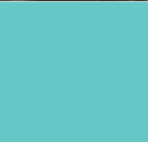
PRACTICE PERSPECTIVES: INSURANCE LIABILITY & RECOVERY

Navigating an Industry in Turmoil



letter from the practice chair

Welcome to the inaugural edition of *Practice Perspectives* for Jones Day's Insurance Liability & Recovery Practice.

Given the turmoil and the fundamental changes underway in the insurance industry, and in light of the ongoing financial crisis, many of our clients are focusing on and reassessing their insurance assets, insurance needs, and insurance providers. Indeed, faced with the near demise and/or restructuring of major insurance companies, many of our clients have no choice but to do so. Insurers and their counterparties are deeply involved in controversies arising from collateralized debt obligations ("CDOs"), mortgage-backed securities, and credit default swaps. And, as corporate resources have dwindled, the importance of obtaining full and complete recovery on insurance claims has dramatically risen.

At Jones Day, we have always represented our client-policyholders in successfully pursuing insurance recoveries from their insurers and in advising on complex insurance purchase decisions and insurance issues in major corporate transactions. But we believe that the scope and effects of this current crisis call for a greater response. In part for these reasons, and in part to respond to increased client needs and demand, we have more formally organized our insurance lawyers, and we formally established our Insurance Liability & Recovery Practice. We recently attracted several strong lateral partners and enhanced our geographic profile and depth in certain coverage areas. We expect that this growth will continue, to the benefit of our clients throughout the world.

In this first edition of the Insurance Liability & Recovery *Practice Perspectives*, we focus on just a few of the areas in which we are helping clients successfully navigate the insurance industry in turmoil—from the evolving landscape for bad faith claims to complex developments in the transfer of insurance rights in M&A. You will notice that our practice is not limited to insurance "recovery" but also focuses on insurance "liability," and one of our articles addresses the handling of potentially insolvent insurers involved in CDOs. We understand that our clients need representation not only to recover wrongfully denied insurance proceeds but also to assess, restructure, and, where appropriate, prevail in litigation or arbitration in connection with their insurance-related exposures.

At Jones Day, we are One Firm Worldwide. We understand and are prepared to address our clients' insurance liability and recovery needs wherever they arise.

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JONES DAY'S INSURANCE LIABILITY & RECOVERY PRACTICE

AT JONES DAY, WE ARE COMMITTED TO MAXIMIZING THE VALUE OF OUR CLIENT-POLICYHOLDERS' INSURANCE ASSETS

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OUR PERSPECTIVE

This view—that insurance is an important corporate asset, the value of which must be protected and maximized—is reflected both in our insurance recovery successes and in our insurance counseling. We have recovered billions of dollars for our policyholder clients, and we work frequently with our clients to enhance their insurance programs and to ensure that their insurance rights are maximized and preserved in corporate acquisitions, divestitures, reorganizations, restructurings, and license transactions.

INSURANCE RECOVERIES AND COUNSELING

Our Insurance Liability & Recovery Practice comprises dozens of partners and associates worldwide who dedicate their practices to representing policyholders in disputes against insurers and to insurance counseling; it also includes more than 40 other Trial Practice attorneys with substantial experience and success in litigating insurance matters. Our experience covers virtually every type of insurance issue, claim, and policy, including those arising out of long-tail environmental and asbestos losses; financial fraud and securities claims; exposure to beryllium, silicon, and welding rods; medical products and devices; industrial accidents; natural disasters/catastrophes; consumer products; intellectual property; contamination; and product recall.

Our insurance attorneys regularly conduct insurance policy and program reviews and recommend changes and enhancements in many lines of coverage for our clients across many industries—from agriculture to private equity. We are frequently called upon to advise on the insurance aspects of significant transactions, including corporate reorganizations, restructurings, acquisitions, divestitures, and licensing transactions, to ensure that insurance rights are created, preserved, and/or transferred as contemplated by the business decision makers and consistent with the complex web of law and regulations governing such transactions.

Corporate policyholders worldwide choose Jones Day for their major insurance matters. Representative of our clients are IBM, Adobe Systems, PepsiCo, Dell Computers, Bridgestone/Firestone, Levi Strauss, Sherwin-Williams, Kaiser, Occidental Petroleum, Toyota, Chevron, and Goodyear.

SUCCESSFUL BAD FAITH CLAIMS AGAINST TROUBLED LIABILITY INSURERS:

AVOIDING EXPENSIVE FAILURE

by Steven E. Sigalow and Mark J. Andreini

Unlike contract law generally, the law of insurance protects the policyholder from an insurer's bad faith refusal to perform. Indeed, the reliability of an insurance company's promise to pay is of such economic significance that it is an important objective of public policy in all 50 states. State laws and regulations, including unfair claims practices laws, reflect and enforce industry standards of good faith and fair dealing in the handling of claims.

While many incidents of insurer bad faith conduct have been documented, insurance companies will ordinarily comply with standards of good faith and fair dealing not only because state law and regulation may require it, but also because in most instances it is in their economic interests to do so. These economic interests include the positive interests of a going concern, such as future customer relationships, future sales and profits, and, in general, a good business reputation. They also include the interest of a going concern not to be held liable for a pattern of evasion of claims.

But for troubled insurance companies facing sizable claims, there is a common strategy for survival that disregards these long-term interests. The elements of such a strategy can include the insurer's

looking for any conceivable reason not to pay claims, paying on claims as little and as late as possible, raising its financial distress as a negotiating ploy, and aggressively manipulating reserves, alone or together with providing financial incentives for claims personnel to resolve claims for less than those reserves. These are strategies intended to place the interests of the insurer ahead of those of the policyholder—the very essence of bad faith.

Financial distress is everywhere in the insurance industry. AIG owes U.S. taxpayers $150 billion and counting and is now a penny stock. Investors have battered the shares of most other insurers as well. Hartford leads a parade of insurers seeking relief from state regulators from capital requirements. The four largest Japanese insurers reported devastating losses for the fourth quarter of 2008. The fact that many troubled insurance companies will get tougher on claims is hardly surprising and nothing new. Premium dollars are held from point of sale, and as long as a claim is disputed, that money can continue to be held and loss reserves can continue to be "managed."

An increase in litigation between corporate policyholders and their insurers is highly likely. Many policyholders will be moved by anger and frustration to assert bad faith claims, and many of these claims will even be meritorious. Most, however, will be expensive failures. We discuss below some of the important reasons for this. But first, some background on this complicated area of the law.

STATE LAWS OF BAD FAITH ARE INCONSISTENT AND POORLY UNDERSTOOD

The law of bad faith is a hodgepodge of different statutory and common law rules developed independently by each of the 50 states. No national set of common law principles has evolved. The 50 states cannot even agree on whether the cause of action sounds in tort or contract. In many states, the duty of good faith and fair dealing is a covenant implied in the policy of insurance, the breach of which sounds in contract. *See*, *e.g.*, *Twin City Fire Ins. Co. v. Colonial Life & Acc. Ins. Co.*, 839 So.2d 614, 616–17 (Ala. 2002). In such states, proving a breach of the covenant entitles the insured to consequential damages flowing from that breach. *See*, *e.g.*, *Acquista v. New York Life Ins. Co.*, 285 A.D.2d 73, 80, 730 N.Y.S.2d 272, 277 (1st Dep't. 2001).

In other states, a bad faith claim sounds in tort, and in addition to damages for breach of contract, separate damages for the tort may be recovered. *E.g.*, *Anderson v. Continental Home Ins. Co.*, 271 N.W.2d 368, 374 (Wis. 1978). In these states, the tort arises from breach of the positive legal duty that, in turn, arises from the special relationship between an insurer and policyholder. *See*, *e.g.*, *Hoskins v. Aetna Life Ins. Co.*, 452 N.E.2d 1315, 1320 (Ohio 1983). In these states, the policyholder is entitled to damages proximately caused by the insurer's breach of duty that are separate from, and in addition to, the damages caused by the breach of contract. *See*, *e.g.*, *Anderson*, 271 N.W.2d at 374; *Zoppo v. Homestead Ins. Co.*, 644 N.E.2d 397, 401 (Ohio 1994).

Every state regulates insurance, and most address in their statutes or regulations unfair claims practices. In some states, the specific prohibitions and requirements of these regulations provide a separate, and sometimes exclusive, private cause of action for the policyholder. *See*, *e.g.*, Mont. Code § 33-18-242; Tex. Ins. Code Ann. Art. 21.21 § 16; N.M. Stat. Ann. § 59A-16-30; *State Farm Mut. Auto. Ins. Co. v. Reeder*, 763 S.W.2d 116, 118 (Ky. 1988). In other states, they don't. *E.g.*, *Masterclean, Inc. v. Star Ins. Co.*, 556 S.E.2d 371, 377 (S.C. 2001). Indeed, some courts have held that violations of unfair claims practices regulations do not even amount to evidence of bad faith. *See*, *e.g.*, *Furr v. State Farm Mut. Auto. Ins. Co.*, 716 N.E.2d 250, 256 (Ohio App. 1998).

For commercial policyholders with large claims, there are two commonly recurring types of bad faith claims. The first arises from an insurer's unreasonable refusal to settle a third-party claim against the policyholder within policy limits. *See*, *e.g.*, *PPG Indus., Inc. v. Transamerica Ins. Co.*, 20 Cal. 4th 310, 312 (Cal. 1999). Most states recognize this bad faith cause of action, and the measure of damages is straightforward—typically the amount of the judgment in excess of the insurer's policy limits.

The second type of bad faith claim, and one that can increasingly be expected to arise from troubled insurance company claims practices, is an unreasonable or intentional refusal to defend or indemnify a covered loss. Fewer states recognize this type of bad faith cause of action, often on the theory that proving an intentional breach of contract adds nothing to the policyholder's breach-of-contract claim. *See*, *e.g.*, *Johnson v. Federal Kemper Ins. Co.*, A.2d 1211, 1213 (Md.

App. 1998); *Wilson v. Colonial Penn Life Ins. Co.*, 454 F. Supp. 1208, 1213 (D. Minn. 1978).

But even where this type of bad faith cause of action is recognized, the elements of the claim vary widely. In some states, bad faith is merely the refusal to pay or settle a claim without "reasonable justification." *E.g.*, *Zoppo v. Homestead Ins. Co.*, 644 N.E.2d at syllabus ¶ 1. Other states require the insured to show not only that the insurer's action had no reasonable justification, but that the insurer acted with knowledge or in reckless disregard of the lack of reasonable justification. *E.g.*, *McCullough v. Golden Rule Ins. Co.*, 789 P.2d 855, 860–61 (Wyo. 1990). In some of these states, an insurer may escape bad faith liability entirely simply by demonstrating that coverage for the claim was objectively "fairly debatable," regardless of intent or evil motive. *Bellville v. Farm Bureau Mut. Ins. Co.*, 720 N.W.2d 468, 473–74 (Iowa 2005).

Policyholders and their counsel too often poorly understand these complexities. As a result, bad faith claims often are pursued without a clear and effective strategy. Depositions of claims personnel are taken, experts are retained and compensated, and documents are reviewed, only to have the bad claim founder as a matter of law. But the complexity of bad faith law is hardly the only—or even the most important—reason why most bad faith claims are expensive failures. Here are three other important reasons particularly relevant to troubled company claims practices.

WHY MOST BAD FAITH CLAIMS ARE EXPENSIVE FAILURES

Reason 1: Policyholders and Their Counsel Too Often Fail to Understand and Successfully Obtain the Compelling Facts That Explain the Insurer's Wrongful Behavior. Bad faith claims must focus on the insurer's decision-making process: Why did the insurer refuse to pay the valid claim or claims? Even in states where intent is not an element of the cause of action, mere mistake or negligence rarely proves enough. As a practical matter, to overcome the insurer's inevitable motion for summary judgment, and ultimately to persuade the jury, the policyholder should strive to prove not only that the troubled insurance company's claims denial was unreasonable and wrong, but that it was inspired by a strategy for survival that placed its interests ahead of those of the policyholder.

This is not easy. Essential to making this case against a troubled insurer is a deep understanding of the industry, its complicated relationship with state regulation and regulators, and the industry's economic incentives to comply (or not) with established standards of good faith and fair dealing. The policyholder must know what to look for. Where the positive incentives of a going concern are present and the insurer responds to them, one expects to find prompt claims handling and investigation, prompt determination of coverage positions, prompt and clear communications with policyholders, and a claims-handling approach of looking for coverage, all pursuant to internal standards and procedures established by the company for the guidance of claims representatives. But in troubled times, when the usual incentives may be overtaken by a business strategy of survival, one may find instead an absence of prompt and comprehensive claims investigation and handling, long delays in taking definitive coverage positions, compensation or advancement contingent on not paying claims, surplus-enhancing targets for claims departments, and payment of major claims only after protracted coverage litigation—and then only at the lowest amount negotiable in the context of compromising the litigation.

By engaging in these practices, the troubled insurer can realistically hope to achieve important objectives. As long as disputes continue, the insurer will continue to earn income on the money it would otherwise have paid on claims. Reserves (perhaps already aggressively discounted) remain on the books subject to further executive refinement, maintaining the appearance of solvency and satisfying regulators. Protracted litigation raises the policyholder's transaction costs, which can be expected to deter some policyholders from pursuing their rights in the first instance and to prompt others to accept less in settlement than the claim is worth. And if individual cases are isolated by confidentiality agreements and protective orders, the insurer can do all this with minimal risk that the uninitiated policyholder or its counsel will be able to detect—much less prove in court—the pattern of evasion.

But most bad faith litigants lose any realistic opportunity to discover and prove these kinds of facts by insisting that the bad faith claim be litigated at the same time as the breach-of-contract claim. This is the second reason why so many bad faith claims are expensive failures.

Reason 2: Too Many Policyholders and Their Counsel Reflexively Seek to Try Together Their Claims for Coverage and for Bad Faith. Insurers usually want, and some states

favor, bifurcation of the coverage and bad faith claims. Policyholders typically resist. While there are circumstances where this may be the right strategy, often it is not.

In a case involving a denial of coverage, there is no winnable bad faith claim without an insurer's failure to pay in breach of the policy. So the policyholder might as well win the breach-of-contract claim first, thereafter putting the insurer in the unenviable position of arguing that even though it was wrong, it made an honest mistake. Juries tend to exaggerate the competence of big businesses; they tend to believe that businesses don't make mistakes, that they know exactly what they are doing. And if the "mistake" can be shown to be part of a pattern of evasion—part of a business strategy for survival—the insurer's defense of a good faith mistake will almost certainly fall on deaf ears.

Just as important, it is only after a judgment of breach of contract that is then linked to a coherent theory of bad faith that the policyholder is most likely to succeed in convincing a court to allow the type of discovery that will yield important evidence of the insurer's decision-making process and business strategy. This evidence can include the (always assertedly sensitive) reserve information and claims handler performance reviews, as well as privileged communications between the insurer and coverage counsel.

A recent example of how this strategy works is *Brush Wellman Inc. v. Certain Underwriters at Lloyd's, London*, Civ. Action No. 03-CVH-08 (Ohio Com. Pl.). Brush Wellman is a manufacturer of specialty metals. For many years, certain London Market insurers, including Underwriters at Lloyd's of London, had been paying tens of millions in defense and indemnity for claims against Brush alleging liability for plaintiffs' exposure to a potentially hazardous substance, beryllium. Beginning in early 2000, however, the London Market insurers began to deny (or not pay in full) Brush's claims for a variety of new reasons. And because of the London Market insurers' insistence on allocating claims to different years in the manner they selected, Brush was bearing an increasingly large share of the costs of defending and settling the beryllium litigation due to self-insured retentions and uninsured years.

In 2002, the Ohio Supreme Court resolved the allocation issue under Ohio law, holding that the policyholder, not the insurer, has the right to select the policy that will respond to each claim. This ruling allowed insureds to allocate a claim to a single policy period, and not to spread out defense and indemnity costs among multiple years, some insured by different insurers and some even uninsured. When Brush asked the London Market insurers to accept vertical allocation on a going-forward basis, the London Market insurers, led by Equitas, the reinsurer and runoff agent for pre-1993 claims at Lloyd's of London, responded by asserting a variety of new coverage defenses, some of which had the potential to render the coverage valueless.

Proving that Equitas' unreasonable failures to pay the beryllium claims were part of a pattern of evasion resulting from Equitas' business strategy for survival was not going to be easy. Brush would have to obtain documents that no policyholder had ever succeeded in obtaining, documents whose very existence most policyholders may not have suspected. No court was likely to allow such discovery in a breach-of-contract case, even one that appended the obligatory bad faith claim. The court needed to be persuaded first that the insurer had actually breached the contracts.

Brush was quick to agree to bifurcation and then, on summary judgment, won all seven of the coverage issues presented, most of which were matters of first impression in the state. *Brush Wellman Inc. v. Certain Underwriters at Lloyd's, London*, 2006 WL 4455491 (Ohio Com. Pl. Aug. 30, 2006). Following that ruling, the court allowed the unprecedented discovery that Brush sought from Equitas, concluding that this discovery was all relevant to Brush's claim that Equitas' claims denials were part of a pattern of evasion that flowed from its business strategy of survival. Shortly before the start of trial, the London Market insurers settled by not only paying all of the breach-of-contract damages and millions more, but also by replacing the existing coverage, which was riddled with insolvent shares, with a new policy with new (and now reliable) security and $150 million in limits.

But understanding and proving a compelling theory of liability is only half the battle, which brings us to the third reason why so many bad faith claims do not succeed. The policyholder must also prove that the insurer's bad faith conduct caused the policyholder to suffer extracontractual damages beyond the coverage and prejudgment interest that can be recovered in a traditional breach-of-contract action.

Reason 3: Policyholders and Their Counsel Too Often Fail to Appreciate the Difficulty of Establishing Bad Faith Damages in Failure-to-Pay Cases. Extracontractual damages are difficult both to measure and to prove in the unreasonable failure-to-pay bad faith claim. Most of the damages flowing from the failure to pay include various forms of unpaid policy benefits—most commonly, the costs of defending the third-party claim and the costs of judgments and settlements that had to be borne by the policyholder—and in some states, foreseeable consequential damages. But an insured needs no bad faith claim to recover such amounts, and in many states, such contractual damages are not recoverable as damages in a bad faith case anyway. In some states, the legal fees and expenses incurred by the insured to obtain policy benefits can constitute "extracontractual" damages resulting from the insurer's bad faith and can be recoverable in a bad faith case, *e.g.*, *Brandt v. Superior Court*, 37 Cal. 3d 813, 693 P.2d 796, 210 Cal. Rptr. 211 (1985), but in other states, attorney fees can be awarded only if a statutory exception to the American Rule is met; *see*, *e.g.*, *Casson v. Nationwide Ins. Co.*, 455 A.2d 361, 370 (Del. Super. Ct. 1982).

Is it futile, then, to pursue a bad faith claim for an unreasonable or intentional failure to pay a valid claim under a policy? No, but one does need to know what one is doing. Two novel damage theories that led to very successful settlements illustrate the point.

The first is the concept of the "forced loan." When an insurer refuses to pay a covered claim—in many cases years after it is due and payable—the policyholder's balance sheet is damaged by, in effect, having been forced to lend to the insurer the amounts that should have been paid. The elements of this damage include the time value of money and the risk of default. Financial experts can testify that such damages are best measured by the insurer's borrowing cost for incremental unsecured debt, *i.e.*, the costs that the insurer would have had to pay to borrow the funds owed (but not paid) to the policyholder. For an insurer that is at risk for insolvency, that cost will be high indeed and can be measured by the payments that would have accrued on a portfolio of bonds of the same amount and with the same default risk as the forced loan to the insurer.

The "forced loan" analysis is economically appropriate where the policyholder faced no capital constraints, *i.e.*, where the forced loan to the insurer did not divert funds the policyholder needed for other profitable projects. But where the policyholder was capital-constrained, as is increasingly true today, and where the forced loan crowded out other profitable projects, an economically appropriate measure of damages may be the lost expected rate of return on those projects.

The second damage concept is the cost of replacing the coverage that has been rendered uncertain by the insurer's bad faith conduct with reliable coverage providing new, secure protection against liability. *E.g.*, *Chicago HMO v. Trans Pacific Life Ins. Co.*, 622 F. Supp. 489, 493 (N.D. Ill. 1985) ("Compensatory damages for bad faith breach of the duty of fair dealing may include other items as well which are not derived solely from the contract, such as compensation for the cost of procuring other insurance or for the necessity of being self-insured"). Under this concept, the insurer is forced to pay the insured as damages an amount that will allow the insured to replace its existing coverage with new, reliable coverage. Replacement value is a theory particularly appropriate to occurrence-based coverage, where the bad faith insurer and policyholder can reasonably be expected to have to deal with each other in the future because of the likelihood of incurred but not reported, or yet-to-be-asserted, future claims.

Replacement cost is measured by the cost of insuring the same risk, on comparable terms, with new, reliable security for the coverage. Brokers, actuaries, and underwriters, or a combination of them, can provide the necessary expert testimony on these topics. This damages theory, although rarely understood and pursued by commercial policyholders, can provide a basis for recovering extracontractual damages where the insurer, through its bad faith conduct, has destroyed the reliability of the insurance promise. Policyholders should not be required to have to continue to deal with such insurers. As one court explained:

> It would be illogical for the court to find as a matter of law that a prevailing plaintiff in a bad faith case should have to continue to submit to the same treatment in order to receive the future benefits of a contract where [the insured] has complied with its terms and the insurance company has not.

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COLD HARD CASH FOR SOFT IP DISPUTES

by Martin H. Myers

Major software companies frequently are targets of significant, costly litigation brought by competitors, licensees/licensors, end users, nondisclosure agreement counterparties, and others. Perhaps just as frequently, software companies fail to investigate and fully exploit valuable insurance coverage they have to pay for such disputes. There are many reasons insurance is an oft-overlooked asset for software companies—from poor communication between legal and risk management groups, to an early misestimate of the seriousness of the claim, to a lack of understanding regarding the scope of coverage. But corporate counsel and risk managers have every reason to investigate coverage—at any point in the life cycle of a major dispute.

In fact, errors and omissions ("E&O") policies typically carried by major software companies in recent years provide coverage for a broad spectrum of claims, from breach of license or other agreements to consumer fraud to breaches of privacy or security. They cover many other traditional "soft IP" claims as well, such as copyright or trademark. Since many E&O policies carry a traditional "duty to defend," the presence of even one potentially covered allegation can compel the insurance company to pay *all* defense fees and costs *for the entire action*. This is true even if coverage for some—or even most—of the claims is barred by an "intellectual property" or other exclusion. And even though E&O typically is written on a "claims made" basis, in many jurisdictions and under many E&O policy forms, "late notice" of a claim—even for a period of *years*—will not preclude coverage.

Several of these important principles, and the value of reviewing potential coverage, are dramatically illustrated in a recent case between a major software company and its E&O insurer, *Adobe Systems, Inc. v. St. Paul Fire and Marine Insurance Co.*, 2007 WL 3256492 (N.D. Cal. Nov. 25, 2007) (vacated by stipulation pursuant to a confidential settlement agreement, Jones Day attorneys Marty Myers and Ray Sheen represented Adobe in the case).

THE *ADOBE* CASE

Adobe's coverage case arose from licensing agreements Adobe had entered with Agfa/International Typeface Corporation ("Agfa"), a font vendor, under which Adobe obtained authority to give its end users certain rights

to use fonts that Agfa and its predecessors had originated, including the popular Times New Roman and Arial fonts. Adobe embedded various Agfa-originated font features into several products, including releases of its ubiquitous Acrobat® software, enabling Adobe end users to render and view the fonts, subject to Adobe end-user license agreements.

In the late fall of 2001, in connection with a license renewal, Agfa began to assert that Adobe's use of "editable" bits in fonts embedded in certain Adobe products violated Agfa's rights under the license agreements and common law and potentially violated the Digital Millennium Copyright Act ("DMCA"). Agfa further asserted that Adobe's end-user license agreements improperly condoned violations of its rights in the fonts. During this period, Adobe's legal department corresponded and met with Agfa representatives, discussed the issues and the "potential litigation" internally, and even engaged outside counsel to assess Agfa's legal positions. Eventually, in May 2002, Agfa made a formal demand to Adobe for damages by sending Adobe's general counsel a "Notice of Breach" of the license agreements. Through that time, Adobe had not provided notice of "claim" or tendered any aspect of the Agfa matters to its E&O insurer, St. Paul. Adobe's E&O policy from St. Paul covered claims first made between September 15, 2001, and September 15, 2002.

Adobe's negotiations with Agfa continued during 2002, when the parties reached an impasse. Believing that Agfa would attempt to file suit in its home forum in the U.S. (Illinois), in early September 2002, Adobe preemptively filed suit against Agfa for declaratory relief on certain issues in the Northern District of California. Adobe also invoked an arbitration clause in the Agfa license agreements and brought claims for declaratory relief on the agreements in London. True to form, Agfa quickly brought counterclaims in the London arbitration and filed two lawsuits against Adobe in Illinois—one asserting only a DMCA claim and the other asserting breach of contract and other claims, all based on the same conduct about which Agfa had been complaining for more than a year. Given the widespread use of Adobe products, collectively, Agfa's claims sought damages measured in the hundreds of millions or billions of dollars. Still, Adobe did not tender or give notice of the Agfa matters to its E&O insurer, St. Paul.

Finally, in the fall of 2003, more than a year into the litigation and arbitration, and after Adobe's risk management personnel were apprised of the Agfa matters, Adobe provided notice and made a tender to St. Paul. St. Paul denied the Agfa claim on numerous grounds, including alleged late notice, an intellectual property exclusion, and a willful acts exclusion. Adobe conducted its own defense, and after a very costly three-year battle, Adobe substantially prevailed against Agfa in the arbitration and litigation. Adobe and Agfa entered a confidential settlement, and Adobe approached St. Paul to recoup some of its losses. St. Paul declined to participate.

Adobe sued St. Paul, and the parties made cross-motions for summary judgment—Adobe on its claims that St. Paul owed but breached a duty to defend Adobe in the Agfa actions, and St. Paul asserting noncoverage for all claims. The court ruled for Adobe on all major coverage issues, finding that St. Paul had breached its duty to defend. The reasons Adobe prevailed are worth noting by software company risk managers and legal counsel.

COVERAGE FOR "WRONGFUL ACTS," INCLUDING BREACHES OF CONTRACT, IS BROAD

E&O policies purchased by major software companies today generally provide coverage of liability for "wrongful acts," which typically are broadly defined to include an "error, omission or negligent act" in connection with or resulting from the insured's "products" and/or "services." These terms apply to most software companies' core operations, activities, and exposures. Indeed, because a claimant may characterize virtually any act of or attributable to the software company as an "error" or as "negligent," the affirmative reach of policy coverage is virtually coextensive with the entire range of liabilities that a software company may face. However, some courts have found that where the word "negligent" precedes the entire phrase "act, error or omission," the "wrongful act" definition is not satisfied unless the claimant expressly alleges that the act, error, or omission at issue was "negligent," *e.g.*, *Group Voyagers, Inc. v. Employers Ins. of Wausau*, 2002 WL 356653 (N.D. Cal.), *aff'd* 2003 U.S. App. LEXIS 11366 (9th Cir. 2003).

Coverage of liability for "wrongful acts" also may expressly include various forms of misstatement and/or breaches of duty, and such allegations frequently are made in consumer class actions and soft IP cases. Many modern, industry-specific E&O policies will explicitly include in the definitions of "covered wrongful acts" specific soft IP exposures of great

concern to software companies, such as infringement of copyright, infringement of trademark, invasion of privacy, and misappropriation of trade secrets, often subject to significant self-insured retentions and a complex variety of exclusions and limitations.

One widely held misconception about software company E&O concerns coverage for damages from breaches of contract. By and large, such damages *are covered*—often expressly so—but once again ordinarily are subject to various exclusions and limitations. *See*, *e.g.*, *Continental Cas. Co. v. Cole*, 809 F.2d 891, 895–96 (D.C. Cir. 1987) ("error, negligent omission or negligent act" provision "encompasses intentional, non-negligent acts like those associated with breach of contract"). The *ex contractu/ex delicto* distinctions historically made by some courts in the context of general liability policies (even if erroneously—*see*, *e.g.*, *Vandenberg v. Superior Court*, 21 Cal. 4th 815, 824–25 (1999)) have not found footing in E&O jurisprudence. Nor has a recent trend of judicial hostility toward coverage for allegedly contractual damages in Directors and Officers Liability ("D&O") cases (*e.g.*, *Oak Park Calabasas v. State Farm Fire and Casualty Co.*, 137 Cal. App. 4th 557, 565 (2006), or *August Entertainment, Inc. v. Philadelphia Indem. Ins. Co.*, 146 Cal. App. 4th 565, 576–77 (2007)) seeped into E&O decisional authority, although exclusionary provisions applicable to contractual damages exposures have evolved substantially. As a consequence, the wording of exclusions and limitations on coverage for breach of contract is critically important and should be the subject of careful negotiation at the time that E&O policies are purchased and when coverage is renewed.

Despite the breadth of most software E&O coverage, insurers can be expected to attempt to characterize contested claims as not involving "wrongful acts" and as not sufficiently connected to or arising out of the insured software company's defined products or services. The *Adobe* case is instructive as to the broad scope of coverage for wrongful acts and contractual damages—and insurers' retroactive efforts to nullify it.

In *Adobe*, St. Paul took the position that, despite Agfa's allegations that Adobe Acrobat® releases had violated its contractual and other rights in fonts, the alleged losses were not "wrongful acts" because they did not "result from" Adobe's "products or work." Rather, St. Paul contended the losses arose from Adobe's decision to include editable bits in the products over Agfa's contemporaneous objections. St. Paul also argued strenuously that its E&O policy was not intended to cover such contractual claims by vendors or licensors—but rather, only claims by end users or consumers of Adobe products. The court quickly dispensed with those arguments, holding:

> The alleged damages in the Underlying Actions resulted from Adobe's "work" and "product," that is, they resulted from the production and distribution of Acrobat 5.0 with the circumvention technology. Further, the underlying allegations were that the damages suffered by Agfa/ITC were caused by wrongful acts, that is, alleged errors in deciding to include the disputed technology. Although St. Paul contends that the policy was intended merely to cover claims made by injured consumers of Adobe's products, there is nothing in the plain language of the policy that precludes coverage for claims made by Adobe's licensor.

As to coverage of liability for breach of contract, St. Paul had to admit it was "true" that the policy covered "amounts [Adobe] must pay as consequential damages for the breach of a contract or agreement" but argued unsuccessfully that the court should limit such coverage to contract claims of consumers and end users of Adobe products, even though the policy contained no such limitation.

INTENTIONAL OR WILLFUL ACTS EXCLUSIONS AND LIMITATIONS ARE NO BAR

Software company E&O policies typically contain exclusions for intentionally wrongful conduct. And, in many states, insurance for intentionally wrongful and/or criminal conduct is barred as a matter of law, *e.g.*, Cal. Ins. Code § 522. These provisions are intended to prevent insurance coverage for acts that are inherently harmful (*e.g.*, murder, child molestation) or that the insured consciously intends to cause the specific injury suffered (*e.g.*, deliberate sabotage of another company's programming operations). If these kinds of exclusions applied to the unintended consequences of intentional acts, however, then most liability insurance policies would provide little coverage. A driver who negligently made a turn and caused an accident would not be covered because she intended to make the turn; a restaurateur who negligently served spoiled food would not be covered because he intended to serve the food, even though he believed it was safe.

Despite the salutary intent of these provisions, and despite their actual language, insurers frequently contend—and occasionally courts will agree—that they bar coverage for claims arising from any acts or business decisions that the policyholder took or made intentionally. Ordinarily, however, courts reject such claims without much fuss. In *Adobe*, for example, the court made short work of St. Paul's claim that coverage was barred because Adobe "intentionally" distributed Acrobat 5.0 and other products with an editable embedding bit even after Agfa had objected:

> Clearly, the very provision of E&O coverage in this Policy contemplated some level of intentionality. However, this exclusion precludes coverage only when the act is intentionally wrongful, and there is no evidence in the record before the Court from which to infer that the business decision allegedly made by Adobe to include the circumvention technology in its release of Acrobat 5.0 was, at the time it was made, subjectively known to be wrongful.

However, not all courts appreciate these distinctions. In a very recent case, a district court in Minnesota held there was no E&O coverage for the intentional distribution of "spyware" that allegedly corrupted a user-claimant's system, because coverage for an "intended act that results in unintended injury ... runs counter to the plain language of the ['wrongful act'] definition." *Eyeblaster, Inc. v. Federal Ins. Co*., 2008 WL 4539497 *6 (D. Minn. October 2008). But the "wrongful act" definition at issue in *Eyeblaster* was an "error, unintentional omission or negligent act" containing the same "error" trigger that was sufficient in *Adobe* and many other cases.

The *Eyeblaster* court did not elaborate or explain its reasoning, and *Eyeblaster* should be regarded as anomalous, perhaps driven in part by the low regard in which those labeled as "spyware" companies are held. In any event, under the weightier and better-reasoned authorities, software E&O will cover intentional conduct, as long as the specific harm suffered is not intentionally caused. *Adobe*; *see also Corporate Realty, Inc. et al. v. Gulf Ins. Co*., 2005 U.S. Dist. LEXIS 236182 at *8–*9 (E.D. La. 2005); *Continental Cas. Co. v. Cole*, 809 F.2d at 895–96 (D.C. Cir. 1987) ("error, negligent omission or negligent act" provision "encompasses intentional, non-negligent acts").

"INTELLECTUAL PROPERTY" EXCLUSIONS OFTEN DON'T BAR COVERAGE AT ALL, OR BAR ONLY SOME COVERAGE

Many software company E&O policies—even those written on industry-specific forms that expressly cover various soft IP causes of action—may contain so-called "intellectual property exclusions," which purport to carve out and exclude specified causes of action (*e.g.*, patent infringement). Insurers routinely invoke these exclusions, arguing, for example, that the claimant's assertion of a patent infringement claim negates coverage entirely, despite related trademark, license, or business tort claims that are potentially covered.

However, the existence of one or more claims that arguably fall within an IP exclusion should not bar coverage—or even substantially diminish it. First, under the law of most jurisdictions, depending, of course, on the E&O policy language, the exclusion of one claim or set of claims in an action will not prevent coverage for other claims not clearly and conspicuously excluded. And where the policy carries a duty to defend, the law almost everywhere is that the insurer must pay for defense of the entire action, including all claims for which there is no potential for coverage. This is subject in some states to the possibility of partial recoupment, but even then only if the insurer can apportion its defense costs between covered and noncovered claims. *See Buss v. Super. Court*, 16 Cal. 4th 35, 48 (1997).

Second, whether a specific claim falls within an IP exclusion is often open to question. Many IP exclusions are imprecise or vague, and in most U.S. states and other jurisdictions, such ambiguities are construed strictly against the insurer. An exclusion must conspicuously, plainly, and clearly apprise a reasonable policyholder—interpreted from a lay and not a professional or technical perspective—of the matters within its scope.

Again, these principles are illustrated dramatically by the *Adobe* case. The E&O policy there contained an exclusion for loss that "results from infringement or violation of any copyright, patent, trade dress … or other intellectual property right or law." St. Paul argued strenuously that this barred all coverage, since Agfa's claims all "resulted from" copyright infringement—including specifically the DMCA violations that Agfa had asserted in its very first court complaint against Adobe in Illinois, and on which Adobe had sought declaratory relief in its first court filing in California. But the court correctly recognized that "[b]ecause there are breach of contract claims

in the Underlying Actions that are not claims for infringement of an intellectual property law, the [IP] exclusion does not serve to preclude coverage completely" and St. Paul had a duty to defend the entirety of the Agfa underlying actions.

THERE MAY EVEN BE COVERAGE FOR "PROSECUTING" AFFIRMATIVE CLAIMS

An insurer's duty to defend is not always limited to matters in which the insured is technically and formally named as a defendant. It is often advantageous, and sometimes even necessary, for a company to preemptively file suit and seek declaratory or other relief in a proper forum, in order to prevent forum shopping (*e.g.*, the Western District of Texas) or other procedural abuses by wily claimants. However, hewing to allegedly strict construction of policy language, E&O insurers refuse to pay attorneys' fees under these circumstances, arguing that because the insured incurred fees in the course of *prosecuting* supposedly "affirmative claims," they do not fall within the scope of the insurer's duty *to defend*.

The *Adobe* court rejected this argument. Adobe had initiated two of the four primary proceedings that comprised the underlying Agfa dispute, in both cases seeking declaratory relief. The court correctly found that Adobe had filed the actions for defensive purposes and held that "even though an insured initiates a lawsuit, that fact does not automatically preclude coverage for defense-type legal fees and expenses where the insured is resisting a contention of liability for damages." This holding is significant for software developers—and indeed, for all insureds—as it recognizes the practical reality that even where the insured technically must be the plaintiff or take the lead in filing suit, the attorneys' fees and costs incurred in such proceedings may constitute covered costs of defense.

LATE NOTICE TO THE INSURER IS NOT NECESSARILY TOO LATE

Perhaps the most startling lesson embedded in the *Adobe* case is that a delay in tendering or providing notice of an E&O claim need not be fatal—and even may have no impact on the insurer's obligations. In *Adobe*, the court found that St. Paul had a duty to defend Adobe in the Agfa matters even though the matters were not formally tendered or noticed to St. Paul for approximately a year and a half after Agfa's claims were first made, about two years after Adobe had commenced negotiations with Agfa leading to the claims, and well over a year after the St. Paul policy had expired.

One key reason Adobe secured coverage was that the St. Paul policy was "claims made" but not "claims made and reported." Thus, coverage was available for claims like those Agfa had first made during the policy period but had not necessarily reported to the insurer until after the policy expired. While the majority of software company E&O policies written today are claims made and reported, a substantial minority do not require reporting during the policy period, and particularly where there is continuity of coverage, the policyholder may have significant flexibility in reporting.

Another key element in Adobe's recovery was the "substantial prejudice" rule, under which a notice delay will not bar coverage unless the insurer can prove that the delay substantially prejudiced its rights—a very significant, often impossible showing. While a majority of U.S. states apply the substantial prejudice rule to notice obligations under occurrence policies, the application of this rule to claims-made policies such as E&O is far more limited, and U.S. states also vary widely regarding recoverability of so-called "pre-tender" fees and costs. Nonetheless, the possibility of the no-prejudice exception to the notice requirement argues for careful consideration of giving notice, even after a seemingly long delay.

CONCLUSION

Software companies should evaluate their E&O policies in connection with all disputes of note—at the earliest time possible, but regardless of the stage of the proceedings. As the *Adobe* case demonstrates, these policies can apply to a tremendous variety of claims and suits, and they may provide a key resource for funding defense, as well as any resulting settlement or judgment. ■

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IN CORPORATE TRANSACTIONS WILL THE INSURANCE FOLLOW THE LIABILITIES?

by Michael H. Ginsberg and Ian F. Lupson

Companies buying and selling corporate assets and subsidiaries often transfer corporate liabilities. Some of these liabilities may be covered by insurance. But is the insurance applicable to those liabilities also transferred? *Not necessarily.* Serious complications can arise out of such transactions, often many years later, unless care is taken to structure the transaction so that insurance follows liability. This article illustrates several important potential complications and proposes some ways of avoiding them. In addition, since so much can turn on the validity of anti-assignment clauses in insurance policies, corporate policyholders ought to consider negotiating exceptions to these anti-assignment clauses when they renew their policies.

SELLING A SUBSIDIARY

In 1990, XYZ Corporation ("XYZ"), a diversified manufacturing company, decided to concentrate on its core businesses and sell off the assets it used to manufacture noncore products. One of the noncore products was widgets, manufactured by the unincorporated division known as the Widget Division of XYZ. To effectuate the sale of the Widget Division, XYZ first created and incorporated a subsidiary ("Widget Company" or

"Widget") and transferred the assets and liabilities of the Widget Division to Widget Company. Then, in 1995, XYZ sold Widget Company to a venture capital fund. The venture fund operated Widget Company until 1998, increasing its margins and EBIDTA, and then sold the company to its management.

Fast-forward 11 years to 2009. Widget Company is now an independent corporate entity. It has operated successfully for the 19 years since XYZ took the assets of the Widget Division and created Widget Company. Unfortunately, three weeks ago, a plaintiff filed a lawsuit against Widget Company alleging that a plastic component in the company's main product, the widget, degraded over time and released vinyl chloride into the atmosphere in the vicinity of the widget's installation. The plaintiff alleges that as a result of his many years of working with and around the widget, he had been exposed to vinyl chloride and is now dying of liver cancer. Upon investigation, Widget discovers that vinyl chloride was in fact used in a plastic component in widgets that were manufactured during the time that XYZ owned the Widget Division, but that the division ceased use of vinyl chloride-containing plastic a year before Widget Company was created.

Widget Company does not dispute that XYZ's transfer of the liabilities of the Widget Division to Widget Company included the liabilities arising out of products manufactured by the Widget Division. Widget Company also believes, however, that XYZ's insurance covering the Widget Division should have accompanied the Widget Division's liabilities. Widget's position is that it should therefore be entitled to insurance coverage from the insurers that covered the operations of XYZ during the time that Widget operated as a division of XYZ.

Believing it has coverage, Widget tenders the claim to those insurers for defense and, if necessary, indemnity for the vinyl chloride exposure claim. The insurers deny coverage on the ground that Widget was not their insured and that (as required by their policies) they had not given their consent to the assignment of the insurance policies, if any, to Widget Company.

Who's right?

As with most insurance coverage questions, the answer depends on the jurisdiction whose law controls and what the documents creating and transferring Widget Company provided. For example, in the creation of Widget Company from the assets of the Widget Division, did XYZ expressly transfer insurance rights? If not, the insurance may not follow Widget Company's liabilities. Even if there were an express transfer of insurance, would that transfer be effective, given the anti-assignment clause of standard form insurance policies? In some jurisdictions the transfer is effective, but in some it is not. Do the answers to these questions depend on whether Widget Company continued its independent existence or was merged into a parent company? Again, the answer depends on which state's law applies.

The unavailability of insurance for the type of claim that Widget faces could be devastating to the company. These questions and others related to them therefore require careful analysis. What we know for certain is that in three states—California, Indiana, and Hawaii—insurance coverage does not automatically follow the liabilities that it formerly covered, even if XYZ had expressly transferred rights to coverage when it created Widget Company. In other words, in California, Indiana, or Hawaii, Widget Company would be out of luck.

> As with most insurance coverage questions, the answer depends on the jurisdiction whose law controls and what the documents creating and transferring the company provided.

HENKEL AND ITS IMPLICATIONS

In *Henkel Corp. v. Hartford Accident & Indemnity Co.*, the California Supreme Court held that where a company's liabilities have been transferred by contract rather than by operation of law (for example, in a statutory merger), the transfer of insurance was "defined and limited" by anti-assignment

clauses in the relevant insurance policies. Since these policies prohibited assignment without the insurers' consent, the corporation with the liabilities was left without insurance coverage for those liabilities—even though the alleged bodily injuries occurred before the assignment of assets and liabilities. In other words, in the absence of consent to assignment, the insurer that insured the manufacturer of the actual products that gave rise to the alleged injuries was not required to respond to the tort claims arising from those products. In our example, Widget Company, which received the liabilities by contract (the agreement spinning off the Widget Division), would have no right to the insurance that covered the Widget Division at the time it made the products that subsequently generated tort claims.

Recently, in *Travelers Casualty & Surety Co. v. United States Filter Corp.*, the Indiana Supreme Court held that the anti-assignment clause barred several purported assignments of insurance rights in a series of corporate transactions. The issue the court focused on was whether the policyholder could assign rights to coverage for injuries that had occurred but had not yet been reported as claims, even in the absence of the insurer's consent. The Indiana Supreme Court, following *Henkel*, concluded that it could not.

In the *Travelers* case, the Indiana Supreme Court held that in order to be assignable, the insured loss must be fixed and not speculative. The court further held that the loss must be reported to the insured before it gives rise to a transferable right to coverage and that a chose in action like this can be assigned only at a time when the policyholder could have brought an action against the insurer for coverage.

Taking a slightly different path, but reaching the same result, the Hawaii Supreme Court, in *Del Monte Fresh Produce (Hawaii), Inc. v. Fireman's Fund Insurance Company*, held that Del Monte Corporation's assignment of all of the assets and liabilities of its Hawaiian operations to Del Monte Fresh did not transfer the insurance policies or the rights to defense and indemnity from those policies. The court noted that under Hawaii law:

> it cannot be said, as Del Monte Fresh asserts, that the duties to defend and indemnify are separable from the terms of the insurance policy itself, and are assignable as such notwithstanding the existence of a no assignment provision. … [W]e hold that Del Monte Fresh is not an insured under any of the … insurers' policies, and is therefore not owed duties to defend or indemnify by … insurers.

Thus, under these three cases, whether or not injuries that subsequently give rise to tort claims have already occurred at the time corporate assets are transferred, insurance rights cannot be transferred without the insurer's consent. *Henkel* and *Travelers* at least make an exception to this rule if a tort claim has already been made against the insured at the time corporate assets are transferred. A second important exception applies when assets are transferred by operation of law, such as in a statutory merger or dissolution. In this situation, insurance rights are also transferred, regardless of any anti-assignment clause contained in a relevant insurance policy.

California, Indiana, and Hawaii are the only states that have thus far determined that the assignment of the right to coverage of pre-assignment losses without insurer consent may not be valid. But *Henkel* is a very prominent decision nationwide, and given the fluid nature of insurance law on questions such as this, there is no guarantee that other states will not follow the reasoning of the California, Indiana, and Hawaii courts.

STRUCTURING TRANSACTIONS TO REDUCE THESE RISKS

Whether or not these cases apply, it is clear that the assignment of insurance rights by operation of law is ordinarily valid. A merger is the clearest example of a corporate transaction that effectuates the transfer of insurance rights. Questions arise, however, when more nuanced situations like the hypothetical above are presented. Is the creation of a subsidiary from the assets of a corporation enough like a dissolution or distribution to shareholders that a court outside California, Indiana, or Hawaii would conclude that insurance rights in such a transaction are transferred by operation of law? Similarly, if a corporation purchases the stock of a subsidiary that is one of the insureds under an insurance program, does that subsidiary bring with it the rights to that insurance?

Since the answers to these questions are uncertain, the emphasis should be on finding ways to structure a deal so that, when only assets are purchased, insurance rights are protected for the owner of the liabilities arising from those

assets. For example, assume that instead of creating a subsidiary out of the Widget Division, XYZ decides to simply sell the assets of the division to ABC Corporation. Because XYZ wants to be rid of the Widget Division and all of its historic liabilities, known and unknown, XYZ and ABC agree that ABC will assume all liabilities arising from operations of the Widget Division and its products. In order to compensate ABC for its assumption of these liabilities, XYZ agrees to make available to ABC the benefits of XYZ's pre-paid insurance. Is this assignment effective?

Obviously, as discussed above, *Henkel*, *Travelers*, and *Del Monte Fresh* create some questions about this assignment. But assume that the jurisdiction under whose laws coverage is determined has not followed these cases. What other problems may arise? If ABC has assumed the liabilities of the Widget Division, the insurers will argue that since its insured, XYZ, is no longer liable, neither are they. In other words, they will assert, ABC's assumption of liabilities alone may have destroyed the coverage. On the other hand, if ABC's assumption of liabilities does not ultimately protect XYZ from tort plaintiffs, the insurers will argue that they are liable to defend only one of the parties, not both.

What are the alternatives? One would be to leave the liabilities with the seller, XYZ, and provide that ABC will indemnify XYZ to the extent that XYZ's insurance is insufficient to make XYZ whole. This type of arrangement, commonly known as a "net-of-insurance indemnity," has the benefit of not including any purported assignment of insurance rights—the insurance stays with the insured and the liabilities. The anti-assignment clauses of insurance policies therefore do not apply. The parties can then incorporate a claims management provision in the deal documents so that ABC is responsible for defending the underlying claims and submitting claims to the insurers. But this approach has disadvantages. One is that it does not necessarily remove the potential liabilities from XYZ's balance sheet. Another is that the net-of-insurance indemnity is only as reliable as ABC.

A second alternative would be to transfer both liabilities and insurance rights to accompany them to ABC, but to make these transfers subject to an unwind provision and a net-of-insurance indemnity if the original transfers are found to violate the anti-assignment provisions of the policies. But this also may present balance-sheet issues for the parties.

TRANSACTIONS SUBJECT TO FOREIGN LAW

If a transaction involves divisions or subsidiaries that are outside the U.S. and that have in place local policies governed by the domestic law of the relevant territory, then additional analysis is necessary. For example, the general principle applicable in England is that liability insurance policies are not assignable without the insurer's consent, even in the absence of an anti-assignment clause in the insurance policy. In addition, under English law, a merger will not necessarily effect the assignment of insurance rights by operation of law. Were English law to apply to our hypothetical situation, then a purported assignment effectively substituting Widget Company as insured (in the place of the Widget Division of XYZ), unless it took place with the insurers' consent, would probably be invalid.

Under English law, however, Widget Company would be unlikely to face liability for any product that it did not manufacture. But Widget Company might not be off the hook entirely. The fact that XYZ's Widget Division liabilities had been transferred to Widget Company would not prevent the vinyl chloride plaintiff from suing XYZ. Were he successful, then XYZ would likely have a right of indemnity (under the agreement creating or selling Widget Company) against Widget Company on the ground that Widget Company had taken on the liabilities of the former XYZ Widget Division. Under English law, this kind of voluntarily accepted contractual liability may well fall outside the terms of a standard insuring clause of product liability insurance. Consequently, it would have been advisable for Widget Company to have secured coverage filling this gap from the date of inception of its own stand-alone insurance program.

GUIDELINES

It should be clear by now that, until a court of last resort in the state whose law will definitely govern a transaction has ruled on issues of this sort, there is no foolproof, disadvantage-free method of transferring liabilities and insurance rights, short of a statutory merger. Nonetheless, following some guidelines can help to reduce the risk that a transaction will create problems down the road:

- Mergers are the safest way to ensure the valid transfer of insurance rights.

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When does an insured forfeit coverage under a professional liability, fiduciary liability, or Directors and Officers Liability ("D&O") insurance policy by settling a lawsuit without first obtaining its insurers' consent? Three 2008 appellate cases examined this question. The three cases reached differing results in terms of coverage, but those results are easily harmonized. Together, the three cases teach lessons valuable for both policyholders and insurers.

SOME GENERAL PRINCIPLES

Typical D&O, business professional liability, and fiduciary liability insurance policies do not impose on the insurer a duty to defend claims against the insured. The policies usually require only that the insurer indemnify the insured for loss incurred, including defense costs, with most policies today requiring the insurer to advance defense costs. Some policies may provide the insurer with the right, but not the obligation, to assume the defense.

Most policies contain a provision requiring the insurer's consent to settlements, and therefore policyholders risk losing coverage if they do not seek their insurers' consent to a proposed settlement. On the other hand, insurers do not have veto power over reasonable deals that they consider too rich. Policyholders that cooperate meaningfully with their insurers may enter reasonable settlements over insurers' objections, as shown in the one 2008 appellate case in which consent was sought and refused. A policyholder does not automatically forfeit coverage if, in the exercise of its judgment, it accepts a settlement over its insurers' objection, especially when insurers hinder the policyholder's legitimate settlement efforts prior to and during a trial in which the policyholder faces significant liability. Also, where an insurer has fully denied coverage, insureds in many states may settle claims without that insurer's consent.

Several recent decisions deal with these issues.

THE *BEAR STEARNS* CASE

In *Vigilant Ins. Co. v. The Bear Stearns Cos.*, 10 N.Y.3d 170 (2008), the Court of Appeals of New York (New York's highest court) held that Bear Stearns lost coverage by failing to comply with a consent-to-settle provision. Vigilant issued Bear Stearns a primary professional liability policy that attached above a $10 million self-insured retention. Federal and Gulf issued follow-form excess policies providing additional coverage.

WHEN CAN YOU SETTLE A CASE WITHOUT YOUR INSURERS' CONSENT?

by Bernard P. Bell

Bear Stearns had sought coverage for underlying claims involving SEC, NASD, and NYSE investigations into the practices of research analysts. Bear Stearns signed a settlement in principle and later a consent agreement agreeing to pay $80 million to settle the claims. Bear Stearns did not request consent from its insurers until three days *after* executing the consent agreement.

The policies provided that:

> The Insured agrees not to settle any Claim, incur any Defense Costs or otherwise assume any contractual obligation or admit any liability with respect to any Claim in excess of a settlement authority threshold of $5,000,000 without the Insurer's consent, which shall not be unreasonably withheld … . The insurer shall not be liable for any settlement, Defense Costs, assumed obligation or admission to which it has not consented.

The court held that Bear Stearns forfeited its coverage by not informing the carriers of the settlement until after the fact. The court reasoned:

> As a sophisticated business entity, Bear Stearns expressly agreed that the insurers would "not be liable" for any settlement in excess of $5 million entered into without their consent. Aware of this contingency in the policies, Bear Stearns nevertheless elected to finalize all outstanding settlement issues and executed a consent agreement before informing its carriers of the terms of the settlement. Bear Stearns therefore may not recover the settlement proceeds from the insurers.

The court of appeals rejected Bear Stearns' argument that the consent agreement was not a settlement within the meaning of the policy because it was still subject to court approval. Having signed the consent agreement, Bear Stearns was not free to walk away.

THE *ARTHUR ANDERSEN* CASE

In a second case, the Seventh Circuit Court of Appeals also held that a policyholder's failure to consent precluded coverage. In *Federal Ins. Co. v. Arthur Andersen LLP*, 522 F.3d 740 (7th Cir. 2008), a number of retired Andersen partners sued Andersen after it discontinued its practice of disbursing lump sums from its pension plan on request. Andersen notified its primary fiduciary liability insurer, Federal, that Andersen had been sued and had hired defense counsel. Federal reserved its rights and requested further information, which Andersen provided. Andersen proposed a $75 million payout to retirees and *then* asked Federal to contribute its $25 million in limits. Federal refused to contribute, and Andersen settled as it had proposed.

A clause in the policy committed Andersen not to settle any claim for more than $250,000 without Federal's "written consent, which shall not be unreasonably withheld." The Seventh Circuit found that Federal did not owe Andersen coverage for the settlement, for several reasons, including that Andersen lacked the consent of its insurers. "Arthur Andersen didn't ask for the consent or even the comments of its insurers; it presented the deal to them as a *fait accompli*. By cutting Federal Insurance out of the process, Arthur Andersen gave up any claim to indemnity."

Andersen argued that Federal's failure to take action during the pendency of the claim estopped Federal from relying on the consent clause as a defense. The court rejected this argument, holding that estoppel would not apply in cases in which the insured indicates that it does not want the insurer's assistance or is unresponsive to or uncooperative with the insurer's legitimate requests for information.

THE *BERNARD SCHWARTZ (GLOBALSTAR)* CASE

The policyholder fared better in *Schwartz v. Liberty Mut. Ins. Co.*, 539 F.3d 135 (2d Cir. 2008). The Second Circuit Court of Appeals there found that the policyholder had not forfeited his right to coverage by requesting, at 10:00 p.m. on a Sunday night, consent to settle a trial that was set to resume at 9:00 a.m. on Monday morning. This description makes *Schwartz* sound very similar to *Bear Stearns* and *Andersen*, but the differences in the policyholders' behavior and the nature of the insurers' involvement in these cases are revealing and important.

Schwartz was CEO of Globalstar, a company in the satellite telephone business. Globalstar's technology fizzled, and Globalstar and Schwartz soon became defendants in a securities class action, of which Globalstar timely notified its D&O insurers before filing for bankruptcy. The $10 million primary layer of D&O insurance was written by Twin City, and several excess carriers provided $5 million layers above that.

The insurance contracts required the insureds to obtain the insurers' consent before entering into a settlement.

Globalstar's insurers took an active role in the securities litigation—monitoring the claims, evaluating settlement possibilities, participating in settlement negotiations, and watching the trial. These insurers participated in three mediation sessions between Schwartz and the plaintiffs. Schwartz and the excess carriers thought a settlement of $12 million to $13 million was reasonable, but the primary carrier, Twin City, would not agree. The insurers collectively pressured Schwartz to move for summary judgment even though the settlement value of the case would increase if he lost. After Schwartz filed the summary judgment motion, the plaintiffs offered to settle for $15 million but said the settlement value would rise if the court denied the motion or the case went to trial. Schwartz sought the insurers' consent to a $15 million settlement, but the insurers refused to fund it. Twin City never authorized Schwartz to offer more than $5 million of its $10 million limit toward settlement.

Trial began, and the plaintiffs were presenting evidence in support of a damage award of $600 million to $800 million. In a settlement conference during trial, the trial judge advised the insurers that the case would go to the jury and that a plaintiffs' verdict could be eight or nine figures.

After two weeks of trial, Schwartz was scheduled to testify on Monday, July 18, 2005. On Saturday, July 16, 2005, defense counsel learned, and notified the insurers, that the plaintiffs would accept $20 million to settle. At 10:04 p.m. on Sunday evening, defense counsel sought the insurers' consent to settle at that figure. Defense counsel offered to discuss the settlement with the insurers that night or before 9:00 a.m. the next morning. None of the implicated insurers consented to the settlement. Nonetheless, Schwartz settled the case on Monday morning for $20 million, which he paid by personal check.

The insurers contended that the settlement was not covered because it was unreasonable, because they had not consented to it, and (in respect of the excess carriers) because the underlying primary carrier had not paid its limits.

Schwartz then sued the insurers. The jury awarded Schwartz full coverage and found that his failure to obtain the insurers' consent did not bar coverage for the settlement because the insurers breached their duties of good faith and fair dealing. The jury imposed a bad faith judgment against the primary carrier, holding it liable for its $10 million limit, plus the difference between the $15 million settlement offer and the $20 million settlement. But the court dismissed the bad faith claims after post-trial briefing.

The Second Circuit (applying California law) upheld the jury verdict in favor of Schwartz, holding that: (1) the insurers had an adequate opportunity to consider and evaluate settlement opportunities; (2) the $20 million settlement was reasonable; and (3) the insurers unreasonably withheld their consent. The insurers argued that the court should have focused the jury's attention exclusively on the 11 hours, starting at 10:04 p.m. on Sunday night, that defense counsel gave the insurers to consent to the settlement. But the Second Circuit held that the insurers' opportunity to consider settlement extended "over a prolonged course of consultation, monitoring and negotiation, so that the settlement was in the nature of anticlimax rather than surprise."

The *Schwartz* outcome may have been influenced by the fact that Schwartz paid the $20 million settlement with a personal check. Obviously, Schwartz accepted defense counsel's view that the settlement was reasonable. The jury's verdict also reflected a view that the primary insurer and not the excess carriers should have borne the consequences of failing to settle at $15 million. The primary carrier escaped without extracontractual liability, but only because of a complex choice-of-law ruling by the Second Circuit.

A FEW LESSONS

The obvious lesson from *Bear Stearns* and *Andersen* is that, absent exigent circumstances or very favorable or manuscripted policy language as to consent, policyholders jeopardize their coverage if they do not attempt to obtain their insurers' advance consent to a proposed settlement.

But a corollary lesson, underscored by the *Schwartz* case, is that insurers do not have veto power over reasonable settlements and that they act at their own peril when they frustrate legitimate settlement negotiations by taking unreasonable positions or asserting objections that in retrospect appear unjustified or contrary to the insured's interests. The holding in *Schwartz* shows the wisdom for policyholders

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Companies with facilities outside the U.S. protect against the financial losses that can result from damage to those facilities through international property insurance programs. International property insurance programs and losses raise many of the same issues as domestic losses, but they also raise issues that are distinct to international programs. These issues range from basic (*e.g.*, in what currency a non-U.S. claim is paid) to complex (*e.g.*, what, if any, choice-of-law or choice-of-forum clauses should be used). Understanding and addressing these and other key issues when a program is placed will go a long way toward avoiding disputes when losses occur.

OPTIMIZING INTERNATIONAL PROPERTY INSURANCE COVERAGE

by Peter D. Laun and John E. Iole

COMMON STRUCTURES OF INTERNATIONAL PROPERTY INSURANCE PROGRAMS

International property insurance programs can be structured in a variety of ways, based on a range of factors, such as: (1) the magnitude of the international exposure; (2) the types and locations of non-U.S. facilities; and (3) insurance laws in the country where the facilities are located. Three common structures are single-insurer programs, where one insurer provides worldwide coverage for all of the policyholder's locations, both domestic and international; multi-insurer programs, in which the policyholder purchases policies from multiple insurers on a country-specific basis; and global master programs that combine a master policy covering the insured's property worldwide with local policies covering specific locations where the master insurer will not provide coverage or significantly limits coverage.

Single-insurer programs typically are used when a policyholder has limited property outside the U.S. and that

property is in countries where either its U.S. insurer can provide coverage or it has a local affiliate that can do so. Such structures, of course, avoid coordination problems that arise when multiple insurers are involved, as well as potential gaps in coverage caused by differing policies. However, such structures are not always feasible; some countries prohibit foreign insurance companies from issuing local policies, necessitating the use of an approved domestic insurance company in each such country. If the available domestic insurance does not provide adequate coverage—in terms of scope, amount, or both—a global master policy that includes "difference in conditions" ("DIC") coverage (discussed below) can be used to fill these gaps.

Companies with substantial overseas assets generally use (and may be required to use) more complex structures. For example, many multinational companies have high-value or far-reaching global operations that involve financial risks that are too extensive for a single insurer to cover. In such circumstances, a company may place a program that is led or fronted 100 percent by a U.S. insurer but then reinsured in whole or in part either by a captive reinsurer affiliated with the policyholder[1] or by commercial reinsurers. Alternatively, a company may place its coverage directly in a quota-share program, in which the risk is shared in defined percentages by several insurance companies.

Each of these structures has advantages and disadvantages. There are, of course, tax and premium advantages associated with captive insurance/reinsurance programs, and quota-share programs can be used to get higher insurance limits than are available through a single insurer. However, when a company, or its captive insurance company, is insured or reinsured by a variety of different entities, receiving timely and complete reimbursement of claims may pose greater difficulty than under a single-insurer system. Furthermore, when a claim is made under a program with multiple insurers, there is a risk that the insurers will take inconsistent coverage positions (and unless the insurance or reinsurance agreements have identical terms, including choice-of-forum and choice-of-law clauses, the risk of inconsistent adjudications also exists). For all of these reasons, the administrative costs associated with a multi-insurer program are likely to be higher, perhaps significantly higher, than with a single-insurer program. The advantages and disadvantages of these different approaches, therefore, should be identified and carefully evaluated when an international property insurance program is formulated and placed.

KEY ISSUES IN PLACING COVERAGE AND MAKING CLAIMS

Inconsistent Terms of Local Policies. When a program includes the use of a local policy or policies, it is highly desirable to ensure, to the extent possible, that the local policies provide the same coverage as the principal U.S. or master policy. Otherwise, the company may be left with substantial international risk that may not be covered under either the local policy or the master policy. For example, U.S.-based insurance companies may write business interruption coverage on either a "gross profit" or a "gross earnings" basis, and some U.S. insurers offer a form under which the policyholder can select between a "gross earnings" and a "gross profit" calculation on a "loss by loss" basis. Non-U.S. insurers, however, may write only on one basis or the other. Such variations can lead to substantial gaps in coverage; for example, payroll coverage may be provided directly under one form but not the other, or certain losses to a U.S. entity resulting from damage to a foreign location may not be covered. A U.S.-based subsidiary or division may thus experience a loss involving an international location for which the available coverage is contrary to its expectations and experience with the domestic policy form.

The best way to attempt to ensure uniformity of coverage between a U.S. policy and a local policy is, of course, for the local insurer simply to use the domestic form, translated by an agreed translator. However, this may not be a viable option, since many non-U.S. insurers will not write coverage using U.S. forms, or the required coverage form may be dictated by local law. And even using a translated policy cannot ensure complete uniformity, since nuanced differences in translation or interpretation, or the lack of pro-policyholder doctrines of construction common in the U.S. (discussed in more detail below), can still lead to potential coverage gaps.

DIC Coverage. As noted above, international programs involving a master policy and local policies often include DIC coverage, which is supposed to protect the policyholder against gaps in coverage that result when the local policy provides narrower coverage or more restrictive limits than those available under the master policy.[2] But even DIC clauses do not fill all potential gaps in coverage; for example, a U.S. insurer is likely to contend that its DIC clause does not cover a

situation where local claim adjustment practice or the interpretation of a local policy provision varies from U.S. insurance adjustment practice or interpretation, because these are not *differences* in terms or conditions. A common example is certain professional expenses: Although the coverage provided under the master and local policies may be the same, the local insurance company may, by practice, refuse to pay certain types of professional expenses that are customarily paid in the U.S., such as the engagement of construction managers to manage a facility rebuild. Or the local insurance company, based on local custom or practice, may resist paying the full rates of U.S.-based or local forensic accountants or consultants used to quantify the loss. These coverage variations may not, in the insurer's view, fall within the DIC coverage of the master policy. When negotiating DIC coverage, therefore, the policyholder should carefully scrutinize the DIC clause to ensure that it is as favorable as possible.

Currency Conversion and Fluctuation. Currency conversion issues can add risk and complexity to international claims. These issues can be particularly complex in master/local programs, in which the per-occurrence and aggregate limits often are stated in dollars. Such programs attempt to address currency conversion issues in various ways. For example, the local policy may state that losses are payable in the local currency (or in dollars), and it may also specify a specific rate of currency conversion applicable to the loss (*e.g.*, the rate of exchange published in a specified newspaper on a specific date, such as the loss date or the date when the policyholder pays the reimbursable amount).

Unfortunately, neither of these provisions provides a risk-free solution. Consider the following scenario: A flood damages the insured property of an international subsidiary, resulting in the need to rebuild the facility, as well as business interruption losses both to that subsidiary and to other, U.S.-based operations. The international losses are accounted for in the local currency and ultimately are converted to dollars and consolidated in the books of the U.S.-based parent company. The U.S. company also sustains separate business interruption losses that are incurred and recorded in dollars. The local policy limits are stated in dollars, but that policy requires local losses to be paid in the local currency, and the currency exchange rate fluctuates substantially against the dollar during the period of the loss.

What happens if the local subsidiary pays for equipment in dollars fairly quickly after a loss occurs? Under the terms of the local policy, that loss should be converted to the local currency at the time the loss is incurred (*i.e.*, when the insured actually pays for the equipment). But if (as is usually the case) the insurance company does not reimburse the policyholder for that loss for several months, during which the local currency has experienced a substantial negative change in value against the dollar, the local-currency payment will not fully compensate the policyholder for the loss it incurred, since it will receive local currency that is worth less (at least in terms of dollars) than the currency was worth at the time the loss was incurred. Conversely, if the policyholder's local operation incurs losses in the local currency (*e.g.*, local business interruption losses), those losses do not need to be converted and should be paid in local currency. However, in the situation described above, the losses ultimately will need to be converted to dollars and applied toward exhaustion of the policy limits (written in dollars), and many policies do not specify the applicable rate of exchange in such circumstances. Should currency conversion be done at the end of the loss, when payments or advance payments are made, or at some other time? If the local currency fluctuates against the dollar during the period of a loss—and business interruption losses often go on for a year or more—each of those dates can lead to a policy limit stated in dollars paying a different total amount in local currency.

These types of issues, of course, are best dealt with at the time the international insurance program is negotiated and placed. However, some local insurance companies may write coverage (by law or practice) only on standard local forms that do not address these issues. In such cases, the issues should be raised as soon as possible after a loss occurs so that the insurer(s) and the policyholder can attempt to agree on how to resolve them. Ideally, the insurer that issued the master policy should also be involved, since currency fluctuation may result in potential DIC claims under a global master policy, although it is not at all clear that a U.S. insurer would view a DIC provision as providing this kind of coverage.

Another way in which coverage can be affected by currency fluctuation involves property valuation. Property values are often submitted at the beginning of a policy period and generally are stated in local currency. Some policies limit the maximum loss payment to the stated value, while some

policies do not. Policyholders with substantial holdings in several countries may not reappraise each property each year. If the currency has experienced significant fluctuation (or does so during the policy period), the stated value may not be correct to begin with or may not remain correct during the policy term.[3] And if substantial currency fluctuation occurs, the coverage limits available for local properties that are stated in local currency may also diverge from the dollar limits stated in the global master policy, or with per-occurrence or aggregate limits in the local policy. The best solution to this problem is either to re-survey properties regularly in countries where currency fluctuation is occurring or to add a clause addressing this issue in the "stated values" section.

When currency fluctuation risks are identified in advance, they can be addressed—and, where possible, allocated to the insurer—through modifications to the policy when the program is negotiated.

Code Upgrade Coverage. Although coverage for the cost of bringing repaired or replaced property up to current code standards is very common in the U.S., non-U.S. insurance policies may not provide this coverage. And even if such coverage is provided, it may be of limited practical value as it is currently written.

Compared to those in the United States, building codes in developing countries are often less stringent or may be enforced less stringently (if at all) in the event of a loss. Thus, if a policyholder experiences a loss in a developing country, it may be allowed by local authorities to rebuild the facility "as it was," without (for example) upgrading building materials or fire protection systems to meet current standards. In such a situation, code upgrade coverage would not be implicated or necessary. If upgrading is required to bring a facility up to current code, however, the costs of doing so can be significant, and therefore it is essential to secure code upgrade coverage under local policies if possible.

Even if a policyholder is not required by local authorities to bring a facility into compliance with current code standards, code upgrade costs can still arise. After an older facility experiences a significant loss, the insurer may insist that the facility be rebuilt to higher standards in order for the insurer to continue to provide coverage (or to maintain a reasonable premium), or the policyholder's own corporate policies may mandate or strongly encourage safety-related construction upgrades when a facility is rebuilt. This can result in a substantial difference between the *actual* rebuild cost and the *covered* rebuild cost, since code upgrade coverage would not be triggered.

Obviously, it is best to address these issues before a loss occurs. While an insurer may not be willing to provide coverage for construction upgrades not mandated by local building authorities, it may be willing to provide coverage for upgrades it specifically requires after a loss, such as an enhanced fire protection system or other loss-prevention upgrades.

Control and Salvage of Damaged Property. Property insurance policies generally allow the insurer to sell damaged raw ingredients and goods for salvage, which benefits the insurer by allowing it to recoup some of its paid losses. Salvage of common or commodity materials (*e.g.*, scrap metal) generally is not problematic, but salvage of damaged raw materials or finished goods can raise difficult issues. Salvaged finished goods and raw materials often can be sold on the "gray market" either in the country where the loss occurred or outside it. It is not uncommon for there to be a market for gray-market products outside the U.S. (for example, in developing countries, whether the product originated in or outside the U.S.), and there are often markets for such products in the U.S. as well.

A policyholder with a substantial investment in a brand name, however, generally does not want gray-market goods that could negatively affect that brand name to be sold in a market where undamaged products are sold. Such policyholders should try to negotiate policy provisions allowing them alone to determine whether and how any potentially salvageable goods can be resold by the insurer. This additional protection can be critical, for example, when a policyholder wishes to protect a brand name or its corporate reputation by ensuring that potentially salvageable but damaged finished goods or raw ingredients cannot be resold by the insurer, inside or outside the U.S. Similarly, a policyholder may not want damaged (but otherwise salvageable) raw materials traceable back to it for liability or image reasons. While these issues may be less problematic (since raw materials are less likely to be immediately traceable to the policyholder than finished goods), the sale of damaged raw materials for certain uses (*e.g.*, human consumption) can pose problems that the policyholder may wish to avoid.

Such restrictions, however, can be the subject of difficult negotiations with insurers, since they limit an insurer's ability to recover amounts it has paid to the policyholder for damaged goods or raw ingredients. If this issue is not specifically addressed in the policy, the insurer may not be receptive to an after-the-fact argument that it cannot or should not exercise its salvage right merely because the resale of gray-market goods could negatively affect the policyholder's brand image. And if the policyholder is able to prevent salvage sales by the insurer, the insurer may insist on a credit for the lost salvage, which can result in a substantial financial detriment to the policyholder.

Choice-of-Law and Choice-of-Forum Clauses. While a full examination of the myriad issues that can arise from different choice-of-law and choice-of-forum clauses in U.S. and non-U.S. policies is beyond the scope of this article, a few key points are worth emphasizing.

First, a choice-of-law clause that provides for the construction of a policy under local laws may well preclude the application of pro-policyholder doctrines common in the U.S., such as: (1) *contra proferentem* (pursuant to which ambiguous or unclear terms are construed against insurers); (2) narrow construction of exclusions and broad construction of coverage grants; and (3) a requirement that an insurer show prejudice to avoid coverage based on late notice (or breach of certain other conditions) by the policyholder.

Second, whether or not it is less favorable than U.S. state law, local insurance law may not be as fully developed on the somewhat arcane areas of property insurance that may be involved in disputes. This can lead to uncertainty and a lack of predictability as to what coverage is likely to exist for certain types of losses.

Third, certain choice-of-law clauses—for example, those common in Bermuda-issued policies—also attempt to eliminate pro-policyholder policy-construction doctrines by stating that the policy will not be construed against the insurer as drafter and that policy provisions will be construed in an evenhanded fashion without reference to drafting history, expressed intent, etc. The elimination of these doctrines can have a dramatic negative effect on coverage.

Finally, arbitration clauses can have a similar effect. Many arbitration clauses, inadvertently or advertently, can result in a pro-insurer bias (for example, by specifying that the arbitrators must be former executives of insurance or reinsurance companies). While such bias may not always result in practice, policyholders generally should resist these types of clauses and insist, if possible, on clauses allowing a broader range of potential arbitrators. Certain arbitration clauses may also attempt to eliminate pro-policyholder policy-construction doctrines from the arbitrators' consideration; again, such clauses should be resisted.

CONCLUSION

Securing sound and predictable coverage for international risks is one of the most complex insurance tasks facing U.S.-based companies today. International insurance programs can be modified to protect against many gaps and risks, and good claim advice can help ensure that potential problems are identified and addressed as early as possible in the claim process, which can avoid later disputes. ■

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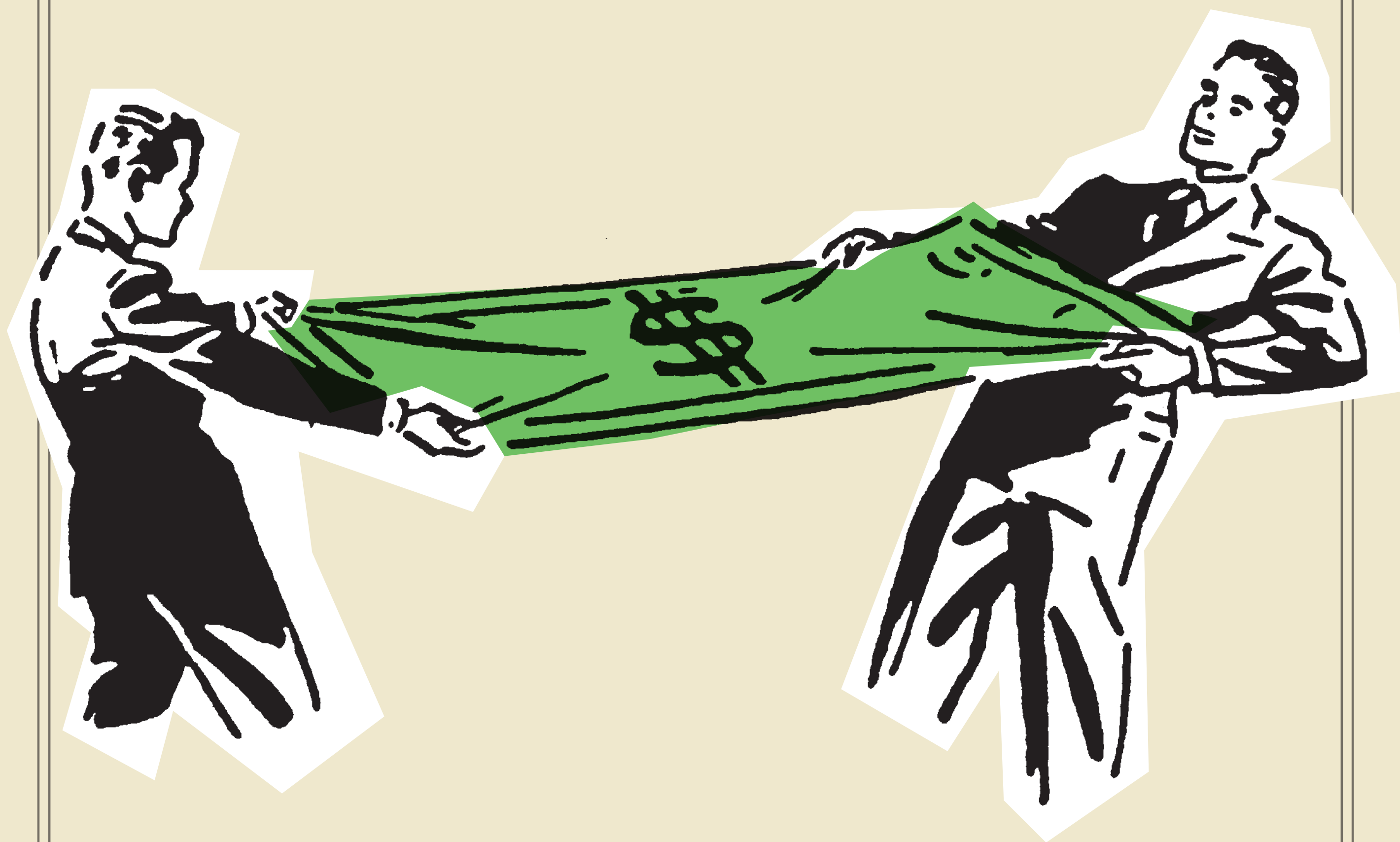
[1] Captive reinsurers, in turn, are often reinsured in large part by commercial reinsurers, U.S.-based or non-U.S. based, with each company taking an agreed percentage of the retroceded risk.

[2] Although the wording may vary depending on program structure, a common DIC provision states:

> This Policy is designated the Master Global Policy for Insured Locations under this Policy and which are insured under an underlying policy(ies) issued by the Company or its representative companies. As respects such Insured Locations, this Policy covers:
> 1) the difference in definitions, perils, conditions or coverages between any underlying policy and this Policy.
> 2) the difference between the limit(s) of liability stated in any underlying policy and this Policy, provided that:
>   a) the coverage is provided under this Policy;
>   b) the limit(s) of liability has been exhausted under the underlying policy; and
>   c) the deductible(s) applicable to such claim for loss or damage in the underlying policy has been applied.
>
> Any coverage provided by the underlying policy that is not provided in this Policy does not extend to this Policy.

[3] If this occurs, providing incorrect values might be viewed by the insurer as a breach of a policy condition, which could result in an insurer declining coverage for a loss in its entirety.

IDENTIFYING AND MINIMIZING **PREFERENCE AND FRAUDULENT CONVEYANCE RISK** FROM INSURER INSOLVENCIES IN CDOs



by Fordham E. Huffman and Tracy K. Stratford

Since 2003, almost $1.5 trillion in collateralized debt obligations ("CDOs") have been issued worldwide. Insurers are involved in CDOs in two primary ways: (a) as investors/parties; and (b) as "guarantors" of the assets on which the CDO is based. As underlying assets in CDOs lose value, the risk of a CDO default rises, and investors—including banks, brokerage firms, and insurance companies facing continued liquidity crises—look to protect their positions. The potential for insurer insolvency and liquidation creates potential peril for investors. Under certain circumstances, adding to a CDO's asset pool may (at least temporarily) prevent the deal from liquidating and locking in losses, but an insurer's contribution may be clawed back in the event of an insolvency. Similarly, if there is a financial guaranty insurer behind the assets of the CDO structure, commuting the financial guaranty insurance policy in exchange for a lump-sum payment may enhance the asset base, but it may also create a voidable transfer.

Insurers that may become insolvent pose clawback risks that must be identified by careful analysis. That analysis includes a review of timing of new transfers to the CDO, the nature of the entity making those transfers, and the obligations and financial condition of the parties to the transaction. The standards against which these transactions will be measured vary widely by jurisdiction, and the law is sparse. Experienced counsel can assist in determining the wisest course to handle the potentially insolvent insurer in these complex and difficult deliberations.

CDO STRUCTURES

As its name suggests, a "collateralized debt obligation" is a structured investment of notes backed by collateral in the form of financial assets such as corporate bonds, residential mortgage-backed securities, commercial mortgage-backed securities, or asset-backed securities. Typically, the assets are held by a special purpose vehicle that finances the purchase of assets by issuing various classes (or tranches) of debt securities and a class of equity securities. Each tranche of debt securities is separately rated on the basis of its attributes, including the tranche's priority to distribution of income from the collateral. Prioritizing payments creates a "waterfall" of distributions, with the highest-rated tranche typically entitled to full payment of interest or principal before similar categories of payments can be made to lower-rated tranches.

CDOs can be classified in various ways, including cash or synthetic, static or managed, and cash flow or market value. Each classification affects how the CDO is constructed, its business purpose, and the remedies and risks its investors have if the asset pool deteriorates in value. For purposes of this discussion, we focus on three aspects of these vehicles that can present voidable transfer issues where insurance companies are involved.

Supplemental Funding. Most CDOs require the maintenance of a certain level of assets or cash flow to provide debt service and principal protection to at least the senior tranche of issued securities. Two types of CDO have very different mechanisms for ensuring that protection, one with potentially drastic consequences for all but the senior noteholders, which may lead subordinate investors to "sweeten the pot" with additional contributions, raising the risk of clawback in the event of a subsequent insurer insolvency.

CDOs use various "coverage tests"—ratios designed to measure the ability of the available assets to service the principal and interest obligations of the CDO to its senior noteholders. In a cash flow CDO, these ratios are relatively simple comparisons of income to expenses and par value of assets to principal obligations under the notes. Shortfalls under either ratio lead to a suspension of payments to the waterfall until the ratios are met or the senior noteholders are paid in full. Once the tests are met, payments to subordinate holders resume.

In contrast, a market value CDO that fails its coverage tests not only will suspend payments to the lower

tranches of debt, but may be required to liquidate its entire portfolio if it cannot bring itself into compliance with its coverage tests in a specified period of time. These types of CDOs employ coverage tests using advance rates assigned to categories of investments by the rating agencies and mark-to-market values for the financial assets. If, applying those advance rates to the mark-to-market values, the portfolio's value falls below a specified percentage of the outstanding principal amount of the CDO notes, assets must be sold and senior notes paid down to rebalance the ratio. If the portfolio value test is not satisfied within a specific period of time, many market value CDOs require that the entire portfolio must be liquidated.

Because the premature and forced sale of assets to satisfy these market value tests can lead to diminished or nonexistent returns for the lower-rated securities, particularly in a market such as that which prevails today, market value CDO transaction documents will often allow equity or subordinated security holders to contribute supplemental funds, which can be used to purchase additional assets to improve the valuation ratio and forestall liquidation of the deal. However, since the value of the CDO may nevertheless continue to deteriorate, it is critical that the supplemental contribution be irreversible. If assets purchased with a supplemental contribution are used to satisfy a ratio test, and those assets are subsequently clawed back from the deal, the senior noteholders may well be in a worse position than they would have been in had the deal liquidated when the ratio test was first failed.

Guaranteed Investment Contracts. In a synthetic or hybrid CDO, the cash raised from the sale of securities is not used to buy financial assets directly. Rather, the CDO sells credit protection with respect to a portfolio of "reference securities" in the form of credit default swaps ("CDS") or other derivatives to counterparties. In this structure, the cash raised from the sale of securities is used to buy conservative investment instruments, often guaranteed investment contracts ("GICs"), and the income generated by those investments, as supplemented by the premium paid by the credit protection buyer, is used to pay the CDO's debt service and other expenses.

GICs simply guarantee a specified rate of return on the invested amount and the return of principal. GICs generally require the GIC counterparty to maintain a minimum amount of collateral for its obligations, tied to the rating of the GIC counterparty. Although GICs are not insurance products, insurers are frequently GIC counterparties, and because their ratings fluctuate in turbulent markets, they may be contractually required to post additional collateral to support their GIC exposures. This collateral posting may create preference or fraudulent transfer risks if the insurer is in hazardous financial condition.

Commutations of Financial Guaranty Insurance Policies. Most CDOs, whether cash, synthetic, or hybrid (or, in some cases, their investors), will utilize CDS or other credit derivatives and may use some form of credit enhancement, such as financial guaranty insurance. In these instances, the insurance company stands behind the financial asset and, in the case of default, will step into the shoes of the obligor to make interest and principal payments as and when due. This insurance is written by a relatively small group of monoline insurance companies, almost all of which are New York-domiciled (Ambac, domiciled in Wisconsin, is the notable exception).

These companies took on large amounts of exposure to CDOs in the last five years and, once financial markets started to slide, began to experience extraordinary deterioration in their surplus as they strengthened the loss reserves related to their structured finance book of business. As their surplus eroded, their ratings fell. As a result, the beneficiaries of their policies—counterparties to CDS—began to review available options to reduce their exposure. One option for a financial guaranty policyholder is commutation of the policy, under which, in exchange for a payment, the policy would be terminated. If a CDO, as the credit protection seller, chooses this course to enhance its asset pool and reduce its exposure to a particular monoline, there are attendant clawback risks associated with it, and they must be recognized and guarded against.

Uncertainty in financial markets has made predicting insolvencies more difficult than ever. Large financial institutions are not immune. Thus, there is real value in attempting to "preference-proof" payments received from insurers at risk of becoming insolvent. In each of the three scenarios discussed above, there is a transfer of assets that, if made by an insurer, will be scrutinized by a subsequent receiver if the insurer is subject to insolvency proceedings in the near term. After a review of the applicable legal provisions, we will discuss how the threat of insurer insolvency should affect the decision making and documentation surrounding these different types of transfers.

PREFERENCES AND FRAUDULENT TRANSFERS

"Preferences," generally speaking, are payments made by an entity that subsequently enters into receivership, insolvency, or bankruptcy proceedings, which payments actually or may have the effect of "preferring" one creditor over others—*i.e.*, giving one creditor a greater share of its due than other similarly situated creditors. Preferences are creatures of insolvency statutes, and the statute that governs the insolvency proceedings of the entity making the payment will define which of its transfers were preferences. The consequence of having received a preference is that it can be "clawed back" by the debtor or its representative (trustee, receiver, liquidator, etc.) if it meets certain statutory criteria. "Attempting to preference-proof payments" refers to taking the steps necessary to create transactions that fall outside the technical statutory definition of "voidable preference."

"Fraudulent conveyances" are also payments by an entity at or near the point of insolvency, and although a subsequent insolvency proceeding is not necessary to obtain redress for a fraudulent conveyance, most insolvency schemes include provisions addressing fraudulent conveyances. Generally, conveyances are deemed fraudulent when they are made while the transferee is insolvent, for less than fair consideration, or with the intent of hindering creditors from collecting on their debts. As stated above, a creditor can seek to avoid a fraudulent conveyance by the debtor without the need for formal insolvency proceedings. Among the remedies available to creditors is a setting aside of the conveyance, or a "clawback."

Although federal bankruptcy laws apply to most business entities, they specifically do not apply to insurance companies. 11 U.S.C. § 109(b)(2). The business of insurance, and regulation of insolvent insurers, is governed by state—not federal—law and thus varies from state to state. *See* the McCarran-Ferguson Act, 15 U.S.C. §§ 1011–1015. However, nearly all states follow either the Uniform Insurers Liquidation Act, promulgated in 1939, or the more comprehensive Insurers Rehabilitation and Liquidation Model Act, promulgated by the National Association of Insurance Commissioners ("NAIC"). In 2006, the NAIC issued the Insurer Receivership Model Act, which has not yet been adopted by any state.

The Uniform Insurers Liquidation Act does not include provisions relating to fraudulent transfers or preferences. Thus, we review here only the Insurers Rehabilitation and Liquidation Model Act. Three sections govern or relate to preferences and fraudulent transfers in the context of insurer insolvency.

Section 29(A) addresses fraudulent transfers and provides, in part:

> Every transfer made or suffered and every obligation incurred by an insurer within one year prior to the filing of a successful petition for rehabilitation or liquidation under this Act is fraudulent as to then existing and future creditors if made or incurred without fair consideration, or with actual intent to hinder, delay or defraud either existing or future creditors.

The statute provides that such fraudulent transfers may be avoided by the receiver except as against a good faith purchaser who gives fair equivalent value and further provides that anyone receiving a fraudulent transfer from an insurer is personally liable for it.

Section 32(A) addresses preferences and provides, in part:

> A preference is a transfer of any of the property of an insurer to or for the benefit of a creditor, for or on account of an antecedent debt, made or suffered by the insurer within one year before the filing of a successful petition for liquidation under this Act, the effect of which transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive.

This section goes on to provide that preferences may be avoided if the insurer was insolvent when it made the transfer, if the transfer was made within four months of the filing of the petition, if the creditor had reason to know or believe that the insurer was insolvent (or about to become insolvent), or if the transfer was to an insider.

Section 46(E) insulates certain transactions from attack by a receiver as fraudulent transfers or preferences:

> Notwithstanding any other provision of this Act, a receiver may not avoid a transfer of money or other property arising under or in connection with a netting agreement or qualified financial contract (or any pledge, security, collateral or guarantee agreement

> or any other similar security arrangement or credit support document relating to a netting agreement or qualified financial contract) that is made before the commencement of a formal delinquency proceeding under this Act. However, a transfer may be avoided under Section 29A of this Act if the transfer was made with actual intent to hinder, delay or defraud the insurer, a receiver appointed for the insurer, or existing or future creditors.

This provision, dealing with qualified financial contracts, was added to the Model Act by the NAIC in 1997, to bring it into alignment with provisions of the federal bankruptcy code and federal banking laws that exempt derivative and netting agreements from the "automatic stay" that protects the assets and positions of a debtor immediately upon entering insolvency proceedings. *See*, *e.g.*, 11 U.S.C. § 362(b)(17). The intent was to ensure that the derivatives markets move freely and that unnecessary losses were not taken by any market participant as a result of an insurance company insolvency. Section 46 creates an absolute shield for transfers made pursuant to a "qualified financial contract," defined as "a commodity contract, forward contract, repurchase agreement, securities contract, swap agreement and any similar agreement that the [regulator] determines to be a qualified financial contract for purposes of this chapter."

These "model" and "uniform" laws are far from the endpoint in determining how to avoid creating a preference or fraudulent transfer. The important starting point is determining the jurisdiction in which the subject insurer is domiciled. That jurisdiction has primary authority to oversee insolvency proceedings, and its preference and fraudulent transfer statutes will apply. While most states have based their statutory schemes on the Insurers Rehabilitation and Liquidation Model Act, there is significant variation from state to state.

For example, the preference statutes of Arkansas and New York do not follow the Model Act at all and are driven solely by intent:

> Any transfer of, or lien created upon, the property of an insurer within twelve months prior to the granting of an order to show cause under this article with the intent of giving to any creditor or enabling him to obtain a greater percentage of his debt than any other creditor of the same class and which is accepted by such creditor having reasonable cause to believe that such a preference will occur, shall be voidable.

N.Y. Ins. Laws § 7425(a). *Accord* Ark. Code Ann. § 23-68-125 (limiting preference period to four months). On the other hand, California, Connecticut, Michigan, and Wisconsin, for example, do follow the Model Act in defining preferential transfers, and thus the focus of the analysis is on whether the transfer was made on account of an antecedent debt, within the prescribed time period. Cal. Ins. Code § 1034; Conn. Gen. Stat. § 38a-930; Mich. Comp. Laws § 500.8128; Wis. Stat. § 645.54. The insurer's intent in those states appears to be irrelevant.

New York has not adopted an insurance-specific fraudulent transfer provision. A New York-regulated insurer is subject to New York's fraudulent transfer statutes, found in the debtor creditor laws. N.Y. D&C Laws §§ 270 et seq. New York's insurance laws do, however, specifically vest the superintendent of insurance, as receiver, with authority to seek to avoid any fraudulent transfer that the insurer's creditor could have sought to have avoided. N.Y. Ins. Laws § 7425(c). Arkansas follows this same approach. Ark. Code Ann. § 23-68-125(c). California, Connecticut, Michigan, and Wisconsin have adopted versions of the fraudulent conveyance provisions of the Model Act. Cal. Ins. Code § 1034.1; Conn. Gen. Stat. § 38a-928; Mich. Comp. Laws § 500.8126; Wis. Stat. § 645.52.

Only six states have adopted Model Act Section 46(E)—the exemption for transfers pursuant to qualified financial contracts. Significantly, the Model Act defines "qualified financial contracts" to include securities contracts and swaps, creating a preference and fraudulent transfer shield for CDO counterparties that are willing to invest in negotiating and documenting a side arrangement. That few states have adopted this provision is not surprising. When the NAIC was drafting the Model Act, some commentators "suggested that Subsection E [of Section 46] be deleted because it creates a dangerous exception to the voidable preference provisions of the model act." 1995 Proc. 4th Quarter 727. Nonetheless, Connecticut, Iowa, Maryland, Michigan, Texas, and Utah have adopted Section 46(E) of the Model Act. Conn. Gen. Stat. § 38a-944a; Iowa Code § 507C.28A; Md. Ins. Code Ann. § 9-229.1; Mich. Comp. Laws § 500.8115a; Tex. Ins. Code Ann. § 443.261; Utah Code Ann. § 31A-27a-611.

STRUCTURING TRANSACTIONS TO MINIMIZE PREFERENCE AND FRAUDULENT TRANSFER RISK

In an earlier section, we described three specific situations in which money or assets could be transferred into a CDO in an attempt to enhance the financial viability of the structured investment. In each of those situations, the transfer could be deemed either a preference or a fraudulent conveyance if the transferor is subsequently placed in insolvency proceedings. As just described, insurance insolvency statutes give broad authority to a receiver to claw back insurer assets transferred prior to the receivership if certain statutory criteria are met. And, depending on the jurisdiction, those criteria can turn completely on the intent of the parties or can be wholly blind to that intent.

Therefore, while there may be good reasons to augment the asset portfolio of a CDO to prevent liquidation or to satisfy contractual requirements, parties must proceed with care when those additional assets are transferred from an insurance company. If the transfer of an insurer's assets into a vulnerable deal is reversed at a future date, there is substantial risk that the vulnerabilities will become fatal, and investors who might have survived an earlier liquidation with minor losses in the higher tranches will, in the event of a clawback, find themselves seriously out of the money in a subsequent, delayed liquidation.

In the few states that protect qualified financial contracts from preference and fraudulent transfer claims in insurance insolvencies, minimizing risk may be accomplished by effecting a transfer under or in connection with a qualified financial contract. For example, an insurer that purchases notes from a CDO pursuant to a securities contract is transferring assets to the CDO pursuant to a qualified financial contract. The transfer of money into escrow for the purchase of notes if certain events arise in the future could also be made in connection with a securities contract. For insurers domiciled in states that have adopted Section 46(E) of the Model Act, that transfer would not be subject to a clawback, absent actual intent to defraud the insurer or its other creditors.

However, for insurers in states without Section 46(E) protections, and whose home-state statutes define preferences in terms of antecedent debt, the task may be more difficult. A straightforward purchase of CDO notes that involves a contemporaneous exchange of assets for notes is not a transfer on account of antecedent debt and thus would not be a preference. On the other hand, a contract that obligates an insurer to purchase notes in the future if certain contingencies arise does create preference risk. We have seen this when a junior noteholder, anticipating an untimely but imminent liquidation, seeks forbearance from the senior noteholders in exchange for a commitment to "shoring up" the deal if the deterioration continues and the coverage ratios are breached, to protect the value of the senior tranche.

A receiver may argue that such a commitment, when given, created a debt and, when the contingency arose and the assets were transferred, the transfer was on account of an antecedent debt, creating a preference that should be clawed back for the benefit of the insurer's estate. While there is room for debate about whether that transfer is on account of an antecedent debt, there is virtually no law interpreting "antecedent debt" in the context of the insurance statutes, giving courts a blank slate on which to write. Federal bankruptcy law has an enormous body of law on antecedent debt, but that law is neither controlling nor dispositive of this issue. Thus, to minimize preference risk, the transaction structure should avoid hidden (and outright) exchanges based on existing obligations. Structures based on contemporaneous exchanges minimize risk.

In states like New York, where the preference analysis is driven by intent to favor one creditor over others in the same class, a transfer of assets from an insurer to a CDO should not be a preference unless the CDO is a creditor. In the context of an insurer simply purchasing notes, there should be no preference because the insurer is not a creditor. In the context of a GIC, however, where the insurer is required by contract to make payments to the CDO and post additional collateral, the CDO is a creditor and there is preference risk. Minimizing the risk of a clawback requires the parties to ensure that the transfer is not and does not appear intended to put the creditor in a position superior to what it would have been in under receivership proceedings. This is difficult. Evidence of intent can include statements made in press releases, annual reports, internal business forecasts, and ever-pervasive email traffic. As a practical matter, little can be done to evaluate the risk because the parties will not know what intent the insurer has manifested internally.

Transferring assets into a distressed portfolio can also be accomplished through commutations of financial guaranty insurance policies. Commutations raise preference concerns but may also be at risk for fraudulent transfer analysis. A commutation involves payment to terminate the insurance coverage, which involves estimating the value of the claims that would have arisen under the policy had it not been terminated. A commutation can be vulnerable to fraudulent transfer claims because a receiver can determine, in hindsight, whether the commutation was to the insurer's benefit. If not, *i.e.*, if the commutation amount exceeded the value of claims that would have been made, the receiver has ammunition to argue that the transfer was not supported by fair consideration and thus was a fraudulent transfer. CDOs that commute insurance policies can reduce their risk by documenting the basis for commuting the policy with calculations that demonstrate an exchange of fair consideration.

CONCLUSION

There is no algorithm for minimizing risk when transfers are made from insurance companies to CDOs. Indeed, the countless variations in deal structure, coupled with the variations in state law and the goals of the parties involved, make it impossible to create an instruction manual for protecting assets from an insurance company receiver's clawback powers. The most important task is to identify the risk in advance, and then evaluate the proposed transaction from the standpoint of an insurance receiver with the statutory tools available to challenge transactions of this type.

There are structures that can be devised—once the risks are known. It takes patience, understanding of the rules and the client's objectives, and creativity. What is crucial, however, is that all involved understand the risk and manage it from day one, particularly in those jurisdictions—including New York—in which intent is paramount. A business purpose for the strategy must be articulated and adhered to throughout, in both internal and external communications, and an affirmative case for the deal must be documented at all stages. ■

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IN CORPORATE TRANSACTIONS, WILL THE INSURANCE FOLLOW THE LIABILITIES?
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- In internal corporate reorganizations, don't forget about insurance. If your client is placing assets in a subsidiary, be specific about insurance rights. If your client is purchasing a subsidiary that was formerly a division, make sure that your due diligence includes a review of transfer-of-insurance issues.
- If possible, keep the liabilities in the same place as the insurance.
- Net-of-insurance indemnities in asset transfers are more likely to pass insurer scrutiny than the assumption of liabilities and the assignment of insurance.
- As the representative of a seller, don't assume that the buyer's assumption of liabilities is sufficient to relieve your client of future liabilities in the event that the buyer is not able to respond. Accordingly, consider retaining insurance rights to the extent of liabilities.
- When insurance policies are renewed, consider negotiating exceptions to anti-assignment clauses so as to avoid the complications that may arise in corporate transactions as a result of these clauses.

All of these questions and structures require careful consideration and contract drafting in consultation with an insurance coverage lawyer. It is far better to consider these insurance issues at the time a deal is being structured than when claims later arise and an insurer denies coverage. ■

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SUCCESSFUL BAD FAITH CLAIMS AGAINST TROUBLED LIABILITY INSURERS
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Hangarter v. Paul Revere Life Ins. Co., 236 F. Supp. 2d 1069, 1089 (N.D. Cal. 2002), reversed in part by *Hangarter v. Provident Life and Acc. Ins. Co.*, 373 F.3d 998 (9th Cir. 2004).

CONCLUSION

Past crises in the insurance industry have resulted in unmistakable cases in which the interests of troubled insurers and their managements and stockholders have prevailed over the interests of policyholders. These are not the priorities recognized in legislative enactments, the case law, or textbooks. In this new period of crisis, we will see many U.S. and non-U.S. insurers embrace these same priorities. As in the past, it will fall to the courts to protect policyholder rights and to punish and deter bad faith practices. But policyholders and their counsel must properly lead the way. Bad faith claims need not be expensive failures. ■

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WHEN CAN YOU SETTLE A CASE WITHOUT YOUR INSURERS' CONSENT?
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in maintaining regular communication with insurers and responding timely to legitimate information requests.

Even after *Bear Stearns*, *Andersen*, and *Schwartz*, there remains no reported decision upholding as reasonable an insurer's refusal, under a D&O or similar fiduciary or management liability policy, to consent to settlement of a covered claim merely because the insurer believes the deal is too rich. The *Schwartz* opinion is the latest in a body of authority establishing that insurers that reserve their rights do not have the unilateral power to reject a reasonable settlement of underlying litigation. When insurers reserve rights, insureds are "allowed to take reasonable measures to defend themselves, including settlement." *Sun-Times Media Group, Inc. v. Royal & SunAlliance Ins. Co. of Canada*, C.A. No. 06C-11-108 RRC, 2007 WL 1811265 (Del. Super. June 20, 2007) (citation omitted).

Finally, *Schwartz* illustrates how risky it is for excess carriers to hide behind the intransigence of a primary carrier. In retrospect, the excess carriers in *Schwartz* may have been better served by helping the policyholder fund a $15 million settlement than by withholding their consent merely because the primary carrier refused to pay its limits. Courts will not interpret policies "to permit an excess insurer to hover in the background of critical settlement negotiations and thereafter resist all responsibility on the basis of lack of consent." *Fuller-Austin Insulation Co. v. Highlands Ins. Co.*, 135 Cal. App. 4th 958, 38 Cal. Rptr. 3d 716 (Ct. App. 2d Dist.), *cert. denied*, 549 U.S. 946 (2006). ■

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