

## Specialty Lines Advisory

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### **JOE SAYS...**

#### **D&O and Other Professional Liability Policies – Have We Lost Our Contract Drafting Skills?**

As recently as about twenty years ago, claims-made policy forms in the specialty lines arena were fairly simple and straightforward. There were a limited number of insurers writing these lines and those insurers used perhaps at most two or three variations of a form in each line of business.

Today, there are a plethora of forms in the marketplace and all are heavily endorsed to meet the most favorable features of an increasing number of competitors. It is not unusual for a policy issued to a large risk, particularly in a D&O line, to go out the door with over thirty endorsements attached at issuance. However, introduction of a new form to incorporate the state of the art in the marketplace is not something that can be lightly or frequently undertaken, particularly when writing on an admitted basis. To have a form be well-written and admitted in most, if not all, of the fifty states, takes time, effort and expense, requiring the involvement of skilled lawyers, underwriting and claims professionals and other experts in the regulatory and compliance sectors.

Nevertheless, when an insurer decides to introduce a new form, there are a number of caveats that need to be borne in mind that will result

in a better product from the perspective of that insurer, the brokers and agents in the distribution chain and the ultimate consumer – the insureds and policyholder of the product.

- First, strive to keep the policy language as simple, clear and concise as possible. That being said, I am not a big fan of the “plain English” or “E-Z read” wordings that are still in somewhat common use in this area and all too often, in my opinion, not at all “easy to read”. While they may make some sense in personal lines where there is much direct selling to individual policyholders and little or no negotiation of policy language, we have all become somewhat used to writing and understanding “Insurancese” in the professional liability contracts, regardless of whether we are lawyers or other professionals. The professionals in this area, as well as the courts, have become quite used to understanding these contracts and comfortable with the terminology in rendering advice to the respective clients. I do a large amount of policy and endorsement drafting and quite often see very well-written provisions crafted by non-lawyer brokers and underwriters, as well as vague and fatally ambiguous language drafted by lawyers who should know better and be more skilled!
- Second, and while still being an advocate of “Insurancese”, some of the many endorsements to the policies have now resulted in unacceptably cumbersome key definitions and other provisions, such as those defining the term “Loss” or “Claim”. A policyholder lawyer at the recent PLUS D&O Symposium made the apt comment that the definition of “Loss” in a D&O policy is now almost a page

*See Joe Says on page 3 for conclusion*

# ILLINOIS APPELLATE COURT LIMITS SCOPE OF MEDICAL MALPRACTICE INSURER'S DUTY TO DEFEND IN UPHOLDING DENIAL OF COVERAGE FOR A MEDICARE FRAUD CLAIM

In *ISMIE Mutual Insurance Company v. Michaelis Jackson & Associates, Inc.*, 2009 Ill. App. LEXIS 1332 (Dec. 30, 2009), an Illinois Appellate court held that a medical malpractice insurance carrier had no duty to defend or indemnify its insured against a claim for Medicare fraud. The underlying complaint sought damages arising from false Medicare billings, not from any patient injuries. Accordingly, even though the complaint alleged that the insured performed unnecessary medical tests and procedures that could conceivably have caused bodily injury, the damages that could potentially be awarded were for fraudulent billing, not for any "personal injury" covered under the policy.

Michaelis Jackson & Associates, LLC and physician Michaelis Billy Jackson, M.D. provided diagnostic eye examinations and eye surgeries to patients. Two of Dr. Jackson's former employees brought a *qui tam* suit against Dr. Jackson and his practice in the United States District Court for the Southern District of Illinois, alleging that he performed medically unnecessary

cataract surgeries and invasive follow up procedures, and submitted false claims to Medicare for reimbursement. (A *qui tam* suit is brought under the federal Civil False Claims Act, also known as Lincoln's Law, the Informer's Act, or the Qui Tam Statute [31 U.S.C. section 3729, et seq.]. Under the False Claims Act, a successful "whistleblower" plaintiff may collect 15 to 30 percent of amounts recovered for false billings under government programs such as Medicaid or Medicare.)

Dr. Jackson and his company tendered his former employees' *qui tam* suit to ISMIE Mutual Insurance Company, which issued a professional liability insurance policy to Dr. Jackson and his practice during the relevant time period. The policy provided coverage for damages arising from "personal injury." The policy defined "personal injury" as "bodily injury ... which arises out of the rendering or failure to render 'professional services.'"

ISMIE initially defended Dr. Jackson under the policy's "Supplementary Payments" provision, which provided \$30,000 in coverage for legal expenses related to Medicare investigations. Once the \$30,000 exhausted, ISMIE notified Dr. Jackson that it would no longer provide him with a defense in the federal *qui tam* action, and filed the instant declaratory relief action in Illinois state court.

Dr. Jackson argued that because some of the claims in the *qui tam* suit alleged that he administered unnecessary medical procedures (which presumably could have caused bodily injury to certain of Dr.



Jackson's patients), the claims involved "personal injury," and should be covered. ISMIE argued that the *qui tam* suit did not seek damages for any "personal injury," but instead sought reimbursement for illegally obtained Medicare reimbursement monies. Although the *qui tam* suit alluded to possible bodily injury as the result of allegedly unnecessary medical procedures, ISMIE argued that there must be a causal connection between the alleged "personal injury" and the damages sought.

The trial court granted ISMIE's motion for a judgment on the pleadings and summary judgment, and denied Dr.

Jackson's motion for summary judgment. Dr. Jackson appealed. The Appellate Court of Illinois (Fifth District) affirmed.

As an initial matter, the Court recited well-established principles of Illinois law: (1) the duty to defend is evaluated solely based on the allegations in the applicable complaint; (2) the insurer has an obligation to defend any claims even potentially within policy coverage, even if the claims are groundless or false; and (3) any ambiguous language in an insurance policy must be construed in favor of the insured and against the insurer. In determining the availability of coverage, the Court discussed a recent Seventh Circuit decision evaluating coverage for a *qui tam* suit, Health Care Industry Liability Insurance Program v. Momence Meadows Nursing Center, Inc., 566 F.3d 689 (7th Cir. 2009). In Health Care Industry, a complaint brought under the False Claims Act alleged in part that nursing home residents suffered personal injuries. However, the complaint sought damages due to the nursing home's fraudulent Medicare claims, and did not seek any damages to compensate injured residents. The Seventh Circuit concluded that the nursing home was not entitled to coverage under a general liability insurance policy, because although the complaint alleged that some nursing home residents were injured, the injured residents were used as illustrative examples in support of a claim for damages arising from fraudulent Medicare billings.

The Illinois Appellate Court agreed with the Seventh Circuit's reasoning, and found that there is a difference between the proof

required to bring a successful *qui tam* suit (i.e. showing that a physician made false Medicare claims), and the conduct underlying a physician's false Medicare claims (i.e. performing unnecessary medical procedures). The Court held that to give rise to coverage, there must be a connection between "personal injury" allegations in the complaint and damages actually sought. In other words, for coverage to be available to Dr. Jackson, the applicable complaint must actually seek damages for "personal injury," not merely allege that some "personal injury" occurred.

The claimants in the *qui tam* suit at issue here sought compensation for fraudulent Medicare billings; they did not seek compensation for any injuries to patients resulting from unnecessary cataract surgeries or other procedures. Accordingly, the appellate court agreed with ISMIE that no coverage was owed, because the *qui tam* suit did not seek damages for any "personal injury."

## TRESSLER COMMENTS

In its decision in this case, the Illinois appellate court limited the insurer's duty to defend by requiring a causal connection between allegations in the complaint and damages sought. For this Illinois Court, it was not enough that the complaint made "personal injury" allegations that might fall within the policy's coverage grant. Rather, the Court found that the allegations must be connected to the damages sought. Not all states require a causal connection between allegations in the complaint and damages sought. However, those states that follow this approach effectively limit the dominance of allegations in the complaint, and allow insurers to evaluate coverage by examining whether the relief the claimant seeks is actually within the scope of covered claims.



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long after considering the various endorsements added to the policy and the definition contains perhaps more exclusions than are found in the Exclusions section of the policy. While this lawyer made the accusation that this was done for the purpose of having the insurer enjoy more favorable judicial interpretation of certain exclusionary provisions, I would submit that the reason is more likely to avoid the negative marketing impact of too many numbered exclusions. Although it may not be feasible to move these exclusions to the Exclusion section, it certainly would add clarity to have them numbered and clearly set for the reader wherever they may appear. Maybe in that whole process, we may even find a way to shorten the length of the definition.

- Insurance companies and their lawyers are not always the prime culprits in creating unworkable language. Again, using D&O as an example, brokers and policyholder lawyers have long tried to limit the sweeping impact of the “insured vs. insured” exclusion. Thus, we now see these exclusions with as many as eight “carve backs” or exceptions to the exclusion and even carve backs from the carve backs. One needs keen diagramming and roadmap skills to make sense of these provisions. Plain and more concise language would help immensely.
- As long as the policy provisions are well-drafted, there is no such thing as a “good” provision or a “bad” provision in an absolute sense. Simply

put, it depends on whose ox is being gored. I can draft a provision that is quite favorable to an insurer, while my counterpart may draft a version equally favorable to the insured. Neither is right or wrong, and what version makes it into the contract should simply be a matter of which side has the most bargaining leverage. Thus, do not waste effort trying to convince the other side of the “quality” of your language.

- A corollary to the last caveat is to, at all costs, avoid using deliberately ambiguous or vague language. Too often I hear requests like “we want to be able to deny coverage for a misrepresentation on the application, but we do not want to set this forth so explicitly in the policy.” While that may arguably be short-term advantageous from a marketing perspective, vague and ambiguous language will only lead to protracted and expensive disputes when claims are presented for coverage. And, as a confidential tip to insurers, when policy language is vague and ambiguous, more often than not, the insurer loses!
- Sometimes it pays to sweat the small stuff. The typical policy contains a number of conditions near the end that are not often the subject of dispute in the event of a claim, and are remarkably similar from one insurer’s form to another. Drafters often pay little attention to these clauses, as do a number of brokers, underwriters and risk professionals. Therefore, when disputes arise and these parties are called upon to testify as to their

understanding of these conditions, their honest answer often has to be that they gave little thought to the meaning of the provision and put it in only because that language is in ABC Insurance Company’s form and everyone else’s that they can recall. That may work well in many cases, but it pays to carefully consider every provision in a policy and be sure that they are (i) necessary and (ii) stated clearly.

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*This column has been a regularly monthly feature in this Advisory for over two years. The time has now come to give some of my Tressler colleagues an opportunity to also pontificate in this space. Thus, this will be my last column on a regular basis, but I do promise (or threaten) to return as the spirit may move me.*



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# VOLUNTARY PAYMENT PROVISION OF POLICY PROVES POTENT AGAINST INSURED

In [American Family Mutual Ins. Co. v. C.M.A. Mortgage, Inc.](#), United States District Court for the Southern District of Indiana, 2010 U.S. Dist. Lexis 2379 (1/12/2010), the Court ruled that an insured, which enters into a consent judgment on a putative class action and assigns its rights under an insurance policy to the putative class without the consent of the insurer and while being defended by the insurer under a reservation of rights, has breached the policy.

On January 12, 2010, a federal court applying Indiana law ruled that American Family Mutual Insurance Company was not obligated to satisfy a consent judgment of \$2,999,000 entered into by its insured with a putative class. This ruling, despite the court's prior finding that American Family had a duty to defend its insured CMA Mortgage ("CMA") against a Class Action Complaint under the Fair Credit Reporting Act (FCRA), discusses the mutual obligations of the insurer and the insured under an insurance policy and determined that the highest court of Indiana would enforce the insured's obligations as well as the insurer's obligations.

American Family issued a business owners policy and commercial liability umbrella policy to C.M.A. Mortgage, Inc. CMA had been sued by Jason Wanek in a putative class action in the Northern District of Illinois for allegedly violating the FCRA. Specifically, Wanek alleged that CMA had sent a solicitation in the mail which included a statement that "Information contained in your credit report was used in connection with this offer." The [Wanek](#) suit alleged that CMA willfully violated the FCRA because he had never given CMA permission to access his credit report. The [Wanek](#) suit sought to recover statutory penalties under the FCRA. Although believing that there were defenses to coverage for the [Wanek](#) suit, American Family issued a reservation of rights, agreed to reimburse an attorney of CMA's choice to defend the class action and filed a declaratory judgment action to determine its defense and indemnity obligations.

While an initial decision on cross-motions for summary judgment in the declaratory judgment action filed by American Family resulted in a determination that American Family had a duty to defend CMA, the court reserved on the issue of the duty to indemnify. More particularly, during the pendency of the initial summary judgment motions on the declaratory judgment action, the insured CMA, without consent of American Family, agreed to a stipulated judgment in the [Wanek](#) class action suit and a pending Wisconsin class action with the express agreement that satisfaction of the judgment could only be obtained from the insurance proceeds of the American Family policies. With this new development,

American Family challenged its obligation to pay the consent judgment voluntarily entered into by CMA.

American Family filed a renewed summary judgment motion which included an argument that its policies specifically



provide that no insured shall make a voluntary payment, assume any obligation or incur any costs without the insurer's consent. Moreover, American Family argued that the policy conditions, which include the insured's obligations of notice and to not make a voluntary payment or assume any obligation, were "threshold requirements" which must be met to invoke coverage. CMA and the class action plaintiffs countered that under [Cincinnati Ins. Co. v. Young](#), 852 N.E.2d 8 (Ind. App. 2006), an insured is permitted to take advantage of "any reasonable settlement demand" while a declaratory judgment action to determine coverage is pending without consent of the insurer, including entering into a consent judgment, even if being defended under a reservation of rights.

Rejecting the insured's argument, and relying upon the principles established by the Indiana Supreme Court in [State Farm Fire & Casualty v. T. B.](#), 762 N.E. 2d 1227 (Ind. 2002) Judge Sarah Evans Barker, U.S.D.J., determined that while American Family did not breach its contractual obligations under its policies by defending under a reservation of rights and pursuing a declaratory judgment action, the insured CMA did breach its obligations under both the business owner's policy and the umbrella policy. CMA's breach, in turn, relieved American Family of any obligation to satisfy the judgment.

Finally, although not necessary to the ultimate determination that the breach by the insured CMA relieved the insurer of any duty to indemnify, the court also considered CMA's argument that American Family's refusal to settle the class actions under the terms proposed by Wanek and the class action plaintiffs constituted bad faith. In rejecting this argument and finding there were "ample reasons" to support American Family's decision not to settle, the court pointed out that not only were summary judgment motions pending in the underlying class actions but the extent of FCRA and interpretations of the Act were pending before the United States Supreme Court and the Seventh Circuit.

## TRESSLER COMMENTS

[American Family v. CMA](#) is a cogent reminder that insurance policies create obligations not only on the part of the insurer but also the insured. The threshold requirements or conditions precedent to coverage should not be overlooked by an insurer as a potential defense.



*Prepared by Joanna Crosby, a partner in our Newark office.*

# NEW JERSEY'S LAW AGAINST DISCRIMINATION PROHIBITS A CUSTOMER FROM REFUSING TO DO BUSINESS WITH A SUPPLIER WHERE THE REFUSAL IS IN RETALIATION FOR THE FACT THAT THE SUPPLIER'S OWNER RESISTED THE CUSTOMER'S SEXUAL ADVANCES

In *J.T.'s Tire Service, Inc. v. United Rentals North America, Inc.*, \_\_\_ N.J. Super. \_\_\_ (App. Div. , Dec. 7, 2009), New Jersey's Appellate Division ruled that, under the State's Law Against Discrimination ("LAD"), the defendant equipment rental company could not refuse to do business with the plaintiff tire company and its female owner in retaliation for the owner's resisting the sexual advances of the defendant's branch manager.

In the employment context, New Jersey courts have traditionally held that the LAD's prohibition against discrimination in employment does not protect an independent contractor. Racial, religious, or sexual discrimination in the hiring or firing of an independent contractor, therefore, has generally not been actionable in New Jersey. However, New Jersey courts have recently extended protection to independent contractors under that portion of the LAD that prohibits a refusal to do business or enter into contracts on the basis of impermissible discrimination.



In *J.T.'s Tire Service*, co-plaintiff Eileen Totorello was the sole owner of the plaintiff tire company, from which defendant United Rentals had traditionally purchased about \$29,000.00 worth of tires each month. The Complaint alleged that a branch manager at defendant United Rentals had demanded sexual favors from Totorello as a condition of allowing J.T. to continue doing business with United, and had on at least one occasion, fondled and groped her without her permission. The Complaint further alleged that, because Totorello had refused the manager's advances, United ceased doing business with her company.

The defendant moved for dismissal of the Complaint, arguing that the sexual harassment claimed by the plaintiffs did not constitute unlawful sex discrimination under the LAD. The trial court agreed, and dismissed the Complaint. It held that the allegations of sexual harassment did not establish a cognizable claim that the defendant had discriminated against the plaintiff based on her sex.

The Appellate Division reversed. It noted, first, the distinction in the LAD between cases involving discrimination in employment, where independent contractors are not protected, and cases involving refusal to do business, where independent contractors are covered. It confirmed its recent prior

rulings that the LAD prohibits refusal to do business with an independent contractor where that refusal is based upon age, sex, or handicap. *Nini v. Mercer County Cmty. Coll.*, 406 N.J. Super. 547, 557 (App. Div.), certif. granted, 200 N.J. 206 (2009); *Rubin v. Forest S. Chilton*, 3rd, Mem'l Hosp., Inc., 359 N.J. Super. 105, 110-11 (App. Div. 2003). It noted, further, that the LAD similarly prohibits termination of contracts premised upon unlawful discrimination.

The Court next ruled that, for purposes of the LAD, sexual harassment does constitute sex discrimination. In this regard, the defendant had argued that sexual harassment is not sex discrimination within the meaning of the LAD's subsection applying to "discriminatory conduct which arises after companies begin engaging in business transactions" and that women business owners do not need protection against sexual harassment by those with whom they do business. The Court noted, first, that where the harassment consists of sexual overtures and unwelcomed touching or groping, "it is presumed that the conduct was committed because of the victim's sex." By alleging that United Rental had stopped doing business with J.T. because plaintiff Totorello had refused to submit to sexual demands from the defendant's branch manager, the plaintiff had properly alleged the discriminatory termination of a contract. The Court observed that the kind of harassment alleged in the Complaint, if permitted, would "stand as a barrier to women's ability to do business of an equal footing with men." Construing the LAD to prohibit such despicable conduct therefore, is consistent with the Legislature's intent to eliminate sex discrimination in contracting.

## TRESSLER COMMENTS

In the employment law context, the New Jersey LAD had traditionally applied only to an employer's discrimination against an employee. It did not cover discrimination against independent contractors in the context of employment. The section of the LAD utilized in the *J.T. Tire* case had,

until a few years ago, not been judicially interpreted.

However, the recent rulings of New Jersey courts have significantly blurred the line between employment discrimination, where an independent contractor is not protected, and discrimination in connection with the refusal to enter into or terminate a contract. It does not require a great leap of logic for an independent contractor who is a victim of discrimination in any context to claim that, as a result of the discrimination, his or her ability to contract with the defendant has been lost. Thus, any creative attorney for an independent contractor in New Jersey can state a viable cause of action under the LAD by alleging that the discrimination in question had caused the refusal to enter into or the cessation of a contractual or business relationship with the defendant.

The *J.T. Tire* case also demonstrates that, in New Jersey, courts will continue to treat sexual harassment as a form of illegal discrimination. As the court observed, the obnoxious behavior in that case occurred because the victim was a woman. Branding such conduct as discriminatory, therefore, is a logical and appropriate course of action. Henceforth in New Jersey, a woman will not have to tolerate sexual harassment as part of the cost of doing business.



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and



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# IOWA APPELLATE COURT FINDS THAT INSURER OWES DUTY TO DEFEND FOR INTENTIONAL WRONGFUL ENTRY UNDER ERRORS AND OMISSION POLICY



Scottsdale Insurance Company v. Attorneys Process & Investigation Services, Inc., Case No. 9-416/08-0944, 2009 Iowa App. Lexis 1636 (Court of Appeals Iowa, December 17, 2009), involves a coverage dispute over whether a claim of wrongful entry triggers an insurer's duty to defend under a policy providing both general liability and errors and omissions coverage.

The Sac & Fox Tribe of the Mississippi in Iowa ("the Tribe") operates the Meskwaki Bingo Casino Hotel ("Casino") near Tama, Iowa. A dispute arose between two factions of the Tribe, the Elected Tribal Counsel and the Appointed Tribal Counsel, over the control of the Tribe and the Casino. The Appointed Tribal Counsel, which was not recognized by the federal government as the leadership body of the Tribe, retained Attorneys Process & Investigation, Inc. ("APIS") as a security firm to provide law enforcement consulting services in the Casino. APIS employees entered the Casino and remained on the premises for less than 24-hours. The Elected Tribal Counsel, recognized as the governing body of the Tribe, then filed suit in tribal court against APIS for trespass to land, trespass to chattel, conversion and misappropriation of trade secrets.

Scottsdale Insurance Company ("Scottsdale") insured APIS under a commercial general liability policy that provides coverage for "bodily injury" and "property damage", "personal and advertising injury" and errors and omissions. Scottsdale filed a declaratory judgment action in an Iowa district court seeking a declaration of no coverage under the policy. The district court granted summary judgment in favor of Scottsdale finding that the torts alleged against APIS were not covered because the policy did not provide coverage for intentional torts.

On appeal, the Iowa Appellate Court initially noted that in determining whether summary judgment is appropriate in a duty to defend context, the court could consider not only the allegations of the complaint, but also relevant and admissible facts beyond the pleadings. In addressing the merits, the Iowa Appellate Court first found that the allegations in the Tribe's complaint did not come within the scope of the "bodily injury" or "property damage" coverage part of the policy as there was no occurrence. The term "occurrence" was defined under the policy as an accident. The Appellate Court reasoned that the allegations were not the result of an accident, i.e., an event that is unexpected and unintended. Rather, the complaint alleges that APIS acted intentionally when it

damaged and destroyed the Tribe's property. Therefore, the trial court's ruling of no duty to defend and indemnify under the property damage or bodily injury coverage part was affirmed.

The Appellate Court next considered the coverage available under the "personal and advertising injury" coverage part. That section of the policy provided that "personal and advertising injury" included any offense for the wrongful eviction from, wrongful entry into or invasion of right of private occupancy of a room, dwelling or premises that a person occupies, committed by or on behalf of its owner, landlord or lessor. The Tribe alleged that APIS was not authorized to enter the casino. Based on these allegations, the Appellate Court concluded the alleged trespass was not committed "on behalf of its owners, landlord or lessor" as required under the personal and advertising injury coverage part. Therefore, Scottsdale similarly did not owe any duty to defend under the personal and advertising injury coverage part.

Finally, the Appellate Court considered whether Scottsdale owed coverage under the errors and omission coverage part of the policy. That portion of the policy provides coverage to APIS for "any negligent act, error or omission while performing services normal to the business of the insured." Scottsdale maintained that E&O coverage was unavailable because the complaint alleged only intentional conduct, not negligent acts. However, in an interesting twist, the Appellate Court concluded that Scottsdale may have a duty to indemnify under the E&O coverage if a fact finder determined that APIS acted negligently. The Appellate Court then stated that because there was a potential duty to indemnify under the E&O coverage, there was also a duty to defend. The Appellate Court reversed the district court's grant of summary judgment in favor of Scottsdale on the issue of coverage under the E&O portion of the policy. The Appellate Court also found that under the definitions of "damages", Scottsdale did not owe a duty to indemnify for the claim of conversion. The E&O exclusion for dishonest and fraudulent conduct did not apply because the complaint did not otherwise raise claims of dishonest,

fraudulent or malicious acts.

## TRESSLER COMMENTS

The Iowa Appellate Court reached its conclusion by employing a somewhat unusual analysis. Rather than looking to the allegations of the complaint to first determine if there was a negligent act, error or omission so as to trigger the duty to defend under the E&O policy, the Court instead first looked at whether a fact finder, presumably relying on unpleaded facts, could determine if the insured acted negligently when it trespassed on the Tribe's property. Having answered the question in the affirmative, the Appellate court then concluded that because there *may* be a duty to indemnify, there must be a duty to defend. Further, the ruling of the Appellate Court in regard to the E&O coverage is arguably irreconcilable with its previous finding of no "occurrence". In addressing Coverage A, the Appellate Court held that underlying complaint alleged intentional conduct which did not fall within the definition of an "occurrence" (i.e., an accident). In addressing the E&O coverage, the Appellate Court reversed its position and concluded that the same conduct could result in indemnity based on negligent (non-intentional) trespass.



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# SIXTH CIRCUIT UPHOLDS D&O INSURER'S DENIAL OF COVERAGE ON GROUND THAT LETTER TO INSURED DID NOT CONSTITUTE A CLAIM UNDER THE POLICY



In *John Warren and James Warren v. Federal Insurance Co.*, 2009 U.S. App. LEXIS 28149 (6th Cir.2009), the Sixth Circuit Court of Appeals, while applying Ohio law, upheld the lower court's granting of a summary judgment motion in favor of Federal Insurance Co., which had denied coverage under a directors' and officers' policy on the ground that a letter sent to plaintiffs by a bank did not present a claim under the plain language of the policy.

Federal Insurance Co. ("Federal") had issued a comprehensive general liability insurance policy to BIS Holdings, which included directors and officers liability coverage. Plaintiffs, brothers John and James Warren, owned a 50% interest in BIS Holdings through their limited liability company, The Warren Group, LTD. The other 50% interest in BIS Holdings was owned by The George Hofmeister Family Trusts. BIS Holdings owned all interest in Prime Measurement Products, LLC, a manufacturer of measurement tools and control sensors for the oil and gas markets.

In February 2004, Prime Measurement obtained a revolving line of credit from PNC Bank. Both John and James Warren signed a personal guaranty on the line of credit. In May 2005, The Warren Group, LTD, sold its ownership interest in BIS Holdings to The George Hofmeister Family Trusts, which made it the sole owner of both BIS Holdings and its subsidiary, Prime Measurement. John and James Warren continued, however, to perform various services for BIS Holdings and Prime Measurement until July 2005 which included John Warren's service as interim CEO of Prime Measurement for the two months following the sale.

Prime Measurement's financial condition began to deteriorate in mid-to-late 2005 after the Warren brothers had sold their interests and were no longer actively involved in the company. PNC Bank advised the plaintiffs that defaults had occurred as to the revolving line of credit, and PNC Bank demanded that the plaintiffs fulfill their obligations under the personal guaranty. Plaintiffs refused, and PNC Bank initiated a lawsuit against them in Ohio state court in January 2006. There were no allegations in the PNC complaint that either of the Warrens had made misrepresentations or had otherwise engaged in any negligent or improper acts. Based on a "cognovits" provision in the guaranty, which allows the bank to enter a judicial confession of judgment, judgment was automatically entered against the Warrens for \$700,000. The Warrens immediately filed for a stay of execution.

On March 22, 2006, PNC Bank sent a

letter to the Warrens' attorney. Most of the letter concerned the guaranty; however, the letter contained a paragraph that stated, in part: "...we believe that the Warrens were responsible for misrepresentations regarding Prime's inventory which affected (a) the borrowing base certificates provided to PNC, and (b) Prime's financial statements upon which PNC relied. We are currently evaluating PNC's right and remedies with respect to these misrepresentations."

Prime Measurement, through its local insurance broker, notified Federal Insurance of a claim being made against the Warrens. Federal Insurance denied coverage on the grounds that the policy did not cover the cognovit guaranty.

The Warrens subsequently settled with PNC Bank for \$350,000. The settlement agreement allocated \$300,000 of the settlement amount as payment for claims asserted by PNC Bank for accounting irregularities and the remaining \$50,000 was allocated as settlement on the guaranty.

The Warrens filed suit against Federal Insurance several months later alleging breach of contract, bad faith and declaratory relief. Federal Insurance removed the case to federal court based on diversity, and argued that the plaintiffs were "simply attempting to escape a liability by converting a personal debt based on their suretyship contract into an insurance indemnification claim." The lower court agreed, noting that it was surprising that so little of the amount was designated as payment under the guaranty, especially when PNC Bank had not even asserted a claim for accounting malfeasance. Accordingly, the trial court bifurcated the bad faith claim from the breach of contract and declaratory relief claims. The breach of contract and declaratory relief claims were decided on summary judgment in favor of Federal Insurance.

This appeal followed, with the plaintiffs contending that Federal Insurance breached its contract by failing to indemnify and defend the plaintiffs in their dispute with PNC Bank.

The Federal Policy indicated that it "shall pay Loss on behalf of Insured Persons resulted from any D&O Claim first made against such insureds during the Policy period...". A "D&O Claim" is defined in the Policy, in relevant part, as a "written demand for monetary damages or non-monetary relief .... against an insured for a Wrongful Act...".

Plaintiffs argued that the March 22, 2006 letter from PNC Bank to the plaintiffs is a D&O Claim that constituted a "written demand for monetary damages" as provided under the Federal Policy. Federal Insurance countered with the argument that the PNC letter indicates that no monetary demand is being made, and that PNC was in the process of evaluating its rights and remedies. The lower court had agreed with Federal Insurance, finding that PNC could not evaluate its rights and remedies on the one hand and simultaneously make a claim for monetary damages, as these two concepts are "mutually exclusive." The lower court also determined that the plain language of the March 22 letter did not contain a monetary demand as required for coverage under the Policy. The Court of Appeals agreed.

The Appellate Court also found that the other evidence upon which the plaintiffs relied constituted "extrinsic and after-the-fact 'evidence', none of which Federal Insurance received before denying the claim" and "does not serve to turn the March 22 letter into a 'written demand for monetary damages' or serve as adequate notice to Federal Insurance that a claim had been made against plaintiffs that would be covered under the policy."

Finally, the Court of Appeals found that it was Plaintiffs who had failed to provide Federal Insurance with all of the necessary documentation which had been specifically requested by Federal Insurance on May 17, 2006 - almost three months before the denial was issued. The Court stated that, under the terms and conditions of the Federal Policy, "it was incumbent upon Plaintiffs to ensure that Federal Insurance had actual notice of a claim before the denial letter was issued."

*See Federal Insurance on page 8 for conclusion*

# EIGHTH CIRCUIT FINDS KNOWINGLY WRONGFUL ACT EXCLUSION AMBIGUOUS IN PROFESSIONAL LIABILITY POLICY

In *American Home Assurance Co. v. Kelly Pope*, 2010 U.S. App. LEXIS 516 (8th Cir. Jan. 11, 2010), the United States Court of Appeals for the Eighth Circuit reversed a District Court's summary judgment ruling in favor of a professional liability insurer and held that the knowingly wrongful act exclusion was ambiguous and therefore could not be construed to bar coverage for claims against a psychologist for his failure to warn state officials about the sexual abuse committed against a child by one of his patients.

Lester Pope began sexually molesting his adopted daughter, Kelly Pope, when she was three years old. The abuse continued over a period of years. The girl's mother discovered the abuse and asked her husband to attend counseling sessions with Dr. Strnad, a psychologist who was an insured under a professional liability policy. Lester Pope admitted to Dr. Strnad that he had committed the abuse, but Dr. Strnad failed to notify the Missouri Division of Family Services as required by state law. Lester stopped attending counseling sessions with Dr. Strnad and the abuse continued. Strnad died and suit was later filed against his estate in Missouri state court, alleging that he breached a common law duty to warn Kelly, or someone in a position to protect her, of the abuse. Eventually, by agreement, the claims were arbitrated and an award was entered in Kelly's favor.

The insurer filed a declaratory judgment action, seeking a declaration that it had no duty to defend or indemnify. The insuring clause in the policy required the insurer to "pay on behalf of the Insured all sums which the Insured shall become legally obligated to pay as damages because of any wrongful act committed during the policy period by the Insured . . . arising solely out of the performance of professional services." The policy defined a "wrongful act" as "any actual or alleged negligent act, error, or omission, or any actual or alleged defamation." The policy contained an exclusion which barred coverage for "any wrongful act committed

with knowledge that it was a wrongful act."

The insurer argued that because Dr. Strnad knew he had a duty to report the abuse and knew he had violated that duty, he committed a knowingly wrongful act. Kelly maintained, however, that the knowingly wrongful act exclusion only excluded intentional, not negligent, conduct which would require a showing that Dr. Strnad intended to harm Kelly or intended the harmful consequences of his actions. The Eighth Circuit held that the exclusion was reasonably subject to two different interpretations and that the Court therefore had to follow the construction most favorable to Kelly. The Court noted that the policy covered negligent conduct, and noted that the arbitration panel had expressly found that Dr. Strnad had been negligent and that the arbitration award was based on that negligence. The Court rejected the idea that a knowing breach of a duty necessarily fell within the scope of the exclusion, stating:

"American Home now attempts to exclude the knowing breach of a duty, which breach is by its nature negligence. A negligence claim necessarily requires a duty to act, that is, a duty known or presumptively known by a defendant."

Citing cases from other jurisdictions, the Eighth Circuit held that the exclusion operated to bar coverage only for intentional

misconduct, not negligence, and noted that the insurer had not challenged the finding by the arbitration panel that Dr. Strnad had been negligent.

## TRESSLER COMMENTS

It is common for a professional liability policy that insures negligent acts to exclude coverage for a "knowingly wrongful" act. Insurers do not wish to underwrite claims arising from acts committed by an insured who knows they are wrongful at the time they are committed and in fact, insuring such acts is prohibited as being against public policy in many jurisdictions. The court in this case seemed to be swayed by the arbitration panel's decision that the psychologist's conduct was negligent despite the fact that he had admitted committing the abuse. In addition, the court may have been influenced by the fact that, by finding as it did, the very sympathetic claimant received benefits under the policy.



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## TRESSLER COMMENTS

Both the lower court and the appellate court quickly recognized that the settlement between the plaintiffs and PNC Bank was allocated in a manner to bolster the plaintiff's bad faith claims against the insurer. Nonetheless, the case may have had a different outcome had plaintiffs not been limited to relying on the March 22 letter as the alleged claim for monetary damages in their attempt to trigger coverage under the D&O Policy. This case illustrates not only how significant the specific wording in a written communication can be for the

purpose of evaluating whether it constitutes a claim, but the importance of ensuring that an insurer has all potentially relevant communications for its evaluation. The court notes that there were subsequent communications between the parties pertaining to the accounting malfeasance/misrepresentation claim which the plaintiffs likely would have used to support their assertion that a "wrongful act" had been committed. However, those communications had not been provided to Federal, despite Federal's request for "copies of any and all correspondence regarding the matters referenced in the March 22, 2006 letter."

Unfortunately for the plaintiffs, their counsel did not enclose certain documents that may have ultimately triggered coverage.



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