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The Executive Summary

Developments Affecting Professional Liability Insurers

No Prejudice Required to Deny Coverage for Late Notice under Claims-Made and Reported Policy

In an unreported decision applying Maryland law, the United States Court of Appeals for the Fourth Circuit has held that an insurer can deny coverage where a policyholder provided late notice of a claim under a "claims made plus reporting" policy regardless of whether the insurer was prejudiced by the untimely notice. *Jenjer Enters. v. Exec. Risk Indem. Inc.*, 2004 WL 1011004 (4th Cir. May 6, 2004).

The insurer issued a claims-made EPL policy to a company. The policy required the company to provide to the insurer written notice of any claim made during the policy period "as soon as practicable and in no event later than sixty…days after such Claim is first made." The policy also stated that "[c]ompliance with this notice requirement is a strict condition precedent to coverage under this Policy."

On March 2, 2001, the company received from the Equal Employment Opportunity Commission (EEOC) a notice of a charge of discrimination, which stated that an employee of the company alleged that she had been subject to gender discrimination. The company did not notify the insurer of this notice from the EEOC. On October 4, 2001, after further EEOC procedures, the employee filed suit against the company. The company tendered the suit to the insurer, which denied coverage because the company had not provided notice of the claim within 60 days after its receipt of the notice of charges from the EEOC. Subsequently, the underlying litigation settled, and the company sued the insurer, arguing that, absent prejudice, an insurer cannot deny coverage for late notice.

The Fourth Circuit noted that the Maryland Insurance Code requires an insurer to demonstrate actual prejudice in order to deny coverage for late notice under a claims-made policy. However, the court explained that Maryland courts have held that the prejudice requirement is inapplicable to

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SEC Investigation Is "Claim," but Cost of Complying with SEC Order Is not "Loss"

The United States District Court for the Northern District of Illinois, applying Illinois law, has held that an SEC investigation that concluded in a cease and desist order constitutes a claim under a D&O policy but that expenses incurred in complying with the SEC order are not "loss" under the policy. *Minuteman Int'l, Inc. v. Great Am. Ins. Co.*, 2004 WL 603482 (N.D. Ill. Mar. 22, 2004). The court also held that the company was not entitled to recover the attorneys' fees it incurred in prosecuting its coverage claim.

A company purchased a claims-made D&O policy from the insurer. The policy defined "claim" as "a written demand for monetary or non-monetary relief." The policy, as amended by Endorsement 1—the Illinois Amendatory Endorsement—defined "loss" as "compensatory damages, punitive or exemplary damages…settlements and Costs of Defense." Endorsement 2 excluded from the definition of "loss" "any obligation of the Insured Entity as a result of

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Proceeds of D&O Policies not Part of Bankruptcy Estate

In an unreported decision, a federal district court in Ohio has lifted the automatic stay of the bankruptcy code to permit litigation to proceed against two former directors and officers of a bankrupt company. *In re MCSi, Inc., Sec. Litig., No.* C-3-03-015 (S.D. Ohio Feb. 26, 2004). In reaching this result, the court held, among other things, that proceeds of D&O policies are not part of the bankruptcy estate and that, as a result, the litigation would not have a detrimental effect on the bankruptcy estate.

Various insurers issued D&O policies to a company that had been named as a defendant in seven class action lawsuits arising out of alleged violations of federal securities laws. Following the filing of the litigation, the company filed for chapter 11 bankruptcy protection. Two former officers of the company were named as co-defendants in the class action lawsuits, and the class action plaintiffs sought to lift the automatic stay so that they could proceed with the litigation against the two individuals. The two individuals argued that the stay should not be lifted because an adverse judgment might be covered under the policy, thereby having a detrimental effect on the bankruptcy estate. (The opinion did not address whether the policy provided entity coverage applicable to the securities litigation.)

The court first noted that the company had not objected to the plaintiffs' motion to lift the automatic stay, suggesting that it did not perceive any impact on the bankruptcy estate. More significantly, the court rejected the argument that an adverse judgment would impact the estate, explaining that the "proceeds of a D&O liability policy are *not* the property of the debtor" since the company does not have a direct interest in the proceeds. The court reasoned that the function of the D&O policy was to pay out proceeds only when a director or officer incurs liability. Thus, according to the court, "it is difficult to imagine any type of D&O liability policy that would permit the corporation to maintain ownership of the proceeds, as opposed to paying them directly to the successful plaintiff in an action against the director or officer." The court concluded that "any proceeds of [the policyholder's] D&O liability policy cannot be considered to inure to its pecuniary benefit and therefore may not rightly be considered property of the bankruptcy estate." ■

Court Rejects Argument that EPL Policy Unambiguously Precludes Coverage for Bodily Injury

The United States District Court for the Western District of Tennessee, applying Tennessee law, has rejected an insurer's argument that the bodily injury exclusion in a hospital's EPL policy unambiguously precludes coverage for bodily injury to a patient resulting from malpractice by an allegedly improperly credentialed doctor. *Methodist Healthcare v. Am. Int'l Specialty Line Ins. Co.*, 2004 WL 632814 (W.D. Tenn. Mar. 30, 2004).

The insurer issued an EPL policy to a medical services corporation. The policy contained a bodily injury exclusion, which provided that the insurer "shall not be liable to make any payment for Loss in connection with a Claim made against the Insured…for bodily injury, sickness, disease [or] death of any person." The policy also excluded claims arising out of the insured's "performance…or failure to perform…medical or other professional services." An exception to that exclusion stated that the exclusion would not "operate to limit coverage for…matters arising out of peer review or credentialing processes." The hospital also had professional liability coverage with a second insurer, and the EPL insurer's policy contained an "other insurance" clause stating that "[t]his policy shall be specifically excess of any other policy pursuant to which any other insurer has a duty to defend a Claim."

In August 2000, the mother of a child born at one of the hospital's facilities filed a suit in Tennessee state court against the insured hospital and a delivery room doctor, alleging that her daughter suffered severe injuries due to the doctor's malpractice. The hospital's professional liability insurer defended the hospital, and the court eventually dismissed the suit against the hospital and granted a default judgment against the doctor. In October 2001, the mother filed a second suit against the hospital, alleging that the hospital was negligent in credentialing the delivery doctor and allowing him to practice at its facilities. The professional liability insurer defended the hospital in that suit without a reservation of rights. The EPL insurer denied coverage for this second suit based on the policy's exclusion for claims

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Amended Complaint Is Claim "First Made" when Original Complaint Was Filed

In an unreported decision, a federal magistrate judge, applying Wisconsin law, has held that an amended complaint that added a new defendant and asserted a new count was a claim "first made" under the language of an EPL Policy when the original complaint was filed prior to the policy's inception. *Preston v. Wis. Health Fund*, No. 02-C-0448 (E.D. Wis. Feb. 12, 2004).

The insurer issued a claims-made EPL policy to the Wisconsin Health Fund. The policy stated that a claim "is first made when any Insured first becomes aware…of the filing of a complaint…or other similar document or pleading commencing a judicial, administrative, or other proceeding against an Insured." The policy also provided that related claims "will be treated as a single Claim made at the time the first of such Related Claims was made," and defined "Related Claims" as "all Claims based on, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving the same or related facts, circumstances, situations, transactions, or events of Employment Practices Wrongful Acts."

> Whether a claim is a 'related claim' is determined by the facts and underlying circumstances, not the particular parties or legal theories.

Prior to the policy's inception date, the underlying plaintiff filed an administrative action and a lawsuit against the health fund and one of its directors, alleging gender and age discrimination and tortious interference with an employment contract. During the policy period, the underlying plaintiff filed an amended complaint in the lawsuit, adding another one of the health fund's directors as a defendant and asserting a new count of conspiracy against all of the defendants. The insurer denied coverage for the amended complaint, which it deemed to be a related claim to the original complaint filed prior to the inception of the policy period. The health fund then filed a third-party complaint against the insurer.

The court held that the insurer properly denied coverage. It reasoned that the policy provided that a claim is first made when "any" insured becomes aware of the filing of a complaint against an insured. It therefore rejected the argument that the claim against the additional insured added in the amended complaint was not made as to him until he became a defendant.

The court also concluded that the amended complaint was a "related claim" to the original complaint, and thus arose before the policy's inception date. The court reasoned that "[w]hether a claim is a 'related claim' is determined by the facts and underlying circumstances, not the particular parties or legal theories," and that the allegations in the administrative action and the original and amended complaints in the lawsuit related to the same set of facts or circumstances. As to the additional defendant, the court explained that it "defies common sense" to hold that a claim that two employees interfered with an employment contract shared no factual nexus with a claim that one of those employees interfered with the same contract. As to the additional count in the complaint, the court stated that the "plaintiff could not allege a claim of conspiracy without alleging what the defendants conspired to do." ■

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District Court Declines to Withdraw Reference to Bankruptcy Court for Coverage Litigation Concerning I v. I Exclusion

The United States District Court for the Northern District of Illinois declined to withdraw the reference to the bankruptcy court of a declaratory judgment action concerning an I v. I exclusion in a D&O policy, holding that prompt and efficient resolution of the matter would be served by allowing the bankruptcy court to decide the matter. *In re HA 2003, Inc.*, 2004 WL 609799 (N.D. Ill. March 24, 2004).

The insured company filed for bankruptcy. After the company sued its former CEO, alleging that his breach of fiduciary duty precipitated the company's bankruptcy, the district court referred that lawsuit to the bankruptcy court. The CEO sought coverage from the company's D&O insurers, and the insurers reserved their rights under the applicable insurance policies based on, among other things, the I v. I exclusion. The company then brought a declaratory judgment action in the bankruptcy court seeking a determination that the I v. I exclusion was inapplicable to its claim. At that point, the insurers filed a motion with the district court to withdraw the reference of the declaratory judgment action from the bankruptcy court.

The district court denied the insurers' motion to withdraw the reference, holding that the declaratory judgment action should proceed in the bankruptcy court. The court explained that it may withdraw a reference "for cause shown," which is determined based on a variety of factors, including judicial economy and efficiency, as well as whether the proceeding is core or non-core. Although the court first found that the declaratory action was a non-core bankruptcy proceeding because it did not arise under the Bankruptcy Code, it reasoned that a number of other factors militated in favor of declining to withdraw the reference. The court explained that judicial economy and efficiency would be hindered by a withdrawal of its reference since the bankruptcy court was familiar with the parties and the coverage issues involved and was already overseeing discovery in the case. The court further opined that the declaratory judgment action, though "non-core," raised some Bankruptcy Code interpretation issues including whether the insured could act on behalf of creditors and whether the I v. I exclusion contained an exception in the case of bankruptcy. Finally, the court stated that it was no more competent than the bankruptcy court to resolve issues of state insurance law. ■

SEC Investigation

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a Claim seeking relief or redress in any form other than monetary damages."

The SEC investigation that gave rise to the coverage dispute commenced with an SEC order initiating an investigation of the company's activities. The ensuing investigation included subpoenas of the company's officers and directors. The company and its officers and directors expended more than $500,000 in fees in connection with the investigation. Ultimately, the company and the SEC reached a settlement pursuant to which the SEC issued a cease and desist order that compelled the company to hire a general accounting officer and an outside auditor to monitor its compliance with generally accepted accounting principles. The insurer denied coverage for all facets of the SEC investigation on the grounds that the investigation did not constitute a "claim" under the policy. Coverage litigation ensued.

The court held that the policy afforded coverage for the SEC investigation because "[a] demand for 'relief' is a broad enough term to include a demand for something due, including a demand to produce documents or appear to testify." The court also held that the company's costs of complying with the SEC order did not constitute "loss" since the policy expressly excluded such costs from the definition of the term. In so ruling, the court rejected the company's argument that Endorsement 1 to the policy overrode all other definitions of loss included in the policy and thus the language limiting the definition of loss in Endorsement 2 was inapplicable. The court reasoned that Endorsement 2 was not inconsistent with Illinois law and therefore applied to bar coverage for expenses incurred in complying with the SEC order.

Finally, the court granted the insurer's motion to dismiss the company's claim for its attorneys' fees incurred in litigating the coverage action under 215 ILCS 5/155. The court held that the statute only provides for fee awards in cases in which the insurer's conduct in delaying payment is unreasonable and vexatious, and that "[t]aking an unsuccessful position is not enough to impose a penalty under this provision; the insurer's behavior must be willful and without reasonable cause." Regarding the instant case, the court noted that some precedent supported the insurer's position as to the definition of "claim" under the policy and that reasonable litigants could differ on the issue. ■

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Claim against Excess Insurer not Ripe where Insolvent Primary Insurer's Liability not Yet Established

In an unpublished opinion, a federal district court, applying New Jersey law, has held that a company and one of its directors did not have a justiciable claim for coverage under an excess D&O policy where they had neither paid up to the primary policy's limits nor secured a judgment that the primary policy afforded coverage for the claim. *G-I Holdings, Inc. v. Reliance Ins. Co.*, No. 00-6189 (D.N.J. Mar. 23, 2004).

The case arose from three underlying actions against an insured company and one of its directors, seeking damages from the company for asbestos-related injuries and from the director for an allegedly fraudulent transfer of the stock of one of the company's former subsidiaries. The company's primary D&O carrier, Reliance, had been placed into statutory liquidation. The excess D&O policy provided that the excess insurer's obligations would not be modified by any financial insolvency of any underlying insurer, and that the insureds would be deemed to be self-insured for the limit of liability of any underlying insurance not paid as a result of financial insolvency. In addition, Section II.E of the excess D&O policy provided that the excess insurer "shall be liable only after the Insurers under the Underlying Insurance shall have agreed to pay or have been held liable to pay the full amount of their respective limits of liability… and, if applicable, the Insureds shall have paid the amount of the limit of liability deemed to be self insured…." (The company and the director also pursued a claim against the primary insurer in the liquidation proceeding.)

The court first granted the excess insurer's motion to dismiss, holding that the claim against the excess insurer was not justiciable because it was not ripe. The court reasoned that the parties did not have a genuine adversity of interests because the company and the director failed to allege that they had paid up to the primary policy's limits in connection with the underlying litigation, and the primary insurer had not agreed to provide coverage and had not yet been held liable under the primary policy in the liquidation proceeding.

> The court rejected the argument of the company and the director that the excess insurer must pay once the insureds incurred costs above the underlying limits.

In so ruling, the court rejected the argument of the company and the director that the excess insurer must pay once the insureds incurred costs above the underlying limits. The court reasoned that "Section II.E of the Excess Policy is a conjunctive construction prohibiting Plaintiffs from simply electing to pay the limit and avoid a determination of [the primary insurer's] liability." Until the company and the director had both (1) paid an amount equal to the underlying policy's limits and (2) succeeded in gaining a judgment against or an agreement to pay from the primary insurer, the court held that the excess insurer had no obligation to the company or the director, and that the parties therefore lacked any adversity of interests. ■

No Prejudice Required

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"claims made and reporting" policies, such as the one at issue in the case. The company argued that the policy should be considered a strict "claims made" policy, to which the prejudice requirement would apply, because the reporting requirement was not included in the declarations page and insuring agreements of the policy. The court rejected this argument, explaining that "[p]arties may also create a 'claims made and reporting' policy, as was done here, by expressly providing in a policy's declaration page or insuring agreement that coverage is subject to certain terms and conditions and setting forth those terms and conditions, including a reporting requirement as a strict condition precedent to coverage, in another part of the policy." The court concluded that since seven months lapsed between when the company received notice of the EEOC complaint and when it notified the insurer of the claim, the insurer properly denied coverage. ■

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Allegations in Original Complaint Irrelevant to Determining Duty to Defend under Amended Complaint

The United States Court of Appeals for the Fifth Circuit, applying Texas law, has held that a court cannot consider the allegations in the original complaint when determining whether an insurer has a duty to defend under an amended complaint. *Northfield Ins. Co. v. Loving Home Care, Inc.*, 2004 WL 547938 (5th Cir. Mar. 22, 2004). The court also held that the duty to indemnify is nonjusticiable until completion of the underlying litigation.

The insurer issued an insurance policy that provided professional liability coverage to a company that provided nannies for in-home childcare. A child died while in the care of one of the company's employees, and the employee was subsequently found guilty of the charge of felony injury to a child. Thereafter, the child's parents filed suit against the insured company, among others. In the initial complaint in the underlying suit, the plaintiffs included allegations relating to the employee's criminal conviction and the intentional nature of her conduct. However, the plaintiffs later amended their complaint, removing all such allegations.

The insurer filed a declaratory action, asserting that it was not obligated to defend or indemnify the company in the underlying action because the policy excluded coverage for "criminal acts" and "physical/sexual abuse." Although the amended complaint did not include allegations implicating those exclusions, the insurer argued that the initial complaint made such allegations and that the plaintiff was attempting to "perpetuate fraud on the court by artfully pleading facts to bring the excluded claims within coverage."

The court of appeals ruled against the insurer based on an "*Erie* guess" that the Texas Supreme Court would not recognize any exception to the eight corners rule in Texas. That rule provides that "if the four corners of the petition allege facts stating a cause of action which potentially falls within the four corners of the policy's scope of coverage, resolving all doubts in favor of the insured, the insurer has a duty to defend." The court concluded that "no matter what facts the previous versions of their petition alleged, the burden shifted to [the insurer] to show that the plain language of the policy exclusions when compared against the facts alleged in the underlying petition precluded coverage."

The Fifth Circuit held that, under Texas law, once a duty to defend is determined, the duty to indemnify becomes nonjusticiable until the underlying suit is concluded. The court also noted that, even if this were not the case, district courts have discretion to decline to grant relief as to the duty to indemnify under the Declaratory Judgment Act. ■

Court Rejects Argument

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involving bodily injury. Coverage litigation ensued, and the EPL insurer moved for summary judgment based on the unambiguous language in the policy precluding coverage for bodily injury, as well as the other insurance provision.

The court disagreed with the insurer and held that the bodily injury exclusion was susceptible to two reasonable interpretations, thereby rendering it ambiguous. The court acknowledged that the bodily injury exclusion, standing alone, appeared to defeat coverage since the mother's suit arose out of alleged bodily injury to her newborn daughter. The court reasoned, however, that the exception to the exclusion for providing medical services expressly included all claims for defects in credentialing medical professionals "regardless of whether they relate to bodily injury or not." The court therefore found that a reasonable interpretation of the policy would be that it afforded coverage for the suit.

The court also rejected the EPL insurer's argument that coverage was unavailable in light of the policy's "other insurance" provision and the fact that the professional liability carrier was defending the action. The court stated in conclusory fashion that this argument was "internally inconsistent" with an endorsement providing that the insurer had "both the right and duty to defend…any Claim against any Insured alleging a Wrongful Act." ■

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Other Decisions of Note

State Insurance Guaranty Association Steps into Shoes of Insurer

In an unpublished opinion, a Delaware trial court has held that the Washington State Insurance Guaranty Association Act required the Washington Insurance Guaranty Association to make payments up to the applicable limits of liability of an insolvent insurer's policy, rejecting the association's argument that the applicable statute limited its liability to $299,900. *Reliance Ins. Co. v. Plum Creek Timber Co., L.P.*, 2004 WL 838634 (Del. Super. Ct. Apr. 15, 2004). After the insured company entered into a multi-million dollar settlement of a class action lawsuit, its insurer became insolvent and the association became obligated, under Washington law, to provide coverage in its place. The association argued that the underlying settlement constituted a single claim, which was therefore subject to the statutory cap of $299,900 per claim. In rejecting the argument, the trial court reasoned that the underlying lawsuit effectively settled 65,000 claims for purposes of the statute since there were 65,000 members of the class. The court explained that the "primary purpose of the Act is to place claimants in the same position they would have been had the liability insurer remained solvent."

No Coverage for Lawsuit that Was Threatened Prior to the Policy Period

A Pennsylvania federal district court has held that a claims-made legal malpractice policy did not afford coverage for a lawsuit filed during the policy period because the claim was first made prior to the inception of the policy when the underlying plaintiff sent a letter to the insured law firm threatening to file suit and directing the law firm to forward the letter to its malpractice carrier. *Westport Ins. Corp. v. Law Offices of Marvin Lundy*, 2004 WL 555415 (E.D. Pa. Mar. 19, 2004). The court reasoned that the letter to the law firm qualified as a "claim," which was defined in the policy as "a demand made upon any insured for loss."

Indiana Federal Court Allows Defense Costs to Be Paid from Interpleaded Funds

A federal magistrate in Indiana, applying Indiana law, has issued a report and recommendation finding that an insured title company is entitled to have its defense costs reimbursed from policy proceeds that its insurer had deposited into the court's registry in an interpleader action. *Chicago Ins. Co. v. Abstract & Title Guaranty Co.*, 2004 WL 692051 (S.D. Ind. Mar. 31, 2004). After the title company was sued, its professional liability insurer deposited the policy limits in the court's registry and filed an interpleader action because it believed the liability of the company would far exceed the policy limits, which would be depleted through the payment of defense expenses. In approving the payment of defense expenses, the court rejected the underlying plaintiffs' argument that they had an equal right to the funds, explaining that the insureds "should be able to use the interpleaded funds, in accordance with policy provisions, regardless of whether [the insurer] shirked its duty to defend by depositing the policy limits in the Court's registry." The court did not address whether the insurer satisfied its duty to defend by filing the interpleader action and depositing the policy limits with the court.

Professional Liability Insurer Has Duty to Defend Unless Policy Excludes All Coverage

A federal district court in Louisiana, applying Louisiana law, has held that an insurer has a duty to defend a law firm insured under a lawyers' professional liability policy against a lawsuit by a former client even though most of the allegations were excluded by the policy because at least one count was not excluded. *Continental Cas. Co. v. Feingerts & Kelly, A.P.L.C.*, 2004 WL 737460 (E.D. La. Apr. 2, 2004). The court noted that the "majority" of the allegations by the former client concerned purportedly excessive fees for which coverage was barred by the policy's exclusion for "legal fees, costs and expenses paid or incurred or charged by the Insured." However, the court concluded that the insurer had a duty to defend since "at least one claim is not excluded under the terms of the policy" and "the duty to defend is triggered unless the petition unambiguously excludes all coverage."

No Duty to Defend Lawsuit Seeking Injunctive Relief

The Supreme Judicial Court of Maine has held that an insurer had no duty to defend a club it insured under a non-profit professional liability policy in a lawsuit seeking injunctive relief arising out of a contested board of directors election because the policy excluded claims "seeking relief, or redress, in any form other than money damages." *York Golf & Tennis Club v. Tudor Ins. Co.*, 2004 WL 757870 (Me. Apr. 9, 2004). The court held that it was required to look beyond the language of the complaint to determine if the underlying plaintiffs sought

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Other Decisions of Note

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monetary damages because, under Maine law, "a court can grant relief to a plaintiff that is not requested in the complaint if the plaintiff is entitled to the relief and the judgment is not granted by default." Analyzing the specific facts on which the underlying plaintiffs' claims for injunctive relief were based, however, the court held that the complaint failed to allege facts that would entitle the plaintiffs to monetary damages. The court also noted that, although the underlying complaint did not contain such language, a catchall request in the complaint for "further relief as the court deems just and proper" would have been insufficient to trigger the insurer's duty to defend. ■

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