wiley

NEWSLETTER

Other Decisions of Note

September/October 2005

Primary Insurer and Policyholder Settlement Binds the Non-Settling Excess Insurer

A West Virginia court has held that a settlement of underlying litigation negotiated with a primary- and secondary-level excess insurer was reasonable and required the non-settling first-level excess insurer to pay its policy limits. *ICT Group, Inc. v. Fed. Ins. Co*. No. 03-C-387 (Cir. Ct. W. Va. Aug. 23, 2005). The first-level excess insurer, National Union Fire Insurance Company, did not participate in the mediation that settled the case between the primary- and secondary-level excess insurer and the policyholder, though it did participate in a failed mediation with the policyholder. After the court approved the settlement, it rejected the first-level excess insurer's argument that the cooperation clause barred coverage, explaining that, under West Virginia law, "the insurer must show that it was prejudiced by its insured's failure to obtain its consent to settle to justify a refusal to pay." The court found that the settlement was reasonable and that the primary- and secondary-level excess insurer "attended both mediations and had every reason to negotiate a reasonable settlement as it faced $10 million in insurance liability." Additionally, the court explained that consent is not necessary if the insurer has reserved its right or denied coverage as the insurer had here.

No Coverage Where Underlying Malpractice Claim Made Prior to Policy Period

The Maryland Court of Appeals, applying Maryland law, has held that a contribution claim made during the policy period of a claims-made medical malpractice policy is not covered where the original malpractice claim from which the contribution claim arose was first made prior to the policy period. *Medical Mut. Liab. Ins. Soc'y of Md. v. Goldstein*, 2005 WL 1866059 (Md. Aug. 9, 2005). The medical malpractice policy provided that "[a]ll 'claims' for damages arising out of any one 'incident' will be deemed to have been made at the time the first of those 'claims' is first made against any insured." The policy defined "incident," in relevant part, as "a single act or omission or a series of related acts or omissions . . . arising out of the rendering or failure to render 'professional services' to a single person." A patient sued the insured doctor and a second physician for malpractice seven years before inception of the malpractice policy at issue. Judgment was entered against the second physician but in favor of the insured doctor. The second physician then brought a contribution action against the insured doctor during the policy period of the malpractice policy. The Maryland high court concluded that the malpractice insurer was not required to defend or indemnify the insured doctor against the contribution claim because, under the malpractice policy, that claim was deemed to have been made at the time of the original malpractice claim because it arose out of the same "incident" of malpractice.

Pollution Exclusion in Policy Bars Coverage for Failure to Provide Asbestos Report

A New Jersey federal court, applying New Jersey law, has held that a pollution exclusion in a lawyer's professional liability policy excludes coverage for a claim that the law firm failed to disclose asbestos present in a home as indicated in an inspector's report, resulting in remediation and relocation costs. *Edwards & Caldwell LLC v. Gulf Ins. Co.,* 2005 WL 2090636 (D. N.J. Aug. 29, 2005). In determining that the policy did not cover the potential claim, the court held that the exclusion barred coverage for "the client's . . . claims for the failure to disclose the presence of a 'pollutant' and the costs associated with the clean-up of the 'pollutant.'"

Failure to Read Complaint Does Not Excuse Non-Compliance with Notice Provision

In an unpublished decision, the United States Court of Appeals for the Third Circuit, applying Pennsylvania law, has upheld a grant of summary judgment in favor of a reinsurer, holding that the failure of an officer of the reinsured company to read a complaint filed against the company does not excuse the company's non-compliance with the reinsurance contract's condition precedent notice provision. *Philadelphia Indem. Ins. Co. v. Fed. Ins. Co.,* 2005 U.S. App. LEXIS 15464 (3d Cir. July 27, 2005). The reinsurance policy provided that "as a condition precedent to exercising their rights under this Policy," the company was required to notify the reinsurer "as soon as practicable . . . of any Claim made against the Insured for a Wrongful Act, of which the Insured's General Counsel or equivalent officer first becomes aware of such Claim." The company's vice president of claims, whom the company conceded was an "equivalent officer," received a complaint filed against the company but did not read it. Only after the company had litigated the lawsuit for 16 months and the vice president was preparing for a deposition did he read the complaint and place the reinsurer on notice of the claim. The Third Circuit concluded that the mere receipt of a complaint placed the company on notice that there was a high likelihood the company faced a claim, thereby triggering its notification obligations under the reinsurance policy.

Forum Selection Clause in D&O Policy Does Not Apply When Insurer Brings Suit

In an unpublished opinion, the United States District Court for the Eastern District of California has held that a forum selection clause in a D&O policy providing that the insurer will submit to the jurisdiction of any court at the "request" of the policyholder does not apply where the insurer institutes a coverage action. *TIG Ins. Co. v. Vision Serv. Plan*, 2005 WL 2105303 (E.D. Cal. Aug. 31, 2005). The insurer filed a lawsuit in federal court in California to rescind the policy for fraud in the application. The "Service of Suit Endorsement" in the D&O policy provided that "if [the insurer] fail[s] to pay any amount claimed to be due under the Policy, [the insurer] will, at [the insured's] request, submit to the jurisdiction of any court of competent jurisdiction in the United States of America." The policyholder, relying on this provision in the policy, sought to litigate the issue in state court in California. The court noted that, while the Ninth Circuit had not yet addressed this endorsement, other courts have uniformly held that this clause allows the policyholder to select the forum only when the policyholder brings suit, and that the insurer may still select the forum when it brings suit.

Notice-Prejudice Rule Does Not Extend to Claims-Made Policies in Pennsylvania

In an unpublished opinion, the Court of Common Pleas of Pennsylvania has held that the notice-prejudice rule does not extend to claims-made policies. *Ace Amer. Ins. Co. v. Underwriters at Lloyds & Cos.,* 2005 WL 2100150 (Pa. Com. Pl. Aug. 26, 2005). Relying on federal court cases addressing the issue, the court held that,

while under an occurrence policy the insurer must demonstrate actual prejudice before it is relieved of its obligations under a policy due to late notice, which is not the case for claims-made policies. The court concluded that, if notice is untimely under a claims-made policy, the insurer "need not demonstrate prejudice in order to deny coverage under the Policy."

Request for Injunction Requiring Production of Documents Is "Claim"

In an unpublished opinion, the United States District Court for the Eastern District of Arkansas, applying Arkansas law, has held that a lawsuit alleging legal malpractice and seeking production of certain documents as well as the surrender of files and trust fund accounts constituted a "claim" under a legal malpractice policy that defined claim as "a demand received by the Insured for money or services." *Continental Cas. Co. v. Jewell, Moser, Flecther & Holleman*, 2005 WL 1925964 (E.D. Ark. Aug. 11, 2005). Since the complaint was filed prior to the inception of the policy, the court held that the insurer properly denied coverage even though an amended complaint seeking monetary damages was filed during the policy period.

Court Orders Arbitration of Defense Costs

The Indiana Court of Appeals has affirmed a trial court's grant of an insurer's motion to compel arbitration regarding a policyholder's breach of contract claim and its denial of the insurer's motion to compel arbitration of the policyholder's bad faith claim. *Hemocleanse, Inc. v. Philadelphia Indem. Ins. Co.,* 831 N.E.2d 259 (Ind. Ct. App. 2005). The insurer issued a D&O policy to the policyholder that contained a clause stating "[a]ny coverage dispute which cannot be resolved through negotiations between any insured and the insurer shall be submitted to binding arbitration." Upon renewal, a "related party" exclusion barring coverage for claims by certain entities related to the policyholder was added to the policy. The policyholder subsequently initiated a lawsuit against three individuals regarding a transaction that involved an entity named in the related party exclusion. The individuals counterclaimed against the policyholder, and the insurer declined to defend the policyholder in connection with the counterclaims, relying on the related party exclusion. The policyholder then filed a lawsuit against the insurer, alleging causes of action for breach of contract and breach of the covenant of good faith and fair dealing. On appeal, the appellate court rejected the policyholder's contention that a dispute over defense costs is not a coverage dispute, holding "it is apparent to us that a dispute over defense costs is well within the meaning of the phrase 'coverage dispute'" because the policy at issue only provided coverage for certain defense costs. The court also rejected the policyholder's contention that the insurer waived its right to compel arbitration by failing to defend the policyholder under a reservation of rights or file a declaratory judgment action. Finally, the appellate court affirmed the trial court's rejection of the insurer's motion to compel arbitration of the policyholder's bad faith claim, reasoning that "[m]erely because resolution of the [bad faith] tort claim requires that a 'coverage dispute' be resolved does not make the tort claim a 'coverage dispute'" within the meaning of the policy's arbitration clause.

Contingent Interest in Policy Proceeds Is Insufficient Grounds for Intervention

A U.S. magistrate judge of the United States District Court of the District of Colorado has issued a report and recommendation recommending denial of a chapter 11 Trustee's motion to intervene in a coverage action filed by an insurer against the directors and officer of the policyholder corporation. *Genesis Ins. Co. v. Crowley,* Case No. 05-00335-WDM-PAC (D. Colo. Aug. 31, 2005). Wiley Rein & Fielding LLP represented the

insurer in this case. The Trustee moved to intervene as of right in the coverage action, asserting that he had a "clear interest" in the policy proceeds because the availability of policy proceeds would impact his ability to collect any judgment he might obtain in the underlying action against the individual insureds. Noting that the Tenth Circuit has not addressed the issue and that federal courts across the nation are split on whether a contingent interest in insurance proceeds is sufficient grounds for intervention as a matter of right, the court held that the Trustee's contingent interest in insurance proceeds was insufficient to permit intervention as of right. The court further held that intervention as of right was also improper because the Trustee had failed to make a sufficient showing that the current parties to the action could not adequately represent the Trustee's interests. Finally, the court rejected permissive intervention as well as intervention as of right, again noting that the Trustee had failed to show why the insureds were not adequately protecting the Trustee's interests in the case.

Insurer Estopped from Denying Coverage

A Virginia circuit court has held that an insurer, whose professional liability policy covered a physician and his practice, failed properly to notify the practice of its coverage position when the insurer sent its reservation of rights letter to the physician's home and the letter failed to reference the policy provisions applicable to the corporate entity. *Estate of Feury v. Princeton Ins. Co.,* 2005 WL 1862629 (Va. Cir. Ct. Aug. 9, 2005). The court further held that the policy's "criminal acts" exclusion operated to bar coverage only where the criminal act directly causes the resulting injury. With respect to the first issue, the court observed that Virginia law requires an insurer to inform all insured parties of its position in a timely manner or else it is estopped from denying coverage. Because the insurer's reservation of rights referenced neither the practice nor the policy provisions applicable to corporate entities, the court deemed the letter inapplicable as to the practice and held that the insurer was estopped from denying coverage as to the insured practice. With respect to the criminal acts exclusion, the court explained that the mere involvement of criminal activity failed to trigger the exclusion. The policy stated that insurance does not apply to "injury resulting from your performance of a criminal act," which the court interpreted as applying to injury that is the "direct" result of a criminal act. Because the criminal act at issue (illegal possession of a drug) did not directly lead to the injury (death from taking the drug), the court held the exclusion inapplicable.

Insurer Not Estopped from Denying Coverage Despite Delay Raising Grounds for Denial

The United States Court of Appeals for the Eleventh Circuit, in an unpublished opinion applying Florida law, has affirmed a magistrate judge's determination that: (1) no coverage existed under a claims-made E&O policy for claims reported outside the policy period and (2) the insurer was not estopped from denying coverage, despite its delay in raising the specific grounds for its denial. *Solar Time Ltd. v. XL Specialty Ins. Co.,* 2005 WL 1803578 (11th Cir. Aug. 2, 2005). Briefly addressing the first issue, the court noted that the claims-made policy at issue covered only those claims based on a negligent act occurring during the policy period that are reported during the policy period and that, here, the insured failed to report its claim during the policy period. With respect to the second issue, the court considered whether the insurer's delay in raising the particular grounds for its coverage denial prejudiced the insured. The court found no prejudice, explaining that the insured received a defense at the insurer's cost to which the insured was not entitled and likewise received appellate defense costs in exchange for a release of claims against the insurer. The court further

observed that, while the insurer issued reservation of rights letters that failed to mention the insurer's ultimate defense, the letters specifically provided that the insurer waived no defenses or rights.

Court Distinguishes "Duty to Defend" from "Duty to Advance Defense Costs"

The United States District Court for the Northern District of Illinois, in an unpublished opinion applying Illinois law, has held that an insurer has no duty to advance defense costs where policy provisions vesting the insurer with discretion as to whether to advance those costs are clear and unambiguous. *Seeger v. Gulf Underwriters Ins. Co.,* No. 04 C 7176 (N.D. Ill. Mar. 17, 2005). In reaching this conclusion, the court rejected the policyholders' claim that the test and analytical framework for the "duty to defend" and the "duty to advance defense costs" are interchangeable and thus declined to apply the former to assess the latter. In doing so, the court noted the policyholders' failure to cite any binding authority for its assertion. Moreover, the court indicated that the policyholders' position failed to give effect to policy provisions agreed to by the parties. Under the clear and unambiguous policy terms, the insurer must advance only those costs that it "in its discretion believes" are covered. Because the policyholders (a) offered no evidence that the insurer believed or admitted that the costs were covered and (b) failed to establish that the defense costs fell within the terms of the policy, the court denied their motion for partial summary judgment.

California Court Dismisses Tort Claims in Nonrenewal Case

A California appellate court has affirmed dismissal of a policyholder's complaint for fraud, defamation and unfair business practices, determining that the complaint failed to state a sustainable cause of action. *Alaiti v. Scpie Indem. Co.*, 2005 WL 2001921 (Cal. Ct. App. Aug. 22, 2005). The policyholder, a plastic surgeon, obtained a professional liability policy from the insurer that allowed the insurer to refuse to renew coverage for any reason. During the policy period, the policyholder was sued for malpractice and disagreed with the insurer over defense strategy. After the case settled, the insurer sent the policyholder a notice of nonrenewal, citing, *inter alia*, "concerns" with the physician's standard of care in the settled case. The insured asserted that the language in the nonrenewal notice forced him to have to purchase new coverage with a different carrier at a substantially higher premium. Under a California statute, insurers may refuse to renew policies, provided written notice is made in a timely manner, without incurring liability. The insurer therefore argued that the suit was nothing more than "an end run" around the law, but the court disagreed with the scope of this interpretation. Although the court dismissed each cause of action on the merits, it stated that the insurer was "not immunized from liability for defamation and other torts simply because [the claims arise] in the context of nonrenewal."

Intentional Acts Not Covered Under Managed Care Professional Liability Policy

An Illinois appellate court has granted summary judgment to an insurer, holding that the intentional acts alleged in the underlying suit were not "Wrongful Acts" as defined by the policy and, therefore, that the insurer had no duty to defend or indemnify the policyholder. *Steadfast Ins. Co. v. Caremark RX, Inc.,* 2005 WL 1981053 (Ill. App. Aug. 17, 2005). The plaintiffs in the underlying class action suit, members of a retirement plan for which the policyholder acted as a pharmacy benefits manager and fiduciary, alleged that the policyholder "secretly and subversively" increased the price of drugs to plan members, thereby breaching its duties as a fiduciary under ERISA. The policy defined a "Wrongful Act" as any "alleged or actual negligent act, error, or

omission" in rendering professional services. The appellate court determined that the alleged acts were intentional in nature and, accordingly, that neither the duty to defend nor the duty to indemnify was implicated.

For more information, please contact us at 202.719.7130