

Specialty Lines Advisory

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JOE SAYS...

Tellabs, Twombly and Iqbal Revisited – Ninth Circuit Decides *Siracusano v. Matrixx Initiatives*

When we first commented upon the June 21, 2007 U.S. Supreme Court decision in [Tellabs, Inc. v. Makor Issues & Rights, Ltd.](#), 551 U.S. 308 (2007) in the July 2007 issue of this *Advisory*, we cautioned our readers that the decision might not be the great win for defendants that some commentators were then espousing it to be. We noted that most defendants and insurers would have much preferred the analysis and standard advocated in the concurring opinions of Justices Scalia and Alito, and that only time and subsequent lower court decisions would determine the value of [Tellabs](#) to the defense.

On October 28, 2009, in the most recent in a series of appellate and district court decisions denying or reversing dismissals, the Ninth Circuit applied the so-called heightened pleading standards of the majority opinion in [Tellabs](#) and found that the plaintiffs met those standards. [Siracusano v. Matrixx Initiatives](#), 2009 WL 3448282 (9th Cir. October 28, 2009).

In brief summary, [Matrixx](#) arose from a securities class action against a pharmaceutical company which sold a well-known cold remedy called

Zicam. The key allegations of securities fraud asserted by the plaintiff investors concerned failure to disclose material information regarding the potential harmful effects of Zicam, particularly that it could cause anosmia, a loss of the sense of smell. It was alleged that Zicam was perhaps the company’s most important product, accounting for about 70% of the company’s sales, and that the company was aware of several cases of anosmia among Zicam users.

The lower court – the United States District Court for the District of Arizona – had granted the defendants’ motion to dismiss applying the pleading requirements of Section 10(b) of the Securities Exchange Act of 1934 and SEC Rule 10b-5. In particular, these requirements state that plaintiffs must allege in their Complaint:

- A material misrepresentation or omission of fact;
- *Scienter*;
- A connection with a purchase or sale transaction in the securities at issue;
- Transactional and loss causation; and
- Economic loss.

In reversing the lower court on the requirement of materiality, the Ninth Circuit applied the standard set forth in the Supreme Court decision in [Bell Atl. Corp v. Twombly](#), 550 U.S. 544 (2007), which arose from an underlying antitrust action, not securities fraud. [Twombly](#) holds that dismissal is inappropriate unless the pleading is so deficient as to fail

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to state a claim to relief that is *plausible* on its face, as opposed to being merely *conceivable*.

With regard to the *scienter* requirement, the Court turned to *Tellabs*, which held that a Complaint can survive dismissal only if a reasonable person would deem the inference of *scienter* cogent and at least as compelling as any other inference. In other words, and to use a baseball analogy, a tie goes to the plaintiff runner if his foot hits the bag at the same time as the throw is caught by the defendant fielder at the base. In an earlier decision, the Ninth Circuit made it clear that *scienter* could be satisfied by “deliberate recklessness”. In re Silicon Graphics Inc. Sec. Litig., 183 F.3d 970 (9th Cir. 1999). Although the Court found that unusual stock sales by corporate insiders could help establish a motive to support an inference of *scienter*, per *Tellabs*, the absence of such motive would not be fatal to the plaintiff’s case. Pulling this all together, the Court had seemingly little trouble in concluding that the inference that the *Matrixx* defendants withheld information about the deleterious effects of Zicam with “deliberate recklessness” (or even intentionally) was at least as compelling as an inference that the information was withheld innocently.

Many commentators believed prior to this decision (and perhaps even after) that *Tellabs* was a potent weapon in the securities defendants’ arsenal, and that *Twombly* provided even further protection. Even more recently, the Supreme Court decided *Ashcroft*

v. Iqbal, 556 U.S. ___, 129 S. Ct. 1957, No. 07-1015 (May 18, 2009), which applied the *Twombly* pleading standards beyond antitrust in a discrimination case. *Iqbal* was perhaps the straw that broke the camel’s back to advocates of lowering pleading standards in favor of plaintiffs. As we commented upon in this space in our September 2009 issue, the cause of these interests are now being championed in legislation introduced by Sen. Arlen Specter (D-PA) that would effectively roll back the defense-oriented pleading reforms to the Stone Age notice pleading standard enunciated in *Conley v. Gibson*, 355 U.S. 41 (1957).

The legislative efforts continue to progress with a companion bill to that introduced by Sen. Specter having been introduced in the House on November 19, 2009 – “The Open Access to Courts Act of 2009” – by Rep. Jerrold Nadler (D-NY). Hearings have continued this month before the Senate Judiciary Committee on the Specter bill.

Regardless of what happens in Congress, the impact of these Supreme Court decisions may continue to be effectively mitigated in the circuits as those courts attempt to give clarity to the heightened pleading standards. Many plaintiff attorneys have opined that they are confident that they can easily “plead around” these new requirements. While that has not always been so easy with respect to loss causation and the standards set forth in *Dura Pharmaceuticals v. Broudo*, 544 U.S. 336 (2005), decisions such as *Matrixx* may be a painful reminder and ratification of the

views expressed earlier that *Tellabs* was not quite a win for the defense.

What all of this suggests is that times are not getting any easier for D&O insurers. Perhaps the one bright spot in the dismal array of ever-broadening coverage terms, increased settlement values and continued frequency of suits was the significant amount of cases resolved upon successful motion practice. If these successes significantly diminish in frequency, the problems for insurers in this market will only be exacerbated.



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PRIOR KNOWLEDGE EXCLUSION BARS COVERAGE WHERE THE INSURED KNEW OF POTENTIAL CLAIMS PRIOR TO THE INCEPTION OF THE POLICIES

In *Executive Risk Indemnity, Inc. v. Pepper Hamilton LLP, et al.*, 2009 N.Y. LEXIS 3911 (N.Y. Oct. 20, 2009), the New York Court of Appeals, that state's highest court, applying Pennsylvania law, held that the prior knowledge exclusion barred coverage under two excess legal malpractice policies where the insured law firm knew that it could possibly be held liable for the fraudulent conduct of its client, but failed to inform the insurers prior to purchasing the policies.



The underlying action arose out of Pepper Hamilton LLP's ("Pepper Hamilton") representation of Student Finance Corporation ("SFC"), its principal, Andrew Yao, and Royal Indemnity Company. SFC was in the business of financing loans to students at vocational schools and acquiring student loans from other lenders. SFC pooled the loans into certificates and then sold them to investors. Additionally, Royal Indemnity Company, also a client of Pepper Hamilton, provided SFC with credit risk insurance for the company's pooled loans from 1999 through 2001.

From April 27, 2001 to October 27, 2002, Pepper Hamilton had two insurance policies; a primary policy issued by Westport Insurance Corporation ("Westport") and an excess policy issued by Continental Casualty Company ("Continental"). Additionally, in the following years, from October 27, 2002 to October 27, 2004, Westport issued a \$10 million primary policy to Pepper Hamilton and Executive Risk Indemnity, Inc. ("Executive Risk"), Twin City Fire Insurance Company ("Twin City"), and Continental each issued \$10 million of excess coverage.

In March 2002, months before the Executive Risk and Twin City policies were issued, Pepper Hamilton learned that SFC had been involved in securities fraud. Specifically, "Yao informed W. Roderick Gagné, an attorney at Pepper Hamilton, that SFC was inaccurately representing its default rate to make its certificates appear more attractive to investors, underwriters and credit risk insurers." In August 2002, in response to an inquiry from Pepper Hamilton's general counsel regarding whether anyone knew of any fact, circumstance, act, error, omission or personal injury which might be expected to be the basis of a claim or suit for lawyers professional liability, Mr. Gagné stated that he knew of lawsuits filed in two other states regarding SFC transactions. Mr. Gagné further stated, "[W]e have not been named in either action. I am not certain as to whether we will be joined in the future." Despite this response, the application submitted to Westport did not include information regarding SFC and Pepper Hamilton never disclosed information concerning SFC to any of its insurers.

SFC was eventually forced into bankruptcy and Pepper Hamilton was sued by the bankruptcy trustee and Royal Indemnity Company. Although Westport did not contest its obligation to defend Pepper Hamilton in the underlying action, the excess insurers denied coverage. Executive Risk then filed this action against Pepper Hamilton and Westport seeking a declaration that it was not obligated to indemnify Pepper Hamilton. Pepper Hamilton then filed a counter-claim against Executive Risk and also brought third party claims against Twin City and Continental. While Executive Risk and Twin City relied on Westport's prior knowledge exclusions, which were expressly incorporated into their policies, Continental cross-claimed for rescission of its excess policies that were in effect between 2002 and 2004.

The first issue addressed by the court was whether Executive Risk and Twin City could rely on the prior knowledge exclusion within the Westport policies to preclude coverage under their excess policies. The Westport policy excluded coverage for "any act, error, omission, circumstance or PERSONAL INJURY occurring prior to the effective date of this Policy if any INSURED at the effective date knew or could have reasonably foreseen that such act, error, omission, circumstance or PERSONAL INJURY might be the basis of a CLAIM." In its analysis, citing *Coregis Insurance Co. v. Baratta & Fenerty, LTD*, 264 F.3d 302, 306 (3d Cir. 2001), the Court held that when determining whether a prior knowledge exclusion applies, a court "must first consider the subjective knowledge of the insured and then the objective understanding of a reasonable attorney with that knowledge." In applying this test, the court found that "[g]iven the law firm defendants' role in the securitization of the loans and Gagné's close involvement with SFC, a reasonable attorney with the law firm defendants' knowledge should have anticipated the possibility of a lawsuit, particularly of which they were aware." Accordingly, the court held that on October 27, 2002, the date on which the Executive Risk and Twin City policies incepted, Pepper Hamilton knew of facts that occurred prior to that date, which they could have foreseen to be the basis of a claim and thus, the prior knowledge exclusions barred coverage under the excess policies. In so holding, the court reversed the Appellate Division's ruling.

Finally, Continental sought to rescind its insurance policy on the basis that Pepper Hamilton had made a false statement in its insurance application. Under Pennsylvania

law, rescission of an insurance policy may occur only if the applicant knowingly made a false statement in bad faith and that false statement was material to the risk. The court concluded that even if Pepper Hamilton's omission of the SFC incident qualified as a false statement, Continental failed to prove, as a matter of law, that the false statement was material to the reinsurance determination and that the false statement was made in bad faith. Accordingly, the court held that the Appellate Division correctly denied Continental's motion for summary judgment on the issue of rescission.

TRESSLER COMMENTS

This is a very significant decision for a number of reasons.

First, it reversed the very controversial lower appellate court decision, which had held in favor of the insured on the basis that the law firm believed it had not committed malpractice even though it knew that it was likely the firm would be sued.

Second, the same facts that supported a denial of coverage based upon the prior knowledge exclusion, proved insufficient to warrant a rescission. Unlike in the case of rescission, the exclusion required no finding of materiality.

Finally and interestingly, in this case, the following form excess carriers relied on an exclusion within the underlying primary policy which the primary carrier did not use as a basis for disclaiming coverage under its own policies. In fact, the court states that the primary carrier did not contest its obligation to defend the insured. This illustrates that even following form excess carriers are not bound by the decisions of the underlying primary carrier and are permitted to take a contrary position even in a situation where the underlying primary carrier has agreed to defend.



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COVERAGE PRECLUDED BY INCREASED LIMITS WARRANTY EXCLUSION

In *Rivelli, et al. v. Twin City Fire Insurance Co.*, Case No. 1:08-CV-01225-RPM (10th Cir. October 26, 2009), the court held that an increased limits warranty exclusion precluded coverage for the defense costs of insured persons that fell within the amount of the increased limit of a renewed policy.

Plaintiffs were directors or officers of Fischer Imaging Co. (“Fischer”), which carried \$5 million in primary D&O coverage provided by Federal Insurance Company (“Federal”). Twin City Fire Insurance Company (“Twin City”) initially provided Fischer with \$2.5 million in excess D&O coverage but, in April 2002, when plaintiffs renewed their excess policy with Twin City, they increased their excess coverage by another \$2.5 million, securing a total of \$5 million in excess D&O coverage. In order to secure the “top” \$2.5 million in coverage,



Fischer supplied Twin City with a Warranty Letter representing that “[n]o person or entity for whom this insurance is intended has any knowledge or information of any act, error, omission, fact or circumstances which may give rise to a claim which may fall within the scope of the proposed insurance detailed above”, and noting that it was “AN EXPRESS WARRANTY FOR ALL INSUREDS”.

In April 2003, two shareholder suits were filed against Fischer, however, both suits were dismissed and not re-filed. In June 2005, the Securities and Exchange Commission (“SEC”) filed a civil enforcement action against plaintiffs, alleging securities fraud, and in May 2008, filed its first amended complaint, alleging that from January 2000 through September 2002, plaintiffs engaged in a scheme to fraudulently inflate the company’s stock price for their personal enrichment by repeatedly and improperly recognizing revenue, materially misstating its financial reports and misleading outside auditors to hide their accounting improprieties. The defense costs for these suits exhausted the \$5 million primary policy provided by Federal and the “top” \$2.5 million of the excess policy provided by Twin City. However, Twin City declined to pay the \$2.5 million increase based on the exclusionary language added to the policy in April 2002, and asserted that the SEC’s complaint and amended complaint show that when Fischer increased its excess D&O coverage in April 2002, plaintiffs had been fraudulently inflating reported company revenues for over a year. Both insurers paid under a reservation of rights to challenge their payouts later.

Thereafter, plaintiffs filed suit against Twin City and summary judgment motions were filed on the issue of whether Twin City was obligated to advance to plaintiffs the \$2.5 million increase in excess liability

coverage. The district court concluded that the exclusion in the Warranty Letter was triggered by the allegations in the SEC’s amended complaint, and therefore, Twin City was not obligated to advance the “top” \$2.5 million in defense costs. Plaintiffs appealed to the Tenth Circuit.

In affirming the decision of the district court, the Tenth Circuit rejected all six arguments proposed by plaintiffs. First, plaintiffs argued that the district court erred in its application

of Colorado’s complaint rule¹ in finding for Twin City because it assumed the existence of the disputed matters not alleged in the SEC’s amended complaint. However, the Tenth Circuit rejected this argument noting that it was confident that the district court confined its analysis to the SEC’s amended complaint as evidenced by the district court’s detailed discussion of the allegations of that complaint in reaching its conclusion. Second, plaintiffs argued that the district court erroneously applied an objective standard in interpreting the exclusion in the Warranty Letter. The Tenth Circuit agreed that the exclusion calls for the application of a subjective standard, but noted that although the district court did not employ the term “subjective knowledge” when it recounted the allegations, the district court outlined in great detail plaintiffs’ subjective knowledge of facts that indisputably could give rise to a claim under the policy— as alleged in the SEC’s amended complaint. Plaintiffs’ third argument—that the district court improperly construed alternative and contradictory allegations in the SEC’s amended complaint as establishing that the SEC’s claim were solely and entirely within the prior knowledge exclusion—also failed. The Tenth Circuit noted that plaintiffs failed to point to the allegedly inconsistent and contradictory allegations, and agreed with the district court that “when read together” the SEC’s claims compel the conclusion that the SEC’s allegations were within the exclusion in the Warranty Letter.

As with plaintiffs’ initial arguments, the

¹ The Tenth Circuit explained that, under the Colorado “complaint rule,” the insurer’s duty to defend is determined by examination of solely the policy and the complaint filed against the insureds. In essence, Colorado is what would be called in other jurisdictions a “four corner state”, i.e. the insurer need only consider what is contained within the four corners of the pleading, and not any extrinsic facts or allegations.

Tenth Circuit also rejected the rest of the arguments raised by plaintiffs. And in doing so, the Tenth Circuit honed its reasoning that the district court correctly concluded that the allegations in the SEC’s amended complaint, when read together, compel the conclusion that the SEC’s allegations were within the exclusion in the Warranty Letter.

TRESSLER COMMENTS

The issues presented by the exclusion in the warranty letter here are similar to those that may arise in rescission cases, but are more similar to prior knowledge exclusions. Like the latter and unlike the former, in most jurisdictions only the simple fact of a misrepresentation or omission need be established by the insurer, without need to prove materiality or detrimental reliance. Although not made explicit in the Court’s decision, it should be noted that the excess insurer here was not seeking to be exculpated from all payment obligations under the policy – only its exposure for the top half of its limits.



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CLAIM MADE PRIOR TO POLICY'S INCEPTION: TENTH CIRCUIT UPHOLDS INSURER'S DENIAL OF COVERAGE UNDER LAWYERS' PROFESSIONAL LIABILITY POLICY BASED ON DEFINITION OF "RELATED WRONGFUL ACTS"

In a recent decision by the U.S. Court of Appeals for the Tenth Circuit, the court affirmed the lower court's decision that there was no coverage under a claims-made policy for claims asserted in a malpractice lawsuit because: (1) the claims of malpractice asserted in a letter to the insured before the policy incepted were logically connected to the claims later asserted in the malpractice lawsuit and therefore the insured's receipt of the letter marked the date on which the claim was made. Berry & Murphy, P.C., et al. v. Carolina Casualty Insurance Co., 586 F.3d 803, 2009 U.S. App. LEXIS 24812 (10th Cir. November 12, 2009).



This insurance dispute arises from attorney Seth Murphy's representation of Oksana and William Burkhardt (the "Burkhardts") in a personal injury lawsuit ("Ciri Lawsuit"). In January 2005, Mr. Murphy, a former co-shareholder of the plaintiff law firm Berry & Murphy, filed the Ciri Lawsuit in Colorado state court and failed to opt out of proceeding under Colorado's simplified procedure rule, Colo. R. Civ. P. 16.1 ("Rule 16.1"). Under Rule 16.1, the maximum allowable monetary judgment is \$100,000 and early disclosures are required.

In March 2006, Mr. Murphy left Berry & Murphy and joined the law firm of Richmond, Neiley, Sprouse & Murphy, LLC, taking the Ciri Lawsuit with him. Around the same time, however, Mr. Murphy filed a motion to withdraw as counsel.

In April 2006, the defendants in the Ciri Lawsuit filed a motion to dismiss the case for failure to prosecute, alleging, among other things, failure to supplement initial disclosures, failure to produce a release for medical records and failure to produce non-expert witness information. The court granted Murphy's motion to withdraw and subsequently granted the defendants' motion to dismiss without prejudice.

The Burkhardts hired new counsel and moved for reconsideration of the court's dismissal order and for reinstatement of the case. The court granted the Burkhardt's motion and set a new deadline for the Burkhardts to file their non-expert witness disclosures.

On January 10, 2007, the Burkhardts' new attorney, Cindy Tester, sent Mr. Murphy

a letter at his new law firm advising him to notify his legal malpractice insurance carrier that the Burkhardts were planning to file a legal malpractice claim against him for his handling of their lawsuit ("Tester Letter"). Mr. Murphy put his current law firm's malpractice carrier on notice of the claim, but did not notify his former firm of the claim.

Subsequently, the defendants in the Ciri Lawsuit renewed their request for dismissal on grounds that the Burkhardts again failed to comply with the court's orders concerning discovery deadlines. The court ultimately granted the defendants' motion with prejudice, and the Burkhardts filed a legal malpractice claim against Mr. Murphy and Berry & Murphy (the "Malpractice Lawsuit"). The Malpractice Lawsuit alleged that Mr. Murphy and Berry & Murphy missed the deadline for filing a notice to elect exclusion from Rule 16.1, were generally negligent and breached their fiduciary duty of loyalty to the Burkhardts.

Timothy Berry accepted service of the Malpractice Lawsuit on behalf of his firm Timothy H. Berry, P.C., successor to Berry & Murphy, and notified the firm's carrier, Defendant Carolina Casualty, of the suit under a claims made policy, effective from February 6, 2008 to February 6, 2009 (the "Policy"). Carolina Casualty denied coverage for the Malpractice Lawsuit on grounds that the alleged malpractice claim was first made against an insured when the Tester Letter was sent to Mr. Murphy on January 10, 2007, which was prior to the inception of the Policy. Mr. Berry and Timothy H. Berry, P.C. (collectively "Plaintiffs") filed a lawsuit against Carolina Casualty seeking declaratory relief, injunctive relief, breach of contract and bad faith. Both parties filed motions for summary judgment on the issue of coverage. The district court granted Carolina Casualty's summary judgment motion, and the Plaintiffs appealed.

The appellate court considered the language

of the Policy, which provided that a claim was deemed to have been first made at the time notice of the claim was first received by any insured. Further, all claims based upon or arising out of the same "Wrongful Acts" or any "Related Wrongful Acts," or one or more series of any similar, repeated or continuous "Wrongful Act" or "Related Wrongful Acts," were considered a single claim.

Plaintiffs argued that the Malpractice Lawsuit, as opposed to the Tester Letter, was the operative claim, and, as such, was made within the policy period. Plaintiffs reasoned that the claims asserted in the Tester Letter had no logical or casual connection with the claims asserted in the Malpractice Lawsuit.

The appellate court disagreed, holding that the phrase "logically connected" means connected by an inevitable or predictable interrelation or sequence of events. The Tester Letter accused Mr. Murphy of not submitting required witness disclosures under Rule 16.1. The Malpractice Lawsuit attacked Mr. Murphy's decision to proceed under Rule 16.1. Both of these acts, the court opined, were predictably interrelated because the decision not to opt out of Rule 16.1 resulted in a timeline for witness disclosures under that rule.

The court further determined that the Burkhardts' Malpractice Lawsuit resulted in a single malpractice claim because the alleged acts of malpractice in the Tester Letter and alleged acts in the Malpractice Lawsuit were "Related Wrongful Acts," as there was but one client – the Burkhardts; one attorney – Mr. Murphy; and one tort claim for which Mr. Murphy was retained.

The court concluded that, although a harsh result for Plaintiffs, the plain language of the Policy required it to affirm the district court's decision that the Burkhardts' malpractice claims were not covered under the Policy because said claims constituted one claim

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COURT TELLS INSURED - "STAND IN LINE": THIRD CIRCUIT ENFORCES INTERRELATED WRONGFUL ACTS PROVISION

On October 26, 2009, the United States Court of Appeals for the Third Circuit affirmed summary judgment in favor of an insurer applying an interrelated wrongful acts provision to bar coverage for fraudulent conveyance claims against the insured and a former executive. The Court also rejected the insured's arguments that notwithstanding the interrelated wrongful acts provision in the policy, the insurer was estopped from applying the provision or otherwise liable. *G-I Holdings, Inc. v. Reliance Insurance Company*, 586 F.3d 247 (3rd Cir. 2009).

G-I Holdings, Inc. ("G-I") purchased a policy from Reliance Insurance Co. ("Reliance") that was to cover claims against G-I's directors and officers between July 1999 and July 2002. The policy contained an interrelated wrongful acts provision which stated that the filing date of all suits arising from the same wrongful act would be deemed to be the date on which the first such suit was filed. Hartford Fire Insurance Company ("Hartford") took over claims administration for Reliance. In the summer and fall of 2000, Hartford acquired renewal and other rights to, and became a reinsurer and servicer of, certain Reliance policies. In July 2000, G-I asked its broker to arrange for G-I to acquire a separate directors and officers policy from Hartford. Reliance changed the termination date of its policy to July 15, 2000 and Hartford (through a subsidiary) issued G-I an identical policy effective July 15, 2000 to July 1, 2002, with the same limits of \$15 million.



Prior to purchasing the Reliance policy, G-I had incurred more than \$200 million in asbestos liabilities and faced the prospect of hundreds of thousands of future claims. After G-I distributed the stock of a profitable subsidiary in 1997 to Samuel J. Heyman ("Heyman"), its CEO, chairman of its Board and controlling shareholder, G-I was sued for fraudulent conveyance in three separate lawsuits by asbestos claimants or their representatives. Heyman was also sued. The first suit was filed on January 3, 2000; the second on September 19, 2000; and the third on September 17, 2001.

G-I and Heyman (hereinafter collectively "G-I") sought coverage for the three fraudulent conveyance actions. Reliance and Hartford denied coverage. Hartford denied coverage on the grounds that under the interrelated wrongful acts provision in the Hartford policy, the filing date of the second and third suits "relate back" to the filing date of the first action, which falls within the amended Reliance policy period.

In light of the liquidation of Reliance pursuant to an order by a Pennsylvania state court, G-I agreed to pursue Reliance in the liquidation proceedings in Pennsylvania. G-I sued Hartford in New Jersey state court. Hartford removed the case to the United States District Court for the District of New Jersey where, after jurisdictional battles (including in Bankruptcy Court after G-I filed for Chapter 11 protection), the case remained. In June 2006, the District Court granted Hartford summary judgment. G-I appealed.

On appeal, G-I argued that Hartford must cover all or some of the fraudulent conveyance actions because: 1) Reliance and Hartford agreed to provide coverage for a single policy period, and therefore the Hartford policy period includes the amended Reliance policy period; 2) the interrelated wrongful acts provision does not apply and consequently, the two later-filed actions fall within the covered Hartford policy period; and/or 3) the purchase, servicing and reinsurance agreements between Hartford and Reliance, and the close relationship of those parties, make Hartford directly liable under the amended Reliance policy. G-I further argued that Hartford should be judicially estopped from relying on the interrelated wrongful acts provision to avoid coverage because Hartford asserted a contradictory argument in a motion to dismiss in the District Court.

The Third Circuit rejected G-I's arguments and affirmed summary judgment in favor of Hartford. It stated that G-I's argument for a single policy period would require the Court to disregard the plain language of the Hartford policy which covered only the period of July 15, 2000 to July 1, 2002. Nonetheless, the Court recognized that New Jersey courts construe insurance policies to reflect the reasonable expectations of the insured in the face of ambiguous language, sometimes even when the literal meaning of the policy is plain. However, in this case, the

Court found that G-I provided no evidence to support a reasonable expectation that Hartford would provide such a policy.

The Court also considered G-I's position that the interrelated wrongful acts provision should not apply to bar or limit coverage. G-I argued that the purpose of the provision was to ensure that risks arising out of the same wrongful act were subject to only one policy and limit and also to prevent changes in policy language from one policy period to another from creating disparate coverage determinations for the same wrongful act. The Court rejected G-I's position, stating that even if it were inclined to make application of the provision contingent on the purposes behind the provision rather than application of the contract language as written, it would still apply the provision because it does have a purpose that applies in this case. It allows Hartford to cap related wrongful acts to a single policy period and allows an insured such as G-I to obtain coverage under a new policy despite facing additional liability exposure from its past acts.

In addition, the Court rejected G-I's arguments that even if the Hartford policy did not cover the fraudulent conveyance actions, Hartford still must cover them because agreements between Hartford and Reliance make Hartford directly liable under the amended Reliance policy. Although Hartford had entered into a series of agreements with Reliance concerning Reliance's coverage obligations, none of those agreements created direct liability to Hartford for the amended Reliance policy. The Court also indicated that it was particularly reluctant to permit direct recovery against Hartford as a reinsurer in this case because Reliance's liquidation proceedings in Pennsylvania could possibly impose liability on Hartford. It commented that G-I could "stand in line in Pennsylvania with other insureds" to seek recovery.

Finally, the Court rejected G-I's judicial estoppel argument. G-I had argued that because Hartford had initially argued that the two later fraudulent conveyance suits were not covered by the Reliance policy, it should not now be allowed to invoke the interrelated wrongful acts provision to

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ALL "OTHER INSURANCE" CLAUSES ARE NOT CREATED EQUALLY: HOSPITAL'S SIR MUST EXHAUST BEFORE NURSE'S OWN POLICY APPLIES

A federal district court sitting in New Jersey has given effect to an "other insurance" clause which requires that all other insurance, including any applicable self-insured retention be exhausted before that policy has to respond. Warren Hospital v. American Casualty Company of Reading, PA, 2009 US District LEXIS 87975 (DNJ September 23, 2009); opinion by the Hon. Jose L. Linares, United States District Judge.

In Warren Hospital, the nurse, a defendant in a medical malpractice action, was defended pursuant to the \$1 million self-insured retention ("SIR") in a hospital's coverage program; she also had her own medical malpractice insurance. The hospital sought equitable contribution



from the nurse's insurer. The court, distinguishing New Jersey state court decisions holding that self insured retentions do *not* qualify as "other insurance," found that because the language in the nurse's own policy expressly included SIRs within the definition of "other insurance", it did not respond until the hospital's SIR was exhausted.

The other insurance clause in the nurse's own policy stated "If there is any other insurance policy or risk transfer instrument, *including but not limited to, self-insured retention*, deductibles, or other alternative arrangements ("other insurance"), that applies to any amount payable under this

policy, such other insurance must pay first." (emphasis added). This policy wording effectively defined or described "self-insured retention" as an "insurance policy or risk transfer instrument." Finding that the policy at issue "clearly and unambiguously puts the insured on notice that it will not step in and pay prior to a deductible or self-insured retention" being paid, the Court found that the nurse's own policy did not have to pay prior to the hospital's self-insured retention being exhausted, even though it did not use "traditional" "other insurance" or "other valid and collectible insurance" language.

TRESSLER COMMENTS

This decision reminds carriers that in analyzing the impact of self insured retentions in claims governed by New Jersey law, the language of the "other insurance" clause in the other insurer's policies will dictate the priority of coverage. Thus, in any case involving more than one policy applicable to an insured, it will be critical to review all potentially applicable policies as early in the claim process as possible.

The decision also presents a teachable

moment for drafters of insurance policy and endorsement language. Most underwriters would intend their policies to be excess of not only other insurance policies, but also self-insured retentions and perhaps even non-insurance sources of indemnification. The lesson is that, if that is your desire, express it specifically or risk having a court construe "self-insurance" as "no insurance". Indeed, that would have been the result under applicable New Jersey law, absent this very specific policy language.



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deny coverage for those actions under the Hartford policy. The Court noted that in the Third Circuit, judicial estoppel is generally inappropriate where the defending party did not convince the District Court to accept its earlier position. Here, the District Court never accepted Hartford's prior position. Consequently, the Court of Appeal declined to bar Hartford's new one.

TRESSLER COMMENTS

In this case, the Court of Appeal rejected

attempts by G-I to circumvent the Reliance liquidation proceedings to secure a potentially more favorable recovery. However, the Court noted that G-I could have paid a higher price to have shifted all of its risk to Hartford in light of Reliance's financial troubles and it chose not to purchase that additional coverage. Moreover, as G-I failed to present evidence to support any reasonable expectation of coverage, the Court did not have to look beyond the plain language of the Hartford policy to apply the interrelated wrongful acts provision.



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NEW JERSEY DISTRICT COURT REJECTS LOSS PAYEE'S CLAIM UNDER FIDELITY POLICY DUE TO INSURED'S FAILURE TO COMPLY WITH PROOF OF LOSS CONDITION

In *Carteret Ventures, LLC v. Liberty Mutual Insurance Co.*, No. 09-2831, 2009 WL 3230844 (D.N.J. Oct. 2, 2009), Carteret entrusted Liberty's insured, Excalibur, with \$11 million to hold as part of a tax deferred exchange under § 1031 of the Internal Revenue Code. Carteret discovered Excalibur could not account for the money and alleged that Excalibur's owners or employees had stolen it.



An endorsement to Liberty's commercial crime policy provided coverage for employee theft of client property while in Excalibur's custody. It expressly provided that "client exchangers" such as Carteret would be loss payees. Any payment under the policy would be made directly to the loss payee. However, the endorsement also stated that the policy was for the benefit of Excalibur only, that any claim had to be presented by Excalibur and that loss payees would have no rights or benefits other than to payment of loss as specified.

Carteret sued Excalibur but dismissed the suit after Excalibur agreed it owed Carteret at least \$8.5 million. Excalibur gave notice of loss to Liberty and filled out a proof of loss form but, expressing Fifth Amendment concerns, refused to sign it. Liberty denied coverage and also rejected a proof of loss signed and submitted by Carteret.

Carteret sued Liberty. The United States District Court for the District of New Jersey granted Liberty's motion to dismiss. Carteret did not have standing either as an insured or as an assignee of the insured. The policy unambiguously provided first-party fidelity coverage to Excalibur alone and prohibited assignment without Liberty's consent. As a mere third party loss payee, Carteret could not make a claim or bring suit on the policy.

Nor did Carteret have any equitable right to recover. Carteret's only right was to receive payment if Excalibur established entitlement. If Excalibur failed to meet the policy's proof of loss condition, Carteret could do nothing about it against Liberty. Liberty never led Carteret to think otherwise, i.e. Liberty never deceived or lulled Carteret into inaction by inducing Carteret to believe that Excalibur had perfected the claim or would not need to do so. Thus Liberty was not estopped and the express language of the policy controlled.

TRESSLER COMMENTS

Client property coverage has become a common feature of fidelity policies. This case illustrates, however, that the victimized client recovers nothing under the policy unless the insured prosecutes the claim. The policy thus retains its nature as first-

party coverage only. Insurers should make this clear to both the client and the insured, and avoid giving the client any reason to believe it can recover if the insured fails to pursue the claim or prove the loss.



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and were first made at the time Mr. Murphy received the Tester Letter in 2007, which was before the Policy inception.

TRESSLER COMMENTS

The court's decision in *Berry* is both unsurprising and correct as it upholds one of the fundamental bases for claims-made coverage. Claims-made insurance policies are not intended to cover claims made prior to the inception of the policy and the premium for such policies is calculated, at

least in part, based on that premise. Under most claims-made policies, in assessing whether a claim was made prior to the policy's inception, the pivotal issues involve what constitutes a claim under the policy and whether a subsequent claim is related to the prior claim such that they constitute one claim instead of multiple claims. This case is a good example of how a clear definition of "Related Wrongful Acts" can effectuate the insurer's intent in drafting the policy. It is also a good example of why insureds must always take care to ensure that notice of a

claim is given under all insurance policies potentially providing coverage for a claim.



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