VOLUME 5 | ISSUE 1

Enforce

The Insurance Policy Enforcement Journal

IN THIS ISSUE

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

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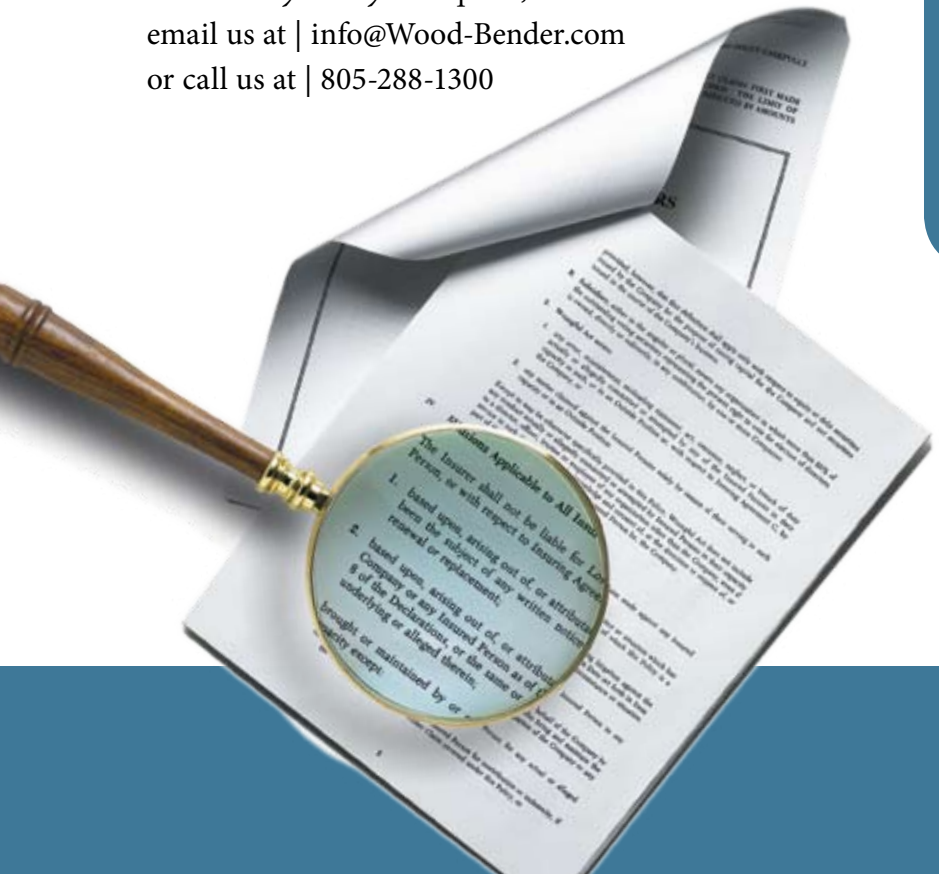

CASE STUDY

Serving on a regional bank's acquisition team in its purchase of a competitor, Wood & Bender LLP identified breaches of certain representations and warranties as a significant source of risk after closing. M&A insurance products were deemed too expensive, so we advised the client how to configure D&O tail coverage (covering the target's officers and directors for post-closing claims) to protect the buyer at a fraction of the cost. When a major breach of representations and warranties was discovered several years later, we represented the bank in litigation against the target's directors and officers, and compelled the D&O carrier to pay most of its policy limits.

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In this first issue of the fifth volume of *Enforce,*

The Insurance Policy Enforcement Journal,

we address a variety of issues of particular concern to business interests.

Our lead article, authored by Steven Spitz, General Counsel of Natrol, Inc., addresses allocation of risk between the manufacturer and the retailer. This edition also discusses the duties of insurance brokers, and when they can be held liable for their actions in procuring insurance.

The SEC is investigating, at last count, 140 corporations for alleged backdating of employee stock options. This edition contains a condensed version of a white paper written by firm attorneys about the coverage issues being raised by insurers in the firm's representation of targeted corporations, and about strategies for recovering different kinds of losses being incurred in these cases.

All companies buy liability insurance providing defense against third party claims conducted by "panel counsel" assigned by the insurer. Dave Shaneyfelt, Senior Counsel at Wood & Bender LLP, identifies in which states and under what circumstances a corporate policyholder may be entitled to retain a lawyer of its choice to defend third party claims.

In California, a recent decision by the Court of Appeal has narrowed a subcontractor's duties under a non-insurance indemnity contract. This decision, now under review by the California Supreme Court, is explained in this edition. On the back cover, we identify four hot topics that we expect to continue to be in play in insurance policy enforcement.

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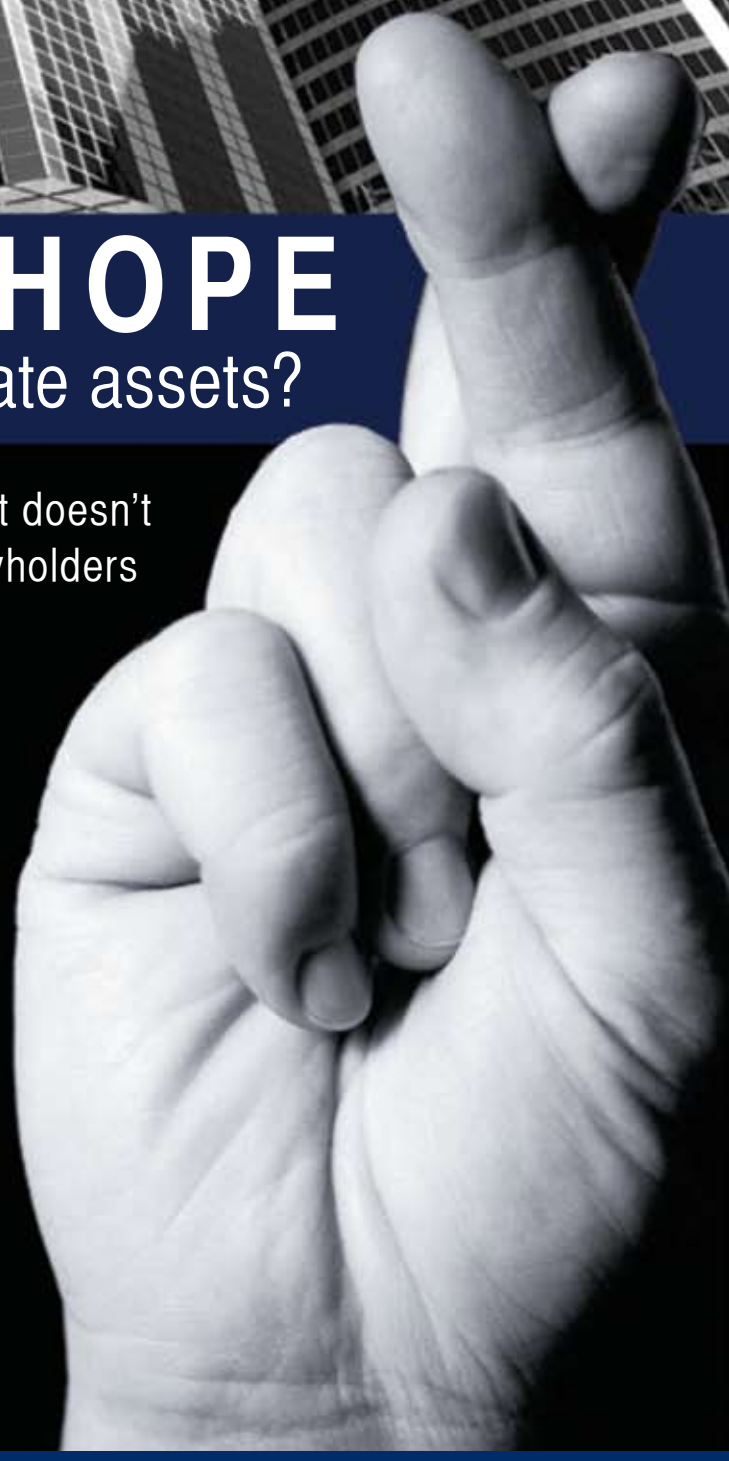

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Scratching Each Others' Backs:

Allocating Risk Between Product Manufacturers And Retailers

Steven S. Spitz,
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David E. Wood,
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We have all heard retailer promises like "satisfaction guaranteed or your money back" or "we stand behind everything we sell." Sales pitches like these work because they reassure the customer, providing a feeling of safety and reduced risk when making a purchase. While the customer may think the retailer alone is backing the product, the reality is that everyone in the chain of production and distribution does so, ending ultimately with the manufacturer. Indeed, most retailers require – as a condition to ordering a product – that its manufacturer agree (1) to defend the retailer and indemnify it for any loss, and (2) to maintain liability insurance under which the retailer is an additional insured. By these means, the retailer transfers to the manufacturer differing levels of risk associated with selling the product to the public.

By its agreement to defend and indemnify the retailer, the manufacturer takes on all risk having anything to do with the retailer's product distribution. This promise is backed by the entire net worth of the manufacturer – if a retailer needs defense and indemnity, the manufacturer must come out-of-pocket to respond. Retailer and manufacturer alike prefer, however, that as much of this risk as possible be transferred from the maker of the product to its general liability insurer. Why?

In the event of a problem with a product, the retailer does not want to have to fight with the manufacturer (which is not in the business of defending and indemnifying others) over the existence and scope of these contractual duties, or (more importantly) rely on the manufacturer's assets for protection. The retailer wants to deal with a professional provider of defense and indemnity whose financial condition is beyond question – an insurer. By the same token, the manufacturer wants to avoid an open-ended risk exposure hanging over its head, for which it cannot meaningfully set capital reserves. It would rather finance this risk by contracting with a company that models and assigns value to risk for a living, *i.e.*, an insurer.

So when a retailer asks a manufacturer to agree to defend and indemnify it in the event of a product-related liability, and to add the retailer to the manufacturer's insurance policy, here is what is really going on. While the manufacturer is contractually bound to back its product by defending and indemnifying the retailer, to the fullest extent of the manufacturer's assets, no one expects the manufacturer ever to have to pay lawyers, settlements and judgments from its own pockets to make the retailer whole. Both parties anticipate that product-related losses will be covered by the manufacturer's insurance, which will provide the retailer a defense and pay settlements and judgments.

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The last thing on anyone's mind is the possibility of the manufacturer having to come out-of-pocket to protect the retailer in the event of some catastrophe involving a product.

The defense and indemnity and additional insured provisions of retailer contracts have become virtually boilerplate. Many retailers do little more than make sure these provisions are in the agreement, then move on to more important issues like pricing and capacity. Yet the scope of insurance coverage for many kinds of products perceived as high-risk has been shrinking for years because of insurer reluctance to take on the potential exposure. For these products, manufacturers have been forced to retain large chunks of risk that in past years they insured in the commercial market. As the scope of insurance coverage narrows, the greater the risk retained by the manufacturer, and the more the retailer must rely on the manufacturer's assets – not those of its insurer – in the event of a catastrophic event. This means that, when a retailer contracts with a manufacturer using the same boilerplate defense/indemnity/additional insured language it has used for years, the retailer may think it has effectively transferred risk through the manufacturer and on to its carrier. In fact, it often has not.

Take for example manufacturers that make dietary supplements. In 2002 and 2003, many commercial insurers whose customers make such products began amending their liability policies to add exclusionary language along the following lines:

We won't cover injury or damage or medical expenses that result from Ephedra, Ma Huang, Ephedrine (including all related formularies with prefixes such as pseudo- and nor-), or Ephedrine HCL, otherwise known as, but not limited to Herbal Phen-Fen.

ADDITIONAL INSURED PROVISIONS PROVIDE SOME PROTECTION TO DOWNSTREAM RETAILERS AND SERVICE PROVIDERS, BUT ONLY FOR LOSSES WITHIN WHAT MAY BE A NARROW SCOPE OF COVERAGE.

This left the manufacturer insureds with a choice: to produce and sell ephedra-based products without insurance to protect them (and their retailers) from liability exposure, or to stop producing these products entirely. Most manufacturers stopped making the products.

But note that any producer that continues making and distributing ephedra-based products to its retailers likely is *not* in breach of its agreements with retailers – even though its retailers are completely uninsured for losses involving ephedra-based products going forward. Why? Because retailer agreements usually require only that the manufacturer defend and indemnify the retailer, and add it as an additional insured to its liability policy. These agreements rarely require the manufacturer to maintain a specific scope of coverage. Therefore, even if the manufacturer's policy is endorsed within an inch of its life, narrowing coverage to a shadow of its former self, the fact that the policy exists and names the retailer as an additional insured usually is enough to satisfy the manufacturer's contractual duties.

No one would argue that this scenario offers the retailer any useful liability protection. The retailer's only recourse in the event of a product liability suit involving the ephedra-based product is the manufacturer's contractual obligation to defend and indemnify the retailer. Without any insurance coverage backing this promise, the retailer will find itself looking solely to the manufacturer's uninsured assets for liability protection. This is not where a retailer wants to be.

Retailer Audits

To avoid this situation, some retailers are going back to their manufacturers and asking to audit their insurance policies to see the scope of coverage they provide. These retailers want to know how much liability protection they really receive from their manufacturers' policies. As retailers become more proactive in evaluating the quality of manufacturers' insurance programs, several areas of concern are emerging.

First, a retailer may not know enough about insurance to effectively evaluate its manufacturers' liability coverage or may not have the capacity to perform an annual audit of all its manufacturers' policies. For a small retailer, employing a professional risk manager fluent in the intricacies of insurance may not be feasible. Even for a retailer with a capable risk manager, reviewing the insurance policies of every one of the sometimes thousands of manufacturers with whom a large retailer does business can be daunting. Many risk managers simply do not have the time to do this job themselves, and outsource the job to firms that specialize in insurance policy audits.

The goal should be to get a good idea of what kind of coverage a manufacturer has *before* renewing a purchasing agreement. The retailer wants to (1) assure itself that there are no deal-breaker exclusions or other limitations on coverage; (2) give the retailer the opportunity to insert into the agreement an available form of coverage it would like the manufacturer to have; and (3) require the manufacturer to give notice of any material change in or cancellation of the policy. It is prudent to perform an annual review of manufacturers' policies thereafter.

The retailer that continues to rely on boilerplate defense/indemnity/additional insured language in distributor agreements is taking on a whole new kind of risk: the chance that when the retailer eventually needs a defense and indemnity in a products liability suit, its manufacturer will be uninsured for the particular product or risk involved in the litigation, leaving the retailer's sole source of recourse the manufacturer's own assets.

Second, not all insurance companies are created equal, and some – though not all – have corporate cultures that encourage their front-line personnel not to pay claims. Some retailers have learned this the hard way, when they tendered a products claim to a manufacturer, who tendered to its carrier, only to spend the next few years wrangling with the insurer over whether the claim is covered. Standard general liability policies contain exclusions that attempt to carve common business risks out of the scope of coverage, and some carriers interpret these exclusions more aggressively than others. Some retailers retain the right to reject the manufacturer's choice of insurers where poor claims service has led to what the retailer perceives as unfair use of such exclusions.

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Third, many manufacturers of products perceived as high-risk are discovering that broad liability coverage is no longer available. As each particular brand of products liability litigation develops, the manufacturer will have coverage for occurrences happening in the policy period then in effect – but will lose that coverage when its carrier amends the policy on renewal to add an endorsement specifically excluding that risk.

For example, a gasoline refiner would have sold unleaded gas from 1979 to 1995 unaware that it faced product liability exposure for MTBE, and would expect its insurer to defend and indemnify it when it was sued for product liability thereafter. The insurer likely would do so – then, on its next renewal, exclude MTBE-related risk on a going-forward basis, leaving the insured uncovered for all occurrences taking place beyond the expiration of the policy then in effect. In short, while the refiner gets coverage for the first suit in a wave of product litigation, it loses coverage for everything after that.

This kind of "insure and retreat" approach to underwriting is maddening to manufacturers. Only the largest companies, with the most substantial resources and the greatest bargaining power in the insurance markets, can achieve any continuity in their general liability insurance programs. For some smaller manufacturers, the unavailability of consistent, predictable liability insurance is the setback that leaves them without a safety net, or pushes them out of business entirely.

A policy with an SIR requires the insured to remain responsible for a liability up to a designated amount, after which the insurer will be liable.

Manufacturer Alternatives

Other manufacturers mount a different, more creative response to the absence of reliable liability coverage, exploring alternatives to traditional, first-dollar insurance *i.e.*, policies that start paying defense and indemnity without any layer of insured's financial responsibility.

High Self-Insured Layer

Some manufacturers purchase insurance policies subject to high self-insured retentions or "SIR's." A policy with an SIR requires the insured to remain responsible for a liability up to a designated amount, after which the insurer will be liable.

Policies with high SIR's are really excess policies. Until the manufacturer has exhausted the amount of its SIR, its insurance carrier has no duty to defend or indemnify. Unless the excess policy provides otherwise, the policyholder must bear its own defense costs until the amount of litigation costs exceeds the amount of the SIR. Under many policies with high SIR's, the excess insurer controls the defense of the policyholder, investigating the claim, assigning defense counsel, making settlement decisions, etc., just as if it was a first-dollar carrier – except that it sends all bills (including, sometimes, the insurer's internal costs of loss adjustment) to the policyholder for payment up to the amount of the SIR. Thus, choosing which plan best suits the individual company requires analysis of the costs and risks unique to that business.

The upside of high SIR's for a manufacturer is that they allow the policyholder to increase control over liability exposures and to reduce their excess insurance premiums. The downside is that they force the manufacturer to become a liability claim professional – for both itself and its retailers. Unless the manufacturer can demonstrate to its retailers that it is proficient in adjusting liability claims, and has the assets to satisfy its SIR, this alternative to traditional, first-dollar insurance may not save any money in the long run.

Fronting Policies And Finite Risk Programs

Manufacturers in industries perceived as high-risk often pay whopping premiums, only to find their coverage constricted or cancelled quickly when new strains of liability suits emerge. Many of these manufacturers find themselves pondering how much better off they would have been had they simply placed the money they paid in premiums over the past 10 years into a reserve account.

Some manufacturers are doing just that, but instead of tucking the money under the mattress, they are forming their own insurance programs – with broad coverage for themselves and their retailers – funded by their premium dollars. Just putting premiums aside is not the same as having insurance: when a claim arises, it must be adjusted properly, defense counsel must be hired and directed, and claims must be tracked for risk management purposes. Under a finite risk program, the insured pays a substantial amount of capital to a fronting insurer, which deposits the money into a segregated account. These funds are paid out by the fronting carrier according to the terms and conditions of the insurance policy the insured provides or selects up front. The only reason to fund a finite risk program is to get coverage broader than that available in the commercial market, so product manufacturers tend to design policies for themselves that have few exclusions.

Finite risk programs can be attractive from the retailer's point of view. Where the manufacturer has commercial insurance, the retailer has recourse to the carrier only to the extent of the narrow scope of coverage. By contrast, where the manufacturer has capitalized a finite risk program with broad terms of coverage, the retailer usually receives better coverage than it would under a commercial policy. Because the fronting carrier generally requires a very significant capital infusion at the outset of a finite risk – exceeding the proposed policy limits – the solvency of the program rarely is a concern.

Captive Insurers

Sometimes a manufacturer has a single item of risk (liability coverage for a single line of products, for example) that cannot be insured in the commercial market in a cost-effective way (meaning insurance is not available or is prohibitively expensive). In this situation, one option is to form a captive insurance company set up for one purpose only: to cover the establishing entity for the single item of risk for which attractively-priced coverage is unavailable from mainstream insurers.

A captive insurer is a wholly-owned entity formed in some location (often offshore) whose regulatory climate is favorable to insurers. Bermuda, the Cayman Islands and the Bahamas are popular spots because these jurisdictions have lower paid-in capital and surplus requirements than most domestic venues, although twenty-one states (as of this printing) have passed legislation to attract captives. As a result, a business can set up an insurance company under some circumstances with no more than a few hundred thousand dollars in capital, without running afoul of insurance regulations. As with a finite program, forming a captive gives the insured manufacturer a free hand in designing the policy terms it wants (instead of accepting the only terms a commercial insurer will offer).

Another solution can be to use the more relaxed regulatory environment of a foreign country or a captive-friendly state to exert greater control over, and provide greater flexibility to, an adequately capitalized captive.

For manufacturers looking to give their retailers peace of mind about the availability of product liability coverage when claims arise, trying to save money by insuring this exposure via an undercapitalized captive insurance company is an unsatisfactory option. Another solution can be to use the more relaxed regulatory environment of a foreign country or a captive-friendly state to exert greater control over, and provide greater flexibility to, an adequately capitalized captive. One of the largest expenses a commercial insurer incurs (and includes in the policyholder's premium) is the cost of legal bills and other claim expenses. Sometimes, inadequate care is taken in controlling these expenses through careful claims administration. If claims are handled aggressively and legal bills and other losses controlled to the fullest extent possible, a captive insurer over time can effectively reduce the cost of insurance – the real reason why the captive was formed in the first place.

To achieve this result, the manufacturer must do a better job handling claims than a commercial insurer does. For a manufacturer who does not wish to take on this challenge (or who sells to retailers that would prefer that the manufacturer stick to its core business), this is not the right alternative. But handling claims is not rocket science, particularly if the claims are limited to one or a handful of products. Some manufacturers can and will do well at managing claims administration expenses, and for them, a captive insurer can be an effective means of covering hard-to-insure product liability risks.

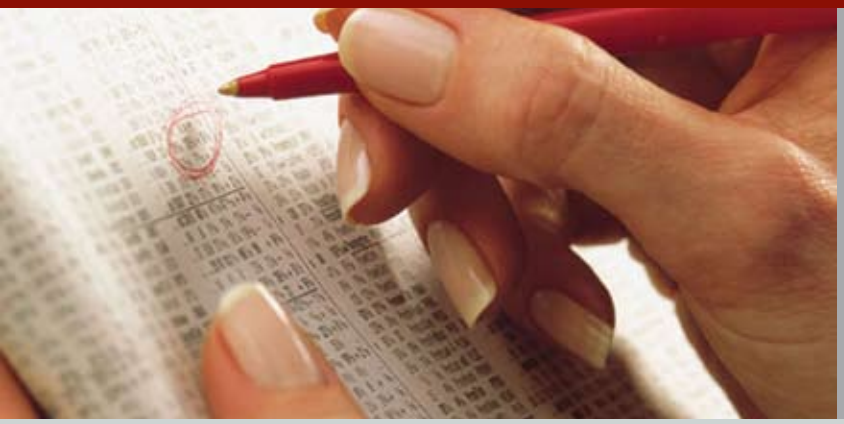
Conclusion

Whatever combination of options is ultimately chosen, the important points to make are that the retailers must undertake the analysis of the true state of their liability protection and that the manufacturers must explore insurance alternatives when their own assets are potentially placed at risk.

By working together – gaining a more complete understanding of their actual liability insurance protection, modifying their supplier contracts to reflect the true allocation of risk and plugging any coverage gaps – manufacturers and retailers can scratch each others' backs and reach an adequate allocation of liability risk that both parties can live with.

Steven S. Spitz is Vice President and General Counsel for Natrol, Inc. Natrol manufactures nutritional products and has received an A rating by the National Nutritional Foods Association. They currently market more than two hundred nutritional products nationwide and in select foreign countries. Mr. Spitz is a graduate of Columbia University School of Law.

Stock Option Backdating Claims: *Are They Covered?*



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(This article is condensed from a white paper on gaining insurance coverage for employee stock option backdating claims, which is available from Wood & Bender LLP upon request.)

Since late 2005, the practice of backdating employee stock options ("ESO's") has resulted in thousands of government investigations and lawsuits, criminal proceedings, and private lawsuits brought by shareholders and corporate employees.

The SEC and Justice Department have initiated informal or formal investigations into alleged ESO backdating at a substantial number of companies. Some of these investigations have culminated in the filing of civil lawsuits against corporations, and the directors, officers and other employees (collectively, the "D&O's") alleged to have participated or been complicit in the ESO backdating. In rarer instances, criminal proceedings have been initiated against a limited number of D&O's alleged to have engaged in criminal conduct related to ESO backdating.

As should be expected, plaintiffs' attorneys have filed "piggyback" suits against the targets of government investigations. Most of these suits have been brought as derivative actions, in which the D&Os' purported ESO backdating is alleged to have caused harm to the corporate entity. Also relatively common are shareholder suits brought against the corporate entity and individual D&O's, in which plaintiffs seek redress for a loss in the value of their holdings. A third variety of suits allege violations of employee benefits law, such as the Employee Retirement Income Security Act.

Irrespective of the specific claims, counts or causes of action asserted, plaintiffs in these suits typically seek monetary and equitable relief under a variety of theories. Plaintiffs argue that liability should be imposed on the D&O's based on their alleged direct involvement in the backdating of ESO's, their alleged actual or constructive knowledge of this practice, or their alleged participation in "insider trading." These suits often assert that even those D&O's who did not personally backdate or receive backdated ESO's are liable on account of being complicit with those who personally participated in the alleged misconduct.

OVERVIEW OF INSURANCE COVERAGE ISSUES

Most corporations carry insurance that should cover most of the losses incurred as a result of alleged ESO backdating. Directors' and officers' liability policies ("DOLP's") and fiduciary liability policies ("FLP's") are the policies most likely to afford coverage for ESO backdating matters. Expenses associated with claims of ESO backdating can quickly exceed $10 million, with the total potential exposure far exceeding that amount. As a result, insurers can be expected to try to limit their exposure to these losses, and to aggressively pursue all available means of achieving this goal. The specific manner in which insurers will attempt to limit their exposure to ESO backdating will depend, as always, on the nature and facts of the underlying ESO matters and the language of the implicated policy.

Insurers appear to be adopting common claim strategies and tactics in ESO backdating matters, as follows:

Internal Investigation Expenses

Insurers have reflexively declined coverage for costs incurred in connection with internal investigations most corporations have undertaken. In doing so, insurers fail to take into account the overlap between work performed in connection with the internal investigation and work performed, or would otherwise need to be performed, in connection with government investigations and securities suits. The facts supporting this argument vary from case-to-case, and developing these facts often requires close work between and among the various firms working for the impacted company.

Government Investigation Expenses

As respects defense costs incurred in connection with government investigations, insurers have been declining coverage on grounds that the investigations do not "target" "Insured Persons," or that there is no evidence the investigation is "formal," as is required by many DOLP's. Insurers advancing these arguments often turn a blind-eye to the fact that most government investigations are conducted under a near absolute veil of secrecy.

Shareholder Litigation

In coverage disputes related to private suits, insurers have been taking a fairly hard line stance on claims they regard as "restitutionary in nature," which are not insurable in most states. Similarly, insurers are commonly taking the position that claims involving allegations of intentional or fraudulent conduct are not covered either. Insurers taking these positions are attempting to capitalize on the intimidation tactics and vitriol employed by plaintiffs' attorneys – which are often

manifest in claims of fraud and disgorgement – accompanying many of the ESO backdating matters.

Notably, a common tactic employed by insurers is to take the position that claims for restitutionary relief or intentional conduct do not fall within the DOLP's definition of "Loss." Insurers do this to circumvent exclusions for restitutionary relief or intentional conduct, which often require an "actual adjudication" or finding "in fact" of an improper benefit or fraud, and in an attempt to shift the burden of proof to the insured. Yielding to an insurer on this position, which in most cases is unsupportable, can result in the loss of a significant portion of the coverage provided by a DOLP.

The insurer's ability to successfully advance these contentions depends, in part, on the specific language of the implicated policy. Definitions of terms such as "Claim," "Loss," and "Wrongful Act," as well as the specific exclusions issued in a policy, may contain language that includes or excludes coverage for the types of relief sought in ESO backdating proceedings, the types of claims advanced in those proceedings, and may otherwise impact the existence of coverage. Thus the importance of reading and understanding the specific provisions of the insurance policy in question cannot be over-emphasized.

Rescission

An insurer may rescind an insurance policy (i.e., return the premium, and behave as if the policy had never been written at all) where the insured makes a material misrepresentation in obtaining the coverage, on which the insurer relies in issuing the policy. In many states, the misstatement can be a simple mistake: as long as it is material to the underwriting decision, and the insurer relies on the misstatement, the remedy of rescission is available. However, "severability" provisions can, in many cases, limit the insurer's ability to rescind or void the policy only as to those insureds with knowledge of the misrepresentation, as opposed to all insureds.

In investigating claims, insurers will closely monitor allegations made and facts developed for anything which may support a rescission claim. This is especially true where an insured restates a prior-year financial statement submitted with an application. In these situations, insurers often contend that the mere act of restatement is an admission of a material misrepresentation in an application. However, insurers may also attempt to use alleged misrepresentations in financial statements as a basis for rescission, even in the absence of a restatement. In the context of an ESO backdating claim, the most significant rescission risk often comes from historical financial statements incorporated into the applications for D&O Policies and Fiduciary Policies which might need to be restated.

A potential loss of insurance coverage cannot serve as a reason not to restate financial statements, but it is one additional factor to bear in mind when investigating allegations of backdated ESO's, and the accounting for them. Care should be taken to ask whether a restatement is necessary to correct a past material misstatement of a company's financial condition. If so, this could serve as a basis for rescission of any coverage purchased via application to which the pre-restatement financial statements were attached. Conversely, if a restatement seeks to make the company's financial condition more transparent, this is not necessarily an admission that the financial statements to be restated materially misrepresented the corporation's financial condition in the first place. There are many reasons to restate financials that are not reflective of material misrepresentations in the original ones.

WHAT CORPORATIONS CAN DO TO PROTECT AND ENHANCE COVERAGE

The corporate policyholder can also be proactive and take steps to avoid or mitigate the insurer's ability to limit or deny coverage. First, before such a claim ever arises, the corporation should be sure when purchasing or renewing coverage that the form of policy under consideration has favorable provisions. For example, "final adjudication" or "in fact" language in the exclusionary provisions related to improper benefits or intentional conduct, discussed above, is important. As are "severability" provisions which actually prevent imputation of knowledge of misrepresentations from one insured to another. Another key provision for public companies is the definition of "claim," which should include government investigations. However, it should be kept in mind that very slight differences in policy language can mean the difference between coverage and no coverage, and all provisions in proposed or specimen policies should be examined very closely in the context of the insured's business risks.

After a claim arises, the corporation must be prepared to deal with its insurers, and must create and employ a strategy that proactively minimizes or eliminates potential coverage issues. To maximize its effectiveness, that strategy should be put into practice as soon as the corporation learns of an existing or potential lawsuit or investigation, and before it notifies its insurer of that lawsuit or investigation. This notice will set the tone for all future dealings between the corporation and its insurer, and it is therefore imperative that this notice contain a description of the underlying facts that is accurate and complete as may be allowed by the knowledge then available to the corporation.

In complex claims that raise a host of complex loss definition and coverage issues (like ESO backdating claims), it is critical that the facts of the claim be presented to the insurer in a manner that "heads off" coverage issues wherever possible. For instance, where a derivative suit demands on behalf of the corporation restitution from senior management of undisclosed, backdated option grants, report this to the insurer while pointing out that no evidence suggests that the recipients reasonably believed the options were improper, which would foreclose any claim for equitable disgorgement of the ESO's to the corporation. Call to the insurer's attention that if there were any exposure arising from this claim (which presumably the insured officers deny), it would be for damages based on breach of fiduciary duty or some other claim at law – not an equitable claim arguably excluded from the definition of "loss" under the policy.

The corporation should assume that each of its insurers will disagree with that conclusion and will provide written notice that it is denying coverage or reserving its right to do so. In anticipation of this, the corporation should be prepared to provide an immediate response to some or all of its insurers, and should include in that response a more detailed discussion of the issues raised in the insurer's letter. In any event, presenting the facts of the claim in a manner most conducive to coverage from the outset can have an anchoring effect, allowing the insurer to establish the parameters of a coverage dialogue going forward.

Finally, the corporation should perform, early and often, a "risk vs. benefit" analysis of the potential settlement of any ESO backdating lawsuits. That analysis should take into account, among other factors, (1) the monetary amount, if any, the corporation may be called upon to contribute toward that settlement; (2) the fact that settlement would preclude any judicial determination of fact or law upon which an insurer might be entitled to rely to deny coverage and seek reimbursement of defense costs; (3) the fact that settlement would deprive the corporation of the opportunity to vindicate itself; (4) whether a settlement can be structured to also resolve any disputes between the corporation and its insurer(s); and (5) whether it is then in the corporation's best interest to resolve any disputes between it and its insurer(s). Defense counsel should be involved in this analysis only if the corporation has exercised its right to assume its own defense.

CONCLUSION

As of this writing, SEC investigations into alleged ESO backdating continue to gain momentum. In the renewal process, insurers are becoming sensitive to the potential for litigation and claims arising from these investigations. They are asking direct questions about ESO programs and grants, and comparing them to public disclosures. ESO backdating issues are on underwriters' "radar screens." Policies are being written with this exposure in mind, even though the vast majority of claims based on allegations of ESO backdating have yet to be resolved. In short, insurers are positioning themselves to avoid catastrophic insured losses arising from ESO backdating claims, by beginning to define the boundaries of coverage they feel is warranted.

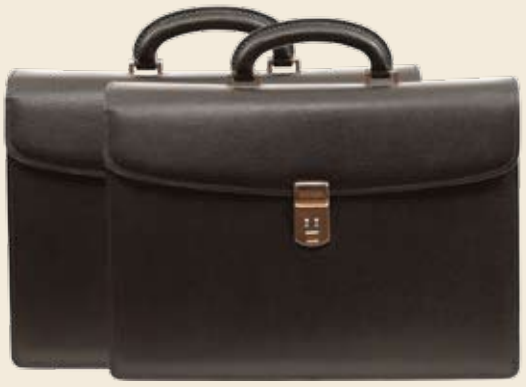
Very recent experience teaches that the scope of coverage these insurers think is appropriate for such claims is significantly narrower than the scope of coverage that corporate policyholders and their advocates believe is correct. Thoughtful planning and careful execution are a must if the insured is to shape the coverage landscape to its advantage, and weather the storm caused by the advent of this kind of liability claim.

When Your Insurance Carrier Must Provide You A Second Attorney:

Appointing No. 2 To Look Out For No. 1

David A. Shaneyfelt
Senior Counsel
Wood & Bender LLP

(First of a two-part series)



Your company bought a liability insurance policy to pay for an attorney to represent it should someone file suit against the company or its employees. Someone then files suit against your company or your employees, and you tender the suit to your carrier for defense. Your carrier says it will appoint an attorney to defend the suit, but under a "reservation of rights." What exactly does that mean? Might you lose your coverage?

If you do not know the answer to these questions, you are not alone. Many policyholders – and the attorneys who regularly represent them – do not know the implications of an insurer's "reservation of rights," and are content to think that their interests are being protected because, at least in the short term, the carrier has appointed them an attorney. Sometimes, their interests will be protected by insurer-appointed defense counsel. But sometimes they won't.

Knowing what to look for when your insurer agrees to undertake your company's defense under a reservation of rights will be key to understanding whether its interests are indeed protected. When these interests are not sufficiently safeguarded, many states allow you to insist that your insurer pay for a second, independent attorney to fully defend your company's interests.

A RESERVATION OF WHAT?

A liability carrier confronted with a potentially covered lawsuit filed against its insured will agree to defend the insured in one of two ways: it will defend under a reservation of rights, or without a reservation of rights. When the insurer defends without a reservation, it is agreeing to pay all legal fees necessary to defend the policyholder in the action, subject only to the insured's payment of any deductible or self-insured retention and the policy limits. The carrier concedes that it has no reason to warn you that it might someday deny coverage if the suit turns out in a particular way. As a result, there is no conflict between your company's interests and those of the insurer: no matter what happens, a settlement or judgment will be covered (in excess of a deductible or retention, up to the policy limits). Because the policy has what is called a "duty to defend," the insurer must select an attorney to defend your company in the action. Because the goals and desires of the insurer and the insured are fully aligned, the defense lawyer need not worry whether the way the lawyer handles the case might push it toward or away from a non-covered result. This assures your company an unbiased defense.

On the other hand, when your insurer agrees to defend your company, but reserves the right to withdraw the defense and refuse paying any settlement or judgment if events unfold in a certain way, there may be trouble on the horizon. A carrier that defends under a reservation of rights is not fully protecting its insured. Rather than stand behind the policyholder come what may, the insurer stands off to one side, ready to bolt as soon as it finds the evidence it needs to deny coverage. The insurer-selected defense attorney is the gatekeeper of the evidence, the one responsible for developing and presenting it, and the one most likely to be able to influence whether the

case has a covered or non-covered outcome. Even if this lawyer is entirely well-meaning, the conflict with which the lawyer is saddled means that, even if you think your company is being fully and zealously protected by counsel loyal only to you, the reality may be radically different.

THE FOLLOWING SCENARIOS ILLUSTRATE THIS PROBLEM

Scenario 1:

One of your truck drivers is involved in an accident, having been charged with driving under the influence of alcohol. The victim files suit against your driver and your company, alleging negligence and intentional acts. Most likely, your policy would provide a defense against the negligence claims, but not against the intentional tort. (Indeed, most states prohibit insurers from insuring against intentional torts on grounds that it would further bad public policy to allow intentional tortfeasors to obtain coverage for inherently wrongful conduct.) In that case, your carrier likely would agree to defend the suit against the accident victim, but would reserve its right to deny coverage (and potentially seek reimbursement from you for defense costs it paid) if your driver is found to have acted intentionally.

Scenario 2:

Your construction company is sued for various building defects on a project. Some of the alleged defects are for matters plainly covered under your insurance policy – for example, poor workmanship causing property damage to the work of others (like a bad weld that causes a pipe to burst, resulting in water damage elsewhere on the property). Some of the alleged building defects are for matters plainly not covered under your policy – for example, shoddy workmanship that does not cause property damage (like painting a wall the wrong color, or installing a prefabricated staircase backwards). Your insurer agrees to defend against the suit, but reserves its right to deny coverage for a settlement or judgment entered against you that is attributable to any of the non-covered claims (and potentially, to recoup defense costs).

In both scenarios, the carrier agrees to defend the suit, while reserving the right to deny any duty to pay future defense costs or a settlement or judgment should the facts turn out a certain way, that is, if the evidence shows that your driver committed uninsurable intentional conduct (as in Scenario **1**) or that plaintiff's losses are from pure construction defects only, and not from damage to property (as in Scenario **2**). If the insurer defends your company under a reservation of the right to withdraw coverage in the event of these results, your company is on a slippery slope. It can do nothing but hope that the insurer-selected attorney defends the non-covered claims, shifting any liability exposure to covered theories of action. Or your company can insist that the insurer pay an independent defense lawyer to protect your company's interests by trying to steer any liability exposure (consistent always with good faith) to a covered result. Why would you choose this second option?

INDEPENDENT ATTORNEY OWES NOTHING TO THE INSURER

In both scenarios the insurer-selected attorney is representing your interests. But in both scenarios, your attorney could also be representing your insurer's interests.

What if, under Scenario **1**, the insurer-appointed defense lawyer reflexively steers the facts, discovery and argument away from the covered negligence theory and, indirectly, toward the non-covered intentional tort theory? If this happens, your company would be on the hook for the intentional tort and your insurer would minimize its expenditures. That strategy would benefit your insurer and harm you.

What if, under Scenario **2**, your attorney argues that the owner's damages are due to construction deficiencies, not property damage? In that case your company would be on the hook for the claim; your insurer would not. Again, your insurer benefits; you lose.

Remember, your insurer is agreeing to pay the attorney to represent you. When it comes to a settlement or judgment in your case, your carrier has every incentive to pay as little as possible on your behalf. At the same time, the attorney appointed to defend you is likely getting repeat business from your insurer. Insurers typically refer cases to a group of attorneys listed on a "panel" from which the insurer draws in selecting defense counsel for suits filed against insureds. These lawyers are, for that reason, referred to as "panel counsel." Such attorneys have primary relationships with the carriers who feed them. You, on the other hand, are unlikely to see the defense lawyer again once the case is over. Panel counsel, therefore, has natural incentives to please a carrier who sends them case after case.

In many states, a "tripartite" relationship is said to exist between the insurer, the panel defense counsel, and the insured, in which panel defense counsel is deemed to represent both the insurer and the insured. Where the carrier defends under a reservation of rights and the panel counsel has the theoretical ability to push the case toward a non-covered outcome, there is now a conflict of interest between the interests of insurer and insured, and the interests of the lawyer's two clients now do not align. The defense attorney's ethical duties expressed in rules of professional responsibility and common law prohibit the lawyer from representing one client over another – even if the lawyer gets substantial repeat business from one client (the carrier) and none from the other (the policyholder).

To cure this conflict, the carrier must appoint at its expense independent counsel to defend the insured in a manner protective of its right to coverage. The rationale for this rule lies in the ethical prohibition against the attorney's dual representation of clients with conflicting interests. Where this conflict potentially cripples a defense attorney's ability to provide the insured an unbiased defense, the insurer must pay for a new defense lawyer aloof from that conflict. Indeed, some states are willing to find that such a conflict exists solely from a carrier's undertaking of defense obligations under a reservation of rights.

THE ATTORNEYS APPOINTED BY YOUR CARRIER HAVE NATURAL INCENTIVES TO PLEASE THE CARRIER THAT FEEDS THEM

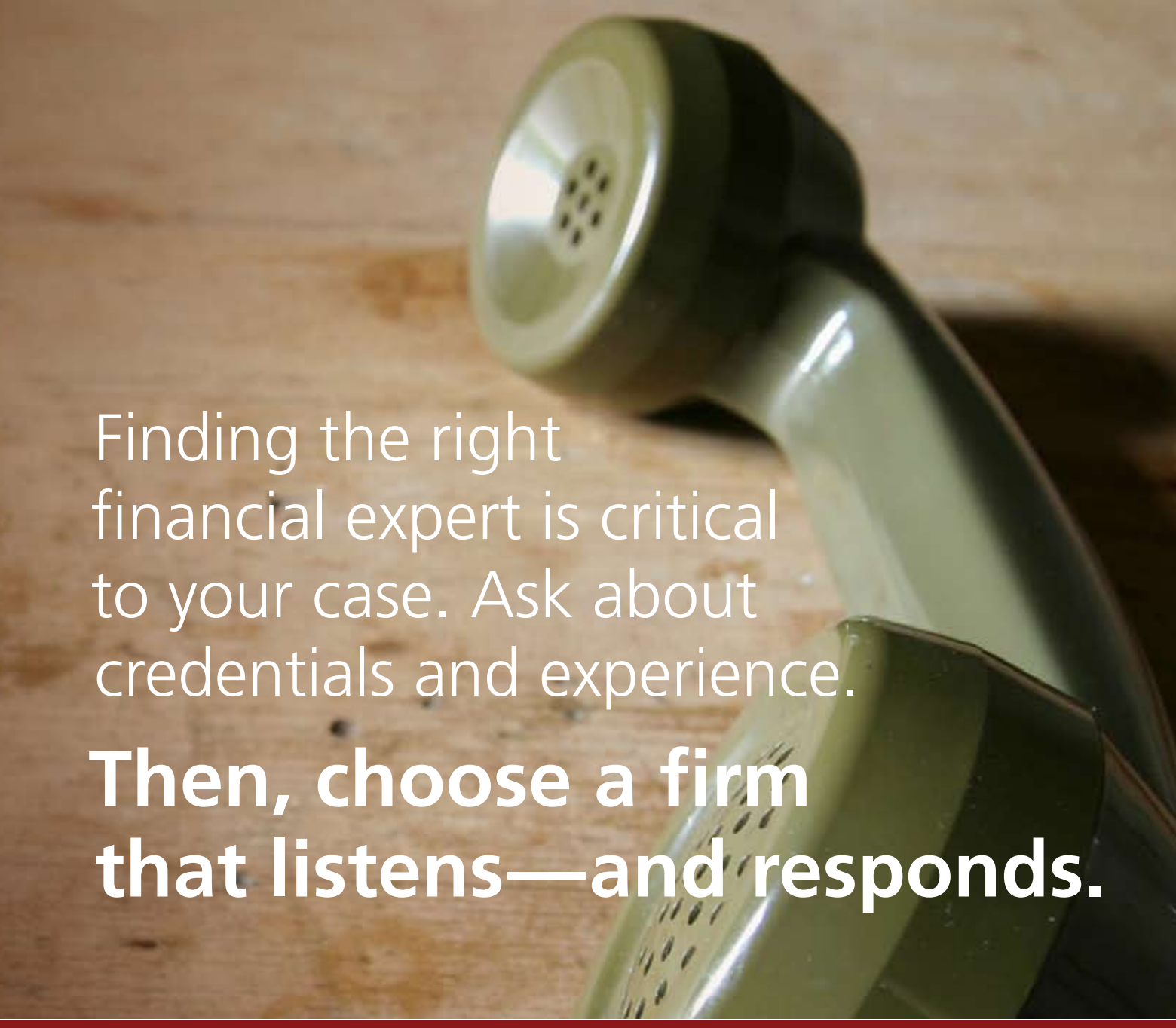
Other conditions and kinds of conflicts may also justify the appointment of independent counsel, such as when an insurer is covering multiple policyholders with adverse interests in the same litigation. Even when a particular state requires the insurer to pay an independent attorney to protect the insured, carriers are often only required to pay independent counsel at hourly rates comparable to those of the insurer's regular panel defense counsel – whose rates may well be tied to the volume of business they receive from the insurer. It pays to know what your state allows when an insurer defends your company under a reservation of rights, so you can request independent counsel if your company is so entitled.

CONCLUSION

None of this is to suggest that the attorney appointed by the insurer to defend the insured is sinister or malevolent. Very likely the attorney is not. Nevertheless, the law in many states recognizes the bona fide conflict of interest that can exist when an attorney appointed by an insurer has every incentive to minimize defense expenses and avoid payment for non-covered claims, while a policyholder has every incentive to maximize benefits under the policy.

For this reason, you should take care to scrutinize not only your insurer's particular reservation of rights, but the particular claims made against your company. The difference could mean allowing your insurer to shift the entire burden of the suit to you.

(Part II will appear in the next issue: State-By-State Analysis.)



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Insurance Broker Malpractice:

Pitfalls Arising Out Of The Broker-Client Relationship

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Traditionally, many corporate policyholders hired insurance brokers to purchase insurance with varying degrees of client involvement. The company risk manager would focus more on risk modeling and less on the nuances of coverage, relying on the broker to analyze the required policies and present options.

As the scope of insurable liability and losses has increased, and the cost of coverage has risen, these corporate policyholders have asked their risk managers to get more involved in buying decisions. They in turn have asked their brokers to provide a higher level of service, advising them about the complexities of definitions, exclusions and other terms that govern the scope of coverage under business policies. In response to the press of competition, many brokers offer a broader scope of services. As a result, when something goes wrong, clients increasingly see their brokers as a source of recourse for losses caused by actual or perceived breaches of the standard of care.

This article addresses the evolving legal standard governing insurance brokers' duties to corporate policyholders.

The Minefield

The changing landscape in insurer practices motivates corporate policyholders to draw their insurance brokers into litigation concerning coverage issues. The coverages available are increasingly complex, and carriers sometimes deny claims on very technical grounds. In the face of an uninsured loss, policyholders sometimes look to the one who recommended the coverage as a potential source of recovery. If the technical coverage defense is the result of broker error, this may fall below the standard of care prevailing in the broker community.

This standard of care can be made more stringent by a broker's own conduct. Competition drives brokers to try to add value for clients, such as offering advice on coverage issues that a client may not have asked about. When a broker does this, he or she automatically assumes a duty to make the advice correct – and is liable if it is not – even if the broker would not have been required by his or her professional standard of care to advise about it in the first place.

The Legal Standard

A broker's duties range from assembling policies to create a wall of protection around the client, to reviewing existing policies for gaps in coverage, to reporting claims to insurance carriers and advocating for payment. The standard of care – meaning the minimum level of competency a broker must deliver in rendering services – is established either by operation of law, or by express agreement or action. The broker's liability does not end at failing to carry out a seemingly perfunctory task with a requisite standard of care. A broker can also be held liable for what he or she does not tell his or her client. In jurisdictions that recognize a cause of action for professional negligence against a broker, brokers are potentially liable for any mistakes that would give an insurance carrier a viable basis for denying coverage.

Insurance brokers have been held liable to insureds on numerous theories including breach of contract, professional negligence, and negligent misrepresentation. At a minimum, the liability of a broker is premised on breach of an oral or written agreement to obtain insurance as requested by the client.[1] The legal standard of care varies among jurisdictions. For example, in New York, insurance brokers are not deemed to be "professionals" in the first instance. As a result, actions against insurance brokers are governed by the statute of limitations for breach of contract claims, not a limitations period for professional errors and omissions.[2] Maine and Vermont also adhere to the notion that insurance brokers are not professionals, and also do not recognize actions against them for professional negligence.[3]

Other jurisdictions, however, are in stark contrast and, over time, have heightened the duty of care owed by a broker. In California, a broker that secures a policy for a client is deemed to act exclusively for his or her client, the insured, by operation of law.[4] The function of a broker is to represent insureds in negotiating with insurance companies on rates, premiums and terms of coverage; insurance agents represent insurers.[5] The general rule is that an agent or broker who fails to procure insurance as requested by an insured will be liable for any resulting damage.[6]

New Jersey and Illinois recognize brokers as professionals and hold that brokers are in a fiduciary relationship with their clients, because of the increasing complexity of the insurance industry and the specialized knowledge required to understand all of its intricacies.[7] Idaho and Illinois also hold insurance brokers to the standard of care of a professional and find that they serve insureds as fiduciaries. Other states, such as Arizona, find that while the insurance broker is not a fiduciary of the insured, the broker does owe duties of care as a professional with special knowledge, skill or expertise, and as such, must perform his or her activities according to the standard of care prevailing in the profession.[8]

Although the laws of some states require the broker to represent the policyholder alone, in practice many brokers contract with their corporate policyholder clients to serve as dual agents, representing both the insured and the insurer in placing coverage for the insured. Such a broker would serve as the insured's agent by assisting in the preparation of an insurance application to present to different markets, obtaining a quote from several underwriters, and advising the insured which scope of coverage and premium amount best suits its needs. When the buying decision is made, the same broker then would issue a binder putting coverage in place pending his or her receipt of the winning insurer's policy, under his or her authority as the carrier's agent.[9] When the broker accepts the policy from the insurer and the premium from the insured, he or she has elected to act for the insurer to deliver the policy and collect the premium, notwithstanding his or her existing role as agent for the insured.[10] Notwithstanding a dual agency, the broker must at all times be mindful of his or her obligations to the policyholder.

In jurisdictions that hold brokers to a heightened duty of care, there is little the broker can do to deflect liability for errors harming an insured. The broker may not argue that the insured's loss was caused by its failure to read the policy at issue. This is because, absent some notice or warning from the broker that he or she lacks sufficient knowledge to meet the standard of care (something no broker is likely to do), an insured is justified in relying on the broker's representations regarding coverage without independently verifying the accuracy of those representations by examining the relevant policy provisions.[11]

Under a negligence theory, a broker is held liable for all foreseeable damage proximately caused by his or her negligence. Usually, the most foreseeable damage caused by a broker's negligence is loss of coverage. However, the inquiry does not end at whether a carrier is justified in denying coverage as a result of the broker's error or omission. If a broker's error or omission gives an insurance carrier a viable basis for refusing coverage and the insured never had the opportunity to guard against a potential shortfall in coverage, the broker is liable for all damages that stem from the coverage denial, including fees and costs incurred in prosecuting a coverage action against the insurance carrier.[12] In such a case, the outcome of coverage litigation would have no bearing on the broker's liability because the insured sustains injury by having to litigate coverage issues that, but for the broker's negligence, would be non-existent. The outcome of the coverage litigation would be relevant only to the amount of damages and not the fact of the insured's injury.[13]

A broker's liability is not limited to affirmative actions taken in the course of carrying out his or her duties. Failure to inform an insured about relevant policy provisions can amount to negligent misrepresentation.[14] A broker cannot avoid liability for foreseeable harm caused by his or her silence or inaction merely because he or she did not expressly make promises or assume specific responsibilities – broad statements concerning the scope of coverage are sufficient to constitute misrepresentations.[15] In this regard, courts find that it is reasonable for an insured to rely on a broker's representations that the coverage procured is what the insured wanted, particularly when the insured had relied on the broker for years in all aspects of its insurance business. In such cases, courts have found it reasonable for an insured to accept the broker's representations as to coverage without reading the policy.[16]

In addition, the broker who negligently (or intentionally) misrepresents the nature, scope or extent of coverage may be liable for losses suffered by an insured in reasonable reliance on the broker's representations. For example, in a case where a broker represented that the liability insurance policies he or she obtained for his or her client provided $1 million in coverage, but there was a $150,000 gap between the insured's primary and excess policies, the broker was held responsible for this difference.[17]

Guarding Against The Pitfalls

The rise in broker malpractice suits and heightened duties of care require increased diligence on the part of brokers. It is essential for brokers to know their clients' businesses and potential areas of exposure. It also is critical for a broker to ensure that the client understands its coverage and important policy provisions. Where, as a matter of practice, a broker might send a policy to his or her client once bound and ask the client to call with any questions, the broker should consider sitting down with the client to review the policies and make sure the client understands material provisions. While brokers may fear taking additional steps in explaining coverage to clients because of their increased exposure, it is better to do so rather than risk the client relying on broad statements and not being able to guard against pitfalls in coverage. It is also critical that the client and the broker have an ongoing dialogue regarding claims activity and the roles and responsibilities of each party, so that both are aware of expectations and potential problem areas.

The playing field for insurance brokers is starting to look more like a minefield. To avoid creating expectations that lead to brokers getting dragged into coverage litigation, insureds should educate themselves on complex coverage, or even get a second opinion before buying insurance. At the same time, the broker should bend over backwards to provide continuing instruction in the art and science of insurance.

1 *Hydro-Mill Company, Inc. v. Hayward, Tilton and Rolapp Insurance Assoc., Inc. (2004) 115 Cal.App.4th 1145, 1153.*

2 *Santiago v. 1370 Broadway Assocs., L.P., 264 A.D.2d 624 (N.Y. 1999).*

3 *Ghiz v. Richard S. Bradford, Inc., 573 A.2d 379 (Me. 1990); Booska v. Hubbard Ins. Agency, 160 Vt. 305 (Vt. 1993).*

4 *Carlton v. St. Paul Mercury Ins. Co. (1994) 30 Cal.App.4th 1450, 1457; Rios v. Scottsdate Ins. Co. (2004) 119 Cal.App.4th 1020, 1026.*

5 *Cal. Ins. Code §§ 33, 1623.*

6 *Hydro-Mill Company, 115 Cal.App.4th at 1153.*

7 *Aden v. Fortsh, 169 N.J. 64, 78 (N.J. 2001); Kanter v. Deitelbaum, 271 Ill.App.3d 750, 755 (Ill.App. 1995).*

8 *Darner Motor Sales v. Universal Underwriters Ins. Co., 140 Ariz. 383 (Ariz. 1984).*

9 *Kotlar v. Hartford Fire Ins. Co. (2000) 83 Cal.App.4th 1116, 1123.*

10 *Krumme v. Mercury Ins. Co. (2004) 123 Cal.App.4th 924, 930.*

11 *Clement v. Smith (1993) 16 Cal.App.4th 39, 45.*

12 *Third Eye Blind, Inc. v. Near North Entertainment Ins. Services, LLC (2005) 127 Cal.App.4th 1311, 1319; Kurtz, Richards, Wilson & Co. v. Ins. Comm. Marketing Corp. (1993) 12 Cal.App.4th 1249, 1258-59.*

13 *Sindell v. Gibson, Dunn & Crutcher, 54 Cal.App.4th 1457, 1460.*

14 *Eddy v. Sharp (1998) 199 Cal.App.3d 858.*

15 *Clement v. Gordon Smith (1993) 16 Cal.App.4th 39, 46-47.*

16 *Greenfield v. Insurance, Inc. (1971) 19 Cal.App.3d 803, 881.*

17 *Troost v. Estate of DeBoer (1984) 155 Cal.App.3d 289, 298 (1984); Reserve Ins. Co. v. Piscotta (1982) 30 Cal.3d 800, 816 [broker was held liable when negligently obtained primary policy $200,000 lower than required by insured's excess carrier, exposing the insured to a gap in protection].*

Non-Insurance Indemnity Contracts Between Contractors And Subcontractors:

Decision Puts New Onus On Subs

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On May 24, 2006, the California Supreme Court granted review of Kirk Crawford v. Weather Shield Manufacturing, Inc. (2006) 136 Cal.App.4th 304. The sole issue for review is whether a non-negligent subcontractor must provide a defense to a suit against a general contractor where the language of the indemnity contract required the subcontractor "to defend any suit or action" against the general contractor "founded upon" any claim "growing out of the execution of the work." Although the Court of Appeal said, "Yes," the holding is superseded by the Supreme Court's grant of review, and no longer viable authority pending the Court's decision.

In *Crawford*, a subcontractor that did tip-top work and caused no losses nevertheless was required to defend and indemnify the general contractor. Wasn't the fact that the subcontractor did a good job enough to insulate it from paying the general contractor's defense costs? The answer is, "No." As long as the indemnity provisions of the subcontract require the subcontractor to defend and indemnify the general contractor whenever the general contractor is sued for loss arising from the subcontractor's scope of work, the subcontractor must pay, whether or not it is actually at fault.

Unlike insurance contracts, which are interpreted broadly in favor of coverage, non-insurance indemnity clauses typically are construed narrowly and against the indemnitee. *Crawford* took a step in the other direction, holding that a subcontractor can be liable for a portion of the general contractor's defense costs, regardless of whether the subcontractor's work was found to be deficient.

In *Crawford*, a group of homeowners brought a construction defect action against the builder-developer of their housing project. The homeowners claimed that the windows were defectively designed and manufactured, causing the windows to leak and fog. The builder filed a cross-complaint against the window manufacturer for indemnification and attorneys' fees incurred in defending the homeowners' suits. At trial, a jury found in favor of the window manufacturer on both the homeowners' claims for negligence and breach of warranty, and on the developer's claims for contractual indemnity. However, even though the jury found that the window manufacturer was not at fault, the Court awarded the developer attorneys' fees against the window manufacturer. The Court held that the indemnity agreement bound the window manufacturer and the framer to defend the developer in lawsuits "founded on" claims growing out of the manufacturer's scope of work: the windows.

On appeal, the window manufacturer argued it was not required to reimburse the developer for its defense costs without an ultimate finding that it was negligent. It contended that since the jury had found the company not negligent with respect to the homeowners' claims, it was under no duty to defend the developer. The Court of Appeal, however, affirmed the trial court's ruling granting the developer a portion of its attorneys' fees. The Court ruled that a finding of negligence was not required to trigger the subcontractor's duty to defend the developer under the indemnity provision of the contract as written.

THE COURT NOTED THAT INDEMNITY IS "THE OBLIGATION RESTING ON ONE PARTY TO MAKE GOOD A LOSS OR DAMAGE ANOTHER HAS INCURRED."

The Court turned to the language of the indemnity contract and the relationship it created between the window manufacturer and the developer. The indemnity contract provided that "[c]ontractor does agree to indemnify and save Owner harmless against all claims for damages to persons or to property and claims for loss, damage and/or theft of homeowner's personal property growing out of the execution of the work, and at his own expense to defend any suit or action brought against Owner founded upon the claim of such damage or loss or theft . . ." The Court noted the distinction between an insurance contract between an insurer and an insured on one hand, and a non-insurance indemnity agreement between a developer or general contractor and a subcontractor on the other. The Court ruled that while an insurance contract must be broadly interpreted in favor of coverage for the insured, non-insurance indemnity agreements are "strictly construed against the indemnitee." In other words, non-insurance contracts are given the narrowest possible interpretation consistent with the contract language, giving the indemnifying subcontractor the benefit of all doubts.

Nevertheless, the Court found that the plain language of the contract required the window manufacturer to defend the developer in suits arising from the manufacturer's work, regardless of fault. The Court reasoned that under the indemnity contract, the subcontractor had two separate and distinct duties: one of indemnification and one of defense. The Court noted that indemnity is "the obligation resting on one party to make good a loss or damage another has incurred." The obligation to defend, on the other hand, is more specific and is defined as "the rendering of a service, viz., the mounting and funding of a defense in order to avoid or at least minimize liability." The duty to defend generally is a current obligation and necessarily arises before either parties' liability is determined. As to the indemnity contract issue, "such language necessarily contemplated application without an adjudication of that party's negligence, because the defense of a claim must necessarily take place before the claim itself is adjudicated. It just can't exist otherwise."

The *Crawford* Court concluded "[b]ecause the obligation to defend undertaken by the window manufacturer here was an obligation to provide a present 'service,' by definition, the obligation could not have been contingent on the establishment of a subsequent indemnity obligation to pay a settlement or judgment." The Court observed that the idea that the window manufacturer had no duty to defend unless it was ultimately adjudged to be negligent is incorrect as a matter of the text on the contract.

Should the California Supreme Court affirm the Court of Appeal's ruling, *Crawford* nevertheless remains limited in its applicability. First, the Court of Appeal was quick to point out that although the case dealt with an indemnity clause, the decision was based on language found in a non-insurance contract. Therefore, this case has limited applicability in adjudicating language contained in insurance contracts between an insurer and their insured. Second, the Court held the subcontractor liable only for its portion of the defense costs "growing out" of the subcontractor's own work, not the cost of a complete defense. Last, and perhaps most importantly, the Court's ruling was based on the specific language of the contract between the subcontractor and the developer. "We only hold that the trial court here correctly interpreted and adjudicated this subcontract, which was made between parties of relatively equal sophistication and bargaining power."

Risk Radar

Hot Topics to Watch in the Coming Months

1

Hurricane-Related Insurance Disputes

After Hurricane Katrina, many property owners learned for the first time that losses caused by wind are covered, but losses caused by water are not. Several property insurers with significant exposure in the Southeast region initially took the position that damage from storm surge amounted to non-covered water loss, not covered wind loss. Angered by this approach, the State of Mississippi sued these insurers to force them to pay claims made by its residents regardless of policy language, on public policy grounds. A class of homeowners brought a companion lawsuit. State Farm recently became the first defendant to settle the case, for $130 million up front and as much as several hundred million by year end. Issues to watch:

- Will any court adopt a "public policy" rationale for overriding insurance policy language where wind coverage and water damage exclusions collide?
- Will other property insurers continue aggressively asserting that damage caused by water driven by wind are non-covered water losses?

2

Discovery of Other-Claims Information

U.S. District Court for the District of Columbia ruled recently that an insured was entitled to discover electronically stored information showing how the insurer handled claims submitted by other insureds concerning the same cause of loss. Insurers often claim they do not have to produce such information because it is (1) irrelevant; and (2) too expensive to produce. In the D.C. case, the court found that the information clearly was relevant to show how the insurer interpreted the "absolute pollution exclusion" in claims by other insureds. The court neutered the cost argument by asking the insurer to use specific keywords to search electronic files and retrieve relevant data. It will be interesting to see whether insureds continue to be successful in forcing insurers to decide similar claims in a similar way, by gaining discovery of other-insured information.

3

Two Notes on Business Interruption Insurance

Two recent decisions involving business interruption insurance are worth noting. First, United Airlines has failed in its efforts to get business interruption coverage under its terrorism policy for 9/11-related damages. This case serves as a reminder that business interruption coverage isn't triggered unless physical property loss is present. Nor was United allowed to recover lost earnings based on an argument that it was denied access to its facilities at Ronald Reagan Airport by the terrorist attack on the Pentagon. Second, some businesses outside of Hurricane Katrina's path of destruction suffered lost business income when suppliers were wiped out by the storm. These insureds did not qualify for business interruption coverage – they had no property damage. However, companies that had an add-on to their property policies, called contingent business interruption insurance, which applies to income lost due to property damage suffered by suppliers, recovered their lost earnings. Is this add-on part of your company's property policy?

4

Renewal Rule Under Attack

In California and other states, insurers are required to give advance notice to all insureds of a material change in the scope of coverage on renewal, or risk the changes being unenforceable. While many carriers comply with this rule as a matter of course, a few that don't argue that the notice obligation should be narrowed or abandoned where the insured is represented by a broker, or where the insured is a cedent in the reinsurance market. These efforts to avoid disclosure of changes in coverage are worth watching. If they are successful, it would impose a heightened burden on corporate insurance professionals and outside brokers to ensure that no changes in coverage go unnoticed.

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