy at issue

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Insurer Has Duty to Defend Even Though "Primary Thrust" of Action Excluded

A federal district court, applying Maryland law, has held that an insurer has a duty to defend a class action brought against an errors and omissions policyholder because, even though the policy excluded coverage for the "primary thrust" of the class action, other allegations involved potentially non-excluded claims. *Hartford Cas. Ins. Co. v. Chase Title, Inc.*, No. CIV.JFM-02-3017, 2003 WL 721931 (D. Md. Feb. 25, 2003).

This case arose from an underlying class action lawsuit brought against a title company alleging deceptive settlement practices on home mortgage loans. The class claimants alleged violations of two statutes as well as common law claims for conversion, breach of fiduciary duty and negligence. The insurer had issued an errors and omissions policy that provided coverage for "damages" resulting from "wrongful acts." The policy

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Written Notice Not Required for Claims-Made Policy

An Ohio appellate court, in an unreported decision, has held that because an insurance policy's terms governing notice of claims were ambiguous, the policyholder was not required to provide written notice of a claim. *Ohio Bar Liab. Ins. Co. v. Hunt*, Nos. 19320, 19321, 2003 WL 1425949 (Ohio Ct. App. March 21, 2003). The court also held that a claim for bad faith could be assigned, but that the insurer's mistaken reading of the ambiguous notice provisions could not provide a basis for a finding of bad faith.

The insurer issued a claims-made policy to an attorney that contained several provisions concerning the reporting of a claim. First, the policy provided that "coverage of this policy is limited to liability for only those claims that are first made against the insured and reported to the Company while the policy is in force." Second, the policy provided that coverage was afforded for "all sums which the Insured shall be legally obligated to pay as money damages because of any claim first made against the Insured and reported to the Company during the policy period." A third provision in the policy stated that "the Insured…shall, during the Policy Period or Extended Reporting Period, give written notice thereof to the Company in accordance with Condition VI.… A Claim shall be considered to be first made when the Company first receives written notice of the Claim or of any event which could reasonably be expected to give rise to a claim." Fourth, the policy provided that "written notice shall be given by or on behalf of the Insured to the Company or any of its authorized agents as soon as practicable…." Finally, an endorsement to the policy, entitled "What to Do in Case of a Claim," provided that "[i]n the event you directly or indirectly become involved in any situation which you believe may result in a claim, you should immediately report it to your [insurer's] claims representative. Telephone:…Mailing address:…" The policy also contained a provision regarding assignment of claims: "The interest hereunder of an insured is not assignable. If the Insured shall die or be adjudged incompetent, this policy shall cover the Insured's legal representative as the Insured with respect to liability previously incurred and covered by this policy."

The policyholder attorney was fired by a client and later sued for malpractice after failing to timely file an appeal. Although the attorney did not provide written notice to the insurer until four years later, long after the expiration of the policy period, he alleged that he called the insurer on the telephone after he was fired to report a potential claim. The insurer denied coverage, and litigation followed.

The appellate court held that the policy was ambiguous as to whether written notice was required and therefore found that a telephone call to the insurer was adequate notice. The court reasoned that because the first provision of the policy concerning notice did not specify the form of notice and the last such provision "expressly allow[ed] for notice by telephone," those provisions were in conflict with the three other policy provisions requiring written notice. The court explained that "[t]he notice provisions found within the policy conflict[ed], creating an ambiguity that must be resolved in the [insured's] favor." Because there was a dispute about whether oral notice had in fact been provided through a telephone call, the court remanded the issue.

The court also held that assignment of the policyholder's claim for bad faith to the underlying plaintiff was proper because the policy provision concerning assignment of claims was ambiguous. The court reasoned that the phrase "interest hereunder of an insured" could "reasonably be construed as extending only to an insured's contractual right to defense and indemnification, not to a tort claim based upon the insurer's bad faith." Thus, construing the policy against the insurer, the attorney could assign a claim for bad faith to his former client. The court held, however, that in these circumstances, a sufficient predicate for a finding of bad faith had not been established because the apparent basis for the claim was simply the insurer's determination that the policyholder had failed to comply with the policy's notice requirements. The court explained that "bad faith is not shown by a mere breach of a contractual duty, nor can it be shown by an insurance company's mistaken actions relating to an unclear contractual provision." ✦

For more information, please contact one of WRF's Professional Liability Attorneys at 202.719.7130

Intentional Acts Exclusion Does Not Bar Coverage for Consumer Fraud Action

The First Circuit has held that Maine law governed a declaratory judgment action concerning an insurer's duty to defend a travel agency, and that, under Maine law, the intentional acts exclusion in the policy did not relieve the insurer of its duty to defend a lawsuit alleging consumer fraud. *Auto Europe, LLC v. Conn. Indem. Co.*, 321 F.3d 60 (1st Cir. 2003).

The insurer issued a policy to a travel agency that provided coverage for "any negligent act, error or omission of the 'insured'…in the conduct of 'travel agency operations' by the 'named insured.'" The policy excluded coverage for "liability arising out of any act, error or omission which is willfully dishonest, fraudulent or malicious, or in wilful violation of any penal or criminal statute or ordinances, and is committed (or omitted) by or with the knowledge or consent of the 'insured.'" The travel agency was sued in a purported class action lawsuit, alleging that the travel agency committed fraud by increasing its commissions in the guise of a charge it claimed was a foreign tax. The complaint alleged a deliberate "fraudulent scheme of overcharges." The insurer refused to defend the suit based on the intentional acts exclusion in the policy. The insured filed suit.

The court held that Maine law should be used to resolve the dispute. Unless an insurance policy specifies the governing law, Maine courts apply the most significant relationship test. The court found that the most significant relationship was with Maine because "a Maine business with offices only in Maine, is alleged to have committed consumer fraud by its conduct in Maine." The court rejected the argument that Florida law was applicable because the pertinent insurance contract was negotiated and delivered in Florida, reasoning that the policy covered numerous related companies located in different states and is therefore deemed a multiple risk policy, which, under Maine law, is viewed as if a separate policy was issued to cover each entity. The court also rejected the argument that Illinois law should be applied because the named plaintiffs lived there, reasoning that Maine's interests in the dispute were greater because Maine is "the principal location of the insured risk."

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Prejudgment and Post-Judgment Interest Are Cost of Defense, Not Part of Policy Limits

A U.S. district court, in an unreported decision applying Pennsylvania law, held that an insurer was obligated to pay prejudgment and post-judgment interest even though it had already paid out its policy limit. *Livornese v. Med. Protective Co.*, CIV. A. No. 3124, 2003 WL 16184645 (E.D. Pa. Mar. 2003).

The insurer issued a medical malpractice insurance policy to two doctors and a medical practice with a limit of liability of $400,000. The policy contained an endorsement providing that the insurer's "liability shall not exceed the stated amount for any one occurrence and subject to the same limitation for each occurrence, [the insured's] total liability during any one policy year shall not exceed the stated annual aggregate." The Pennsylvania Medical Professional Liability Catastrophe Loss Fund (CAT Fund) provided coverage in excess of $400,000. A jury returned a medical malpractice judgment of $2,058,000 against the doctors, and the court added $713,923 in prejudgment interest. Substantial post-judgment interest also accrued. After the insurer paid $400,000 into the court and argued that it had no further obligation, coverage litigation ensued.

The court held that the insurer was obligated to pay that portion of the prejudgment interest attributable to its $400,000 in coverage. The court first noted that the endorsement made no reference to interest. It then pointed to a decision by the Pennsylvania Supreme Court, *Incollingo v. Ewing*, 379 A.2d 79 (Pa. 1977), to which the same insurer had been a party. In that case, the Pennsylvania Supreme Court had held that similar language was ambiguous, reasoning that the insurer was obligated to assume the full cost of a defense and "[t]he costs of a full defense may reasonably include interest, which is as much a cost of conducting a defense as court costs." The district court therefore concluded that policy was ambiguous and should be construed against the insurer.

The court also held that an insurer's liability could include post-judgment interest in excess of the policy limits. It reasoned that if it were to hold otherwise, insurers would have incentive to retain their money as long as possible so that they could earn interest. Applying the same reasoning, however, the court also held that the insurer was entitled to indemnity from the CAT Fund for post-judgment interest obligations incurred after the insurer paid the $400,000 into the court and the CAT Fund "took exclusive control of the litigation." ✦

For more information, please contact one of WRF's Professional Liability Attorneys at 202.719.7130

Policy Language Trumps Alleged Agreement With a Broker

The Supreme Court of Nebraska held that the terms of a professional liability insurance policy, rather than an alleged agreement reached between an insurance broker and the policyholder, controlled the scope of coverage. *Cont'l Cas. Co. v. Calinger*, No. S-02-565, 2003 WL 1393356 (Neb. Mar. 21, 2003).

The policyholder lawyer, through an insurance broker, purchased a claims-made legal malpractice policy. After the expiration of the policy period, the lawyer was sued for malpractice arising out of alleged actions taken prior to the effective date of the policy, and ultimately found liable for $1.5 million. Nine years later, the lawyer filed a claim with his insurer. The lawyer did not dispute that the plain language of the policy barred coverage because the lawyer made the claim after the policy period had expired. The lawyer argued, however, that the actual scope of coverage for the policy was reflected in correspondence with the broker stating that the insurer would provide "FULL PRIOR ACTS COVERAGE." Coverage litigation followed.

The Nebraska high court held that the plain and unambiguous terms of the policy controlled and that the insurer was not required to provide coverage to the policyholder. The court relied on its decision in *Rodine v. Iowa Home Mutual Casualty Co.*, 171 Neb. 263, 106 N.W.2d 391 (1960), in which it had held that "[a] litigant cannot, however, disregard the written contract as evidenced by a policy of insurance issued to him and have an action at law upon an alleged oral agreement inconsistent with the policy or a recovery not warranted by the policy." Accordingly, the court explained that the policyholder "should have filed its counterclaim in equity seeking to reform the policy language." Having failed to do so, the lawyer could not obtain coverage that was inconsistent with the plain and unambiguous language of the policy. ✦

Suit by Law Partner Over Legal Fees Does Not Involve "Professional Services"

A Florida appellate court has held that a professional liability insurer had no duty to defend a law firm that was sued by a former partner in a dispute over how to divide legal fees because the suit did not involve "any act, error or omission in Professional Services provided." *See Roberts v. Florida Lawyers Mut. Ins. Co.*, No. 4D02-1223, 2003 WL 729067 (Fla. 4th Dist. Ct. App. Mar. 5, 2003).

Following the termination of her employment with a law firm, an attorney sued her former law partner and the law firm for reimbursement of loans and for distribution of fees the firm had earned while she was at the firm. Her complaint included both individual claims and a derivative claim on behalf of the firm, alleging that the defendant attorney breached a fiduciary duty in his handling of the firm's money. The defendant law firm had lawyers professional liability coverage for "[a]ny act, error or omission in Professional Services provided or that should have been provided," including "services performed…as an administrator, conservator, receiver, executor, guardian, trustee, or any other similar fiduciary capacity," but not including "any matter pertaining to an insured lawyer's charges for services or expenses." The policy also contained an exclusion for "[a]ny Claim made against an Insured by a present, former or prospective partner…unless the Claim arises out of legal services[] performed in a lawyer-client relationship." The insurer denied coverage.

The court held that the policy did not provide coverage to the law firm because a dispute as to "how to divide money received from a lawsuit" was not an "act, error or omission in Professional Services provided." The court reasoned that "provide" contemplates the provision of services to third parties. Consequently, even though the derivative complaint alleged that the defendant attorney acted "as an administrator" or in a "fiduciary capacity," those actions did not arise from "Professional Services provided." Additionally, the court concluded that a dispute as to how to divide fees constituted a "matter pertaining to…charges for services or expenses," and thus was not included in the policy's definition of "Professional Services." Finally, the court reasoned that the exclusion for claims made against the firm by partners reinforced its conclusion. The court rejected as unreasonable the policyholder's argument that the exclusion did not apply to disputes between partners arising out of legal services performed in a lawyer-client relationship. ✦

For more information, please contact one of WRF's Professional Liability Attorneys at 202.719.7130

Application of "Other Insurance" Clause Not Dependent on Theory of Liability

A federal district court, applying Illinois law, has held that an insurer whose "other insurance" clause provided that its coverage was excess if the insured had other coverage for the "loss" in question, provided excess coverage where the second insurer's policy provided coverage for only one of five theories of liability. *First Specialty Ins. Corp. v. Cont'l Cas. Co.*, No. 01C9175, 2003 WL 1220238 (N.D. Ill. Mar. 14, 2003).

This coverage dispute arose from a lawsuit against an association that had both a general liability and a nonprofit organization liability policy. The lawsuit against the association, which ultimately settled, contained five counts. The general liability policy provided potential coverage for one of the five counts. The nonprofit policy provided potential coverage for the remaining four counts. After the underlying case settled, litigation ensued between the insurers over their relative obligations to the policyholder.

The general liability policy indisputably provided primary coverage. The nonprofit policy contained an "other insurance" provision stating that "[i]f the 'entity'…has other insurance against a 'loss' covered by this policy, the insurance provided by this policy shall apply in excess of other such insurance."

The court held that the nonprofit policy provided excess coverage and rejected the general liability insurer's argument that both policies provided primary coverage that was to be allocated "pro rata." The court initially noted that the policyholder had "incurred a single loss based on multiple theories of liability," and that the lawsuit "was settled in a manner that makes it impossible to know what theory of liability (if any) was dispositive." The court explained that in a case involving similar facts and an "other insurance" clause identical to that contained in the nonprofit policy, the Seventh Circuit had held that "a 'loss' is not the same as a theory of liability." *W. Cas. & Sur. Co. v. W. World Ins. Co.*, 769 F.2d 381 (7th Cir. 1985). The court therefore rejected the general liability insurer's argument that the insurers provided "distinct" coverage because they provided coverage for different counts in the complaint. Instead, the court reasoned that both policies covered the same "loss"—the alleged injury to the underlying plaintiff by the insured.

The court also held that the nonprofit insurer was not estopped from contesting coverage. The court reasoned that the insurer had not breached a duty to defend and had promptly filed a declaratory judgment action after the general liability insurer requested fees. Additionally, the court reasoned that even if the nonprofit insurer had breached a duty to defend, "the failure to defend estops an insurer from raising exclusionary defenses, not an excess carrier defense." ✦

Comprehensive Excess Policy Applicable Only After Exhaustion of Professional Liability Policy

An Illinois appellate court has held that a comprehensive excess policy issued to a hospital and its employees provided coverage to policyholder nurses for a malpractice claim only after the limits of the nurses' professional liability policies were exhausted. *Travelers Indem. Co. v. Am. Cas. Co. of Reading*, No. 1-02-2014, 2003 WL 751081 (Ill. App. Ct. Mar. 5, 2003).

A medical malpractice suit was brought against three nurses at a hospital, and the suit ultimately settled for $4.5 million. Each of the nurses had purchased professional liability insurance policies from Insurer One. Two of the policies had a $500,000 limit per medical incident; the third had a $1 million limit per incident. Each of Insurer One's primary policies included an "other insurance" provision stating that: "[i]f you have other insurance…the other insurance must pay first." Insurer Two issued both a primary general liability policy and a comprehensive excess insurance coverage policy to the hospital. Insurer Two's primary general liability policy had a limit of $500,000 per occurrence, and the excess insurance policy had a limit of $10 million per claim and in the aggregate. Insurer Two's excess policy contained an "other insurance" provision stating that the policy "is excess over any other insurance available to the Insured (including a policy purchased by any additional insured hereunder)." Litigation between the two insurers followed over whether Insurer Two's excess policy was excess over Insurer One's professional liability policies.

The court held that Insurer Two's excess policy applied only after exhaustion of the professional liability policies.

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For more information, please contact one of WRF's Professional Liability Attorneys at 202.719.7130

Sexual Molestation Not Covered Under Educator's Employment Liability Policy

A Kentucky appellate court has held that a claim for sexual molestation is not covered under an educator's employment liability policy because the teacher was not acting within the scope of his duties. *Goodman v. Horace Mann Ins. Co.*, No. 2000-CA-001924-MR, 2003 WL 1389120 (Ky. Ct. App. Mar. 21, 2003).

The insurer issued an educator's employment liability policy that provided coverage to a teacher for "damages which *you* shall become legally required to pay as a result of any claim which comes from an *occurrence* in the course of *your educational employment activities*." The policy contained an exclusion for "*occurrences* involving damages which are the intended consequence of action taken by *you* or at *your* direction." The insured, a teacher, was sued for the alleged improper touching of four students.

The court held that the policy did not provide coverage for sexual abuse. Relying primarily on California law, the court noted that "[c]ourts have consistently held that a teacher engaging in sexual molestation is not acting within his educational employment activities." The appellate court stated its agreement with the application in these decisions of "the doctrine of reasonable expectations, which requires construction of the policy so as to give the insured the protection he reasonably has a right to expect." The court concluded that it "could not fathom a more personal activity less related to the goal of education than teacher's acts." Accordingly, coverage was not available for the sexual abuse allegations. ✦

Sexual Misconduct by Teacher Does Not Constitute "Educational Employment Activity"

A Kentucky appellate court has held that sexual misconduct by a teacher is not "educational employment activity" as defined by an educator's liability policy. *Wilson v. Horace Mann Ins. Co.*, Nos. 2000-CA-001826-MR & 2001-CA-001033-MR, 2003 WL 1406998 (Ky. Ct. App. Mar. 21, 2003). The court also held that the insurers were not liable to the underlying plaintiffs for extra-contractual claims arising out of the handling of the claim.

Plaintiffs, as alleged third-party beneficiaries, sued a number of insurers seeking to recover a $451,000 judgment entered in the plaintiffs' favor against a teacher for sexual abuse, as well as attorneys' fees and costs. The insurers provided coverage to the teacher pursuant to an educator's liability policy. The policy at issue provided coverage for losses arising from "educational employment activities." The policy defined "educational employment activities" to include "activities of the insured performed…pursuant to the express or implied terms of his or her employment by an educational unit…at the express request or with the express approval of his or her supervisor,…or as a member of a state board or commission…."

The court held that no coverage existed for sexual abuse by the teacher because such acts did not constitute "educational employment activities" within the plain meaning of the educator's liability policy. In addition, the court noted that public policy demanded such a result because otherwise an insurer would be subsidizing the sexual abuse of children. The court rejected the plaintiffs' argument that coverage for sexual abuse should exist just as coverage is afforded to sexual harassment of women in the workplace, reasoning that the majority of courts have found that in child molestation cases there is an "inferred intent" to injure and that courts have consistently held that teachers who sexually molest their students are not engaging in "educational employment activities."

The court also rejected a series of extra-contractual claims by the plaintiffs. The court first rejected the plaintiffs' statutory bad faith claim reasoning that the claim was not available in the absence of an obligation to provide coverage. The court also rejected plaintiffs' arguments that the insurers were liable for wrongful use of civil proceedings by authorizing and financing a counterclaim against plaintiffs during the underlying litigation. The court explained that an essential element of this tort is that the defendant acted without probable cause. Here, the court noted, the trial court in the underlying proceeding had found as a matter of law that the teacher had probable cause to bring a counterclaim against one of the plaintiffs for perjury, which the plaintiff admitted to committing.

Finally, the court rejected the plaintiffs' argument that insurers were estopped from asserting a reservation of rights because they did not disclose this reservation to the plaintiffs. The court reasoned that estoppel requires that the claimant have been prejudiced, which plaintiffs did not allege. The court also noted that there was no authority indicating that an insurer is required to notify underlying plaintiffs of its reservation of rights to the insured. ✦

For more information, please contact one of WRF's Professional Liability Attorneys at 202.719.7130

WRF Expands Insurance, Litigation and Privacy Practices

Wiley Rein & Fielding LLP is pleased to announce that Cynthia T. Andreason has joined the firm as a Partner in the Insurance, Litigation and Privacy Practices.

Ms. Andreason comes to the firm with more than 19 years of legal experience. Her practice will focus on representing clients in insurance litigation matters on behalf of life, disability and property/casualty insurance companies. In addition, Ms. Andreason will advise insurers regarding emerging privacy and e-commerce issues.

Ms. Andreason has defended clients in complex class action litigation, major regulatory proceedings, as well as environmental, advertising liability and products liability matters. She also regularly counsels financial services clients on compliance and litigation avoidance related to privacy and various other market conduct matters.

Ms. Andreason received her Bachelor's degree in Music, with high honors, from the University of Colorado and earned her J.D. from the University of Utah where she was a member of the *Utah Law Review*. She served as a law clerk to the Honorable I. Daniel Stewart, Associate Justice, Utah Supreme Court. ✦

For more information, contact Cynthia T. Andreason (202.719.7364 or candreason@wrf.com).

Comprehensive Excess Policy Applicable Only After Exhaustion of Professional Liability Policy

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The court observed that if two insurance policies have "mutually repugnant" clauses providing that each will be excess over any other applicable insurance, then each insurer is liable for a *pro rata* share of the judgment or settlement, but only if the policies are on "the same level." The court stated that it "'must construe the policies as a whole'" in determining whether two policies are on the same level. Noting that primary and excess insurance serve different functions, the court said that an umbrella excess liability policy is not on the same level as a primary coverage policy and therefore reasoned that the Insurer Two's excess policy was not intended to pay the first dollar of loss. The court pointed out that the excess policy provided coverage to an entire hospital for a variety of risks. Conversely, each professional liability policy covered only one nurse for one type of risk. Moreover, the excess policy's "other insurance" clause expressly stated that it would be "excess over any other insurance… *purchased by an additional insured thereunder*." The court concluded that this provision did not contemplate a *pro rata* contribution with other insurance policies. Construing the policies as a whole, the court found the excess policy to be a "true excess policy," and not merely an extension of the primary policy issued by Insurer Two. ✦

Insurer Has Duty to Defend Even Though "Primary Thrust" of Action Excluded

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stated that "damages" did not include "[d]isputes over fees, commissions, deposits, premiums or charges made for services rendered or which should have been rendered." The insurer denied coverage on the grounds that the lawsuit arose out of a dispute over fees. Coverage litigation ensued.

The court held that the lawsuit was covered under the policy because it potentially involved more than a dispute over fees. The court relied on *Utica Mutual Insurance Co. v. Miller*, 746 A.2d 935 (Md. Ct. Spec. App. 2000), in which a Maryland appellate court had held that an errors and omissions insurer had a duty to defend an insurance broker who had been sued over the premiums he charged, even though the policy excluded coverage for the "primary thrust" of the underlying complaint—a policyholder's mishandling of premiums. The *Utica* court had reasoned that the claims against the policyholder concerned more than just a failure to remit premiums because the complaint contained a negligence claim alleging failures to monitor business operations and to turn over certain records. Likewise, the court here concluded that, although the "primary thrust" of the class action lawsuit was a dispute over fees, two of the counts, which alleged misrepresentations to borrowers and violations of statutory obligations, potentially encompassed non-excluded claims. Since the policy potentially covered at least some of the class action claims, the court granted summary judgment in favor of the policyholder and held that the insurer had a duty to defend the entire class action lawsuit. ✦

For more information, please contact one of WRF's Professional Liability Attorneys at 202.719.7130

Intentional Acts Exclusion Does Not Bar Coverage for Consumer Fraud Action

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The court then held that, under Maine law, the insurer had a duty to defend and rejected the insurer's argument that because the underlying complaint only alleged intentional fraud, the exclusion for willfully dishonest or fraudulent acts applied. The court reasoned that "not only does the cause of action at issue—the Maine [Unfair Trade Practices Act]—permit liability in the absence of an intent to deceive, but Maine law also broadly extends the duty to defend to claims that could be developed either legally or factually at trial so as to fall within the policy's coverage." The court concluded that coverage could be implicated because a jury in the underlying case could reject plaintiff's theory of deliberate fraud but still find liability under the applicable statute. Accordingly, the insurer had a duty to defend. ✦

Third-Party Claimant Lacks Standing to Sue D&O Insurer

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obligating the insurer to "pay on behalf of" the directors and officers and the company reflected a duty to settle running to the insureds, not the third-party claimant. The court contrasted the obligation under a D&O policy with a medical-payment provision, which "is widely recognized as a provision intended to benefit third parties." In the case of a medical-payment provision, the court explained, an insurer's payment obligation is premised on the injury to the third party and not fault on the part of the insured, which is why the injured party is deemed to be an intended beneficiary. The D&O policy at issue in this case required payment only after the insured was found to be at fault. Accordingly, the court concluded that "[e]ven though [the third party] would stand to gain from the contract's enforcement, it is merely an incidental beneficiary who would 'fortuitously' benefit from [the insurer's] agreement to indemnify the insured." ✦

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