Wiley Rein & Fielding

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The Executive Summary

Developments Affecting Professional Liability Insurers

Northern District of Illinois Rules I v. I Exclusion Bars Claim

The United States District Court for the Northern District of Illinois, applying Illinois law, has held that an insured's claim for coverage in connection with a securities class action lawsuit is barred by the I v. I exclusion in a D&O policy because the insured provided information to the securities class plaintiffs that allowed them to reach a "more advantageous settlement" with the insured defendants. *Denari v. Genesis Ins. Co., et al.* (N.D. Ill. Dec. 12, 2003). In addition, the court accorded preclusive effect to a prior determination in a related action that fees incurred by the plaintiff in objecting to the underlying securities settlement or seeking coverage did not constitute "Cost of Defense" as defined by the operative policy because they were incurred in connection with the plaintiff's affirmative claims.

The policyholder company procured D&O coverage from two insurers. The policy issued by the first insurer contained an I v. I exclusion which, among other things, excluded coverage for all claims "brought by or at the behest of, or with the assistance or active participation of" any insured under the policy. A second insurer had an I v. I exclusion in its policy; however, the policy lacked the "assistance or active participation" language of the first insurer's policy.

The company and several directors and officers were named in a securities lawsuit. One of the defendant officers provided information to the underlying plaintiffs. Once a proposed settlement was reached, the same officer hired counsel to attempt to derail the settlement. Those efforts failed, and the settlement was ultimately approved. The objecting officer then brought suit against the company's two D&O insurers seeking recovery for fees incurred in objecting to the settlement as well as fees for his coverage action. The officer also asserted that he was entitled to extra-contractual damages under Illinois law because the insurers had refused to pay the costs incurred in objecting to the settlement. Both insurers argued that their policies' I v. I exclusions barred coverage because the officer had actively assisted the underlying securities plaintiffs.

After determining that the officer had failed to rebut the insurers' showing that he had provided affirmative assistance to the plaintiffs, the court granted summary judgment to the first insurer with respect to all fees incurred after the date the officer first provided assistance to the plaintiffs based on the plain language of the I vs. I exclusion. The court denied summary judgment to the second insurer, however, reasoning that its policy lacked the "assistance or active participation" language of the first insurer's policy.

The court also determined that the officer's efforts to derail the settlement or to seek coverage under the D&O policies

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Also in This Issue

Bankruptcy Court Stays Litigation of Rescission Action Against Adelphia Directors and Officers

The United States Bankruptcy Court for the Southern District of New York has stayed the litigation of rescission issues in a declaratory judgment action brought by Adelphia's D&O insurers. *Adelphia Communications Corp., et al. v. Associated Elec. & Gas Ins. Servs., et al. (In re Adelphia Communications Corp.)*, Adv. Proc. No. 03-09580 (Bankr. S.D.N.Y. Dec. 5, 2003). The bankruptcy court also held that the coverage litigation could continue as to the remainder of the coverage issues, including whether the insurers are obligated to advance defense costs until any judicial determination that the directors and officers are not entitled to coverage.

In March and June 2002, Adelphia and its affiliate (collectively, "Adelphia") filed voluntary petitions for relief under chapter 11. Subsequently, the United States Department of Justice brought criminal charges against five Adelphia directors for conspiracy and securities fraud, the Securities and Exchange Commission sued Adelphia and five directors seeking disgorgement of ill-gotten gains and civil penalties and shareholders filed several securities lawsuits against Adelphia and its directors and officers for securities fraud.

In September 2002, several Adelphia directors and officers requested relief from the automatic stay to permit the advancement of defense costs under Adelphia's D&O policies. Thereafter, the insurers sought to rescind the policies based on fraud and brought a declaratory action against the Adelphia directors and officers. At the same time, the insurers moved for relief from the automatic stay "to the extent necessary" to name Adelphia and its affiliate as additional defendants in the declaratory judgment action. In response, Adelphia filed an adversary proceeding against the insurers seeking to enjoin the further prosecution of the coverage action grounded in either the automatic stay or the bankruptcy court's equitable powers under Section 105 of the Bankruptcy Code.

Initial Bankruptcy Court Decision

The bankruptcy court initially denied the insurers' motions for relief from the automatic stay to pursue coverage litigation against Adelphia and held that the automatic stay applied to the insurers' pending coverage litigation against Adelphia's directors and officers. The bankruptcy court, however, did grant relief from the automatic stay to five Adelphia directors to make a claim for payment or advancement of up to $300,000 per insured for defense costs. As a predicate for its holdings, the bankruptcy court determined that the D&O policies, which provided entity coverage for securities claims, and their proceeds were property of the bankruptcy estate.

District Court Decision

The district court vacated the bankruptcy court decision, holding that the D&O policy proceeds are not property of the bankruptcy estate. *See In re Adelphia Communications Corp.*, 298 B.R. 49 (S.D.N.Y. 2003). The court reasoned that although the D&O policies afforded entity coverage, the debtors did not have a "cognizable equitable and legal" property interest in the policies at this juncture because: (1) the debtors had not made or contemplated making any payments for which they would be entitled to indemnification coverage, and (2) no claims for entity coverage were pending. Instead, the court characterized the debtors' interest as "akin to a car owner with collision coverage claiming he has the right to proceeds from his policy simply because there is a prospective possibility that his car will collide with another tomorrow." Having determined that the automatic stay did not apply to the rescission action, the court remanded the case to the bankruptcy court to determine whether the litigation should be stayed under Section 105 of the Bankruptcy Code, a provision that has been construed liberally to enjoin suits against third parties that might impede the reorganization process.

Bankruptcy Court's Decision on Remand

With respect to the insurers' attempts to add Adelphia to the coverage action, the bankruptcy court held on remand that the automatic stay or, at a minimum, Section 105(a), would apply to enjoin such litigation or any other act by the insurers seeking to rescind the D&O policies as to Adelphia. The court reasoned that (1) the insurance policies themselves are estate property and thus the automatic stay applies; and (2) that the "destruction" of the policies or the loss of their value that would result if the insurers were successful would be detrimental to Adelphia's reorganization efforts.

Turning to the insurers' rescission claim against the Adelphia directors and officers, the bankruptcy court also held that it was appropriate to enjoin the insurers' rescission claim against the directors under Section 105(a) because the litigation "threatened to thwart or frustrate" Adelphia's reorganization efforts. The court reasoned that although Adelphia is not a party to the coverage action, it has "legitimate concerns as to possible prejudice to [it] under principles of collateral estoppel or *stare decisis*." While the court recognized uncertainty about those doctrines' possible application in subsequent litigation involving the subsidiaries, it also explained "that most courts are loath to come to a

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North Dakota Supreme Court Upholds Agreement by Policyholder to Assign Claim Against Insurer to Underlying Plaintiff

The Supreme Court of North Dakota has held that a settlement in which a policyholder stipulates to a judgment in an underlying action in exchange for a covenant by the plaintiff to execute against only the policyholder's insurer is valid and that the underlying plaintiff was therefore entitled to bring a negligence claim against the insurer and the insurer's agent for failure to issue proper coverage. *Wangler v. Lerol*, 2003 WL 22674285 (N.D. Nov. 13, 2003). The court also held that based on the facts at issue, the insurer was not estopped from denying coverage.

An employee of the policyholder company was injured while working on a turkey farm. In July 1999, the employee brought a negligence action against the company, which then submitted the claim to its insurer, under a farm liability policy. After the insurer withdrew coverage on the grounds that the company (unlike two of its affiliates) was not a named insured under the policy, the company filed suit against the insurer and its agent, alleging that they negligently failed to procure insurance on its behalf. Subsequently, the underlying litigation settled pursuant to an agreement in which the company and the injured employee stipulated to a judgment in favor of the employee in an amount of $200,000, the company assigned its right against the insurer and the agent to the employee and the employee agreed "in no way to collect this judgment" from the employer. The court referred to this settlement as a *Miller-Shugart* settlement. *See Miller v. Shugart*, 316 N.W.2d 729 (Minn. 1982).

The court first rejected the argument that the insurer was estopped from denying coverage because the insurer's agent never expressly denied that the company was insured when asked during the company's annual review of its insurance policies. The court reasoned that "the doctrines of waiver and estoppel will not operate to create an insurance contract

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Court Applies "Deliberate Acts" and "Law Enforcement" Exclusions in Municipal Policy

A federal district court in Pennsylvania, applying Pennsylvania law, has held that an insurer was not obligated to defend or indemnify a city and city officials who were sued for civil rights violations in connection with a racially motivated murder that went unsolved for more than thirty years because the allegations fell within the "deliberate acts" and "law enforcement" exclusions in the city's public officials and employment practices liability policy. *Clarendon Nat'l Ins. Co. v. City of York, PA*, 2003 WL 22519921 (M.D. Pa. Nov. 6, 2003).

The city of York, Pennsylvania purchased a public officials and employment practices liability policy. The policy excluded claims "[a]rising out of the deliberate violation of any federal, state, or local statute, ordinance, rule, or regulation committed by or with the knowledge and consent of the insured[.]" Additionally, the policy specified that no "law enforcement department or agency" was insured and specifically excluded claims "[a]rising out of operational law enforcement functions and activities…."

The underlying litigation against the city of York was the result of an investigation into the shooting death of an African-American citizen of York during racial violence in July of 1969. Ultimately, two former York police officers were found guilty of the thirty-year old murder and the surviving family members of the victim filed the underlying civil suit alleging numerous civil rights violations against the city and individual former police officers. After the civil rights action was filed, the city of York tendered defense of the action to the insurer under the public official and employment practices liability policy. The insurer denied coverage and filed a declaratory judgment action.

The district court held, based on a comparison between the allegations in the underlying complaint and the terms of the policy, that no coverage was available. The court reasoned that four of the counts in the underlying complaint alleged knowing and intentional violations of the plaintiffs' civil rights and that they therefore fell squarely within the "deliberate acts" exclusion. The court further determined that "[a]ll of the[] actions or inactions at the center of the…case relate to the police officers' duties as police officers" and that the "law enforcement" exclusion therefore barred coverage under the policy. Additionally, the court held that because the clear terms of the policy barred any possibility of coverage for the city's claim, the insurer had no obligation to defend the city in the underlying litigation. ✦

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I v. I Exclusion Does Not Bar Coverage for Claims Brought by Liquidator Against Trustees of Company

A federal district court in Illinois has held that the I v. I exclusion in a D&O policy does not bar coverage for claims brought against trustees of a workers compensation trust by the state-appointed liquidator of the trust. *QBE Int'l Ins. Ltd. v. Clark*, 2003 WL 22433117 (N.D. Ill. Oct. 24, 2003). The court also held that material issues of disputed fact precluded a ruling on the insurer's motion for summary judgment to rescind the policy.

The insurer issued a D&O liability insurance policy to a workers compensation trust formed under Illinois law. After a state court entered an order liquidating the trust, the director of the Illinois Department of Insurance became liquidator of the trust. Under the Illinois Insurance Code, the director was authorized to "both sue and defend on behalf of the Trust in his name as Liquidator of the Trust, or in the name of the Trust" and "on behalf of the creditors, members, policyholders or shareholders of the company." The liquidator subsequently brought suit in state court on behalf of the trust, as well as its creditors, members and policyholders, alleging that the trustees, who were insured under the policy, had breached their fiduciary duties to the trust and its participants.

The insurer argued that the plain language of the exclusion precluded coverage for any claim brought against the trustees by the liquidator on behalf of the trust.

The insurer denied coverage for the suit based on the I v. I exclusion contained in the policy. That exclusion provided that there is no coverage for claims made "by or on behalf of the Company or any Affiliates" or "by any security holder of the Company, whether directly or derivatively except where such security holder bringing such Claim is acting totally independently [of], and totally without the solicitation of, or assistance of, or participation of, or intervention of, any of the Directors and Officers, or the Company or any Affiliate." The insurer argued that the plain language of the exclusion precluded coverage for any claim brought against the trustees by the liquidator on behalf of the trust.

The district court explained that the Illinois Insurance Code empowered the liquidator to bring claims both on behalf of the trust itself and on behalf of the trust's participants. Although the court appeared to agree that if the liquidator had brought claims solely on behalf of the trust, those claims would be barred by the I v. I exclusion, it held that the exclusion did not apply in this case because the liquidator also brought claims on behalf of the trust participants. The court explained that but for the liquidation order, trust participants would have been able to bring such claims on their own behalf without running afoul of the I v. I exclusion. The court also reasoned that nothing in the policy prescribed a method for allocating between covered and non-covered claims and that exclusions should be narrowly construed. Finally, the court rejected the insurer's argument that the decision exposed it to a risk of collusion, explaining that the insurer had not shown any evidence of collusion between the liquidator and the trust in bringing the suit.

The insurer also moved for summary judgment on its right to rescind the policy because of material misrepresentations in the insured's application for insurance. The insurer first argued that the trust had failed to disclose changes in management in response to a direct question in the application for insurance. The application stated that the "underwriter will have relied upon this renewal application and attachments in issuing any policy.... If the information in this renewal application materially changes prior to the effective date of the policy, the applicant will notify the underwriter, who may modify or withdraw any quotation." While the trust's answer regarding changes in management was correct on the day the application was signed, the trust failed to inform the insurer when two of its trustees departed shortly thereafter, before the policy was issued.

The court agreed that the trust had failed properly to disclose the departure of one of the trustees, but it held that there was a factual dispute concerning whether the trust had properly disclosed the departure of the other trustee. Although the trust never updated the answers on its application, it did provide the insurer with board resolutions signed by its trustees that would, upon comparison, have

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Extended Reporting Period Available Even Where Policy Is Renewed

The United States Court of Appeals for the Eleventh Circuit, applying Florida law, has held that the extended reporting period in a claims-made and reported professional liability insurance policy is available even where a policy is renewed, thereby requiring the insurer to provide coverage for a claim that was made during one policy period and reported during a subsequent policy period. *Cast Steel Prods., Inc. v. Admiral Ins. Co.*, 2003 WL 22434728 (11th Cir. Oct. 28, 2003).

The insurer issued a claims-made professional liability policy to a mining and waste energy product manufacturer, which subsequently renewed the policy. The policy contained an extended reporting period provision stating that "[i]f the policy is cancelled or not renewed by the Named Insured, an automatic thirty (30) day Claims Extension Period shall apply to claims provided such claims are not covered under any subsequent insurance purchased by the Named Insured." The policy did not explicitly address whether this extended reporting period applied in case of renewal.

During the initial policy period, a third-party claimant alleged that one of the company's products was defective. As a result of an error by the company's insurance agent, however, the claim was not reported to the insurer until after the inception of the subsequent policy period. The insurer sought to deny coverage based on late notice and litigation ensued.

The court initially acknowledged that, under a claims-made and reported policy, coverage is generally afforded only for those claims that accrue and are reported during the policy period. The company argued, however, that the extended reporting period should also apply to a renewed policy, notwithstanding the language in the extended reporting provision. The court agreed with the company, reasoning that the extended reporting clause was ambiguous through its silence regarding whether the provision applied in cases of renewal. The court stated that the ambiguity must be interpreted against the insurer, concluding that the provision allowed for the reporting of a claim under a renewed policy where the claim accrued under the initial policy period. In so ruling, the court observed that it would be "both illogical and inequitable to deny coverage to the insured who chooses to renew its claims-made policy for successive years with the same insurer…." Therefore, renewing the policy "should not precipitate a trap where claims spanning the renewal are denied." The court thus held that "the most reasonable interpretation of the extended reporting clause is that it automatically extends the reporting period through renewal." ✦

"Stop Loss" Policy Not Claims-Made Policy; Notice Prejudice Rule Applies

The Northern District of California, applying California law, has determined that a "stop loss" policy is not a claims-made policy and that, as a result, an insurer must show actual prejudice in order to deny a claim based on late notice. *Operating Eng'rs Health & Welfare Trust Fund v. Mega Life & Health Ins. Co.*, 2003 WL 22416395 (N.D. Cal. Oct. 21, 2003).

The insurer issued a "stop loss" policy to an employee trust fund that provided medical and welfare benefits to union members and their dependents. The policy provided coverage for catastrophic medical claims by providing that the insurer would reimburse the trust fund for claims in excess of $250,000 and up to $1 million per claimant. The policy stated that "[r]eimbursement…will be made when the Company receives all of the information it requires for payment of reimbursements (Proof of Loss) [and the] Proof of Loss must be satisfactory to the Company and received by the Company no later than 90 days after the date Plan Benefits are paid…."

More than 90 days after the trust fund had paid medical benefits to five separate claimants totaling $1.3 million dollars, it submitted the proof of loss to the insurer seeking reimbursement. The insurer denied the claims, contending that the notice was both late and failed to provide "satisfactory" proof of loss. Litigation ensued.

Ruling on the parties' cross-motions for summary judgment, the court first addressed whether the 90-day notice provision set forth in the reimbursement section of the policy applied despite the absence of any mention of a time limit in the coverage part. The court determined that, in order to give effect to all terms and parts of the policy, the 90-day notice limitation applied to the claims regardless of the absence of a time limitation in the coverage part.

With respect to the sufficiency of the information provided in the notice, the court held that the terms "satisfactory" and "proof of loss" were ambiguous. The court concluded because these

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Ninth Circuit Holds Renewal Constitutes Separate and Distinct Policy

In an unreported decision, the United States Court of Appeals for the Ninth Circuit, applying California law, has held that the renewal of an existing insurance policy creates a new policy for purposes of determining the timeliness of a notice of potential claim. *St. Paul Fire & Marine Ins. Co. v. "K" Line Am., Inc.*, 2003 WL 22508197 (9th Cir. Oct. 31, 2003).

In 1992, the insurer issued a one-year, claims-made insurance policy to the policyholder company. The policy provided coverage for "claims or suits brought against the Insured during the policy period provided the Insured had no knowledge or could not have reasonabl[y] foreseen that such negligent act, error, or omission whenever occurring could be the basis of a claim or suit, at the time this policy took effect." The company renewed the policy annually through 1998.

The company provided notice of a potential claim in 1998; however, the trial court had held that the insurer could deny coverage because the company should have given the insurer notice of the potential claim by at least 1997. On appeal, the Ninth Circuit affirmed the lower court's decision and rejected the company's argument that the timing of the notice was irrelevant because it had purchased a single, continuous policy of insurance from 1992 to 1998. The court held instead that a renewal constitutes a "separate and distinct contract for the period of time covered by the renewal." Accordingly, the court concluded that the policy barred coverage because the insured had failed to make its claim during the policy period when it first became aware of the claim. ✦

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were not covered under either policy. With respect to the first insurer, the court accorded preclusive effect to a ruling made in connection with the securities litigation that specifically determined that the officer's efforts to obtain coverage or to oppose the settlement were incurred in connection with "asserting [the plaintiff's] own affirmative claims or positions" and thus did not constitute "Cost of Defense" as defined by the policy. Although the prior ruling did not involve the second insurer, the court found the underlying logic of the prior ruling persuasive, and determined that the officer's claim for the same fees under the policy was likewise without merit, as they were not costs incurred in "defending or investigating claims," and thus were not defense costs as defined by the policy.

Finally, the court determined that the claims by the officer for extra-contractual damages and civil conspiracy failed as a matter of law. According to the court, under Illinois law, extra-contractual damages must be supported by "vexatious and unreasonable" conduct, which is not present where an insurer asserts a legitimate policy defense or there is otherwise a bona fide coverage dispute. Accordingly, as the insurers' coverage defenses were meritorious, the court denied recovery under the statute. Similarly, because the first insurer acted lawfully in accordance with its policy's plain language, the court held that the officer could not show the requisite "unlawful purpose" to support his civil conspiracy claim under Illinois law.

Wiley Rein & Fielding LLP represented the first insurer in connection with this matter. ✦

"Stop Loss" Policy Not Claims-Made Policy; Notice Prejudice Rule Applies

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terms were not defined in the policy, the trust fund's reasonable expectations would apply. Since, based on the record, the court could not discern the trust fund's reasonable expectations, it simply read the ambiguity against the insurer.

Finally, the court addressed the trust fund's argument that the insurer must demonstrate that it was prejudiced by the trust fund's non-compliance with the 90-day notice provision. The insurer argued that the policy was similar to a claims-made policy and therefore not subject to the notice prejudice rule. The court disagreed, holding that there was nothing in the policy to suggest that a claim for coverage must be made during a policy period. After determining that the excess policy was subject to the notice prejudice rule, the court focused on whether the insurer had shown that it was actually prejudiced by the policyholder's late notice of the claims. The insurer argued that the late notice impaired its ability to investigate the claims and increase premiums. The court, however, determined that the question of prejudice was a genuine issue of material fact and could not be resolved at the summary judgment stage. ✦

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Under Choice of Law Analysis, Law of State Where Contract Was Negotiated and Premiums Paid Applies

A federal district court in Pennsylvania, applying Pennsylvania's choice of laws rules, has held that Maryland law would govern the determination of how defense and indemnity costs should be allocated among several insurers because the insurance contract was negotiated, signed and performed in Maryland. *Manor Care, Inc. v. Cont'l Ins. Co.*, 2003 WL 22436225 (E.D. Pa. Oct. 27, 2003).

A nursing home company purchased various professional and general liability insurance policies and was also self-insured for a period of time. The company's facilities were located in more than 30 states, with 17.6 percent of its facilities in Pennsylvania. The insurance policies at issue were negotiated and signed in Maryland, and the premiums were paid in Maryland. After the company was sued in 13 states concerning the level of care it was providing, it sought coverage from its insurers, and coverage litigation ensued.

One of the issues in the coverage dispute concerned how to allocate costs and reimbursement among multiple insurers when a claim implicates more than one insurance policy. The parties moved for summary judgment as to whether Maryland or Pennsylvania law should apply, and the court found that there was a conflict between the laws of the two states. Maryland prorates indemnity and defense duties among insurers based on "their time on the risk," accounting for any periods of self-insurance. By contrast, Pennsylvania takes a joint and several approach, allowing an insured to choose which policy will indemnify and defend it, even if an event triggers coverage under several policies.

The court held that Maryland law applied because the contract had been negotiated and signed in Maryland, and the premiums were paid in Maryland. In so holding, the court rejected the argument that Pennsylvania was the principal location of the insured risk because more of the company's facilities were located in Pennsylvania than in any other state. The court noted that most of the company's facilities were not in Pennsylvania, but instead were distributed among 30 states. The court therefore concluded that "because Maryland is the state with the most significant relationship to this dispute, and the state with the greatest governmental interest in interpreting" the relevant underlying policy, its law should apply. ✦

Former Subsidiary Has Right to Enforce ADR Clause in Policy

The United States Court of Appeals for the Seventh Circuit has held that a former subsidiary was entitled to arbitration under the parent company's professional liability policy, but that the insurer had not waived its right to object to such arbitration. *Am. Int'l. Spec. Lines Ins. Co. v. Elec. Data Sys. Corp.*, 347 F.3d 665 (7th Cir. 2003).

An insurer issued a professional liability policy that provided specified coverage to a company and to certain past Subsidiaries of the Named Insured. The policy covered "claims of liability that are first made against the Insureds during the Policy Period" arising out of "wrongful acts" committed by the Insureds. "Insureds" was defined as "any subsidiary of the Named Insured, but only with respect to wrongful acts which occur while it is a subsidiary and are otherwise covered by this policy." The policy also stated that disputes under the policy "shall be subject to the alternative dispute resolution process (ADR) set forth in" the policy, and "the Named Insured shall act on behalf of all Insureds in selection of the ADR in accordance with this clause."

A former subsidiary of the policyholder was sued in connection with work that it did for the New York Police Department. The subsidiary had been a subsidiary of the policyholder company at the time it completed the work for the police department, but it was sold before the department made its claim for damages. The subsidiary tendered a claim to the policyholder's insurer for the suit against it and invoked the ADR clause of the policy, demanding arbitration. The insurer filed suit to enjoin the arbitration and to obtain a declaration that the subsidiary's claim had no merit. The trial court ordered arbitration. After the arbitrator awarded a judgment of $14 million against the insurer, the insurer appealed, arguing that the subsidiary was not entitled to arbitration.

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"Bodily Injury" and "Assault and Battery" Exclusions Held Inapplicable to Claims Against School Board After Teacher Molested Student

A Kentucky appellate court, in an unpublished opinion, has held that an insurer that issued an educators legal liability insurance policy to a school board had a duty to defend the school board in a suit brought by a student after he was allegedly molested by a teacher even though the policy contained exclusions for claims arising out of bodily injury and out of assault and battery. *Kentucky Sch. Bd. Ins. Trust v. Bd. of Educ., 2003 WL 22520018 (Ky. App. Nov. 7, 2003).*

An insurer issued an educators legal liability insurance policy to a school board that provided coverage for "any civil claims" that any members of the board of education became "legally obligated to pay…because of a wrongful act." The policy contained exclusions for "[a]ny claim based upon or arising out of bodily injury, sickness, disease or death, mental or emotional injury or distress" and "[a]ny claim based upon or arising out of false arrest, assault and battery, detention or imprisonment."

The insured was sued by a former student at the county high school, who alleged that he had been enrolled in special education classes taught by a teacher who coerced him into having a sexual relationship. The complaint asserted that the board of education was liable for violation of his substantive due process right to be free from sexual molestation by his teacher, violation of his right to bodily integrity, negligent hiring and failure to provide a safe school environment. The complaint further contended that the board knew or should have known about the sexual molestation and about the fact that the teacher had a history of drug abuse and behavioral problems when she was hired.

The court rejected the insurer's argument that the phrase "arising out of" in the policy requires only a causal connection between the assault and battery and the lawsuit's allegations.

After the board tendered the claim to the insurer, the insurer denied coverage and refused to defend on the grounds that the allegations against the board were excluded because they arose out of bodily injury and assault and battery. The school board then filed suit against the insurer.

The appeals court held that coverage was available notwithstanding the exclusions in the policy. The court rejected the insurer's argument that the phrase "arising out of" in the policy requires only a causal connection between the assault and battery and the lawsuit's allegations. Relying on *Yeller v. Nationwide Mutt's Fire Insurance Co.*, 824 S.W.2d 855 (Ky. 1992), the court explained that the policy's exclusionary language required the claim to result directly from the assault and battery or the mental or bodily injury in order for the exclusion to apply. Here, there was no allegation that the school board had engaged in the excluded behavior. The court cited support for its reasoning from a factually similar case, *Board of Public Education v. National Union Fire Insurance Co.*, 709 A.2d 910 (Penn. 1997), in which the Pennsylvania Supreme Court had held that an underlying plaintiff's claims for negligent supervision did not "arise out of" an assault and battery or bodily injury, as defined by an insurance policy issued to the school board. The court concluded, quoting *Watkins Glen Central School District v. National Union Fire Insurance Co.*, 732 N.Y.S.2d 70 (App. Div. 2001), that "[b]ecause the alleged liability of the Board is predicated upon its conceptually independent negligent supervision, application of the subject exclusions would 'effectively eviscerate [the policy] altogether.'" ✦

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Insurer May Recoup Defense Costs Absent Duty to Defend; Reservation of Rights Preserves Right to Recoup Costs

The Supreme Court of the Territory of Guam, applying Guam law, has held that where a professional liability policy obligates an insurer to advance defense costs, but does not impose a duty to defend, the insurer may recoup defense costs for allegations "for which there was no possibility of coverage." *Nat'l Union Fire Ins. Co. v. Guam Hous. & Urban Renewal Auth.*, 2003 WL 22497996 (Guam Terr. Nov. 4, 2003). The court also held that the right to recoup costs was preserved by a unilateral reservation of rights that was timely made, and specifically notified the policyholder that the insurer may seek reimbursement of defense costs.

The insurer had issued a public officials and employees liability insurance policy to a governmental agency. The policy provided that "[w]ith respect to any such Wrongful Act for which insurance is afforded by this policy…the Company shall, as part of and subject to the limits of liability, pay on behalf of the Insured Defense Costs, Charges and Expenses." The policy also stated that the insurer had "the right but not the duty to assume the defense of any claim or suit against the Insured." The policy excluded coverage for "any Wrongful Act committed with knowledge that it was a Wrongful Act"; "claims alleging…malicious acts"; "any claim seeking non-pecuniary relief"; "any awards…of back salary or wages"; and "fines, penalties, or punitive, exemplary or multiplied damages."

The coverage action arose from three wrongful termination lawsuits filed by former employees of the agency, who alleged that the agency violated their constitutional and statutory rights and breached their employment contracts. The first two lawsuits sought compensatory, treble and punitive damages, reinstatement of the employees to their former positions and back pay commencing from the date of termination. The third lawsuit requested reinstatement, back pay, interest and costs. After the first lawsuit was filed, the insurer agreed as an accomodation to defend and reserved the insurer's right to withdraw from the defense and to "seek reimbursement of defense costs incurred [in] defending claims for which there is no potential for coverage." The insurer subsequently agreed to defend the second and third lawsuits, but did not issue a further reservation of rights. After the three lawsuits were dismissed, the insurer sought reimbursement for defense costs incurred in the three actions. Coverage litigation ensued.

The court initially explained that under the terms of the policy, the insurer did not have a duty to defend, but instead had an obligation to pay defense costs for claims "for which there was a possibility of coverage." However, since the insurer did not have a duty to defend, it could seek to recoup defense costs for claims for which there was no possibility of coverage.

The court then reviewed the counts in the complaints to determine which ones were potentially covered. The court held that the insurer had a duty to pay defense costs related to the claims in the first two lawsuits that the agency had violated the employees' constitutional rights, holding that the exclusion for "any Wrongful Act committed with knowledge that it was a Wrongful Act" did not preclude coverage for the constitutional claims, even though the claims required proof of more than negligence. The court reasoned that the plain language of the exclusion precluded coverage only for "intentional acts which were done with appreciation of [their] wrongfulness," and not for acts that were merely intentional. The court stated that neither the employees' constitutional claims nor almost any other possible causes of action required such proof, but opined that if the insurer "intended the exclusion to cover intentional acts, it could have drafted the exclusion more precisely." The court also concluded that the breach of contract counts in the first two lawsuits were "more properly viewed as one[s] to vindicate constitutional rights," and consequently held that the defense costs related to these counts were covered. However, the court concluded that the policy precluded coverage for back pay and wages, reasoning that since the policy exclusions precluded coverage for "awards" of such amounts and not specifically for "claims" seeking these amounts, the policy necessarily precluded coverage for counts whose sole relief requested is excluded. The court also held that the exclusion for "fines, penalties, or punitive, exemplary or multiplied damages" precluded coverage for the employee's treble damages request. The court noted that even though the remainder of the exclusion allowed coverage for up to $25,000 of punitive damages "where permitted by law," this provision did not apply because punitive damages were non-recoverable in suits against governmental entities.

The court next held that the insurer did not have a duty to pay defense costs for the employees' demands for reinstatement and back pay. The court first reasoned that injunctive relief did not qualify as "damages" under the policy, and that the policy specifically precluded coverage for any non-pecuniary relief. Moreover, "to the extent that back pay is considered damages," the court held that the back pay and wages exclusions precluded coverage. Finally, the court concluded that even though the plaintiffs sought punitive damages in

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North Dakota Supreme Court Upholds Agreement by Policyholder to Assign Claim Against Insurer to Underlying Plaintiff

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that never existed" and that the cases where a court has estopped an insurer from denying coverage have "involved situations in which the misrepresentations were in the form of a definite statement or act indicating that a particular insurance policy provided a specific type of coverage." Here, the court found there was no allegation of any definite statement by the insurer or its agent that could create coverage by estoppel.

The court then turned to the question whether the insurer and its agent had been negligent in issuing the policy. The insurer argued that the employee could not pursue the negligence claim because he released his claim against the company when he entered into the *Miller-Shugart* agreement, which meant that the company no longer had a basis for seeking coverage. The court first explained that under a typical liability policy, an insurer must only reimburse an insured for amounts that the insured becomes "legally obligated to pay." The court noted that other courts have taken differing views as to how this language impacts stipulated judgments and covenants not to execute. It noted, however, that the majority of courts have held that a stipulated judgment coupled with a covenant not to execute is merely a contract, and not a release, so that the underlying tort liability remains and the insurer retains its obligation to pay. The court adopted the majority rule, holding that a stipulated tort judgment coupled with an agreement not to execute against the insured is not a release of the insured's liability. The court explained that any other interpretation would render *Miller-Shugart* type agreements useless because an insured abandoned by its insurer "would be precluded from settling within policy limits with injured third parties." The North Dakota Supreme Court therefore remanded the case to the trial court to determine whether the insurer and its agent had, in fact, acted negligently. ✦

I v. I Exclusion Does Not Bar Coverage for Claims Brought by Liquidator Against Trustees of Company

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shown that the trustee had departed the trust. The court held that whether these documents were sufficient to give the insurer notice of the change in management was an issue for the jury. The court also held that fact issues existed as to whether the alleged misrepresentations were material to the insurer's decision to issue the policy. Although the application specifically requested information regarding changes in management, the court noted that the insurer's employees were unable to recall ever declining an application for insurance based on a change in a company's board of directors.

The insurer also argued it was entitled to rescind the policy because the trust made material misrepresentations about its financial condition. At the time the trust was applying for insurance, it faced a deficit, and represented that it intended to charge its members an increased premium in order to eliminate the deficit. The insurer asked to be kept informed of the members' response to this proposal. The trust represented that the response from its members was "healthy," and that it had obtained full payments from various members. During the litigation, however, employees of the trust testified that the members' response could hardly be characterized as "healthy," and that at the time the trust represented that it had received a "healthy" response, it had collected only $11,000 of its $1.5 million deficit.

The district court noted that the document containing the trust's representation of a "healthy" response was not anywhere in the insurer's underwriting files, creating a fact issue as whether the insurer relied on the representation. The court further observed that the insurer never asked the insured to define the term "healthy" and never asked how much money the trust had collected from its members. Accordingly, the court denied summary judgment to the insurer based on material issues of disputed fact. ✦

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Bankruptcy Court Stays Litigation of Rescission Action Against Adelphia Directors and Officers

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completely different decision about an identical policy involving an identically situated party." Accordingly, the risk that Adelphia might potentially be collaterally estopped was sufficient to warrant a stay of the rescission issues in the coverage action under Section 105(a).

The bankruptcy court also stayed deposition discovery under Section 105(a) for the non-rescission related aspects of the coverage action, reasoning that if the defendants being prosecuted criminally "were called upon to testify and then [they] took the Fifth Amendment, there is a risk that adverse consequences might attach not only to [those directors], but also" to Adelphia and its reorganization efforts.

Finally, the bankruptcy court held that the directors and officers could continue to litigate whether the insurers are obligated to advance defense costs unless and until there is a judicial determination of no coverage, such as a finding that they are guilty of wrongdoing. The directors and officers agreed to limit their requests for defense costs to $300,000 per insured. (In total, 10 insureds are each seeking $300,000 from a $50 million insurance tower.) The court explained that the concession by directors and officers to limit the amount of defense costs that would be sought was significant because "[w]ithout it, unlimited drains on policy proceeds would have the effect of destroying the policies themselves."

Interestingly, the court acknowledged the unfairness of permitting the directors and officers to litigate "an asserted duty of the insurers to advance defense costs" without likewise permitting the insurers to litigate issues relating to rescission, but indicated that it was constrained to follow the district court's mandate and that the insurers could raise this issue in the coverage action. Moreover, in footnote 38, the bankruptcy court set forth a number of counterarguments to the district court's holding that D&O policy proceeds are not estate property that "the bankruptcy community will likely wish to consider when this issue arises next." ✦

Insurer May Recoup Defense Costs Absent Duty to Defend; Reservation of Rights Preserves Right to Recoup Costs

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the first two lawsuits and the policy excluded coverage for malicious acts and punitive damages, coverage for these lawsuits was not precluded because the lawsuits potentially could also have resulted in covered compensatory or nominal damages. The court held that no coverage was afforded for the third lawsuit because the plaintiffs sought only reinstatement and back pay, which were excluded by the policy.

The court then held that the insurer had preserved its right to recoup defense costs in a reservation of rights letter. Relying heavily on the decision by the United States Court of Appeals for the Sixth Circuit in *United National Insurance Co. v. SST Fitness Corp.*, 309 F.3d 914 (6th Cir. 2002), the court concluded that "the use of a unilateral reservation of rights letter is appropriate to apprise the insured of the fact that it cannot accept the windfall of defense costs for which it was not entitled to under the Policy." In so holding, the court reasoned that the insured had no reasonable expectation of coverage for defense costs that relate to claims that "are not potentially covered," and thus had a duty to reimburse the insurer for such amounts which the insurer advanced under a sufficient reservation of rights. The court explained that a reservation of rights protected this interest when made "in a timely and explicit manner" with "specific and adequate notice of the possibility of reimbursement." The court further noted that although the insurer's reservation of rights acknowledged only the first lawsuit, the insurer had reserved its right to recoupment with respect to all three lawsuits because the letter met the necessary criteria and "was broad enough to extend to all suits involving the claims raised in [the first lawsuit.]" In so holding, the court reasoned that the first lawsuit's claims "were the exact same claims in the later two suits," and that it would be "disingenuous" for the agency to claim that it was not notified of the insurer's position with respect to the latter two suits after having received the insurer's reservation of rights letter and accepted the insurer's defense.

Finally, the court remanded the case to the trial court to determine whether the insurer could demonstrate which portion of the defense costs were attributable to non-covered claims, and whether the insurer had made its claim for reimbursement from the agency within the relevant deadlines imposed by Guam's Claims Act. ✦

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Former Subsidiary Has Right to Enforce ADR Clause in Policy

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The court first rejected the subsidiary's procedural argument that the insurer had waived its right to object to the arbitration because it had willingly participated therein. The court reasoned that the insurer had not waived its objection because it had initially objected to ADR and participated in the arbitration only after the district court ordered it to do so.

On the merits, the court held in favor of the subsidiary, explaining that since it "did not cease to be an Insured under the policy by reason of being a former subsidiary of [the Named Insured], it seems very odd that it should be unable to invoke a dispute resolution mechanism, namely arbitration, that the policy authorizes—at the Insured's election—for resolving such disputes." The court also rejected the insurer's argument that only the named policyholder should be able to invoke the ADR mechanism, explaining that because the policyholder no longer had any stake in the former subsidiary, "an interpretation that places the sole power to invoke arbitration in an entity that has no stake in the arbitration makes no commercial sense." ✦

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