Wiley Rein & Fielding

March 2003

The Executive Summary

Developments Affecting Professional Liability Insurers

No Coverage for Claim Reported a Year Late, Even With Extended Reporting Period

The Fifth Circuit Court of Appeals, applying Texas law, has held that an insured's delay of approximately one year in reporting to its insurer a claim made against it was untimely. *Fed. Ins. Co. v. CompUSA, Inc.*, No. 02-10768, 2003 WL 173960 (5th Cir. Feb. 12, 2003), incorporating by reference *Fed. Ins. Co. v. CompUSA, Inc.*, No. 3:01-CV-0593-D, 2002 WL 1285263 (N.D. Tex. June 4, 2002).

The insurer issued a claims-made professional liability policy to the policyholder company and to its directors and officers. The policy provided that "[t]he Insureds shall, as a condition precedent to exercising their rights under this coverage section, give to [the insurer] written notice as soon as practicable of any Claim made against any of them for a Wrongful Act." The policy contained a clause specifying how notice was to be provided. The policy also contained a provision allowing the company to extend the reporting period for one year for claims based on acts committed during the policy term, and that provision was subsequently increased to six years.

During the policy period, the company and its president were sued for fraud, tortious interference, conspiracy and unjust enrichment. The company viewed the suit as frivolous and did not notify the insurer of the suit. Thirteen months later (after expiration of the policy) the jury returned a $265.5 million verdict. No longer viewing the claim as "frivolous," the company notified the insurer, which denied coverage because of late notice. Coverage litigation ensued.

The court initially held that the notice to the insurer was untimely, concluding that notice provided after the jury verdict did not comply with the requirement of the policy to provide notice "as soon as practicable." The appellate court then adopted the district court's order, rejecting the three arguments made by the company to avoid the plain language of the policy, arguments which the appellate court characterized as "lying somewhere between wholly specious and downright frivolous."

continued on page 9

Fraud Exclusion Applicable Where Policyholder Found Negligent

A Massachusetts appellate court, in an unpublished opinion, held that coverage was not available to a policyholder under a fraud and dishonesty exclusion where the policyholder had been found negligent in a separate action. *New England Ins. Co. v. Stewart Title Guar. Co.*, 782 N.E.2d 557 (Mass. App. 2003).

The insurer issued a professional liability policy to a three-person law firm that was structured as a professional corporation. The policy stated that it would not apply "to any claim arising out of any dishonest, fraudulent or malicious act, error or omission of any insured committed with actual dishonest, fraudulent or malicious purpose or intent." One of the attorneys at the law firm was sued and subsequently

continued on page 8

Also in This Issue

© 2003 Wiley Rein & Fielding LLP ✦ Washington, DC ✦ Northern Virginia ✦ www.wrf.com

Laddering Suits Allowed to Proceed

The U.S. District Court for the Southern District of New York (Judge Scheindlin) has granted in part and denied in part a series of motions to dismiss filed in connection with the so-called "laddering" consolidated class action lawsuits. *In re Initial Pub. Offering Sec. Litig.*, No. 21 MC 92 (SAS), 2003 WL 358003 (S.D.N.Y. Feb. 19, 2003). Those lawsuits allege that numerous public offerings for high technology and Internet-related stock from 1998 to 2000 were manipulated by the underwriting investment banks through the use of "laddering" or "tie-in agreements," whereby the underwriters required customers wishing to receive stock in connection with the public offerings to agree to buy additional shares of the stock in the aftermarket and, in some cases, to agree to make the aftermarket purchases at predetermined escalating prices. In addition, the complaints allege that the underwriters required certain customers to pay them a portion of the profits made by selling the IPO shares (referred to by the court as "undisclosed compensation"). In response, the defendants argued that the complaints failed to meet the pleading requirements of the Private Securities Litigation Reform Act of 1995 (PSLRA) and Federal Rules of Civil Procedure and otherwise failed to state a claim upon which relief could be granted.

In a detailed opinion that focused at length on the parties' legal and factual arguments, the court determined that the majority of the plaintiffs' claims were sufficiently pled under the PSLRA and constituted cognizable claims. According to the court, the plaintiffs successfully alleged "one coherent scheme to defraud, the entire purpose of which was to artificially drive up the price of securities" and which "offend[ed] the very purpose of securities laws." In considering each of the claims for relief, the court found at least one group of plaintiffs could proceed with the lawsuit, as follows:

- Section 11 Claims: The court determined that the plaintiffs sufficiently pled, under Federal Rules of Civil Procedure 8, that all those defendants who signed the registration statements or prospectuses violated Section 11 because the documents failed to disclose the tie-in agreements and the undisclosed compensation to the underwriters. Moreover, the court determined that, with respect to certain secondary offerings, the complaints adequately pled that the registration reports were prepared by analysts who were "tainted by undisclosed conflicts of interest." The court also concluded, however, that certain plaintiffs who sold their shares above the offering prices had no damages as a matter of law and, accordingly, dismissed their claims.

- Section 15 Claims: The court held that these claims were likewise adequately pled with respect to the individual defendants who allegedly controlled the issuers subject to the surviving Section 11 claims.

- Section 10(b) Claims (Material Misstatements and Omissions): Under both the PSLRA and Federal Rules of Civil Procedure, the court concluded that the plaintiffs successfully pled that all underwriters made material misstatements and omissions in connection with the public offerings, and that those misstatements damaged the plaintiffs. In particular, the court focused on the fact that the various registration statements did not disclose the tie-in agreements or the undisclosed compensation, that they misstated the amount of compensation the underwriting syndicates were to receive, that the underwriters were sharing in profits of their customers and were charging excessive commissions, and that the registration statements were otherwise inaccurate. The court did, however, determine that these claims were not adequately pled as to the intent of every issuer and individual defendant. Specifically, the court permitted the claims to proceed against those issuers who allegedly exploited the excessive profits through a subsequent merger or to raise more money through further offerings and against those individual issuer defendants who allegedly sold large amounts of stock at a significant profit near the time of the IPO were adequately pled. The court indicated that, "in all other instances, the pleading of intent to defraud is inadequate and therefore the claims" against those issuers and individual issuer defendants were dismissed.

- Section 10(b) Claims (Market Manipulation): The court determined that the plaintiffs successfully pled market manipulation claims against allocating underwriters through allegations that those defendants acted with the requisite intent to defraud by requiring customers to engage in tie-in agreements and pay undisclosed compensation.

continued on page 6

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

© 2003 Wiley Rein & Fielding LLP

Lawyer's Policy Voided Due to Misrepresentation

The U.S. District Court for the Western District of Virginia, applying Virginia law, held that an insurer may rescind a professional liability policy it issued to a law firm based on a material misrepresentation by the law firm in its renewal application. *TIG Ins. Co. v. Robertson, Cecil, King & Pruitt*, No. 1:01CV00143, 2003 WL 253167 (W.D. Va. Jan. 31, 2003).

The insurer issued a professional liability policy to a law partnership. When completing a renewal application, one of the partners checked "No Change" instead of "Yes" to a question inquiring whether "any attorney in [the] firm [was] aware of any claims made, wrongful acts, or errors or omissions that could result in a professional liability claim against any past or present attorney of the firm…." Subsequently, that same partner died of a self-inflicted gunshot wound. It was later determined that he was misappropriating client funds, and claims were made against the partnership because of his conduct. When the insurer was asked to cover the claims, it filed an action seeking rescission of the policy based on material misrepresentations.

The court first held that rescission was an available remedy to the insurer. The law firm argued that the cancellation clause of the policy entitled it to 30 days notice before cancellation of the policy, which it had not received. The court rejected this argument, reasoning that cancellation is a different remedy than rescission. The insurer, the court

continued on page 9

Objective Standard Used to Assess Knowledge of Prior Wrongful Acts

An Illinois trial court held that an objective standard should be used to determine whether an insured attorney knew or should have known that a prior wrongful act could result in a claim against him. *TIG Ins. Co. v. Corbett*, No. 02 CH 525 (Ill. Cir. Ct. Feb. 10, 2003).

An individual who had been injured in a traffic accident retained the attorney in 1996. Although the attorney filed three lawsuits on behalf of the individual, he never obtained service. Accordingly, the complaints were dismissed for want of prosecution. Six months after filing the third complaint, the attorney paid the individual $5,000 and obtained a release that purported to protect the attorney and his law firm from any claims by the individual. On May 15, 2001, the individual filed suit against the attorney and the law firm.

The insurer issued a claims-made lawyers professional liability policy to a law firm with a policy period that began on January 1, 2001. The policy provided coverage for claims made during the policy period for acts, errors or omissions after April 1, 2000 provided that "neither the Insured, nor any partner, shareholder, or the Insured's management committee knew or should have known that a wrongful act, error, or omission or Personal Injury had occurred or had a reasonable basis to foresee that a Claim would be made against an Insured." Coverage litigation ensued over whether the malpractice claim was covered under the policy.

The trial court held that, for two reasons, coverage was not available under the policy. First, the court concluded that no coverage was available because the actions by the attorney that resulted in the failure to prosecute occurred prior to April 1, 2000, reasoning that the underlying action had become time barred under the Illinois statute of limitations by November 1999. Second, the court held that coverage was unavailable under the prior knowledge exclusion. The court explained that "[a]n objective standard should apply in determining whether [the attorney] had reason to know of any wrongful act, error, or omission." The court concluded that, under this standard, the attorney should have known of the complaint based on the facts that he appeared to concede as much in his deposition; as an attorney, he should have been aware of the applicable statute of limitations; and he decided to seek a release, which suggested he knew he had committed malpractice.

The court also held that the other partners in the law firm were not entitled to coverage under the innocent insured provision in the policy. The court reasoned that, under the language in the policy, the innocent insured provision applies only to intentional acts. Since there was no intentional act by the attorney, the court held that the provision was inapplicable. ✦

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

© 2003 Wiley Rein & Fielding LLP

Excess Insurer Has Right to Select Counsel in Medical Malpractice Action

The U.S. Court of Appeals for the Third Circuit, in an unpublished opinion applying Pennsylvania law, held that an insurer that issued excess and umbrella policies to a hospital has the right to select counsel for and defend a medical malpractice claim against the hospital. *St. Paul Fire & Marine Ins. Co. v. Temple Univ. Hosp.*, No. 01-4467, 2003 WL 550031 (3d Cir. Feb. 27, 2003).

The policyholder was a hospital that had an insurance program in which it had a self-insurance retention of $1.2 million, an excess policy of $1, a shared excess retention of $2 million and an umbrella policy of $23 million. The same insurer provided coverage for the excess, shared excess retention and umbrella policies. Subsequent to purchasing the policies for the program, the hospital purchased a fronting policy from a second insurer that obligated the second insurer to assume the hospital's obligations in the event of insolvency. When parents of a minor child sued the policyholder for medical malpractice, the hospital refused to allow the excess insurer to select counsel for, and defend, the medical malpractice action. The excess insurance contract provided:

> Right to Defend. We'll have the right but not the duty to defend any covered claim or suit for injury or property damage made against any protected person. We have this right even if we believe defense costs and the total amount any protected person will be legally required to pay as damages for injury or property damage will not exceed the self-insured retentions. We have no duty to perform other acts or services.

The umbrella policy provided that the insurer has no duty to defend "if your Basic Insurance has such a duty to defend. However, we do have the right to associate in defense and control of any claim or suit that is reasonably likely to involve us."

The appellate court first held that the plain language of the excess policy afforded the excess insurer the right to defend, which includes the right to select counsel. The hospital argued that the insurance contract as a whole was ambiguous because the umbrella policy did not provide a right or duty to defend. Disagreeing, the court noted that it was not necessary that the excess and umbrella agreements provide the same duty to defend to avoid ambiguity and that each insuring agreement need not contain the same obligations and rights. Thus, the court concluded that under the excess agreement it was unambiguous that the excess insurer had the right to defend the hospital's medical malpractice action.

continued on page 10

Claims-Made Policy With Limited Retroactive Coverage Does Not Violate Public Policy

A New Jersey appellate court, applying New Jersey law, held that a professional liability claims-made policy with limited retroactive coverage does not violate public policy where factual circumstances render such limited coverage reasonable and expected. *President v. Jenkins*, 814 A.2d 1173 (N.J. Super. Ct. App. Div. 2003).

A physician had purchased a series of one-year occurrence-based medical malpractice policies from an insurer. After repeated nonpayment of premiums, the insurer, in a letter dated January 9, 1998, canceled the policy effective October 26, 1997 even though the policy would otherwise have been effective until February 1, 1998. The physician, through a broker, then purchased a claims-made policy from a second insurer. The new policy was issued to a physician's alliance created by the broker, and individual doctors were added to the policy through endorsements. The physician in this case negotiated an endorsement that had both an effective and a retroactive date of February 1, 1998 because he told the broker that was the date on which his prior policy would expire. The endorsement provided that "[w]e will pay on behalf of a physician, damages that the physician shall become legally obligated to pay because of a claim first made during the policy period arising out of a medical incident which occurred on or after the retroactive date and which is reported to us during the policy period." The physician was subsequently sued for malpractice allegedly committed in early January 1998, during the coverage gap. The insurer denied coverage, and litigation ensued.

The court rejected the physician's contention that a policy limiting claims-made coverage to claims for wrongful acts during the policy period violates public policy. The court initially noted that, under the holding of *Sparks v. St. Paul Fire Insurance Co.*, 495 A.2d 406 (N.J. 1985), "provisions of a policy limiting coverage to claims brought for negligence committed during the policy term and providing only limited retroactive coverage were unenforceable as violating public policy *absent* factual circumstances that would render such limited retroactive coverage both reasonable and expected."

continued on page 5

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

© 2003 Wiley Rein & Fielding LLP

No Coverage for Claim Made After the Policy Period

A California appellate court, in an unpublished opinion applying California law, held that an insurer that had issued a claims-made D&O liability policy had no duty to defend a claim that was made after the end of the policy period. *Ananda Church of Self-Realization v. Am. Int'l Surplus Line Ins. Co.*, No. C038514, 2003 WL 205126 (Cal. Ct. App., 3d Dist. Jan. 31, 2003).

The D & O insurer issued a claims-made policy to a religious organization. The policy provided coverage for loss "arising from any claim or claims which are first made against the insureds, jointly and severally, during the Policy period." Eight months after the policy expired, the religious organization and two of its directors were sued by a plaintiff alleging sexual discrimination and harassment, intentional infliction of emotional distress, fraud and battery. The organization promptly tendered the claim to its insurer, which denied coverage. Coverage litigation ensued.

The court held that the insurer had no duty to defend or indemnify the organization because the claim was made eight months after the policy expired. The court rejected the organization's contention that the print classifying the policy as "claims-made" was too small, noting that the print required no additional magnification to read the language describing the policy as claims-made. The court stated that there is "no authority holding that a court may rewrite an insuring clause of a policy more to the insured's liking simply because its font size is deemed insufficiently large." The court also rejected the organization's argument that the claims-made nature of the policy was contrary to its reasonable expectations, explaining that a policyholder's reasonable expectations are considered only in cases where the language of the policy is ambiguous. Finally, the court rejected the organization's argument that, because the underlying plaintiff initially complained about the work environment and sought an apology letter from one of the directors within the policy period, this constituted a claim made during the policy period. The court explained that a claim "[i]n the context of a D & O policy, [is]…'the assertion of a liability of the party, demanding that the party perform some service or pay some money,'" not a request for an apology. ✦

Claims-Made Policy With Limited Retroactive Coverage Does Not Violate Public Policy

continued from page 4

In this case, however, the court concluded that the limited retroactive coverage was reasonable and expected because the claims-made policy "immediately followed a prior period of 'occurrence' coverage, thus obviating the need for any greater retroactive coverage than was bargained for and obtained by [the policyholder]." The court noted that "occurrence plus" policies characteristically provide coverage for acts occurring within the policy period and "claims-made" policies provide coverage for claims made and noticed to the insurer during the policy period. Had there been no cancellation of coverage, "there would have been seamless, uninterrupted coverage provided." The court also rejected the physician's argument that the policy was vague. The court reasoned that the endorsement clearly indicated that the retroactive date was February 1, 1998, and the physician had purposefully bargained for the February retroactive date because, had the occurrence policy been in effect, it would have expired on that date.

The physician also brought a claim against the broker, alleging that the broker was negligent for failing to procure coverage to bridge the gap between the two policies. The court rejected this contention, noting that the policyholder never informed the broker of any lapse in coverage, and stating that "absent notice or a specific initiating inquiry from the [policyholder]…an insurance broker has no affirmative duty to advise an insured of gaps in [the policyholder's] insurance coverage."

The malpractice plaintiff also sought to bring a direct action against the first insurer for failing to notify the hospital where the physician practiced that it had canceled the policy. The court held that the plaintiff could not do so because "an injured person possesses no direct cause of action against the insurer of the tortfeasor prior to recovery of judgment against the latter." The court also noted that, in any event, the occurrence insurer had no duty to notify the hospital that coverage had lapsed due to nonpayment.

The malpractice plaintiff also sought to bring a claim against the hospital for failing to ensure that the physician complied with the requirement in the hospital's by-laws that all physicians maintain adequate malpractice insurance. The court held that the hospital had no such duty, reasoning that the by-laws shifted "the burden of compliance [to] the shoulders on those uniquely situated and in a superior position—the physicians." The court also held that the hospital had no common law duty to ensure that physicians practicing there had malpractice insurance. ✦

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

© 2003 Wiley Rein & Fielding LLP

Section 1983 Claim Sounds in Tort and Is Not Excluded Under Breach of Contract or Debt Financing Exclusions

A federal district court, applying Pennsylvania law, has held that a claim against a county for civil rights violations under 42 U.S.C. § 1983 is not within the scope of policy exclusions that apply to breach of contract or debt financing claims. *Cont'l Cas. Co. v. County of Chester,* 2003 WL 359526 (E.D. Pa. Feb. 19, 2003).

The insurer issued a public officials liability policy to the county, which provided that the insurer "will pay those sums that the insured becomes legally obligated to pay as compensatory civil damages arising out of a 'wrongful act' to which insurance applies." The policy contained a breach of contract exclusion, which barred coverage for "[a]ny 'claim' arising out of a breach of contract, or out of liability assumed by an insured under any contract or agreement." The policy also excluded coverage for "[a]ny debt financing, including but not limited to bonds, notes, debentures and guarantees of debt."

The insured county sued a physician for breach of contract for failing to develop a public health care facility with funds provided by the county. The physician filed a counterclaim against the county, asserting a variety of breach of contract claims as well as a claim for violation of 42 U.S.C. § 1983 because the county allegedly deprived the physician of a real property interest, deprived him of the use of equity in the property and harmed his credit rating. The insurer disclaimed coverage for the entire counterclaim based on the breach of contract and debt financing exclusions. Coverage litigation ensued.

The court held that the counterclaim based on Section 1983 was a tort claim and thus not excluded by the breach of contract exclusion. The court reasoned that "[f]or coverage purposes, before a claim can be construed as a tort action, the wrong ascribed to the defendant must be the gist of the action with the contract being collateral." (quoting *Phico Ins. Co. v. Presbyterian Med. Servs. Corp.,* 663 A.2d 753, 757 (Pa. Super. Ct. 1997)). The court explained that the "gist" of the Section 1983 counterclaim was tort because it alleged substantive due process claims that purportedly resulted in a deprivation of property rights. The court also noted that in *City of Monterey v. Del Monte Dunes at Monterey, Ltd.*, 526 U.S. 687, 709 (1999), the Supreme Court had stated that "there can be no doubt that claims brought pursuant to § 1983 sound in tort." Finally, the court explained that tort actions "lie from the breach of duties imposed as a matter of social policy while [contract actions] lie for the breach of duties imposed by mutual consensus," and the duties imposed on public officials not to abuse their positions were socially imposed and thus sounded in tort.

The court also rejected the insurer's claim that the debt financing exclusion barred coverage because the county had provided financing to the physician. The court reasoned that the debt financing exclusion referred "to the insured's obligations and not the obligations of third parties." Since the county was not the borrower, the court concluded the exclusion was inapplicable. ✦

Laddering Suits Allowed to Proceed

continued from page 2

- ✦ Section 20 Claims: Determining that the plaintiffs adequately alleged control of the entities subject to the surviving 10(b) claims, the court allowed all Section 20 claims relating to such entities to proceed.

The court denied leave to replead the dismissed Section 11 and Section 15 claims, as well as certain Section 10(b) claims against issuers whose alleged motive was derived from events occurring far after the initial public offerings occurred or from relatively minor sales of stock (less than 10 percent of their total holdings), as it determined those claims failed as a matter of law. In addition, the court indicated that, with respect to other claims dismissed based on insufficient particularity, the plaintiffs had been aware of those deficiencies for over a year and had multiple opportunities to correct their pleadings to date. Accordingly, with respect to those claims, leave to replead was denied, with the limited exception of a number of complaints specifically identified by the court. ✦

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

© 2003 Wiley Rein & Fielding LLP

Ds &Os of Parent Corporation Not Insured; Cancellation of Policy Does Not Violate Bankruptcy Automatic Stay

A federal district court, applying Colorado law, held that the directors and officers of a policyholder company's parent corporation were not entitled to coverage for a claim because they were not "Insured Persons" under the company's D&O policy and because the personal profit exclusion barred coverage. *See Nicholls, et al. v. Zurich Am. Ins. Group, et al.*, No. CIV.A.01-WY1687CBOES, 2003 WL 354686 (D. Colo. Feb. 7, 2003). The court also held that cancellation of the bankrupt company's D&O policy for nonpayment of premiums did not violate the automatic stay under Section 362(a)(3) of the Bankruptcy Code.

Prior to the chapter 7 bankruptcy of the policyholder company and its parent corporation, the policyholder acquired a D&O policy from the insurer through two insurance brokers. The declarations and the definitions in the policy provided that the company, and not the parent, was the insured. The policy also contained a personal profit exclusion that barred coverage for "any Claim made against any Insured Person:…based upon, arising out of, or attributable to such Insured Person gaining in fact any personal profit, remuneration or advantage to which such Insured Person was not legally entitled."

An insurance premium financing entity funded the premium in return for nine monthly payments and the express authority to cancel the policy upon nonpayment. Subsequent to its bankruptcy, the company failed to remit a required payment. The financing entity canceled the policy and the insurer refunded the unearned premium. The bankruptcy trustee brought an adversary proceeding against four individuals who were directors and officers of both the company and its parent corporation, alleging that they unlawfully sold their personal shares of parent corporation stock under the guise of a private placement and pocketed the proceeds. The carrier denied coverage for the claims. Coverage litigation ensued.

The court held that the policy did not afford coverage for the adversary proceeding because the directors and officers of the parent corporation were not "Insured Persons" under the policy. The court reasoned that because the policy provided coverage for wrongful acts of the directors and officers of the company and its subsidiaries, wrongful acts committed by the directors and officers of the company's parent corporation did not fall under the policy's insuring clause. The court rejected the trustee's argument that the insurer should be estopped from arguing that the directors and officers were not "Insured Persons" because the insurer did not make such an assertion when it declined to defend them in the adversary proceeding. The court reasoned that estoppel did not apply because the bankruptcy trustee "could not have been 'ignorant of the true facts' surrounding the denial of insurance coverage," and because "equitable estoppel cannot be asserted to bring within the scope of an insurance policy risks that are not covered by the policy." The court also rejected the trustee's argument that the parent corporation was an insured because someone had crossed out the name of the company on the renewal policy application and had inserted the parent corporation's name. The court noted that the insurer did not require a renewal application and the application was not part of the policy. Additionally, the court reasoned that the insurance binder issued by the insurer "clearly identified" the company, rather than its parent corporation, as the insured, and that the company had responded to the binder not by objecting, but by financing the renewed policy.

The court additionally found that even if the parent corporation was an insured under the policy, the policy's personal profit exclusion would bar coverage for its directors and officers. The court reasoned that the amended complaint inescapably alleged that the directors and officers received all of the proceeds from the sham stock transaction—allegations that fell entirely within the personal profit exclusion.

The court also held that the cancellation of the bankrupt company's D&O policy did not violate the automatic stay under Section 362(a)(3) of the Bankruptcy Code. In so holding, the court relied heavily on *In re Trigg*, 630 F.2d 1370 (10th Cir. 1980), in which the Tenth Circuit held that a "contract that provides for termination on default of one party may terminate under ordinary principles of contract law even if the defaulting party has filed a petition under the Bankruptcy Act." Reasoning that the company "failed to satisfy its contractual obligations" to make the required payments and the contract terminated by its own terms, the court concluded that it was "powerless to rewrite [the] terms" of the D&O Liability Policy to prevent its termination.

Finally, the court held that the insurance brokers and financing entity could not be liable under common law theories for canceling the policy. The court held that the financing entity was not liable for unjust enrichment since it refunded the full amount of the unearned premium to the company and clearly informed the company that the policy was canceled and not in force. The court held that any claims against the brokers for their failure to secure insurance for the parent corporation were moot because the personal profit exclusion precluded coverage in any event. ✦

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

© 2003 Wiley Rein & Fielding LLP

Administrative or Ministerial Acts Are Not Professional Services

In an unpublished decision, a U.S. District Court in California, applying California law, held that a professional services policy did not provide coverage for allegations that a policyholder charged improper rates for its services, reasoning that billing practices are an administrative or ministerial service, not a professional service. *PMI Mortgage Ins. Co. v. Am. Int'l. Specialty Lines Ins. Co.*, No. C-02-1774 PJH (N.D. Cal. Dec. 16, 2002).

The insurer issued a policy to a mortgage insurer that provided mortgage insurance to lenders providing loans to homebuyers with a higher risk of default. The policy provided that "[t]his policy shall pay the Loss of the Insured…for any actual or alleged Wrongful Act of any Insured in the rendering or failure to render Professional Services." The mortgage insurer was sued for allegedly undercharging its lender clients for other insurance products in exchange for referrals on mortgage insurance. The plaintiffs in the underlying litigation had purchased mortgage insurance and alleged that the mortgage insurer failed to pass on the savings it generated from its lender clients on to them. Coverage litigation ensued over whether the allegations involved "professional services."

The trial court, while acknowledging that it was an "extremely close case," held that the allegations against the mortgage insurer did not involve "professional services" because they involved the ministerial or administrative tasks of billing. The court explained that "PMI is not accused of improperly issuing insurance policies or failing to provide insurance services to a client; rather, PMI has been charged only with undercharging its client for those products and services. Billing in and of itself is not a 'special risk inherent in the practice' of providing mortgage insurance." ✦

General Liability Policy Excludes Professional Services

A Louisiana appellate court has held that a professional services exclusion in a general liability policy barred coverage for allegations that an architecture firm was negligent in supervising repair work on a roof. *Doucet v. Huffine Roofing & Constr.*, No. 02-CA-1049, 2003 WL 468485 (La. Ct. App. Feb. 25, 2003).

The insurer issued a general liability policy to an architecture firm that excluded coverage for "bodily injury, property damage or personal injury due to rendering or failure to render any profession [sic] services or treatments." Professional services was defined to include "engineering, drafting, surveying or architectural services." A complaint was filed against the architecture firm alleging that the firm negligently supervised the repair and replacement of a roof. The insurer filed for summary judgment, arguing that the professional services exclusion barred coverage.

The appellate court agreed with the insurer. The court reasoned that the exclusion in the policy for professional services was "clear and unambiguous." The court also noted that the architecture firm "understood that a separate policy for coverage of professional liability was required, because the firm has such a policy" with another insurer. ✦

Fraud Exclusion Applicable Where Policyholder Found Negligent

continued from page 1

held liable for certifying two first mortgages on the same property to two different lenders. The finding of liability was based on theories of negligence, breach of fiduciary duty and statutory violations, but not fraud. The insurer then filed suit seeking a declaration that no coverage was available under the fraud exclusion in the policy.

The appellate court reasoned that fraud could properly be found based on evidence from the trial that the attorney had a ten-year relationship with the borrower, there was a very short interval between the two mortgages and the attorney failed to take any of the reasonable steps he should have taken when dealing with the second lender. The court also held that the actions of the attorney could properly be imputed to the entire firm since at the time of the transactions the attorney was the sole proprietor of the corporation. Finally, the court held that the insurer was not bound by the legal and factual determinations in the underlying case even though the insurer had provided the lawyer with a defense because "the defense was not directed or controlled by the insurer, and the fraud issue was not even raised [by the law firm]." ✦

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

© 2003 Wiley Rein & Fielding LLP

No Coverage for Claim Reported a Year Late, Even With Extended Reporting Period

continued from page 1

First, the court rejected the company's argument that the insurer had "constructive notice" of the claim because an underwriter had read the company's form 10-Q, which contained a reference to the underlying lawsuit. The court held that, even if the insurer had actual knowledge of the claim, that fact did not relieve the company of its obligation to comply with the specific notice requirements in the policy. Next, the district court rejected the company's argument that the insurer should have to demonstrate actual prejudice because the extension of the reporting period converted the claims-made policy into an occurrence policy. The court explained that, under Texas law, insurers may deny coverage under claims-made policies without showing prejudice, and the extension of the reporting period was entirely consistent with a claims-made policy. Finally, the district court rejected the argument by the president of the company that the policy prohibited the president from reporting the claim against him personally because the policy provided that the company agreed "to act on behalf of all Insureds with respect to the giving and receiving notice of claim." The court reasoned that the clause neither prohibited the president from complying with the notice provision, nor excused him from doing so. Since he was the president, he was authorized to give notice for the company. ✦

Lawyer's Policy Voided Due to Misrepresentation

continued from page 3

explained, did not want to cancel the policy sometime in the future; instead, it wanted to rescind the policy *ab initio*. The court therefore concluded that the insurer did not relinquish its right of rescission by including a cancellation clause in the policy.

The court rejected the law firm's argument that no misrepresentation had occurred. The court stated that the renewal application question "clearly asked the lawyer to disclose his own misconduct," and a reasonable attorney would know that misappropriating client funds would probably result in a claim. The court also rejected the law firm's argument that the misrepresentation was not material to the risk insured, noting that one of the insurer's underwriters had filed an affidavit stating that the insurer would not have issued the policy had it known the partner engaged in such conduct. Agreeing with the insurer, the court found it "unimaginable" that the partner's conduct would not be material to the risk being insured.

Next, the court held that the insurer was not estopped from rescinding the policy even though it had settled some of the claims that arose under the policy after the partner's death. The court reasoned that it was undisputed that the insurer issued a reservation of rights and preserved any defenses it had before handling the settled claims.

Finally, the court rejected the law firm's contention that the other partners were entitled to coverage because they did not commit wrongful acts or know of the deceased partner's wrongdoings. The argument that the "innocent partners" were entitled to coverage was based on the fact that the policy excluded claims arising from any "dishonest, fraudulent, criminal, malicious or knowingly wrongful act…." but provided an exception for "any Insured who did not commit, participate in, or have knowledge of any such act…." The court, though expressing sympathy for the innocent partners, held that the provision of the policy did not preclude the remedy of rescission. It stated that "[t]here is an obvious difference between affording coverage to an innocent insured under this Policy provision and rescinding the Policy because the Law Firm, through its authorized partner, lied on the application. Had [the partner] committed an act otherwise excluded under this provision of the Policy, without any misrepresentation in the application, his innocent partners would have had coverage." ✦

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

© 2003 Wiley Rein & Fielding LLP

Excess Insurer Has Right to Select Counsel In Medical Malpractice Action

continued from page 4

The court also held that the excess insurer's policy language did not contravene the Pennsylvania Medical Professional Liability Catastrophe Loss Fund statute, which provided that only basic insurers, including self-insurers, can defend medical malpractice claims. The court explained that "[n]othing in the statute or in the general principles of contract law prevents such a contracting away by the self-insured of the duty to defend." Rather, the purpose of the statutory requirement was to ensure that the insurer defend post-exhaustion claims, even though the Fund would pay post-exhaustion losses or damages.

The hospital also argued that its contract with a second insurer for a fronting policy served to name that insurer as the basic insurance carrier and conferred the duty and right to defend on the second insurer. Disagreeing, the court held that a fronting policy is not a contract for basic insurance, but instead is a surety agreement because the insurer only assumes the policyholder's liability if it becomes insolvent. In any event, the court noted, the excess insurer's agreement would be valid against a subsequent agreement conferring a right to defend on another insurer. Thus, the court concluded that the excess insurer had a right to defend the hospital and select its counsel in the underlying medical malpractice action. ✦

Contributors

Joseph A. Bailey III	202.719.4554	jbailey@wrf.com
Mary E. Borja	202.719.4252	mborja@wrf.com
Thomas W. Brunner	202.719.7225	tbrunner@wrf.com
Brian F. Chandler	202.719.3555	bchandle@wrf.com
Jason Cronic	202.719.7175	jcronic@wrf.com
Dale E. Hausman	202.719.7005	dhausman@wrf.com
Kathleen S. Kim	202.719.7434	kkim@wrf.com
Kimberly M. Melvin	202.719.7403	kmelvin@wrf.com
Karalee C. Morell	202.719.7520	kmorell@wrf.com
Leslie A. Platt	202.719.3174	lplatt@wrf.com
Alicia C. Ritter	202.719.3575	aritter@wrf.com
William E. Smith	202.719.7350	wsmith@wrf.com
Daniel J. Standish	202.719.7130	dstandish@wrf.com
E. Kenneth Stegeby	202.719.7456	kstegeby@wrf.com
Sandra Tvarian Stevens	202.719.3229	sstevens@wrf.com
David H. Topol	202.719.7214	dtopol@wrf.com

1776 K Street NW ✦ Washington, DC 20006 ✦ (ph) 202.719.7000 ✦ (fax) 202.719.7049

7925 Jones Branch Drive ✦ Suite 6200 ✦ McLean, VA 22102 ✦ (ph) 703.905.2800 ✦ (fax) 703.905.2820

For past issues of WRF Newsletters, please visit **www.wrf.com/publications/newsletter.asp**

You are receiving this newsletter because you are subscribed to WRF's *The Executive Summary*. To sign up to receive this newsletter by email or to change the address of your current subscription, please visit **www.wrf.com/newsletters.asp**. To unsubscribe from this list, please send an email to wrfnewsletters@wrf.com with "Remove: *The Executive Summary*" in the subject line. This is a publication of Wiley Rein & Fielding LLP providing general news about recent legal developments and should not be construed as providing legal advice or legal opinions. You should consult an attorney for any specific legal questions.

© 2003 Wiley Rein & Fielding LLP ✦ Washington, DC ✦ Northern Virginia ✦ www.wrf.com