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NEWSLETTER

Other Decisions of Note

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Notice-Prejudice Rule Inapplicable to Claims-Made and Reported Policy

A Florida appellate court has held that compliance with a notice requirement in a professional liability policy was a prerequisite to coverage and that the insured's failure to comply with that provision precluded coverage under the policy, regardless of whether the insurer was prejudiced. *The Doctors Co. v. Health Management Associates, Inc.*, 2006 WL 2614287 (Fla. Ct. App. Sept. 13, 2006).

The claims-made and reported policy at issue provided coverage for certain claims made after the expiration of the policy if the underlying incident occurred during the policy period and was reported to the insurer within 60 days of the policy period's expiration. The appellate court held that the 60-day reporting requirement defined the scope of coverage, so the insurer was not required to show prejudice to deny coverage.

21-Month Delay in Notification of Wrongful Act Negates Coverage

A New York court has held that an insured's 21-month delay in reporting an alleged wrongful act to its E&O insurer negated coverage because the delay constituted a failure to comply with the policy's notice provision. *Rael Automatic Sprinkler Co. v. Schaefer Agency,* 821 N.Y.S.2d 118 (N.Y. App. Div. 2006). The court held that, under New York law, "[c]ompliance with an insurance policy notice provision is a condition precedent to coverage, and the failure to comply vitiates the policy." As there was no dispute as to when the insured became aware of the wrongful act, the court granted the insurer summary judgment based on the policy's notice requirements.

No Coverage Available to Insured Bond Issuer for Default and Breach of Fiduciary Duty

A California appellate court has held that an insured healthcare provider that issued municipal bonds and was sued for its default and mismanagement of such bonds was not entitled to coverage under a "Nonprofit Organization Liability Insurance" policy because the policy did not cover "loss" "arising out of...breach of any contract." *Medill v. Westport Ins. Corp.*, 2006 WL 2820996 (Cal. App. Oct. 4, 2006). The definition of loss in the policy did "not include ... Damages 'arising out of' breach of any contract." The policy defined "arising out of" to mean "based upon, arising out of, or in connection with." The policy also barred coverage for any "'loss'... 'arising out of'... any 'insured's' issuance or endorsement of... bonds." The court determined that there was no "loss" because the healthcare provider was sued for its mismanagement of the municipal bonds—management governed by a contract. According to the court, it did not matter that the underlying plaintiffs did

not bring a claim based specifically on breach of contract because their mismanagement claim nonetheless arose out of the breach of the contract specifying the management duties. The court then stated that, even if there were a covered "loss," that coverage would be barred by the exclusion for "loss" arising out of the issuance of bonds.

The court then rejected the insured healthcare provider's argument that the directors and officers were entitled to coverage because they personally did not issue the bonds. The court reasoned that the plain terms of the exclusion provided that, if any insured issued bonds and a claim arose out of that issuance, there could be no coverage for any insured under the policy.

No Coverage for Disciplinary Proceedings Where Two of Six Counts Were Dismissed

The U.S. District Court for the Southern District of Ohio, applying Ohio law, has ruled that a judge who was insured under a professional services policy and was found guilty of four out of six counts brought against her by a disciplinary board is not entitled to coverage where the policy provided reimbursement for the defense of a disciplinary proceeding "only in the absence of a finding of fault or guilt." *O'Neill v. Kemper Ins. Co.,*2006 WL 2795186 (S.D. Oh. Sept. 27, 2006).

The insured argued that because two of the counts were dismissed, she should be entitled to coverage for at least a portion of her attorneys' fees. The court disagreed, stating that "[t]he policy clearly states that reimbursement occurs only in the absence of a finding of fault or guilt." The court held that because the proceedings before the disciplinary board "resulted in a finding of fault," the insurer was not obligated to reimburse the insured for the defense costs.

Prior Knowledge of Wrongful Acts Bars Coverage

In an unreported decision, the U.S. Court of Appeals for the Second Circuit has held that because a policyholder had knowledge of wrongful acts alleged in a suit against it before the effective date of a claims-made policy, coverage under the policy was precluded. *Cement & Concrete Workers Dist. Council Pension Fund v. Ulico Cas. Co.*, 2006 WL 2793013 (2d Cir. Sept. 25, 2006).

A pension fund was insured under a claims-made policy with a $10 million coverage limit beginning on April 1, 1999. The insuring agreement of the fiduciary claims-made policy at issue provided coverage for claims during the policy period alleging wrongful acts where the insured fund "had no knowledge of such wrongful act prior to the effective date of the Policy."

A class of plaintiffs brought suit against the fund in December 1999, alleging that the fund's benefits formula violated provisions of the Employee Retirement Income Security Act of 1974 (ERISA). Following settlement of the underlying suit, the fund filed suit against its insurer. The Second Circuit concluded that coverage was excluded under the policy since the fund "unquestionably" had knowledge of the wrongful acts alleged in the underlying suit. Prior to the inception of the policy, the fund had been sued and settled with an individual plaintiff who made the same allegations at issue in the class action suit. According to the Second Circuit, "[i]t was at least foreseeable, if not highly probable, that the Fund would soon face a class-action suit seeking to

extend the ruling of [the individual suit] to all eligible members—and that is precisely what [the class action] was."

Breach of Exclusive Agency Agreement Not a "Professional" Act

The U.S. District Court for the District of Massachusetts has held that, under Massachusetts law, a policyholder's alleged breach of an exclusive agency agreement, through the transfer of business to another firm, did not arise out of the rendering of professional services as required by the insurance contract. *Massamount Ins. Agency, Inc. v. Utica Mut. Life Ins. Co.*, 2006 WL 2640260 (D. Mass. Sept. 15, 2006).

The policyholder sought coverage under an E&O policy for a demand letter alleging that it had breached an exclusive agency agreement when it transferred certain business to another firm. The court quoted from the Massachusetts Supreme Judicial Court's prior construction of "professional service" as set forth in *Rose v. Federal Insurance Co.*, 587 N.E.2d 214 (Mass. 1992): "Something more than an act flowing from mere employment or vocation is essential. The act or service must be such as exacts the use or application of special learning or attainments of some kind. . . . [W]e must look not to the title or character of the party performing the act, but to the act itself." The court concluded that the transfer of accounts to another company did not constitute a "professional" act because "[t]he decision to perform or not perform did not involve any specialized knowledge or skill, but rather was simply a business decision." The court distinguished the case from ones involving "true malpractice" or breach of warranty.