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Mass Tort Litigation Insurance Coverage in the Wake of the End of Federal Preemption

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Following President Obama's May 20, 2009, "Memorandum for the Heads of Executive Departments and Agencies," it is critical for policyholders susceptible to mass tort litigation to ensure that their insurance policies and programs provide the proper coverage for such mass tort suits. The Memorandum, which is aimed at rolling back the federal regulatory policies of the Bush Administration that sought to limit jurisdiction for such suits by way of an aggressive preemption regulatory system, is likely to result in increased mass tort litigation in a variety of state and federal jurisdictions. Because of the protracted and costly nature of mass tort litigation, policyholders need to evaluate their insurance programs with an eye toward the concerns specific to these suits, notably the payment of defense costs.

Rolling Back A System Designed For Preemption

The preemption regulatory system implemented by the Bush Administration had been sought for years by industries frequently engaged in mass tort defense as a way to avoid the confusion brought about by 50 different state regulations. President Obama's Memorandum requires all executive department and agencies to: (1) not include "in regulatory preambles statements that the department or agency intends to preempt State law through the regulation except where preemption provisions are also included in the codified regulation;" (2) not attempt to preempt State law "except where such provisions would be justified under legal principles governing preemption;" and (3) undertake a review of the past 10 years of regulations that contain statements in regulatory preambles or codified provisions designed to preempt State law "in order to decide whether such statements or provisions are justified under applicable legal principles governing preemption."

Increased Access To State Courts Equals Increased Defense Costs

The likely affect of the presidential memorandum will be a return to widespread litigation in state jurisdictions as mass tort plaintiffs seek to take advantage of less stringent state regulations, as well as potentially lengthier litigation absent preemption, which often allows for earlier dismissal of such suits. Although any company with mass-marketed products now may face increased risk of claims, recent reports indicate that pharmaceutical manufacturers, including manufacturers of diet supplements and weight-loss pills, are particularly likely to face an abundance of new claims. Consequently, it is imperative that manufacturers of such products be aware of the insurance-related consequences in defending against such suits.

This increased risk of litigation in numerous state courts underscores the critical importance of a company's insurance coverage. Because mass tort litigation is predictably lengthy and costly, policyholders pay hefty insurance premiums for unlimited defense protection, in addition to the normal insurance policy limits. Moreover, the unique nature of mass tort litigation often requires that a company defend these claims in a more expensive manner that protects its reputation in order to discourage additional claims. Insurance companies are well aware of these risks and policyholders need to be aware of their rights in the situation where their insurance company denies coverage or defends claims under the specter of a "reservation of rights."

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Insurance Companies Have A Duty To Defend Whenever A Possibility Of Coverage Exists

Courts across the country recognize the duty to defend as being broader than the insurance company's duty to indemnify. Importantly, in most jurisdictions, the duty to defend is recognized as independent of the duty to indemnify, meaning that a company may be found liable for damages that are not covered under the policy, but is still entitled to have the insurance company cover the defense costs.

In determining whether an insurance company has a duty to defend, most courts look to the underlying complaint and the policy, but also look to whether an insurance company has actual knowledge of facts establishing a reasonable possibility that coverage may apply. Different states apply slightly different standards, but the general rule is that "[t]he duty to defend arises whenever claims asserted by the injured party potentially come within the coverage of the policy." *Regis Ins. Co. v. All American Rathskeller, Inc.*, No. 773 MDA 2007, 2009 WL 1483504, at *2 (Pa. Super. Ct. May 28, 2009). Other courts, such as courts in Connecticut and New York, look to whether the underlying complaint suggests a "possibility" of coverage. If there is any doubt as to whether the underlying complaint asserts or suggests a covered loss, that doubt is resolved in favor of the policyholder and for coverage. The broad duty to defend also requires that the insurance company defend all claims, even those outside of coverage, so long as any claim is potentially or possibly within the coverage of the policy.

Although the duty to defend applies even if the underlying claims are groundless, most states have held that the duty to defend expires if the underlying claim is narrowed to claims patently outside of coverage. Consequently, it is important for policyholders to stay apprised of motion practice and other developments within a mass tort case that may impact coverage for defense of the claims.

Recognize When Policy Exclusions Are Merely Red Herrings

Insurance companies often rely upon exclusions in an effort to avoid their obligations to defend their policyholders. An informed policyholder, however, will recognize when such arguments are simply red herrings. First, it is important to remember that the burden of proving that an exclusion applies falls entirely on the insurance company. This heavy burden requires not only proving that an exclusion applies, but also requires proof that any applicable exclusions apply to all of the claims asserted.

Second, even if the exclusion may apply to all of the claims, an insurance company must also demonstrate "that the exclusion is subject to no other reasonable interpretations, and that there is no possible factual or legal basis upon which the [insurance company] may eventually be held obligated to indemnify the [policy-

holder] under any policy provision." *Frontier Insulation Contractors v. Merchants Mut. Ins. Co.*, 91 N.Y.2d 169, 175 (1997). The high burden imposed by this standard presents a difficult challenge for insurance companies seeking to apply exclusions to deny the duty to defend.

Successfully Defending Policyholder Rights When A Reservation Of Rights Is Received

Most states recognize that if a conflict of interest arises between a policyholder and its insurance company, a policyholder is entitled to retain independent counsel, separate from counsel appointed by the insurance company, and the insurance company is obligated to pay for this independent counsel. The most common conflict of interest that arises is when the insurance company defends its policyholder under a reservation of rights. In this circumstance, a policyholder should consider whether the insurance company will steer the defense of the underlying action in a manner adverse to the policyholder, such as by settling or defending claims in a manner that precludes coverage or following a defense strategy that ignores the damage to the company's goodwill. Under such circumstances, policyholders should immediately seek independent counsel or, at a minimum, consult independent counsel. If a policyholder in fact retains independent counsel, its insurance company should pay the costs incurred for that retention.

Conclusion

With the risk of increased and protracted litigation facing many industries following President Obama's May 20, 2009, Memorandum, policyholders likely will see increased mass tort product liability claims in state and federal courts across the country. The protracted and expensive nature of mass tort suits may threaten a company's very existence as a profitable enterprise. In order to protect against this threat, a policyholder must be aware of its insurance policies and, in case a claim is filed, secure an immediate and complete defense commitment under the applicable insurance policies. This defense must continue until: (1) the insurance company can conclusively prove the absence of any possibility of coverage under the policy; or (2) the limits of the insurance policy are exhausted.

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Competing Insurance Interests in Bankruptcy

By Joshua Gold

As bankruptcy filings rise in this prolonged economic downturn, insurance claims are becoming a focal point for the administration of debtor assets and liabilities. Many insurance claims that arise in bankruptcy — particularly D&O claims — give rise to conflicts issues between competing insureds.

A recurring question in bankruptcy proceedings is whether the benefits of a D&O policy are assets of the estate or personal assets of the insured officers and directors. Creditors of a bankruptcy estate have an obvious interest in keeping available as many assets as possible to satisfy claims. In the Enron case, a state attorney general tried to bar Enron officers and directors from tapping the defense cost insurance coverage of Enron's D&O insurance, arguing that to permit payment of defense costs would siphon off money from the estate that could be used to pay creditors' claims.

The question of whether a D&O insurance policy is property of the estate or the insured officers and directors becomes even more heated when the D&O policy expressly provides so-called "entity" insurance coverage to the company itself, as most now do. Some have argued that a D&O insurance policy which promises "entity" coverage transforms the policy into an asset of the bankruptcy estate with the potential effect of leaving the officers and directors "bare" in the event of litigation. While the bulk of the cases rendered thus far do not necessarily support this conclusion, the issue is still debated. Even insurance companies have seized on this debate as a marketing point for the sale of non-entity D&O coverage and so-called Side A policies.

In a bankruptcy, insurance benefits, like all other assets, become increasingly sought after by trustees, creditors and other claimants. Different groups of "insured" often vie for limited amounts under the D&O insurance before the well runs dry.

Policyholders in these situations should be aware of certain critical points of potential conflict. One is whether a priority of payments clause is contained in the primary or excess D&O insurance policies. These clauses typically provide a strict

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formula for divvying up policy proceeds, affording a coverage preference to non-indemnifiable claims first, followed by claims indemnified by the corporation, and then furnishing entity coverage last.

Priority of payment clauses can generate their own ambiguities, however. In particular, most such clauses purport to have no application until a "loss" exceeds the remaining limits of the policy. Accordingly, the timing of loss payments claimed under the policy often comes under dispute. To figure out whether the clause is triggered, can one extrapolate from a monthly or quarterly burn rate to determine when something such as defense costs will exhaust the policy? If so, can the priority of payments provision be triggered at that moment and require the application of the formula months before the policy limit is actually exhausted? Depending upon the competing interests in the policy, one side will argue yes and the other no. Very little guidance as to which side is correct is provided under the express terms of the clauses I have reviewed.

Also, a question may arise as to whether application of the clause is discretionary or automatic. Both forms exist. If discretionary, which insured has the discretion to invoke it? Typically, the corporation as "Named Insured" will have that right, but it may be charged that there is a conflict of interest even in that scenario, as current management might want to invoke it even if it would be in the entity's coverage interest not to.

Where a trustee in bankruptcy brings suit against current or former officers of the bankrupt company, a coverage battle with the D&O insurance company may ensue. Some D&O insurance companies argue that claims made by a trustee on behalf of the estate implicate and otherwise trigger the so-called "insured vs. insured" exclusion.

Most commentators and courts agree that the insured vs. insured clause is designed to prevent collusive lawsuits brought by one insured against another with the purpose of tapping D&O insurance proceeds to bolster the company's bottom line. Despite this historic rationale, too many D&O insurance companies have sought far broader applications – including a forfeiture of coverage for any lawsuit brought by a bankruptcy trustee. While cases have split on whether a trustee's claims against officers or directors of the company invoke the insured vs. insured exclusion, the majority of decisions rendered on this favor policyholders. As long as the trustees' suit is not collusive in nature, the exclusion should not apply to the insured officers and directors. Some recent D&O forms have sought to clarify this point and specifically except from the exclusion trustee claims.

Despite this, attorneys representing debtors 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.

More broadly, all parties to a bankruptcy with some claim on insurance assets must be aware of the ambiguities, the potential conflicts and the direction from which competing claims are likely to arise.

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