402 Insurance Basics for the In-house Generalist

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Faculty Biographies

Ronald E. Baldwin

Ronald E. Baldwin is general counsel of Risk Management Solutions, Inc., a specialty software applications company, which provides catastrophic risk management services to the insurance industry. He is responsible for all legal matters regarding the company. This includes acting as legal counsel to the executive team and board of directors, oversight of outside counsel, corporate governance, and general management of the legal department. His areas of experience include software licensing, intellectual property, corporate law, securities law, transactional matters, and insurance.

Mr. Baldwin is currently sitting as the elected representative on the ethics committee at Haas, UC Berkeley.

Mr. Baldwin received his B.A. from the University of Southern California and J.D. from the University of California, Hastings College of the Law. He is currently enrolled in the Berkeley-Columbia Executive M.B.A. program.

A. Peter Prinsen

A. Peter Prinsen is vice president and general counsel at The Graham Company, a commercial insurance broker and consultant headquartered in Philadelphia, Pennsylvania. In addition to serving the company as general counsel, Mr. Prinsen works with The Graham Company's claims services department to maximize insurance coverage, aggressively handle claims, ensure accurate reserves, and advise its insureds on coverage and claims matters.

Prior to joining The Graham Company Mr. Prinsen practiced insurance coverage and defense litigation in the Philadelphia office of Duane, Morris.

Mr. Prinsen is actively involved in and serves on the board of SquashSmarts, a program that combines academic tuitoring, squash instruction, and monitoring of urban youth. He is a licensed Insurance Agent. He is also a Chartered Property and Casualty Underwriter (CPCU), Registered Professional Liability Underwriter (RPLU), and has the Associate in Claims (AIC) designation provided by the Insurance Institute of America. He has received numerous awards in trial advocacy, including the International Academy of Trial Lawyers Award and the Lewis F. Powell Award for Excellence in Trial Advocacy.

Mr. Prinsen is a graduate of Penn State University, where he graduated with high honors, and Villanova Law School.

Susan T. Travis

Susan T. Travis is the vice president, general counsel and secretary for Huber Engineered Woods LLC, a leader in research, development, and manufacturing of engineered wood products, in Charlotte, North Carolina. Huber Engineered Woods LLC is a diversified multinational developer and supplier of engineered wood products. Ms. Travis has overall responsibility for providing legal support to the company.

Prior to joining Huber Engineered Woods LLC, Ms. Travis was senior corporate counsel with Pitney Bowes, Inc. for the intellectual property and technology law department. Also, Ms. Travis has counseled not for profit organizations, and worked for a $40 billion global Fortune 100 pharmaceutical corporation conducting domestic and international negotiations and transactional work. Previously, she initiated the in-house legal function and handled the general counsel, litigation management, and contractual negotiations for the North American subsidiaries of a Fortune 1000 multinational company. She has also been general counsel for a privately held entrepreneurial company that supplied global consulting services, designed and built gas and chemical delivery systems in the semiconductor and pharmaceutical marketplace.

Ms. Travis is a former faculty member of Pace University School of Law, litigation associate for a New York firm, and labor counsel for a New York labor union. She has written various articles and treatise chapters, and is a lifelong member of Pennsylvania State University Alumni Association, and former member of the Town of Somers zoning board.

Ms. Travis received her B.S., cum laude, from Pennsylvania State University and her J.D. from Syracuse University.

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402 - Insurance Basics and Producer Compensation

Ronald Baldwin, General Counsel of Risk Management Solutions, Inc.

Susan T. Travis, Vice President and General Counsel of Huber Engineered Woods LLC

Peter Prinsen, CPCU, RPLU, AIC, Vice President and General Counsel of The Graham Company

Additional Resources Available

- As an additional resource, the CD-ROM disc provided to you will contain the following:
  1) An excellent paper written by Randy Paar, Esquire of Dickstein Shapiro Morin & Oshinsky LLP entitled "Insurance 101 – What Every In-House Counsel Should Know". We're sure that you'll find it an excellent resource as you analyze insurance coverage issues;
  2) IRMI Contract Review Checklist.

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Role of the Insured, the Insurer and the Broker

- **Role of the Insured:**
  - Selection of a competent insurance broker
  - Honesty/Forthrightness in the completion of applications
  - Payment of premium
  - Prompt notice of losses
  - Competence in the claims process

Role of the Insured, the Insurer and the Broker *(Cont.)*

- **Role of the Insurer:**
  - Issuance of quotation based upon applications supplied
  - Collection of premium
  - Issuance of insurance policy
  - Adjustment of claims (TPA exception)
  - Payment of claims
  - Collection and reporting of loss information
  - Loss control

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Role of the Insured, the Insurer and the Broker *(Cont.)*

- **Role of the Insurance Broker:**
  - Identify and evaluate exposures
  - Develop coverage specifications
  - Market insurance program to selected insurers
  - Recommend appropriate proposals
  - Additional services: Claims services, loss control, contract reviews, certificate of insurance issuance.

Standard Insurance Coverages

- **Workers' Compensation:**
  - Workers Compensation is a statutory benefit program for injured employees.
    - Medical benefits
    - Indemnity benefits - lost wages based on state guidelines

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Standard Insurance Coverages *(Cont.)*

- **Workers' Compensation:** ***(Cont.)***
  - Provides insurance coverage for injuries to workers which occur during the course and scope of their employment.
    - Not fault based
    - Can include coverage for employees of uninsured subcontractors
    - Can include coverage for presumed "independent contractors"
    - Subrogation (recovery from responsible party of what was paid) permitted

Standard Insurance Coverages *(Cont.)*

- **General Liability:**
  - Covers claims for bodily injury and property damage to third parties which arise out of your operations or the ownership of the property.
    - "Third Party" Coverage
    - Legal Liability Requirement

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Standard Insurance Coverages *(Cont.)*

- **General Liability:** ***(Cont.)***
  - Includes contractual liability to indemnify others
  - No coverage for damage to "your work" or "your product" (policy is not a warranty)
  - Includes advertising injury and personal injury (libel, slander, etc.) coverages

Standard Insurance Coverages *(Cont.)*

- **Automobile Liability & Physical Damage:**
  - Two Part Coverage:
    - Automobile liability covers bodily injury and property damage claims that arise out of the operation, maintenance and use of automobiles and trucks.
      - Third party bodily injury and property damage covered
      - Legal liability requirement

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Standard Insurance Coverages *(Cont.)*

- **Automobile Liability & Physical Damage:** ***(Cont.)***
  - Automobile physical damage covers direct physical damage to owned autos and can be extended to cover physical damage to rented or leased autos.
    - Comprehensive
    - Collision
  - Covered Auto
    - Coverage follows the auto not individuals

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Standard Insurance Coverages *(Cont.)*

- **Property:**
  - Covers damage to scheduled buildings and other real property
  - Covers damage to personal property (may extend to personal property of others)
  - Can include business interruption coverage
  - Generally written on an "All Risk" or specified perils basis
  - Be careful of co-insurance, unscheduled locations
  - Flood coverage desired/required?

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Standard Insurance Coverages *(Cont.)*

- **Boiler and Machinery:**
  - Covers damage to "objects"
  - Expansiveness of coverage depends upon definition of "objects" selected
  - Can cover production machinery
  - Can include business interruption coverage

Standard Insurance Coverages *(Cont.)*

- **Umbrella/Excess Liability:**
  - Umbrella coverage may provide broader coverage than underlying coverages
  - Excess coverage supply increases the limits of insurance
  - Beware of new exclusions in the umbrella/excess layer
  - Be sure to schedule all primary coverages

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Standard Insurance Coverages *(Cont.)*

- **Benefits Insurance:**
  - Health/Accident
  - Life Insurance
  - Dental/Vision

Additional Coverages Most Medium to Large Size Companies Maintain

- **Directors & Officers:**
  - Both direct and corporate reimbursement coverage generally in same form
  - Claims-made coverage
  - Entity coverage may be available
  - Wrongful Act trigger
  - Legal liability/third party only coverage

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Additional Coverages Most Medium to Large Size Companies Maintain *(Cont.)*

- **Directors & Officers:** ***(Cont.)***
  - Rescission
    - Non-Rescindable Policies
    - Severability of the Application
  - Bankruptcy Issues
    - Priority of Payments Provision
    - Trustee not an insured
  - Fraud/Criminal Acts Exclusion
    - Final Adjudication vs. Infact wording

Additional Coverages Most Medium to Large Size Companies Maintain *(Cont.)*

- **Crime:**
  - Four basic coverages:
    - employee dishonesty
    - forgery or alteration
    - theft/robbery
    - computer fraud
  - First party coverage

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Additional Coverages Most Medium to Large Size Companies Maintain *(Cont.)*

- **Employment Practices Liability:**
  - No standard form (policies vary significantly)
  - Coverage for discrimination/harassment claims
  - Front pay may be excluded
  - ADA accommodation cost generally excluded

Additional Coverages Most Medium to Large Size Companies Maintain *(Cont.)*

- **Pollution:**
  - Two types:
    - Site specific
    - Non-site specific
  - Covers clean-up costs and third party liability
  - Generally no landfill coverage
  - Available in occurrence and claims-made triggers

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Additional Coverages Most Medium to Large Size Companies Maintain *(Cont.)*

- **Professional Liability:**
  - Covers economic loss claims arising out of professional services
  - Professional services definition issue
  - Bodily injury and property damage generally excluded
  - Generally claims-made coverage

Additional Coverages Most Medium to Large Size Companies Maintain *(Cont.)*

- **Fiduciary Liability:**
  - Covers liability arising out of the operations of employee benefit plans
  - May not be needed if third party vendor and employee benefits plan Gl Endorsement

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Additional Coverages Most Medium to Large Size Companies Maintain *(Cont.)*

- **Electronic Data Processing (EDP):**
  - Specifically designed to cover computers and other computer-aided or run machinery
  - Be careful of EDP definition

More Unusual/Industry Specific Coverages

- **Financial Institution Bonds:**
  - The crime policy for the financial industry

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More Unusual/Industry Specific Coverages *(Cont.)*

- **Marine Insurance:**
  - General Liability insurers exclude coverage for owned as well as non-owned watercraft > 26 feet
  - Hull coverage
  - Protection & indemnity coverage for injury to seamen.

More Unusual/Industry Specific Coverages *(Cont.)*

- **Internet Liability:**
  - Forms vary widely
  - Coverage available for transmitting viruses, computer hacking and data loss

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More Unusual/Industry Specific Coverages *(Cont.)*

- **Owner Controlled Insurance Program (OCIP):**
  - OCIP or "Wrap-Up"
    - Wrap-Up Insurance Program involves the purchase of certain insurance by the owner, protecting both the owner and the various contractors involved with the construction project.
    - In return for these coverages, the contractors exclude insurance costs for these coverages from their bids.

More Unusual/Industry Specific Coverages *(Cont.)*

- **Owner Controlled Insurance Program (OCIP):** ***(Cont.)***
  - Types of Wrap-Ups
    - Conventional Wrap-Up
      - Single Defined Job Site
    - Rolling Wrap-Up
      - Multiple Job Sites with some common features/efficiencies

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More Unusual/Industry Specific Coverages *(Cont.)*

- **Owner Controlled Insurance Program (OCIP): *(Cont.)***
  - Maintenance Wrap-Up
  - Ongoing operations at completed site or sites

More Unusual/Industry Specific Coverages *(Cont.)*

- **Owner Controlled Insurance Program (OCIP): *(Cont.)***
  - Coverages Normally Provided by an OCIP
    - Workers' Compensation and Employers Liability
    - Commercial General Liability
      - Completed Operations Coverage - Usually 2-3 Years
    - Commercial Excess Liability
      - Limits Determined by Scope of Work - Usually $75,000,000 and up

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More Unusual/Industry Specific Coverages *(Cont.)*

- **Owner Controlled Insurance Program (OCIP): *(Cont.)***
  - Commercial Excess Liability (Cont.)
    - Completed Operations Coverage - Usually 2-3 Years
  - Coverage purchased for the benefit of all parties.

Claims-Made vs. Occurrence Triggers

- **Occurrence Coverage:**
  - The most prevalent
  - Policy triggered is the one in place when the "occurrence" takes place.

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Claims-Made vs. Occurrence Triggers *(Cont.)*

- **Claims Made Coverage:**
  - Usual for D&O, Professional Coverages
  - Policy triggered is the one in place when the "claim" is made
  - Watch out for retroactive date
  - "Tail Coverage" issue

Named Insured vs. Insured vs. Additional Insured Coverage

- Named insured pays the premium and gets notices.
- Named insured can address coverage with the insurer.
- Additional insured gets all the coverage the named insured gets if not limited by endorsement.

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Named Insured vs. Insured vs. Additional Insured Coverage *(Cont.)*

- Additional insured coverage frequently limited to vicarious liability arising out of the named insured's work.
- New additional insured endorsements exclude indemnification Sole Fault

Named Insured vs. Insured vs. Additional Insured Coverage *(Cont.)*

- **Primary and Non-Contributory Additional Insured Status:**
  - Some contracts may require that the named insured's insurance program be endorsed so that insurance program is primary to any other insurance carried by the Additional Insured.

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Interplay of Additional Insured Coverage and Contractual Liability Coverage

- Additional Insured will, most likely, also be an Indemnitee.
- Named Insureds are insured for their indemnification of Another's Tort Liability (Contractual Liability Coverage).

Interplay of Additional Insured Coverage and Contractual Liability Coverage *(Cont.)*

- If one is broader than the other (Additional Insured vs. Indemnity) which will apply? - The one most favorable to the protected entity!

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Certificates of Insurance

- Show insurer, line of coverage, policy period, policy number and limits of coverage
- Frequently issued by insurance brokers
- Should show additional insured status, waiver of subrogation and loss payees (on property coverages)

Producer Compensation

- Historic Producer Compensation
  - Commissions
  - Profit sharing (contingent commissions)
- Marsh/Global Brokering Compensation
  - Placement service agreements
  - Market service agreements
  - Subsidiary (affiliate compensation)

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Producer Compensation *(Cont.)*

- The Spitzer Investigation
  - Steering
  - Bid rigging
- New Producer Compensation Models
  - NAIC Model Act
  - NCOIL Model Act

Broker Compensation – Emerging Issues

- State Action
- What's going on in the trenches?
- Clarifying Client – Producer Relationships

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What's Going On?

- General Compensation Structure
- State Investigations/Legislation
- **Concern:** Contingent commissions could give rise to conflicts of interest – or to potential conflicts of interest

Defining the Relationship

- Clarify the precise roles and responsibilities the firm is agreeing to undertake on your behalf
- Define the scope of representation
- Determine compensation practices

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The Marsh, AON, Willis and Gallagher Funds

	Amount	Deadline
Marsh	$850 Million	9/20/2005
AON	$190 Million	10/30/2005
Willis	$50 Million	12/20/2005
Gallagher	$27 Million	12/31/2005

- Application Process
- Watch out for the Release!

Insurance 101
What Every In-House Counsel Should Know

By

Randy Paar*

Presented In Conjunction With
The Westchester/Southern Connecticut Chapter of the
American Corporation Counsel Association

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INSURANCE LAW

Randy Paar, Esq.
Dickstein Shapiro Morin & Oshinsky LLP[1]

I. Introduction

Every in-house lawyer should have an understanding of, or at least be able to identify, basic insurance issues. Mass tort and product liability litigation, the recent corporate scandals, the increase in securities class action and derivative claims, and the business interruption losses caused by the World Trade Center tragedy all are examples of recent circumstances that highlight the importance of a corporation's insurance program. The risk management department needs, and is entitled to, assistance from in-house counsel in making sure that the insurance purchased is the insurance the corporation requires and intended to buy, and that, through the submission of claims, the insurance is used in a way that will maximize recovery.

Risk managers typically focus on the financial aspects of insurance: the premium and the limits. In-house counsel can assist the risk management department by focusing on other aspects of the transaction that can have significant impact on the value of the insurance, such as the legal implications of the various policy terms, and whether the policyholder should accept certain provisions, such as those concerning arbitration and choice of law. Counsel can also assist in the submission of the claim, including adherence to the notice and cooperation provisions in the policy. Counsel can also bring their understanding of the underlying liability so that the claim is described and managed in a way to maximize coverage.

[1] Cherylyn Briggs, Hollye Mann, and Judy Howard have provided invaluable assistance in putting this Appendix together.

This paper is intended to give inside corporate counsel background so that they can identify insurance issues that may arise, participate in substantive insurance discussions relating to those issues, and assist risk managers in maximizing the protection afforded by insurance. Section II provides an introduction to the basic structure of an insurance program and the types of insurance policies that are sold, and a discussion of the key documents that form an insurance agreement and the principal sections of an insurance policy.[2]

The paper then goes on to provide a more detailed treatment of some of the current hot insurance issues that are troubling in-house counsel. Section III addresses issues of significance regarding third-party liability policies, including how to manage the insurance companies' defense obligation, and the current disputes over trigger of coverage, number of occurrences, and allocation. Section III also discusses an allocation issue under Directors and Officers insurance that is of particular interest in the context of the bankruptcy filing of corporations such as Enron, Adelphia and World.com. Section IV discusses issues of recent significance regarding first-party policies, especially with regard to business interruption claims presented by the World Trade Center tragedy. Section V provides some practical considerations for inside corporate counsel.

II. Insurance Basics

A. Types of Insurance

Insurance policies generally fall into two categories: first-party and third-party policies. First-party policies typically insure against loss of, or damage to, a policyholder's property. They also may provide coverage for lost business revenue.

[2] An insurance policy is a form of commercial contract. Although it is hoped that the general statements in this paper will be helpful to an understanding of the policyholder's rights and the insurance company's obligations, the language of the individual policy at issue will control.

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Examples of first-party coverages are comprehensive business property policies (which can include business interruption coverages),[3] and Fidelity and Crime policies, which insure against loss of the policyholder's property due to the fraud or dishonesty of an employee.

Third-party policies typically provide insurance for the policyholder's liability to third parties for alleged injury or damage. The most important example of a third-party policy is the general liability policy, which provides broad insurance for claims against the policyholder alleging bodily injury, property damage, personal injury, and/or advertising injury. Businesses typically purchase general liability insurance in Comprehensive General Liability ("CGL") policies, or Commercial General Liability policies. Other liability policies include Directors and Officers ("D&O") insurance policies, which protect corporate officers and directors against claims alleging wrongful acts in their capacity as directors and officers,[4] and Errors and Omissions ("E&O") insurance policies, designed to protect the policyholder against claims that it was negligent in providing professional services.[5]

Businesses generally purchase both first-party and third-party insurance, in varying amounts and layers. The first so-called "layer," referred to as a deductible or a self-insured retention ("SIR"), generally is not insurance, but an amount that the policyholder must pay before an insurance company's obligation to pay is triggered. Although frequently confused, deductibles and SIRs operate in different ways. If the insurance policy has a deductible, the insurance company pays the limits of the policy, but the amount of the deductible is billed back to the policyholder. If, for example, a $1,000,000 policy with a $100,000 deductible is required to pay a claim, the policyholder must reimburse the insurance company for the deductible amount, or $100,000. In essence, the $1,000,000 policy provides only $900,000 of insurance. On the other hand, if the insurance policy with $1,000,000 in limits has a $100,000 SIR, the insurance company pays the entire $1,000,000 limit after the policyholder makes an initial $100,000 payment.[6]

After the deductible or SIR, the "primary policy" provides the first real layer of insurance for a covered claim. The primary policy contains the basic coverage provisions that define the scope of the particular type of insurance.

Above the primary policy, corporations (and sometimes individuals) purchase layers of "excess insurance." Excess insurance generally is triggered when the underlying policy is exhausted by, or has paid its limits for, a covered claim. The first layer of excess insurance, if it contains its own terms and conditions, is referred to as an "umbrella policy." An umbrella policy may be broader than the underlying primary policy (or policies) and may cover certain types of losses or claims that are not covered by the primary policy. If there is no underlying policy that covers a claim within the insuring provisions of the umbrella policy, then the umbrella policy will be triggered after the policyholder pays a certain amount toward the claim. This is referred to as a "retained limit."

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[3] *See* 1 Linda G. Robinson & Jack P. Gibson, International Risk Management Institute, Inc., *Commercial Property Insurance* (2001).

[4] In recent years, D&O insurance has been expanded to protect the corporation against claims based on the federal securities laws.

[5] E&O insurance is particularly important for those corporations that sell services, as opposed to products. Professional malpractice insurance is a form of E&O coverage. Other forms of liability insurance include: Fiduciary Liability insurance, intended to protect against claims that the company's pension fund has been mismanaged; Employment Practices Liability insurance, intended to protect against various forms of employee claims; and Workers Compensation and Employers Liability insurance, intended to protect against workers' compensation claims brought pursuant to state law.

[6] If the insurance policy has a duty to defend, as well as a duty to indemnify, separate deductibles or SIRs can apply to the insurer's defense and indemnity obligations.

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Excess policies in layers above the umbrella policy (or policies) generally do not contain their own terms and conditions, but merely adopt, or "follow form" to, the provisions of the umbrella policy. Most excess policies are triggered only when the limits of the underlying policies have been exhausted through the payment of judgments or settlements.[7] Alternatively, the excess policies can be triggered after a retained limit has been paid for a loss that would be covered by the excess policy (usually equal to the total of the limits of the underlying policies).

It is not uncommon for more than one insurance company to share an excess layer sold to a corporate policyholder.[8] For instance, a $100 million layer of insurance might be shared by company X, which takes 50% of any loss in that layer, and by companies Y and Z, which each take 25% of any loss in that layer. Each company's percentage is referred to as its "quota share."[9]

Problems can, and often do, arise when excess policies do not "follow form" to the underlying umbrella policy, but contain their own terms and conditions. If layers of insurance are to work as intended, all of the policies, at least above the primary, must cover the same risks. Inconsistencies in policy language may create gaps in coverage. Those gaps will make it difficult to trigger excess policies because disputes will arise as to whether the underlying policy limits, or the retained limit, have been exhausted properly.

[7] Some policies have "drop-down" language under which a policyholder can argue that the excess insurance company must pay even without the payment of the entire limits in the underlying coverages. This is particularly important if the underlying coverage is unavailable because the underlying insurance company is insolvent.

[8] This practice is particularly common for insurance bought in the London insurance market.

[9] A loss that falls within that layer is borne by the insurance companies according to their quota share. For instance, a $50 million loss in that layer is paid for by $25 million from company X and $12.5 million each from companies Y and Z.

Although it is the broker's obligation not to place an insurance program with inconsistent policy provisions in layers of insurance, such errors can and do occur. Indeed, policies even within the same layer can be issued with inconsistent policy provisions. In-house counsel can be helpful to risk managers in providing additional broker oversight by reviewing policy language for inconsistencies in the policy language between, or within, different layers of coverage. Alternatively, counsel may suggest that the policyholder insist that the broker obtain only "follow form" excess policies.

B. Insurance Documents

The "Insurance Binder" is the initial document that evidences that insurance was sold.[10] The binder is only a few pages long, and refers in summary fashion to the basic terms of the insurance contract, often by reference to standard policy forms. The binder is important because it may be the only documented "contract" that exists during portions of the policy period. Formal policies frequently are not delivered until well after the policy period has begun, and sometimes are not delivered until after the policy period has expired.[11]

When the insurance policy eventually is delivered, the policyholder must determine whether the actual policy is consistent with the terms as outlined in the binder.

[10] For insurance sold in the London insurance market, the initial contracting document is a "Slip," which serves the same function as a binder for U.S.-based insurance companies. The Slip outlines the coverage to be provided, and each syndicate or London market company is bound to insure its quota share of the risk when its underwriter subscribes to, or signs onto, the Slip.

[11] For instance, in the litigation over coverage for the billions of dollars in loss at the World Trade Center, there are no formal policies of insurance at issue, only binders. *World Trade Ctr. Props. v. Travelers Indem. Co.*, No. 01CV12738 (S.D.N.Y. filed Dec. 28, 2001); *SR Int'l Bus. Ins. Co. v. World Trade Ctr. Props., Inc.*, No. 01CV9291 (S.D.N.Y. filed Oct. 22, 2001).

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If inconsistencies are not corrected immediately, problems may arise if and when a claim for insurance coverage is made.

The formal policy generally consists of: (1) a Declarations Page; (2) a Policy Form; and (3) Endorsements. The "Declarations Page" provides a summary of the insurance provisions, including the specific type of insurance provided, the designation of the named insureds, the policy period, and the amount insured or limits of liability. The Declarations Page often may be the only document that is customized for the individual policyholder and the particular type of insurance being sold.

The "Policy Form" generally is a preprinted document that describes (1) who (or what) is insured; (2) the insuring agreements (and definitions); (3) the exclusions; and (4) the conditions. *See infra.* For general liability policies sold today, this form most frequently has been created by the Insurance Services Organization, an insurance industry organization commonly referred to as ISO.[12] Other types of insurance policies (e.g., D&O, E&O, Fidelity, and property policies) often are written on an insurance company's own standard forms,[13] which sometimes are customized for a particular industry. For example, a Bankers Blanket Bond form is a Fidelity policy customized for the financial industry.

The insurance industry uses standard language in order to project covered losses and set premiums based upon prior loss experience under the same insurance provisions. Policyholders, therefore, generally have no opportunity to negotiate the language of the basic insuring agreements in the Policy Form. The negotiations that do take place concern principally the premiums and limits of coverage. Accordingly, under general rules of insurance contract construction, ambiguities in standard policy language are construed against the insurance company.[14]

"Endorsements" are modifications to the Policy Form. There are standard, preprinted endorsements, such as nuclear energy, asbestos, or pollution exclusions, and customized endorsements that list, for example, additional insureds, or exclude an aspect of the policyholder's business from coverage. There may be negotiations over the language of endorsements dealing with the scope of coverage, but most often these "negotiations" concern which of the insurance company's various standard endorsements will be used.

In some limited circumstances, insurance policies may be tailored for the particular policyholder. These policies are referred to as "manuscript" policies. Insurance companies often argue that policy language is negotiated between the insurance company and the policyholder and, thus, the policy is manuscripted to avoid the rules of policy construction that favor policyholders. True manuscript policies, where the language of the insuring agreements is negotiated, are rare, however. In most cases, "manuscript" policies merely involve standard insurance company language that is

[12] For additional discussion regarding the development of standard-form language in CGL policies, see discussion in *American Home Products Corp. v. Liberty Mutual Insurance Co.*, 565 F. Supp. 1485, 1500-02 (S.D.N.Y. 1983), *aff'd as modified*, 748 F.2d 760 (2d Cir. 1984).

[13] *See* www.royalsunalliance-usa.com (allows user to search policy forms by state in Management Assurance Portfolio section); www.kemperinsurance.com and www.cnapro.com (allow user to view or download sample policy forms such as directors and officers and employment practices liability).

[14] *Am. States Ins. Co. v. Natchez Steam Laundry*, 131 F.3d 551, 553 (5th Cir. 1998); *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 538-39 (9th Cir.), *cert. denied*, 498 U.S. 1013 (1990); *O'Brien v. United States Fid. & Guar. Co.*, 235 Conn. 837, 843, 669 A.2d 1221, 1224-25 (1996); *see* 2 Jerold Oshinsky & Theodore A. Howard, *Practitioner's Guide To Litigating Insurance Coverage Actions* § 8.02(E) (2d ed. 2002); *see also* 2 Lee R. Russ & Thomas F. Segalla, *Couch on Insurance 3d* § 22:14 (1997); 4 Rowland H. Long, *The Law of Liability Insurance* §§ 16.04, 16.06 (1996).

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retyped, rather than duplicated on a preprinted form. In this case, the pro-policyholder rules of construction still should apply.[15]

Finally, some aspects of the insurance relationship, such as how a deductible will operate or how a retrospective premium will be calculated, may be included as "side agreements" to the actual policy.[16] Another common form of side agreement is a claims-handling agreement, which addresses various aspects of the management of the defense of the underlying claims, including the selection of counsel and the authorization necessary for a settlement. Claims-handling agreements often are presented to the policyholder after coverage is bound.[17]

Insurance companies also may have billing or claims-handling guidelines which they distribute to defense counsel. These guidelines attempt to regulate the conduct of counsel by declaring what defense costs will be reimbursed by the insurance company. For instance, the guidelines may provide that the insurance company will not pay for: (i) more than one attorney to attend a court conference or deposition; (ii) any internal conferences between defense counsel; (iii) any research unless prior approval is obtained from the insurance company; and (iv) the filing of any motions or discovery unless prior approval is obtained from the insurance company.[18] Whether or not insurance company billing guidelines are appropriate for simple claims, insurance companies also seek to impose them on complicated litigation, such as the defense of mass tort litigation. In recent years, however, courts, bar associations, and state legislators have begun to question the ethics behind the use of claims-handling guidelines.[19]

C. Sections of the Policy Form

1. Who (or What) Is Covered?

Liability policies provide insurance for specifically described persons and entities. Typically, there is a "named insured," which will be the corporate entity. In a provision entitled "Who is an Insured" the policy may describe other persons (such as employees) or entities (such as vendors) who will be considered "insureds" under the policy. D&O policies, for example, will typically include former, as well as current, directors and officers of the corporation as individuals who are "insureds."

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[15] *ACandS, Inc. v. Aetna Cas. & Sur. Co.*, 764 F.2d 968, 973 (3d Cir. 1985); *Ogden Corp. v. Travelers Indem. Co.*, 681 F. Supp. 169, 173 (S.D.N.Y. 1988); *see* John H. Mathias, Jr., John D. Shugrue & Thomas A. Marrinson, *Insurance Coverage Disputes* § 1.03(4) (2002).

[16] The existence of retrospective premiums often comes as a surprise to persons unfamiliar with insurance. Where a retrospective premium exists, the cost of the insurance, the premium, is not fixed, but rather is adjusted to reflect losses paid under the insurance policy. Thus, many policyholders are surprised when, after collecting insurance for a claim, all or a portion of that payment is billed back to the policyholder as part of the retrospectively rated premium.

[17] If aspects of claims management are important to the policyholder, they should be addressed at the time of the underwriting. Obviously, the policyholder's leverage is greatest before the premium is paid, at a time when various insurance companies are competing for its business.

[18] Insurance-imposed guidelines can vary in the extent to which they seek to control the management of the defense, or impose unreasonable restrictions on defense counsel. One commonly used set of guidelines has been drafted by the Defense Research Institute ("DRI"), an organization of defense trial lawyers and insurance companies. Its "Recommended Case Handling Guidelines for Insurers" are available at http://www.dri.org/dri/committees/pdf/ILC_guidelines.pdf. Although not ideal, the DRI guidelines are, from a policyholder's perspective, less onerous than many of the insurance company's own guidelines.

Often policyholders are unaware of these guidelines until a claim is made. Inside counsel should review these "guidelines" before the insurance is purchased so that they can compare guidelines used by different insurers or obtain modifications.

[19] *See generally* Michael F. Aylward, The American Law Institute, *Insurance Ethics: The Future of the Tripartite Relationship*, SG004 ALI-ABA 217, 220 (2001). Some guidelines have been held to violate court rules regarding the conduct of litigation. *See Frederick v. UNUM Life Ins. Co. of Am.*, 180 F.R.D. 384, 385 (D. Mont. 1998) ("The problem as I see it is that UNUM's bottomline GUIDE is in conflict, not only with the local rules of practice, but also with the Federal Rules of Civil Procedure. The GUIDE hamstrings the lawyer charged with defending the claim.").

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Liability policies also may extend coverage to other parties generally listed in an endorsement. Often these "additional insureds" will include corporate affiliates of the "named insured," or persons or entities with whom the named insured has a close commercial relationship, or to whom the named insured is contractually bound to provide insurance.

The equivalent provision in first-party property policies is the "Covered Property" provision, which describes the type of property covered by the policy. This description may list the type of property covered (e.g., inventory, goods in transit, elevators, and art) or identify property at certain defined locations. The "Covered Property" provision also may specifically identify property that is *not* covered by the policy.

2. Insuring Agreements (and Definitions)

The insuring agreement defines the type of risk covered by the particular policy. Each type of insurance policy has different types of insuring agreements, including the duty to defend and to pay defense costs and the duty to indemnify. A policyholder cannot understand the scope of the insurance provided without reading the insuring agreement in conjunction with the Definitions section of the policy. Indeed, much of the litigation surrounding the scope of insurance coverage involves disputes over the meaning of key words, such as "Loss," "Wrongful Act," "Occurrence," "Property," and "Property Damage."[20] In an insurance coverage dispute, the policyholder has the burden of proving that a loss falls within the insuring agreement.[21]

[20] If a term is not defined or the definition is not clear, the policy may be considered ambiguous and the interpretation most favorable to the policyholder adopted. *See, e.g.*, *Liverpool & London & Globe Ins. Co. v. Kearney*, 180 U.S. 132, 136 (1901); *New Castle County v. Hartford Accident & Indem. Co.*, 933 F.2d 1162, 1182 (3d Cir. 1991); *Gulf Ins. Co. v. Edgerly*, 31 Cal. App. 3d 334, 340, 107 Cal. Rptr. 246, 250-51 (4th Dist. 1973); *State Farm Mut. Auto. Ins. Co. v. Seeba*, 209 Ga. App. 328, 329, 433 S.E.2d 414, 416 (1993); *Thornton v. Ill. Founders Ins. Co.*, 84 Ill. 2d 365, 371, 418 N.E.2d 744, 747 (1981); *Gen. Cas. Co. v. Olsen*, 56 Ill. App. 3d 986, 990, 372 N.E.2d 846, 850 (2d Dist. 1977); *Cowan v. Ins. Co. of N. Am.*, 22 Ill. App. 3d 883, 889, 318 N.E.2d 315, 323 (1st Dist. 1974).

a. The Duty to Defend and to Pay Defense Costs

The duty to defend in a primary general liability policy arises out of the statement in the insuring agreement that "[the insurance company] will have the right and duty to defend any 'suit' seeking damages [covered by the indemnity provisions of the policy]." Standard form general liability policies also contain provisions that require the policyholder to cooperate with the insurance company in its defense of the underlying claims. Those same policies prohibit the policyholder from settling a covered claim, or otherwise making a "voluntary" payment, without the insurance company's consent. The above provisions constitute the standard insurance policy language relating to the insurance company's obligation to defend the policyholder.

For those policies with a separate duty to defend (principally primary general liability policies), the defense obligation is broader than the duty to indemnify for a claim.[22] This means that the insurance company must defend, or reimburse for the costs of defense, even if the claim is only potentially covered by the policy. Moreover, an

[21] *E.g.*, *Chem. Leaman Tank Lines, Inc. v. Aetna Cas. & Sur. Co.*, 89 F.3d 976, 984 n.6 (3d Cir.), *cert. denied*, 519 U.S. 994 (1996); *Colonial Gas Co. v. Aetna Cas. & Sur. Co.*, 823 F. Supp. 975, 979 (D. Mass. 1993); *Allstate Ins. Co. v. Morgan*, 806 F. Supp. 1460, 1463 (N.D. Cal. 1992); *State Farm Fire & Cas. Co. v. Hiermer*, 720 F. Supp. 1310, 1314 (S.D. Ohio 1988), *aff'd*, 884 F.2d 580 (6th Cir. 1989); *Sentinel Ins. Co. v. First Ins. Co. of Haw., Ltd.*, 76 Haw. 277, 292 & n.13, 875 P.2d 894, 909 & n.13 (1994); *SCSC Corp. v. Allied Mut. Ins. Co.*, 536 N.W.2d 305, 311 (Minn. 1995); *Wexler Knitting Mills v. Atl. Mut. Ins. Co.*, 382 Pa. Super. 405, 408, 555 A.2d 903, 905 (1989).

[22] *See*, *e.g.*, *United States Fid. & Guar. Co. v. Armstrong*, 479 So. 2d 1164, 1167 (Ala. 1985); *Missionaries of the Co. of Mary, Inc. v. Aetna Cas. & Sur. Co.*, 155 Conn. 104, 110, 230 A.2d 21, 24 (1967); *Tropical Park, Inc. v. United States Fid. & Guar. Co.*, 357 So. 2d 253, 256 (Fla. Dist. Ct. App. 1978); *Wolford v. Wolford*, 662 S.W.2d 835, 838 (Ky. 1984); *Seaboard Sur. Co. v. Gillette Co.*, 64 N.Y.2d 304, 310, 476 N.E.2d 272, 275, 486 N.Y.S.2d 873, 876 (1984) ("*Gillette*"); *Sanderson v. Ohio Edison Co.*, 69 Ohio St. 3d 582, 585-86, 635 N.E.2d 19, 23 (1994).

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insurance company must defend the entire action, even if only some of the claims are covered.[23]

In primary general liability policies, the duty to defend is usually outside of the indemnity limits of the policy and defense cost payments do not erode the limits of liability of the policy. Defense costs paid by the insurance company, therefore, potentially are unlimited. The obligation to defend terminates only if and when indemnity payments (judgments or settlements) exhaust the policy limits.[24]

The costs of defending an action may far exceed the amount of any judgment or settlement. For instance, an oft-cited 1983 RAND report on the costs of asbestos litigation advises that the underlying plaintiffs received, on average, only thirty-seven cents of every dollar spent by defendants and insurers on asbestos litigation.[25] As a result, primary general liability insurance is sometimes referred to as "litigation insurance."[26] Litigation insurance is particularly valuable where the underlying actions involve mass torts or related product liability claims, where defense costs often equal or exceed the amount of any ultimate liability.

[23] *See, e.g.*, *Gillette*, 64 N.Y.2d at 310 476 N.E.2d at 275, 486 N.Y.S.2d at 876.

[24] *See* 7C John Alan Appleman, *Insurance Law and Practice* § 4682, at 34 (1979).

[25] Thomas E. Willging, Federal Judicial Center, *Appendix C: Mass Torts Problems & Proposals: A Report to the Mass Torts Working Group* 3 (Jan. 1999), *available at* http://www.fjc.gov (last visited Aug. 12, 2002) (literature review examining problems related to mass torts and discussing proposals for resolving those problems). This same study explains that mass tort litigation tends to have higher defense costs than other types of litigation.

[26] *See, e.g.*, *Avondale Indus., Inc. v. Travelers Indem. Co.*, 887 F.2d 1200, 1204 (2d Cir. 1989), *cert. denied*, 496 U.S. 906 (1990); *City of West Haven v. Liberty Mut. Ins. Co.*, 639 F. Supp. 1012, 1020 (D. Conn. 1986) (stating that one of the "basic purposes of the defense provision is protection of the insured from the expenses of litigation").

Most excess general liability policies, as well as other forms of liability policies, such as Fiduciary, D&O, and E&O policies, agree to pay defense costs within limits. For example, a typical defense payment provision in a D&O policy provides:

> The Company has not, under the terms of this policy, assumed any duty to defend, nor any of the costs, charges and expenses of defense payable by the Company in addition to the limit of liability. Costs, charges and expenses of defense are elements of loss incurred under this policy and as such are subject to all of the provisions of this policy.

The contractual basis for the reimbursement for defense costs often is provided in the definition of a covered "Loss," which includes the costs of defense.

In most specialized liability policies (e.g., Fiduciary, D&O, and E&O policies), the insurance company has no "duty to defend," but rather has a duty to reimburse for the costs of defending a covered claim. In these types of coverages, the scope of the duty to reimburse for defense costs is coextensive with, not broader than, the duty to indemnify.[27]

A defense obligation generally is irrelevant to first-party coverage. However, first-party policies may contain a liability component. For instance, property or Fidelity policies often cover the loss of property owned by third parties in the policyholder's possession. In such a situation, first-party policies may include coverage for the costs of defending claims brought against a policyholder by the owner of property that was lost while in the policyholder's possession. The costs of that defense generally will be included in the definition of "Loss" in the first-party policy.

b. The Duty to Indemnify

In a general liability policy, the insurance company typically agrees:

[27] *Valassis Communications, Inc. v. Aetna Cas. & Sur. Co.*, 97 F.3d 870, 876 (6th Cir. 1996); *Kenai Corp. v. Nat'l Union Fire Ins. Co. (In re Kenai Corp.)*, 136 B.R. 59, 64 (S.D.N.Y. 1992); *Harristown Dev. Corp. v. Int'l Ins. Co.*, No. 87-1380, 1988 WL 123149, at *11 (M.D. Pa. Nov. 15, 1988); *Faulkner v. Am. Cas. Co.*, 85 Md. App. 595, 627, 584 A.2d 734, 749-50, *cert. denied*, 323 Md. 1, 590 A.2d 158 (1991).

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> to pay those sums that the insured becomes legally obligated to pay as damages because of "bodily injury" or "property damage" to which this insurance applies. . . . This insurance applies only to bodily injury and property damage which occurs during the policy period. The "bodily injury" or "property damage" must be caused by an "occurrence." The "occurrence" must take place in the "coverage territory."[28]

A general liability policy also may have separate insuring agreements for "personal injury" and "advertising injury." Personal injury generally is defined to cover such claims as false arrest or detention, malicious prosecution, slander, libel, and violation of the right of privacy. Advertising injury generally is defined to include such claims as infringement of copyright, title, or slogan; misappropriation of advertising ideas or style of doing business; or publication of material that slanders a person or organization, or a person's or organization's goods, products, or services.

A typical insuring agreement for a D&O policy provides that the insurance company will reimburse the insured for all "Loss" that arises out of claims alleging "Wrongful Acts" committed by a director or officer in his or her capacity as a director or officer. The scope of coverage is dependent upon the definition of, and case law construing, the terms "Loss," "Wrongful Intent," and "capacity."

Property policies generally provide that the insurance company will "'pay for direct physical loss of or damage to Covered Property at the premises described in the Declarations caused by or resulting from any Covered Cause of Loss.'"[29] Such policies come in two general categories: "All Risk" and "Named Peril" policies. An All Risk policy provides insurance for "all risk of direct physical loss or damage to property" owned, leased, or under the control of the insured. "Risk" refers generally to the cause of the loss. Numerous risks are then carved out of the insurance by exclusions. A Named Peril policy insures against a particular risk, such as fire, flood, or tornado. Fidelity policies, which insure against the risk of loss from employee dishonesty, are a form of Named Peril policies. Recently, there has been discussion about government-backed insurance policies for loss caused by terrorist acts. Such insurance would be another form of a Named Peril policy.

3. Exclusions

The insuring provisions must be read, not only in conjunction with the Definitions section of the policy, but also in conjunction with all exclusions to coverage. Indeed, it is not unusual to find an insuring provision that is a simple one-sentence declaration of coverage, followed by four pages of exclusions.

Standard exclusions vary depending upon the type of coverage involved. General liability policies, for example, typically include exclusions for, among others, property owned, operated, and leased by the policyholder, business risks, completed operations, known prior acts, design defects, and the policyholder's own products. D&O policies may exclude coverage for, *inter alia*, illegal personal gain, short swing profits, failure to effect or maintain insurance, discrimination, and claims against directors and officers by regulatory agencies. First-party property policies that include business interruption coverage may exclude losses caused by, among other things, lease cancellations, interference by strikers, consequential losses, and interruption of utility services.

Many types of policies also exclude insurance coverage for losses arising out of intentionally harmful conduct. D&O policies, for example, may exclude coverage for loss arising out of the directors' and officers' fraud or self-dealing, but only if the wrongful conduct is proved "in fact." Thus, the policy provides reimbursement for

[28] The words in quotation marks are separately defined.

[29] Mathias et al., *Insurance Coverage Disputes* § 11.01, at 11-3 (quoting standard grant of coverage policy provision).

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defense of such claims, but not a judgment based upon a finding of liability for fraud or self-dealing.[30]

General liability policies often contain an exclusion if the "bodily injury" or "property damage" was expected or intended by the policyholder. Although insurance companies try to argue that this exclusion applies whenever the policyholder's conduct is intentional, this position has been uniformly rejected. To apply, the policyholder must have intended the resulting *harm*.[31]

This "expected or intended" exclusion may align an insurance company with the plaintiff asserting an underlying claim against the policyholder. For instance, the facts that may establish a claim against the policyholder for punitive damages are the same facts on which an insurance company could deny insurance based upon the expected or intended exclusion. This can lead to a conflict of interest and will impact upon whether the insurance company can control, or even participate in, the defense.

Often, exclusions are written in response to an increase in a certain type of litigation. For instance, exclusions for liability caused by asbestos, pollution, lead, or mold claims now are common in general liability policies. These exclusions were added to policies in response to the explosion of mass tort litigation involving such claims. There also can be exclusions specific to the policyholder. For instance, a pharmaceutical company may have coverage for claims arising out of specific drugs "lasered" or excluded from coverage. For example, exclusions for claims arising out of DES are common.

The rules of policy construction are particularly helpful to policyholders with respect to the interpretation of policy exclusions. Generally, exclusions must be read narrowly.[32] The insurance company has the burden of proving that an exclusion applies to a claim.[33]

There also are a number of fictional "exclusions" claimed by insurance companies that are related to the expected or intended exclusion. Two of these "exclusions" are "known loss" and "lack of fortuity." These "exclusions" are not contained in the policy,

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[30] *See* Peter J. Kalis, Thomas M. Reiter & James R. Segerdahl, *Policyholder's Guide to the Law of Insurance Coverage* § 11.05[D][2] (2002).

[31] *Allstate Ins. Co. v. Sparks*, 63 Md. App. 738, 493 A.2d 1110, 1112 (1985); *SL Indus., Inc. v. Am. Motorists Ins. Co.*, 128 N.J. 188, 207, 607 A.2d 1266, 1276 (1992); *Cont'l Cas. Co. v. Rapid-American Corp.*, 80 N.Y.2d 640, 649, 609 N.E.2d 506, 510, 593 N.Y.S.2d 966, 970 (1993); *Vt. Mut. Ins. Co. v. Singleton*, 316 S.C. 5, 446 S.E.2d 417, 420-21 (1994); *see* 2 Oshinsky & Howard, *Practitioner's Guide to Litigating Insurance Coverage Actions* § 7.03[F].

Moreover, the test is a subjective one. It is not sufficient that a reasonable person should have expected or intended the harm, but the actual policyholder must have expected or intended the resulting injury or damage if the exclusion is to apply. *Chem. Leaman Tank Lines*, 89 F.3d at 983-86, 997; *Aetna Cas. & Sur. Co. v. Dow Chem. Co.*, 28 F. Supp. 2d 421, 427-29 (E.D. Mich. 1998); *MAPCO Alaska Petroleum, Inc. v. Cent. Nat'l Ins. Co.*, 795 F. Supp. 941, 947 n.14 (D. Alaska 1991); *Armstrong World Indus., Inc. v. Aetna Cas. & Sur. Co.*, 45 Cal. App. 4th 1, 70-73, 52 Cal. Rptr. 2d 690, 719-21 (1st Dist. 1996); *United States Fid. & Guar. Co. v. Wilkin Insulation Co.*, 193 Ill. App. 3d 1087, 550 N.E.2d 1032 (1st Dist. 1989), *aff'd*, 144 Ill. 2d 64, 578 N.E.2d 926 (1991); *State v. CNA Ins. Cos.*, 172 Vt. 318, 328, 779 A.2d 662, 670 (2001).

[32] *Chicago Title Ins. Co. v. Resolution Trust Corp.*, 53 F.3d 899, 905 (8th Cir. 1995); *Am. Family Mut. Ins. Co. v. Johnson*, 816 P.2d 952, 953 (Colo. 1991); *Aetna Ins. Co. v. Weiss*, 174 N.J. Super. 292, 296, 416 A.2d 426, 428 (App. Div.) ("*Weiss*"), *certification denied*, 85 N.J. 127, 425 A.2d 284 (1980); *Borg-Warner Corp. v. Ins. Co. of N. Am.*, 174 A.D.2d 24, 33, 577 N.Y.S.2d 953, 958 (3d Dep't), *leave to appeal denied*, 80 N.Y.2d 753, 600 N.E.2d 632, 587 N.Y.S.2d 905 (1992); *Bebber v. CNA Ins. Cos.*, 189 Misc. 2d 42, 43, 729 N.Y.S.2d 844, 845-46 (Sup. Ct. Erie County 2001); *City of Burlington v. Glens Falls Ins. Co.*, 133 Vt. 423, 424, 340 A.2d 89, 90 (1975); *see also* 13 John Alan Appleman & Jean Appleman, *Insurance Law and Practice* § 7405 (1976); *see* 2 Lee R. Russ & Thomas F. Segalla, *Couch on Insurance 3d* § 22:31 (1997).

[33] *Garvey v. State Farm Fire & Cas. Co.*, 48 Cal. 3d 395, 406, 770 P.2d 704, 710, 257 Cal. Rptr. 2d 292, 298 (1989); *Diamond Shamrock Chems. Co. v. Aetna Cas. & Sur. Co.*, 258 N.J. Super. 167, 216, 609 A.2d 440, 464 (App. Div. 1992), *certification denied*, 134 N.J. 481, 634 A.2d 528 (1993); *Weiss*, 174 N.J. Super. at 296, 416 A.2d at 429; *Am. States Ins. Co. v. Md. Cas. Co.*, 427 Pa. Super. 170, 183, 628 A.2d 880, 887 (1993); *Am. Reliance Ins. Co. v. Mitchell*, 238 Va. 543, 547, 385 S.E.2d 583, 585 (1989); *see also* 17 Lee R. Russ & Thomas F. Segalla, *Couch on Insurance 3d* § 254:12 (2000).

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but are alleged to arise out of what the insurance industry claims is the basic nature of insurance.[34] For the most part, these fictional "exclusions" have been rejected by the courts.

The news on exclusions is not all bad. Sometimes insurance can be hidden within an exclusion, usually as an exception. For instance, in general liability policies, there is a standard exclusion for liability assumed by contract. However, that exclusion has an exception for "insured contracts." The standard definition of "insured contracts" lists six categories of contracts where assumed liabilities are covered. More categories of "insured contracts" can be added by endorsement. This exception to an exclusion is often relied upon as a grant of coverage.[35]

Finally, even if an exclusion applies to one theory of liability or loss, there may be theories of liability or loss that are not excluded. This is sometimes referred to as the "concurrent cause" doctrine.[36] As long as one theory of liability (in a third-party policy) or one type of peril (in a first-party policy) is covered, then the loss is covered. Thus, a legal analysis of the potential underlying liability or loss is necessary if a policyholder is to maximize recovery under an insurance policy.

4. Conditions

Most insurance policies have a Conditions section of the policy, which sets forth various duties of the policyholder and the insurance company. The most important condition relates to the policyholder's obligation to provide prompt notice of a claim made against the policyholder, or of an occurrence that might give rise to a loss or a claim under the policy. Liability insurance policies generally provide, with regard to notice:

> In the event of an occurrence, written notice containing particulars sufficient to identify the insured and also reasonably obtainable information with respect to the time, place and circumstances thereof, and the names and addresses of the injured and of available witnesses, shall be given by or for the insured to the company or any of its authorized agents *as soon as practicable.*

(Emphasis added.)

The policies also may require the policyholder to forward a copy of any underlying complaints that have been filed:

> If a claim is made or suit if brought against the insured, the insured shall immediately forward to the company every demand, notice, summons or other process received by him or his representative.

Closely related to notice is the condition that requires a policyholder to cooperate with its insurance company in the investigation of a loss or a claim under the policy or the defense of a third-party claim.

First-party policies have a requirement that a proof of loss must be filed by a particular date. A failure to provide prompt notice, to file a proof of loss, or to cooperate with your insurer can result in a forfeiture of coverage.[37]

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[34] Robert E. Keeton & Alan I. Widiss, *Insurance Law* § 5.3(a) (Practitioner's ed. 1988); Kalis et al., *Policyholder's Guide to the Law of Insurance Coverage* § 13.06.

[35] *Gibson & Assocs., Inc. v. Home Ins. Co.*, 966 F. Supp. 468, 476 (N.D. Tex. 1997); Eugene R. Anderson, Jordan S. Stanzler & Lorelie S. Masters, *Insurance Coverage Litigation* § 17.04 (2d ed. 2002).

[36] *See generally* Francis J. MacLaughlin, Brief, *Third-Party Liability Policies: The Concurrent Causation Doctrine And Pollution Exclusions*, 24-SPG Brief 20 (Spring 1995) (discussing the doctrine and providing a state survey of cases addressing the doctrine).

[37] The law varies in jurisdictions as to the consequence that may follow upon a breach of these provisions. Under the law of some states, the insurance company must prove that it was prejudiced by late notice. *E.g.*, *Steelcase, Inc. v. Am. Motorists Ins. Co.*, 907 F.2d 151 (Table), 1990 WL 92636, at **2 (6th Cir. 1990) (unpublished); *Falcon Steel Co. v. Md. Cas. Co.*, 366 A.2d 512, 514 (Del. Super. Ct. 1976); *Johnson Controls, Inc. v. Bowes*, 381 Mass. 278, 409 N.E.2d 185, 188 (1980); *Alcazar v. Hayes*, 982 S.W.2d 845, 853 (Tenn. 1998); 13 Lee R. Russ & Thomas F. Segalla, *Couch on Insurance 3d* § 193.30 (1999). In other jurisdictions, the policyholder has the burden of establishing that the insurance company was not prejudiced. *E.g.*, *Aetna Cas. & Sur. Co. v. Murphy*, 206 Conn. 409, 538 A.2d 219, 224 (1988); *Bankers Ins. Co. v. Macias*, 475 So. 2d 1216, 1217-18 (Fla. 1985); *Ormet Primary Aluminum Corp. v. Employers Ins. Co. of Wausau*,

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Notice requirements are particularly important in various claims-made policies. D&O and E&O policies are examples of claims-made coverages and general liability policies can be written on a claims-made form. These types of policies are triggered only if a claim is made against the policyholder and reported to the insurance company during the policy period. However, even under an occurrence policy – which is triggered by the alleged bodily injury or property damage – late notice can result in the insurance company's being able to avoid payment.

5. Limits of Liability

The liability limits of the policy set a maximum that the insurance company will pay under certain specified circumstances. Policy limits are generally stated on the Declarations Page. Insurance policies can have many types of limits. An aggregate limit sets the most that the policy will pay under any circumstances, regardless of how many claims are submitted. Some policies do not have aggregate limits. A per occurrence limit provides the total that the policy will pay per occurrence, or cause of the loss. There can also be limits for certain types of coverages, such as a specific limit for product liability or completed operations coverages.

In the World Trade Center case, there are no aggregate limits in the first-party property policies, only a per occurrence limit. Thus, a key dispute in the current litigation over the loss of the World Trade Center is whether the insurance companies must pay a single limit because there was one occurrence (one terrorist conspiracy), or must pay two limits because there were two occurrences (two planes that hit two buildings).[38] Similarly, in the area of environmental insurance coverage, there typically are only per occurrence limits that apply to the premises operations insurance at issue. Thus, a key question for a pollution claim is how to determine the number of occurrences – each polluting event? each type of polluting operation? or each site?

Insurance companies also can use limits as a form of an exclusion. For instance, extensive litigation has surrounded the meaning and scope of various versions of the pollution exclusion. When insurance companies were frustrated in their efforts to exclude such claims, in part due to rules of contract construction which require that exclusions be interpreted narrowly and ambiguities construed against the insurance company, some insurers have responded by placing a low sub-limit on coverage for pollution claims.

III. Issues Of Significance In Third-Party Liability Policies

The most frequently litigated issues in cases involving complex insurance claims involve the mechanics of a policy and how the policy works when claims are submitted. In cases involving third-party liability policies, the issues include, among others, management of an insurance company's defense obligation, and determination of the appropriate trigger of coverage, number of occurrences, and allocation.[39] These issues

No. 808, 1998 WL 774997 (Ohio Ct. App. 7th Dist. Oct. 30, 1998), *aff'd*, 88 Ohio St. 3d 292, 725 N.E.2d 646 (2000); 13 *Couch on Insurance 3d* § 193.30.

In New York, late notice, even without prejudice, can result in a loss of insurance. *E.g.*, *Am. Home Assurance Co. v. Int'l Ins. Co.*, 90 N.Y.2d 433, 440, 684 N.E.2d 14, 16, 661 N.Y.S.2d 584, 586 (1997) (reversing Appellate Division's decision relaxing per se rule with regard to notice to excess insurance companies, 219 A.D.2d 143, 641 N.Y.S.2d 241 (1st Dep't 1996)); *State v. Taugco Inc.*, 213 A.D.2d 831, 832, 623 N.Y.S.2d 383, 385 (3d Dep't 1995).

[38] *E.g.*, *World Trade Ctr. Props. v. Travelers Indem. Co.*, No. 01cv12738 (S.D.N.Y. filed Dec. 28, 2001); *SR Int'l Bus. Ins. Co. v. World Trade Ctr. Props., Inc.*, No. 01cv9291 (S.D.N.Y. filed Oct. 22, 2001) .

[39] Insurance companies can and do differ among themselves as to the meaning of the policy language that controls these issues. Insurance companies appear to accept a certain level of ambiguity, using the flexibility that ambiguity provides to take different positions on the meaning of policy language in responding to claims presenting a different level of exposure.

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may determine how much money the policyholder will recover from its insurance companies, or, indeed, whether the policyholder will recover any money at all. Courts have struggled over the issues discussed below and the law varies in different jurisdictions. Because the law is neither clear nor settled, in-house counsel need a clear understanding of these issues to protect the policyholder's interests.

A. Managing an Insurance Company's Defense Obligation

General liability policies generally provide that the insurance company has the "right and duty to defend." *See* discussion *supra*. Thus, the insurance company will argue that it has the right to control the defense. This is not a problem when the insurance company has accepted coverage. When the underlying claim is fully covered, the insurance company will bear the entire consequence if judgment is obtained against the policyholder. As a consequence, the insurance company is motivated to provide a sufficient defense and the policyholder is fully protected if it does not.

Unfortunately, there are many circumstances where the entire risk of an adverse result in the underlying claim has not been shifted to the insurance company. In those circumstances, policyholders and their insurance companies often find themselves in conflict on any number of issues regarding management of the defense.

As an initial matter, a policyholder and its insurance company may have a very different view of the quality of the defense that is appropriate. Insurance companies frequently want to hire an "insurance defense" firm – a firm that has a long-standing relationship with the insurance company from whom it receives a significant portion, or sometimes all, of its business.[40] The insurance defense firm's handling of the underlying claims can be characterized as economical and efficient, or inadequate, depending upon one's standards and perspective.

Policyholders, on the other hand, generally want "the best defense that money can buy," particularly when the costs of that defense are borne by the insurance company. These differing views as to the quality of the defense often arise when there are non-insurable consequences from the underlying action, such as damage to reputation, or interference with future business prospects.

These differences can lead to numerous disagreements, particularly when an insurance company rejects defense expenditures that the policyholder believes are necessary to protect its interests, or the insurance company imposes limitations on the work defense counsel can do, which the policyholder believes will negatively affect the quality of the defense. For example, the policyholder facing a series of lawsuits in different jurisdictions – such as mass tort or products liability suits – may believe that national defense counsel is necessary to ensure that the positions and strategies undertaken in each individual action are consistent, and to determine the overall strategy of defense to be followed in those actions. Insurance companies often object to the added expense of hiring national defense counsel.

This unlimited defense obligation contained in many general liability policies also can create a conflict between the interests of the insurance company and those of the policyholder in the outcome of the underlying claim. It may be in the financial interest of the insurance company to reach early settlements, or even suffer early losses, so that the policy's indemnity limits can be exhausted and the insurance company's defense obligation extinguished. However, the insurance company's interest in quick "nuisance settlements" can be devastating to the policyholder's interests in many ways. Not only

[40] Frequently, these firms agree to charge the insurance company a below-market rate for their services, and agree to abide by all aspects of the insurance company's billing or claims-handling guidelines.

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may there be a portion of the loss not covered by the insurance (e.g., damage to reputation), but word of quick settlements in a few early actions can lead to the filing of many more claims against the policyholder, as well as increasing the "war chest" available to underlying plaintiffs' counsel to fund additional claims. The insurance company's financial interest in exhausting its indemnity limits and exiting the case quickly is in direct conflict with the policyholder's interests in vigorously defending the underlying claims.

For example, in *Emons Industries, Inc. v. Liberty Mutual Insurance Co.*,[41] the policyholder was sued in numerous underlying actions relating to its manufacture and sale of the drug DES. The court found that there were "substantial conflicts of interest" between the policyholder and the insurance company because the insurance company had "a strong interest in reducing the defense costs it must pay by quickly settling these cases irrespective of whether they are reasonable or are within the per claim limit," while it was in the policyholder's best interest to vigorously defend these suits and obtain the smallest possible settlement or judgment. In the face of that conflict, the court enjoined the insurance company from interfering with the policyholder's choice of counsel.

Insurance companies often respond to notice of an underlying action by agreeing to defend under a reservation of rights ("ROR"). An ROR letter will set forth various defenses to indemnity coverage. Often the strength of the insurance company's defenses to coverage will depend upon the facts developed in the underlying action. Sometimes the ROR letter also will attempt to preserve the insurance company's right to recoup any money spent in defense of the action if the insurance company is successful in establishing that there was no indemnity coverage.

[41] 749 F. Supp. 1289, 1297 (S.D.N.Y. 1990).

The insurance company may take a position in the ROR letter that is similar to the position taken by the underlying plaintiffs asserting claims against the policyholder. As already mentioned, the insurance company may reserve its right to deny coverage on the ground that the policyholder expected or intended to cause bodily injury or property damage. Based upon those facts, the insurance company will argue that there is no occurrence, or that the claim arose out of a "known loss." These insurance defenses are based upon an alleged factual premise that is similar, if not identical, to what the underlying plaintiffs allege against the policyholder to support their claims for an intentional tort or for punitive damages. If the insurance company seeks to deny coverage based upon a factual argument that is similar to what is asserted against the policyholder in the underlying claims, there is a conflict of interest between the policyholder and insurance company in the defense of that claim. Under these circumstances, allowing the insurance company to control the defense is akin to putting the fox in charge of the chicken coop.

It is also typical for an underlying action to involve both covered and not covered claims. For instance, many product liability claims are based upon negligence (covered), but also include intentional or punitive damage claims, or contract and warranty claims (generally not covered). An insurance company's defense obligation is triggered whenever the underlying complaint contains allegations that are arguably within the policy coverage. In most states, the law requires that the insurance company must defend the entire action as long as even one potentially covered claim is at issue. This creates a conflict, as the insurance company's primary interest is in defeating only the *potentially covered* claim, and thereby ending its duty to defend, while the policyholder's interest is in defeating *all* claims filed against it.

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For example, in *Lockwood International, B.V. v. Volm Bag Co.*,[42] after spending four years defending its policyholder, the insurance company entered into a settlement agreement with the underlying plaintiff in which the insurance company paid the underlying plaintiff to file an amended complaint that pled only not covered claims. The appellate court, reversing the trial court's entry of final judgment on the covered claims, recognized that the insurance company's actions arose directly from the conflict of interest created when the insurance company controlled the defense of both covered and not covered claims:

> We have difficulty imagining a more conspicuous betrayal of the insurer's fiduciary duty to its insured than for its lawyers to plot with the insured's adversary a repleading that will enable the adversary to maximize his recovery of uninsured damages from the insured while stripping the insured of its right to a defense by the insurance company. The limits of coverage, whether limits on the amount to be indemnified under the policy or, as in the present case, on the type of claims covered by the policy, create a conflict of interest between insurer and insured. The insurer yielded to the conflict, in effect paying its insured's adversary to eliminate the insured's remaining insurance coverage.[43]

The law provides policyholders with certain protections when there is a conflict between the interests of the insurance company and those of the policyholder.[44] For instance, the ethical rules governing an attorney's conduct require that the defense counsel's sole loyalty is to the policyholder client, rather than the insurance company that is paying the legal bills.[45] Insurance companies contend that this ethical rule solves the problems that arise when there is a conflict of interest between the insurance company and the policyholder.

This "protection," however, may be insufficient. First, such ethical rules are binding only on the attorney, not on the insurance company. They may not, for example, prevent the insurance company from attempting to interfere with the management of the case through enforcement of its claims-handling guidelines or through a dispute over what is reimbursable under the billing guidelines. Moreover, the defense counsel's ethical rules do not prevent the insurance company from initiating settlement discussions directly with an underlying plaintiff despite the policyholder's objections.

Second, insurance companies often do not agree that, when there is a conflict, the right to control the defense shifts to the policyholder. For instance, in a brief filed in Montana related to the use by insurance companies of claims-handling guidelines to control the defense of claims, the insurance companies argued:

> [D]efense counsel represents both the insured and the insurer. Insurers, like any other client, are thus entitled to define the objectives of the representation.[46]

Third, whatever the rules formally state about the loyalty required of defense counsel, that loyalty can be sorely tested when a significant portion of the attorney's practice depends upon receiving continued defense assignments from the insurance company's claims handlers.

Because of the inadequacy of the one-client rule, the vast majority of courts addressing the conflict issue have held that, when a conflict of interest exists, the policyholder must be allowed to select defense counsel and to manage the defense of an

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[42] 273 F.3d 741, 744 (7th Cir. 2001).

[43] *Id.* (citations omitted).

[44] The relationship among the policyholder, the insurance company, and the defense counsel is often referred to as the triangular, or tripartite relationship.

[45] *See* Michael F. Aylward, The American Law Institute, *Insurance Ethics: The Future of the Tripartite Relationship*, SG004 ALI-ABA 217, 223-24 (2001); Ronald D. Rotunda, The American Bar Association, *Legal Ethics – The Lawyer's Deskbook On Professional Responsibility* § 8-6.13.1 (2002-03 ed.); *see generally* Laura A. Foggan, Practicing Law Inst., *Ethics and Professional Responsibility Issues: The Tripartite Relationship*, 673 PLI/Lit 479 (2002) (recent survey of each state's view on who defense counsel represents).

[46] Joint Brief of Respondents, In re Rules of Professional Conduct and Insurer Imposed Billing Rules and Procedures, No. 98-612 (Mont. filed May 17, 1999).

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underlying action, even in the face of policy provisions clearly and unambiguously granting such management to the insurance company. For example, in *Mundry v. Great American Insurance Co.*,[47] the Second Circuit held that under both Connecticut and New York law, an insurance company must notify its policyholder if it disputes insurance coverage in order to allow the policyholder to exercise its right to "retain independent counsel and to take over the defense, and either settle the case or conduct the defense more vigorously than the insurer would after announcing an intention to disclaim." Cases in other jurisdictions routinely hold that the insurance company must pay for independent counsel chosen by the policyholder, when there is a conflict between the interests of the insurance company and those of its policyholder.[48]

As a leading authority on insurance coverage states: "Where the insurer lacks an economic motive for vigorous defense of the insured, or the insurer and insured have conflicting interests, the insurer may not compel the insured to surrender control of the litigation."[49] Neither the theoretical "sole-client" rule nor the policy provision that the insurance company has the "right and duty to defend" the policyholder justifies exposing the policyholder to the risk that the insurance company will advance its own interests at the expense of the defense to which the policyholder is entitled.

B. The Controversy over Trigger of Coverage

"Trigger of coverage" refers to the event that must take place during the policy period that requires the policy to respond. Some policies are "claims-made," meaning that the policy must respond if the claim is made against the policyholder (and reported to the insurance company) during the policy period. Other types of policies contain specific triggering provisions. For instance, personal injury and advertising liability coverages in general liability policies provide that the policy must respond if the alleged wrongful act took place during the policy period. By far, the greatest degree of controversy concerns the trigger of coverage in "latent" injury claims that are submitted under the bodily injury or property damage occurrence coverages provided by general liability policies.[50] Under these coverages, the policy is triggered if the alleged bodily injury or property damage takes place during the policy period.

Another example of "latent" claims is environmental property damage claims. These differ from the bodily injury claims discussed above in that they typically involve a

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[47] 369 F.2d 678, 681-82 (2d Cir. 1966).

[48] *See, e.g.*, *Am. Family Life Assurance Co. v. United States Fire Co.*, 885 F.2d 826, 831 (11th Cir. 1989) (applying Georgia law); *Cunniff v. Westfield, Inc.*, 829 F. Supp. 55, 57 (E.D.N.Y. 1993); *CHI of Alaska, Inc. v. Employers Reinsurance Corp.*, 844 P.2d 1113, 1121 (Alaska 1993); *San Diego Navy Fed. Credit Union v. Cumis Ins. Soc'y, Inc.*, 162 Cal. App. 3d 358, 373, 208 Cal. Rptr. 494, 504 (4th Dist. 1984); *Ill. Masonic Med. Ctr. v. Turegum Ins. Co.*, 168 Ill. App. 3d 158, 163, 522 N.E.2d 611, 613 (1st Dist. 1988); *Nandorf, Inc. v. CNA Ins. Cos.*, 134 Ill. App. 3d 134, 138, 479 N.E.2d 988, 992 (1st Dist. 1985) (insurance company that issued reservation of rights meets its defense obligation "by reimbursing the insured for the costs of independent counsel," including costs of counsel selected by policyholder); *Snodgrass v. Baize*, 405 N.E.2d 48, 51 (Ind. Ct. App. 2d Dist. 1980); *Belanger v. Gabriel Chems., Inc.*, 787 So. 2d 559, 565-67 (La. Ct. App. 1st Dist.), *writ denied*, 802 So. 2d 612 (La. 2001); *Moeller v. Am. Guar. & Liab. Ins. Co.*, 707 So. 2d 1062, 1071 (Miss. 1996); *Pub. Serv. Mut. Ins. Co. v. Goldfarb*, 53 N.Y.2d 392, 401 n.*, 425 N.E.2d 810, 815 n.*, 442 N.Y.S.2d 422, 427 n.* (1981); *Nat'l Mortgage Corp. v. Am. Title Ins. Co.*, 41 N.C. App. 613, 622-23, 255 S.E.2d 622, 629-30 (1979), *rev'd on other grounds*, 299 N.C. 369, 261 S.E.2d 844 (1980); *Socony-Vacuum Oil Co. v. Cont'l Cas. Co.*, 144 Ohio St. 382, 396-97, 59 N.E.2d 199, 205 (1945).

However, in a small minority of jurisdictions, the courts hold that, as long as the insurance company hires independent counsel, the fact that counsel's loyalty is to the policyholder provides sufficient protection. *See Finley v. Home Ins. Co.*, 90 Haw. 25, 31-33, 975 P.2d 1145, 1151-53 (1998).

[49] 7C John Alan Appleman, *Insurance Law and Practice* § 4681, at 5 (1979).

[50] A "latent injury claim" or "long tail claim" refers to a claim where the bodily injury or property damage goes on for many years while remaining undetected. Examples of such latent injury bodily injury claims are those arising from exposure to asbestos or harmful drugs. The activity causing the claims is typically of long duration, and the alleged injury or damage is widespread. Such claims often involve multiple plaintiffs and can give rise to mass tort litigation and class actions. Latent injury claims also can involve multiple defendants, multiple insurance companies, multiple coverage layers, and many policy periods.

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single claimant, usually a governmental entity. However, environmental damage is usually widespread and not detected until years after the activity that caused the problem. Perhaps the most important characteristic of latent injury claims is that, although typically difficult to evaluate, they usually involve a lot of money.

In the standard general liability policies, the policy language that provides the trigger of coverage is generally found in the definitions of bodily injury and property damage. Typical definitions provide that:

> "bodily injury" means bodily injury, sickness or disease sustained by any person which occurs *during the policy period*, including death at any time resulting therefrom;
>
> "property damage" means (1) physical injury to or destruction of tangible property which occurs *during the policy period* including the loss of use thereof at any time resulting therefrom, or (2) loss of use of tangible property which has not been physically injured or destroyed provided such loss of use is caused by an occurrence *during the policy period*.[51]

The references to "during the policy period" in the definitions of bodily injury and property damage provide the trigger of coverage.

In the late 1970s and early 1980s, there was significant coverage litigation concerning asbestos-related bodily injury claims. Insurance companies took different positions on trigger of coverage, arguing that: only policies on the risk at the time when the claimant was exposed to asbestos were triggered; or only the policy on the risk on the date of *first* exposure was triggered; or only the policy on the risk at manifestation or discovery of the asbestos disease was triggered; or only the policy on the risk when the injury *could have been* discovered was triggered. Not surprisingly, the trigger position advocated by each insurance company tended to minimize its exposure, either in the context of the particular claim presented or in the context of the insurance company's entire book of business.

These coverage limiting theories were rejected in *Keene Corp. v. Insurance Co. of North America*,[52] which held that all policies on the risk from first exposure to asbestos to manifestation of the disease were triggered. The *Keene* theory is referred to as the "continuous trigger." It imposes a legal presumption that latent injury claims involve continuous injury, but allows the insurance company to prove, as a matter of fact, that injury or damage did not take place during any particular policy period.

Closely related to the *Keene* decision is the "injury-in-fact trigger" adopted by *American Home Products Corp. v. Liberty Mutual Insurance Co.*[53] Under this theory, the policyholder has the burden of proving, as a matter of fact, that injury or damage took place during each policy period.

The injury-in-fact and continuous trigger theories often lead to the same result, particularly in toxic tort cases. All policies from first exposure to manifestation are triggered. The difference is one of burden of proof: whether the policyholder has the burden of proving injury during each policy period ("injury-in-fact trigger"), or whether the burden shifts to the insurance company to disprove injury in its particular year or years ("continuous trigger"). Although most jurisdictions appear to be moving towards either an injury-in-fact[54] or continuous trigger[55] of coverage, there still are exceptions, and some courts apply an exposure[56] or manifestation[57] trigger to certain types of claims.

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[51] International Risk Management Institute, Inc., *Commercial Liability Insurance*, 1973 Policy Jacket Specimen (2002) (emphasis added).

[52] 667 F.2d 1034, 1048 (D.C. Cir. 1981), *cert. denied*, 455 U.S. 1007 (1982).

[53] 565 F. Supp. 1485 (S.D.N.Y. 1983), *aff'd as modified*, 748 F.2d 760 (2d Cir. 1984).

[54] *Am. Home Prods. Corp. v. Liberty Mut. Ins. Co.*, 748 F.2d 760 (2d Cir. 1984); *Avondale Indus., Inc. v. Travelers Indem. Co.*, 774 F. Supp. 1416 (S.D.N.Y. 1991); *Sentinel Ins. Co. v. First Ins. Co. of Haw., Ltd.*, 76 Haw. 277, 875 P.2d 894 (1994); Eugene R. Anderson, Jordan S. Stanzler & Lorelie S. Martens, *Insurance Coverage Litigation* § 4.04 (2d ed. 2002).

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One area relating to trigger of coverage that currently is causing disputes in coverage litigation is how the factual issues surrounding trigger of coverage are litigated in the mass tort context, where coverage often is sought for thousands, or tens of thousands, of claims. To require a factual inquiry into each claim has the practical effect of denying coverage because of the procedural difficulties of proof. Accordingly, courts have allowed the factual issues surrounding trigger of coverage to be resolved using exemplar claims,[58] a statistical sample,[59] the testimony of a series of independent experts which provides an opinion of a particular fact,[60] or summary testimony of a fact witness who has reviewed all or a statistically valid sample of the universe of claims.[61] In-house counsel, who are involved both with defending underlying claims as well as pursuing coverage, can, at an early stage, begin to gather the facts on the timing of injury or damage so that the policyholder can establish this element of its insurance claim.

Another issue of recent interest relating to the trigger of coverage involves the question of whether policies can be triggered when there has been no determination in the underlying case of the existence, much less the timing, of bodily injury or property damage. This is an issue of particular significance in underlying mass tort litigation because the policyholder often contends that no bodily injury or property damage actually occurred. If the underlying case is settled, there may be no factual determination as to whether, much less when, bodily injury or property damage actually took place.[62] In many jurisdictions, a policyholder need not prove its own liability for a settled claim in order to obtain coverage. All the policyholder needs to establish is that it had *potential* liability based upon the facts known at the time of the settlement, and that the settlement was reasonable.[63]

A recent case to demonstrate this point is *Dow Corning Corp. v. Continental Casualty Co.*,[64] which concerned insurance coverage for breast implants. All of the parties in the coverage litigation, including the court, believed that the implants did not cause bodily injury. Dow Corning settled the underlying claims because, regardless of the medical evidence, Dow Corning believed it could lose the underlying claims if tried by a jury. The court held that, despite the absence of actual bodily injury, the underlying implant claims could still trigger coverage.[65]

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[55] *Keene Corp. v. Ins. Co. of N. Am.*, 667 F.2d 1034 (D.C. Cir. 1981), *cert. denied*, 455 U.S. 1007 (1982); *New Castle County v. Cont'l Cas. Co.*, 725 F. Supp. 800 (D. Del. 1989), *aff'd in part, rev'd in part on other grounds sub nom. New Castle County v. Hartford Accident & Indem. Co.*, 933 F.2d 1162 (3d Cir. 1991); *Lac D'Amiante Du Quebec, Ltee. v. Am. Home Assurance Co.*, 613 F. Supp. 1549 (D.N.J. 1985); Anderson et al., *Insurance Coverage Litigation* § 4.02.

[56] *Commercial Union Ins. Co. v. Sepco Corp.*, 765 F.2d 1543 (11th Cir. 1985); *Ducre v. Executive Officers of Halter Marine, Inc.*, 752 F.2d 976 (5th Cir. 1985); *Ins. Co. of N. Am. v. Forty-Eight Insulations, Inc.*, 633 F.2d 1212 (6th Cir. 1980), *cert. denied*, 454 U.S. 1109 (1981); *Burroughs Wellcome Co. v. Commercial Union Ins. Co.*, 632 F. Supp. 1213 (S.D.N.Y. 1986); *Allstate Ins. Co. v. Colonial Realty Co.*, 121 Misc. 2d 640, 468 N.Y.S.2d 800 (Sup. Ct. Kings County 1983); Anderson et al., *Insurance Coverage Litigation* § 4.03.

[57] *Mraz v. Canadian Universal Ins. Co.*, 804 F.2d 1325 (4th Cir. 1986); *Eagle-Picher Indus., Inc. v. Liberty Mut. Ins. Co.*, 682 F.2d 12 (1st Cir. 1982), *cert. denied*, 460 U.S. 1028 (1983); *Am. Motorists Ins. Co. v. E. R. Squibb & Sons, Inc.*, 95 Misc. 2d 222, 406 N.Y.S.2d 658 (Sup. Ct. N.Y. County 1978); Anderson et al., *Insurance Coverage Litigation* § 4.05.

[58] *Celotex Corp. v. AIU Ins. Co. (In re Celotex Corp.)*, 152 B.R. 661, 665 (Bankr. M.D. Fla. 1993).

[59] *UNR Indus., Inc. v. Cont'l Cas. Co.*, 942 F.2d 1101, 1107 (7th Cir. 1991), *cert. denied*, 503 U.S. 971 (1992); *see also Manual for Complex Litigation—Third* § 21-493 (1995).

[60] *Eagle-Picher Indus., Inc. v. Liberty Mut. Ins. Co.*, 829 F.2d 227, 242 (1st Cir. 1987).

[61] *See* Fed. R. Evid. 1006.

[62] Moreover, often there are additional underlying claims on the horizon, so that if the policyholder were required to prove its own liability in order to obtain insurance, that would invite more underlying tort claims to be filed.

[63] *Luria Bros. & Co. v. Alliance Assurance Co.*, 780 F.2d 1082, 1091 (2d Cir. 1986).

[64] Nos. 200143 et al. (Mich. Ct. App. Oct. 12, 1999), *reprinted in Mealey's Litig. Reports - Ins.* at F-1 (Oct. 19, 1999).

[65] *Id.*, slip op. at 7.

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C. The Debate over Number of Occurrences

The insuring agreements in general liability, umbrella, and excess policies generally provide coverage for bodily injury and property damage resulting from an "occurrence." Generally, that term is defined as follows:

> "Occurrence" means an accident, including continuous or repeated exposure to conditions, which results in personal injury, property damage or advertising injury neither expected nor intended from the standpoint of the insured.[66]

That standard definition of "occurrence" was introduced in 1966, when the liability insurance industry changed the policy language to provide insurance on an "occurrence" basis, rather than on an "accident" basis. The change in the standard policy language from "accident" to "occurrence" required that the term "occurrence" be interpreted "from the standpoint of the *insured*," not from the standpoint of the injured person. Insurance provided by other forms of coverage, such as first-party property policies, also can be provided on an occurrence basis.

The number of occurrences involved in underlying litigation may affect: (i) the number of deductibles or SIRs the policyholder must pay; (ii) the number of per occurrence limits the primary policy must pay; and (iii) whether the loss will be borne principally by the primary layer of coverage (in the case of multiple occurrences) or shifted to the excess layers (in the case of one occurrence). The number of occurrences also may impact whether it is appropriate to allocate the entire loss over many years (if occurrence is considered synonymous with loss) and whether a "non-cumulation clause" (present in some policies) applies. Accordingly, a determination of the number of occurrences can have an enormous impact on which layer of insurance responds to a claim and for how much.

Because the number of occurrences issue affects many aspects of how the policy works, and often affects how the loss is spread among multiple insurance companies, it is an issue on which insurance companies and policyholders take different positions, depending upon how their interests are affected.[67] It is also an intensely factual issue that must be determined on a case-by-case basis. This allows for creativity in the dispute over the number of occurrences, and diversity (or inconsistency) in the results.

The vast majority of courts hold that a determination of the number of occurrences requires reference "to the cause or causes of damage, rather than to the number of individual claims or injuries."[68] Cases that have considered the change from

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[66] *See generally* 9 Lee R. Russ & Thomas F. Segalla, *Couch on Insurance 3d* § 126:29 (1997); 12 Am. Jur. 3d *Proof of Facts* § 3 (1991); James L. Rigelhaupt, Annotation, *Construction and Application of Provisions of Liability Insurance Policy Expressly Excluding Injuries Intended or Expected by Insured*, 31 A.L.R.4th 957, 971-72 (1984).

[67] Insurance companies that principally write primary coverage are likely to argue that multiple claims arise from a single occurrence. If this argument is accepted, the insurance company can confine its payments to a single occurrence limit and cut off its duty to pay defense costs. Insurance companies that principally write excess coverage tend to argue that each claim is a separate occurrence, in an attempt to confine the loss to the primary layer. Insurance companies that write both primary and excess coverage may take inconsistent positions depending upon their exposure on a particular claim. Knowledgeable policyholders, and their counsel, can and should exploit these differences, arguing that the language is imprecise and, therefore, ambiguous.

[68] 2 Allan D. Windt, *Insurance Claims & Disputes* § 11.24, at 559 (4th ed. 2001); *see Newmont Mines Ltd. v. Hanover Ins. Co.*, 784 F.2d 127, 135-36 (2d Cir. 1986); *Mich. Chem. Corp. v. Am. Home Assurance Co.*, 728 F.2d 374, 379-80 (6th Cir. 1984); *Appalachian Ins. Co. v. Liberty Mut. Ins. Co.*, 676 F.2d 56, 61 (3d Cir. 1982); *Greaves v. State Farm Ins. Co.*, 984 F. Supp. 12, 16-17 (D.D.C. 1997), *aff'd*, 172 F.3d 919 (D.C. Cir. 1998); *Air Prods. & Chems., Inc. v. Hartford Accident & Indem. Co.*, 707 F. Supp. 762, 772-73 (E.D. Pa 1989), *aff'd in part, vacated in part on other grounds*, 25 F.3d 177 (3d Cir. 1994); *Uniroyal, Inc. v. Home Ins. Co.*, 707 F. Supp. 1368, 1380-81 (E.D.N.Y. 1988); *Champion Int'l Corp. v. Liberty Mut. Ins. Co.*, 701 F. Supp. 409, 412-13 (S.D.N.Y.), *amended by* 758 F. Supp. 127 (S.D.N.Y. 1988); *Transcontinental Ins. Co. v. Wash. Pub. Utils. Dists.' Util. Sys.*, 111 Wash. 2d 452, 467, 760 P.2d 337, 345-46 (1988); *see also* 12 Lee R. Russ & Thomas F. Segalla, *Couch on Insurance 3d* § 172:12 (1998); 46 C.J.S. *Insurance* § 1129 (1993); Michael P. Sullivan, Annotation, *What Constitutes Single Accident or Occurrence Within Liability Policy Limiting Insurer's Liability to a Specified Amount Per Accident or Occurrence*, 64 A.L.R.4th 668, 673 (1988); 44 Am. Jur. 2d *Insurance* § 1552 (1982).

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accident-based, to occurrence-based, coverage have recognized that, in determining the "cause" of the loss, the analysis must focus on the policyholder's conduct and not the resulting individual injury.[69] A minority of cases look to the effect, or resulting injury, to determine the number of occurrences.[70]

Courts applying the cause test may, depending upon the circumstances of the particular case, reach different conclusions on the number of occurrences. In *Metropolitan Life Insurance Co. v. Aetna Casualty & Surety Co.*,[71] for example, the issue was the number of occurrences that were involved in thousands of asbestos claims arising out of an alleged failure to warn of asbestos dangers. Although the court adopted a cause test, it found that the cause of the alleged bodily injury was each claimant's exposure to asbestos, not the alleged conduct of the policyholder. Thus, it held that each claim presented a separate occurrence.

In *Uniroyal, Inc. v. Home Insurance Co.*,[72] the court held that hundreds of thousands of Vietnam veterans' exposures to Agent Orange, as a result of numerous sprayings, all arose from a single occurrence. The single occurrence was the policyholder's delivery of Agent Orange to the military.[73] The *Uniroyal* court rejected the insurance company's argument that the number of occurrences should be determined "by reference to the time and place of the ultimate injury," and instead looked at the underlying conduct for which the policyholder was being held liable.[74]

An interesting example of a court wrestling with the number of occurrences issue is presented by two decisions involving claims against Dow Chemical Company. In *Dow Chemical Co. v. Associated Indemnity Corp.*,[75] a federal court in Michigan held that multiple claims based upon the sale of a building product should be treated as multiple occurrences. The same court a few years later, interpreting the same policies, held in a subsequent case, *Associated Indemnity Corp. v. Dow Chemical Co.*,[76] that the sale of defective resin used to make pipes that failed, resulting in multiple claims of property damage, constituted a single occurrence. The only way to harmonize these apparently conflicting decisions is through the court's belief that the policy language was ambiguous. Accordingly, in each case, the court interpreted the language in a manner that favored Dow Chemical for that particular claim.

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[69] In *Uniroyal*, the court recognized that the insurance industry developed the "occurrence" policies to make clear its intent to provide insurance for "gradual, continuous, and prolonged events that might have been excluded by the instantaneous connotation of 'accident.'" 707 F. Supp. at 1381 (citing *American Home Prods. Corp. v. Liberty Mut. Ins. Co.*, 565 F. Supp. 1485, 1501 (S.D.N.Y. 1983), *aff'd as modified*, 748 F.2d 760 (2d Cir. 1984)); *see also Newmont Mines*, 784 F.2d at 135-36 ("occurrence" provides broader coverage than "accident"); *Burroughs Wellcome Co. v. Commercial Union Ins. Co.*, 632 F. Supp. 1213, 1216-17, 1219 n.2 (S.D.N.Y. 1986) (same); *Am. Motorists Ins. Co. v. E. R. Squibb & Sons, Inc.*, 95 Misc. 2d 222, 223-24, 406 N.Y.S.2d 658, 659-60 (Sup. Ct. N.Y. County 1978) (same).

[70] *Lombard v. Sewerage & Water Bd.*, 284 So. 2d 905, 915-16 (La. 1973); *Gibbs v. Armovit*, 182 Mich. App. 425, 429, 452 N.W.2d 839, 840-41 (1990).

[71] 255 Conn. 295, 765 A.2d 891 (2001). Several courts in New York have adopted an "unfortunate events" test, which looks to the "unfortunate event" from which the claim or claims arose to determine the number of occurrences. Under this test, there may be more than one cause for purposes of determining the number of occurrences. *See, e.g.*, *Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp.*, 73 F.3d 1178, 1213 (2d Cir. 1995), *modified on other grounds on denial of reh'g*, 85 F.3d 49 (2d Cir. 1996); *DiCola v. Am. S.S. Owners Mut. Protection & Indem. Ass'n (In re Prudential Lines Inc.)*, 158 F.3d 65, 81 (2d Cir. 1998); *see also Consol. Edison Co. of N.Y. v. Employers Ins. of Wausau*, No. 96 Civ. 6235 (MBM), 1997 U.S. Dist. LEXIS 18486, at *7 (S.D.N.Y. Nov. 21, 1997).

[72] 707 F. Supp. 1368, 1379-87 (E.D.N.Y. 1988).

[73] *Id.* at 1382.

[74] *Id.* at 1380.

[75] 727 F. Supp. 1524 (E.D. Mich. 1989).

[76] 814 F. Supp. 613, 622-23 (E.D. Mich. 1993).

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A related issue involves interpretation of the so-called "batch" clause, which some policies also include in their definition of "occurrence." Such a provision may (there are different versions) provide:

> For purposes of determining the limit of the company's liability and the retained limit, all bodily injury and property damage arising out of continuous or repeated exposure to substantially the same general conditions shall be considered as arising out of one occurrence.

This type of provision generally is referred to as a batch clause because it is intended to combine, or "batch," all related claims emanating from substantially the same conduct into a single occurrence. Under a batch clause, only one occurrence arises when the insured's conduct creates conditions leading to similar injuries and multiple claimants.

Disputes over the meaning of a batch clause may arise with respect to the interpretation of the phrase "exposure to substantially the same general conditions." Parties have argued that claims should be "batched": (i) only when multiple exposures are suffered by the same injured party; (ii) only when similar exposures are suffered by multiple bodily injury claimants (e.g., asbestos);[77] (iii) when multiple dumpings of wastes at a single environmental site cause property damage;[78] (iv) when multiple claims arise out of the sale of the same product;[79] or (v) when multiple claims arise out of a similar course of conduct.[80]

D. Allocation in General Liability Insurance Policies

The issue of allocation refers generally to whether a loss will be spread horizontally over multiple triggered policies or will be assigned to a single triggered policy year.[81] Traditional general liability policy language defines an insurance company's obligation as follows:

> [The insurance companies will pay] on behalf of the insured all sums which the insured shall become legally obligated to pay as damages . . . .

Policyholders argue that, once a policy year is "triggered" by injury or property damage, each of the individual insurance policies in that year must indemnify the policyholder for "all sums" for which the policyholder becomes liable, subject to each policy's limits. "All sums" allocation divides the loss among policies "vertically." Each triggered policy is jointly and severally liable for "all sums" until the policy's limits are exhausted and then the policies that sit above the exhausted policy are called upon in the same manner. Each of the paying insurance companies then can pursue its contribution claims against the other insurance companies whose policies are triggered in different policy years.

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[77] Numerous courts have held that multiple claims resulting from exposure to asbestos must be considered a single occurrence under liability insurance policies containing a batch clause. *Air Prods. & Chems.*, 707 F. Supp. at 772-73; *Owens-Illinois, Inc. v. Aetna Cas. & Sur. Co*., 597 F. Supp. 1515, 1527-28 (D.D.C. 1984); *United States Gypsum Co. v. Admiral Ins. Co.*, 268 Ill. App. 3d 598, 648-49, 643 N.E.2d 1226, 1258-59 (1st Dist. 1994), *appeal denied*, 161 Ill. 2d 542, 649 N.E.2d 426 (1995).

[78] *See, e.g.*, *Endicott Johnson Corp. v. Liberty Mut. Ins. Co.*, 928 F. Supp. 176, 180-81 (N.D.N.Y. 1996) (court focused on the batch clause to consolidate many waste disposals over many years into a single occurrence at each of two separate waste sites), *appeal dismissed*, 116 F.3d 53 (2d Cir. 1997).

[79] *Champion Int'l Corp. v. Cont'l Cas. Co.*, 546 F.2d 502, 505-06 (2d Cir. 1976), *cert. denied*, 434 U.S. 819 (1977).

[80] *See, e.g.*, *Chemstar, Inc. v. Liberty Mut. Ins. Co*., 797 F. Supp. 1541, 1545-48 (C.D. Cal. 1992) (involving underlying allegations of a policyholder's "failure to warn" over an extended period), *aff'd*, 41 F.3d 429 (9th Cir. 1994), *cert. denied*, 517 U.S. 1219 (1996).

[81] *See generally* John H. Mathias, Jr., John D. Shugrue & Thomas A. Marrinson, *Insurance Coverage Disputes* § 14.06 (2002).

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Insurance companies generally argue for "pro rata allocation" or "pro rata by time on the risk allocation," which refers to dividing a loss "horizontally" among all triggered policy periods, with each insurance company paying only a share of the policyholder's total damages. When courts adopt proration, they tend to rely upon general principles of equity, rather than policy language, ruling that, given the facts in a particular case, it is fair to spread the loss over the several years.[82]

Cases at the level of state supreme courts are fairly evenly divided between these two theories of allocation. The highest courts of California, Delaware, Illinois, Ohio, Pennsylvania, and Washington,[83] as well as numerous federal courts,[84] have refused to imply a pro rata limitation in policies where no express limitation exists. For example, the Washington Supreme Court, in *American National Fire Insurance Co. v. B & L Trucking & Construction Co.*,[85] rejected an insurance company's argument for proration based upon "fairness" considerations, emphasizing that the policy language controls:

> [The insurance company] drafted the policy language; it cannot now argue its own drafting is unfair. Further, because insurance policies are considered contracts, the policy language, and not public policy, controls. We will not add language to the policy that the insurer did not include. Instead, [the insurance company] agreed to pay "all sums" arising out of an "occurrence" which, by its own policy definition, may take place over a period of time.

Other state supreme or appellate courts have adopted pro rata allocation.[86] These cases reached their results based upon considerations of the particular equities in their cases, not upon the policy language. Thus, if a court is to adopt pro rata allocation, it must weigh the particular equitable factors in its case before deciding to what time period or periods a loss should be assigned.

For instance, in *Stonewall Insurance Co. v. Asbestos Claims Management Corp.*,[87] the Second Circuit, applying a pro rata allocation, refused to allocate to years beyond 1985, although injuries continued after that date, because of the factual finding

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[82] *Carter-Wallace Inc. v. Admiral Ins. Co.*, 154 N.J. 312, 326, 712 A.2d 1116, 1124 (1998); *Owens-Illinois, Inc. v. United Ins. Co.*, 138 N.J. 437, 475, 650 A.2d 974, 993 (1994); *see also* Eugene R. Anderson, Jordan S. Stanzler & Loreli S. Masters, *Insurance Coverage Litigation* § 4.07[D] (2d ed. 2002).

[83] *E.g.*, *Aerojet-General Corp. v. Transp. Indem. Co.*, 17 Cal. 4th 38, 74-76, 948 P.2d 909, 931-32, 70 Cal. Rptr. 2d 118, 141-42 (1997); *Hercules, Inc. v. AIU Ins. Co.*, 784 A.2d 481, 489-94 (Del. 2001); *Monsanto Co. v. C.E. Heath Compensation & Liab. Ins. Co.*, 652 A.2d 30, 33-35 (Del. 1994); *Zurich Ins. Co. v. Raymark Indus., Inc.*, 118 Ill. 2d 23, 57, 514 N.E.2d 150, 165 (1987) ("the appellate court did not err insofar as it declined to order the *pro rata* allocation of defense and indemnity obligations among the triggered policies"); *Goodyear Tire & Rubber Co. v. Aetna Cas. & Sur. Co.*, 95 Ohio St. 3d 512, 516-17, 769 N.E.2d 835, 841-42 (2002); *J.H. France Refractories Co. v. Allstate Ins. Co.*, 534 Pa. 29, 39-40, 626 A.2d 502, 507-08 (1993); *Am. Nat'l Fire Ins. Co. v. B & L Trucking & Constr. Co.*, 134 Wash. 2d 413, 427-29, 951 P.2d 250, 256-57 (1998).

[84] *See, e.g.*, *ACandS, Inc. v. Aetna Cas. & Sur. Co.*, 764 F.2d 968, 974 (3d Cir. 1985); *Keene Corp. v. Ins. Co. of N. Am.*, 667 F.2d 1034, 1048 (D.C. Cir. 1981) ("There is *nothing* in the policies that provides for a reduction of the insurer's liability if an injury occurs only in part during a policy period." (emphasis in original)), *cert. denied*, 455 U.S. 1007 (1982); *Aetna Cas. & Sur. Co. v. Wallace & Gale Co.* (*In re Wallace & Gale Co.)*, 275 B.R. 223, 235-36 (D. Md. 2002); *Fed. Ins. Co. v. Susquehanna Broad. Co.*, 727 F. Supp. 169, 175 (M.D. Pa. 1989), *aff'd*, 928 F.2d 1131 (3d Cir.), *cert. denied*, 502 U.S. 823 (1991).

[85] 134 Wash. 2d 413, 430, 951 P.2d 250, 257 (1998) (footnote omitted) (rejecting the argument that an insurance company on the risk for a short period would be unfairly burdened by imposing joint and several liability on it for the indemnification of expenses to remediate pollution spanning several years).

[86] *See also Ins. Co. of N. Am. v. Forty-Eight Insulations, Inc.*, 633 F.2d 1212, 1224-25 (6th Cir. 1980), *clarified on reh'g*, 657 F.2d. 814 (6th Cir.), *cert. denied*, 454 U.S. 1109 (1981); *Mayor of Balt. v. Utica Mut. Ins. Co.*, No. 866, Sept. Term, 2000, 2002 Md. App. LEXIS 114, at *88-*89 (Md. Ct. Spec. App. July 2, 2002); *Owens-Illinois, Inc. v. United Ins. Co.*, 138 N.J. 437, 479, 650 A.2d 974, 995 (1994); *Consol. Edison Co. of N.Y., Inc. v. Allstate Ins. Co.*, No. 39, 2002 N.Y. LEXIS 1041, at *21-*23 (N.Y. May 2, 2002); *Sharon Steel Corp. v. Aetna Cas. and Sur. Co.*, 931 P.2d 127, 140-42 (Utah 1997). These cases were criticized by *Aerojet* for failing to adhere to a stricter contract analysis, and for instead relying upon "vague" notions of "fairness" and "rough justice," when they determined that the policyholder should be liable for a pro rata portion of the liability for those years that the policyholder was self-insured. *Aerojet*, 17 Cal. 4th at 72-74 & nn.22-24, 948 P.2d at 930-31 & nn.22-24, 70 Cal. Rptr. 2d at 140-41 & nn.22-24.

[87] 73 F.3d 1178 (2d Cir. 1995), *modified on other grounds on denial of reh'g*, 85 F.3d 49 (2d Cir. 1996).

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that the policyholder had not voluntarily assumed the risk of asbestos liability after 1985 when no coverage for asbestos liability was available in the marketplace.[88] *Stonewall* thus held that proration to the insured was appropriate only if there was a finding (i) that liability insurance was available and (ii) that the policyholder consciously decided to underinsure for that period.

The "all sums" theory of allocation is also supported by the language related to the issue of exhaustion of underlying policies. Excess policies contain a "Schedule of Underlying Insurance" specifying the particular policies that must be satisfied before the relevant policy must pay. The Schedule typically refers only to the policies directly "underneath" the excess policy for that particular policy year. The "Schedule of Underlying Insurance" does not require that all other available insurance across all horizontal policy periods be exhausted before an excess policy must respond. It requires only vertical exhaustion.

E. Allocation in the Context of D&O Policies with Entity Coverage

Corporate directors and officers currently are under siege. Stock prices have fallen, balance sheets must be restated, CEOs will personally certify to the accuracy of the balance sheet, and indictments are being filed.[89] The frequency of federal securities fraud, class action lawsuits has increased in the last year, as well as the average payment to shareholder claimants. At a time like this, it is reasonable for directors and officers to view the D&O insurance policy as the corporation's most important asset. They expect the D&O policy to be designed to maximize their protection.

However, many current D&O liability policies now provide protection for claims both against the individual directors and officers and against the corporate entity, particularly for securities claims. As a result, the individuals and the corporation may both seek access to the same insurance policy limits to defend against, and ultimately settle, claims. These competing interests are involved in the current dispute over allocation of the limits of the D&O insurance policies sold to the now defunct Enron Corporation. Although the court hearing the Enron bankruptcy recently allowed the primary D&O insurance company to advance defense costs for the individual directors and officers, payment to defense counsel has been significantly delayed and the dispute is not over.

Under a traditional D&O insurance policy, the insurance company agrees to indemnify, or to pay on behalf of, the individual directors or officers for all "Loss" that those individuals become legally obligated to pay arising out of a "Wrongful Act" committed in their capacity as a director or officer. This promise, referred to as Coverage A, or "direct" or "liability" coverage, protects only the individual directors and officers for claims made against them. It does not provide insurance for claims against the corporate policyholder.

Under Coverage B, referred to as "reimbursement" or "indemnity" coverage, the insurance company agrees to reimburse the corporate entity for all "Loss" for which the company is required to indemnify, or has legally indemnified, the directors or officers for

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[88] *Id.* at 1203-04.

[89] In a recent speech to the National Press Club in Washington, D.C., Henry Paulson, Chairman and CEO of The Goldman Sachs Group, stated:

> Today we face another challenge – what some have called a crisis of confidence in the way in which companies do business. . . . In my lifetime, American business has never been under such scrutiny. To be blunt, much of it is deserved. . . . [T]he Enron debacle and subsequent revelations have revealed major shortcomings in the way some US companies, and those charged with their oversight have gone about their business. And it has, without doubt, eroded public trust.

Henry M. Paulson, Jr., "Restoring Investor Confidence: An Agenda for Change," Speech at the National Press Club (June 5, 2002).

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a claim alleging a Wrongful Act. Coverage B does *not* provide insurance for claims asserted directly against the corporate policyholder. It merely reimburses the corporation for monies spent to protect the individual directors and officers.

Many, if not most, lawsuits filed against the individual directors and officers, such as securities claims, also are filed against the corporation. Thus, there was often a dispute over how to allocate the cost of defense, and any resulting settlements or judgments, between the insured individuals and the uninsured corporate entity.

In partial response to this allocation dispute, the insurance industry developed and sold Coverage C, or "entity" coverage. Under "entity" coverage, the insurance company agrees to reimburse the corporate policyholder for liability arising out of claims frequently filed directly against the corporation, such as claims brought by investors under the securities laws. If "entity" coverage exists for a particular claim, there is no need to allocate liability between the individual and corporate defendants because both are covered by the policy.

However, because D&O policies generally contain a single aggregate limit, any payment by the insurance company, whether under liability (Coverage A), reimbursement (Coverage B), or entity (Coverage C) coverage, reduces and can ultimately exhaust the limits of the policy. As a result, the corporation with a claim to coverage may be in conflict with the individual directors and officers for those limits. For instance, the creditors of Enron contend that the limits of the D&O policy should be part of the bankrupt estate, available to satisfy their claims. The former directors and officers of Enron demand that the D&O insurers advance money from the same limited fund for their defense costs.

The issue of allocating fixed limits among covered parties can arise with any form of insurance policy. In general, an insurance company must act in good faith and cannot pay its entire limits to some insureds while leaving other insureds without any protection.[90] A number of cases have addressed the problem of allocation of fixed D&O limits when the corporation is in bankruptcy.[91] These decisions suggest that, particularly when the D&O insurance policy provides entity coverage, both the policy and its proceeds will be considered an asset of the bankruptcy estate and may not be available to fund the defense of lawsuits brought against the individual directors and officers.

One option is to include language in the insurance policy that specifically deals with how the policy will operate if the entity declares bankruptcy. For instance, a policy can contain an "order of payments" provision which specifically provides that, if individual directors and officers and the entity are competing for the limits of the policy, the individual directors and officers are paid first. There is little, if any, case law that can give an individual director or officer comfort as to how a bankruptcy court, which tends to be pro-debtor, will apply such language. Therefore, if the debtor has any property interest in the policy limits, even a contingent interest, the ability of the directors and officers to obtain insurance can be frustrated.

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[90] *Smoral v. Hanover Ins. Co.*, 37 A.D.2d 23, 25-26, 322 N.Y.S.2d 12, 14 (1st Dep't 1971); *see also Great Lakes Dredge & Dock Co. v. Commercial Union Assurance Co.*, No. 94 C 2579, 1999 WL 705599, at *7 (N.D. Ill. Aug. 27, 1999), *aff'd in part, vacated in part on other grounds sub nom. Great Lakes Dredge & Dock Co. v. City of Chicago*, 260 F.3d 789 (7th Cir. 2001), *cert. denied*, 122 S. Ct. 1593 (2002); *Lehto v. Allstate Ins. Co.*, 31 Cal. App. 4th 60, 75, 36 Cal. Rptr. 2d 814, 822 (2d Dist. 1994), *cert. denied*, 516 U.S. 820 (1995).

[91] *See Pintlar Corp. v. Fid. & Cas. Co. (In re Pintlar Corp.)*, 124 F.3d 1310 (9th Cir. 1997); *Homsy v. Floyd (In re Vitek, Inc.)*, 51 F.3d 530 (5th Cir. 1995); *In re Sacred Heart Hosp.*, 182 B.R. 413 (Bankr. E.D. Pa. 1995).

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A second option is to provide separate limits for the coverage afforded the individual directors and officers, or to purchase policies that provide excess insurance only for Coverage A, the insurance designed for the individual directors and officers. A third option is to remove entity coverage entirely from the D&O insurance policy. In-house counsel can help risk managers evaluate the various options meant to address the conflicts and problems that arise out of the incorporation of entity coverage in the D&O policy.

IV. Issues Of Significance For First-Party Policies

A. What Type of Property Is Covered

First-party property policies generally provide insurance for "direct physical loss or damage to property." A key issue in such coverage, which arose several years ago in the context of the concern over potential Y2K losses, is whether the loss of intangible property, such as information or computer software, is covered by first-party insurance. Although Y2K losses did not materialize, the dispute sparked a debate over whether the loss of or damage to intangible property is covered by insurance policies.

Some first-party policies specifically contain endorsements that expand coverage to include loss of or damage to "electronic data processing or electronically controlled equipment" or "storage mediums," "data stored on such medium," or "records on mediums." However, without these clarifications, the policyholder may be faced with the issue of whether the loss of information or software is insurable under its first-party property policy. This issue can arise both under first-party and third-party liability policies.

In *Seagate Technology, Inc. v. St. Paul Fire & Marine Insurance Co.*,[92] the insured manufactured allegedly defective disk drives which were incorporated into the claimant's computers, causing them to malfunction. The court held that the failure of the computers was not physical damage to tangible property and, thus, did not constitute "property damage" under the terms of the third-party liability insurance policy. *Seagate* based its reasoning upon the fact that the disk drives were not inherently dangerous products and, therefore, their failure did not cause physical property damage to the whole computer.[93]

Two Minnesota cases also address whether lost data constitutes property damage under a general liability policy. In *Retail Systems, Inc. v. CNA Insurance Cos.*,[94] the policyholder lost a computer tape that contained its client's data. The policyholder submitted the resulting claim to its insurance company, which denied coverage on the ground that the lost data was not property damage within the definition of the policy – physical damage to tangible property. The court ruled that because the data had been integrated into, and was located only on, the lost tape, there was "tangible property damage" under the policy.[95]

In *St. Paul Fire & Marine Insurance Co. v. National Computer Systems, Inc.*,[96] the policyholder's employees had taken proprietary data in binders from a previous employer when they changed jobs. The court found that there was no property damage, and no coverage, because:

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[92] 11 F. Supp. 2d 1150 (N.D. Cal. 1998).
[93] *Id.* at 1153-55.
[94] 469 N.W.2d 735 (Minn. Ct. App. 1991).
[95] *Id.* at 737.
[96] 490 N.W.2d 626 (Minn. Ct. App. 1992).

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(1) the underlying claim did not seek damages for the stolen binders; and

(2) the underlying claimant did not lose the use of the data, because it was duplicated in other records.[97]

Given the likely future magnitude of claims involving intangible property, these few cases are hardly indicative of where the law will evolve on the issue of whether lost information or the breakdown in a computer system constitutes property damage. In-house counsel should help risk managers evaluate the corporation's insurance needs and, if necessary, obtain endorsements that expand the meaning of the term "property damage," as used in the insurance policy.

B. Business Interruption Policy Issues

The area that has received the most recent attention under first-party policies is the coverage provided for business interruption claims, particularly contingent business interruption claims. Business interruption insurance is most often found not in a separate policy, but as an additional endorsement that supplements the policyholder's first-party property insurance. A typical business interruption provision provides that:

> Coverage is afforded against loss resulting directly from necessary interruption of business caused by direct physical loss or damage to, or destruction of, from the perils insured against, real or personal property insured hereunder.

In general terms, the first-party property policy indemnifies the policyholder for the value of the covered property that has been lost or damaged. The business interruption coverage indemnifies the policyholder for the income that is lost when, as a result of the lost or damaged property, there is a disruption to the policyholder's business. Recovery is limited to the income lost while the property is being repaired or replaced. Contingent business interruption is the loss that results when loss or damage to the property of another causes an interruption in the policyholder's business.

[97] *Id.* at 631.

The aftermath of 9/11 has focused the attention of the business community on the availability and potential benefits of business interruption and contingent business interruption insurance. Many questions have arisen, including: what is business interruption insurance? what does it cover? how can the coverage be enhanced? and what are the common problems faced in presenting a claim?

Given the variations in the language in the basic insuring agreement, each business interruption claim can present its own set of issues. Whether or not there will be coverage for that claim will depend not only upon the underlying facts, but also upon the particular bundle of provisions and endorsements that make up the insuring agreement. However, the following five elements typically contribute to a business interruption claim:

(1) there must be a covered peril;

(2) the covered peril must result in a loss of covered property;

(3) the loss of covered property must result in an interruption of the policyholder's business operations;

(4) the business interruption must result in a covered loss; and

(5) the covered loss must occur during the "period of restoration," while the lost or damaged property is restored or replaced.

As should be evident from the above, it is not sufficient that the policyholder prove that the above elements are present. The policyholder also must prove a causal connection between those elements in order to recover on a business interruption claim.

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1. Covered Peril

The policyholder must prove that the risk falls within the "peril"[98] for which the insurance policy provides protection. The insurance company will have the burden of showing that one or more of the exclusions applies.

For instance, after 9/11 there was significant discussion as to whether the "war risk" exclusion found in many first-party policies excluded the losses that resulted from the destruction of the World Trade Center. Insurance companies concluded that the terms of the "war risk" exclusion did not apply because the exclusion required that the act of war be committed by a hostile government. Insurance companies are now seeking approval for separate terrorist exclusions to insert into future "All Risk" policies. Insurance companies also have discussed the sale of a separate "Named Peril" policy that would provide coverage for a loss caused specifically by a terrorist act.

An example of coverage that has drawn particular attention since 9/11 is coverage that applies when ingress or egress to a business has been prohibited by a civil authority. This form of coverage can be grafted onto a business interruption insurance policy through a separate endorsement. Thus, if a governmental entity orders an area closed, or otherwise denies access to the premises, the business interruption coverage could be triggered. Some of the civil authority or ingress/egress coverages still require physical damage to the premises of the policyholder or at adjacent locations, but others do not.[99]

There are many other forms of "named peril" coverages that may be relevant to business interruption claims. For instance, there is "service interruption" coverage, which specifically indemnifies the policyholder for a loss to the policyholder's business that results from an interruption of utility service such as electricity, gas, or sewer services, or telecommunications services. These "service interruption" policies may also be viewed as a form of "contingent business interruption" insurance discussed *infra*.

2. Loss of Covered Property

"Covered Property" typically is defined to include all property at certain specified locations (or premises), or within a certain number of feet of the listed locations. For instance, typical "All Risk" policy language provides insurance "against all risks of direct physical loss or damage to the property described in Paragraph 1 from any external cause."

The issue of the need to show actual physical damage to the policyholder's property may be obviated if the policy contains "contingent business interruption" coverage. This form of insurance explicitly covers the policyholder for losses that arise in its operations because of damage to the property of another business or individual upon which the policyholder depends. In the case of "contingent business interruption" coverage, the third-party property is generally referred to as "contributing" or "dependent" property.

Generally, the third-party property is specifically described on a schedule annexed to the policy. A typical insuring provision provides:

> We will pay for the actual loss of Business Income you sustain due to the necessary suspension of your "operations" during the "period of restoration." The suspension must be caused by direct physical loss of or damage to "dependent property" at a premise described in the Schedule caused by or resulting from any covered Cause of Loss.

"Dependent property" is generally limited to property at the following four types of businesses:

> (1) a business that provides goods or services needed for the policyholder's operations;

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[98] As already mentioned, there are two general types of first-party policies: (1) an "All Risk" policy, and (2) a "Named Peril" policy.

[99] *See, e.g.*, *Fountain Powerboat Indus., Inc. v. Reliance Ins. Co.*, 119 F. Supp. 2d 552, 556-57 (E.D.N.C. 2000).

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(2) a business that purchases the policyholder's goods or services;

(3) a business that manufactures products that the policyholder sells; and

(4) a business that attracts customers to the policyholder's business.

Some "contingent business interruption" policies can be broader in scope and can extend to the interruption of business "'caused by damage to or destruction of real or personal property . . . of any supplier of goods or services which results in the inability of such supplier to supply an insured locations [sic].'"[100] For instance, in *Archer-Daniels-Midland Co. v. Phoenix Assurance Co.*,[101] the court held that there was "contingent business interruption" coverage when a flood of the Mississippi River disrupted transportation on the river, requiring the policyholder to obtain substitute transportation and supplies for its farm product manufacturing operation. However, when, as in *Archer-Daniels-Midland*, the policy contains the more generalized reference to "dependent property," there is likely to be a dispute over whether the particular loss triggers coverage.

3. Interruption of Policyholder's Business Operations

Demonstrating that the covered peril interrupted the policyholder's business operations often presents two issues for resolution. The first issue is one of causation – did the damage to covered property actually *cause* the business interruption? The facts in *Harry's Cadillac-Pontiac-GMC Truck Co. v. Motors Insurance Corp.*[102] illustrate how this issue can arise. In *Harry's Cadillac*, a snowstorm caused the roof of the automobile dealership to collapse. The storm also blocked access to the dealership for one week. The damage to the roof was covered by the first-party property policy. The dealership sought coverage for the week of lost sales under the business interruption provisions of the policy. The court held that the property damage, the collapsed roof, did not cause the lost sales. Rather, the lost sales were due solely to the storm. Accordingly, the court held that the policy did not cover the loss.[103]

The second significant issue that arises in connection with this element is whether the level of interruption to the business has been sufficient under the policy language. Business interruption insurance commonly uses the phrase "necessary suspension of operations." The issue is whether a significant *slowdown* in operations is sufficient, or whether the policy requires a total *shutdown* in operations. For instance, in *Home Indemnity Co. v. Hyplains Beef, L.C.*,[104] the court held that the "common understanding of the term 'suspension' [is] a temporary, but complete, cessation of activity."

As a result, policyholders should submit their claims in a form that maximizes the chance of recovery. A "slowdown," or a reduction in productivity, might accurately be described as a partial "shutdown" of some of the operations. Moreover, a policyholder has a duty to mitigate damages by resuming operations at the covered location or elsewhere. Performance of this duty to mitigate, by resuming some operations when possible, should not be used to void coverage. In *American Medical Imaging Corp. v. St. Paul Fire & Marine Insurance Co.*,[105] a fire rendered the policyholder's business premises unusable. The policyholder rented an alternative site and resumed operations, albeit at reduced capacity. The court in *American Medical Imaging* rejected the

[100] *Archer-Daniels-Midland Co. v. Phoenix Assurance Co.*, 936 F. Supp. 534, 540 (S.D. Ill. 1996) (quoting policies).

[101] 936 F. Supp. 534 (S.D. Ill. 1996).

[102] 126 N.C. App. 698, 486 S.E.2d 249 (1997).

[103] If the *Harry's Cadillac* policy had contained ingress/egress coverage, the loss might have been covered.

[104] 893 F. Supp. 987, 991 (D. Kan. 1995), *aff'd*, 89 F.3d 850 (10th Cir. 1996).

[105] 949 F.2d 690 (3d Cir. 1991).

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insurance company's argument that coverage should be denied because the policyholder's business operations were not totally suspended, reasoning that the policyholder's compliance with the mitigation provisions should not be used as a basis to deny coverage.

4. Covered Loss

The policyholder must establish that, but for the suspension of its operations, it would have earned income. This element requires a showing not just that there were lost sales, but that those sales would have resulted in a profit.[106] If the interruption is to an ongoing business, with a history of sales and profits, then the calculation of loss may be straightforward. However, the marketplace is not static. New products appear, demand for existing products changes, and the prices of materials fluctuate. The event that caused the loss (for instance, a natural disaster like a hurricane, or the 9/11 tragedy) may impact the economy generally. The insurance company may use volatile economic factors to argue that the lost income under a business interruption policy is much less than the policyholder contends. The problems of calculating lost income, a somewhat speculative activity, require the early intervention of an accounting expert.

A significant and common endorsement to business interruption coverage which will affect the scope of the insurable loss is "extra expense" coverage. This endorsement extends coverage to those expenses necessary to continue operating the business while the property is being repaired and the operations' capacity is brought back to normal. The most obvious example of these mitigation costs would be the costs of renting alternative space.

[106] *See Dictiomatic, Inc. v. United States Fid. & Guar. Co.*, 958 F. Supp. 594, 603-05 (S.D. Fla. 1997).

5. Period of Restoration

The "period of restoration" is the period that it takes to repair the damaged property and return the business back to its normal level of operation. Generally, only losses incurred during the period of restoration are reimbursable under a business interruption policy.

Two issues often arise regarding calculation of the period of restoration. Property or premises destroyed are often not replaced as they were, but in a modernized or improved form. Thus, there often is a dispute over whether the actual time of restoration includes additional time to improve or modernize the facility. The insurance company will contend that some portion of the lost income is attributable to the additional time period and is not reimbursable.

The second issue arises when loss, otherwise covered by the policy, takes place after the period of restoration. For instance, if, during the period of restoration, the policyholder makes sales out of inventory, the depleted inventory may result in reduced sales after the period of restoration when the business is operational. Courts have reached different results as to whether losses incurred in the post-restoration period are covered.[107]

Some of these problems can be resolved through the purchase of an extended business interruption period. This provision allows coverage for losses that occur after the period of restoration. However, the losses must still be caused by the initial business interruption.[108]

[107] *Compare Vinyl-Tech Corp. v. Cont'l Cas. Co.*, No. CIV. A. 99-1053-CM, 2000 WL 1744939 (D. Kan. Nov. 15, 2000), *and Lexington Ins. Co. v. Island Recreational Dev. Corp.*, 706 S.W.2d 754 (Tex. Ct. App. 1986), *with Pennbarr Corp. v. Ins. Co. of N. Am.*, 976 F.2d 145 (3d Cir. 1992).

[108] *See Fountain Powerboat*, 119 F. Supp. 2d at 557-58.

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First-party property insurance in general, and business interruption insurance in particular, have not been the subject of much judicial scrutiny. The events of 9/11 may change that. Policyholders are now painfully aware of the perils that can lead to a business interruption, as well as the types of policies that are being offered by the insurance industry to cover those risks. Additional litigation will result in further examination of the language used in these types of policies. In-house counsel should become aware of the package of insuring provisions that are available to protect against these risks and how to prosecute business interruption claims if they expect to properly serve their clients.

V. Practical Considerations For Corporate Counsel

A. Corporate Roles Vis-à-Vis Insurance

Risk managers generally are part of the finance department and report to the treasurer. They focus on the economics of the transaction, the limits provided, and the costs of the insurance (i.e., premiums). Moreover, risk managers sometimes are not comfortable in pursuing a claim, because it may make renewal, or the acquisition of new policies, more difficult or expensive. Insurance policies are commercial contracts that create valuable corporate assets. Although often millions of dollars are spent on premiums, insurance policies often receive little or no attention from the corporate legal departments until a time of crisis, generally when the insurance company denies coverage. If in-house counsel work with risk managers, the policyholder will have the benefit of both financial and legal advice in entering into and managing the insurance assets of the company.

B. Negotiating Terms of Insurance Contract

In-house counsel can assist the risk management department in the purchase of insurance. Lawyers are trained to focus on the terms of a contract, in this case the policy language. They can provide valuable help in evaluating alternative policy language and the implications that language will have when and if a claim is made under that policy or a coverage dispute arises. For example, a lawyer may be able to advise a risk manager as to what language should be included in an endorsement that clarifies "property damage" as including the intangible assets of a corporation. A lawyer may also be in the best position to evaluate what type of product liability claims the corporation may face, and whether to include a "batch" clause and what type of wording the batch clause should contain.

A lawyer also may be in a better position than a risk manager to evaluate whether a policyholder should accept certain dispute resolution provisions, such as a choice of law or a mandatory arbitration clause.[109] Similarly, a lawyer may be more likely than a risk manager to check the actual policy language against the outline of coverage contained in the initial insurance binder, and to insist that inconsistencies be corrected.

A lawyer, particularly with a litigation background, also can assist in structuring the policy so that it maximizes protection for the policyholder when a claim is made. For example, a lawyer in the in-house legal department can best evaluate insurance company claims-handling guidelines and seek modifications that are appropriate. The time to review those guidelines is not after a claim is made, when the policyholder is distracted by the underlying claim and has no bargaining strength with its insurer. Rather, at the time the insurance is purchased, when different insurance companies may be competing for the business, inside counsel should be part of the policyholder's negotiating team so

[109] A choice of law provision generally is an attempt by the insurance company to impose the law of a forum that is not favorable to policyholders, such as New York, to insurance coverage disputes. Arbitration is a form of dispute resolution that is less favorable to a policyholder than an action in court.

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that the most favorable language related to management of an underlying claim can be obtained.

Counsel should particularly be involved in the purchase of D&O insurance. An attorney will be in the best position to understand the conflict of interest between the individual directors and officers and the corporate entity that may arise, particularly when the D&O policy contains entity coverage. The in-house lawyer may be able to assist the risk manager in asking for and evaluating different terms and endorsements that are currently available to deal with these conflict situations. Moreover, counsel can help the risk manager address the problems that arise when a corporation is in bankruptcy, and when the protection is most needed by the individual directors and officers.

C. Notice of a Loss, Claim, or Occurrence

The most important contribution that in-house counsel can make in the area of insurance is to guarantee that the policyholder satisfies the notice conditions of the policy. Every form of insurance requires that notice be given promptly. If the circumstances are such that the policyholder asks whether notice should be given, the answer is yes. For liability policies, the lawyer is often the first person who becomes aware that a claim has been made. Notice should be given. A lawyer is often in the best position to know that an event, an occurrence, might lead to a claim. Notice should be given. If the lawyer learns of a first-party loss, notice should be given, and a proof of loss filed consistent with the terms of the policy.

D. Presentation of Loss or Claim in a Manner That Will Maximize Coverage

When a loss or claim has occurred, and after notice has been properly given, the attorney should assist the risk manager in presenting the claim in a way that will maximize coverage. This Appendix has raised a number of issues, such as trigger of coverage, number of occurrences, and allocation, that can significantly affect recovery under a policyholder's insurance. Resolution of these issues is dependent upon the particular law that will be applied, the facts presented by a claim, and the way in which the facts are developed and presented. Trigger of coverage, number of occurrences, and allocation are not simple issues and require a certain level of legal sophistication if the policyholder is to obtain the insurance that is possible under the policy. Moreover, certain causes of loss or liability may be excluded from coverage, while others are not. Analyzing the underlying loss or claim, and understanding the possible bases of coverage, is a task for counsel. Accordingly, in-house counsel can assist risk managers in identifying and developing the facts sought to establish a risk covered by the insurance.

E. Evaluation of a Reservation of Rights Letter

In-house counsel can assist the policyholder in evaluating a reservation of rights ("ROR") letter. Such letters are common and are often misconstrued by a policyholder as a denial of coverage and the end of the insurance discussion. Rather, ROR letters should be viewed as the first step in recovery under an insurance policy. They assist the policyholder in defining the issues on which the policyholder must focus in order to obtain payment from its insurance company.

F. Working with the Insurance Company to Defend a Claim

At the earliest stage (after prompt notice has been provided), in-house counsel should analyze the underlying claims and the insurance policy to determine whether there is a conflict between the interests of the policyholder and those of its insurance company with respect to the defense of the underlying claims. This analysis is particularly necessary if the insurance company has issued an ROR letter. In-house counsel also

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should become familiar with the applicable law as to the consequence of the conflict of interest in the jurisdictions that may have an interest in the dispute.[110]

The policyholder's counsel needs to evaluate the defense being offered by the insurance company, including the defense counsel selected. The defense mounted by the insurance company may be perfectly appropriate for the circumstances.

However, if no conflict is apparent, and the insurance company is controlling the defense, the policyholder should resist the inclination to assume that "everything is under control." In-house counsel should receive status reports regularly, as well as copies of all pleadings, discovery demands, and correspondence with the underlying plaintiffs' counsel. The policyholder should also receive copies of all communications defense counsel have with the insurance company regarding the matter. If the stakes are high enough, the policyholder may consider employing "shadow counsel," a separate law firm that can monitor the conduct of defense counsel and warn the policyholder if it appears that the defense is being adversely affected by the insurance company's protection of its own interests.

If there is a conflict and the policyholder has not contractually secured the right to control the defense in the policy or the claims-handling agreement, the policyholder may be able to control the defense under the law that exists in most jurisdictions. Although the policyholder's rights can be asserted in a declaratory judgment action, counsel may be able to negotiate control of the defense with the insurance company by agreeing to pay for the difference in billing rate between the counsel selected by the insurance company and the counsel selected by the policyholder.

[110] The laws of the jurisdictions where the policyholder and insurance company are located, and where the underlying claims are pending, should be considered.

Separate from any dispute over the policyholder's right to select defense counsel, the insurance company may contend that the defense costs incurred are not "reasonable and necessary." As part of the claims-handling agreement, the policyholder should seek the insurance company's consent that non-disputed items will be paid immediately, so that the dispute over the reasonableness of some fees will not be used as an excuse to withhold payment on the entire bill. Moreover, the parties should agree to a mechanism to resolve fee disputes promptly, such as through the submission to a third-party arbitrator.

Throughout the process – with or without conflict – in-house counsel must make sure that the policyholder performs all of its obligations under the insurance policy and the claims-handling agreement. If the policyholder does not, the insurance company may try to avoid not only its defense, but also its indemnity obligations. In addition to prompt notice, the policyholder, if it is controlling the defense, must keep the insurance company regularly informed of the conduct of the litigation. This can be achieved through regular written reports or telephone conferences, or through periodic meetings where the insurance company claims handler is invited to review the non-privileged underlying case file and ask questions of defense counsel. All settlement offers from underlying plaintiffs must be forwarded promptly to the insurance company. The insurance company has a right to receive copies of all pleadings, if requested. It is the responsibility of in-house counsel to make sure that the insurance company does not have an argument to deny coverage based upon an alleged lack of cooperation.

In the event there is a conflict of interest, in-house counsel should make sure that the insurance company does not receive privileged documents. Not only may the insurance company use that information against the policyholder to deny coverage, but a

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court in the underlying tort action may find that the policyholder has waived its privilege by providing the information to an adverse party.

G. Settling the Underlying Claim

In-house counsel will generally be involved with any settlement of an underlying claim, but, as part of this task, should at all times consider the insurance implications of that settlement, and the language used in the settlement documents. First and foremost, counsel should make sure that the insurance companies are informed of settlement negotiations and given an opportunity to participate and object. Second, settlement documents must be reviewed for any impact they may have on insurance recovery. The choice of language in a settlement agreement, or the very structure of a settlement, may have insurance implications that must be considered. If the settlement requires court approval, such as a settlement of class action claims, the insurance companies should be notified and invited to attend the hearing at which the settlement is reviewed by the court.

H. Litigation with the Insurance Company

It should be clear from the above discussions that the law on various insurance issues varies depending upon the jurisdiction. Accordingly, if litigation with the insurance company is likely, the forum for that litigation is critical. Counsel to the policyholder must review the law on the key insurance issues and know which jurisdiction is most favorable. Moreover, many insurance companies have a practice of "jumping" their policyholder and bringing a declaratory judgment action in a forum favorable to the insurance company's position. It is important for in-house counsel to evaluate the likelihood that a litigation may be brought and either: (1) file first; (2) negotiate the right to select a forum; or (3) have a complaint drafted so that, if jumped, the policyholder can immediately file, leading a court likely to view the actions as having been commenced simultaneously.

I. Settling with Your Insurance Company

If a settlement is reached with an insurance company, it is important that in-house counsel understand the financial impact of that settlement on the insurance program. For instance, how will losses paid by the insurance company be allocated to different policies? what effect will the settlement payment have on the exhaustion of different policy limits? and what effect will the settlement have on the computation of retrospective premiums? Policyholders have been surprised, after receiving a settlement check, also to receive a bill for a retrospective premium adjustment. Surprises such as these can be avoided if addressed explicitly in the settlement agreement, or through a release signed by the insurance company.

Another important issue often overlooked in a settlement with an insurance company is the impact of that settlement on the policyholder's claim against other policies in the program, particularly on those policies that are excess of the settling policy. To be triggered, the excess policies generally require exhaustion of the underlying policy through the payment of the entire underlying policy limits in judgments or settlements. Attempts by the policyholder and settling defendant to "exhaust" the underlying limits by agreement may jeopardize any recovery under excess policies. Finally, insurance companies often try to impose settlement terms in which the policyholder agrees to a position on certain issues, such as the number of occurrences or allocation. These concessions can only hurt the policyholder and should be avoided.

J. Managing Relationships with the Broker

The broker occupies the middle space between the policyholder and the insurance company. Although the facts in any particular situation may differ, the broker generally fulfills many roles: agent for the policyholder for some purposes; agent for the insurance company for other purposes; or a principal in the transaction, particularly when the

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broker is an owner or participates in one of the entities providing insurance or has put together the policy or the facility that provides the insurance. This means that the broker may have many interests, some of which conflict with the interests of the policyholder.

Risk managers often treat the broker as part of the "in-house" team. The broker is not an employee of the policyholder and should not be treated as such. This mistake manifests itself frequently in the dispute over the confidentiality of the broker's files. Simply, the broker's files are not confidential. Any communication to the broker is discoverable by the insurance company. In this world of e-mails, it is common and unfortunate for a risk manager to forward an opinion of counsel on coverage and ask the broker for comments. Privileged documents become discoverable when sent to the broker. It is also common for a risk manager to ask the broker for a written opinion on coverage. This also should be avoided. That opinion may become public, and whether or not it is correct, the insurance company will argue that the broker's opinion limits the policyholder. In-house counsel can help alert risk managers that a broker must be treated as an independent third party.

Finally, an important role that the broker can fulfill is to make sure that communications are sent to all interested insurance companies. In the initial notification of loss, claim, or occurrence, it is the broker's job to determine all possibly implicated coverages and make sure that notice is provided to all relevant insurance companies. The broker also is responsible for keeping all potentially implicated insurance companies informed of developments in the underlying litigation or in the investigation of the loss. The broker also can make sure that excess insurance companies are notified of side agreements between the primary insurance company and the policyholder, or any other act that the excess insurers could later claim impacts their risk, allowing them to avoid coverage.

VI. Conclusion

Insurance is one of the most important assets of the corporate policyholder. In-house counsel should assist the risk management department in the acquisition, maintenance, and use of this asset to help maximize the corporation's recovery.

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