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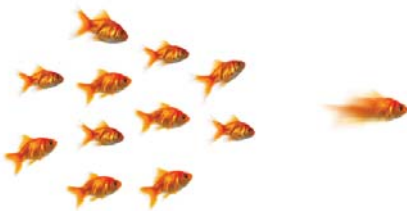

We have a different name, but we are still the same firm. In a time of commoditization, we refuse to be a commodity. In a time of contraction, we continue to grow. In a time of self-absorption, we remain committed to our profession and the communities in which we live. In a time of indifference, we still listen. In a time of uncertainty, we stand confident and prepared for whatever lies ahead.

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Specialty Lines Advisory

JOE SAYS...

Some Inside Baseball Talk – Or At Least Inside *The Specialty Lines Advisory*

I am writing this near the end of October and, not that this is a slow period in my practice or in the insurance industry, but I thought it would be nice to share with you some information as to why we write this *Advisory* and how we select its contents.

This Advisory had its origins about five years ago as *The D&O Advisory*, and its focus then was almost exclusively on coverage decisions in the area of D&O insurance. As our practice grew in size and scope, we decided to expand the publication and eventually renamed it *The Specialty Lines Advisory*.

Although we do not feature decisions from all of these areas every month, we consider the following key topical areas for inclusion of articles:

- Securities Fraud Litigation
- D&O Coverage
- Lawyers Malpractice Coverage
- Employment Litigation
- Employment Practices Liability Coverage
- Miscellaneous Professional Liability Coverage
- Medical Malpractice and Other Healthcare Professional Liability Coverage
- Crime and Fidelity
- Agents and Brokers Professional Liability
- Accountants Professional Liability
- Cyberliability and Technology Errors & Omissions

How do we select decisions on which to write?

We constantly monitor decisions issued in each of the jurisdictions in which the firm practices, as well as various reporters and electronic services providing notices of key judicial decisions on a national basis. It is no overstatement to say that in a given month that we identify well over two dozen decisions that could be worthy of commentary. Because we need time to do what we do best, i.e., practice law, and because we do not want to overload

See Joe Says on page 2 for conclusion

Joe Says continued from page 1

our readers, we do a culling process so that each month we now try to limit our articles to six or seven key decisions, including some that may be commented upon in this column.

What are some of the factors that contribute to our selecting a decision? First, we consider whether a decision may have already received widespread commentary to which we would have little to add. Yes, we respect our colleagues and competitors in the profession and, if one of them has already said well all that needs to be said about a decision, we typically decide to pass on that one.

Second, we consider whether the decision teaches a cogent lesson. If a decision is fairly fact-sensitive and of little precedential value, we usually will not write on it. We are proud of the "TRESSLER COMMENTS" that we append to each article. Those explain why the decision presents a teachable moment.

Third, with regard to precedent, it is important to note that many of the decisions featured in the Advisory are not necessarily officially reported decisions. Thus, such decisions have more limited precedential value in a judicial sense. However, over the past twenty-five years, we have seen a vast increase in the number of unreported decisions that make their way into various reporters and electronic research media and are cited more and more in legal proceedings despite the officially limited precedential weight given them. This is in many respects a good development, and we believe that we and others are delivering a valuable service in making these decisions known.

We look to constantly improve on this publication and your feedback is very important to us. Would you like to see us write more on a particular area? Write shorter articles? More articles? Please share your thoughts.

I will now return to more interesting activities such as preparing for the PLUS Annual International Conference in Chicago and contemplating the incongruency of baseball still being played into November.

Joe Monteleone is a partner in our New York office. He has more than 25 years of experience as the former head of global professional liability and other specialty lines claims operations for major insurance companies and in the practice of law representing insurance clients.

Are You Attending the 2009 PLUS International Conference?

<u>Tressler Attendees Include:</u>

- Carrie Cope
- Michael Delhagen
- Daniel Formeller
- Thomas Hanekamp
- Joe Monteleone
- James Pinderski
- DJ Sartorio
- Courtney Scott
- Dana Sheridan

We'll See You There!

CALIFORNIA COURT CONSIDERS D&O INSURER'S CLAIM HANDLING TRAINING PRACTICES IN DECIDING WHETHER INSURER'S FAILURE TO RAISE EXCLUSION IN COVERAGE DENIAL LETTER CONSTITUTES A WAIVER OF ITS RIGHT TO DENY COVERAGE

In a recent decision by the United States District Court for the Eastern District of California, a D&O insurer was not estopped from denying coverage under a particular exclusion because its insured had failed to allege the elements of estoppel. Nonetheless, the Court held that the insured sufficiently pled that the insurer waived its right to rely on the exclusion as a basis for denying coverage by not specifically mentioning the exclusion in its final denial of coverage letter. California Dairies, Inc. v. RSUI Indemnity Company, No. 01-CV-00790, 2009 WL 2475004 (E.D. Cal. Aug. 11, 2009).

The case stems from a class action suit filed in January 2008 against California Dairies, Inc. ("CDI") by both current and former employees alleging various violations of the California Labor Code regarding wage payments, hours, and other related employment practices. Subsequent to CDI's tender of defense and indemnity to RSUI Indemnity Company ("RSUI") under a D&O Liability Policy, the insurer initially denied coverage based on three specific exclusionary provisions. At CDI's request, RSUI reconsidered its denial of the claim and conceded that two of the previously asserted provisions would not apply. In doing so, RSUI denied coverage solely on Exclusion 4 of the Policy which, in relevant part, excluded coverage for "Loss" in connection with any "Claim" made against the "Insured" for any of the following:

> "violation of any of the responsibilities, obligations or duties imposed by . . . the Fair Labor Standards Act . . . or any similar provision of federal, state or local statutory law or common law . . ."

In response, CDI filed an action for declaratory relief regarding coverage under the Policy. After CDI's initial complaint was dismissed with leave to amend, a First Amended Complaint was filed and RSUI moved to dismiss contending that coverage was precluded by not only Exclusion 4, but also Exclusion 7 of the Policy which, in relevant part, excluded coverage for any claim:

> "[b]rought by or on behalf of any Insured, except: . . . (b) an Employment Practices Claim brought by an Insured Person . . ."

However, as was emphatically pointed out by CDI in its response to RSUI's dismissal motion, Exclusion 7 was not previously raised in RSUI's denial of coverage letter. As a result, CDI argued that RSUI violated California's Fair Claims Practices Regulations by failing to articulate all bases for the denial of coverage in the final letter denying coverage and was therefore estopped from asserting it as a coverage defense. The Court rejected CDI's argument on the basis that CDI had failed to demonstrate that it had reasonably relied, to its detriment, on RSUI's failure to include Exclusion 7 in the final coverage denial letter because RSUI had denied coverage from the outset on alternative grounds. CDI requested, and was granted, an opportunity to amend its complaint but it did not pursue the estoppel theory.

In its First Amended Complaint, CDI also argued that as a matter of law, RSUI had impliedly waived its right to rely on Exclusion 7. As the Court noted, under California law, to demonstrate waiver the insured "bears the burden of demonstrating that the carrier intentionally relinquished a right or that the carrier's acts are so inconsistent with an intent to enforce the right as to induce a reasonable belief that such right has been relinquished." Here, the Court rejected CDI's contention that RSUI's failure to comply with California insurance regulations constituted a per se waiver of its right to rely on Exclusion 7 to deny coverage.

Nevertheless, the Court held that it was not unreasonable to infer that a waiver might have occurred if RSUI had trained its representatives that the failure to include all potentially applicable coverage provisions in a denial letter could constitute a waiver of RSUI's right to subsequently assert any omitted bases for denying coverage. The Court further found that RSUI's failure to include Exclusion 7 therefore arguably constituted conduct "so inconsistent with an intent to enforce" Exclusion 7 so as to "induce a reasonable belief that such right has been relinquished."

While the Court concluded that Exclusion 7 applied to bar coverage for all of the claims in the underlying action, the Court also found that CDI had sufficiently alleged that RSUI, by failing to mention Exclusion 7 in its final denial letter, may have waived its right to assert Exclusion 7 to deny coverage in the present case. As a result, RSUI's dismissal motion was denied only with respect to the validity of CDI's claim for coverage based on RSUI's implied waiver.

TRESSLER COMMENTS

The court's analysis in this case is another good example of the types of issues that arise in the claim context that can prove to be pivotal in upholding a denial of coverage. For an insurer, the decision whether, or the extent to which, it should reserve rights upon issuing a coverage letter, is a necessary analysis as the law on this issue varies dramatically in different jurisdictions. For example, in some jurisdictions, an insurer that reserves it right to deny coverage under an insurance policy in which it has the duty to defend the insured, loses it right to appoint counsel. In California Dairies, the insurer's failure to raise a relevant exclusion may have ultimately prevented it from denying coverage for the claim based on that exclusion. Also significant in this case was the insurer's practice in training its representatives on compliance with California's Fair Claims Practices Regulations. While an insurer's actions in instituting such a program are laudable, this case is yet another reminder that all of insurer's actions in the claim-handling process may be subject to scrutiny in an action challenging a denial of coverage.

Prepared by Ryan Taylor, an Associate in our Chicago office.

FIRST CIRCUIT SHUTS DOWN INSURED'S CLAIM FOR D&O COVERAGE AS NO CLAIM WAS "MADE AGAINST" THE INSURED DIRECTORS AND OFFICERS GIVEN CORPORATION'S STATUS AS THE SOLE DEFENDANT

In Medical Mutual Ins. Co. of Maine v. Indian Harbor Ins. Co., Case No. 08-2525 (1st Cir. Oct. 8, 2009), the U.S. Court of Appeals for the First Circuit upheld the district court's holding that no coverage existed under a D&O policy where an administrative and judicial complaint named only the corporation itself, rather than any individual directors and officers, despite the fact that underlying complaints contained many allegations of wrongdoing by directors and officers.

Patrick Dowling ("Dowling") served as Medical Mutual Insurance Company of Maine's ("MMIC") chief executive officer, but following a stroke in April 2005, MMIC ousted Dowling from his post. In October 2005, Dowling's counsel wrote a demand letter to MMIC based on claims of disability discrimination. As no settlement was reached, Dowling filed an administrative complaint with the Maine Human Rights Commission and the U.S. Equal Employment Opportunity Commission naming MMIC as the sole respondent. The allegations within the administrative complaints charged MMIC with disability discrimination, based in part on allegations of discriminatory conduct of MMIC's directors and officers. Upon receiving his "right-to-sue" letters from the agencies, Dowling instituted a civil action in the U.S. District Court for the District of Maine again naming only MMIC as a defendant. The complaint contained numerous allegations that individual directors and officers had engaged in discriminatory conduct, and in his prayer for relief, Dowling requested that the court enjoin MMIC, along with its agents, directors and officers from violating his rights.

MMIC and Dowling eventually settled the civil action, and MMIC then sought reimbursement for its loss under a D&O policy issued by Indian Harbor Insurance Company ("Indian Harbor"). After Indian Harbor denied MMIC's claim, MMIC instituted a civil action in the federal district court to compel Indian Harbor to reimburse it for its loss. The trial court ruled on cross-motions for summary judgment that the D&O policy did not cover losses from the administrative complaints or the judicial complaint against MMIC, and granted summary judgment in favor of Indian Harbor.

On appeal, the U.S. Court of Appeals for the First Circuit affirmed the district court's grant of summary judgment in favor of Indian Harbor. Proceeding under Maine substantive law, the court first noted that where the language in the policy is unambiguous, as it found in this case, the court will apply the plain and ordinary meaning of the language used in the policy, including any explicit definitions in the policy. Both parties agreed that the only provision in the policy that could possibly provide coverage stated, in relevant part, as follows:

> The Insurer shall pay on behalf of the Company Loss which the Company is required or permitted to pay as indemnification to any of the Insured Persons resulting from a Claim first made against the Insured Person during the Policy Period[.]

An insured was defined under the policy as "any past, present or future director or officer . . . of the Company." The court held that to establish coverage, MMIC would have to show, first, that Dowling made a "claim" and, second, that the claim was made against directors or officers of MMIC. MMIC argued on appeal that Dowling made three claims against it: (1) the October demand letter; (2) the administrative agency complaints; and (3) the civil complaint.

The Court rejected the first "claim" since MMIC had not raised this issue at the district court level and had waived the issue on appeal by failing to raise it in its initial brief to the appellate court.

With respect to the administrative complaints, the Court held that they did not fall within the policy's definition of "claim." To constitute a "claim," the administrative filing had to "identify[y] in writing [an] Insured Person . . . as a person . . . against whom a proceeding . . . may be commenced." The administrative complaints only named MMIC as the respondent and did not identify any of the individual directors or officers. While some allegations in the complaints related to conduct by directors and officers, the Court found that, based on the express wording of the definition of "claim", no coverage existed for the administrative complaints.

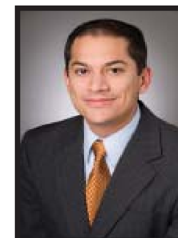
As to the complaint filed in federal court, the First Circuit held that it did constitute a claim, as the "claim" definition included the "commencement of a civil proceeding in a court of law." However, the Court found that the claim was not made against a director or officer, but rather was brought against only MMIC. The court rejected MMIC's argument that the phrase "made against" was ambiguous and thus should be construed against the insurer. Although the court noted that the phrase was not expressly defined, the plain meaning and common usage of that phrase permitted only one reasonable interpretation: the complaint must identify the person as a defendant. The fact that the complaint largely consisted of allegations based on conduct by the directors and officers was irrelevant to the coverage issue because the linchpin was that the complaint did not name the directors and officers as defendants.

Further, the Court held that the existence of "wrongful acts" by directors or officers alone was insufficient to confer coverage; rather, a claim had to be made against the directors or officers for those wrongful acts. The Court also rejected MMIC's contention that Dowling's prayer for relief, which requested an injunction against MMIC and its directors and officers ordering them to stop violating his rights, constituted a claim against MMIC's directors and officers. In rejecting this argument, the court found that the prayer for relief was not a "meaningful demand for relief" against the directors because the complaint did not name them as defendants. Thus the injunction could only be issued as to the corporation, and by implication, those acting on its behalf as corporate representatives, but not to directors and officers in their individual capacities.

Finally, MMIC argued that Dowling's release of future claims against MMIC, along with its agents, directors and officers, as part of the settlement of the underlying discrimination civil suit, demonstrated that Dowling had made claims against the directors and officers since Dowling had agreed to release claims against them. The Court disagreed, stating that the fact that MMIC had prudently negotiated for a release of claims against directors and officers in no way changed the scope of the original litigation, which was solely against MMIC.

TRESSLER COMMENTS

The Court here shut down all arguments by the insured with impunity, and found that the insurance policy's coverage provisions were unambiguous. In our opinion, this is a well-reasoned decision and it should not be controversial even from the insured's standpoint. The Side B coverage commonly affords coverage to the entity if it must indemnify the directors and officers. If there is no claim against the directors and officers, no indemnification obligation is triggered for the entity and thus, the insurer's coverage obligation is likewise not triggered under the Side B insuring agreement. However, an organization may have the option to purchase coverage for claims made directly against it under some types of D&O insurance policies on the market today. As litigation can be both costly and time-consuming for both insurers and insureds, this decision highlights why it is important for both parties to have a "meeting of the minds", at the most basic level, of what coverage the insured requires and the scope of coverage being purchased.



Prepared by Nikolai Guerra, an Associate in our Chicago office.

STATUTE OF LIMITATIONS BARS INSURERS' SUIT TO RESCIND PROFESSIONAL LIABILITY POLICIES ISSUED TO THE MILBERG FIRM

In Certain Underwriters at Lloyd's v. Milberg LLP, No. 08 Civ. 7522 (S.D.N.Y., September 30, 2009), a federal district court dismissed a suit by two insurers who sought to rescind professional liability policies issued to the Milberg law firm, finding that the rescission claim was time-barred by the statute of limitations.

The insurers' complaint alleged that from 1979 through 2005, the Milberg law firm, and several of its partners, had engaged in a fraudulent scheme involving the payment of kickbacks to named plaintiffs in class action securities cases in which the firm served as lead counsel. The complaint alleged that on November 16, 1998, while the scheme was proceeding, the Milberg firm applied for professional liability policies. One of the firm's partners had declared, in the insurance application, that no attorney at the firm was aware of "any circumstances . . . which may result in a claim being made" against the firm. The insurers alleged that because the kickback scheme was underway at the time the application was submitted, the application contained a fraudulent statement which the insurers relied upon in issuing the policies. They sought to rescind the policies, which went into effect on January 31, 2001 and expired on January 31, 2004.

In January 2002, the Milberg firm became the subject of a criminal investigation by the government and was subpoenaed to testify before two grand juries. Milberg notified the insurers of the investigation and requested that the London insurers fund the firm's defense of the government investigation under a primary policy they had issued. After the London insurers disputed coverage, Milberg and the London insurers entered into an "Interim Funding Agreement" under which the parties reserved their rights and London agreed to fund the defense of the government investigation. On May 18, 2006, the Milberg firm and two of its partners were indicted for their role in the kickback scheme. They publicly denied any wrongdoing at the time. After the London insurers were notified of the indictment, they denied coverage. On June 16, 2008, the Milberg firm pleaded guilty. The individual partners plead guilty earlier.

On August 26, 2008, the London insurers filed their declaratory judgment complaint and asserted three causes of action, including rescission. Illinois Union Insurance Company, which had issued an excess liability policy, intervened as a plaintiff on November 25, 2008 and asserted the same causes of action as the London insurers, plus several other causes of action seeking declaratory relief with respect to certain coverage issues.

Milberg and its partners moved to dismiss the case under Rule 12(b)(6) for failure to bring the action within the time allowed by the statute of limitations. The London insurers asserted three main arguments against the application of the statute of limitations: (1) that Milberg and its partners were equitably estopped from invoking the statute of limitations; (2) that no limitations period applied to the rescission claim; and (3) that even if a limitations period applied, it did not begin to run until Milberg pleaded guilty to the indictment in June of 2008. The court rejected all three arguments and dismissed the rescission claim.

The London insurers had argued that Milberg and its partners should have been equitably estopped from asserting a statute of limitations defense based on the public representations they had made that the firm was not guilty of the kickback scheme. Under New York law, which all parties agreed was controlling, in order to succeed on an estoppel argument, a plaintiff must establish that it "was induced by fraud, misrepresentation or deception to refrain from filing a timely action," and that it "reasonably relied on the defendant's misrepresentation." Under New York law, however, a mere denial of wrongdoing is insufficient to create an estoppel because a defendant "is not legally obligated to make a public confession, or to alert people who may have claims against it to get the benefit of the statute of limitations." Based on this case law, the court held that the estoppel argument failed because estoppel cannot be based on a mere public denial of wrongdoing.

The court also held that the estoppel argument failed because the London insurers had not shown that their reliance on the public assertions of innocence was reasonable. The court noted that on January 11, 2002, which was less than one year after the policies had been issued, Milberg had informed the London insurers of the government investigation and in May of 2002 Milberg explicitly advised the London insurers in detail of the nature of the allegations the government was looking into. The court, however, found that the London insurers made no inquiry as to whether the allegations being investigated were true and made no inquiry into whether the alleged unlawful conduct occurred during or before the time Milberg had applied for the polices. Based on the nature of the allegations that were being investigated and based on the London insurers' knowledge of those allegations, the court concluded that the London insurers had good cause to doubt Milberg's claims of innocence and, accordingly, the London insurers had not demonstrated reasonable reliance on Milberg's public proclamations of innocence.

Having rejected the estoppel argument, the court then turned to the argument made by the London insurers that no statute of limitations applied to their rescission claim under New York law. The London insurers had relied on case law from New York holding that the statute of limitations does not apply to contracts that are void at their inception, citing Riverside Syndicate, Inc. v. Munroe, 882 N.E.2d 875 (N.Y. 2008). The court, however, distinguished Riverside, noting that the insurance policies at issue were not illegal contracts and hence were not void from their inception. Instead, the policies were merely voidable based on the alleged misrepresentation in the application. The court went on to hold that under New York law, a six-year statute of limitations applies when a plaintiff alleges fraud in the procurement of a policy and held that the six-year period begins to run on the date the policy is issued, or two years from the time the plaintiff discovered, or with reasonable diligence, could have discovered the fraud, whichever is later.

Because the six-year statute of limitations began to run on the date the policies went into effect on January 31, 2001, the statute of limitations expired on January 31, 2007,

See Milberg on page 9 for conclusion

COURT UPHOLDS PROPRIETY OF INTERPLEADER AS SHIELD FOR INSURER FROM CONTRACTUAL INSURED COMPETING FOR SAME POLICY PROCEEDS AS ANOTHER INSURED

The United States District Court for the District of the Virgin Islands upheld an insurer's interpleader action finding that the insurance carrier acting as a stakeholder had a right to suspend payment of the remainder of the policies' limits rather than choose which claimant had a better claim. Lexington Insurance Company v. Hovensa, LLC, 2009 U.S. Dist. LEXIS 81538 (September 8, 2009).

Jacobs Maintenance ("Jacobs") purchased two consecutive employment liability policies incepting on September 30, 2001 and September 30, 2002 and totaling $6 million in limits of liability, from Lexington Insurance Company ("Lexington") for claims arising out of any contracting maintenance related work at Hovensa, a St. Croix refinery. The insureds on the policy included Jacobs, its affiliates and Hovensa. A number of lawsuits were filed from 2000 to 2002 against Jacobs alleging workplace discrimination; also naming Hovensa. Lexington indemnified Jacobs and Hovensa for the lawsuits paying a total of $2,414,396.33 of the $6 million in limits by June 2005 for the defense and settlement of the claims with $3,585,603.67 remaining on the limits under both policies.

Negotiations commenced in the spring of 2005 to settle the remaining lawsuits naming Hovensa and Jacobs as defendants. Lexington informed the insureds that it would not settle any claims without the consent of both Hovensa and Jacobs. Hovensa purportedly reached a global resolution of the remaining lawsuits, but Jacobs did not consent to the terms of the settlement. Hovensa requested that Lexington pay the remainder of the policy limits for its proposed settlement agreement. Lexington refused to do so as Jacobs would not agree to the settlement.

Lexington consequently filed an interpleader action under 28 U.S.C. § 1335 against Jacobs Engineering, its subsidiary Jacobs, Hovensa; their attorneys; and the underlying lawsuit parties and their attorneys. The action sought Lexington's release of liability from the underlying lawsuits alleging that the underlying lawsuits would probably exceed the policies' limits with defense and liability costs. Lexington filed a bond for $3,585,603.67, or the balance of the remaining limits. Both Hovensa and Jacobs filed counterclaims to this action. Hovensa alleged that Lexington breached its contractual obligations under the policies and should tender the remaining limits to it, and Jacobs alleged breach of contract and breach of the implied covenant of good faith and fair dealing.

Hovensa and Jacobs settled all of the underlying actions for $10.6 million in April 2007 and agreed to share the expenses beyond the bond limits. The bond was subsequently discharged by the court and distributed toward the $10.6 million settlement.

Hovensa and Jacobs thereafter sought summary judgment on the unresolved breach of contract claim alleged against Lexington in the United States District Court for the District of the Virgin Islands, Division of St. Croix.

The focus of the court's discussion centered on a Third Circuit case Prudential Insurance Company of America v. Hovis, 553 F. 3d 258 (3d Cir. 2009) presented by Lexington during its oral argument for summary judgment[1]. The issue in Prudential concerned whether "a valid interpleader action shield[s] a stakeholder from further liability to the claimants not only with respect to the amount owed, but also with respect to counterclaims brought by the claimants." Id. at 259. The Third Circuit found that an interpleader may protect a stakeholder from liability "[1] where the stakeholder bears no blame for the existence of the ownership controversy and [2] the counterclaims are directly related to the stakeholder's failure to resolve the underlying dispute in favor of one of the claimants." Prudential at 259.

Following the Third Circuit analysis, the Lexington court first asked whether Lexington was to blame for refusing to deliver the remainder of the policy limits. According to the court, Lexington acted as a stakeholder because the insurance company held money or property for a dispute in which it had no interest. Lexington neither commenced the underlying actions, nor supported them, but rather refused to tender the remainder of policy limits when one of its insureds refused to settle. The court instead found that Lexington acted appropriately in filing an interpleader action because it protected the interests of one of its insureds. Lexington openly tendered its policy limits to the court and did not try to cap its liability (as a tortfeasor with multiple claims would when filing an interpleader). See Prudential, 553 F. 3d at 263 n.4. In contrast, if Lexington decided to tender the remaining limits as requested, it would have been faced with the challenge of inequitable distribution to one of its insureds while the other non-settling insured would have been left without funds to settle.

The court then looked to whether the counterclaims asserted against Lexington were the result of its failure to pay the limits of the policies. The court reasoned that the insurance company in this case acted like the insurance company in Prudential where the counterclaims resulted from the alleged failure of the insurer to relinquish the insurance policy proceeds. Since Lexington failed to deliver the remaining balance of the policies' limits of liability upon the request of Hovensa, the Hovensa counterclaims are directly related to Lexington's refusal.

Finding that both circumstances were affirmative in the Prudential test, the court concluded that Lexington was not subject to liability and rejected Hovensa's breach of contract claim. The court also noted that a stakeholder's refusal to favor one party over the other in tendering its holding may not be a breach of duty in and of itself. A stakeholder's inability to file an interpleader would remove the intended purpose of filing an interpleader as a procedural remedy. The stakeholder should not have to choose which claimant has a better claim. Lexington at 13; citing Prudential (quotations and citations omitted).

TRESSLER COMMENTS

Interpleader actions are not common in insurance disputes, but are useful in cases such as the instant one where there is no real dispute as to coverage and the insurer recognizes that a loss exceeds its available limits of liability for insureds competing over entitlement to those same limits. It's refreshing in this case to see the insurer not punished for the good deed of paying into the court the remaining limits of its policy, and not having to suffer any more than its contractual obligation to pay the policy limits.

Prepared by Jill Ellman, an Associate in our New York office.

1 - In Prudential, the insurance company filed an interpleader to avoid distributing the proceeds of a life insurance policy to two competing beneficiaries. One of the claimants filed a counterclaim alleging that Prudential acted in bad faith and breached its fiduciary duty in processing changes in the policy. The District Court found that the filed interpleader shielded Prudential from implementing such changes to the policy.

FEDERAL COURT IN WASHINGTON RULES IN FAVOR OF INSURED IN DISPUTE OVER PRIOR KNOWLEDGE EXCLUSION IN LAWYERS PROFESSIONAL LIABILITY POLICY

Westport Insurance Corp. v. The Markham Group, Inc., No. CV-08-221-RHW (Aug. 26, 2009 E.D. Wash.), 2009 U.S. Dist. LEXIS 76877, involved the application of the "prior knowledge exclusion" in a professional liability policy. The court framed the issue as follows: "[W]hether a lawyer that loses an important discretionary ruling, which he believes can be cured, is required by his insurance policy to notify the carrier of the loss." The court concluded it was not necessary to do so and determined that it is not reasonably foreseeable that a claim might be brought against an attorney until there are no longer any meaningful avenues open for curing the adverse ruling available to the client.

In this case, the insured attorney had been continuously insured under a claims-made professional liability policy issued by Westport since 1996. On January 24, 2008 (during the July 1, 2007-July 1, 2008 policy period), the insured reported to Westport a potential malpractice claim from Rachel Naidu.

The insured had represented Ms. Naidu in a wrongful death action resulting from an accident that occurred at Des Moines Vista Assisted Living, Inc. On behalf of his client, the insured sued Vista, Inc. ("Vista") as the owner and operator of the facility. Vista advised the insured shortly after suit was filed that it had sold the facility to another entity seven months before the accident took place. Vista's answer also denied it was the owner or operator of the facility. Three months after filing its answer, Vista sent the insured documentation regarding the sale of the property. Vista then filed a motion for summary judgment, supported by an affidavit of the President of Vista, attesting to the fact that Vista was never the operator of the facility and that it had sold the facility prior to the accident in question. The lawsuit was dismissed on August 4, 2006, after the trial court granted Vista's motion for summary judgment. In its order the court noted that if the insured had made a reasonable inquiry as to the actual operation of the facility, he would have determined that the licensed operator on the date of the alleged negligent acts was not Vista but another party. The court thus awarded Rule 11 sanctions against the insured.

The insured's subsequent motions for reconsideration and for leave to file an amended complaint were denied. The insured appealed. The Court of Appeals affirmed the summary judgment and sanctions order and found no abuse of discretion by the trial court in denying the motions for reconsideration or leave to amend the complaint. Only after the Court of Appeals' ruling came down did the insured report the matter to Westport as a potential claim under its policy.

Westport took the position that the insured could have reasonably foreseen, prior to the inception of the July 1, 2007 policy, that Naidu might assert a legal malpractice claim in light of the dismissal of her lawsuit, with prejudice, on August 4, 2006. Thus, Westport believed it owed no coverage obligations to the insured under the "prior knowledge exclusion." That exclusion states:

> This Policy does not apply to any Claim based upon, arising out of, attributable to, or directly or indirectly resulting from any act, error, omission, circumstance, or PERSONAL INJURY occurring prior to the effective date of the 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 the claim.

The insured attorney argued that the term "might" as used in the exclusion renders it ambiguous and that the exclusion should not apply to defeat coverage for a malpractice claim until the insured no longer had any meaningful avenues open for curing the adverse ruling against his client. The Court agreed with the insured, finding that the term "might" was ambiguous under the facts at issue. Having made that finding, the court was then free to construe the exclusion against the drafter – Westport.

Interestingly the Court started out its discussion with an acknowledgement that there were "eight potentially triggering events that would seemingly indicate that an act, error or omission committed [by the insured] might be the basis for a claim," ranging from the date the court denied the summary judgment motion to the date that the Washington Court of Appeals affirmed that judgment. Seven of those events occurred prior to the inception of the July 1, 2007 policy. The only event that the did not occur until after the policy had incepted was the Washington Court of Appeals' decision which affirmed the summary judgment ruling against the insured's client, affirmed the Rule 11 sanctions entered against the insured and his client and found that the trial court had not abused its discretion in denying the insured's motion for reconsideration or its motion for leave to file an amended complaint.

The Court found that it was not reasonable to conclude that the insured had an obligation to report the potential of a malpractice claim after the adverse summary judgment ruling. It stated that in reviewing the pleadings presented to the trial court, the Court could not conclude that the insured's position was unjustified or untenable or that his position was clearly impossible.

Empirical evidence would likely support the proposition that when a trial court rules against a party on a motion for summary judgment and also awards Rule 11 sanctions against that party and his counsel, that a subsequent discretionary motion filed by the same party before the same trial judge is not likely to meet with success. Thus, even if the motion is well founded, it may not be *objectively* reasonable to believe that the trial court will grant the relief requested such that the insured could avert a malpractice claim. Added to that reality is the fact that where the motion that is denied involves a discretionary ruling, the chances of a reversal on appeal are greatly reduced. To obtain a reversal of a discretionary ruling, the appellant must convince the reviewing court that the trial court *abused its discretion*. The reviewing court is not permitted to substitute its own judgment for that of the trial court.

The declaratory judgment court's ruling in

See Prior Knowledge Exclusion on page 9 for conclusion

CALIFORNIA FEDERAL COURT FINDS THAT D&O INSURER'S DUTY TO DEFEND TRIGGERED BY CLAIMS OF INSURED

A California federal judge recently found that a D&O insurer's duty to defend a company's Chief Executive Officer against underlying wrongful acts claims was triggered because there was potential indemnity coverage under the Policy. In doing so, the Court rejected the insurer's contention that the Policy's Insured vs. Insured exclusion precluded coverage. Lloyd Chartrand v. Illinois Insurance Co. and Does 1-50, inclusive, 2009 WL 2776484 (N.D. Cal.)

The insured, Lloyd Chartrand, asserted that the defense costs incurred in an underlying lawsuit against him were covered under a D&O liability policy issued by Illinois Union Insurance Co. to Mentura Inc. The case was originally filed by sixteen investors in Mentura who alleged that Chartrand, Mentura's CEO, had made misleading statements, omissions, and committed other wrongful acts. Mentura's directors and officers insurer, Illinois Union Insurance Co., declined coverage for Chartrand's defense costs, contending that because Mentura's Chairman of the Board was one of the sixteen investor claimants in the underlying action, by virtue of the Exclusion, the claims of the Chairman, as well as those of the other investors, were all barred from coverage in the underlying action. The legal question was: whether the Insured v. Insured Exclusion applied to preclude coverage where there were claims asserted by both insureds and parties that were not insured. Judge Jeffrey S. White, citing Montrose Chem. Corp. v. Superior Court, found that the insurer's duty to defend was triggered because there was a potential for indemnity coverage under the Policy. 6 Cal. 4th 287, 299-300, 24 Cal.Rptr.2d 467, 861 P.2d 1153 (1993). In order to find that Illinois Union had a duty to defend under the Policy, Chartrand had the initial burden of demonstrating that after interpreting the facts in a light most favorable to the insured, it was possible that the Policy could potentially cover some damages alleged in the underlying action. See Chartrand v. Illinois Union Insur. Co., 2009 WL 2776484 *3 (N.D.Cal 2009). Illinois Union's burden was to demonstrate, while construing ambiguities and restraints on coverage in favor of the insured, that there was no possibility of coverage for any claim made in the underlying action. Id. Judge White reasoned that Illinois Union could not meet its burden to demonstrate that, at the time it denied coverage, it had facts and information conclusively demonstrating that there was no potential for coverage under the D&O provision. Thus, Illinois Union had a duty to defend under the Policy. Id. at 4. Quoting the language of Waller v. Truck Ins. Exch., Judge White's opinion further elaborated on the applicable law, stating that there is no duty to defend when underlying complaints and any relevant extrinsic evidence do not demonstrate that the underlying claims sought damages potentially covered under the Policy. 11 Cal 4th 1, 19, 44 Cal.Rptr. 2d 370, 900 P.2d 619 (1995).

In the instant case, the Court accepted the undisputed fact that the claims in the underlying action were made by both insureds and parties that were not insured under the relevant policy. This fact, when viewed in light of the holding in Megavail v. Illinois Union Ins. Co., triggered Mentura's duty to defend. 2006 WL 2045862 *2-3 (D. Or. July 19, 2006) (finding that the exclusionary clause was not a complete bar to defendant's obligation to defend the underlying lawsuit where duty is triggered by the presence of uninsured plaintiffs in the underlying lawsuit). Applying California law holding that policy exclusions are strictly construed, whereas exceptions to exclusions are broadly construed in favor of the insured, the Court found that the operative exclusionary clause in Mentura's policy did not limit coverage for defense costs associated with the claims made by non-insured parties under the Policy. See MacKinnon v. Truck Ins. Exch., 31 Cal 4th 635, 648, 3 Cal.Rptr.3d 228, 73 P.3d 1205 (2003). Judge White found out-of-circuit cases persuasive to the extent they found that Insured v. Insured Exclusions do not preclude coverage for all underlying suits instituted by both insured and non-insured claimants where the court can allocate the costs of defense between covered entities and non-insureds. See Federal Insurance Co. v. Infoglide Corp., 2006 WL 2050694, *5-6 (W.D. Tex. July 18, 2006). Ultimately, Judge White denied Illinois Union's motion for summary judgment and granted Chartrand's cross-motion for summary judgment.

TRESSLER COMMENTS

Readers should contrast the result here with the decision in Westchester Fire Ins. Co. v. Wallerich, 2007 U.S. Dist. LEXIS 71579 (D. Minn., September 25, 2007), a decision which was featured in an article in the November 2007 issue of this *Advisory*. Wallerich also involved a duty to defend policy, but the court there had little difficulty in applying the exclusion severally as to the claims of insured and non-insured plaintiffs. Unfortunately for D&O insurers, if a court is to follow the reasoning and result in the instant case and cases such as Megavail discussed therein, the insurer will have little hope of a practicably beneficial allocation despite the allocation theoretically permitted. While there could be some allocation in the event of a settlement or judgment, an allocation of defense costs under a duty to defend policy would not be permitted in most jurisdictions.

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Joe gratefully acknowledges the substantial work on this article by Jillianne Arguello, a 2009 American University Law School graduate in our New York office, who is currently awaiting her bar results.

Milberg from page 5

well before the London insurers filed their action to rescind the policies. Thus, the rescission claim would be time-barred unless it was saved from the statute of limitations by the two-year discovery rule. In addressing the two-year discovery rule, the court noted that under New York law, the test as to when a plaintiff could have discovered an alleged fraud is an objective one. The court also noted that under New York case law, notice of a government investigation relating to a contract at issue "clearly trigger[s] a duty on the part of the plaintiff to inquire as to potential fraud" with respect to that contract. Prand Corp. v. County of Suffolk, 878 N.Y.S.2d 198, 200 (App. Div. 2009). Further, quoting Higgins v. Crouse, 42 N.E.2d 6, 7 (N.Y. 1895), the court noted that "where the circumstances are such as to suggest to a person of ordinary intelligence the probability that he has been defrauded, a duty of inquiry arises, and if he omits that inquiry when it would have developed the truth, and shuts his eyes to the facts which call for investigation, knowledge of the fraud will be imputed to him."

Turning to the facts of the case, the court noted that the London insurers received notice of the government investigation in January of 2002. The court found that the government investigation was inconsistent with the statement made in the insurance application that none of the lawyers in the Milberg firm were "aware of any circumstances . . . which may result in a claim being made against" the firm. The court therefore ruled that knowledge of the investigation in January of 2002 triggered a duty on the part of the London insurers to investigate whether the policies had been procured through fraud. The court ruled that because the London insurers failed to make any inquiry into whether the policies had been procured through fraud, knowledge of that fraud was imputed to them as of January of 2002. Because the London insurers did not file suit until 2008, they could not rely on the two-year discovery rule to save their rescission claim.

Moreover, the court noted that on July 14, 2006, the London insurers had acknowledged receipt of a copy of the government's indictment of the Milberg firm. The indictment expressly referenced Milberg's fraudulent activities prior to the procurement of the insurance policies. The court held, therefore, that a "prudent insurer, upon giving the indictment a cursory review, should have known in July of 2006 that it may have had a claim" against Milberg for rescission of the policies. Because the London insurers did not file suit until August of 2008, the court ruled that the rescission claim was still time-barred even if the two-year period began to run in July of 2006.

Illinois Union had joined in the arguments made by the London insurers and the court found that Illinois Union's rescission claim was also time-barred for the same reasons.

TRESSLER COMMENTS

In ruling against the insurers in this case, the court found it pivotal that the insurers had failed to inquire whether the insurance policies had been procured through fraud. One might reasonably wonder why, in raising this issue, the court did not seem to consider the probable response the insurers would have received had they asked the Milberg firm whether they were guilty or whether any fraudulent activities occurred before they filled out the application for the policy. In fact, the Milberg firm may have taken the position that responding to such an inquiry may waive their Fifth Amendment right against self-incrimination. However, as discussed in our July/August 2008 issue of *The Specialty Lines Advisory*, some courts have held that "...a Fifth Amendment right against self-incrimination does not trump an insurance policy's duty to cooperate requirement." Bogatin v. Federal Ins. Co., 2000 WL 804433 (E.D. Pa., June 21, 2000). We noted that Bogatin is a continuing reminder that, even though the failure to communicate may be supported by legitimate reasons, the insured withholds information at the peril of losing coverage. Milberg provides a cautionary corollary for insurers: the failure to make a reasonable inquiry regarding the insured's knowledge of fraudulent activities at the time of application may place the insurer in peril of losing its right to rescind the policy.

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Westport embraces the view that only after all available avenues of review have been exhausted will an insured attorney need to *subjectively* acknowledge the potential of a malpractice claim – even where obtaining a reversal of the adverse ruling is remote. That is indeed the circumstance that existed in the underlying Naidu case, when one considers that the basis of the summary judgment order entered against the insured's client was that the insured had sued the wrong party and that he knew before the motion for summary judgment was filed that the party he sued was not the owner or operator of the facility. The insured's motion for leave to file an amended complaint was not filed until *after* the summary judgment ruling was entered against his client and all issues in the case had been resolved. In that circumstance, leave to amend is not as readily available, particularly where a court finds that the party knew of the existence of the entity it now wants to add to the suit long before the motion to amend was filed and well before the motion for summary judgment, which disposed of all issues in the suit.

The declaratory judgment court supported its conclusion that the insured might not reasonably foresee that a claim might be brought against him after losing the summary judgment ruling and after denial of his motion for reconsideration and for leave to file an amended complaint by noting that the insured's pleadings were not "unjustified or untenable" and his positions were not "impossible." Those are not the usual standards used in evaluating whether one's acts or omissions might be the basis of a malpractice claim.

TRESSLER COMMENTS

The ruling in this case gives new meaning to "hope springs eternal" and even exceeds a subjective standard for determining when acts or omissions might result in a malpractice claim. Rather, the standard employed is arguably a procedural one – determined by when there are no longer any meaningful avenues open for curing the adverse ruling. So, under the court's rationale, which in its view applied an objective or reasonable insured standard, until the insured had exhausted his client's last hope of appeal, he or she would not reasonably foresee that any act, error, omission, or circumstance might be the basis of a claim so as to fall within the terms of the prior knowledge exclusion.

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