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EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | August 2013

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No Coverage for Attorneys' Fees Award Where Underlying Contract Action Did Not Allege "Wrongful Act"

The United States District Court for the Central District of California has held that coverage was not available for an attorneys' fees award entered against an insured in a breach of contract action because the underlying action did not allege a "Wrongful Act." The court reasoned that, "in practical terms . . . if a contracting party fails to pay amounts due under a lawful contract and is sued for failure to pay, it cannot then obtain a windfall by having its payments covered by an insurance policy covering only 'wrongful acts.'" Coverage, the court held, "cannot be bootstrapped based solely on a claim for attorney's fees." *Screen Actors Guild Inc. v. Fed. Ins. Co.*, 2013 WL 3525273 (C.D. Cal. July 11, 2013).

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Sales of Allegedly Defective Products Are Not Excluded Professional Services

Applying California law, the United States District Court for the Northern District of California has held that a medical equipment company's sales of allegedly defective products are not professional services excluded under a D&O liability policy. *Scottsdale Ins. Co. v. Coapt Sys., Inc.,* 2013 WL 3146781 (N.D. Cal. June 18, 2013). In addition, the court held that the company's alleged fraudulent conveyance of corporate assets to evade the claims of injured patients was not derivative of the patients' injuries such that it is barred by the policy's bodily injury exclusion.

Numerous physicians and patients brought claims against a medical device company that allegedly sold defective products to the physicians. The claimants asserted that the physicians' use of the products caused serious side effects to the patients, which, in turn, caused damage to the physicians' reputations. In addition, the claimants contended that once the medical device company and its directors and officers learned of the harm caused by their products, they transferred the company's assets to hinder the physicians and patients from collecting on their claims. The company's directors and officers sought coverage under a D&O

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Oral Suggestion That Company Settle a Potential Suit Gives Insured a "Reasonable Basis" for Believing That a Claim Might Be Made

The United States District Court for the District of Maryland, applying Virginia law, has held that an oral suggestion that a company settle a potential suit gave an insured a "reasonable basis" for believing that a claim might be made, and that the insured's failure to report this in response to a question on an insurance application was a material misrepresentation. *Prosperity Mortg. Co. v. Certain Underwriters at Lloyd's,* No. 12-2004 (D. Md. July 15, 2013).

A mortgage financing company issued a home equity line of credit to a couple. Two years later, the couple sued the mortgage financing company for alleged high loan values arising out of a faulty appraisal. The couple hired an attorney, who initiated settlement negotiations with the finance company. This attorney also represented a second couple. During those settlement negotiations, the attorney orally suggested that the mortgage financing company also settle with the second couple, even though the second couple had not yet filed a lawsuit. The mortgage financing company ultimately settled only with the first couple.

After the settlement, the mortgage financing company applied for an E&O policy with a carrier. The application asked the mortgage financing company whether it had "knowledge or information of any act, error or omission which might reasonably be expected to give rise to a claim(s), suit(s), investigation(s) or action(s)" and to identify "any claim(s), suit(s), demands for arbitration, or administrative/regulatory actions" pending prior to the application. The mortgage financing company did not identify the attorney's reference to settlement with the second couple in response to either question. After the policy was

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Conspiracy Did Not Occur "Solely" in the Rendering of "Professional Services"

The Indiana Court of Appeals, applying Indiana law, has affirmed a trial court's judgment in favor of reinsurers, holding that lawsuits alleging that a health insurer conspired with managed-care organizations to deny, delay, and diminish payments to doctors did not arise "solely" in the rendering of "Professional Services" and was not covered under the health care insurer's professional liability policies. *Wellpoint, Inc. v. Nat'l Union Fire Ins. Co.*, 2011 WL 2893095 (Ind. Ct. App. June 19, 2013).

The insured, a health care insurance provider, was sued by several plaintiffs asserting violations of the Racketeer Influence and Corrupt Organizations Act (RICO), among other causes of action, in connection with an alleged scheme by the insured and managed care providers to delay and deny payments to doctors. The health care insurer issued primary and excess E&O policies to itself, for which it then obtained reinsurance from several reinsurers.

The reinsurers denied coverage for the RICO litigation on the basis that the claims did not fall within the scope of coverage of the relevant insuring agreement, which extended to loss for wrongful acts occurring "solely in the rendering of or failure to render Professional Services." "Professional Services" were defined as "services rendered or required to be rendered solely in the conduct of the Insured's claims handling or adjusting."

> The court reasoned that "the policy language is not ambiguous, and that 'solely' means solely [and] implies 'exclusively' or 'entirely.'"

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Court Finds No Coverage for a Claim First Made During Policy Period of a Claims-Made-and-Reported Policy But Not Reported Until After Inception of Successive Policy

The United States District Court for the District of South Carolina has held that there was no coverage for a claim first made during the policy period of a claims-made-and-reported policy but not reported until the successive policy period. In so doing, the court rejected the insured's argument that the consecutive policies issued by the same insurer formed a single continuous policy. *GS2 Eng'g & Envtl. Consultants, Inc. v. Zurich Am. Ins. Co.*, 2013 WL3457098 (D.S.C. July 9, 2013).

The policyholder first purchased a claims-made-and-reported insurance policy in 2005, and it renewed that policy annually for a total of six successive one-year policies. With nearly four months remaining on its second-to-last policy, the insured was served with a lawsuit. The insured did not notify its insurer of that suit for approximately five months, however, which was 47 days into the next policy period. The policies at issue contained a provision stating that an automatic 30-day extended reporting period would apply upon termination of coverage, but that provision stated that coverage was only "terminated" by cancellation or nonrenewal. After a coverage dispute arose, the policyholder filed suit against its insurer.

The court granted summary judgment in favor of the insurer. The court first analyzed the terms of the policies, which provided that coverage applied only if "the claim is first made against the insured during the policy period and reported to us during the policy period, the automatic extended reporting period or the extended reporting period, if applicable." Relying on that policy language, the court ruled that there was no coverage for the claim at issue because it was not both made and reported during either of the policy periods.

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New York Trial Court Enforces Late Notice Provision

A New York trial court has held that a law firm breached an insurance policy's notice requirements when it failed to give notice of an error that gave rise to a malpractice suit until after it lost a motion regarding the effect of the error. *Prop. & Cas. Ins. Co. of Hartford v. Levitsky*, 2013 WL 3184625 (N.Y. Sup. Ct. Jan. 25, 2013).

The policyholder law firm represented a plaintiff injured during construction of a mall. By answer filed five days before the statute of limitations expired, the defendant denied ownership of the mall. At a deposition more than a year later, a witness testified that the defendant did not own the mall, but provided more information about the relationship between the owner and the defendant. Shortly thereafter, the defendant moved to dismiss. The law firm opposed the motion and cross-moved to join the true owner as a defendant. The trial court granted the motion to dismiss and denied the cross-motion. The policyholder law firm then advised its client to obtain new counsel, and the new counsel advised the policyholder that its former client was considering a malpractice suit. The policyholder notified the carrier of the potential claim shortly thereafter.

The policy specified that the insured "must see to it that we are notified immediately, but in no event later than sixty (60) calendar days after the insured becomes aware of any circumstance which may give rise to a claim." The carrier agreed to defend the eventual malpractice suit, but reserved the right to deny coverage based on late notice. The carrier then sought declaratory relief.

The trial court held that the policyholder failed to comply with the unambiguous notice provisions because the policyholder became aware of circumstances that "may" give rise to a claim either when the defendant denied ownership of the mall or a few days later, when the statute of limitations expired. The policy required the law firm to notify the carrier "when a reasonable

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Legal Services Provided Without Charge in Settlement of Prior Claims Constitute "Professional Services"

Applying Virginia law, a federal district court has held that legal services provided to a client in exchange for a release of prior claims of malpractice constitute "professional services" within the scope of coverage of the insured lawyers' professional liability policy. The court also found that the policy's "past acts" exclusion did not apply to bar coverage for the subsequent claim. *Admiral Ins. Co. v. Marsh*, 2013 WL 3270555 (E.D. Va. June 26, 2013).

Before the inception of the policy at issue, the insureds had acknowledged certain errors in connection with the handling of three separate legal matters for a client. In settlement of those claims, and as "full compensation for the release," the insureds agreed to handle any future litigation for the client without charge for a period of one year. Pursuant to this agreement, the insureds defended the client in a defamation action in which a judgment ultimately was entered against the client. The client subsequently sued the attorneys, alleging that they committed malpractice in that case.

The lawyers' insurer denied coverage for the malpractice claim, contending that the services rendered to the client in the defamation action did not constitute "professional services," which the policy defined to mean "service[s] performed by an Insured . . . for remuneration inuring to the benefit of the Named Insured." According to the insurer, because the services were provided at "no charge," they were not performed for "remuneration." The court disagreed, finding that the plain meaning of the term, as set forth in *Black's Law Dictionary*, includes "payment" and "compensation." In this regard, the court pointed out that, by the express terms of the parties' settlement agreement, the legal services provided in the defamation action were provided as full "compensation" for the release of the prior claims of malpractice.

The court also rejected the insurer's reliance on the policy's "past acts" exclusion, precluding coverage for any claim involving a wrongful act

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Insurer Prejudiced by Insured's Failure to Report Adverse Trial Court Decision in Underlying Action

The United States Court of Appeals for the Fourth Circuit, applying Maryland law, has held that no coverage was available for a legal malpractice claim because the "claim" was first made when a trial court granted summary judgment against the law firm's client for failure to submit a properly executed affidavit and because the law firm failed to provide notice of the "claim" during the relevant policy period. *Minn. Lawyers Mut. Ins. Co. v. Baylor & Jackson, PLLC*, 2013 WL 3215246 (4th Cir. June 27, 2013). The court held that the insurer suffered prejudice—without deciding whether Maryland Code § 19-110 required the insurer to prove prejudice to deny coverage for late notice—because the insurer was denied a "true mitigation opportunity" concerning the appeal of the adverse trial court ruling.

The insured law firm represented a client who was sued in Maryland state court. In response to the plaintiff's motion for summary judgment, the insured law firm filed an opposition brief but failed to submit either an affidavit or sworn statement to support its client's contentions that a material fact existed as required by Maryland Rule 2-501. Based on this failure and other arguments, the judge granted summary judgment to the plaintiff in August 2006. In July 2009, an appellate court affirmed the trial court's ruling because the insured's "failure to comply with Maryland Rule 2–501 severely undermined their opposition to summary judgment on all the counts." The insured provided notice of the appellate court's decision to its insurer. The insurer denied coverage under the 2006 policy because the insured failed to provide notice to the insurer when the trial court granted summary judgment in 2006.

The court held that the "claim" was first made when the trial court granted summary judgment against the law firm's client for failure to file a properly executed affidavit with its opposition brief. The 2006 policy provided that a "claim is

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Real Property Investment Transaction Does Not Constitute a "Covered Product" Under an Insurance Agents E&O Policy

A federal court in West Virginia, applying West Virginia law, has found that allegations regarding a fraudulent real estate deal did not fall within the coverage grant of an insurance agency's E&O policy, as the underlying real estate transaction did not constitute a "Covered Product" as defined by the policy. *Am. Auto. Ins. Co. v. Smith*, 2013 WL 3327918 (S.D.W.Va. July 1, 2013). Accordingly, the court entered a default judgment against the insureds, who had failed to contest the insurer's declaratory judgment action.

The insureds presented a property investment to the claimant. The claimant alleged that the insureds breached their fiduciary duty to the claimant by failing to use reasonable care in their investigation of the subject property. According to the claimant, the insureds should have known that the actions of others involved in the transaction were fraudulent because the purchase price, appraisal, and subsequent loan were in excess of the actual value of the land. The claimant filed suit, for which the insured sought coverage under an insurance agents E&O liability insurance policy.

Although the insureds did not contest the insurer's subsequent motion for a default judgment, the court nevertheless reviewed the motion on the merits and determined that no coverage was available under the policy, which provided coverage only for claims for a "Wrongful Act in the rendering or failure to render Professional Services in connection with a Covered Product . . . ." "Covered Product" was defined as "property and casualty insurance coverage," "life insurance . . . , accident and health insurance, disability income insurance or fixed annuities . . . ," "group employee benefit plans or disability plans," or "group or ordinary Pension or Profit Sharing Plans, Individual Retirement Accounts . . . , and fixed retirement annuities." The policy was amended to add "variable products . . . ," "Mutual Funds," and "any Securities sold by the Insured as a Registered Representative" to the definition of Covered Product.

According to the court, the policy did not provide coverage for the underlying action because the suspect real estate transaction did not constitute a "Covered Product." The court explained that, while the underlying action loosely could be characterized as involving an "investment," it did not involve securities and was instead a "tort claim related to the purchase of real property." As such, the court concluded that the claim was "entirely foreign to the risk covered" by the policy and entered judgment in favor of the insurer, providing that it had no duty to defend or indemnify the insureds. ■

Dishonesty Exclusion Bars Coverage for Legal Malpractice and Breach of Fiduciary Duty Claims

A federal court in Colorado, applying Colorado law, has found that a dishonesty exclusion bars coverage for legal malpractice and aiding and abetting breach of fiduciary duty claims when such claims "arise out of" acts that require proof of unlawful purpose or intent. *Hackstaff Law Group, LLC v. Hartford Cas. Ins. Co.*, 2013 WL 2557394 (D. Colo. June 11, 2013).

The insured law firm's client, a construction company, needed additional financing to complete a construction project, which it sought from a third party. As part of that transaction, the third party demanded a direct ownership interest in the underlying property. Although the construction company did not have an interest in the property, a fact of which both the insured and the third party were aware, the construction company—with the insured's assistance—executed a deed that conveyed a direct ownership interest in the property to the third party.

The third party then brought suit against the owners of the property, who, in turn, added the insured and the construction company to the litigation. The property owners asserted claims for civil conspiracy, aiding and abetting a breach of fiduciary duty, and legal malpractice against the insured. The insured reported the lawsuit to its professional liability insurer. The insurer determined that it had no duty to defend the insured as a result of an exclusion for "'Claims' arising out of an act, error or omission, or 'personal injury' committed by the 'insured' or at the 'insured's' direction with dishonest, fraudulent, criminal, or malicious purpose or intent."

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No Duty to Defend Where Employee Participated in Scheme to Siphon Millions of Dollars of Class Action Settlement Proceeds

The United States District Court for the Eastern District of Pennsylvania has held that an insurer has no further duty to defend a negligence suit against an insured class action settlement administrator because the actions of one of its employees in approving fraudulent claims fell within the policy's sublimit for misappropriation, misuse, theft, or embezzlement of funds. *Camico Mut. Ins. Co. v. Heffler, Radetich & Saitta, LLP*, 2013 WL 3481527 (E.D. Pa. June 27, 2013).

The employee of the insured administrator participated in a scheme to siphon several million dollars of settlement proceeds to his co-conspirators and subsequently pled guilty to mail fraud and wire fraud. Following the discovery of the scheme, members of one of the settlement classes sued the administrator for damages resulting from the employee's actions. The administrator's insurer had funded the defense against the class-members' claims but sought a declaratory judgment that the policy's $100,000 sublimit for claims "arising from, related to or in connection with any Insured's misappropriation, misuse, theft or embezzlement of funds" should apply and relieve it of any further coverage obligation.

The court granted summary judgment to the insurer and allowed it to recoup the costs it had paid beyond the sublimit, finding that the employee's conduct fell within each of the terms of the exclusion. The court found it irrelevant whether the employee was the ringleader of the scheme or had directly received any or all of the stolen money. At the very least, the court held, the employee had aided and abetted the commission of misappropriation, misuse, theft, or embezzlement.

With respect to the insured's argument that the sublimit should not apply because the employee was not an insured under the policy, the court noted that the policy provided coverage for former employees "but only while performing Professional Services on or after the Retroactive Date." The administrator argued that the employee had worked for the company only prior to the relevant policy year and that his criminal acts were not performed for the company's benefit. The court rejected this argument, determining that the former employee's acts were covered because they were performed after the retroactive date. Moreover, the court held that the policyholder's interpretation would render the language of the sublimit redundant. The court determined instead that because the employee had engaged in misappropriation, misuse, theft, or embezzlement in connection with his work for the administrator, he was performing professional services for the benefit of the company when he committed the acts at issue.

The court also rejected the administrator's argument that the insurer could not deny coverage for negligence claims asserted against an innocent insured that were related to a criminal act committed by another insured. The court noted that the policy contained a specific provision allowing coverage for innocent insureds in certain circumstances but that it specifically did not apply to the exclusion for misappropriation, misuse, theft, or embezzlement. The court also emphasized the breadth of the exclusion, in particular, the use of the term "any Insured" and the phrase "related to," which does not require any causal connection.

Finally, the court granted summary judgment to the insurer on the administrator's claim for bad faith because the insurer's reliance on the sublimit was reasonable and appropriate and therefore could not constitute bad faith. ■

Dishonesty Exclusion Bars Coverage for Legal Malpractice and Breach of Fiduciary Duty Claims

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In determining that the exclusion applied, the court first reviewed the interpretation of the terms "dishonest," "fraudulent," and "malicious." The court then reviewed the allegations against the insured, noting that the property owner asserted that even though the insured knew the construction company "had no right to convey an ownership interest, [the insured] conspired to design [a] sham transaction . . . , and did so with full knowledge of its fraudulent purpose and intended fraudulent effect." According to the court, such allegations were sufficient to trigger the exclusion. Even though legal malpractice may be established by a showing of negligence, the court determined that those allegations "flowed from" the dishonest, fraudulent, or malicious conduct at issue, and thus coverage was barred. ■

Oral Suggestion That Company Settle a Potential Suit Gives Insured a "Reasonable Basis" for Believing That a Claim Might Be Made *continued from page 2*

issued, the second couple filed a putative class action lawsuit against the mortgage financing company. The carrier sought rescission of the policy, arguing that the oral suggestion to settle with the second couple was a "claim" within the meaning of the application, and the failure to identify that claim on the application was a material misrepresentation.

The court agreed with the carrier that the oral suggestion was a "claim" or a potential claim within the meaning of the application, and that the failure to identify it as such was a material misrepresentation. Although "claim" was defined in the policy in a manner that did not include oral demands for relief, the court did not apply this definition because the policy had not yet been issued at the time of the application. The court thus applied the "ordinary and customary meaning" of the word "claim," which, under Virginia law, was merely a "demand for something as rightful or due." Although the court indicated that the oral suggestion may or may not be construed as a "demand," it deemed it unnecessary to decide this issue because the application merely required identifying "any act, error or omission which might reasonably be expected to give rise to a claim," and the oral suggestion was sufficient to give the company a "reasonable basis" for believing that a claim might be made. Accordingly, the court concluded that the company's answer to this question was a misrepresentation. Additionally, the court deemed the misrepresentation to be material under Virginia law because the carrier had stated in a counterclaim that "had [the carrier] known about the [non-settling couple's] claims . . . it would not have agreed to issue the [policy], or would not have issued the [policy] on the same terms and conditions, or for the same premium." As a result, the court entered judgment on the pleadings in favor of the insurer and declared the policy at issue rescinded. ■

Sales of Allegedly Defective Products Are Not Excluded Professional Services *continued from page 1*

liability insurance policy. The insurer denied coverage based on the policy's bodily injury and professional services exclusions.

In the subsequent coverage litigation, the court ruled that the exclusions did not bar coverage for the claims. First, the court addressed the professional services exclusion, which precluded coverage for "any Claim alleging, based upon, arising out of, attributable to, directly or indirectly resulting from, in consequence of, or in any way involving the rendering or falling to render professional services." The insurer argued that the reputational injury and fraudulent conveyance claims came within the exclusion because the medical device company was involved in the manufacturing and sale of its products, which constitute professional services under California law. The court disagreed that all sale and marketing activities constitute professional services, finding instead that the company's alleged activities were ordinary commerce and thus not within the professional services exclusion.

The insurer also contended that coverage for the fraudulent conveyance claims was precluded by the policy's bodily injury exclusion, which barred coverage for claims "for actual or alleged bodily injury . . . ." The directors and officers argued that the claims were not "for" bodily injury. The insurer asserted that the claims were derivative of the patients' personal injury claims, which were excluded bodily injury claims, and thus, the derivative claims were also excluded. The court disagreed, finding that the patients had asserted two separate and distinct torts: the sale of defective products that caused injury, and the transfer of corporate assets to defraud creditors. The latter did not flow directly from the former, the court held, and thus, they were not subject to the same exclusion. Further, the court stated that the exclusion was narrowly drafted, omitting broad phrases like "arising out of." As such, the court held that the fraudulent conveyance claims did not come within the bodily injury exclusion. ■

No Coverage for Attorneys' Fees Award Where Underlying Contract Action Did Not Allege "Wrongful Act" *continued from page 1*

In 2007, an actor and member of the insured union, the Screen Actors Guild, filed a class action suit against the union. The complaint alleged that the union had been collecting "foreign levy funds" due to actors and had held those funds for an "unreasonably long time." The complaint further alleged that the plaintiff class members were entitled to possession of their share of the funds. The union tendered the suit to its insurer, which agreed to provide coverage for defense costs, but stated that "there is no coverage for indemnity" and further reserved its rights. In 2010, the union settled the suit, agreeing to use reasonable efforts to allocate 90% of the foreign levy funds to the proper recipients within three years. In approving the settlement, the court awarded a $15,000 enhancement payment to the lead plaintiff and $315,000 in class counsel fees. The union then sought reimbursement from its insurer for the $330,000 award. The insurer denied coverage for the award, and the union filed suit for breach of contract and bad faith.

Ruling on cross-motions for summary judgment, the court held that there was no coverage for the award because the underlying breach of contract allegations—*i.e.*, the allegations that the union had not distributed funds due and owing to the actors—did not allege a "Wrongful Act." Quoting *Health Net, Inc. v. RLI Insurance. Co.*, 141 Cal. Rptr. 3d 649 (Ct. App. 2012), for the proposition that "[p]erformance of a contractual obligation . . . is a debt the [insured] voluntarily accepted . . . not a loss resulting from the wrongful act," the court stated that, in the present case, the union's own position was that it was obligated to account for and distribute the funds to actors. The court noted that California courts have reached this result "even in the absence of an express exclusion." Rejecting the insured's attempt to distinguish *Health Net*, the court explained that while the definition of "loss" in the policy at issue here was broader, that "is irrelevant to the determination whether the claims in this case arise out of a 'Wrongful Act.' . . . '[I]f the entire action alleges no covered wrongful act under the policy, coverage cannot be bootstrapped based solely on a claim for attorney's fees.'" ■

Court Finds No Coverage for a Claim First Made During Policy Period of a Claims-Made-and-Reported Policy But Not Reported Until After Inception of Successive Policy *continued from page 3*

After noting the apparent "intuitive appeal" of the insured's argument in favor of a "single continuous period," the court rejected it, ruling instead that its determination of no coverage better reflected the language and nature of the policies at issue.

Additionally, the court concluded that the policies were unambiguous and that the automatic extended reporting period did not apply since the policy at issue was renewed, not terminated. The court also held that, even if the automatic extended reporting period applied, notice was untimely since the claim was first reported more than 30 days after the close of the relevant policy period. ■

New York Trial Court Enforces Late Notice Provision *continued from page 3*

possibility of a claim under the policy arose, even if such a claim remained uncertain." The court further held that later-acquired evidence that might have supported a reasonable good faith belief that no malpractice claim could be maintained—the testimony about the relationship between the defendant and the owner—could not cure the failure to give notice earlier. The court accordingly declared that the carrier had no duty to defend against or indemnify with respect to the malpractice suit. ■

Legal Services Provided Without Charge in Settlement of Prior Claims Constitute "Professional Services" *continued from page 4*

that occurred on or after July 3, 2006, which, together with a wrongful act occurring prior to that date, constituted a "related wrongful act." The policy defined "related wrongful act" to mean "wrongful acts, which are logically or causally connected by reason of any common fact [or] circumstance." According to the court, even though the prior acts of malpractice for which the insureds obtained a release occurred before July 3, 2006, the exclusion did not apply because those acts were not in any way connected to the later acts allegedly committed in connection with the defamation action "other than by an ongoing relationship between [the client] and the [insureds]." ■

Insurer Prejudiced by Insured's Failure to Report Adverse Trial Court Decision in Underlying Action *continued from page 4*

deemed made when . . . an act, error or omission by any insured occurs which has not resulted in a demand for damages but which an insured knows or reasonably should know, would support such a demand." The court reasoned that a lawyer who received notice of the opinion and was present at the summary judgment hearing would have considered the possibility of a malpractice claim. Because the insured did not provide notice of the claim during the 2006 policy period, notice of the claim was not timely provided.

Although refusing to decide whether the insurer was required to prove prejudice under Maryland Code § 19-110, the court did find that the insurer was prejudiced by the insured's failure to provide notice until after the adverse appellate court decision. In this regard, it held that the insurer had been prejudiced because "by the time [the insured] provided notice of a possible claim, the harm supporting the malpractice judgment was irreversible." ■

Conspiracy Did Not Occur "Solely" in the Rendering of "Professional Services" *continued from page 2*

The court concluded that the wrongful acts alleged in the RICO litigation were not professional services in the form of claims handling or adjusting. According to the court, the underlying lawsuits did not simply allege that the insured improperly denied claims. Rather, they alleged an unlawful agreement or conspiracy to deny, delay, and diminish payments to doctors. Alleged wrongful conduct included the insured's participation in a managed care enterprise and its involvement in trade associations and industry groups that disseminated unified information and exchanged upper-level employees in order to facilitate unified action. Unlawful agreements and conspiracies are not claims handling activities, the court reasoned. Even if some professional services were implicated, the court held, the underlying actions did not arise "solely" out of the rendering or failure to render such services.

The court reasoned further that "the policy language is not ambiguous, and that 'solely' means solely [and] implies 'exclusively' or 'entirely.'" Accordingly, the court rejected the insured's argument that coverage was "not negated for . . . wrongful acts that did occur in the performance of claims handling." That argument, the court held, is inconsistent with the meaning of "solely" as "exclusively" or "entirely." The court therefore affirmed the trial court's decision that the reinsurers' policies did not provide coverage for the underlying litigation. ■

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