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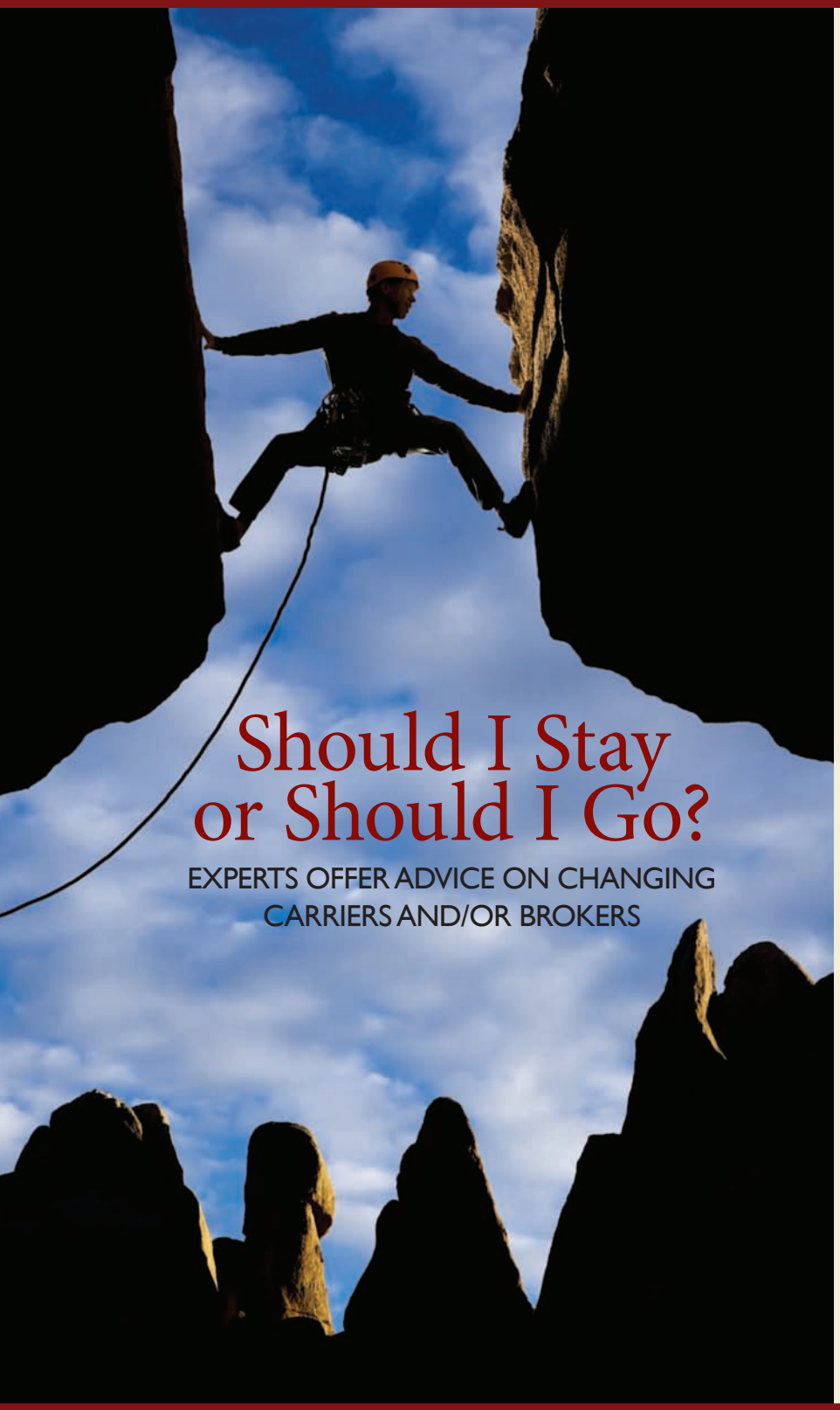
Enforce

The Insurance Policy Enforcement Journal



Should I Stay or Should I Go?

EXPERTS OFFER ADVICE ON CHANGING CARRIERS AND/OR BROKERS

IN THIS ISSUE

Enforce: The Insurance Policy Enforcement Journal is the industry's premiere source for information and analysis of the enforcement of insurance policy provisions.

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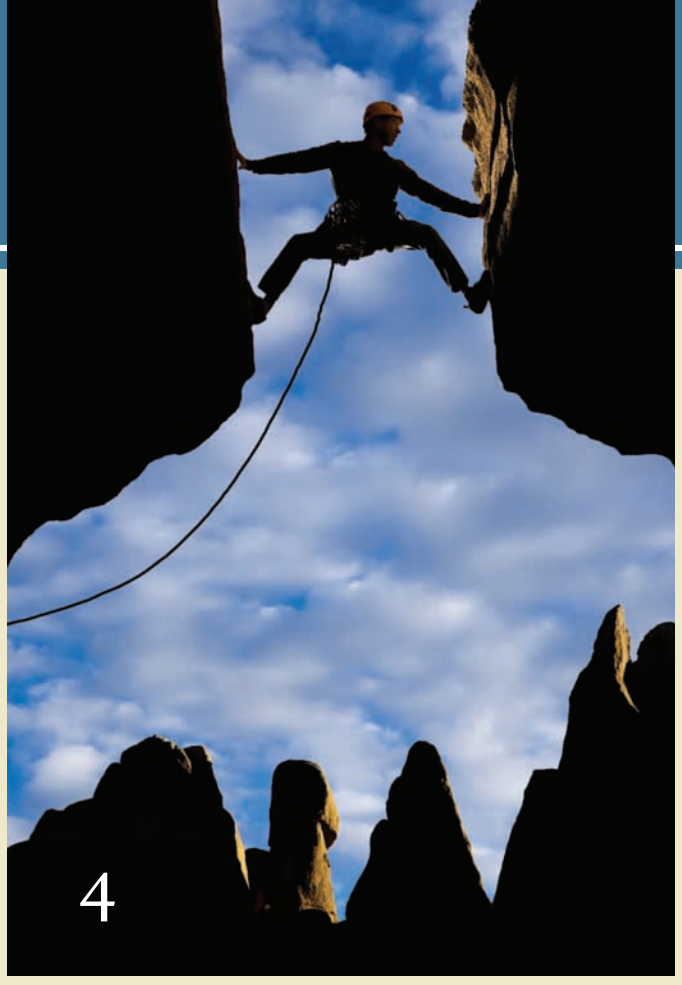

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From the Publishers

DAVID E. WOOD AND DAVID P. BENDER, JR.

Dear Readers:

The first 2010 edition of *Enforce* comes during a crossroads for America and its business community. Are we poised for a breakthrough return to a vigorous economy? Or will 2010 be another year in which we muddle through?

No matter which direction the year takes, this is an important year for insurance policyholders to ensure they are protected and that their insurance companies follow through on their obligations. The merger that formed Anderson Kill Wood & Bender a little more than a year ago has created, without question, the strongest national insurance firm in the country. We have no ties to insurance companies, no conflicts of interest. We represent the interests of policyholders only. When American businesses are looking at every expense and every source of revenue, it is imperative that they ensure their insurance companies are paying the full extent of their obligations.

Many of our clients ask how the merger is going. We answer, "It couldn't be better." We have blended talents seamlessly with our colleagues in the New York office and we've added expert attorneys to our California office. The combined firm is a wonderful marriage of culture and talents.

We hope you'll enjoy this issue of *Enforce*. It is filled with helpful advice for these trying times, and it offers insights into how to protect your company. As always, we welcome your feedback.

Sincerely,

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Should I Stay or Should I Go?

Experts Offer Advice on Changing Carriers and/or Brokers

Every year as renewal day approaches, companies are faced with a difficult decision: do they renew with their incumbent insurance companies, or do they risk changing carriers to take advantage of lower rates, broader policy language or coverage add-ons? But the truth is, insurance carriers and brokers are helping businesses reach that decision every day of the year with their execution, their knowledge and their business practices.

With the soft market in insurance and the underlying economic unsteadiness of many carriers, there might never have been a time when so many companies are willing to question whether it is time to change insurance carriers or brokers. Even decades-long relationships can be tested in times such as these. And what if the incumbent carrier is exiting the market or unwilling to renew for another reason? Policyholders must move cautiously and comprehensively to avoid a lapse or gap in coverage.

Enforce interviewed several risk managers and general counsels who have recently made or considered a change in carriers or brokers. Their advice? Be methodical. Be professional. Be precise. Be a tough customer. Evaluate the carrier's and broker's history with you on a day-by-day basis. And don't fall for the short-term savings.

"A lot of people get caught up in short-term savings," said Jigisha Desai, vice president and treasurer at Granite Construction in Watsonville, California. "They do not think about long-term implications. Right now the insurance market has softened. I would be cautious when people are trying to buy business. As a treasurer I don't think about what I can save today or tomorrow. At the end of the day the relationship comes into play when the market is tough. And the claim still gets paid. How do they treat you when the market is tough? When the market is soft everyone is going to treat you nicely."

And the market is soft. Most interviewed by *Enforce* said the changes in the market had them considering changing carriers or brokers. But not everyone made the leap. And not everyone who changed, changed all of their coverage. Here is their advice if you are considering a change.

A Comprehensive RFP

All of the leadership in all the departments affected by the insurance coverage need to be involved in developing the coverage needs. This needs to be done months before the policy is set to expire.

"You need open communication with the legal group, CFO, CEO, treasurer, risk manager," said Helen Johnson, senior vice president and treasurer at Insight Enterprises, the Arizona-based provider of brand-name computing products, software and advanced IT services.

Granite's Desai said, "We go through the full RFP process. We look at everything from loss control to claims to obviously the underwriting practices and the pricing and we go through a thorough analysis."

Bill Noonan, vice president of Risk Management at Structure Tone, an international giant in construction services, goes one step further. "Before you award business, it's important to have a very well put together RFP and to ask for resumes of [the carrier's] employees, to ask to meet with a couple candidates for each staff position that I need on my account. I want to

meet a couple of people to see if they will fit with my organization's culture and people. And also to make it a part of the business deal that I am involved with replacing the people, whether they leave the company, are promoted, or they retire."

Noonan's a believer that the world of insurers is made up of two kinds of people: salespeople and technical people. "Rarely do I find someone who excels at both qualities. Both are important but it is very important that I make clear to my broker that I consider them equally important on my account. A salesperson may bring my business in the door but the technical staff will keep my business with that broker.

"In today's brokerage world it seems to me that technically competent people seem to not get the same respect from their employers that the sales side receives. I'm not against salespeople but at the end of the day I cannot underestimate how important technically competent people on my account are."

Mind the Gap

"Mind the gap" is not just an important reminder for London subway passengers. It refers to the gaps that can occur when changing from a carrier familiar with your business to one who is just learning your business. Lori Seidenberg, vice president at Enterprise Risk Management for Centerline Capital Group, a real estate finance and investment company, says the insurance tower built with several policies can appear solid, but actually contain gaps hidden between the layers of coverage. "It's always important to understand what limits extend throughout the tower. We're finding more sublimits on quotations and policies."

Bill Ojile, senior vice president and chief legal and compliance officer at Westwood College in Denver, went through the same gap-searching process as he integrated a new carrier from an industry trade group in with his existing carrier. "Instead of the towers, all of their policies are combined with shared limits. We got more coverage for about the same or lower cost."

Excess insurers have a love/hate relationship with primary carriers, pushing them constantly to pay claims within the primary layer to avoid attachment of the excess. If a new primary insurance company with which the excess has a particularly fractious relationship on other risks is swapped into a program, the excess may become more aggressive in pressing for within-primary-limits results, making claims against the policyholder more difficult to settle.

Study History

Centerline's Seidenberg said it is important to review your new carrier's history of paying claims. "There are some carriers who are known for being very tight with their money. The reason why you buy a policy is to make sure there is coverage afforded when a claim is made. Make sure defense and claim payment are the major factors [in your buying decision]." The anticipated cost of enforcing claims has to be factored into that decision.

John Lambdin, director of insurance at Weyerhaeuser, the Seattle-based giant in wood and pulp products, said, "You have to steer toward the companies that are honest when it comes to paying claims. Draw a line between

Continued next page

[the insurance company that pays] legitimate claims as opposed to a company just throwing its weight around and holding on to your money longer."

The other history lesson, aside from price, is finding carriers who know your business. Weyerhaeuser's products are international and so specialized that the company sometimes has to search for a carrier who knows the products and will cover the business. In the academic world, Ojile solved a similar problem by finding a collegiate affiliate organization that had made specialized deals with carriers tailored just for academic institutions. Such "trade organization" specialties might exist in your industry, he said, but when they do, they can be an attractive alternative to direct markets.

Andrews added, "From the standpoint of the law department, the days of having a few hours to complete a policy application are over, but it wasn't that long ago that companies were far too nonchalant about the application process. In today's environment, the law department does a lot of work as early as possible in the application process, in order to ensure accurate and complete information to the carriers. This helps avoid coverage issues down the road, and provides the carrier with a greater degree of assurance that you and your company are responsible and take your obligations under the policy as seriously as you would expect them to take theirs."

Get the policy in your hands before you sign it, said Noonan. "What's in between the four corners of the policy is my contract with the carrier." In

THEY DO NOT THINK ABOUT LONG-TERM IMPLICATIONS. I WOULD BE CAUTIOUS WHEN PEOPLE ARE TRYING TO

If You Go

If, after all this consideration, you decide to change carriers, the experienced have some advice.

The application process is critical. Too many leave this to the last minute. Steve Andrews, general counsel at Insight Enterprises, said, "[It] used to be that someone in the treasurer's office would toss you the application and say this has to be done by the end of the day, or worse yet, in a few hours."

And the consequences of forgetting something on the application can be disastrous. Seidenberg said, "You might not know that when you complete the application and think you've disclosed everything, you can find out someone, such as local counsel or management in another area, is holding on to something and forgot to tell the risk manager, or thinks the item is not insurance-related." Such an oversight can lead the new insurance company to determine that the claim is not covered.

Structure Tone's RFP, it demands a copy of the policy with the bid. "In order to be able to bid you have to be able to give us the policy you intend to issue. We review it with our staff and counsel and then we send it back to them with what we want to change and what the deal breakers are and what they need to do to stay in the bidding process."

Finally, if you change, Andrews reminds you not to burn bridges. "When carriers opt out, I think it's important to remain professional because it's a small world of carriers and a long life. They may just want to take a break if they think the level of exposure is going to improve in a year or two. So it's important to maintain a good relationship if at all possible."

Advice from *Enforce* publishers: Many liability policies, and claims-made-and-reported policies in particular, limit coverage for pre-policy claims so the insurance company can be assured that its coverage obligations begin at the inception of the policy without relating back to earlier events.

There are ways to ensure that new coverage picks up seamlessly where expiring coverage leaves off, such as deleting prior acts exclusions to create coverage for circumstances of which the policyholder was unaware at inception, and warranty statements enumerating all known and therefore excluded events. Avoiding gaps is technical and calls for intimate knowledge of the expiring and incoming policy forms.

Changing Brokers

First of all, almost everyone said that changing brokers should not happen often. "It's an absolute last resort," said Seidenberg. There are steps you can take before changing brokers. "Ask for another team," she said. Sit down and look at the personalities on the team and find the ones that fit you.

- The new broker did business in a part of the world where the company does business and is familiar with the locale.

The same caveat about not burning bridges applies to changing brokers. Often a retiring broker may have a great relationship with an in-place insurance company and carry leverage over the carrier when a disputed claim arises. If that broker is no longer in the picture, and a disputed claim is pending, the insurer may suddenly become uncooperative, and may not be influenced by the incoming broker, said Seidenberg.

The retiring broker may have exclusive access to or relationships with some insurance companies or programs, leaving the incoming broker to put together or fill gaps in new programs from scratch,

RIGHT NOW THE INSURANCE MARKET HAS SOFTENED. BUY BUSINESS. JIGISHA DESAI, VP AND TREASURER, GRANITE CONSTRUCTION

The right broker becomes the critical point in your insurance DNA. Insight's Johnson spoke for everyone when she said, "Understanding the business is critical to this relationship with the broker."

Said Seidenberg, "I want my broker to know my business inside and out. If my carrier asks a question I want my broker to understand my business and be able to answer it on the spot. I don't want them to tell the underwriter, 'I'll have to hang up and call you back.' Or, even worse, articulate the answer incorrectly." And it takes time for your broker to understand your business, so holding on to them is critical.

Many of the companies interviewed for this article had kept a longstanding relationship with a broker, but added another one for a few reasons:

- The new broker tapped into some new markets.
- The new broker was better able to handle complex issues.

said Lambdin. This may put the policyholder at a disadvantage if changing brokers means changing insurance companies as well.

The retiring broker may have intimate knowledge of the policyholder's claim history and operations that the incoming broker must work over a period of time to achieve. This happened at Granite where Desai made a "best of both worlds" decision. She kept a longstanding relationship with a local broker intact, but brought on a new broker with broad industry knowledge for specific coverages. Westwood College's Ojile had a similar situation and made the same decision. "It's like the difference between seeing an orthopedist and a general doctor when you have a shoulder injury. The orthopedist is going to give you more of an informed opinion," said Ojile.

The benefits of changing brokers can be lower commissions translating into premium savings, lower broker fees, greater scope of services unrelated to insurance placement (such as risk

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evaluation, captive formation and management, claim advocacy or third-party administrator services). The new broker may provide more of a one-stop-shopping experience for the policyholder, or may offer better programs and better insurer relationships.

Noonan likes to have a team of brokers, for these very reasons. "We have so much insurance here we are always looking for gaps and making things better. If I'm depending on the brokers to make sure there are no gaps between different types of coverage, then the brokers need to work carefully together. I need to set up a relationship to where they are working together."

Working together. Working deliberately. Giving the process time. These are the key lessons passed along by those who have carefully studied the question of "Is it time to change carriers or brokers?" ▲

Top Ten Lessons Learned

Our experts offered these lessons learned when considering a change in carriers or brokers.

1. Never change carriers and brokers at the same time.
   Lori Seidenberg, Centerline Capital Group

2. Don't get caught up in short-term savings. Keep your eye on the long run.
   Jigisha Desai, Granite Construction

3. When changing carriers keep it professional. It's a small world of carriers.
   Steve Andrews, Insight

4. Make sure defense and claim payment are the major factors (in your decision).
   Lori Seidenberg, Centerline Capital Group

5. Engage outside counsel to review the whole thing.
   Steve Andrews, Insight

6. Probably most important is to have relationships with strong carriers even if you are not currently doing business with them. You might do business eventually.
   John Lambdin, Weyerhaeuser

7. It is important to avoid arbitration and to keep your choice of counsel.
   Lori Seidenberg, Centerline Capital Group

8. Consider splitting the insurance and giving part of the coverage to a trade or professional group coverage that has expertise in the areas of your business.
   Bill Ojile, Westwood

9. The process is the thing. Make sure everyone is involved.
   Bill Noonan, Structure Tone

10. Get the policy delivered in your hands before you sign.
    Bill Noonan, Structure Tone

This Port in a Storm

Policyholders Should Insist on Full Coverage Promised by D&O Policies

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The subprime credit crisis, as well as the associated scandals, has spawned a still-burgeoning number of prosecutions, claims and lawsuits. Subsequent to the Madoff, Dreier and Stanford frauds, the Securities and Exchange Commission (SEC) and federal and state prosecutors have increased the prosecution of those accused of wrongdoing. The increase in SEC scrutiny, federal and state prosecutions, and shareholder lawsuits for the resulting financial losses, expose directors and officers to increased criminal and civil liability. Similar results are also expected in the United Kingdom and elsewhere in the European Union because of the actions of regulators, prosecutors and shareholders.

Already, approximately 200 subprime-related shareholder lawsuits have been filed. Each of these has the potential for massive policyholder losses. These cases often generate defense costs, settlements and damages totaling millions and even billions of dollars. Most corporations provide indemnity protection to their directors and officers, and also purchase directors' and officers' (D&O) liability insurance, primary and excess, specifically designed to cover such losses.

Today's Environment is a 'Perfect Storm' for D&O Liability Insurance

The economic, liability and claims environment presents an unprecedented "perfect storm" of potential difficulty for D&O liability insurance policyholders. Four powerful forces are conspiring to cause this storm. First, the subprime and related stock market catastrophe triggered *huge* losses; second, the same negative investment income that hit the market in general also hit insurance companies; third, insurance companies are facing a continuing "soft" market for insurance premiums; and finally, the current economic environment impels policyholders to seek to maximize insurance recovery — which means that more policyholders are insisting that insurance companies provide the full coverage promised by their D&O policies.

This perfect storm is bound to result in stricter claims review and an increase in denials of payment by insurance companies.

Here are some steps to take and factors to consider with regard to filing D&O claims.

When a Loss Occurs, Think D&O Insurance

D&O liability insurance is usually not the first thought to come to mind when considering how to recoup a loss. It should be. Most D&O liability insurance policies broadly insure directors and officers, other high-ranking employees and the corporation for a loss alleged to stem from a wrongful act. Moreover, D&O polices should offer *timely* relief, insofar as they provide for current advancement of defense costs.

Many D&O liability insurance policies insure broader categories of individuals than those narrowly defined as "directors" and "officers," i.e., other high-ranking employees. Moreover, these policies cover directors' and officers' "wrongful acts," often expansively defined as any act, error, misstatement or omissions, neglect or breach of duty committed by the directors or officers while serving in that capacity. D&O policy language typically is also broad in what it

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characterizes as "loss," generally identified as the damages, settlements and defense costs that the corporation is legally obligated to pay as a result of the directors' and officers' wrongful acts. Finally, D&O policies also provide for current advancement of defense costs — a benefit that looms large as the legal bills mount swiftly after a lawsuit is filed.

Effect of Defense Counsel's Relationship with the Insurance Company

From the outset of a claim or lawsuit, corporate counsel should work with outside defense counsel to help ensure reimbursement for the loss. Many defense counsel are well-versed in submitting defense invoices to insurance companies for reimbursement, and often have long-term relationships with insurance companies. Defense counsel should format their invoices to be easily transferred to the insurance company for payment. Defense counsel may be on a "panel counsel" list, and should probably comply with the insurance company's billing guidelines to the extent they are reasonable. Such practical cooperation will likely ease reimbursement under D&O liability insurance policies.

Of course, when a significant D&O liability loss occurs, the small print gets magnified, and insurance companies raise all manner of often specious "coverage defenses" in an effort to avoid their payment obligations. Defense counsel often face a conflict in opposing such arguments, and a policyholder often needs independent insurance "conflicts counsel" to respond adequately.

Delaware has Clarified the Stability of the Indemnity Obligation to Former Directors and Officers

Given the liability environment facing current directors and officers, they demand a *secure* indemnity obligation running from the corporation. Indeed, over the last two years many corporate counsel were asked about potential weakness in those indemnity rights. A corporation's articles of incorporation, bylaws and indemnity agreements should be checked to confirm the scope of indemnity protection. A recent Delaware decision in a case that tested a corporation's right to alter its obligations to directors and officers, *Schoon v. Troy,* and the Delaware legislature's subsequent action, have thrown this issue into stark relief.

The *Schoon* court held that a former director's right to advancement of expenses under indemnification provisions in the corporation's bylaws did not "vest" until an indemnifiable claim was asserted against him (either when the corporation's payment obligation triggered or the date of the filing of pleadings against such former director). Therefore, prior to such time, the corporation could amend its bylaws to eliminate the right to advancement of expenses with respect to such former director. See *Schoon v. Troy,* 948 A.2d 1157 (Del. Ch. 2008). Subsequently, an amendment to Delaware General Corporation Law § 145(f), effective August 1, 2009, addressed the decision in *Schoon*. The amendment provides:

> A right to indemnification or to advancement of expenses arising under a provision of the certificate of incorporation or a bylaw shall not be eliminated or impaired by an amendment to such provision after the occurrence of the act or omission that is the subject of the civil, criminal, administrative or investigative action, suit or proceeding for which indemnification or advancement of expenses is sought, unless the provision in effect at the time of such act or omission explicitly authorizes such elimination or impairment after such action or omission has occurred.

Thus, subsequent to the statutory amendment, Delaware directors and officers are more secure in their right to indemnification.

Since D&O liability insurance policies largely are designed to dovetail with indemnity exposure, these aforementioned changes have a concomitant impact on D&O liability insurance rights as well.

Can the Justice Department Force Waiver of Attorney-Client Privilege? —— The Impact of the Filip, McNulty and Thompson Memoranda

Federal investigations of a corporation or its directors and officers are jarring events. Corporations are reported in the past to have stopped paying defense costs after they were pressured to comply with federal prosecutors' demands that the payment of defense costs to indicted directors and officers would be viewed as a sign of noncooperation under the so-called Justice Department's Thompson Memorandum. The Justice Department more recently issued revised guidelines by Deputy Attorney General Filip that changed the earlier McNulty Memorandum. Among other things, the new guidelines mean that federal prosecutors cannot de-

mand that corporations waive privilege over "attorney-client communications or non-factual attorney work product" nor condition cooperation credit on such a waiver. Further, in determining cooperation, federal prosecutors may not consider whether a corporation has: 1) advanced attorneys' fees to employees; 2) entered into a joint defense agreement; or 3) terminated the employees involved in wrongdoing. The Filip memo is available online, "Principles of Federal Prosecution of Business Organizations," memorandum from Mark R. Filip, Deputy Attorney General, to Heads of Department Components and United States Attorneys (Aug. 28, 2008) at 9-28.760 (available at http://www.usdoj.gov/opa/documents/corp-charging-guidelines.pdf).

Consistent with the Filip Memorandum, corporate counsel can continue to advance defense costs to directors and officers while under federal investigation, and not jeopardize the Justice Department's determination of cooperation.

Investigation Costs are Covered

Many corporations face formal and informal investigations by the SEC as well as federal and state prosecutors. The costs associated with these investigations can be significant.

Courts have found that investigation costs are covered under D&O liability insurance policies. Specifically, these cases broadly construed what triggers an insurance company's obligation to pay the policyholder for such costs. When faced with an investigation, corporations should also look to their D&O policies for coverage.

D&O Liability Insurance Can be Important in Bankruptcy

The current increase in corporate bankruptcies means that D&O liability insurance takes on added importance to the corporations and individuals it is designed to protect. If the corporation's indemnity obligations are lessened or eliminated in bankruptcy, the directors and officers will care dearly how their D&O policies function.

Accordingly, among other things, look for the following in typical D&O liability insurance policies:

1) the wording of the so-called "insured versus insured" exclusion;

2) the "change in control" provisions; and

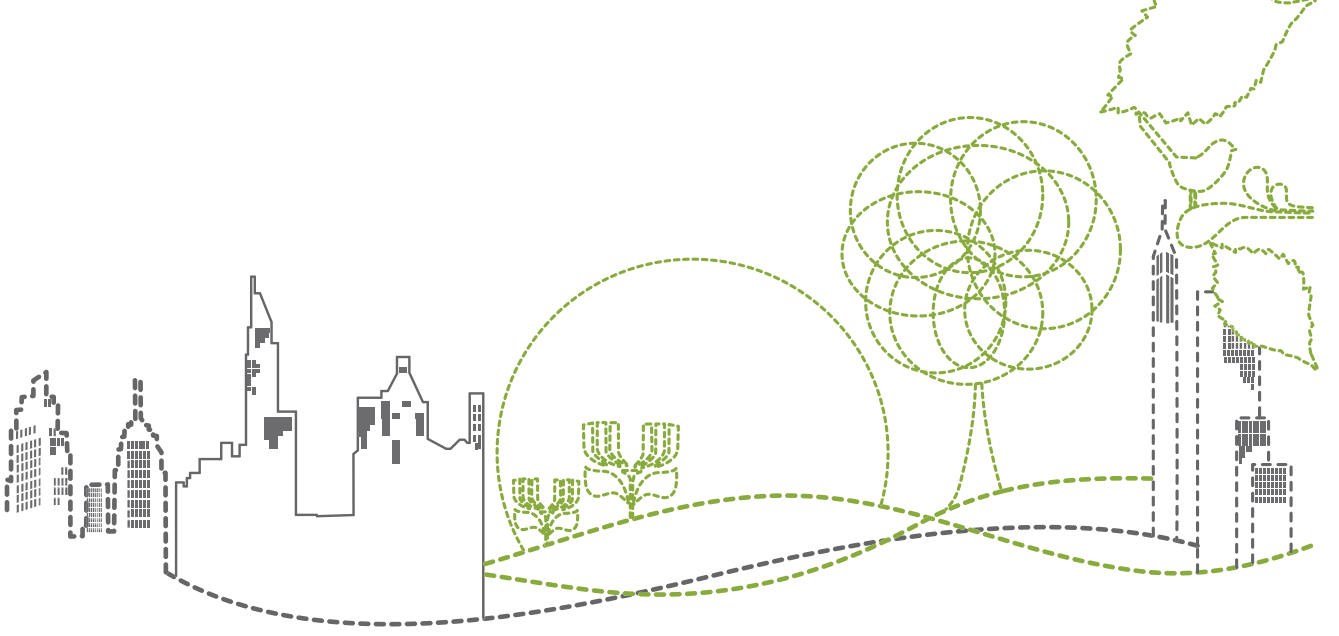
3) an "order of payments" that forces direct coverage for the directors and officers.

For example, the insurance company will likely argue that a trustee's claims against the corporation's directors and officers fall under the "insured versus insured" exclusion. Courts have found that the trustee's claims do not fall under the exclusion.

Examining D&O liability insurance policies prior to a bankruptcy can promote superior protection in the event of a bankruptcy. Even with enhanced terms, policyholders still need to be prepared to assert their rights to D&O liability insurance.

Do Not Take No for an Answer When Presenting a D&O Liability Insurance Claim

Insurance companies know that denying claims means some policyholders simply walk away. An enlightened approach to handling a D&O liability insurance claim means insisting upon full value and refuting any overly broad coverage defenses asserted by the insurance company. If an in-house analysis tells you that you have coverage, do not take no for an answer. ▲



Gone Green?

What to Consider When You Build to the Changing Environmental Standards

Thomas R. Petty, Partner ANDERSON KILL & OLICK, L.L.P.
John G. Nevius, Shareholder ANDERSON KILL & OLICK, P.C.

As commercial real estate markets begin to recover from the economic downturn, many developers and operators will be surprised to learn that building codes and laws on energy efficiency and sustainability may have changed the playing field dramatically. In the past few years, 13 federal agencies, including the GSA (U.S. General Services Administration), 33 state governments and 190 local governments, have adopted sweeping new "green" laws and regulations.

Many of these new laws and regulations require or encourage some level of compliance with LEED® standards. LEED (Leadership in Energy and Environmental Design) is a system developed and administered by the U.S. Green Building Council for certifying a building's overall sustainability, using a wide range of criteria in five categories: sustainable sites, water efficiency, energy & atmosphere, materials & resources and indoor environmental quality. Buildings that satisfy certain prerequisites and earn a sufficient number of optional points are awarded LEED certification on a 100-point scale, ranging from Certified (40–49 points), to Silver (50–59 points), Gold (60–79 points), to Platinum (80 points or more).

In California, for example, Executive Order S-20-04, known as the "Green Building Initiative," requires all new and renovated state-owned buildings to meet LEED Silver standards. The accompanying Green Building Action Plan requires all state-owned buildings to reduce energy consumption by at least 20 percent by 2015, and encourages private sector buildings to reach the same goal. Many localities have adopted regulations that impose strict green standards on private as well as public buildings. In July 2008, the California Building Standards Commission adopted the California Green Building Standards Code, which mandates sustainable design standards and construction practices applicable to a wide range of building types in the state of California.

Real estate operators nationwide should be assessing now how new green laws and regulations will impact their future development and operations. Sustainable thinking should be integrated into the entire development process.

LEED-related issues cannot be left solely to the architects, as some decisions that can have a critical impact on LEED certification, such as site selection, are made even before design professionals are hired. Some low-cost or no-cost LEED credits can be achieved simply by having certain policies and good recordkeeping in place, and requiring tenants, property managers and other contractors to comply with these policies. Smart businesses will begin to anticipate necessary changes in operations in their budgets and business plans. Measures to reduce water and energy consumption can be less costly, for instance, if they are implemented strategically over a period of time, before benchmarking regulations require such reductions.

Real estate operators should also reassess their insurance coverage. The insurance industry is poised to provide coverage for a wide range of risks associated with the design, construction and maintenance of buildings designed to meet specific benchmarks of energy efficiency, comply with updated building codes and obtain specific certifications of energy efficiency. As is generally true with insurance for construction projects, the time to consider a green building coverage program is before construction. Such insurance can also facilitate transactions by addressing stakeholder concerns. In other words, risks associated with financing or purchase and indemnity commitments can be managed using insurance in order to reassure potential participants in a development deal.

As with other legal contracts, an insurance audit designed to assess green building risks should involve all participants in the construction project. Ensure that the entire development and risk management team — including the disciplines that are not directly impacted by LEED — is aware of the LEED objectives. Identify the disciplines that are impacted by LEED and see that relevant policy language reflects the LEED requirements. Becoming an additional insured on other people's insurance policies is an economical way to manage risk. The package of contracts that is entered into for the project represents an opportunity to share the risk of LEED-certification failure with all participants — such as the architect, LEED consultant and constructors — whose acts and omissions can make the difference between success and failure. Contractors and other project participants also need to remember that policyholders may not be able to rely on commercial general-liability insurance to respond to claims that acts and omissions, or those of subcontractors, caused the project to fail to receive certification, or to reach the target certification level or incentive-qualifying goal.

Inevitably, the uncharted nature of green building risks will give rise to disputed claims. Policyholders can reduce such disputes by consciously assessing the risks that green building commitments entail. Coverage must be molded and underwritten to fit the unique green building risks and scenarios outlined below.

A growing number of insurance companies are beginning to offer "green" insurance policies that provide specific green building replacement coverage and, for buildings that are not yet green, "upgrade" coverage that will cover the costs of upgrading damaged non-green products with green products. At least one insurance company provides specific business interruption coverage to cover lost income and increased energy costs resulting from damage to renewable energy generation systems.

While specialty insurance products may prove to be a prudent purchase, an insurance audit should begin by considering the extent to which a company's existing insurance program covers green building risks. Even when new technology or code-compliance replacement costs are not specifically addressed in insurance-policy language, coverage for such costs may still be available under traditional forms of insurance. Just because coverage was not specifically contemplated should not mean that it does not exist. Some holes may be plugged or ambiguities resolved by negotiating policy language or purchasing endorsements.

An Overview of Green Building Risks

The most basic green building risk for which developers must make sure they purchase insurance coverage is the risk that green technology will not function properly and save costs. Such failure may give rise to risk transfer and coverage issues involving both general and professional liability. These include:

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- Policyholder rights against contractors and/or architects when construction projects fail to obtain LEED certification or yield the benefits envisioned. Failure of new technologies to yield cost saving or perform as promised can significantly undermine the initial success and future viability of green construction projects.

- The scope of property coverage if and when additional costs associated with obtaining LEED certification or with increased or supplemental energy-related construction costs are incurred.

> *"Property insurance policies for green buildings should be worded to cover the costs to replace sustainable materials in a fire or as a result of some other natural or man-made calamity."*

Property insurance policies for green buildings should be worded to cover the costs to replace sustainable materials in a fire or as a result of some other natural or man-made calamity. Most standard property insurance policies may not cover loss or damage to, or resulting from, some of the most common green building features. For instance, a policy may cover roof replacement, but not the landscaping, dirt, irrigation equipment, waterproofing, additional load support and specially trained labor necessary to replace a vegetated green roof. By the same token, a policy may not cover water damage to a building resulting from storm water runoff or faulty irrigation associated with a green roof installed by the owner.

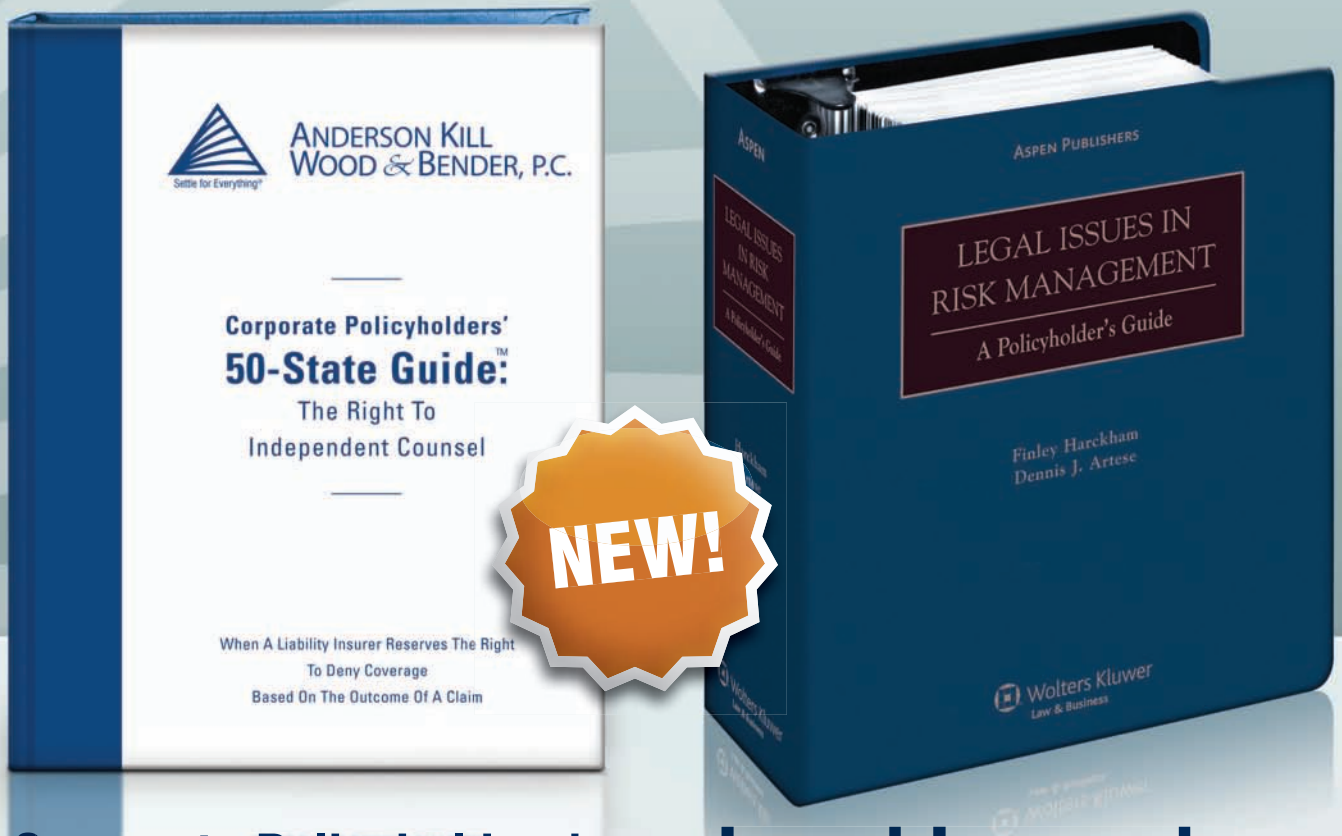
Insurance should also be tailored to cover regulatory liabilities associated with green building. Legal challenges to municipalities' new municipal codes and ordinances can create ambiguity, which in turn may lead to liability. For example, a federal judge has already granted a preliminary injunction barring enforcement of such laws pending the outcome of a lawsuit brought by HVAC contractors and distributors against the city of Albuquerque, New Mexico. In *The Air Conditioning, Heating and Refrigeration Institute v. City of Albuquerque,* the plaintiffs allege that Albuquerque's 2008 Energy Conservation Code, which requires more insulation in single-family houses, outlaws electric water heaters and imposes high efficiency standards for heating and cooling equipment, is preempted by existing federal law. The Energy Policy and Conservation Act sets efficiency standards for HVAC equipment and may preclude states, municipalities or other entities from taking independent action. Where there is litigation, liability insurance should be available to offset defense costs.

Not all green insurance innovations are addressed to new risks. Due to *lower* risk factors and more prudent and carefully monitored property management associated with green design and operation, some property insurance companies are beginning to offer premium discounts for green buildings.

Real estate operators, lenders and investors should review the terms not only of their insurance contracts, but of all their standard legal documents. As with any change in laws, building standards and market expectations, the greening of the built environment compels us to reexamine our contracts and legal strategies to address emerging issues. Contracts, leases and other documents should be updated to address and take advantage of green issues.

In commercial real estate, the playing field is becoming much greener. New laws and regulations create new burdens, new liabilities and new opportunities. ▲

Two Great Guides from the Industry Leaders



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Risking It All

When is a business insured for intentional acts? The risk manager's most significant function within the operation is to plan for disaster, then insure against it. So how does the risk manager anticipate and insure against intentional conduct by the company and its employees?

David E. Wood, Shareholder ANDERSON KILL WOOD & BENDER, P.C.

For any risk manager, the worst nightmare is a loss that — despite the risk modeling, despite the careful planning of risk transfers and despite having placed a high-quality set of insurance programs — falls into some unforeseen gap in coverage. Every time the risk manager thinks he or she has anticipated all reasonably foreseeable losses, another scenario raises its head and forces everybody back to a planning mode. The only way to anticipate and prevent gaps is planning, planning and more planning. Indeed, the risk manager's most significant function within the corporation is to plan for disaster, then insure against it.

Anticipating and Insuring Against Intentional Conduct

How does a risk manager anticipate and insure against intentional conduct by the company and its employees? Purely intentional acts are not covered by insurance. Most states have statutory or common-law prohibitions against insuring acts undertaken intentionally, with the intent to cause harm. Society simply does not permit a gross wrongdoer to profit by shifting financial responsibility for inherently bad acts to an insurance company. That is why commercial general liability (CGL) policy forms exclude losses that are "expected or intended from the standpoint of the insured," and why employment practices liability insurance (EPLI), directors and officers (D&O) and errors and omissions (E&O) policies have provisions excluding proven dishonest or fraudulent conduct. These inherently culpable acts do not qualify to be insured, and therefore are referred to as uninsurable.

But sometimes CGL policies do allow alleged bad actors to shift to insurers the expense of defending them — and even the expense of paying settlements or judgments. The difference between

> *"Society simply does not permit a gross wrongdoer to profit by shifting financial responsibility for inherently bad acts to an insurance company."*

uninsurable intentional conduct and insurable intentional conduct can be hard to identify and anticipate, creating a gap into which some losses can — unforeseeably — fall.

Insurable vs. Uninsurable Intentional Conduct

CGL policies have two parts. The first part, called Coverage Part A (or something similar), covers bodily injury and property damage caused by an "occurrence," usually defined as something sudden and accidental. The second part, Coverage Part B, covers the corporate policyholder for third-party suits alleging wrongful or misleading advertising.

Coverage Part B also covers the policyholder when it is sued for "personal injury," defined as suits alleging malicious prosecution, wrongful entry to or eviction from land, false imprisonment, slander or invasion of privacy. These offenses are inherently intentional, and yet they are insurable. By contrast, Coverage Part A makes clear that it responds only to negligent, unintentional acts by covering only liabilities of the insured for accidentally causing someone bodily injury or property damage, and by excluding losses caused intentionally.

Say a fight breaks out at a restaurant and the operator drags the instigator into a back room, demanding that he calm down before he can be released. When eventually he is allowed to go, he complains of chest pain and later collapses and dies. If his surviving family sues the restaurant operator for intentionally harming the unruly patron in an effort to stop the fight, the insurer will point to the absence of an "occurrence" and to the expected or intended exclusion, and will not provide a defense. But if the same family sues the operator for false imprisonment — even intentional false imprisonment — the carrier will reserve the right to deny indemnity (coverage for a settlement or judgment) if a jury finds that the policyholder intentionally injured the deceased patron, but it will provide a defense.

What's the difference? Why are the same allegations of intentional acts excluded under Coverage Part A but covered under Coverage Part B? If not all intentional conduct is uninsurable, where will the insurer draw the line? And how can the policyholder anticipate what intentional conduct will be covered and what will be excluded?

'Four Corners' and 'Extrinsic Evidence' States

The answer may depend upon the state in which the claim arises. States have two ways of determining whether the duty to defend is triggered when an intentional act is alleged.

In a "four corners" state, the carrier has a duty to defend if there is an allegation of potentially covered conduct within the four corners of the complaint. In the example above, the patron's family framed its lawsuit against the restaurant operator in terms of intentional conduct. As a result, if they file this complaint in a four corners state, the operator will not be covered — even if there is evidence that it did nothing intentional or wrongful at all.

In an "extrinsic evidence" state, the opposite result would happen. There, the insurer cannot rely solely upon what is alleged in the complaint to decide whether it has a duty to defend. If there is evidence outside of the four corners of the complaint that suggests the policyholder — if it is at fault at all — caused the bad result (death of the patron) accidentally rather than intentionally, the carrier must defend. The policyholder often is the source of this evidence.

Here, if the operator points to evidence not alleged in the complaint, such as the incident report showing that the employees who moved the patron to the back room took great care to assure he was not injured, this creates the possibility that the operator — again, if it is at fault at all — committed negligent rather

Continued next page

than intentional acts. Because the carrier must defend if there is the barest potential for coverage found in the complaint augmented by extrinsic evidence, it has a duty to defend in this example.

Therefore, in four corners states such as Tennessee and Colorado, an allegation of strictly intentional conduct is uninsurable, while in an extrinsic evidence state like California or Maryland, the same allegation is insurable — and triggers a duty to defend — assuming there is some evidence that the insured might have acted unintentionally. Whether the restaurant operator receives a defense in the deceased patron example will depend on where the restaurant is located.

Defend and Indemnify Duties

A CGL policy contains two duties: the duty to defend and the duty to indemnify. The duty to defend has a hair trigger, and attaches when there is a potential for coverage. The duty to indemnify, referring to its duty to pay a settlement or judgment, attaches only if the settlement or judgment is caused (by a preponderance of the evidence) by a covered offense. Because the duty to defend is broader than the duty to indemnify, an insurance company may have a duty to defend a policyholder against allegations that it committed a potentially covered act, but not ultimately have any duty to pay a settlement or judgment. This distinction often drives the extent to which intentional acts are insurable.

Insurable intentional torts (like false imprisonment) are general intent torts. If the actor intends the act (here, confining another without right), then it doesn't matter whether he or she intended any harm. The actor's general intent is enough to establish the elements of the tort. False imprisonment, therefore, is an insurable intentional act — so long as no specific intent is pleaded (in four corners states) or proven (in extrinsic evidence states).

In a four corners state, where false imprisonment is claimed without any allegation of specific intent to harm, the carrier has a duty to defend and the act is insurable. But the minute an assertion that the policyholder intended the harm is added, the resulting specific intent tort is not insured and the insurer has no duty to defend. Extrinsic evidence states are more forgiving, requiring the carrier to at least provide a defense to an assertion of specific intent if there is evidence outside the complaint of the insured's lack of such intent. Yet even in extrinsic evidence states, if the evidence ultimately shows that the insured specifically intended the plaintiff harm, the loss is uninsurable and the carrier will be barred by law from indemnifying it.

Retail businesses that deal closely with the general public sometimes purchase assault and battery coverage by endorsement to their CGL policies or as a stand-alone coverage, essentially adding it to the list of torts enumerated in Coverage Part B. This add-on typically covers defense costs only, or defense costs subject to a low indemnity sublimit. This structure reflects what underwriters usually consider the intent of intentional acts coverage under CGL policies: to respond primarily as a defense coverage, with less emphasis on indemnity.

Getting the Most from Your CGL Policy

This intent is not always consistent with policy language. To get the most from a CGL policy, when faced with a lawsuit that claims the company did something inherently intentional, ask the following questions:

Is the alleged tort called out in the CGL policy's coverage grants?

Coverage Part A: Does plaintiff allege an act that, but for the intentional conduct allegation, would otherwise be covered (e.g., bodily injury or property damage, no applicable exclusion)?

Coverage Part B: Does plaintiff allege one of the torts enumerated in the insuring agreement (malicious prosecution, wrongful entry to or eviction from land, false imprisonment, slander or invasion of privacy) without an applicable exclusion?

Was the alleged tort committed in a four corners or extrinsic evidence state?

Four corners: If the answer was no to both parts of the first question above, and plaintiff's suit alleges strictly intentional conduct, then the insurer has no duty to defend or indemnify. This

will remain so unless plaintiff amends to allege some otherwise covered, unintentional act.

Extrinsic evidence: If the answer was yes to both parts of the first question above, and no evidence extrinsic to the complaint indicates the possibility of unintentional conduct, then the insurer has a duty to defend.

If the case is resolved by settlement, is the insured able to show by a preponderance of the evidence available for trial that if it is held liable, liability will be for a general intent tort (i.e., covered) rather than a specific intent tort (i.e., not covered)?

> *"A CGL policy contains two duties: the duty to defend and the duty to indemnify."*

If yes, and the tort is otherwise covered (i.e., the answer to one or both of the first questions is yes), then the insurer must indemnify the settlement. If the tort is not otherwise covered, then it need not do so.

If no, then there is no indemnity obligation.

If the case is resolved by adverse judgment at trial, does a preponderance of the evidence show liability for a general rather than specific intent tort (assuming no general or special verdict form answering this question directly)?

If yes, then the insurer likely must indemnify the judgment, although it may take another round of litigation to establish what the facts were leading to the general verdict (a good way to keep open the option of arguing a general intent tort, absent a punitive damages award).

If no, then the insurer need not indemnify the judgment, and may under some circumstances be able to recover reimbursement of defense costs from the policyholder. ▲

Whither the FDIC

It Might Become the 800-Pound Gorilla of Corporate Insurance Recovery

David E. Wood, Shareholder ANDERSON KILL WOOD & BENDER, P.C.
Joshua Gold, Shareholder ANDERSON KILL & OLICK, P.C.

The Federal Deposit Insurance Corporation (FDIC) will have its hands full for years to come in dealing with the aftermath of the implosion of the global banking system and the decimation of the U.S. housing market. The fallout for financial institutions in particular has been devastating, with a number of banks, both big and small, collapsing or otherwise on the brink. By November 13, 2009, 123 banks had failed since the beginning of the year — four times as many as in 2008. For the quarter that ended September 30, 6.25 percent of U.S. mortgages were at least 60 days past due, an all-time high.

In stark contrast, in 2005 and 2006, there were no FDIC-insured bank failures. In 2007 there were three. In 2008 there were 25. In 2009, there were 140. A number of factors are driving the spike in bank failures, including bad management, bad risk controls, record loan delinquencies, and both internal and external theft. Insurance policies that address these perils include directors, and officers, (D&O) insurance policies, fidelity/financial institution bonds, commercial crime insurance policies and mortgage default insurance.

The FDIC functions in two capacities: 1) its corporate capacity, under which it insures the deposits of its 8,305 member banks and regulates their financial condition; and 2) its capacity as a receiver or conservator for failed and failing banks. The higher rate of bank failures is increasing strain on the FDIC's resources in both of its capacities, and putting added pressure on the agency to recover losses from insurers and

insured third parties. The agency's insurance-fund balance dropped by almost half in the fourth quarter of 2008, from $35 billion to $19 billion. To keep funds from dwindling, the FDIC raised deposit-insurance assessment rates in the second quarter of 2009, adding to the burden that already troubled banks will have to bear.

Never has the FDIC been more motivated to be aggressive about insurance recoveries.

The FDIC is well versed in insurance coverage battles with the insurance industry, having fought numerous and heavily litigated contests in the wake of the S&L crisis over D&O insurance coverage and financial institution bond coverage. In the current crisis the FDIC is again pursuing insurance assets of failed banks, such as mortgage insurance policies that were purchased to protect the bank against the risk of default by borrowers under various types of mortgage products. There are already reports of disputes over mortgage insurance coverage where insurance companies are refusing to honor their coverage obligations.

> *"Given the sheer number of bank failures, the FDIC will have its hands full with insurance claims. A threshold question is: How did the bank become insolvent?"*

As such, the FDIC is poised once again to be at the forefront of protecting depositors and others by marshalling, among other things, insurance assets to defray the costs of bank failures to the American taxpayer.

Did an Insurance Coverage Denial Help Precipitate the Failure?

Given the sheer number of bank failures (with more to come), the FDIC will have its hands full with insurance claims. A threshold question to always ask (and answer) is, how did the bank become insolvent? If it turns out that an insurance company's misconduct in handling an insurance claim imperiled the bank's financial condition, then the insurance company may be liable for consequential and exemplary damages. By way of example, if a mortgage insurance company refuses to provide coverage for mortgage loan defaults (especially in this environment with record numbers for delinquencies) and this causes the bank to become insolvent, then the insurance company can be liable for consequential damages in addition to the amount of the coverage owed to the policyholder all along.

In a landmark case decided recently, *Bi-Economy Market, Inc. v. Harleysville Insurance Company of New York, et al.*, 10 N.Y. 3d 187 (2008), New York's highest court ruled that where an insurance company wrongly denies coverage and causes the demise of its policyholder's business, it is responsible for consequential damages. In the New York case, the policyholder had suffered a covered loss. Rather than provide coverage in full, the insurance company disputed its obligations and paid only a fraction of the policyholder's property claim and a bit more than half of the policyholder's business income claim. The court held that the policyholder's "claim for consequential damages including the demise of its business, were reasonably foreseeable and contemplated by the parties[.]" *Id.* at 196. The court also found that the insurance policy required the insurance company to "evaluate a claim, and to do so honestly, adequately, and — most importantly promptly." *Id.* at 195.

Other jurisdictions have long held that an insurance company that wrongfully denies coverage can be liable for consequential losses, bad faith, exemplary damages and attorney fees. The bottom line for the FDIC and others representing policyholder interests under such circumstances is that it is critically important to evaluate and pursue bad faith and consequential damages claims against insurance companies which have improperly refused to provide coverage for covered claims.

FDIC/RTC/FSLIC Suits vs. Former Management

The FDIC is also likely to see a repeat of coverage defenses it has previously had to litigate with the insurance industry. Many D&O insurance companies have tried to void coverage by arguing that claims made by the FDIC, FSLIC and the RTC trigger the so-called "insured vs. insured" exclusion found in the majority of D&O policies. Some insurance companies have also relied upon so-called "regulatory agency" exclusions in an attempt to escape their insurance coverage obligations. Many courts have rejected

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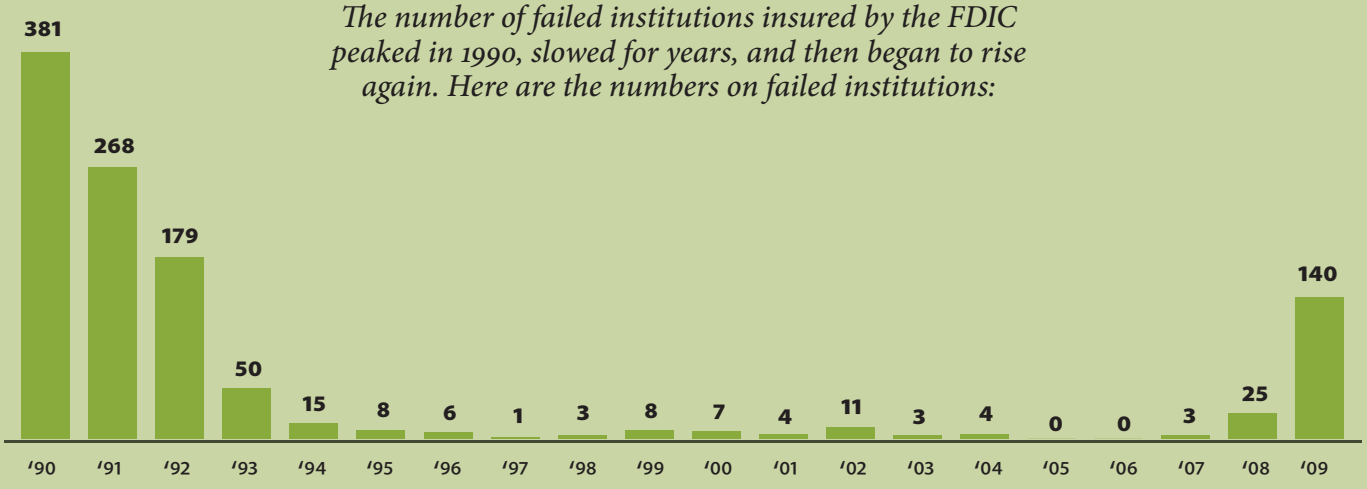
The Ups and Downs of Bank Failures

The number of failed institutions insured by the FDIC peaked in 1990, slowed for years, and then began to rise again. Here are the numbers on failed institutions:



Source: *FDIC*

> *It is worth remembering that as long as the suit by the receiver or administrator is not collusive in nature, then the insured vs. the insured exclusion should never cause a forfeiture of insurance coverage.*

these arguments on the basis of the policy terms, the intentions of the parties and public policy grounds. Nevertheless, because there is neither uniformity throughout the various legal jurisdictions nor within the terms of the various forms of D&O insurance coverage on these exclusions, the FDIC can count on having to litigate many of these same issues.

It is worth remembering that as long as the suit by the receiver or administrator is not collusive in nature, then the insured vs. insured exclusion should never cause a forfeiture of insurance coverage. Is very hard to imagine an instance in which a suit commenced by the FDIC would ever be collusive in nature. Some of the more recent forms of D&O insurance seem to recognize this fact, and seek to clarify this point by specifically excepting from the exclusion claims brought by any examiner, trustee, receiver, liquidator or rehabilitator.

Despite this, the FDIC and attorneys representing its interests should be aware of the background and purpose for the insured vs. insured exclusion to combat improper insurance company attempts to apply the exclusion beyond its intended scope.

Conclusion

Given the staggering number of bank failures to date, the FDIC can safely count on having to battle the insurance industry under at least three insurance products: D&O insurance, fidelity insurance, and mortgage insurance. Securing this insurance coverage will be critical to ameliorating the impact of the huge spike in bank failures. Given the sheer scope of the banking crisis, as well as the record number of failures, the FDIC — whose mandate is to mitigate losses from bank failures wherever possible — can be expected to pursue insurance recoveries on a scale not seen since the 1980s. And given the insurance industry's predictable desire to avoid having this exposure shifted to its shoulders, we can expect to see the gloves come off. ▲

Make No Mistake
How to Avoid the Common Errors Made on Insurance Applications

Alex Hardiman, Shareholder ANDERSON KILL & OLICK, P.C.

When faced with a policyholder's claim for insurance coverage, with increasing frequency insurance companies will comb through the policyholder's policy application in an effort to identify potential misrepresentations or omissions that could justify the insurance company's rescission (voiding) of the policy or pressure the policyholder into accepting less than full payment of a claim. This practice is often referred to as "post-loss underwriting."

The use of misrepresentations or omissions in a policy application as a means for insurance companies to escape payment of an otherwise covered claim is exemplified by a recent case. In *Pope v. Mercury Indem. Co. of Georgia,* the policyholders made a claim for insurance coverage as a result of damage to their property from a tornado. The insurance company's investigation, however, revealed that contrary to the representation made in the insurance policy application that the policyholders' pool had no diving board, the policyholders' pool did in fact have a diving board. The insurance company subsequently refused to pay the tornado damage claim and sought to rescind the policy on the basis of the diving board misrepresentation in the policy application. The appellate court affirmed the insurance company's right to rescind the policy, even though the tornado damage claim was unrelated to the policyholders' use of a diving board.

The *Pope* case exemplifies why policyholders should be aware of the potential pitfalls when completing policy applications and of the strategies to minimize the consequences of any misrepresentation or omission if it occurs.

Beware of the 'Broad' Question in an Insurance Policy Application

Whether in a property policy, a commercial general liability policy, a directors' and officers' liability policy or any other type of policy, what

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questions are asked in an application and the breadth or specificity of those questions can often determine whether an insurance company may later succeed in rescinding a policy on the basis of a misrepresentation or omission.

Many rescission cases have centered on a policyholder's failure to disclose knowledge of facts at the time of the application that ultimately led to a claim after the policy was sold. An application that broadly asks, "Does any director, officer, manager, supervisor, employee or partner have knowledge of any claim(s), fact(s), circumstance(s), situation(s), transaction(s) or event(s) as of the date this application is signed, which could reasonably give rise to a claim and/or allegation?" sets a standard that is next to impossible to satisfy in any organization that has significant numbers of employees by essentially requiring the application signer to conduct interviews with all employees and potentially requiring the policyholder to list an infinite number of events or facts which could give rise to a claim in the future. In contrast, an application that requests the same information but limits its scope to the knowledge of the application signer, leaves much less potential for a future accusation of misrepresentation or omission by the insurance company.

> *"Even if a misrepresentation or omission in an application occurs, a policyholder does not automatically forfeit its insurance coverage."*

Policyholders should also ensure that all questions are answered as completely and accurately as possible. For example, a number of rescission cases have focused on the policyholder's failure to disclose all aspects of its business, leading to accusations by the insurance company that the policyholder misrepresented the nature of the risk being insured.

Accordingly, policyholders should work closely with their brokers to change or clarify questions in applications that are overly broad or ambiguous. They may even wish to consider the breadth of questions in an insurance application as a factor when deciding which insurance company to purchase a policy from.

Know Your Defenses to Rescission

Even if a misrepresentation or omission in an application occurs, a policyholder does not automatically forfeit its insurance coverage. Although it varies by state, an insurance company must meet a number of standards in order to rescind a policy and a policyholder may have a number of defenses available.

In general, an insurance company must prove that any misrepresentation or omission is "material" in order to justify rescission of an insurance policy. "Materiality" typically is determined by whether the insurance company would have issued the policy or changed the premium in the absence of the misrepresentation or omission. Unlike the *Pope* case, to meet the materiality standard some states require the misrepresentation or omission to be causally related to the insurance coverage claim at issue. In addition, to meet the materiality standard some states also require that a policyholder's misrepresentation or omission must have been made with intent to deceive the insurance company.

Even assuming that an insurance company meets the applicable state's materiality standard, a policyholder may still have a number of defenses available to defeat a rescission attempt. For example, policyholders should closely examine the application questions giving rise to the material misrepresentation or omission for any ambiguity. To the extent that an application question is ambiguous, a court may refuse to permit an insurance company to rely on the policyholder's answer to that question as a ground for rescission of the policy. In addition, if an insurance company had knowledge that should have caused the insurance company to investigate the policyholder further at the time of the application (whether because of a policyholder's answers in the application or otherwise), a policyholder may have a defense that the insurance company has waived its right to rely on any undisclosed or misrepresented fact that could

have been discovered in such an investigation. Similarly, if an insurance company continues to accept premiums or otherwise takes any actions that ratify the policy after the insurance company has knowledge of the misrepresentation or omission, then the insurance company may have waived its right to rescind the policy.

Insurance companies use alleged misrepresentations and omissions in insurance policy applications as a tool to support claim denials or pressure their policyholders into accepting less than full payment on a claim. Policyholders can minimize their exposure to these tactics by ensuring that they provide accurate and comprehensive information during the application process and by being aware of the defenses available in the face of an insurance company's attempted rescission of a policy. ▲

Risk Radar

HOT TOPICS TO WATCH IN THE COMING MONTHS

Litigation & Insurance Coverage Update: Important Coverage Considerations for Chinese Drywall Claims

Thousands of U.S. homeowners have filed lawsuits against homebuilders, installers, distributors and manufacturers involved in the construction and repair of homes and buildings using faulty Chinese drywall. The drywall is alleged to emit noxious odors, damage electrical circuits and cause a range of health problems. These claims, likely to result in substantial liabilities, raise a host of insurance coverage issues.

Robert M. Horkovich is lead counsel to the first construction company trust to file an insurance coverage action stemming from Chinese drywall liability. The action is currently pending in the Chinese Drywall Multi-District Litigation in the United States District Court for the Eastern District of Louisiana. The key coverage issues in defective Chinese drywall coverage actions include:

- **Will the drywall fumes trigger the pollution exclusion?** Some courts have applied the pollution exclusion to preclude coverage for the escape of carbon monoxide in an apartment building, ammonia leaks in a warehouse, insecticide in an apartment complex, mercury spilling in a home and sealant being applied to the exterior of a building. Other courts, however, have limited the application of the pollution exclusion to industrial waste, widespread environmental contamination, active polluters and releases into the atmosphere. Still other courts have held that the pollution exclusion did not apply because the agent did not constitute a "pollutant."

- **Do the "your work" or "your product" exclusions take away the central cost of replacing the drywall?** Coverage for the cost of repairing or replacing a policyholder's faulty work or product is excluded. Nevertheless, insurance coverage does exist for the loss of use or consequential damages caused by the policyholder's work or product.

- **Other important exclusions include:** ongoing operations; damage to impaired property or property not physically damaged; and recall of products, work or impaired property.

The type of insurance policies that may provide coverage for losses arising from defective Chinese drywall include general liability, homebuilders protective, pollution and first-party property policies.

It is critical that the policyholder actually get and review the insurance policies. Standard ISO forms included in policies sold to contractors and subcontractors except contractors and subcontractors from the pollution exclusion. Also, the FC&S (Fire, Casualty, and Surety) bulletin for Chinese drywall claims expressly states that the pollution exclusion does not apply to Chinese drywall products claims. Jurisdictional and venue issues may prove to be paramount. ▲

Continued on back page

Is the Attorney-Client Privilege Bulletproof

When Insurance Companies Use it to Disguise Bad Faith Claim-Handling?

Caroline R. Hurtado, Shareholder ANDERSON KILL WOOD & BENDER, P.C.

When policyholders challenge their insurance companies' claims-handling practices, insurance companies often play a game of Russian roulette, using attorney-client privilege to shield their factual claim investigations from disclosure and policyholder criticism. By claiming that an attorney performed the claims-handling function, the insurance company may waive the privilege and blow the top off its putative protection, exposing the facts (good and bad) underlying a coverage denial to the cold light of day.

Insurance companies take another deadly spin in the game of chance when they invoke the advice of counsel defense. This occurs when an insurance company — usually unwillingly — claims that its coverage denial was based on the advice of coverage counsel and therefore reasonable, for purposes of defending against allegations of bad faith. Once the insurance company places its attorney's advice at issue, however, the privilege may be waived.

When conducting discovery in coverage litigation, a policyholder should not be deterred when John Doe, Esq., instead of John Doe, claims department representative, writes the denial letter. Nor should a policyholder assume that attorney activity on a privilege — or claims — log, or involvement of an attorney in internal communications regarding coverage, will automatically be protected from disclosure. Determining whether an attorney is acting as a claims handler or legal advisor is a fact inquiry

that looks to the dominant purpose of the attorney's function.

There are many reasons why an insurance company would pass off its claims-handling function to an attorney: experience, knowledge, the desire to protect sensitive information, reliance

on the advice of counsel defense in bad faith litigation, or simply protecting a claims employee from being deposed. Indeed, a recent insurance industry publication tailored to claims adjusters characterized a deposition as a "Maalox moment that may be about as much fun as a root canal."

The Lawyer in the Claims-Handling Function

Insurers cannot shield claims files from disclosure on the basis of the work-product privilege by having lawyers handle claims. For the work-product doctrine to apply, the investigation must be outside of standard claims-handling process. For attorney-client privilege to apply, the attorney must provide legal advice and not conduct a factual investigation.

> *"Before the coverage dispute, the lawyer is acting as claims adjuster who investigates the claims, analyzes them and determines whether payment should be made and, if so, at what amount."*

Insurance companies commonly use lawyers for two primary purposes: 1) to perform the business function of address coverage issues (adjusting claims, supervising the claims process or monitoring the investigation of claims); or 2) to be the litigator litigating a coverage dispute. Before the coverage dispute, the lawyer is acting as claims adjuster who investigates the claims, analyzes them and determines whether payment should be made and, if so, at what amount. At some point, the lawyer turns into a coverage lawyer who does not make such business decisions. If the matter could be handled by a layperson just as easily as a lawyer, the matter may not be privileged.

Under the same rationale, documents in a claims file created by or for an insurance company as part of its ordinary course of business, are not afforded work-product protection, even if prepared by a lawyer. Courts often presume that documents prepared by or for an insurer prior to a coverage determination are prepared in the ordinary course of the insurer's business and are not afforded work-product protection.

Similarly, documents created after the insurance company's retention of counsel are not necessarily afforded work-product protection where the insurance company continues to investigate the claim without denying coverage — the hiring of outside counsel does not, by itself, indicate a determination to litigate. Therefore, insurance companies cannot claim that investigative documents are privileged because they were prepared in anticipation of litigation before a coverage denial, because claims investigations often continue after outside counsel is hired.

The Insurance Industry Recognizes Waiver in Investigatory Circumstances

Even the insurance industry affirms this challenge to the privilege that is traditionally raised by policyholders. Recently, AIU, an insurance company similarly situated to a policyholder in coverage litigation, sued its reinsurer, TIG, alleging that TIG had breached the reinsurance contracts at issue by failing to indemnify AIU for its share of settlement payments in an underlying matter. In an attempt to compel TIG's claims files and challenge TIG's assertion of the attorney-client and work-product privileges, AIU argued (in the same manner that a policyholder would argue in bad faith litigation against an insurance company) that TIG's counsel was acting solely in an investigatory function, and not as a lawyer.

Ultimately, on a motion to reconsider, the AIU court found that certain documents were, in fact, privileged, but it was only after a detailed and fact-intensive inquiry into the nature of the claimed privileges and documents at issue. Nonetheless, this case is noteworthy because it

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highlights the insurance industry's recognition of this challenge to the privilege.

Uncovering Bad Faith

To prove bad faith, a policyholder must show how the insurance company processed the claim, how the claim was considered and why the insurance company took the action that it did. Once it has made this factual inquiry, the policyholder must also show the absence of a reasonable basis for denying benefits of the policy and the insurance company's knowledge or reckless disregard, or the lack of a reasonable basis for denying the claim. An insurance company's intentional denial, failure to process or failure to pay a claim without a reasonable basis can give rise to a bad faith lawsuit. Therefore, some courts find that an insured's claim of bad faith may also be the basis for disclosure of privileged insurance company communications, in what is referred to as the bad faith exception.

> *"Do not be fooled by the involvement of the insurance company's lawyer in handling or litigating a claim. As a policyholder, you are entitled to discovery to prove your bad faith claim."*

In these jurisdictions, the policyholder's need for the claims file is found to be "overwhelming" because it is a unique, contemporaneously prepared history of the company's handling of the claim.

The Advice of Counsel as Shield

An insurance company in bad faith litigation can also waive the attorney-client privilege when it asserts its good faith due to its reliance on its counsel's advice. Insurance companies commonly defend bad faith or malicious claim handling allegations giving rise to punitive damages by providing evidence that the insurance company relied on the advice of competent counsel. This is an implied waiver, whereby the insurance company voluntarily puts its state of mind and attorney advice at issue. In such circumstances, the policyholder is entitled to discover communications between the lawyer and insurance company, which relate to the advice on denial of coverage.

When an insurance company makes factual assertions in defense of a claim, which incorporate the advice and judgment of counsel, it cannot deny a policyholder the opportunity to uncover the foundation for those assertions in order to contradict them. The policyholder should be entitled to test the reasonableness of the attorney's opinion and the insurance company's reliance on the opinion.

What to Do

Do not be fooled by the involvement of the insurance company's lawyer in handling or litigating a claim. As a policyholder, you are entitled to discovery to prove your bad faith claim. If an attorney was involved in the insurance company's investigation of the claim, push for the information and shift the burden to the insurance company to tell you why the information is privileged.

Do ask for: the underwriting file, claims file (including all documents regarding the processing, payment and/or denial of the claim, and investigative reports regarding the claim), loss reserves, underwriting manuals and guidelines, communications with the insurance broker, document retention policy, reinsurance information (including reinsurance policy and communications with reinsurer[s]) and marketing materials concerning the coverage purchased. ▲

A Primer For Builders
How To Handle A Construction Insurance Claim

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The general contractor's job is to keep the many moving parts of a project working in synchrony to achieve a finished structure. Then, just when the builder thinks the project is completed and can begin the next one, the owner begins to complain that water is intruding here, the wrong finish was used there, or the windows are falling apart somewhere else. Pretty soon, a claim resolution process is set in motion that can determine whether the general contractor retains or loses its profit on the job.

Negotiating this claim resolution process with its insurance companies, the general contractor will be opposite professional insurance adjusters who work on construction claims every day or most days of their working lives. These people generally know what they are doing. Unless the general contractor has similar talent and knowledge at its disposal — either in the form of claim personnel, coverage counsel or both — it runs the risk of being out-manned and out-gunned.

While nothing can substitute for professional advice, particularly not in the case of complicated construction claims, there are some hard-and-fast rules to handling a construction claim that will get the general contracting firm started.

All Policies

Put all available carriers on notice: builders risk, general liability (GL), additional insured (AI) and errors and omissions (E&O). When the contractor learns of an actual or potential construction loss, it should immediately give notice to all insurance companies potentially on the risk. It should not have to delay giving notice while it gathers the relevant policies from the various custodians. Even if other parties (the owner, subcontractors, etc.) were responsible for obtaining applicable coverage, the contractor should have assembled a file of these policies, or at least certificates of insurance documenting them, well in advance.

Builders Risk: If the loss occurs during ongoing operations, particular attention to builders risk (but not to the exclusion of giving notice to other insurance companies — there is no downside to giving notice and a big potential downside to not doing so) and course of construction GL policies.

GL: If the loss occurs after the project is completed, pay particular attention to the GL polic(ies) with products/completed operations risk (even if you are still working through a punch list — if the work is mere repair and replacement of otherwise complete work, under many policy forms the project is still deemed completed).

AI: If your company is an AI under subcontractors' policies, give notice under those policies (having figured out their particulars by reference to the certificate of insurance provided by the sub, documenting the AI coverage). The same warnings stated above with respect to ongoing operations and completed operations, and indeed all other coverage issues arising under the sub's GL policy, apply to the AI coverage provided to the general contractor.

E&O: If the loss is caused by a core construction dispute (e.g., a delay claim) or a pure construction defect case with no occurrence,

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with no resulting property damage and it's strictly an economic loss (e.g., painting a building the wrong color), pay particular attention to the contractor's E&O policy if there is one. If there is any property damage, or the potential for property damage, E&O coverage will not apply — go back to the GL policy.

General Liability Policies

Do your own investigation. Even if the dispute concerns a core construction dispute, have the contractor's own people look for property damage. If the dispute concerns construction deficiencies, get an engineer or other expert to evaluate the defects, the damage and the cost of repair/replacement. Do not wait for your insurance companies to do this. They are more likely to perceive a nascent or ambiguous loss scenario as non-covered, consistent with their own interests. Getting your own opinion will tell the contractor whether, objectively, the loss can be fairly presented as covered. Then you can calibrate prosecution of the claim to emphasize its strengths and compensate for its weaknesses.

Demand a defense from your company's carriers. Insurance companies like to contend that GL policies do not cover construction defects. In fact, these policies do cover deficient construction, if there is an occurrence and resultant property damage, and if certain other restrictions (such as those noted below) do not apply. Also, the contractor should not be afraid to argue that the occurrence occurs early in the chain of causation, advocating an exposure or injury-in-fact trigger coverage theory. In states where a good faith argument can be made that one of these triggers applies, resulting damage to the element of construction, without more, may suffice.

Your work exclusion: Watch out that the contractor's own work is not implicated, and that the subcontractor exception to your work exclusion applies.

Ongoing vs. completed operations: If you go for an exposure trigger, be careful not to push the exposure date back so far that it lands in ongoing operations (i.e., before project completion) or you'll implicate Exclusion j(6), the faulty workmanship exclusion.

Demand a defense from your company's AI carriers. The general contractor's master subcontract should always provide that AI coverage is primary and the named insured contractor's coverage excess. If the contractor frames its contract this way, it can require the AI carrier to provide a defense, protecting the excess nature of its own coverage. If the contractor does not do this, and demands that its own insurance company bear the obligation to defend as if it were primary, it can expect to pay higher, primary policy premiums — having missed the opportunity to pay lower, excess premiums by contracting with its subs to make its own insurance excess.

Demand independent counsel where the insurance company reserves rights. When an insurance company accepts a contractor's tender of defense, it will assign a lawyer from its panel of qualified counsel to defend the policyholder. Often, the carrier also will reserve the right to deny coverage sometime in the future if the facts of the claim turn out a certain way. If it does, this is your signal to demand that the insurance company hire an independent lawyer, one who (unlike panel counsel chosen by the insurance company) is selected by the contractor and owes its allegiance solely to the policyholder. Some states allow the contractor to demand independent counsel whenever a reservation of rights is made. Others ask whether panel counsel could in theory steer the case toward a noncovered result. Know the law of the state in which the loss occurs, and, if allowed, use your right to independent counsel. It is always better to be defended by independent counsel who will serve the company's interests alone, and who will present the loss at settlement time in a manner consistent with coverage.

At settlement time, get all AI and named insured carriers together. When the contractor is named as an AI under its subcontractors' policies, each insurance company will face the costs of defending the named insured subcontractor, as well as the general contractor under the AI coverage. Demonstrate to each insurance company the cost of continued litigation, and the benefit of settling to meet repair costs.

Elect the defending carrier. In many states, the general contractor covered by a number of AI carriers for different subcontractors may elect to enforce the duty to defend against any single insurance company — it need not pursue all insurers. Use this device to impress upon the

AI carrier with the greatest exposure the high cost of being the sole defender of the general contractor (at least until its cross-complaints against other AI carriers are resolved) and the efficacy of settling.

Never waive a contract balance. If the project is completed and the owner still owes the general contractor money, the builder must resist the insurance companies' pressure to contribute the contract balance — waiving the right to receive these funds from the owner — to get the case settled. Unless the general contractor's insurance includes a self-insured layer equal to this contract balance, there is no reason to spare the insurance companies this expense. If the contractor does, it is self-insuring a covered liability risk without consideration.

Use indemnity agreements as weapons. Subcontractors' indemnity obligations toward a general contractor usually are broader than the AI insurance coverage the subcontractors are bound by contract to obtain for the general contractor's benefit. Subcontractors often forget this, assuming that by obtaining AI and named insured coverage, they are immune from personal loss. This is incorrect.

Check the kind of indemnity agreement you have. In many states, indemnity agreements under which the subcontractor must indemnify the general for the latter's own negligence (Type I indemnity agreements) are barred. In others, they are enforceable if clear and unambiguous. In still others, they are enforceable for commercial jobs but not residential ones.

"Have your team of insurance professionals in place before a claim arises, and when it does, use the team proactively."

Check the scope of AI insurance. If the AI coverage is narrower than the coverage required under your master subcontract, the subcontractor is liable for breach of the contractor's insurance requirements.

Check policy conditions and exclusions. An indemnity agreement is unlikely to be subject to conditions and exclusions. The insurance policy always is. Be mindful of the fact that, if the AI coverage excludes a loss, the indemnity agreement likely will not — leaving the subcontractor personally exposed.

Bypass coverage disputes: If the insurance company raises defenses to coverage that you think are wrong, shift the risk to the subcontractor by pointing out that if the carrier does not pay, the broader indemnity will take over and the subcontractor will pay the loss from its own pocket. This will incentivize the sub to put maximum pressure

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on its insurance company to pay on behalf of the general contractor.

E&O Policies

Determine whether the policy is a duty to defend or reimbursement coverage, and adjust your strategy accordingly. Most E&O policies do not contain a duty to defend; they oblige the insurance company to reimburse reasonable and necessary attorneys' fees and costs excess of a retained limit or self-insured retention. If there is a duty to defend, watch for the right to independent counsel. If not, recognize that the general contractor must control the defense and settlement of all claims, subject to the insurance company's consent.

Understand the boundary between GL and E&O coverage. GL policies cover the builder for claims caused by some unintentional, abrupt event for which the builder is legally responsible. E&O policies are professional services policies, they insure the builder for monetary losses caused by some mistake other than physical harm to people and things. If a loss represents the cost of repairing or replacing property that has been physically and accidentally damaged (including loss of use of the property), it probably is a GL loss. If a loss consists of economic damages caused by a covered hazard not involving physical harm to property, it probably is an E&O loss.

> **Example:** A builder hires a subcontractor to apply stucco to the exterior of a building. The sub applies it incorrectly and it begins to peel off, allowed water to intrude and damage the interior. The interior damage represents physical harm to property caused by an occurrence (which may be the faulty workmanship itself, the point at which the injury to property occurs, or the point at which the damage manifests itself, depending on the state). The builder's liability for the cost of repairing or replacing the interior damage is a GL loss. By contrast, if the subcontractor is hired to finish the stucco with a certain material, and uses something else, the loss consists of the cost to replace the stucco. The builder's liability for these economic damages is an E&O loss.

Watch out for claims based on intentional acts. Virtually all E&O policies exclude intentional, dishonest acts. But what happens if the suit against the builder alleges such conduct? Does the mere accusation of fraud bar coverage for the claim in whole or in part? This depends on the language of the exclusion. Typical language excludes any claim arising out of "any dishonest, fraudulent, criminal, or malicious act, error or omission or those of a knowingly wrongful nature." Other professional liability policies (D&O policies, general corporate E&O policies, bankers professional liability policies, etc.) usually include limiting language making clear that allegations of intentional conduct do not cut off coverage — only actually proven or finally adjudicated allegations of intentional conduct do. Some contractors' E&O policies do not include this limiting language, leaving the insured vulnerable to a reduction in defense or indemnity based on yet-unproven allegations of fraud.

Conclusion

Investigating a construction claim and presenting it to an insurance company is a complicated and sometimes risky business. If you do not understand ahead of time the precise facts of the claim, and the potential coverage issues it raises, you could inadvertently walk into a coverage defense that could have been avoided. Have your team of insurance professionals in place before a claim arises, and when it does, use the team proactively. This will give the general contractor the horsepower to play the insurance company's game on a level playing field. ▲

Head in the Sand

'Un-Insurance' is No Business Solution for Mortgage Insurance Companies Facing Bad Risks

Rhonda D. Orin, Partner ANDERSON KILL & OLICK, L.L.P.
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Since things are tough all over, some businesses are turning to innovative ideas to shore up their bottom lines. One of the most innovative is the mortgage insurance industry's effort to deal with an unexpectedly large problem: the risks and liabilities that they face today due to past sales of private mortgage insurance (PMI) policies.

The innovative idea? Un-ring the bell or — in this case — un-sell the policies. And many insurance companies have decided to do just that.

In December, Moody's Investors Service announced that mortgage insurance rescission rates have skyrocketed to about 20%–25%, up from their historical average of 7%.

In terms of dollars, the cost is in the billions. Moody's estimates that approximately $6 billion of claims were rescinded in 2008 and 2009. As many as $10 billion in claims may be rescinded before this cycle is through.

Even though these mortgage insurance policies were purchased and paid for years ago, were required by law in many circumstances, and were integral to the lenders' decisions to sell the mortgages in the first place, many insurance companies seem to perceive rescission as an option for mitigating risks — an alternative to that other "option" of paying the claims.

In the eyes of the lenders, it's like rewriting history. And the lenders are not buying it. In December two divisions of Bank of America filed a complaint in state court in California against Mortgage Guaranty Insurance Corp., seeking declaratory relief against its rescission practices.

The insurance companies see things differently. Like unhappy spouses seeking to annul their marriages, they say that the recent wave of policy rescissions reflects their sudden discovery of extensive amounts of fraud and misrepresentation by policyholders who purchased the insurance policies.

Certainly, this explanation may justify some of the rescissions and denials. But the context of certain corporate announcements and the timing of these "sudden discoveries" cast doubt upon whether fraud and misrepresentation justifies most — or all — of them.

For example, in a press release announcing substantial losses in the fourth quarter of 2008, Genworth Financial stated that it reduced its total loss exposure by $84 million by rescinding policies and denying claims. Chillingly, it made the announcement in connection with its report on the corporation's overall liquidity, including the steps it was taking "to further reduce risk in response to ongoing difficult market conditions."

During that same quarter, Fitch Ratings apparently took such announcements into account in assessing whether to downgrade the ratings of three mortgage insurance companies, including Genworth. In October, Fitch announced that it was

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downgrading them regardless, but it identified the increase in rescissions and denials as a favorable part of the mortgage insurance industry's "loss mitigation" strategy:

> Offsetting increased losses, however, Fitch notes a meaningful increase in claim denial (or rescission) activity across the industry relating to fraudulent loans. Fitch believes that rescission activity will play a significant role in the MI industry's loss mitigation strategy over the short term, particularly with regard to the 2007 vintage and Alt-A exposure, allowing to varying degrees some control over the amount and timing of losses.

Policyholders, state insurance departments and courts should take every action necessary to fight disproportionate surges in PMI rescission attempts and make clear to mortgage insurance companies that these tactics will not be allowed.

Private Mortgage Insurance — Myth or Reality

To insurance companies, private mortgage insurance, or PMI, is a tool to help borrowers buy a home when they cannot make a down payment of 20%. According to an insurer's marketing materials, PMI allows these borrowers to "responsibly buy a home years sooner," makes the dream of homeownership possible, and leads to "sooner, safer, and smarter homeownership."

To lenders, PMI is supposed to mean that they can sleep at night. PMI simultaneously allows loans to buyers who cannot make a 20% down payment and protects the lenders from situations where borrowers do not make payments on their loan. Lenders rely on PMI to make loans safer and more secure.

Like most insurance policies, PMI is underwritten and priced based upon the risk that is perceived to exist at the time that the insurance policy is sold, as MGIC underwriting guidelines specify. Risk is the essence of the insurance business; whenever insurance companies sell insurance policies and collect premiums, they are purchasing the risk of future obligations to pay.

The entire industry would be eviscerated if insurance companies were allowed to look back

months or even years after the PMI policy is priced and sold and try to rewrite the terms of the insurance policy based upon an actual or perceived increase in risk. If this type of "look-back" were allowed, policyholders would not be purchasing protection against possible losses when they buy insurance policies. They would be purchasing absolutely nothing at all.

A Decline in Property Value is Not a 'Breach' by the Lender

No mortgage insurer could seriously contend that a decline in property values constitutes a breach of contract that justifies rescission. A breach of contract is, by definition, a "failure, without legal excuse, to perform any promise which forms the whole or part of a contract." Uncertainty about a property's value is an inherent risk in the mortgage industry. No lender could ever, or would ever, "promise" that the value of a property will not decline over the period of the loan. Since guaranteeing market conditions is not a promise that the lender

> *"Like everyone else affected by the mortgage crisis, mortgage insurance companies should be held accountable for the consequences of their decisions."*

makes as part of a mortgage insurance policy, a decrease in property values is not a breach of the lender's obligations. It also is not grounds for the mortgage insurer to cry "fraud."

Mistake About Property Values Does Not Justify Rescission

Rescission is sometimes warranted where the parties make a mutual mistake regarding a key term of a contract. More specifically,

1. Where a mistake of both parties at the time a contract was made as to a basic assumption on which the contract was made has a material effect on the agreed exchange of performances, the contract is voidable by the adversely affected party unless he bears the risk of the mistake.

2. In determining whether the mistake has a material effect on the agreed exchange of performances, account is taken of any relief by way of reformation, restitution, or otherwise (Restatement of [Second] of Contracts § 152 [1981]).

However, rescission is not universally permitted even where there is a mutual mistake by the parties. In fact, rescission "is only appropriate where a mistake of both parties has such a material effect on the agreed exchange of performances as to upset the very basis for the contract." Additionally, the mistake must be "as to a basic assumption on which both parties made the contract."

Mistakes as to assumed market conditions — and the changes in market conditions — are not "basic assumptions" which, if wrong, might make the contract voidable. It is well-established that "just as shifts in market conditions or financial ability do not effect discharge under the rules governing impracticability, mistakes as to market conditions or financial ability do not justify avoidance under the rules governing mistake" (Restatement of [Second] of Contracts § 152 [1981]).

Getting Hit From All Sides —— Look Closely at Attempts to Rescind Policies

Lenders are getting hit from all sides. Lower property values, increased incidences of borrower defaults and attempts to rescind private mortgage insurance, are among the parade of horribles that they are facing.

Certainly, mortgage insurance companies are facing horribles as well. No one is contending otherwise. But, like everyone else affected by the mortgage crisis, mortgage insurance companies should be held accountable for the consequences of their decisions. They should not be allowed to "un-sell" their insurance policies and pass the risks straight back to their policyholders. They are not entitled, at this late date, simply to "change their minds." ▲

Risk Radar

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Texas Court Finds Asbestosis Exclusion Applies Only to Asbestosis

Policyholders facing liability because of asbestos claims will benefit from a March 11, 2009, Texas state court ruling, to the effect that the asbestosis exclusion bars coverage only for asbestosis claims and does not bar coverage for claims involving mesothelioma, lung cancer, pleural plaques or any other asbestos-related disease.

The ruling came in a case brought by ASARCO LLC on the scope of an asbestosis exclusion sold by Fireman's Fund Insurance Company. *ASARCO LLC, et al. v. Fireman's Fund Ins. Co., et al.,* No. 01-2680-D (105th Jud. Dist. Ct. Nueces County Tex. Mar. 11, 2009).

On motion for partial summary judgment, ASARCO sought a ruling that the exclusion applied only to claims arising from the specific disease known as asbestosis. In opposition, Fireman's Fund argued that the exclusion barred coverage for all asbestos-related diseases.

The decision impacts other insurance companies with such exclusions and thus constitutes a major victory for policyholders seeking insurance coverage for asbestos liabilities. Indeed, it benefits all policyholders seeking to enforce the plain meaning of the language in an insurance policy and a narrow construction of any exclusionary language.

Rhonda D. Orin, managing partner in the Washington, D.C., office of Anderson Kill & Olick and lead insurance counsel to ASARCO, said, "We are pleased with this ruling because we believe it essentially calls a spade a spade. The ruling simplifies the case considerably and eliminates an unnecessary factual issue."

ASARCO, a copper company based in Tucson, Arizona, declared bankruptcy in 2005. At issue at the time of the ruling was the existence and scope of coverage and the determination of past, present and future asbestos liabilities.

Judge J. Manuel Bañales of the 105th Judicial District Court of Nueces County, Texas, issued the order granting partial summary judgment to ASARCO. Jorge C. Rangel of the Rangel Law Firm in Corpus Christi, Texas, is ASARCO's local counsel in the case.

In June, the same court denied a motion for partial summary judgment to Fireman's Fund Insurance Company (FFIC), enabling ASARCO to pursue a claim for recovery of millions of dollars in legal expenses stemming from asbestos claims. ▲

NJ Superior Court Negates Stealth Exclusion in Taco Bell Franchisees' Insurance Policies

In a decision that will cheer restaurant owners and other food-serving businesses, the Superior Court of New Jersey granted partial summary judgment in favor of franchisees of Taco Bell Restaurants against Underwriters of Lloyds, which sold trade name restoration, loss of business income and incident response insurance for food-borne illness (TNR) policies to the franchisees. *Quick Service Management, Inc., v. Underwriters of Lloyds, et al. (*MID-L-4861-07).

Noting that for an insurance company to limit insurance coverage, "Any exclusion must be clear," Hon. Judge Phillip Lewis Paley found that the "aggregate supplier incident sublimit" in the policy could not be used as a stealth exclusion to deny coverage for business-income losses stemming from food contamination allegedly caused by lettuce that went into some Taco Bell menu items.

From 1999–2002, the Taco Bell franchisees bought food-borne illness (FBI) insurance from the Lloyd's market. Beginning in 2003, when FBI coverage was discontinued, the franchisees instead bought TNR coverage also from the Lloyds market. The court noted that marketing materials for TNR stated, "Even the best restaurants can suddenly be trapped in an infectious health situation ... due to a food-borne illness or supplier mistake that ends up totally out of control." At the same time, Lloyds asserted that the TNR policies contained an "aggregate supplier incident sublimit," not present in the FBI predecessor policies, indicating a dollar amount of $0.

When the franchisees suffered lost income stemming from the 2006 so-called "Taco Bell outbreak" of E. coli, allegedly traced to lettuce delivered to some northeastern Taco Bell franchises, Lloyds asserted that the $0 sublimit precluded insurance on account of any alleged involvement of a "supplier" and refused to cover the losses.

Noting the plaintiffs' contention that "no one explained that that sublimit would exclude coverage previously provided under FBI insurance," the court concluded:

> The underwriters did not state what the sublimit meant; they did not communicate that it was an exclusion. The sublimit does not exclude coverage for the outbreak.

The court further found that the language describing the sublimit did not on its face apply to the particular occurrence, as the sublimit paragraph was rife with undefined terms that rendered the policy, at the very least, ambiguous.

The court implicitly determined that because Lloyds was the sole drafter of the policy, it bore responsibility for any aspects of the policy that were subject to multiple reasonable interpretations. An insurance company cannot draft a less-than-clear policy and then later argue for an overly restrictive interpretation of that policy. ▲