

Specialty Lines Advisory

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Joe Says ...



Why Securities Fraud Class Actions Are Rarely Tried

Securities fraud class actions are the paradigm high exposure claims in the world of D&O insurance. In the so-called modern era of securities fraud class actions, incepting with passage of the Private Securities Litigation Reform Act of 1995, there have been nine (9) of these class actions that resulted in settlements over \$1 billion. Median settlement value is well into the eight figures, and even the average or mean settlement value is close to \$10 million. Even a “nuisance settlement” may range anywhere from a few hundred thousand to a little over a million dollars.

In this settlement context, there are a fair number of cases (in some jurisdictions in excess of 35% of all securities fraud class actions brought) that are disposed of with a complete win for the defendants via either a motion to dismiss or motion for summary judgment.

However, only a handful of cases are ever tried to a conclusion on the merits before a judge and jury. Most data surveys would peg the number at no more than about two dozen out of in excess of 2,000 companies sued in securities fraud class actions since the beginning of 1996. I’ll do the math for you – that is about 1%.

A fair number of these trials have resulted in defense verdicts. That would explain, in part, reluctance on the part of plaintiffs’ lawyers to try these cases. The plaintiffs’ bar handles these cases on a *de facto* contingency basis, i.e., no settlement/no trial win = no pay day. Those pay days, which can reach into the hundreds of millions of dollars in the mega billion dollar settlements, are perhaps too tempting to forego by trying a case and coming up empty.

What do defendants have to lose?

Plenty.

Although many of these suits are still settled in their entirety with D&O insurance funds, exposures above and beyond the total D&O policy limits arise now with greater frequency. There have been a number of matters where defense costs have so eroded the available insurance limits that settlements had to be cobbled together with a combination of the remaining insurance limits, corporate contributions and even money from the individual directors and officers. The latter source becomes even more likely when the corporation becomes bankrupt or otherwise financially impaired. In a trial situation all bets are off for limiting the exposure of any of these contributors, including the insurers which, in certain circumstances, may face potential exposure beyond their policy limits if they unreasonably withhold consent to a settlement at or within their policy limit.

The most recent example of a securities class action proceeding to trial occurred in early May 2009 when a jury in federal court in the Northern District of Illinois returned a verdict in favor of the plaintiff class against the subprime lender Household International and certain of its executive officers. This was a trial on the causation and liability aspects of the case only, with the damages portion having been set aside for a subsequent trial if the litigation does not settle in the interim.

The jury had to consider some forty (40) allegedly false and misleading statements by the defendants and in fact found in favor of the defendants on most of these statements. However, the jury found reckless conduct on the part of all of the defendants and knowing misconduct on the part of the corporate defendant and its former CEO. Although we have no knowledge of Household’s D&O insurance program, the establishment of knowing misconduct may well have coverage consequences.

Household was one of the earlier subprime lending class actions to have been brought and this adverse verdict comes on the heels of a recently announced \$30.5 million settlement in a class action involving the residential builder Beazer

Homes. Hopefully, for the defendants and their insurers, these are not harbingers of a reversal of fortune after a number of early wins on motion practice in the subprime arena.

The takeaway here is certainly not to ever try a securities fraud class action. Certainly, in cases where the scope of potential damages may be limited and perhaps contained within the limits of the available insurance, there is much to be said about the wisdom of trying a case where causation and liability defenses are strong, even after failures to knock out the case by motions. However, Household and prior cases gone to trial are illustrative of what can go wrong (or right, dependent upon perspective) in the event of a trial. Even for the Household plaintiffs, this win may prove ephemeral dependent upon post-trial and/or appellate challenges. An educated guess is that the case may now settle, albeit at a higher value than would have been attainable before the plaintiff “win”.

Would you like to offer a comment? [Click here to let me know what you think.](#)

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Special Alert

To the surprise of many in the insurance industry, the new reporting requirements of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA") can impact insurers issuing D&O, employment practices liability and other specialty lines' liability insurance products. It works like this: Under federal law, Medicare is a secondary payor to commercial insurance and self-insurance under some circumstances. 42 U.S.C. §1395y(b)(2)(A). Primary payors and entities that receive payment from a primary plan are obligated to reimburse Medicare for conditional payments when it is shown that a primary plan "has or had a responsibility" to make payment. This responsibility may be demonstrated by a judgment or a payment conditioned upon a recipient's compromise, waiver and release, as well as a settlement. While coverage for medical payments is not traditionally afforded by specialty lines liability insurance policies, MMSEA is implicated where a settlement or judgment includes payment amounts for Medicare covered costs, such as those for mental health services. In fact, it is not unusual for a claimant to support an emotional distress claim with evidence of services provided by a psychologist or other mental health professional. Insurers affording coverage under such liability policies must report information

about the claim payment to Centers for Medicare & Medicaid Services and satisfy the other requirements of MMSEA. As a result, insurers will need to have procedures in place to address this development in the law. Due to confusion about how the new requirements apply, the deadlines for complying with the new law have been extended. Liability insurers have until September 30, 2009 to complete electronic registration via the Coordination of Benefits Secure Website. Other deadlines have been extended through next year.

If you have questions or comments regarding this Special Alert, please contact Carrie Cope at ccope@tsmp.com or 312.627.4188.

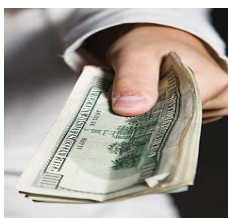


Prepared by Carrie E. Cope, a Partner in our Chicago office and Co-Editor of the *Advisory*.

EIGHTH CIRCUIT REJECTS D&O INSURER'S CLAIM TO RECOUP DEFENSE COSTS UNDER MINNESOTA LAW

In Westchester Fire Ins. Co. v. Wallerich, 563 F.3d 707 (8th Cir. 2009), the Eighth Circuit Court of Appeals declined to find that a D&O insurer had a right of recoupment of the defense costs it advanced to the insured, even though the Court determined that no duty to defend was owed by the D&O liability insurer because of the “insured versus insured” exclusion and even though the insurer expressly reserved its right to seek recoupment of any defense costs advanced under that circumstance. The Eighth Circuit distinguished an earlier Minnesota case which had allowed a right of recoupment and an earlier opinion issued by the Eighth Circuit itself, which had found that an insurer was allowed to seek recoupment of defense costs.

In Wallerich, Westchester Fire, a directors and officers insurer, initially declined coverage but then agreed to provide a defense to its insured under a reservation of rights. Its reservation of rights letter stated that it would seek reimbursement for any sums advanced if a court later ruled that it did not have a duty to defend. The insureds objected to Westchester's reservation, but accepted its offer to advance their defense expenses.



Westchester thereafter filed a declaratory judgment action and ultimately obtained a ruling that the “insured versus insured” exclusion in its policy precluded any duty to defend.

While the Eighth Circuit determined that Westchester had no duty to defend, it rejected Westchester's claim to recoup the defense costs it had paid. The Court took note of the split in authority around the country and the growing number of courts that have rejected the insurers' claim for recoupment and concluded that it was persuaded by the more recent state and federal court opinions from other jurisdictions that have adopted the “minority” position barring reimbursement of defense costs paid under a unilateral reservation of rights.

The Court distinguished the facts in Knapp v. Commonwealth Land Title Insurance Co., 932 F. Supp. 1169 (D. Minn. 1996), where a title insurer was permitted to recoup defense costs that it had paid pending a determination of whether it owed coverage for the underlying title dispute. The Eighth Circuit focused on the fact that the insurer in Knapp had expressly reserved a right of recoupment when it agreed to defend and that the insured had not protested this claimed right. The court concluded: “Under these circumstances, the Court finds it appropriate to determine that Knapp's silence in response to Commonwealth's reservations of rights letter, and subsequent acceptance of the defense provided by Commonwealth, constitutes an implied agreement to the reservation of rights.”

In contrast, in the Wallerich case, the insured had not acquiesced in the insurer's assertion of this right and, in fact, explicitly rejected such terms. The Court ruled that Westchester's decision to still go forward with a defense despite the insured's rejection of the terms in its reservation of rights letter constituted an implied acceptance of the insured's terms.

The Court also distinguished its earlier decision in St. Paul Fire & Marine Ins. Co. v. Compaq Computer Corp., 457 F.3d 766 (8th Cir. 2006) (applying Texas law), in which it had recognized an insurer's right of recoupment of defense costs. The court noted that in the Compaq case, the insurer explicitly agreed to forgo another right that it had under the policy in return for the reservation of rights. In the Wallerich case, however, Westchester never explicitly offered to forgo any right to the insureds in exchange for tendering a defense. In addition, the Court explained that the insurer's assertion of a right to recoupment in the Compaq case was not “unilateral” but rather was impliedly agreed to by Compaq when it accepted St. Paul's partial payment of its defense costs after the insured itself had demanded a defense beyond that provided for under the policy. As a result, the court found that the insured had, in effect, created a supplemental agreement that required payments beyond those contemplated in the original agreement but that also gave St. Paul both rights asserted in the reservation of rights letter pursuant to which it had agreed to make any such payments.

The Court stated that it found the most recent state and federal court decisions' adoption of the minority position more persuasive. It noted, in conclusion that “Westchester could have included in the policy an express provision for such reimbursement. Westchester cannot now unilaterally amend the policy by including the right to reimbursement in its reservation-of-rights letter.”

The insurer did win a small victory in the Wallerich case. The district court *sua sponte* awarded the insureds their attorneys' fees in pursuing declaratory relief. The Eighth Circuit reversed, stating: “We have already

determined that the policy's “insured v. insured” exclusion applies and that the language of the policy is unambiguous.... Therefore, there was never “arguable coverage.” As a result, Westchester never had a duty to defend the insureds. Applying Minnesota law, the insureds were not entitled to such fees because Westchester never had a duty to defend.

TRESSLER COMMENTS

This case provides a detailed overview of the split in authority on the issue of whether an insurer can seek recoupment of defense costs. The Court also provides a discussion of the rationale of both camps on the subject. The divergence of view is, in some respects, driven by whether the jurisdiction is receptive to equitable arguments or whether it will only allow a right of recoupment when the policy expressly provides for such a right. Even in those jurisdictions that allow a right of recoupment, the insurer must specifically reserve its right to seek such recoupment in a reservation of rights letter. The Eighth Circuit did not reject equitable considerations altogether. It recognized that tacit acquiescence to the insurer's unilateral reservation of rights with respect to recoupment of defense costs can create such a right. However, absent that circumstance, an insurer cannot seek such recovery unless the policy contains language allowing it to do so. Obviously, an insurer can also seek a bilateral agreement with the insured in which such right of recoupment is negotiated as a term of that separate agreement.



Prepared by Shaun McParland Baldwin, a Partner in our Chicago office.

NEW YORK COURT'S DECISION FINDING EXISTENCE OF SEVERABILITY LANGUAGE IN POLICY APPLICATION AND EXCLUSIONS CREATES AN AMBIGUITY WHICH IS PROBLEMATIC FOR NON-FOLLOWING FORM EXCESS INSURER

Can the existence of severability language in both the application for a liability insurance policy and a prior knowledge exclusion significantly impact an excess insurer's ability to exclude coverage for potential claims about which an insured had knowledge prior to the application for the policy? According to the recent decision of U.S. District Judge Gerard E. Lynch in XL Specialty Insurance Co. v. Agoglia, No. 08 Civ. 3821, 2009 WL 1227485 (S.D.N.Y. April 30, 2009), it most certainly can.

In October, 2005, just two months after its initial public offering, the brokerage and clearing services company, Refco, Inc., first disclosed that for several years it had been carrying a \$430 million receivable from a separate corporation controlled by Refco's CEO, Philip Bennett. This revelation immediately resulted in a loss of more than \$1 billion in market capitalization in Refco's stock, a bankruptcy filing and a spate of litigation against Refco's directors and officers. Refco's CEO and two other officers eventually pleaded guilty to criminal charges, admitting that they were actively involved for several years in unlawfully packaging Refco's uncollectible debt in such a way as to disguise the losses.

In preparation for its August, 2005 IPO, Refco had obtained directors and officers liability insurance in a \$70 million tower of coverage, with a \$10 million primary policy from U.S. Specialty Insurance Company ("U.S. Specialty") and five layers of excess coverage. Allied World Assurance Company ("AWAC") issued the third layer excess policy with limits of \$12.5 million. Arch Insurance Company ("Arch") issued the 4th layer of \$10 million, and XL Specialty Insurance Company ("XL") issued the 5th layer with \$20 million. AWAC and Arch both issued following form excess policies, except to the extent that their policies were different from U.S. Specialty's primary policy, in which instance the conflicting provisions of the excess policy would control.

The primary policy contained a "full severability" clause so that the knowledge or information possessed by any one insured regarding representations in the application for the policy would not be attributed to any other insured. Both the AWAC and Arch policies contained similar prior knowledge exclusions, which excluded coverage if any insured had knowledge prior to inception of the policy of any facts, circumstances, acts, errors or omissions which might give rise to a claim. The XL policy did not follow the form of the primary policy, but instead had its own "full severability" clause and a form of prior knowledge exclusion known as an inverted representation endorsement. All three policies were issued months after

Refco's demise. All three excess insurers denied coverage, became embroiled in coverage litigation and filed motions for summary judgment prior to discovery based upon the prior knowledge exclusions of their respective policies. The factual basis for the summary judgment motions was the guilty plea to the criminal indictment by the former CEO.

In dealing with the prior knowledge exclusions, the Court found that there were three requirements:

1. Knowledge by "any insured" of facts and circumstances that might give rise to a claim under the policy.
2. The known fact or circumstance must give that insured reason to suppose that there are grounds for a claim.
3. The claims must have arisen out of or be based upon or attributable to the facts and circumstances known to that insured.

Regarding the first criterion, the Court had no problem finding that Refco's former CEO, Phillip Bennett, based upon his plea allocation for the criminal indictment, had knowledge of the unlawful treatment of Refco's uncollectible debt. As the Court noted, there was no real dispute regarding Bennett's knowledge, and in fact Bennett had previously stipulated to a judgment that he was not entitled to any coverage under the Arch and AWAC policies. The Court just as easily dispensed with the second criterion, finding the "reason to suppose" that the known fact or circumstance might afford grounds for a claim under the policy was an objective "reasonable person" standard, which was easily met. This was bolstered by Bennett's affirmative acknowledgment in his guilty plea of the illegality of his conduct.

The insureds only seriously contested the third criterion, arguing that the insurers could not demonstrate that each of the individual claims made in the multiple lawsuits against Refco arose out of the facts and circumstances known to Bennett,

as admitted in his plea allocation. The Court noted that the New York Court of Appeals has recently given a broad interpretation to the "arising out of" language in an exclusion in a homeowner's policy. Armed with that principle, the Court held that, as a whole, the claims in all of the lawsuits against Refco arose out of acts, errors, omissions, facts or circumstances of which the former CEO had prior knowledge. Consequently, the prior knowledge exclusions in the AWAC and Arch policies were triggered, and the CEO's knowledge of the financial wrongdoing was attributed to other insureds.

The principal focus of the insureds' opposition to the summary judgment motions on behalf of AWAC and Arch, however, was based upon the severability provision in the primary policy. The insureds first argued that the severability clause was a general non-imputation clause, whereas the insurers alleged that the severability clause only applied to statements in the application for the purpose of rescission, and not to the exclusions. The Court alluded to its prior interpretation of the very same provision of the primary policy in Axis Reinsurance Co. v. Bennett, Nos. 07 Civ. 7924, 08 Civ. 3242, 2008 U.S. Dist. LEXIS 47697, 2008 WL 2485388 (S.D.N.Y. June 19, 2008), in which it held that the severability clause extends only to the statements in Refco's application for the policy. However, when interpreting the severability clause endorsement with the severability language in the general conditions of the policy, the Court concluded that Arch and AWAC could not establish, as a matter of law, that the severability provision was limited to the application questions.

The deciding factor in granting summary judgment to AWAC and Arch was the Court's interpretation of the severability clause and endorsement of the primary policy in conjunction with the prior knowledge exclusions of the two excess policies. As a matter of contract interpretation, the Court held that the prior knowledge exclusions in these two excess policies superseded any potential, contradictory provisions of the primary policy, including the severability clause. Consequently, the facts and

CITY FAILED TO GIVE TIMELY NOTICE AND LOSES COVERAGE FOR NINE MILLION DOLLAR SUIT

In American Safety Casualty Insurance Company v. City of Waukegan, 2009 WL 855795 (N.D. Ill. March 30, 2009), a federal district court ruled that Scottsdale Insurance Company was relieved of any defense or indemnity obligation under three Law Enforcement Liability policies based on the City of Waukegan's failure to provide timely notice of an underlying suit.

The plaintiff in the underlying suit, S. Alejandro Domiguez, filed an action against the City of Waukegan, Illinois and several of its police officers on April 23, 2004. Domiguez asserted claims for false arrest, malicious prosecution, deprivation of constitutional rights and several other claims. Domiguez alleged that he had been arrested by Waukegan police on September 21, 1989 and charged with two counts of aggravated sexual assault and one count of home invasion following an incident that occurred a few days before his arrest. He was convicted of home invasion and aggravated sexual assault and was sent to prison. Years later, however, a post-conviction DNA test excluded him as the rapist, his conviction was vacated, and he was found not guilty.

The trial of the underlying suit began on October 3, 2006. Scottsdale Insurance Company ("Scottsdale"), received notice of the suit on September 29, 2006, which was some 28 months after the suit had been filed and only four days before the trial began. Scottsdale did not appear at the trial and did not defend the City. It issued a reservation of rights letter on October 9, 2006, before the jury trial had concluded, citing to the notice provisions in the policies. Scottsdale then filed a declaratory judgment action against the City on January 7, 2007, three months after it had received notice. Meanwhile, on October 17, 2006, the jury in the underlying suit found in favor of Domiguez and against Paul Hendley, a Waukegan police officer, and awarded Domiguez over \$9 million. The court in the underlying suit ruled that the City of Waukegan was liable, as an indemnitor, for the judgment against Hendley.

The notice provisions in the Scottsdale policies required the insured to give notice of a suit immediately. The district court, applying Illinois law, granted Scottsdale's motion for summary judgment, finding that Waukegan breached the notice clause by waiting 28 months to give notice. The district court noted that: compliance with a notice clause is a condition precedent to coverage; when an insured breaches a notice clause, the insurer is relieved of any defense or indemnity obligation; and, when the facts are not in dispute, the issue of whether the insured gave notice within a reasonable amount of time is a question of law for the court to decide. The district court also noted, however, that a lengthy

passage of time between when a suit is filed and the time when notice is given does not necessarily bar coverage if the insured has a justifiable excuse for the delay. Against that backdrop, the district court then employed a four-part test to determine whether Scottsdale had a valid late notice defense, focusing on (1) what the language of the notice clause required, (2) how sophisticated the insured was in the area of coverage, (3) when the insured became aware of the claim, and (4) how diligent the insured was in determining the availability of coverage after it learned of the claim.

The district court found against the City on all four factors. It found that: the policies required immediate notice of a claim or suit; the City had notice of the suit some 28 months before notice was given; and, a delay of some 28 months in providing notice breached the policy language. The district court also found that the City was a sophisticated insured in the area of coverage under Law Enforcement Liability policies, citing to numerous lawsuits that had been filed against the City for constitutional violations similar to those that had been alleged by Domiguez. Finally, the court found that the City had not been diligent in taking steps to determine whether coverage was available under the Scottsdale policies. The City had promptly notified its broker, Arthur J. Gallagher Risk Management Services, of the suit, but was told by Gallagher to notify another insurer – International Special Risk Services. The City ultimately determined that the policies issued by International did not provide law enforcement liability coverage. The City then searched its archives in a basement and discovered the Scottsdale policies. While the court found that the City notified Scottsdale promptly after it discovered the Scottsdale policies, the City offered no valid excuse for failing to find those policies during the 28-month delay.

The district court also noted that under Illinois law, if the insurer does not receive notice within a reasonable amount of time, the insured is not entitled to coverage irrespective of whether or not the insurer has been prejudiced. Having concluded that notice was not given to Scottsdale within a reasonable amount of time, the court did not need to address whether Scottsdale had been prejudiced, but the court nonetheless addressed the issue and found that Scottsdale had been prejudiced.

The court ruled that because notice had been given only four days before the start of the trial, Scottsdale had been deprived of the opportunity to investigate the claims and had been deprived of the opportunity to prepare a defense to the claims, thus defeating the entire purpose of the notice clause.

In addition, the court rejected the argument that notice to Arthur J. Gallagher Risk Management Services constituted notice to Scottsdale. Finding that Gallagher was a broker for the City, rather than an agent for Scottsdale, the court ruled that notice to Gallagher did not satisfy the notice requirements in the policies. Finally, the court rejected the argument that Scottsdale should be estopped from raising its late notice defense. Under Illinois law, in order to avoid estoppel, an insurer that disputes coverage must either defend under a reservation of rights or file a timely declaratory judgment action. The court found that the filing of the declaratory judgment action by Scottsdale within three months after receiving notice was reasonable and therefore timely, even though the trial of the underlying suit had already concluded.

TRESSLER COMMENTS

Two important points bear emphasis as a result of this decision.

First, unless a broker is expressly designated in writing as being an agent of the insurer for purposes of receiving notice of a claim, they are typically not such an agent and an insured acts at its peril if it operates under the assumption that notice to the broker is legally the equivalent of notice to the insurer.

Second, in Illinois, as in many other states, the wisest course for an insurer in a situation of disputed coverage is to immediately bring a declaratory action to obtain a judicial resolution of defense and coverage obligations.



Prepared by Michael W. Morrison, a Partner in our Chicago office.

ARKANSAS COURT HOLDS THAT MISREPRESENTATION IN RENEWAL APPLICATION RENDERS D&O POLICY VOID *AB INITIO*

In *Platte River Insurance Co. v. Baptist Health, et al.*, 4:07-cv-0036 (E.D. Ark. Apr. 17, 2009), the U.S. District Court for the Eastern District of Arkansas held that due to renewal application misrepresentations, a hospital's D&O insurance policy was void *ab initio*. The hospital was ordered to refund amounts the carrier previously paid as defense costs.



Background: At the heart of this insurance dispute were: (i) Baptist Health's ("Baptist") adoption of an Economic Conflict of Interest policy ("ECOI Policy") in May 2003; (ii) Baptist's renewal of

its D&O policy ("D&O Policy") in December 2003; and (iii) the filing of the three suits against Baptist in connection with the ECOI Policy in February 2004.

At the time, Baptist adopted the ECOI Policy, (which provided that no physician that directly or indirectly owns or acquires an interest in a competing hospital would be eligible to apply for an initial or renewed appointment or clinical privileges for the professional staff at any Baptist hospital), Baptist knew that legal challenges had been raised in connection with other hospitals' attempts to adopt similar ECOI policies. Baptist was also aware that questions had been raised as to whether the ECOI policies violated federal anti-kickback laws and that adoption of the ECOI Policy could result in a lawsuit. The hospital had even made a list of physicians whom they anticipated would be affected by the ECOI Policy. Those physicians subsequently sued Baptist for its adoption of the ECOI Policy.

In December 2003, months after its adoption of the ECOI Policy, Baptist chose to renew its D&O policy with a new insurance carrier. Baptist's expiring D&O coverage, which had been in force for the period of December 12, 2002 to December 12, 2003, had been with a prior insurer. As part of the renewal process, Baptist completed two renewal applications, one with each of the carriers. Both renewal applications contained a *prior knowledge* question that asked whether any entity or individual proposed for coverage was aware of any fact, circumstance, situation or event that could result in a claim. Both renewal applications also stated that if any such fact, circumstance, situation or event exists, any claim arising therefrom was excluded from coverage. Baptist responded "None" to the *prior knowledge* question in each of the renewal applications.

In February 2004, a group of physicians filed the first of three suits against Baptist alleging that the ECOI Policy violated federal anti-kickback laws. Baptist submitted this

first suit, and later submitted the other two subsequent lawsuits, to its new D&O insurer carrier as claims under its D&O Policy. Soon thereafter, the new D&O carrier became aware of the circumstances in connection with Baptist's knowledge about ECOI policies that had preceded Baptist's adoption of its ECOI Policy. The D&O carrier then sought a judicial declaration that no coverage existed under the D&O policy for the three physician suits as a result of Baptist's failure to disclose in the renewal application that it had knowledge that adoption of the ECOI Policy may lead to a lawsuit. Baptist counterclaimed seeking a declaration of coverage. The case was before the court on the parties' cross-motions for summary judgment.

Legal Standard and Discussion: The Court relied on Arkansas law to hold that because the renewal application misrepresentations were material to the underwriting of the D&O policy, they operated to bar coverage and rendered the D&O policy void *ab initio*. Accordingly, the Court held that the D&O Policy should be rescinded.

In finding for the D&O carrier, the Court concluded that Baptist was "specifically aware" of a wide variety of facts and circumstances that suggested the possibility of a claim when it answered the *prior knowledge* questions on the application. In light of Baptist's knowledge before answering the *prior knowledge* questions, the Court found that it seemed "inescapable" that Baptist's answers were "misrepresentations." The Court further explained that Baptist "was not required to predict the precise nature of any such claim or specifically by whom the claim would be brought but it was required to notify the D&O insurer that a claim may result in or arise out of its adoption of the ECOI Policy." The Court specifically applied the objective standard in examining the language of the *prior knowledge* questions, and held that "no reasonable person would not foresee that adoption [of the D&O policy] in these circumstances may give rise to or result in a claim."

The Court rejected Baptist's argument that it had provided a copy of its ECOI Policy to its D&O insurer, and that the insurer could have researched or inquired as to ECOI policies. The Court found that the important fact was that Baptist had selected it for its D&O coverage after providing inaccurate and false information. Further, the Court found that, under Arkansas law, the insurance

carrier had no affirmative duty to make an independent investigation to ascertain the truthfulness of the facts set forth in insured's application. It was Baptist's responsibility, as set forth in the language of the prior knowledge questions, to alert the D&O carrier to the fact that its ECOI Policy may result in or give rise to a claim based on circumstances surrounding its adoption of that policy.

In addition, the Court also found that because the D&O carrier had no duty to Baptist under the D&O policy, Baptist's retention of those defense expenses advanced by the D&O carrier would be unjust, and as such, the D&O carrier was entitled to recover the amount of defense expenses advanced to Baptist.

Finally, the Court also determined that because the D&O policy was void *ab initio* and rescinded as if it were never in effect, Baptist was entitled to a refund of the premiums tendered to and received by the D&O carrier. Accordingly, the Court granted the D&O carrier's motion for summary judgment and denied Baptist's cross summary judgment motion.

TRESSLER COMMENTS

This decision is perhaps most remarkable for the thoroughness of the insurer's win here. Not only did they succeed in rescinding the policy, but they also recovered defense expenses that had already been paid. While such a recovery is entirely consistent with the fact that a rescission voids the policy *ab initio*, such recoveries are not commonplace in rescission litigation. The decision is also very interesting and instructive for its discussion of how the underwriting process takes place, and the Court's seeming abhorrence of the ECOI policy practiced at the insured institution, or at least the lack of candor in its disclosure regarding the consequences of same on its application.



Prepared by Elizabeth Caraballo, an Associate in our New York office.

SUMMARY JUDGMENT DENIED TO EPLI INSURER BY FEDERAL COURT IN NEW JERSEY DESPITE INSURED'S FAILURE TO DISCLOSE CLAIM ON APPLICATIONS

In a decision by the United States District Court, District of New Jersey, Judge Peter Sheridan, U.S.D.J. denied summary judgment to an EPLI insurer which sought to avoid coverage for a wrongful discharge case. The EPLI insurer had issued two consecutive policies. The EPLI insurer denied any coverage was owed because the insured failed to provide notice of claims under the first claims-made policy at issue and failed to disclose the claim on the application for the second claims-made policy. Despite sound arguments by the EPLI insurer, Axis Reinsurance Company, the court denied summary judgment.

Medpointe Healthcare, Inc. instituted a declaratory judgment action against its insurer Axis Reinsurance Company when Axis refused to defend or indemnify it on a suit filed by a former Medpointe employee, Smith. In Medpointe Healthcare, Inc. v. Axis Reinsurance Company, U.S. District Court, NJ (3/31/09), Axis argued that no coverage was owed under its September 2003 to September 2004 policy or the September 2004 to September 2005 policy because Medpointe knew of Smith's claim in October 2003 when it received a letter from Smith, through an attorney, asking for reconsideration of her termination, but Medpointe did not report it to Axis. Further, Axis argued that Medpointe knew of the Smith claim but did not report it when Medpointe was served with an EEOC charge in August 2004 alleging that Smith had been terminated due to her gender, age, race and disability. Medpointe first notified Axis in April 2005 after service upon it of a suit filed by Smith.

In denying Summary Judgment to Axis, the court found that while Medpointe received the EEOC charge notice in August 2004, the charge notice indicated Medpointe did not need to take action. Further, the court noted that the EEOC dismissed the charge 39 days after Medpointe learned of the charge. Specifically, the EEOC sent a letter to former employee Smith, copying Medpointe, that it was closing its file on the charge because

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circumstances known to any insured, namely the former CEO Bennett, was held to preclude coverage for all insureds as a matter of law.

There was a minor side issue as to the AWAC policy because the binder for the policy did not include a reference to a prior knowledge endorsement, but instead mentioned an inverted warranty endorsement. Because the language of the prior knowledge and inverted warranty endorsements were deemed to be materially identical, and pre-binder correspondence reflected knowledge on the part of Refco or its broker of the inverted warranty endorsement, the Court concluded that the prior knowledge endorsement was properly a part of the AWAC policy.

As to XL, however, summary judgment was denied for several reasons. First of all, because the XL policy did not follow the form of the primary policy, there was no

Smith had failed to respond within 30 days, as required by the EEOC. That notification from the EEOC advised Smith of the right to sue within 90 days and on the ninetieth day Smith filed suit against Medpointe.

Despite Axis' argument that Smith's letter of October 17, 2003 to Medpointe constitutes a "claim" as that term is defined in the policy, the court found that while the Smith letter requested reconsideration of the decision to terminate and sought reinstatement, it did not request damages. Moreover, the court noted that Smith's letter did not contend that the termination was wrongful but rather that her termination be reconsidered. Indeed, while Axis argued that Smith sought legal counsel and faxed the letter to Medpointe from an attorney's office, the court pointed out that Smith's husband is the attorney from whose offices the letter was faxed thereby creating an issue of fact as to the nature of the letter and whether Smith actually obtained legal counsel. Finding numerous questions of fact, the court denied Axis' motion for Summary Judgment.

Indeed, even though the court recognized that the Axis policies require reporting "as soon as practicable", the court determined that a reasonable juror could find that Medpointe did not violate its duty to report because the policy contains a 60 day period from policy expiration during which time a claim could be reported.

inconsistency between the severability clause of the primary policy and the exclusionary language of the excess policy as was true for AWAC and Arch. Consequently, there was no language in XL's policy to supersede the severability provision. Additionally, XL's binder did not make reference to its inverted representation endorsement or any functional equivalent, as was the case for the AWAC binder. While there was evidence before the Court on the motion suggesting that the parties did intend to include the inverted representation endorsement in the XL policy, it was insufficient extrinsic evidence to warrant summary judgment. Consequently, XL's summary judgment motion was denied and the insureds were given an opportunity to conduct discovery.

TRESSLER COMMENTS

Anyone versed in the art of drafting policy

TRESSLER COMMENTS

It is worthy of note that the court found "[s]ome of the language of Question 4 [within the policy application] is vague." While the court did not indicate what specific language it considered vague and did not set forth the entire question in the opinion, it noted that the application inquired whether the insured was "cognizant of any.... situation...which he/she has reason to suppose might afford grounds for any Claim such as would fall within the scope of the proposed insurance." It is also puzzling as to why the Court focused in the manner that it did on the application question. Although it is not readily apparent from the Court's opinion, most EPLI policies define Claims to include an EEOC proceeding and, despite the insured's subjective impression that the matter may have been over, the former employee did receive the standard right to sue letter from the EEOC. Seemingly, this should have been enough for the Court to have found no coverage under either policy but, alas, it did not.



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D&O INSURER DENIED INTERPLEADER ON GROUNDS THAT UNDERLYING CLAIMS DO NOT ARISE UNDER THE INSURANCE CONTRACT

In a fairly recent opinion by the United States District Court for the Eastern District of Kentucky, the Court denied an insurer the right to intervene in a set of consolidated cases on the ground that a potential denial of coverage for several of the insured defendants, based on the policy's fraud exclusion, did not constitute a "common question of law or fact" sufficient to Intervene under Fed. R. Civ. P. 24 (b), where none of the underlying disputes in the actions before the Court arose under the insurance policy. In re ClassicStar Mare Lease Litigation, 2009 WL 159152 (E.D.Ky. Jan. 22, 2009)

Travelers Casualty and Surety Company of America ("Travelers") issued a policy affording directors and officers liability coverage to GeoStar under which it, and certain other insured defendants including ClassicStar sought a defense and indemnity for several consolidated lawsuits filed against them. Travelers agreed to provide a defense to the insured parties in several of the matters under a reservation of rights. However, the accrued defense costs had eroded the policy's limit of liability and the settlement demands of the plaintiffs in the consolidated matters (when totaled) exceeded the available limit of liability. Consequently, there were limited funds available to cover both the insureds' defense expenses as well as payment for any liability under the policy.

Travelers sought to intervene in the litigation and filed a Complaint for Interpleader, under Fed. R. Civ. P. 24 (b), with the intention of ascertaining the insureds' rights to the remaining funds with regard to payment of the defense costs and settlement of the pending matters. Travelers also sought to place the remaining limit of liability into the Court's registry so that the Court could supervise the distribution of the remaining funds. Several defendants filed a Response, stating that they did not oppose Travelers' motion and requested a conference with the insureds under the policy to discuss a fair distribution of such funds if the Motion were granted. Two defendants opposed the Motion as untimely, stating that the relief requested would prejudice the insureds,

and that shifting the administrative costs of reviewing and approving payment of defenses expenses was inequitable as it excused Travelers from its duties under the policy. The Motion was denied.

Fed. R. Civ. P. 24 (b) provides that "on timely motion, the court may permit anyone to intervene who...has a claim or defense that shares with the main action a common question of law or fact." Under 28 U.S.C. § 1335, Interpleader is "a suit to determine a right to property held by a usually disinterested third party who is in doubt about ownership and who therefore deposits the property with the court to permit interested parties to litigate ownership." Here, Travelers wanted to join any dispute over the funds under its control in the set of cases pending before the Court. However, the Court determined that none of the cases arose under the contract of insurance or concerned the enforcement or breach of the insurance contract. Consequently, the Court found no "common law or fact" existed that provided sufficient grounds to grant the intervention.

The Court noted that while Travelers may have relied upon the fraud exclusion in the policy to deny coverage to some or all of its insureds, the coverage issues raised by Travelers in its Interpleader Complaint were, at best, tangentially related, and, ultimately, irrelevant to resolution of the allegations and cross-allegations made in the cases before the Court. The Court also noted that there can be no common question

of law and fact when the party seeking to intervene would, in its intervening complaint in interpleader, effectively disavow the only arguable common question of law or fact between the consolidated matters and the proposed intervention.

TRESSLER COMMENTS

As provided in 28 U.S.C. § 1335, Interpleader is usually brought by a disinterested third party. Not raising the fraud exclusion in the Complaint for Interpleader comported with the "disinterest" requirement in the statute. However, the lack of a common question of law or fact between the consolidated matters and the proposed intervention ultimately derailed the insurer's case. While the facts of this case produced an incongruous result in a situation where the insurer was simply trying to take a prudent course of action, interpleader can be a very effective tool for insurers under many circumstances. Another option, which may not have been feasible in this situation, given the numerous parties and the number of cases, would be for the insurer to seek declaratory relief under 28 U.S.C. § 2201.



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