August 2004

The Executive Summary

Developments Affecting Professional Liability Insurers

Personal Profit Exclusion Bars Coverage for All Directors and Officers Where CEO Found Liable

The United States Court of Appeals for the Fifth Circuit, applying Texas law, has held that the personal profit exclusion in a D&O policy bars coverage for litigation against a number of directors and officers of an insured company, including those who reached settlements in the underlying litigation, since a jury found in the underlying litigation that the CEO had engaged in, and personally profited from, the sale of stock through fraudulent means. *TIG Specialty Ins. Co. v. Pinkmonkey.com Inc.*, 2004 WL 1429933 (5th Cir. July 14, 2004).

An insurer issued a D&O policy to a company that sold shares of its stock and stock of another corporation to various third parties. The policy contained a personal profit exclusion that precluded coverage for "any Claim made against any Insured arising out of [ ] the following:…any Claim based upon, arising from, or in consequence of an Insured having gained in fact any personal profit, remuneration, or advantage to which such Insured was not legally entitled." The policy also contained an endorsement providing entity coverage to the company for securities claims. The policy defined a "securities claim" as "[a] claim made against an Insured of the Company alleging a violation of the Securities Act of 1933, the Securities Exchange Act of 1934, and rules or regulations of the Securities and Exchange Commission adopted thereunder; similar federal and state or foreign statutes regulating securities; and any rules or regulations of any state or foreign jurisdiction, or any common law, relating to any transaction arising out of, involving, or relating to the sale of securities." The policy also provided that "[a]ll Claims arising from the same Wrongful Act or interrelated or continuous Wrongful Acts of one or more Insured shall constitute a single claim."

The underlying plaintiffs filed suit against the company, its former CEO and other directors and officers of the company, alleging violations of Texas securities laws, including control person liability, deceptive trade practices and negligent misrepresentation. Four of the defendants settled before trial. At trial, the jury found that the company, through the former CEO and another officer, had sold the stock through fraudulent means and that the former CEO profited from the sale. The insurer denied coverage for all insureds based on the personal profit exclusion in the policy. Coverage litigation ensued.

The Fifth Circuit ruled in favor of the insurer, holding that the personal profit exclusion applied to bar coverage for claims against the former CEO and the other directors and officers. The court first determined that the former CEO had received a personal profit or advantage, relying on the jury's determination in the underlying case. The court next held that the former CEO was not legally entitled to the profits. In so ruling, the court stated that "[a] defendant is not legally entitled to an advantage or profit resulting from his violation of law if he could be required

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Endorsement Raising Aggregate Limit for Acts Occurring after Date of Endorsement Does Not Convert Policy to Occurrence-Based Policy

The United States District Court for the Eastern District of New York, applying New York law, has held that an endorsement to a claims-made E&O policy raising the aggregate limit of the policy for a wrongful act, or series of continued, repeated or interrelated wrongful acts first occurring on or after the date of the endorsement did not impermissibly alter the policy from a claims-made to an occurrence-based policy. *Am. Int'l. Specialty Lines Ins. Co. v. Nat'l Ass'n of Bus. Owners & Professionals*, 2004 WL 1551585 (E.D.N.Y. June 29, 2004).

The claims-made policy at issue incepted on March 6, 1998 and was effective through March 6, 1999. On July 10, 1998, Endorsement No. 4 was added to the policy.

> **"The court also found that incorrect use of punctuation in the endorsement—misplaced semicolons—did not render the endorsement ambiguous as it is not "reasonably susceptible to more than one reading.""**

This endorsement stated that the aggregate limit of the policy would be increased from $1 million to $3 million for "a Wrongful Act which first occurs; or, a series of continuous, repeated or interrelated Wrongful Acts where the first Wrongful Act occurs; on or after July 10, 1998, and before the end of the policy period." The endorsement also provided that the $1 million limit would continue to apply "for any claim for: a Wrongful Act which first occurs; or, a series of continuous repeated or interrelated Wrongful Acts where the first Wrongful Act occurred; before July 10, 1998 and before the end of the policy period."

The coverage dispute arose out of a number of lawsuits filed against the insured association, alleging that the association failed to pay medical benefit claims. The litigation settled with an independent receiver for $1 million, driven in part by the conclusion about the applicable policy limit. In order to evaluate the fairness of the settlement, the court requested a briefing concerning the aggregate limit of the policy.

Both the insurer and the parties challenging the settlement agreed that the $1 million limit applied to claims made prior to July 10, 1998. However, the parties disputed which aggregate limit applied to claims asserted on or after July 10, 1998. The parties challenging the settlement argued that Endorsement No. 4 improperly changed the policy from a claims-made to an occurrence-based policy. The court rejected this argument. It first noted there are many types of claims-made policies, including a "hybrid," whereby not only must the claim be made during the policy, "but also that the claim arise out of the wrongful acts that take place after the inception of the policy, and during the policy period."

The court concluded that Endorsement No. 4 "merely changed the amount of coverage for claims asserted during the policy period alleging a Wrongful Act which first occurs or a series of continuous, repeated or interrelated Wrongful Acts where the first Wrongful Act occurs on or after July 10, 1998 and before March 6, 1999." The court opined that this was a permissible modification of the policy to a hybrid, claims-made policy. It also found that incorrect use of punctuation in the endorsement—misplaced semicolons—did not render the endorsement ambiguous as it is not "reasonably susceptible to more than one reading."

The court also held that a $3 million aggregate limit applied only to claims asserted between July 10, 1998 and March 6, 1999, inclusive, alleging Wrongful Acts occurring on or after July 10, 1998, or a "'continuous, repeated or interrelated Wrongful Acts' when the first Wrongful Act occurred on or after July 10, 1998 and before then end of the policy period." Although "'continuous, repeated or interrelated'" were not defined in the policy, the court explained that legally similar claims asserted by the same person satisfied this definition within the meaning of the policy; however, the court held that legally similar claims asserted by different individuals alleging wrongful denial of medical benefits beginning after July 10, 1998 would be subject to the higher aggregate limit in the endorsement.

In light of its prior reasoning, the court stated, "[I]t appears that a large percentage of these claims" are subject to the $1 million limit. It therefore approved the $1 million settlement as reasonable. ■

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Professional Liability Policy Is Excess to General Business Policy

In an unreported decision, an Ohio appellate court has held that a professional liability policy issued to a pharmacist is excess to a general business policy issued to the pharmacy that employed the pharmacist because the professional liability policy was expressly excess. *Monroe Guar. Ins. Co. v. Pharmacists Mut. Ins. Co.,* 2004 WL 1595120 (Ohio Ct. App. July 16, 2004).

A pharmacist was sued by a customer for incorrectly measuring a prescription dosage. The pharmacist sought coverage under his professional liability policy and under a general business policy issued to the pharmacy where he worked. The general liability insurer accepted the defense and demanded that the professional liability insurer contribute to the defense costs. The professional liability insurer refused to contribute to defense costs or indemnification, contending that its policy was excess and exhaustion had not occurred. This declaratory judgment action followed.

On appeal, the court found that the professional liability policy was excess to the general liability policy and that the professional liability insurer was not required to contribute to defense costs. The court relied on language in the insuring agreement of the professional liability policy stating, "We will pay on your (but not your employer's) behalf the ultimate net loss in excess of the underlying insurance." The policy defined underlying insurance as "an insurance policy or program of self insurance, including deductible, or risk retention either primary, contingent, excess or otherwise, which requires the providing of a defense and/or indemnification related to pharmacy or pharmacist (or druggist) professional liability, which provides coverage for you as an insured in any capacity."

The policy also stated in various places that it was an excess policy, including one provision stating in all capital letters that it is "specifically designed to be excess coverage for You. This policy is intended to be your personal professional umbrella policy, as it is excess to other professional liability policies and is rated to be excess. This insurance does not apply until the limits of your employer's professional liability coverage…has [sic] been exhausted."

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Insurer Not Required to Defend Suit "Related" to Previous Suit that Exhausted Policy Limits

The California Court of Appeal has held that an insurer had no duty to defend a doctor against a patient's battery suit under a 1996 medical malpractice policy because the battery suit was "related" to the patient's earlier malpractice action, which had exhausted the limits under a 1993 medical malpractice policy. *Friedman Prof'l Mgmt. Co., Inc. v. Norcal Mut. Ins. Co.,* 2004 WL 1462202 (Cal. Ct. App. June 29, 2004).

The insurer issued a series of one-year, $1 million claims-made medical malpractice policies to the owner of an outpatient surgical center. One policy covered claims made in 1993; a second covered claims made in 1996. The policies provided that if a second claim was made that stemmed from the same "occurrence" at issue in a prior claim, then only the policy covering the first claim would cover the second claim. Both policies defined "occurrence" as a "single act or omission or series of related acts or omissions involving direct patient treatment."

In 1993, a patient was injured during surgery at an outpatient center. The patient subsequently brought a medial malpractice action against the owner and the medical center and won a $9 million judgment. The case eventually settled for more than $1 million and the insurer paid out its policy limits under the 1993 policy.

In 1996, the patient filed a second suit against the owner and the center for battery, sexual battery and invasion of privacy, stemming from actions taken by the owner during the botched medical procedure that had been the subject of the prior litigation. The insurer denied coverage for this lawsuit since it involved the same occurrence covered under the 1993 policy, and the limits of that policy had been exhausted.

The Court of Appeal initially addressed the question of why, if the medical malpractice and battery suits were "related," the second suit was not subject to a *res judicata* defense. The court explained that California courts use a different standard for *res judicata* than federal courts or the courts in most other states. According to the court, the majority of jurisdictions assess *res judicata* based on whether the second action resulted from the

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Suit Concerning Corporate Spin-Off Is Not a "Securities Claim"

An intermediate appellate court in New Jersey, in an unpublished decision, applying New Jersey law, has held that a D&O policy with entity coverage for securities claims did not afford coverage for a lawsuit against the insured corporation in connection with the spin-off of one of its subsidiaries because the spin-off did not involve the purchase or sale of securities. *Federal Ins. Co. v. Campbell Soup Co.*, 2004 WL 1631405 (N.J. Super. Ct. Law Div. June 25, 2004).

The insurer issued a D&O policy to a corporation. The policy provided entity coverage to the corporation for "all Loss for which it becomes legally obligated to pay on account of any Securities Claim." The policy defined "Securities Claim" in relevant part as "any Claim which is, in whole or in part,...based upon, arising from or in consequence of a Securities Transaction..." The policy defined "Securities Transaction" as "the purchase or sale of, or offer to purchase or sell, any securities issued by an Insured Organization." The policy did not define "purchase" or "sale."

The successor to a bankrupt, former subsidiary of the corporation filed a lawsuit against the corporation alleging that the former subsidiary became bankrupt because of the corporation's actions in connection with the corporate "spin-off" of the subsidiary. During the spin-off, the subsidiary allegedly assumed $500 million of the parent corporation's debt and issued new stock to the parent to be conveyed to the parent's shareholders. The parent in turn purportedly transferred certain stock and business assets to the subsidiary. The parent's shareholders did not pay any consideration for the newly issued shares of the subsidiary. The lawsuit alleged that the subsidiary employed no independent accountants, lawyers or representatives during the spin-off, and that the same individuals simultaneously represented both parties in executing the transaction. The insurer denied coverage for the lawsuit on the ground that it was not based upon, did not arise from or was not in consequence of a purchase or sale of securities, and therefore did not constitute a securities claim. Coverage litigation ensued.

The court agreed with the insurer that the spin-off transaction did not constitute a "securities transaction" under the policy. Reasoning that the purpose of the policy was to insure the parent against private actions arising out of alleged violations of federal securities laws, the court looked to the meaning of "sale" and "purchase" under the same body of law. The court noted that "[t]he case law supports [the] assertion that a spin-off transaction does not constitute a 'purchase' or 'sale' of securities under the scheme of securities regulation." The court relied in particular on the decision by the United States Court of Appeals for the Seventh Circuit in *Isquith v. Caremark International, Inc.*, 136 F.3d 531 (7th Cir. 1998), in which the court held that a transaction was a spin-off and not a sale of securities because the corporation's shareholders received stock without giving any consideration in return. The Seventh Circuit reasoned that the shareholders "no more 'bought' [the securities] than the recipient of a stock dividend...buys the stock that he receives as a dividend." Noting that the parent's shareholders similarly had not paid consideration for the newly-issued shares of the subsidiary's stock, the court held that, in this case, a "purchase" or "sale" of securities had not taken place.

The court rejected the parent corporation's argument that dictionary definitions of "sale" and "purchase" warranted a different result, noting that the federal securities laws' definitions of the same terms "do not differ from their dictionary meanings." The court also rejected the parent's reliance on the decision by the United States Court of Appeals for the Second Circuit in *Vesco v. International Controls Corp.*, 490 F.2d 1334 (2d Cir. 1974), in which the court recognized a line of cases holding that "certain subsidiary spin-offs constituted 'sales' for purposes of the Securities Act of 1933...." The New Jersey court stated the Second Circuit's finding in *Vesco* was "odd" because the *Vesco* court concluded that a spin-off was a sale of securities even though no consideration was exchanged, and because the *Vesco* court ignored precedents holding that transactions analogous to stock dividends were not a "purchase" or "sale." The court also reasoned that in the present case, unlike in *Vesco*, the parties to the transaction were both controlled by the same individuals, and the SEC had expressly determined that the transfer of securities pursuant to the spin-off did not have to be registered under federal securities laws.

Finally, the court explained that although the corporation had cited to other decisions finding that a "purchase" or "sale" had taken place, "in all of the cases cited, the courts which did find a purchase and sale were struggling to do so in order to insure a remedy for the wrong, i.e. so that registered securities would not enter the marketplace, or the mischief of an 'unsympathetic' defendant...would not go without a federal remedy." Reasoning that these cases did not provide an "internally consistent or legally cohesive precedent," the court instead held that the spin-off constituted "a mere transfer between corporate pockets," rather than a sale or purchase of securities, and consequently concluded that the policy did not afford coverage for the litigation. ■

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Reliance on Marketing Brochures Unreasonable

The United States Court of Appeals for the Fifth Circuit, applying Louisiana law, has held that statements made by an insurance company in a renewal letter and marketing brochures did not contradict the clear terms of a medical malpractice policy, and that any reliance by the insureds on these statements was unreasonable. *Drs. Bethea, Moustoukas & Weaver LLC v. St. Paul Guardian Ins. Co.*, 2004 WL 146437 (5th Cir. June 30, 2004).

This case involved a putative class action filed by former policyholders against an insurer for detrimental reliance and unjust enrichment under medical malpractice policies issued by the insurer. The insurer issued medical malpractice policies, which gave both the doctors and the insurer the right not to renew the policy, in which case the doctors would have the right to purchase additional tail coverage. The policies also provided that if a doctor died, became disabled or retired during the policy period, then the insurer would provide tail coverage for no additional premium. The policies also contained an integration clause requiring that any modification to the policy be in writing.

After the doctors renewed their policy, the insurer decided to leave the medical malpractice market, but continued to provide coverage under its current policies, including free tail coverage to doctors who retired while their current policies were in effect. The doctors alleged that a renewal letter and marketing brochures issued by the insurer promised free tail coverage upon retirement and that by exiting the market before they could retire and take advantage of the free tail coverage, the insurer breached its promise.

The court rejected the doctors' argument, holding that, as a matter of law, the doctors' reliance on these statements was unreasonable. The court explained that the policies

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I v. I Exclusion Does Not Bar Coverage for Claim against CFO; Court Addresses Allocation

A New Jersey appellate court has held that an insurer had a duty to pay defense costs incurred by the CFO of a hospital in defending a lawsuit brought by the hospital because the I v. I exclusion in the applicable D&O policy barred coverage for suits by other directors and officers, but not the hospital. *Hebela v. Healthcare Ins. Co.*, 2004 WL 1431733 (N.J. Super. Ct. App. Div. June 28, 2004). The court also provided substantial guidance on how the trial court should allocate defense costs between covered and uncovered allegations.

The insurer issued a D&O policy to an incorporated hospital. The policy provided coverage "on behalf of an 'insured person' because of any claim made against an 'insured person' for a 'wrongful act….'" "Wrongful act" was defined as "any actual or alleged error or misstatement or misleading statement or act or omission or neglect or breach of duty." "Insured person" was defined as any "past, present or future director, officer or trustee" of the hospital. The policy also contained an I v. I exclusion precluding coverage for claims "made against any director, officer, or trustee by any other director, officer or trustee whether directly or derivatively."

The former CFO of the hospital brought suit against the hospital, alleging wrongful termination. The hospital counterclaimed, alleging that the CFO was negligent in the performance of his duties. The CFO sought coverage for defense of the counterclaim from the D&O insurer, but the insurer denied coverage based on the I v. I exclusion. Ultimately, the counterclaim was dismissed on summary judgment.

The appellate court held that the policy covered the hospital's counterclaim. The court explained that the language of the policy's insuring clause "amply encompassed" the basis for the counterclaim, an allegation of negligence against the insured director. The court also found that the I v. I exclusion was inapplicable because "the policy does not exclude a claim brought against a director or officer by the corporation, as here, although it does exclude claims brought against a director or officer by another director or officer."

The court then addressed the apportionment between the covered costs incurred by the CFO in defending against the counterclaim and the uncovered costs he incurred in bringing his wrongful termination suit. Although the invoices of the CFO's attorney contained little specification supporting whether the costs related to defense of the counterclaim or prosecution of the original case,

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No Coverage for Suit Filed after Claims-Made Policy Expired

In an unpublished opinion, the Eastern District of Louisiana has held that an insurer that issued a claims-made public officials and employees liability policy to a city did not have an obligation to provide coverage for a lawsuit filed three years after the policy expired. *Global ADR, Inc. v. City of Hammond*, 2004 WL 1562840 (E.D. La. July 12, 2004). The court rejected the city's argument that the lawsuit related back to a prior lawsuit filed during the policy period, reasoning that the prior lawsuit was for injunctive relief only and therefore did not constitute a claim under the policy.

The insurer issued a claims-made policy to the city for the period from July 1, 1999 to July 1, 2000. The policy provided that "all Claims against any insureds arising out of the same Wrongful Act, or logically or causally connected Wrongful Act, will be considered one Claim. All such Claims will be considered first made at the time the earliest such Claim was made against any insured." The policy defined "claim" as a "demand for money as of right." The policy also stated that if the insured provided written notice of Wrongful Acts "which might reasonably be expected to give rise to a Claim…then any Claim subsequently made against the Insured by reason of the Wrongful Act shall be deemed to have been first made during the Policy Period."

The plaintiffs sought to purchase a piece of real property with the intent to use it for commercial purposes. However, because the property was in an area that was zoned as "residential," they requested a "conditional use" exception from the city. The city council passed an ordinance granting the conditional use. The plaintiffs then closed on the property. During the policy period, a group of neighbors challenged the ordinance in state court and the ordinance was stricken on the basis that the city council failed to advertise amendments to the ordinance prior to its passage. The complaint sought only injunctive relief. Three years later, after the policy had expired, the underlying plaintiffs brought suit against the city, its insurer and individual city officials, asserting Fifth Amendment, tort and substantive due process claims pursuant to 42 U.S.C. § 1983. The insurer sought dismissal from the case, arguing that the policy did not provide coverage for the lawsuit since it was filed after the policy had expired.

The plaintiff argued that the initial litigation challenging the ordinance, which was commenced on December 6, 1999, was a claim made during the policy period, and that the present claim should be deemed to have also been made during the policy period because it arose out of the same Wrongful Act. The court rejected that argument, explaining that the earlier litigation was not a "claim" under the policy since it sought injunctive relief, not money damages. The court also found that a letter dated December 13, 1999, seeking coverage for the prior litigation did not serve as notice of a potential claim under the policy because it simply informed the insurer of the suit for injunctive relief, and "it cannot be said that [the insurer] knew or should have known of any further litigation or potential claim." ■

Pharmacist Liability Policy

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The general business insurer argued that it also had an excess insurance clause in its policy, thereby requiring the court to apply the rule in Ohio that where two policies both have excess insurance clauses, the insurers are liable in proportion to the amount of coverage provided by their respective policies. The excess insurance clause of the general business insurer provided that if other insurance is available for the same loss, the policy will pay only "the amount of covered loss or damage in excess of the amount due from that other insurance, whether you can collect on it or not" and that the insurer will only defend a claim or suit if no other insurer agrees to defend. The policy also provided that it is "excess over any other insurance that insures for direct physical loss or damage."

The court rejected the general insurer's argument, reasoning that the professional liability policy and the general business policy did not cover the same risk since the professional liability policy did not afford coverage "until all other insurance is exhausted." The court explained that the excess insurance provision of the general business insurer's policy "has no legal significance unless there is another policy of primary coverage or until the condition precedent of the exhaustion of coverage from all other policies has been achieved." Since the professional liability policy did not provide primary coverage, this provision was inapplicable and, as a result, only the general business insurance policy provided primary coverage. ■

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Personal Profit Exclusion

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to return such profit." The court observed that one of the remedies available in the underlying case was "rescission, which requires the return of any money paid." The court therefore concluded that the personal profit exclusion applied to the former CEO because he had gained a personal profit to which he was not legally entitled.

The court next held that the personal profit exclusion barred coverage for the other directors and officers of the company even though it had not been established that they received personal gain or advantage. The court first observed that "[t]he exclusion does require that the claim be based upon *the Insured, that Insured,* or *such Insured*, having gained a personal profit or gain, but based upon *an Insured* having gained a personal profit." The court concluded that this language demonstrated that the exclusion was intended to apply to all insureds and not merely to the insured who personally profited. The court also noted that "the Personal Profit Exclusion does use the specific term 'such Insured' to indicate the same insured as previously referred to, when it states that the claim must arise from 'an Insured having gained in fact any personal profit…to which *such Insured* was not legally entitled.' The use of more specific language within the same provision further indicates that 'an Insured' does not necessarily refer to the same insured against whom the claim was brought."

Having determined that the exclusion applied to all insureds, the court addressed whether the allegations against the other directors and officers were based on the former CEO having gained personal profit to which he was not legally entitled. The court first determined that as directors and officers of the company, the allegations made against them were allegations against insureds under the policy. The court then noted that one of the underlying causes of action against the other directors and officers was control person liability. The court explained that "[t]he rationale behind control person liability is that a control person is in a position to prevent the securities violation at issue." The court concluded that the allegations against the other officers and directors arose out of the former CEO's improper personal gain because the allegations were based on the former CEO's fraud, which led to his illegal personal profit.

Finally, the court held that coverage for the allegations against the company was also barred by the personal profit exclusion because the allegations against the insureds and the allegations against the company "arise from the same Wrongful Act and constitute a single claim. As such, the claim against the Company is also a claim against an Insured." The court concluded that because the exclusion applied to bar coverage for the allegations against the directors and officers of the company, the personal profit exclusion barred coverage for the company. ■

I v. I Exclusion

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the trial court had "summarily concluded" that the CFO was entitled to 50 percent of his attorneys' fees. The appellate court held that a more rigorous analysis was required. The court pointed to the decision of the New Jersey Supreme Court in *SL Industries, Inc., v. American Motorists Insurance Co.,* 607 A.2d 1266 (1992), in which the court addressed apportionment between covered and uncovered claims and stated "[w]e recognize that insurers, insureds, and courts will rarely be able to determine allocation of defense costs with scientific certainty. However, the lack of scientific certainty does not justify imposing all of the costs on the insurer by default. The legal system frequently resolves issues involving considerable uncertainty." The appellate court therefore remanded the allocation question back to the trial court to determine the proper allocation of fees.

In so doing, the appellate court provided some guidance as to how the trial court should allocate defense costs. The court explained that the trial court: (1) should allow for the submission of all evidence which might bear on the issue and utilize its own legal experience and understanding of the case; and (2) must consider the reasonableness of the costs incurred, lest an opportunity be provided for insureds that have been wrongfully denied a defense to generate excessive fees. However, the court rejected the insurer's argument that the defense costs were implicitly unreasonable because the CFO's counsel could have more economically and expeditiously defended the counterclaim, finding that the insurer could not, after denying a defense, complain about the manner in which a defense was provided. The court noted that the judgment of defense counsel should not be second guessed, but simply that the reasonableness of billable hours and time expended should be reviewed. ■

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Exhausted Policy Limits

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"same transaction." Here, there was "no doubt" that the two lawsuits arose from the same "series of interconnected events." The court noted that under California law, however, *res judicata* is based on the "primary right" test, which looks to the type of harm suffered. In this case, the patient had suffered two different types of harm—the owner and center had violated her right to be free from negligence, as a result of errors during the operation, and the owner had violated her "dignitary and privacy interests" as alleged in the second underlying suit. Therefore, at least in California, the patient was able to bring two separate actions arising from the same underlying "transaction." The court advised, however, that even though the lawsuits involved different harms, that fact did not resolve the question whether the harms were "related" for purposes of insurance coverage.

In the court's opinion, there was "absolutely no doubt that the battery and invasion of privacy claims were causally related to the malpractice claim," and therefore that the two lawsuits involved interrelated acts arising out of the same occurrence.

The court then looked to California precedent on the meaning of "related" under a claims-made insurance policy. The court pointed to the decision of the California Supreme Court in *Bay Cities Paving & Grading, Inc. v. Lawyers' Mutual Insurance Co*., 855 P.2d 1263 (Cal. 1993), which held that "the term 'related' as it is commonly understood and used encompasses both logical and causal connections." That is, if two events are either causally connected or logically connected, then they are "related." In the court's opinion, there was "absolutely no doubt that the battery and invasion of privacy claims were causally related to the malpractice claim," and therefore that the two lawsuits involved interrelated acts arising out of the same occurrence.

The court also addressed the owner's argument that because a "claim" was made during the effective period of the 1996 claims-made policy, there was the "potential" for coverage. Although the court acknowledged that the determination of coverage "potential" rested on facts known to the insurer in addition to facts alleged in the underlying complaints, the court stated that "[a]n insured is not entitled to a defense just because one can imagine some additional facts which would create the potential for coverage." In this instance, the insurer was aware of no facts that suggested the owner touched the patient for any other reason than to stop the damage caused by the botched operation. Since this act was related to the basis of the medical malpractice claim, there was no potential for coverage under the 1996 policy. As a result, the court held that the insurer was within its rights to discontinue defending the owner in the battery action once the 1993 policy limits were exhausted by the medical malpractice action.

In rendering its decision, the court briefly discussed some of the policy reasons for including related act provisions in claims-made policies. In the court's opinion, related act provisions make insurers more willing to write renewal policies to insureds who have been "hit with a claim" because they know that any related claims will be covered by an earlier policy. Absent such provisions, insurers would have an incentive to drop every insured that had suffered a claim in order to avoid the possibility of a second claim from the same occurrence. ■

Marketing Brochures

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unambiguously provided free tail coverage only to a doctor retiring during the current policy period. According to the court, "the contract's integration clause and Louisiana law require that any change to the policy be in written form and incorporated into the policy. One could not reasonably rely on a renewal letter explaining policy changes and marketing brochures as a promise to provide free tail coverage without limit, especially considering that such a promise is not mentioned in the documents and would directly conflict with the policy."

The court also rejected the doctors' argument that the insurer was unjustly enriched by receiving higher premiums without providing free tail coverage. The court explained that Louisiana law does not allow a claim for unjust enrichment under a valid contract. ■

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Other Decisions of Note

Per Claim Limitation Applies to Medical Malpractice Suit

In an unpublished decision, the United States Court of Appeals for the Sixth Circuit, applying Kentucky law, has held that a medical malpractice policy did not afford coverage to a doctor for a loss of consortium lawsuit filed by a deceased patient's husband because the suit against the deceased wife's doctor was part of the same claim as the malpractice lawsuit by the wife's estate that had previously settled for the policy's "per claim" limit. *Nat'l Cas. Co. v. Hajjar*, 2004 WL 1491634 (6th Cir. June 22, 2004). The court provided no substantive discussion, explaining that the district court's reasoning in support of the same result sufficiently articulated the basis for the ruling. ■

Insurer Not Liable for Prejudgment Interest in Excess of Policy Limits

The Supreme Court of Oklahoma has held that an insurer is not liable in a garnishment action for a prejudgment interest award in excess of its policy limits in a case in which the policy required the insurer to obtain the policyholder's consent to settle third-party claims and the policyholder twice withheld his consent. *Parish v. Henry*, 2004 WL 1542213 (Okla. July 6, 2004). The insurer issued a professional liability policy to a doctor. The policy conditioned the insurer's right to settle third-party claims against the doctor on the doctor's consent to any settlement. During litigation against the doctor, the doctor twice rejected offers to settle within, or for, the limits of the policy. Under such circumstances, the court held that the doctor should be held liable for any prejudgment interest in excess of policy limits. The court further reasoned that cases holding an insurer liable for prejudgment interest in excess of policy limits where the insurer "has complete control of litigation" were inapplicable. ■

Insurer May Be Estopped from Withdrawing Defense

A Florida appellate court, relying on the decision of the Florida Supreme Court in *Doe v. Allstate Insurance Co.*, 653 So. 2d 371, 374 (Fla. 1995), has held that where an insurer initially assumed the defense of a policyholder, it may be estopped from denying coverage for an otherwise appropriate reason if "the insurer's assumption of the insured's defense prejudiced the insured." *Family Care Ctr. v. Truck Ins. Exch.*, 2004 WL 1335724 (Fla. Dist. Ct. App. June 16, 2004). The policy in question provided medical malpractice coverage to a physician and named his employer as an additional insured "but only as respects professional services rendered" by the physician. Suit was brought against a second physician and the employer. The employer sought coverage under the policy, and the insurer initially provided a defense to the employer during statutorily required pre-suit proceedings. Following completion of the pre-suit proceedings, the insurer denied coverage and withdrew its defense as to the employer. The court agreed that the employer was not covered under the policy; however, it remanded the case for further proceedings to allow the employer to litigate its claim that the insurer made decisions when initially defending the employer that prejudiced the employer's defense after the denial of coverage. ■

Third Circuit Holds Insurer Did Not Waive Coverage Defense By Not Specifically Reserving Its Rights

In an unpublished decision, the United States Court of Appeals for the Third Circuit, applying Pennsylvania law, has held that a professional liability insurer did not waive its right to deny coverage based on a breach of the cooperation clause, even though it had not specifically reserved its rights under that provision of the policy, because it had generally reserved its right to raise other terms and conditions of the policy. *Pizzini v. Am. Int'l Specialty Lines Ins. Co.*, 2004 WL 1543274 (3d Cir. July 12, 2004). The professional liability insurer defended the policyholder pursuant to a reservation of rights letter. The policyholder refused to testify, which undermined the defense counsel's ability to provide an effective defense. Thereafter, without consent of the insurer, the insured settled with the underlying plaintiffs, who then brought suit against the insurer seeking indemnity for the settlement. The court rejected the plaintiffs' argument that the insurer waived its right to deny coverage based on the breach of the cooperation clause by not specifically reserving its rights under that provision of the policy. The court noted that in reserving its rights, the insurer delineated specific defenses and also generally reserved the right to deny coverage based on any other defenses that might affect coverage. ■

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