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NEWSLETTER

Other Decisions of Note

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Market Timing Affecting Clients Constitutes E&O Claim, Could Constitute D&O Claim

In an unpublished opinion, the United States District Court for the Eastern District of Pennsylvania, applying Pennsylvania law, held that a declaratory judgment action seeking coverage for claims stemming from alleged market timing was not subject to dismissal because the allegations sufficiently alleged coverage under both the E&O and the D&O clauses in the insurance policy. *Rightime Econometrics, Inc. v. Fed. Ins. Co.*, 2006 WL 560145 (E.D. Pa. Mar. 6, 2006). The policy issued to the insured provided E&O coverage "on behalf of an Insured [for] all Loss on account of any Investment Advisers Errors or Omissions Claim first made against such Insured during the Policy Period . . . for a Wrongful Act while performing Investment Adviser Services, including failure to perform Investment Adviser Services." The policy provided D&O coverage for "any Loss on account of any D&O Claim first made against an Insured Person during the Policy Period." The investment firm policyholder was one of many defendants named in a lawsuit concerning alleged market timing allowed by a mutual fund company. The underlying claimants alleged that the insured was one of the investors who was allowed to engage in market timing by a mutual fund management company. The insurer argued that the only damage was to the other investors who were not involved in market timing and that the E&O clause only afforded coverage where the clients of the insured were damaged. The court accepted this characterization, but noted that the complaint sufficiently stated that "plaintiffs" were damaged, and among the plaintiffs were the insured's clients. Therefore, the court held this was not a proper basis on which to deny coverage. The insurer had also argued that there was no coverage under the D&O coverage clause. The court agreed that the plain language of the clause did not afford coverage unless a director or officer had been named a defendant, but found that the reasonable expectations of the investment firm precluded dismissal. The court explained that the reasonable expectations claim had been well pled because the investment firm stated it had been repeatedly assured that the D&O clause provided coverage for the insured company and had relied on these representations in purchasing the insurance. Finally, the court refused to dismiss the bad faith claim. The court ruled that the elements of bad faith had been pled and that it was bound to accept the factual assertions supporting the claim in deciding a motion to dismiss.

Refusal to Settle Does Not Constitute Bad Faith

The Supreme Court of Kentucky has held that a medical malpractice insurer did not act improperly by refusing to pay the portion of a judgment that exceeded the policy's limits of liability where the policy gave the policyholder the right to consent to any settlement and the policyholder refused to consent to a settlement offer that was within policy limits. *Am. Physicians Ass. Corp. v. Schmidt*, 2006 WL 733995 (Ky. Mar. 23, 2006).

The court also rejected the argument that the insurer had an obligation to pay sums in excess of its limits because of "unused defense costs" resulting from the decision not to appeal the judgment, concluding that any so-called "savings" were irrelevant to the insurer's duty to indemnify.

Telephone Call and Resignation Letter Do Not Constitute Claims

A federal court in West Virginia, applying West Virginia law, has held that a call to a company hotline reporting harassment and a resignation letter do not constitute claims under an employer's liability policies because neither requested compensation. *Cornett Mgmt. Co., LLC v. Lexington Ins. Co.*, 2006 WL 898109 (N.D. W.Va. Mar. 31, 2006). The policyholder who operated restaurants was sued by several plaintiffs for harassment. The policyholder purchased employment practices liability policies that covered "claims," which was defined in the policy as "a written demand or notice received by an Insured in which damages likely to be covered by this policy are alleged. . . . Claim shall not include a proceeding for injunctive or non-monetary relief." On motions for summary judgment, the court held that an employee's resignation letter was not a claim "because the letter does not contain an 'allegation of damages' as required by [the policy]." The court explained that "damages" requires a request for compensation, not simply a complaint about an injury. The court also found that the employee's call to the human resources hotline to report the incident was not a claim because it was not in writing as required by the policy and did not allege damages.

Repeated Failure to Fund Pension Plan Not a Wrongful Act Under E&O Policy

In an unreported decision, the United States District Court for the Northern District of Illinois, applying Illinois law, has held that an insurer that issued an employee benefit plan administration liability policy to a village had no duty to defend the village in a lawsuit alleging that the village repeatedly and intentionally refused to fund a pension plan. *St. Paul Fire and Marine Ins. Co. v. Village of Franklin Park*, 2006 WL 862902 (N.D. Ill. Mar. 31, 2006). The court explained that the village had "acknowledged" the money owed to the pension fund and made "formal commitments" to pay the fund. It concluded that there was no duty to defend because the village's "repeated failure to fulfill formal commitments to transfer funds" did not constitute a "negligent act, error, or omission" and thus did not fall within the policy's definition of a "wrongful act."

Attorney's Fees and Costs in Suit Seeking Only Equitable Relief Constitute Damages

In an unreported decision, the United States Court of Appeals for the Ninth Circuit, applying California law, has reversed a district court's grant of summary judgment for an insurer, holding that an underlying suit seeking equitable relief was nonetheless a claim for damages, as defined by the directors and officers liability policy at issue, because the suit also sought payment of the underlying plaintiff's fees and costs. *Nat'l Cas. Co. v. Coastal Dev. Servs. Found.*, 2006 WL 700943 (9th Cir. Mar. 20, 2006). The policy obligated the insurer to pay "all Damages . . . for any Claim(s) made against" the policyholder and to "defend any Claim made . . . seeking Damages . . . ." The policy defined "Claim" as "a demand or suit made upon the Insured for Damages" and "Damages" as "a monetary judgment, award or settlement arising from a covered Claim, including prejudgment interest awarded against the Insured on that part of the judgment paid by the Company and all costs taxed against the Insured . . . ." The court rejected the insurer's contention that the policy distinguished between monetary and non-monetary relief, holding that the policy was ambiguous in this respect and thus must be construed in favor of the insured. Further, the court held that, contrary to the insurer's

position and that of the dissenting opinion, the decision in *Cutler-Orosi Unified School District v. Tulare County School Districts Liability/Property Self-Insurance Authority*, 31 Cal. App. 4th 617, 37 Cal. Rptr. 2d 106 (1994) did not announce a categorical rule that attorney's fees and costs sought in connection with an action for equitable relief do not constitute damages under California insurance law.

Policy Is Void Based on Policyholder's Material Misrepresentations

In an unpublished opinion, the United States Court of Appeals for the Fourth Circuit, applying Maryland law, has affirmed a summary judgment ruling in favor of a professional liability insurer holding that an insurance policy was void *ab inito* because of material misrepresentations in the original and renewal applications. *Scottsdale Ins. Co. v. Nat'l Center on Institutions & Alternatives, Inc.*, 2006 WL 521734 (4th Cir. Mar. 3, 2006). Before the insurer issued the policy to an operator of residential facilities, a disabled adult choked on a sandwich while at a vocational program, leaving him in a vegetative state. A Maryland state agency investigated and intended to sanction the policyholder but reached a consent agreement instead. The policyholder failed to disclose this incident on its original or renewal applications, answering that it "could not have reasonable [sic] foreseen that any prior acts or incidents might be the basis of any claim or suit" and that it was not aware of "any circumstances known which may give rise to a claim or lawsuit." During the renewal policy period, the mother of the victim sued the policyholder. The court held that the policy was void because the policyholder failed to disclose the choking incident on its applications, and therefore, the lawsuit was not covered.

Failure to Heed Settlement Evaluations and Appointment of Counsel Constitutes Bad Faith

In an unpublished opinion, the United States District Court for the Eastern District of Pennsylvania, applying Pennsylvania law, held that the insurer's refusal to heed the settlement evaluations of multiple parties, including the judge presiding over the trial, and appointment of a single lawyer to represent both of the named defendants, in violation of ethical rules prohibiting representation posing a conflict of interest, constituted bad faith subject to punitive damages. *Jurinko v. The Med. Protective Co.*, 2006 WL 785234 (E.D. Pa. Mar. 29, 2006). The insurer provided a defense in the underlying action in which the policyholder, a medical doctor, was found liable in an amount $1.3 million above his aggregate policy limits. To prevent execution of the judgment against him, the doctor assigned his rights to a bad faith claim to the underlying claimant. Upon trial for the bad faith allegations, the claimant was able to establish bad faith, and the jury awarded him $1.7 million in compensatory damages and $6.25 million in punitive damages. The court ruled there was sufficient evidence to establish a bad faith refusal to settle for the policy limits when it was shown that the insurer had offered no more than $50,000, two judges had valued the claim at more than $1 million, and the claims handler had admitted that the claim was likely worth $1 million. Further, the court ruled there was sufficient evidence to establish a bad faith provision of defense when the insurer had knowingly appointed an attorney to represent both doctors named in the underlying suit when the doctors' interests diverged. Accordingly, the court approved the punitive damages award. The court ruled that the punitive damages were not excessive given the reprehensibility of the conduct of the insurer, the relative lack of disparity between the compensatory and punitive damage awards and the difference between the punitive damages award and the statutory civil damages.

Policy Does Not Cover Alleged Fraud by Attorneys

A federal district court for the Eastern District of Arkansas, applying Arkansas law, has held that an exclusion in a legal malpractice policy for claims alleging dishonest or fraudulent acts barred coverage for the insured attorneys' intentional misrepresentation of the ownership and structure of an investment company the policyholders controlled. *Continental Cas. Co. v. Moser*, 2006 WL 827319 (E.D. Ark. Mar. 29, 2006). Although the suit alleged negligence, the court determined that the "real character" of the suit was based on the fraudulent acts and omissions of the attorney policyholders in controlling an investment company through which they funneled client money from client trust accounts. According to the court, "[c]overage is not created under the professional liability insurance policies merely because the complaint labels the claim as 'negligence' when the facts alleged constitute dishonest and fraudulent conduct."

Negligent Preparation of Financial Statements Constitutes Single "Claim"

In an unpublished decision, a California intermediate appellate court has held that lawsuits alleging that an accounting firm negligently prepared a company's financial statements for several years constitute a single "Claim" under the "Multiple Claim" provision of a professional liability policy. *Camico Mut. Ins. Co. v. Rooney, Ida, Nolt & Ahearn Accountancy Corp.*, 2006 WL 866321 (Cal. App. April 5, 2006). The accounting firm issued audited financial statements for a number of years on behalf of a group of investment companies. It was later revealed that the owners of the investment companies were operating a "Ponzi scheme," which the accounting firm failed to detect. Investors brought suit against the accounting firm, alleging that its negligent auditing and preparation of the financial statements caused them to lose their investments. The appellate court held that the accounting firm was only permitted to recover up to the "per claim" limit of liability under its professional liability policy, rather than the higher aggregate limit. The court concluded that the firm's negligent issuance of several financial statements constituted only a single "Claim" under a policy definition that included, within the term, "a *Multiple Claim*, which is formed by two or more *Claims* arising out of or resulting from a single act, error or omission in the rendering of *Professional Services*, or from related or identical acts, errors or omissions." The court held that only a single claim was alleged because "the allegations in the complaints were certainly of similar, bordering on identical, acts."

No Coverage When Insured Had Prior Knowledge of Facts That Would Result in Claim

The United States District Court for the Eastern District of Michigan, applying Michigan law, has granted an insurer's motion for summary judgment, holding that, under an educators legal liability policy, coverage for underlying racial discrimination litigation was precluded because, at the time of the application for insurance, the insured had knowledge of facts that an insured "could reasonably expect would result in a claim." *Ann Arbor Pub. Schs. v. Diamond State Ins. Co.*, 2006 WL 724550 (E.D. Mich. Mar. 21, 2006). The policy provided coverage to the insured from August 1, 2001 to August 1, 2002. Exclusion N to the policy barred coverage for "any loss or defense expenses for any claim or circumstance . . . based on any circumstance or fact known at the time of the application which any Insureds could reasonably expect would result in a claim." The underlying litigation concerned claims filed by seven of the insured's employees in September 2001, alleging discrimination on the basis of race under state and federal law. The insurer refused to pay for either defense or settlement costs relating to the claims. The court concluded that Exclusion N precluded coverage for the underlying litigation as the insured had known at the time it applied for the policy that several of its

employees had filed a Class Action Grievance in April 2000, as well as charges with the Equal Employment Opportunity Commission in November 2000, all of which were based on claims of racial discrimination. Therefore, according to the court, the insured should have reasonably expected that such filings could result in a claim.

Court Holds Third Party Claim "First Brought" When Written Notice Provided

A California appellate court has held that a third party claim was "first brought" in California when, under a claims-made E&O policy that covered claims "first brought" in North America, the third party first made the claim via letter to the policyholder at its offices in California even though the claim was ultimately resolved in an arbitration proceeding in England. *Nat'l Cas. Co. v. Sovereign Gen. Ins. Servs.*, 40 Cal. Rptr.3d 591 (Cal. Ct. App. Mar. 14 ,2006). The policy provided coverage for wrongful acts committed anywhere in the world "provided that the Claim is first brought" in the United States, Puerto Rico or Canada. The insurer argued that the term "brought" requires a formal legal proceeding. The court disagreed and found the phrase ambiguous because the policy defined claim to include "a demand or assertion of a legal right seeking Damages."

Insured Covered Under E&O Policy for Claim Based on Acts of Independent Agents

The United States District Court for the Central District of Illinois, applying Illinois law, has held that a professional liability policy provided coverage to a policyholder life insurance company that was sued in connection with litigation against independent agents who sold their policies. *Country Life Ins. Co. v. St. Paul Surplus Lines Ins. Co.*, 2006 WL 771323 (C.D. Ill. Mar. 27, 2006). The insurer argued that the litigation was not covered because the life insurance company was acting as an insurer and was not providing professional services as an agent or broker. The court rejected the argument, reasoning that the policy applied to professional services "rendered by or on behalf of" the life insurance company. The court concluded that the insurer's interpretation "would render the 'on behalf of' language a nullity."