DECISIONS OF NOTE IN 2002-2003 ON RESCISSION OF POLICIES

The following discussion addresses recent developments in the case law concerning rescission of third-party coverage, as opposed to the first-party context, which, historically, has seen more in the way of decisions on this topic.

The recent string of corporate scandals followed by related coverage litigation tends to implicate D&O insurance, although it has produced relatively few reported decisions on rescission of such coverage between September, 2002 and October 2003. However, the general hesitancy of carriers to consider rescission as a defense to claims under third-party coverage in commercial lines may be gaining greater currency, partly as a result of this apparent explosion of mendacity amongst corporate and professional policyholders. Moreover, given the continuing hard market and the severing of long term relationships between carriers and their commercial market accounts, it may be a defense insurers are more willing to consider than has been the case in the past.

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The decision in *Adelphia Comm. Corp. v. Assoc. Electric & Gas Ins. Svcs, Ltd, Federal Ins. Company, and Greenwich Ins. Co., 285 B.R. 580 (S.D.N.Y. Bankr, Nov., 2002)*, involved two related bankruptcies arising out of the collapse of the Rigas family cable empire amidst allegations of various improprieties in the use of corporate assets for the private gain of certain corporate insiders. The Rigas family members, and two former employees, sought relief from stay under *11 U.S.C.S. § 362*(d)(1), to make defense costs claims against a directors' and officers' policy and to sue the insurers, if necessary. The insurers also sought relief from the stay to join the debtors in a declaratory judgment action on the policies seeking, among other things, rescission of the D&O coverage.

The Court initially decided whether the proceeds of the D&O policies were assets of the debtors' estates for purposes of the automatic stay. It found that one debtor's estate was worth more with the policies than without them due to entity coverage, while the other debtor's estate was worth more with the policies due to entity coverage and the need to secure independent directors. Thus, the Court held that the policies and their proceeds were property of the debtors' estates under *11 U.S.C.S. § 541*(a)(1). In answering these questions, the Court specifically distinguished the cases of *In re Youngstown Osteopathic Hospital Association, 271 B.R. 544 (N.D. Ohio 2002), In re CyberMedica, Inc., 280 B.R. 12 (Bankr. D. Mass. 2002),* and *In re EnronCorp., No. CV010383979, 2002 WL 1008249 (S.D.N.Y. May 17, 2002).* It found relevant the fact that, in *CyberMedica*, while the estate had entity coverage as well as indemnification coverage, there was no reasonable basis to believe that the estate would need its entity coverage, and in *Youngstown Osteopathic*, there was indemnification coverage only, which likewise was not needed. In *Enron*, the indemnification and entity coverage was contractually subordinated to the defense costs coverage. Thus, each of those cases was arguably distinguishable from the *Adelphia* situation, where the Court felt entity coverage might ultimately be more significant.

Despite concluding that the D&O proceeds were assets of the corporate debtors, the insurers were authorized - but not required - to advance defense costs to directors and officers, but only up to $ 300,000, so as to preserve the bulk of the proceeds, without prejudice to further requests. Further, the ruling was without prejudice to other parties' rights to later litigate whether, and to what extent, the remaining proceeds would be allocated, and to address whether an insured was advanced more than his rightful share. The declaratory judgment action was stayed, to be reconsidered after the conclusion of the criminal proceedings pending against several individual insureds, including members of the Rigas family.

Among other things, the Court felt that it was reasonable to preclude any parties from litigating the question of entitlement to rescission because there was little prospect that such litigation could advance, regardless of the Bankruptcy Court's ruling. The chief reason for such pessimism was the fact that United States Attorney had sought to stay other civil litigation arising out of the Adelphia imbroglio, on the ground that it might adversely affect the criminal proceedings. Given the fifth amendment considerations of the criminal defendants, and the Justice Department's desire to curb the relatively broader discovery available in civil proceedings, this same rationale would likely apply to the coverage litigation. In any case, if the carriers remain reluctant to advance defense expenses, even with court approval, there will

undoubtedly be further litigation involving the D&O coverage before the overall litigation is concluded.

The case of *Qwest Comm. Intl., Inc., v. Natl. Union Fire Ins. Co. Of Pittsburgh, Pa.,* C.A. No. 20009, *821 A.2d 323 (Del. Ch., Dec. 2002)* addresses the application of a policy provision concerning the insured's right to choose between different forms of alternative dispute resolution (ADR) in connection with the carrier's claim of entitlement to rescission. The insured corporation had policies of officers', directors', and pension fiduciaries' liability coverage with its primary insurer, as well as various excess policies. The policies provided for either non-binding mediation or binding arbitration respecting coverage issues, both under the auspices of the American Arbitration Association ("AAA"). In addition, they gave the insured the option to reject the carrier's choice of the specific form of ADR "at any time prior to its commencement."

When the insured became the focus of accounting investigations and notified the insurers of pending lawsuits arising out of those circumstances, they eventually responded by seeking to rescind the policies, claiming they were issued in reliance on misrepresentations by the insured. At the same time as they advised the insured of the decision to rescind, the insurers announced that they had requested binding arbitration as the form of ADR, and had already filed a Demand for Arbitration with the AAA. The court held that the insured, which preferred non-binding mediation, was entitled to a permanent injunction precluding the insurers and the arbitration association from proceeding with scheduled arbitration. The Court found that the "choice of ADR" provision would be illusory if the arbitration were held to have commenced at the date of the initial request, particularly where the first notice of the intent to rescind was provided contemporaneous with the "commencement" of the arbitration. Without attempting to set the outer boundaries of the calculation, the Court found that the insured had to have a "reasonable opportunity" within which to decide whether to elect a different ADR method.

The decision rendered in the case of *Genesis Insurance Company vs. Homestore, Inc*., Case No. 02-CV-7738 (C. D. Cal., July 15, 2003) had, at press time, not yet yielded a formal opinion from the trial judge, and seems certain to be headed for an appeal. It is noteworthy, even in the absence of a formal opinion at this stage, if for no other reason than that it has the potential for providing what is frequently elusive in the type of litigation spawned by the "dotcom" meltdown and other recent corporate scandals involving questionable accounting practices - a substantive ruling on the merits of a claim for rescission of D&O coverage. Moreover, as the trial judge in the underlying securities class action litigation for which a defense and coverage was sought described it, "[t]his Complaint provides one explanation of how the now-infamous internet 'bubble' occurred." *In re Homestore.com, Inc. Securities Litigation,* 252 F. Supp.2d 1018, 1019 (C.D. Cal. March 7, 2003). Thus, the rationale for the order granting Genesis Insurance Company's Motion for Summary Judgment on its claim for rescission of the D&O policy issued to Homestore, Inc., effective against "all insureds," would be of interest to all parties involved in similar litigation throughout the country.

What can be gleaned from the record available in the *Genesis* case is the fact that summary judgment was granted pursuant to California Insurance Code § 650, which provides that statutory rescission will apply to all insureds under the contract, including additional insureds, unless the contract of insurance provides otherwise. Further, the order granting the motion stated that the application for the policy contained misrepresentations "made with the actual intent to deceive and/or which were material to the risk and hazard assumed by Genesis,"

and that the signatory knew them to be untrue when he signed the application. An endorsement to the D&O policy defined the "Application" to include "any public documents filed ... with any federal ... regulatory agency (including but not limited to the Securities and Exchange Commission (SEC))." The policy also contained a provision declaring that it was void if the Application contained misrepresentations known to be untrue by the individuals signing the Application. The signatory on the Application, former Chief Financial Officer Joseph Shew, had pled guilty in certain criminal proceedings initiated against various Homestore.com officers. Thus, Genesis was able to establish that he knew, at the time of signing the Application, that the material representations contained in the Form 10-Q filed with the SEC for the quarter ending approximately five (5) months prior to the August 2, 2001 Application date were, in fact, false.

It may be that the *Genesis* case simply reflects the inevitable result when the D&O policy in question lacks a so-called "severability" clause, and/or contains the type of "blanket rescission" clauses that became common as some of the root causes of the bursting of the internet "bubble" became all the more evident to D&O carriers. Any eventual appeal will, nonetheless, be of interest.

B. AUTOMOBILE LIABILITY POLICIES:

The case of *Maryland Automobile Ins. Fund vs. Lumbermen's Mutual Casualty Co., et al. 148 Md. App. 690; 814 A.2d 52 (Md. App., Dec. 2002),* is one of the rescission cases involving auto liability insurance that were decided within the past year. The unique aspect of this particular case is that the "insurer" here was the state auto insurance fund ("MAIF"), the so-called "insurer of last resort." The principal question before the intermediate appellate court was whether MAIF retained the right to rescind a policy of insurance if it did not do so within 60 days from issuance of a binder. Rescission was based on the fact that the insured, in applying for the MAIF policy, had misrepresented that she was a resident of Maryland, as required by *Md. Ann. Code art. 48, § 20-502(e)* (1997, 2002 Repl. Vol.). Maryland's highest court, the Court of Appeals, had previously decided that the statutory compulsory motor vehicle insurance scheme, introduced in Maryland in 1972, had abrogated entirely a private insurer's common-law right to void a policy of auto insurance, *ab initio*, if it was obtained fraudulently through any material misrepresentation in the policy application. See, *Van Horn vs. Atlantic Mutual Insurance Co.*, 334 Md. 669, 680, 641 A.2d 195 (Md. 1994).

The *MAIF* case also had occasion to address the sometimes neglected distinction between statutory and other law dealing with cancellation, and that dealing with rescission of a policy, *ab initio*. In addition, this case dealt with the question of waiver or estoppel to assert rescission, after a fashion, in that its addresses the question of whether the statute requiring MAIF to cancel a policy within 60 days after coverage is effective provided the outside limits of a "reasonable time" within which to also effect rescission of the policy. The Court held, in essence, that MAIF did not have to *choose to exercise its right to rescind* a policy issued on the basis of an intentional misrepresentation, either within the 60 day limit argued by Lumberman's Mutual, or within any other particular time. Instead, it held that § 20–502 (e), outlining the eligibility requirements for prospective MAIF policyholders, was a *legislative declaration that any policy issued on such a basis was void* from the outset. Thus, MAIF's only role in effecting a rescission is to the determine whether there has been an intentional misrepresentation. If so, the policy is automatically void, *ab initio*.

The Court justified this significant departure from the rule applicable to private auto insurers on two grounds. First, unlike private insurers, MAIF does not have the option of declining an applicant on the basis of the degree of risk presented, so long as the applicant meets the statutory criteria. Second, the Court felt that the rationale of *Van Horn* did not apply as readily to MAIF, which was an insurer of last resort. See, MAIF, *supra*, 814 A.2d at 60.

In contrast to the decision in MAIF, the case of *United Services Auto Ass'n. v. David Pegos, 107 Cal. App. 4th 392; 131 Cal. Rptr. 2d 866 (Cal. App., March 2003)* favored the policyholder on the question of the rescission of a policy of auto liability insurance. However, it, too, justified its result by reference to the public policy it found expressed in the state's compulsory financial responsibility scheme. Perhaps more interesting, and potentially more broadly applicable, was the Court's reference to the "quasi–public" nature of insurance contracts as a ground for requiring the insurer to establish that it had undertaken a reasonable investigation of the insurability of the risk in question.

The general rule in most jurisdictions is that, absent notice - actual or constructive - of a reason to investigate further, an insurer is entitled to accept representations of the applicant at face value in determining whether to issue a policy. A decades old decision by the California Supreme Court, however, in *Barrera vs. State Farm Mutual Automobile Insurance Company* (1969) 71 Cal.2d 659, 681, held that an insurer had to undertake a reasonable investigation of the insured's insurability within a reasonable period of time from the acceptance of the application and the issuance of a policy. It also held that this duty inured to the benefit of third parties injured by the insured. The question in *Pegos* was whether this same duty applied to an insured's request to add a vehicle to an existing auto liability policy. The insurer contended that it did not, and that the insurer should be allowed to rescind the policy on the basis of alleged misrepresentations regarding the intended use of the cars insured thereunder. The trial court agreed, entering summary judgment for the insurer on that basis. The Court of Appeals, however, in a relatively straightforward application of the rule in *Barrera*, reversed and remanded for a determination of the reasonableness of the insurer's investigation of the request to add the additional vehicle to the policy.

Interestingly, the Court distinguished an earlier ruling in *International Service Insurance Company vs. Gonzalez* (1987) 194 Cal.App.3d 110, 120, where it was held that a simple renewal of an existing policy did not trigger the insurer's obligation to reinvestigate its insured. At a minimum, in the effort to distinguish *Gonzalez*, the *Pegos* court seemingly endorsed a view that an insurer is not required to review verified information obtained in an original application for insurance at the time of a renewal of the coverage, unless the insured is seeking to add some new, additional risk to the policy. Whether this is merely *dicta*, and if not, whether it means there is no duty to investigate whatsoever in most renewal situations, remains to be seen.

The case of *Palisades Safety & Ins. Assn., v. Leonel Bastien, Paule Bastien, and Mary Laroche, 175 N.J. 144; 814 A.2d 619 (N.J. S.C., Jan. 2003)*, like *MAIF*, resulted in a decision on the question of rescission that was favorable to the insurer. Here, an insured and his resident spouse appealed a decision by the Superior Court, Appellate Division (New Jersey), that affirmed a trial court's grant of summary judgment denying personal injury protection (PIP) benefits to the spouse under an automobile policy that was conceded to be void, *ab initio*. When the insured applied for automobile insurance, he falsely represented that he was single and the

sole driver of the vehicles to be insured. The policy precluded coverage for insureds based on misrepresentations. The resident spouse, unaware of the misrepresentation, was subsequently involved in an auto accident, and sought PIP benefits, which the insurer denied. The state supreme court held that the policy was void *ab initio* based on the misrepresentations, and further held that the resident spouse, as a first-party insured pursuant to *N.J. Stat. Ann. § 39:6A-2*g, was not entitled to recover.

The Court acknowledged that its ruling was a departure from the public policy, as expressed in statutory and decisional law, that required an insurer to pay PIP benefits to innocent third-parties, even in the face of rescission. The rationale here was two-fold: first, it found that the fraud by the insured husband was intentional; and, second, the resident spouse was an incidental beneficiary of reduced premiums made possible, in part, by the success of the fraud. Thus, the resident spouse was not entitled to take advantage of the public policy otherwise favoring the interests of innocent injured parties over a defrauded insurer.

C. MISCELLANEOUS LIABILITY POLICIES:

The unpublished decision reported in the case of *Chicago Insurance Company v. Kreitzer & Vogelman, et al, No. 97 Civ. 8619, 2003 U.S. Dist. LEXIS 9023 (S.D.N.Y. June, 2003)*, follows an earlier, published decision by the same court, also involving the question of entitlement to rescission. In the earlier case, reported as *Chicago Insurance Company vs. Kreitzer & Vogleman, 210 F. Supp.2d 407 (S. D. N.Y., 2002)*, the Court found that summary judgment was not proper given the absence of documentary evidence to support the insurer's contention that the matter misrepresented was material. As with the earlier decision, the fact of the misrepresentation was a given. Moreover, the materiality of the matter misrepresented was seemingly conceded as well. What was in issue, and what makes the decision of particular interest, is the determination of whether the insurer had waived, or was estopped from asserting, its right to rescind the policy due to the alleged delay in seeking rescission.

While this question comes up frequently in rescission disputes - both in the third-party and first-party context - this opinion explores in unusual detail the circumstances of the rescission investigation conducted for the insurer by outside coverage counsel before ultimately concluding that his client was entitled to rescind. In the course of the decision, the Court lays out a roadmap for what would constitute an acceptable time frame for conducting a coverage investigation into the question of the entitlement to rescind, as well as an acceptable methodology for such an investigation when confronted with an ongoing stream of information relevant to that question. In the case at hand, the insurer already knew that the subject lawyer had been suspended from the practice of law, and that 10 actual claims had been filed against the law firm from 1993 to 1996. Based upon a methodical review of the coverage investigation, however, the Court concluded that such seeming "red herrings" did not constitute sufficient knowledge of the grounds for rescission, such that the insurer waived its rights to rescind following receipt of the law firm's premium in April 1997.

In the unpublished decision in *Thomas M. Petersen and Petersen Law Offices, P.C. vs. TIG Ins. Co., No. 8:01CV308, 2002 U.S. Dist. LEXIS 20801 (D. Neb., Oct. 2002)*, the primary holding of the Court consisted of a finding that the insured attorneys did not have actual notice of a potential "claim," as that term was defined in the policy. Basically, the court refused to charge the attorneys in the firm with knowledge possessed by their office manager of the receipt of a

letter placing the firm on notice of a potential claim, and requesting that they put their malpractice insurer on notice. Accordingly, the failure to report this letter in the renewal application was not fatal to coverage for the malpractice action that subsequently ensued. That conclusion, in turn, addressed the argument that the insuring agreement, by its own terms, made lack of prior notice of a reasonable basis to foresee that a claim would be made a part of the coverage "trigger" in the first instance. Thus, the question of rescission is only addressed in what the Court essentially concedes may be *dicta*, albeit of interest for the issues it does choose to explore.

Among other things, the Nebraska court takes pains to distinguish between legal and equitable rescission, and the respective burdens of proof applicable to the two different types of rescission, a distinction not often explored in decisions in other jurisdictions. Moreover, Nebraska has a statutory provision concerning rescission, and that statute requires that there be misrepresentations that deceive an insurer to its injury, or that contribute to the loss in question. This formulation, too, is somewhat unique, and is stated to require that the carrier "must show prejudice." Essentially, the court concluded that the lack of actual knowledge on the part of the attorney completing the application of the alleged misrepresentations provided no basis to rescind, even though the firm's office manager actually received the letter which the carrier contended should have been disclosed in the application process. Suffice it to say that Nebraska does not appear to side with the significant number of other states that hold that an innocent misrepresentation or omission can be sufficient to rescind a policy if it is material to the risk, or - in the words of the Nebraska statute - if it "contributes to the loss."

The decision in *Commercial Cas. Ins. Co. Of Georgia, dba Environmental and Casualty Ins. Co., v. Robert Kinann, et al., No. C 02-5765 CRB, 2003 U.S. Dist. LEXIS 9473 (C.D. Cal. 2003)* presents that rare case in the survey that actually involved an effort to rescind a commercial general liability policy. It arose out of a house fire, and the underlying litigation included a suit against the insured builder by the purchasers of the new residence that had burned down. In addition to seeking a declaration of no coverage owing to the issue of the identity of the named insured, the carrier also sought rescission on the basis of an allegedly material misrepresentation that the insured only did remodeling, and not major new construction. The insured moved for discretionary dismissal in deference to multiple pending state court actions, including a later-filed declaratory judgment action initiated by the insured. Thus, the thrust of the decision concerned an analysis of the typical discretionary dismissal issues arising in federal insurance coverage litigation filed in the face of pending state court litigation involving the insured.

The insurer's federal action was dismissed without prejudice, once again illustrating how difficult it can be to get the merits of a claim for rescission decided. As with many such cases, the principal barrier to entertaining the federal coverage case was the arguable overlap of factual issues to be decided in the underlying third-party action against the insured and in the rescission action. The insurer attempted to preserve its right to have the federal court entertain the rescission claim by arguing that the issue of the misrepresentation on the insured's application could be tried without overlapping with the state court proceedings. In theory, whether the insured misrepresented the scope or extent of its activities, and if so, whether such misrepresentation was material to the decision to insure, were not issues to be decided in the underlying action, which appears to have been in the nature of a construction defect claim.

The court seemed to have some sympathy for the insurer's argument regarding the lack of factual overlap, but ultimately decided that the presence of certain non-diverse defendants in the underlying litigation would only guarantee multiple suits arising out of the loss that gave rise to the coverage litigation. Of interest is the Court's rationale for departing from the general rule in the Ninth Circuit, to the effect that a district court should not decline to exercise jurisdiction where other claims are joined with an action for declaratory judgment. Here, the "other claim" was the count for rescission. The district court noted that the rescission count was, in effect, an after-the-fact effort to obtain a declaration that the rescission the carrier contended it had already effected was, in fact, proper. Impliedly, had the carrier not unilaterally rescinded prior to filing suit, and not joined other coverage defenses in its action, but instead, filed a claim solely for rescission, it might have stood a better chance of convincing the district court that it was not being asked to issue a discretionary declaratory judgment. However, the normal desire to assert all valid coverage defenses in one action generally means that most carriers with a potential rescission claim will be reluctant to take such a risk, simply to preserve federal jurisdiction.

The case of *Pekin Ins. Co. v. Amanda Adams, v. Nicholas Marshall, as Father and next Friend of Christopher Marshall, a Minor, 334 Ill. App. 3d 1083; 778 N.E.2d 1240; (Ill. App., Oct., 2002)* seemingly illustrates a corollary to the old saw that "every dog gets one free bite." Apparently, in Illinois, every homeowner gets free insurance against liability for one dog, at least if it is a Doberman pinscher. The *Pekin* case is an example of a decision construing an insured's responsibility for an incorrect answer in an application, where that answer is supplied by an agent for the insurer, and its accuracy is attested to by the insured. Here, it was conceded that there was an absence of fraud or collusion between the insured and the agent in denying that the insured owned any animals, when she actually owned a Doberman pinscher that, in fact, bit the injured party. Despite the clear connection between the misrepresented fact and the resulting injury, the Court nonetheless held the insurer was estopped from denying coverage based on the misrepresentation.

The Court did not find dispositive the fact that the signed application contained a statement that the insured had read the application and that its contents were true, at least in the absence of the agent's collusion with the insured, or the insured's bad faith. Remarkably, the court rejected the argument that an insured who owned a Doberman pinscher should have known that a negative answer to a question asking whether she owned any animals was inaccurate. The court found that the insured could reasonably have assumed that the agent knew what the insurer was looking for, and that the insurer was not concerned with animals like Doberman pinschers. Although a Doberman is not exactly a poodle, one wonders if the same result would have obtained if the insured had owned a somewhat more notorious pit bull.

The final case in this survey is an unpublished decision that illustrates how Virginia courts
respond to various arguments raised by so-called "innocent insureds" in order to avoid rescission of an entire policy based upon the actions of the individual insured that made misrepresentations in an application. In *TIG Ins. Co. v. Robertson, Cecil, King & Pruitt, LLP, 2003 U.S. Dist. LEXIS 1481* (W.D. Va. Jan. 31, 2003), the question of the insurer's right to rescind in the first instance was not vigorously contested, for the most part. Rather, with one exception, all arguments were directed to efforts to find a waiver or estoppel to exercise that right, or, in the alternative, limit the impact of its exercise on the innocent partners now facing suits by defrauded former clients. All such efforts were unsuccessful, and the Court found that the policy

was rescinded as to all insureds.

The partner who signed the policy application on behalf of the insured law firm failed to reveal his own misappropriation of client funds in his negative response to the following question:

> Is any attorney in your firm aware of any claims made (whether reported or not), wrongful acts, errors or omissions that could result in a professional liability claim against any past or present attorney of the firm or to its predecessors or is there a reasonable basis to foresee that a claim would be made against any past or present attorney or the firm or its predecessors?

The innocent partners first argued that the negative response to this question was not a misrepresentation, relying on the earlier published decision in *St. Paul Fire & Marine Insurance Co. vs. Jacobson*, 48 F.3d 778 (4th Cir. 1995). In *Jacobson*, a doctor who had fraudulently injected his own sperm into his patients during artificial insemination procedures, rather than the sperm of the patient's husband or donor, failed to disclose this misconduct in response to an application question that stated as follows: "Do you have knowledge of any pending claims or activities (including requests for medical records) that might give rise to a claim in the future?" Id., at 781. In *Jacobson*, the Fourth Circuit interpreted the term "activities" in the question as referring to third party activities, rather than the insured's own activities. Therefore, it concluded that the doctor's negative answer to that specific application question was not untrue. The district court in *TIG* rejected reliance on *Jacobson*, finding that the question found in the application before it did refer to the attorney applicant's own conduct.

Two other arguments rejected by the *TIG* court are worth noting, as they illustrate situations where Virginia takes a different position than some other jurisdictions have in the past. The first argument concerns the fact that the policy contained a provision allowing the carrier to cancel the policy if there was a misrepresentation in the application. The insureds argued that the time limitation on the right to cancel for such misrepresentation had expired, and therefore, the policy also could not be rescinded based upon such misrepresentation. The Court rejected this, pointing to the prospective nature of cancellation, in contrast to the remedy of rescission *ab initio* of a policy. Further, it held that the inclusion of this clause dealing with cancellation did not demonstrate an intention to relinquish the insurer's equitable right of rescission. The second argument was an effort to bring the innocent insureds within the exception to an exclusion for claims arising out of fraudulent conduct for insureds who had no knowledge of such conduct. The Court again rejected the effort to find an implied waiver of the right to rely upon equitable rescission as a separate defense to claims under the policy.