Court of Appeals

STATE OF NEW YORK

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Appellate Division Index No.

SECURITY MUTUAL LIFE INSURANCE COMPANY OF NEW YORK,

Plaintiff-Appellee,

-against-

CHRISTOPHER E. DIPASQUALE,

Defendant-Appellant.

BRIEF OF AMICUS CURIAE, UNITED POLICYHOLDERS, IN SUPPORT OF THE MOTION FOR LEAVE TO APPEAL OF CHRISTOPHER DIPASQUALE, DEFENDANT-APPELLANT

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PRELIMINARY STATEMENT

This is an amicus brief in support of a motion for leave to appeal from decisions and orders of the Supreme Court and the Appellate Division, First Department, refusing to permit the policyholder defendant-appellant Christopher DiPasquale to assert a claim based on Section 349 of the General Business Law against a combination of insurance companies.

This Court should accept the appeal and then the orders appealed from should be reversed on the law and on the facts with directions to the Courts below to order the immediate payment of insurance benefits to Mr. DiPasquale and to pay all past due benefits. By granting leave to appeal this Court would have an opportunity to void the June 30, 1995 illegal agreement between two insurance companies, Security Mutual and Berkshire.

INTEREST OF AMICUS CURIAE

United Policyholders is a non-profit organization dedicated to educating policyholders about their rights and duties under their insurance policies. United Policyholders engages in charitable and educational activities by promoting greater public understanding of insurance issues and policyholder rights. United Policyholders' activities include organizing meetings, distributing written materials, and responding to requests for information from individuals, elected officials, and governmental entities. These activities are limited only to the extent that United Policyholders exists exclusively on donated labor and contributions of services and funds.

Amicus curiae has a vital interest in seeing that policyholders have access to information so they can make informed decisions. As a public interest organization, United Policyholders seeks to assist and to educate the public and the courts regarding policyholders' insurance rights and support efforts to have them enforced consistently throughout the country.

No party to this case has contributed directly or indirectly to the cost of this brief.

ISSUES

This case involves a secret insurance combination operating illegally and shamelessly on a statewide basis contrary to New York's statutory insurance law.

This case involves the judicial nullification by the Supreme Court and the Appellate Division of Section 349 of the General Business Laws.

This case involves a pro se insurance claimant, defendant-appellant here, trying doggedly - and thus far unsuccessfully - to find the correct legal rubric with which to pursue his claims while struggling with emotional and physical problems and faced with a well heeled, litigation savvy illicit insurance combine.[1]

The case overall involves the flouting by the illicit insurance combination of a specific ruling by New York's Superintendent of Insurance regarding this specific controversy, this policyholder and these insurance companies.

The case in the Courts below involved an attempted SLAP suit against Mr. DiPasquale and an attempted gag to suppress Mr. DiPasquale's First Amendment rights. These tactics were not allowed by the Supreme Court.

STATEMENT OF FACTS

There are sufficient undisputed facts to enable this Court to reverse the contested order.

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[1] For most of the time during the proceedings below Mr. DiPasquale proceeded pro se. Pro se litigants are obviously a serious pain in the neck for the judiciary. On one of the appeals of this case to the Appellate Division, Mr. DiPasquale had a mountain of facts about service of process; a relatively immaterial issue. This misplaced emphasis obscured the simple fact that Mr. DiPasquale had an eminently qualified upstate lawyer in Broome County who has successfully litigated a very similar matter for another Security Mutual policyholder. Mr. DiPasquale could not then find a lawyer in New York County. The courts of this state have yet to grasp the economic fact that insurance coverage litigation in New York is an economic wasteland for lawyers representing policyholders and claimants. Eugene R. Anderson, et al., Insurance Nullification By Litigation, RISK MGMT., Apr. 1994, at 46, copy of which is attached as item 1.

Mr. DiPasquale purchased two disability insurance policies from a New York insurance company, Security Mutual Life Insurance Company of New York ("Security Mutual"). Different insurance companies have different "claims paying" philosophies. Some insurance companies see claims payment as a positive and honorable part of the public service nature of insurance.[2] Other insurance companies see claims payment as a cash drain and a profit drain rewarding only an avaricious, cheating and dishonest horde of scalawags (aided and abetted by mendacious "plaintiffs' lawyers.")

Apparently, Security Mutual was an honorable public service oriented insurance company when it sold the insurance policies to Mr. DiPasquale and when he first filed his claim. Mr. DiPasquale had every reason to believe - when he purchased the policies and when he made his claim -that Security Mutual would remain true to its principles.

Years after the sales of the insurance policies Security Mutual changed! On June 30, 1995 Security Mutual entered into a secret[3] agreement with Berkshire Life Insurance Company (Berkshire) delegating to Berkshire the right and obligation to handle Security Mutual claims.

Berkshire was not licensed as an adjuster in New York. See the August 22, 1997 conclusion of the New York State Insurance Department (Record 526-528) and letter dated October 26, 1999 from the New York State Insurance Department to David Kalib, a lawyer working for Berkshire. Berkshire and Security Mutual are collaterally estopped from contesting

[2] See, Anthony J. Falkowski, The Risk Manager's Pivotal Role in D&O, RISK MGMT., Apr. 1993, at 57, a copy of which is attached as Item 2; Kirk L. Jensen & Sanford Victor, Update on D&O Coverage, J. OF CORP. BD., July/Aug. 1995, a copy of which is attached as Item 3; and Stephen Sills, Shopping the D&O Market: Directors and Officers Liability Insurance, RISK MGMT., July 1995, at 65, a copy of which is attached as Item 4.

[3] Note the provisions in the June 30, 1995 agreement designed to avoid disclosure of the fact that Security Mutual policyholders are being shunted to Berkshire and to hide the fact that policyholders' medical

this conclusion of the Superintendent of Insurance. The designation of Berkshire to handle Security Mutual claims was illegal. No Article 78 proceeding was filed by either company contesting the Superintendent's decision.

The illegal agreement has a further and more reprehensible feature. The June 30, 1995 agreement provides, in effect, that the less Berkshire pays to the mutual insurance company's policyholders the more Berkshire "earns." A bonus to claims handlers for not paying claims is illicit. In addition, the record shows that, contrary to law, Berkshire does not send out blank claim forms to New York policyholders.

The June 30, 1995 secret, illicit agreement explicitly provided that it was to be governed by Massachusetts law. New York law should govern New York claims handling by New York insurance companies for New York policyholders. The New York Insurance Department is proud of its regulatory role and protective of its turf in this regard. Security Mutual and Berkshire act as though they have managed to "white-out" the New York Insurance Department and New York law.

The illegal claims handling arrangement applies to every New York claimant. This is a very clear example of a statewide wrong.

POINT I.
THE JUNE 30, 1995 CONTRACT IS VOID

As the record in this case stands today, the June 30, 1995 contract is illegal. It is null and void.

The actions taken by Berkshire pursuant to the contract are a nullity. This case should be accepted for review and then returned with directions from this Court to the courts below to enter partial judgment for Mr. DiPasquale directing Security Mutual immediately to

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records are being illegally disclosed to Berkshire. It does not take citation of authority to establish that disclosure of medical records to an unlicensed adjuster is a wrongful.

make all past due payments and thereafter to continue making payments pending a determination by that court with respect to Mr. DiPasquale's entitlement.

Courts have generally found that contracts which violate licensing statutes are void. American Store Equipment & Construction Corp. v. Jack Dempsey's Punch Bowl, 174 Misc. 436, 21 N.Y.S.2d 117 (N.Y. Sup.), aff'd, 258 A.D. 794, 16 N.Y.S.2d 702 (1st Dep't. 1939); Carmine v. Murphy, 285 N.Y. 413,35 N.E.2d 19 (1941); Richards Conditioning Corp. v. Oleet, 21 N.Y. 2d 895, 289 N.Y.S.2d 411 (1968); Mortise v. 55 Liberty Owners Corp., 63 N.Y. 2d 743, 480 N.Y.S.2d 208 (1984); Vereinigte Osterreichische Eisen Und Stahlwerke v. Modular Building and Development Corp., 64 Misc. 2d 1050, 316 N.Y.S.2d 812 (N.Y.Sup. 1970), modified, 37 A.D.2d 525 (1971). Voiding contracts, which are in violation of becoming statutes, encourages the enforcement of licensing statutes.

This Court should not countenance the effort to make the judiciary a party to the enforcement of the illegal contract. This Court has condemned lying to the courts. See, Aufrichtig v. Lowell, 85 N.Y.2d 540, 626 N.Y.S.2d 743 (1995). Aufrichtig provides guidance to this Court in handling of the illegal contract in this case.

The void contract provides a basis for this Court to grant review of the decision below and warrants an order by this Court directing the lower courts immediately to require Security Mutual to pay Mr. DiPasquale's insurance policy benefits.

Because of the statewide impact of the illegal contract the Supreme Court and the Appellate Division should have permitted the Section 349 claim to go forward.

POINT II.
THE FAILURE TO DISCLOSE THE CHANGE OF CLAIMS HANDLING PHILOSOPHY WAS A FRAUDULENT NON-DISCLOSURE

As shown by the June 30, 1995 agreement, Security Mutual and Berkshire went to great lengths to avoid disclosure of the massive changes in Security Mutual ' s claims handling.

These included, among other things, having Berkshire employees lie about their identities to all New York Security Mutual policyholders with claims and the illegal disclosure of medical records by Security Mutual to Berkshire. Even fraudulent non-disclosure is actionable. See, Brass v. American Film Technologies, Inc., 987 F.2d 142,150 (2d Cir. 1993); Caracci v. State of New York, 203 A.D.2d 842, 844, 611 N.Y.S.2d 344, 346 (3d Dept. 1994); Strasser v. Prudential Securities, Inc., 218 A.D.2d 526, 527, 630 N.Y.S. 80,82 (lst Dept. 1995).

When Security Mutual and Berkshire decided not to honor the Security Mutual insurance policies sold to New Yorkers, their illicit secret agreement directly conflicted with Security Mutual's insurance policy obligations and the history of Security's Mutual's claims handling with Mr. DiPasquale and other New York policyholders. Mr. DiPasquale and the other New York Security Mutual policyholders were entitled to know that an essential part of their insurance protection had been eliminated. Since the Security Mutual policyholders were kept in the dark, it was not possible for them to make other insurance arrangements.[4] Mr. DiPasquale and the other Security Mutual policyholders in the State of New York were lulled into inactivity by these deceptions. Such misrepresentations (by omission) of existing fact inducing the purchaser's inaction is clearly actionable as fraud. See Deerfield Communications Corp. v. Chesebrough-Ponds, Inc., 68 N.Y.2d 954, 956, 510 N.Y.S.2d 88, 89 (1986); Sabo v. Delman, 3 N.Y.2d 155, 160,164 N.Y.S.2d 714, 717 (1957); Graubard Mollen Dannett & Horowitz v. Moskovitz, 86 N.Y.2d 112, 629 N .Y .S.2d 1009 (1995). Contrast the secrecy surrounding this policyholder "bad news" with Security Mutual' s touting "good news." See R 176. The fraudulent non-disclosure argues for review by this Court and supports a Section 349 claim with its statewide impact.

[4] It is not possible to replace insurance after a loss happens.

POINT III.
TORTIOUS BREACH OF CONTRACT -BAD FAITH

> Section 205 of the Restatement (second) of Contracts, states that, "every contract imposes upon each party a duty of good faith and fair dealing in its performance and its enforcement." Comment (e) then provides:
>
> "e. Good Faith and Enforcement. The obligation of good faith and fair dealing extends to the assertion, settlement and litigation of contract claims and defenses. See, e.g., sections 73, 89. The obligation is violated…by asserting an interpretation contrary to one' s own understanding...."

Clearly the present dispute involves the assertion by Security Mutual of an interpretation contrary to its pre-litigation understanding. This bad faith activity supports the Section 349 claim.

POINT IV.
SECURITY MUTUAL IS A FIDUCIARY

Security Mutual ' s role as a fiduciary is an important consideration for this Court in connection with a resolution of this case. See, Hartford Accident & Indemnity Co. v. Michigan Mutual Insurance Co., 93 A.D.2d 337, 462 N.Y.S.2d 175, 178 (N.Y. App. Div. 1983), aff'd, 61 N.Y.2d 569, 475 N.Y.S.2d 267 (1984), the principal authority in New York relating to the fiduciary obligations of insurance companies. Be careful to note that the insurance company in the Hartford case attempted to raise the fiduciary issue with this Court. This Court did not reach the issue.

"The insurance business is a fiduciary business. You get access to other people's money under conditions where in many cases the other people have very little knowledge or control of where the money's going. So you need a cop." See, Warren Buffet on Insurance: The Maestro in His Own Words, 7 Emerson, Reid's Ins. Observer, Nov. 1995, at 1,11, a copy of which is attached as Item 5. Among other investments, Mr. Buffet's company owns Geico, the second leading automobile insurance company in New York.

In Michigan Mutual in making a determination regarding Michigan Mutual Insurance Co.'s -- the primary insurance company -- fiduciary duty to Hartford Accident & Indemnity Co. -- the excess company - the court noted that the fiduciary duty owed by Michigan Mutual to Hartford was the same as Michigan Mutual's fiduciary duty owed to its own policyholder. The Court held:

> It is well established that, as between an insurer and its assured, a fiduciary relationship does exist, requiring utmost good faith by the carrier in its dealings with its insured. In defending a claim, an insurer is obligated to act with undivided loyalty; it may not place its own interest above those of its assured. Similarly, it has been recognized in this and other States, as well as in the Federal courts, that the primary carrier owes to the excess insurer the same fiduciary obligation which the primary insurer owes to its insured, namely a duty to proceed in good faith and in the exercise of honest discretion, the violation of which exposes the primary carrier to liability beyond its policy limits. (extensive citations omitted) Id. at 340-341.

In affirming, this Court held: Michigan Mutual as the primary liability insurance company owed to Hartford as the excess insurance company the same duty to act in good faith which Michigan owed to its own policyholders. Id. at 574. Security Mutual has not acted properly as a fiduciary or even as a quasi-fiduciary with respect to the claims of New York policyholders. Section 349 is an appropriate remedy.

POINT V.
WRONGFUL DEFENSE

Insurance defense lawyers contend that insurance coverage litigation is a no-holds barred fight. This attitude is reminiscent of Justice Byron White's holding in a criminal case many years ago. Justice Byron White wrote in United States v. Wade, 388 U.S. 218, 256-57 (1967).

> [D]efense counsel has no...obligation to ascertain or present the truth. Our system assigns him a different mission. He must. ..defend his client whether he is innocent or guilty... If he can

> confuse a witness, even a truthful one, or make him appear at a disadvantage, unsure or indecisive, that will be his normal course. Our interest in not convicting the innocent permits counsel to put the State to its proof, to put the State's case in the worst possible light, regardless of what he thinks or knows to be the truth....In this respect, as part of our modified adversary system and as part of the duty imposed on the most honorable defense counsel, we countenance or require conduct which in many instances has little, if any, relation to the search for truth.

This litigation credo is dramatically opposed to an insurance company's duty of good faith, utmost good faith and fiduciary duty .

Application of Section 349 to insurance will ameliorate wrongful defense tactics.

See also Jonathan K. Van Patten & Robert E. Williard, The Limits of Advocacy: A Proposal for the Tort of Malicious Defense in Civil Litigation, 35 Hastings L.J. 891 (1984), a copy of which is attached as item 6.

POINT VI.
CONTINUING DUTY OF GOOD FAITH AND FAIR DEALING

An insurance company's duty of good faith and fair dealing continues during litigation. White v. Western Title Ins. Co., 40 Cal. 3d 870, 885, 710 P. 2d 309, 316-317 (Cal. 1985).

POINT VII.
GENERAL BUSINESS LAW SECTION 349

General Business Law Section 349 declares unlawful "[d]eceptive acts or practices in the conduct of any business, trade or commerce or in the furnishing of any service in this state..." It is a remedial statute meant to be given broad application. Hart v. Moore, 155 Misc. 2d 203, 204-05, 587 N.Y.S.2d 478, 479 (Sup. Ct. Westchester Co. 1992).

The Supreme Court decision was based on the New York University case in this Court. New York University v. Continental Ins. Co., 87 N.Y.2d 308, 639 N.Y.S. 2d 283 (1995). Mr. DiPasquale is not New York University.

The insurance policies in this case were not "tailor made." These are form insurance policies.

Whether Mr. DiPasquale was at one time an "insurance agent", as the Supreme Court wrote in one opinion, or a "broker", as the Supreme Court wrote in a second opinion, does not deprive Mr. DiPasquale of the consumer protection afforded to others. It is strange that people who may know the most should get the least. Does ignorance pay? The insurance policies have no "odor".

The Security Mutual and Berkshire illegal conduct involved in this case and in respect of other Security Mutual New York policyholders happened after the insurance policies were purchased. Assuming, contrary to the facts in this case, that a policyholder was the most sophisticated entity in the world and that the purchase of a Security Mutual insurance policy reflected the sophistication. The subsequent unknowable and unpredictable change at Security Mutual long after the purchase would render that sophisticated purchaser just as unsophisticated as any other New York policyholder.

The decision below is contrary to Gaidon v. Guardian Life Ins. Co., 94 N.Y.2d 330, 704 N.Y.S.2d 177 (1999); Karlin v. IVF America, Inc., 93 N.Y.2d 282, 690 N.Y.S.2d 495 (1999), DiDonato v. INA Life Ins. Co., No. 99 Civ. 470, 1999 WL 436444 (S.D.N.Y. June 24, 1999) [R. 286-287]; Riordan v. Nationwide Mutual Fire Ins. Co., 977 F.2d 47 (2d Cir. 1992). The decision raises the issue that was mooted in Wender v. Gilberg Agency, 711 N.Y.S.2d 399 (N.Y. App. Div. 1st Dept.), vacated, No. 1315, 276 A.D. 2d 311, 716 N.Y.S. 2d 40 (N.Y. App. Div. Oct. 12,2000). See Batas v. Prudential, 281 A.D.2d 260 (1st Dept., March 20,2001); Acquista v. New York Life Insurance Co., 2001 WL 752640 (1st Dept., July 5,2001) N.Y.L.J.,

July 10, 2001, at 17; and The American Medical Association of the State of New York, et al. United Healthcare Corporation, 00 Civ. 2800 (LMM) (S.D.N.Y. July 30,2001).

New York state is a policyholder unfriendly jurisdiction. An insurance industry lawyer recently explained why New York remains the most anti-policyholder state in the United States. See Krinick, Evan H. *New York Law Journal*, Insurance Law, (Jan. 10, 2000) at 9, a copy of which is attached as item 7. This lawyer who battles policyholders in court noted:

> Over the past decade the New York Court of Appeals has issued a number of decisions .severely limiting the liability of insurance carriers in lawsuits alleging that they acted in "bad faith" in handling policyholders' claims (so-called "first party" bad faith lawsuits) or in responding to claims brought against their policyholders ("third party" bad faith actions).

Insurance companies know that the scales of justice in New York are rigged against policyholders.

POINT VIII. LEGISLATIVE HISTORY OF SECTION 349

Mr. DiPasquale has collected an impressive array of legislative history material, which is in the record, and deserves the very careful attention of this Court.

POINT IX. THE SUPREME COURT BELOW IMPROPERLY DENIED MR. DIPASQUALE'S MOTION TO AMEND HIS COMPLAINT

Mr. DiPasquale sought, and the Supreme Court below refused, permission to amend his complaint. Such leave should have been freely granted upon a prima facie showing of merit. CPLR § 3025(b); cf. Morgan v. Prospect Park Assocs. Holdings, L.P., 251 A.D.2d 306, 674 N.Y.S.2d 62 (2d Dept. 1998).

POINT X. REAL PARTY IN INTEREST

The June 30, 1995 contract vests control of litigation in the hands of Berkshire. The indemnity provisions in the contract may require Berkshire to be responsible for any

judgment in this case. This Court should grant review and conduct an independent inquiry as to which of the two insurance companies, if not both, is the real party in interest in this case.

POINT XI.
SLAPP SUIT

The Supreme Court dismissed Security Mutual's "SLAPP SUIT" against Mr. DiPasquale. The dismissal was clearly correct. See, NY CIV RTS §70-a. The insurance company did not appeal this decision.

POINT XII.
REVERSE BAD FAITH

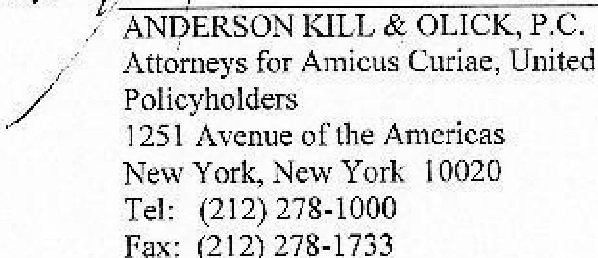
Security Mutual contended in the Supreme Court that Mr. DiPasquale had committed bad faith. The California courts flirted with "reverse bad faith" for a number of years. The California Supreme Court has now firmly rejected the concept. See, Kransco v. American Empire Surplus Lines Insurance Co., 97 Cal.Rptr.2d 151, 2P .3d 1 (2000). Empire Surplus Lines Insurance Co., 97 Cal.Rptr.2d 151, 2P.3d 1(2000).

CONCLUSION

The amicus curiae, United Policyholders, prays that this Court grant the requested leave to appeal decisions and orders below refusing to permit the defendant-appellant to assert a claim based on Section 349 of the General Business Law.

Dated: New York, New York
August 17, 2001

ANDERSON KILL & OLICK, P.C.



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Insurance nullification by litigation.
Eugene R. Anderson Stacy L. Gordon Paul Liben

The practicalities and economics of denying insurance coverage weigh very heavily in favor of insurance companies. And all too often the grounds given in court by insurance company lawyers for denying insurance coverage run to the ridiculous. In recent years, insurers have tried to deny coverage: for the World Trade Center (WTC) bombing, by claiming that WTC executives were to blame for the occurrence; for the Exxon Valdez disaster, by asserting that it was caused by Exxon's "intentional misconduct"; and for the alleged fraud in the marketing of the Prudential partnership interests, by maintaining that Prudential executives knew about this but failed to disclose it. And when an insurer denies a claim, most policyholders simply give up - insurance companies win by default.

Insurance claims handling and insurance coverage litigation involving large claims have four speeds: slow, very slow, stop and reverse. Delay works in favor of insurance companies. That's because claim inflation - the increase in the value of claims during the delay - is actually offset by the investment interest the insurance company earns by holding on to the insured's money. A policyholder is out of pocket money during an insurance coverage dispute and frequently faces cash flow problems, sometimes small, but more often severe. Moreover, many courts do not award pre-judgment interest.

Pre-settlement interest is virtually unheard of in a settlement. When an insurance controversy is settled, the policyholder's loss of use of money usually is a "give-up." Thus, if a policyholder pays a covered claim in year one and does not recoup the loss from the insurer until year four, the policyholder has lost - and the insurer has gained - the time value of money.

When a policyholder does challenge an insurance company in court or in a regulatory proceeding, the cards are stacked against the policyholder. A policyholder can expect a major casualty loss once every 30 years. Thus, policyholders, both large and small, generally have no experience with insurance coverage disputes. One of the very reasons policyholders buy insurance is that they are averse to litigation.

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Jungle Cats

On the other side, litigation is the bread and butter of insurance companies. Litigation is their business, and they are comfortable with it. Franklin W. Nutter, former president of the Alliance of American Insurers, has written that "the liability system is fuel for the insurance engine." Insurance companies file "tens of thousands" of briefs against policyholders. Regular insurance industry trade associations file frequent anti-policyholder briefs, and the insurance industry even has a trade association devoted solely to anti-policyholder litigation.

Tellingly, insurance companies have described themselves as "jungle cats," a phrase employed by an executive vice president of American International Group Inc., according to a May 24, 1993, article in the National Underwriter. Clearly, insurers regard policyholders as pussycats when it comes to litigation. Liberty Mutual Insurance Co. put it this way in a legal memorandum filed July 5, 1988, regarding its case National Union Insurance Co. vs. Liberty Mutual Insurance Co.: "Unlike the insured, an [insurance company] is not a novice as to matters involving litigation."

Litigation costs for policyholders are enormous and are increased because lawyers representing policyholders must "reinvent wheels" while insurance companies with vast experience in litigating against policyholders can simply reuse some of their "tens of thousands" of briefs. In a reply brief filed May 4, 1992, in National Casualty Co. vs. Great Southwest Fire Insurance Co., National Casualty summarized the reality of the stacked deck as follows: "It is preferable to litigate multi-insurer coverage disputes between insurers than it is between insurers and insureds, who often lack the resources to wage these disputes."

Should an insurance company capriciously deny a claim, it can do so without fear of regulatory reprisal. insurance regulators rarely take effective steps to protect the rights of individual policyholders. In Riordan, et al vs. Nationwide Mutual Fire Insurance Co. (1992), the response of the New York Superintendent of Insurance to the policyholder's complaint was to advise the policyholder to "retain an attorney and sue."

Even more rarely do insurance regulators act on behalf of commercial policyholders. In fact, state insurance regulation has been construed to be a license to engage in anti-consumer activity. The insurer in the Riordan case contended that it could mishandle 20 percent of the claims against it and still not violate the New York Unfair Claims Practices Act. The Oakland Hills, California, fire is an example of the ineffectiveness of regulatory action. Eleven months after the fire, Best's Review reported that 30 percent of the claims remained unsettled.

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Strained Relations

Litigation against an insurance company can exacerbate the policyholder's underlying liability problems. For example, Lloyd's of London and London Market Companies savaged their policyholder, Shell Oil Co., by asserting in a legal brief filed on March 5, 1991, in Shell Oil Co. vs. Accident & Casualty Insurance Co. of Winterthur, that Shell was "a company which, in the face of irrefutable evidence that it was poisoning the environment with some of the most dangerous chemicals known to man, refused to stop." These inflammatory anti-policyholder diatribes can only worsen a policyholder's liabilities.

Given the insurer point of view, policyholders claiming liability insurance coverage are, by definition, either "tort-feasors" (those who have committed a wrongful act) or "alleged tort-feasors." Governments, charities and businesses purchase insurance cognizant of the possibility that their operations can run afoul of ever-changing rules, regulations and public perceptions. Nonetheless, insurance companies attempt to deny coverage to their policyholders by proving their policyholders intentionally violated the rules.

During the course of intensive and extensive discovery, insurers seek to find information damaging to the policyholder. For instance, insurance companies know that complex insurance coverage litigation will develop "smoking guns" from the policyholder files. The insurers will then use them to build a litany of "bad acts" to be used against the policyholder to justify **insurance nullification.** An experienced corporate lawyer explains: "Nothing is quite as dismaying - or as inevitable - as finding a memorandum written by some employee that seems to prefigure the opposing party's theory of the case. ... Inevitably, some people will write things that are foolish or wrong." Thus, the policyholders are forced to fight on two fronts at one time. They must defend both the underlying tort action and the attack from their insurers.

The irony of the attack from the insurance industry is that, since the days of Lord Mansfield (the "father" of insurance law), insurance companies have been presumed to be familiar with the business operations of their policyholders - they regularly visit and inspect their policyholders' operations. Aetna has even advertised that its agents "know your business as they know their own. ... They ... understand your needs, analyze your risk, and give you a policy that's just perfect for you."

Settling for Less

Even if the policyholder persists in pursuing payment from an insurance company in court, the compromises inherent in the civil justice system work to the disadvantage of the policyholder. More than 97 percent of all civil cases are settled. In the insurance coverage context, this means that the policyholder settles and agrees to take

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less than the amount to which it is entitled. For the insurance company this means that just by litigating insurance coverage, it guarantees that less than full value will be paid out. It bears repeating that when an insurance coverage dispute is settled, the policyholder loses - and the insurance company gains - the time value of its money.

Inevitably some cases are wrongly decided against policyholders. The dispute of Maryland Casualty Co. vs. Armco Inc., (1987, 1988) (holding that environmental cleanup costs are not covered "damages") is one of the two most criticized insurance coverage cases on the law books. After costing policyholders and other beneficiaries of insurance untold millions, this case was reversed last year in Bausch & Lomb vs. Utica Mutual.

Even where policyholders win, such as in Keene Corp. vs. Insurance Company of North America (1981, 1982) (holding that a policyholder could tap all of its insurance coverage from the date the claimant is exposed to asbestos until the claimant manifests asbestos-related disease); and AIU Insurance Co., et al vs. The Superior Court of Santa Clara County (1990) (holding that cleanup costs are covered "damages'), the courts may inadvertently say something that insurers will seize upon to restrict insurance coverage in future cases. For example, in the Keene case, the court made the unnecessary remark that liability insurance policies could not be "stacked." Stacking - the application of two or more policies to the same loss or occurrence, allowing for significantly higher limits of liability to pay claims - was not an issue in the case and was not briefed by the parties. Clearly, the insurance industry drafters and marketers intended that the policies would be stacked. Although not often followed on this point, the decision in Keene is now the insurance industry's leading authority for the proposition that insurance policies should not be stacked.

Plausible Denial?

Insurance companies respond to criticism with a firm, "That's a bad rap." Maurice R. Greenberg, chairman of American International Group Inc., was quoted as saying in a December 1992 issue of Business Week, that "you're always going to find you haven't made someone happy." insurers contend that there are countervailing factors that may inhibit them from making capricious denials, but policyholders reply that none of these factors is persuasive.

There are several arguments insurers make to support their contention that they honor their commitments. For example, insurers note that they, too, incur legal fees and expenses when battling their policyholders. However, insurance companies buy legal services in bulk and at far cheaper rates than policyholders. insurers also assert that they lose goodwill and reputation by engaging in anti-policyholder litigation. Yet, this does not apply to large-scale losses where an insurance company denies coverage to the large policyholder who submits asbestos, environmental or similar claims. Who cares if an insurance

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company says "No" to the likes of a Johns-Manville? Insurance companies further claim they will go broke if they have to pay significant claims. On the other hand, the policyholder, especially the small to medium-sized policyholder, risks financial ruin if it is barred from utilizing the insurance coverage for which it paid premiums.

Another often heard argument from insurers is that insurance regulators can take action if necessary. However, insurance regulators rarely, if ever, take action to protect policyholders with large claims from unscrupulous insurance coverage practices. Effective enforcement by state regulators for individual policyholders runs from spotty to nonexistent. Insurers also maintain that if the insurance coverage litigation enhances the claims against the policyholder and the insurer loses the insurance coverage case, it may have to make greater indemnity payments. Yet, the insurance industry's steadfast practice of attempting to prove its policyholders are "willful" wrongdoers makes it clear that the industry is unable to recognize how self-defeating this practice is or that the industry considers the risk to be worth taking. Finally, insurers claim that they may get hit with a bad faith or punitive damage verdict. For at least some insurers, an occasional bad faith judgment may simply be a cost of doing business. In fact, insurance companies do not even regularly purchase errors and omissions insurance coverage to protect against the occasional bad faith verdict, believing instead that this risk is manageable.

The "security" aspects of insurance exacerbate the problems inherent in the insurance company/policyholder relationship. Policyholders expect to be taken care of. When their protector becomes their betrayer and persecutor, policyholders are appalled. Insurance companies add insult to injury by contending that the financial pain they are inflicting on a policyholder is either for the policyholder's own good or for the greater good of all policyholders. For example, a group of nationwide insurers told a Wisconsin appellate court in Fortier vs. Flambeau Plastics Co. et al (1989): "[D]istorting contractual language in the search for a short-run deep-pocket' would have long-run adverse effects not only on insurers but also on other policyholders, victims of environmental contamination, and the environment."

Making Adjustments

To a skeptical and often hostile public, insurance claims adjusters portray themselves as public service guardians who provide recompense for meritorious claims and protect the public from an onslaught of false claims. Insurance smooths the rough edges of a humane industrial democracy by providing a source of compensation for the injured and ameliorating catastrophes. Insurance through loss control services and financial incentives decreases the incidence of accidents and other undesirable happenings. The end begins to justify the means.

Not only are adjusters under attack from the public they serve, but they are undervalued within their industry. The insurance industry is

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sharply divided into two groups: underwriters and claims adjusters. Underwriters are at the top of the insurance industry totem pole; claims adjusters are at the bottom. To put it crassly, underwriters are "profit centers" while adjusters are "loss centers." These divisions are referred to within the industry as "tribes" or "church and state." There is very little cross fertilization and almost no personnel crossover.

Claims people believe that they are underpaid and undervalued and that their functions are unappreciated even within their own companies. As one long-time claims person, quoted in a February 1990 Best's Review article, said: "Claims people are treated like doormats at many insurance companies, yet they persevere." He went on to state: "One of the first things I learned as a claims trainee was that although most of the other tribes (particularly underwriting and marketing) were undisciplined and self-serving, their members tended to earn more, were considered more valuable, and were more likely to progress to general management positions. As if that weren't depressing enough, I was told I would always be viewed skeptically by top management because I had chosen to get involved in the "unsavory" part of the business, that is, the part that involves paying out the company's money to demanding and/or hostile people who have been damaged somehow as a result of an unpleasant event. in other words, the good tribes generated the money and my tribe spent it."

In connection with large losses, it is essential to keep in mind that the claims adjuster, with three decades of experience beating down, chiseling and cheating policyholders, and with a good sense of survival in a bureaucracy, will eventually rise to the top of the hierarchy and become home office vice president of claims. The individual and the individual's attitude toward policyholders do not change with the promotions, but the dollar size of the cases does change.

The status, stature and self-perception of claims people have enormous consequences for policyholders with large claims whether the policyholder is industrial, financial, charitable or governmental. From the policyholders' side, the insurance transaction is handled by financial personnel working with brokers and underwriters to structure insurance programs. The purchase of insurance is viewed by all three parties as a financial transaction. The three parties all went to the same schools, they belong to the same clubs, they share common bonds and a common orientation.

A serious loss destroys all this sameness. The underwriter literally and figuratively disappears. Underwriters have no part in the claims process. The insurance company financial type is replaced by a series of claims people with 30 years of what they believe to be experience in protecting the insurance company from cheats and chiselers, and an equal period of experience in protecting policyholders from themselves. The insurance company fraud-finders and crime-busters go to work on the policyholder. The results are devastating for the policyholder. Already

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stung by a loss of substantial size, the policyholder's financial officials are simply not up to an onslaught of heavy-handed innuendo and allegations of cheating, chiseling and fraud. Policyholder financial officials are left dumbstruck.

Claims adjusters search for fraud and expect to find it. The search is immensely profitable for insurance company lawyers who get paid by the hour to find needles in haystacks. Thus, the entire litigation system - its enormous costs and lengthy delays - works to the advantage of the insurance company. The system is structured so that the insurer, by denying a claim, gains the time value of money and the likelihood that the claim will be settled for less than its full value. Moreover, at the same time the policyholder is fighting an uphill battle against the insurance company's lawyers, it is forced to defend endless allegations of fraud by the claims adjuster. Whether in negotiation or in litigation, insurance companies win by saying "NO."

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The Risk Manager's Pivotal Role in D&O

BY ANTHONY J. FALKOWSKI

Due to its highly sensitive nature, handling a directors' and officers' liability (D&O) claim can be a much more complex process than managing a claim that occurs under other types of insurance. Therefore, the risk manager who brings expertise about D&O insurance into the claim process plays a pivotal role for his or her company – whether that role is played in a direct, highly visible manner or largely behind the scenes. An effective risk manager will serve three constituents in this process: senior management, the company's general counsel and the selected outside defense counsel. Those who understand in advance of a lawsuit what to expect in the D&O claim process can perform their tasks to the best possible outcome for all parties concerned.

"Undoubtedly, D&O claims draw more attention than other claims because they bring a response from the highest level of management – the parties at risk."

Undoubtedly, D&O claims can draw more attention than other claims because they bring a response from the highest level of management, the parties at risk. And as defendants in a lawsuit, senior management will definitely receive a copy of the insurance company's Reservation of Rights letter – generally a strongly worded document that tends to anger management and can put the risk manager in a very difficult position. Because of the nature of the typical allegations in a D&O claim, a Reservation of Rights letter will be issued and should be

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expected. But one can avoid — or at least minimize — a negative reaction by preparing management well in advance for what is going to happen during the claim process, and why.

A Reservation of Rights letter, written when a claim is first presented, points out potential exclusions from coverage and advises the client that in the event of a judgment or settlement based on allegations not covered in the policy, the insurer will not pay. There are valid reasons for sending such a letter. An insurance company is required to inform its insured of the possibility of coverage exclusions at the onset of a claim. At this point, the insurer may not have all the information needed to make a decision about coverage. If the company did not send such a forthright letter, a court may later decide that it had waived its right to deny coverage for some of the allegations being made, as the policy indicates.

Even though many companies have experienced at least one D&O claim, often the Reservation of Rights letter still comes as a shock to risk managers. According to Corbette Doyle, a senior vice president of advanced risk management services with Willis Corroon in Nashville, Tennessee, risk managers accustomed to other types of insurance think of these letters only as a signal that the carrier is denying coverage altogether. Yet the real reason for their prevalence is that in the majority of D&O cases, some portion of the claim will not be covered because either some of the allegations or some of the parties named in the claim are not covered in the policy.

Actually, the Reservation of Rights letter can benefit both the insurer and the risk manager. It gives the insurer more time to investigate the specifics of the case or to develop information through the discovery process. At the same time, it precludes the risk manager's being surprised far into the claim by noncoverage of certain allegations. It also enables him or her to evaluate any non-covered risk in the claim and advise management of the financial exposure.

Yet the fact that these letters are seen as confrontational reflects in part the D&O insurance industry's frequently ineffective handling of this

"A Reservation of Rights letter, written when a claim is first presented, points out potential exclusions from coverage."

essential communication, which sets the tone for the working relationship during the claim process. An insurer that is sensitive to its customers' needs will consider improving both the form and tone of the Reservation of Rights letter. At the same time, risk managers should look for certain characteristics that are indicative of the insurer's willingness to communicate in a forthright and non-confrontational manner.

In other words, while the risk manager's primary thrust should be to educate senior management about D&O coverage and the claim process, he or she can also help to improve the D&O claim scenario by signaling insurance carriers that good communication is expected if a claim occurs. For example, an insurer's explanatory phone call to a risk manager prior to sending the Reservation of Rights letter and an invitation to call with further questions are courtesies that go a long way in opening the lines of communication for handling the entire claim. This approach creates the opportunity for a risk manager to advise management again about what to expect and why, just prior to their receiving the Reservation of Rights letter.

Many risk managers have objected to the length and tone of these letters. Long citations of policy language and large portions of the complaint against the insured obscure the message. Also, presidents of companies and general counsel become angered by overly inclusive letters that raise all issues with the same intensity. The tone of the letter is the most important indicator of the way insurer and insured will work together for the remainder of the claim and of a sensitivity to the risk manager's position.

ADVISING GENERAL COUNSEL

Responsible for handling several important areas of the D&O claim process, a company's general counsel is usually not trained to understand insurance — especially not the complexities of D&O insurance. Charles Kolodkin, vice president of insurance services for the Harris Methodist Health System in Fort Worth, Texas, was actively involved in the successful resolution of a major D&O claim resulting from a hospital closing. "In health care, the legal team, which includes the risk management department, typically directs sophisticated cases, such as malpractice claims. Having negotiated coverage terms with the D&O carrier, the risk management department should participate as part of the legal team, bringing its insurance familiarity to bear during significant D&O claims and smaller

claims that may have D&O elements."

By providing this expertise, the risk manager helps the general counsel to act in an informed manner, to know what to expect without encountering surprises and to know the right questions to ask of various parties. Specific information is particularly important in two areas that can have a considerable impact on achieving a satisfactory resolution of the claim: selection of defense counsel and allocation of defense expenses.

Typically, the general counsel hires defense counsel for the company. Unlike with other types of insurance, the D&O insurer has no duty to defend. The insured selects its own defense counsel with the approval of the insurance company, who will want to ascertain that the defense counsel selected is competent in this particular area. Some insurers will resist approving a defense counsel who has also been the transactional counsel. For instance, if a law firm prepared documents for the company to file with the Securities and Exchange Commission and the validity of those documents later turned out to be the basis of the claim, the insurer would probably insist that the company choose a different firm for defending the claim.

If the general counsel does not have a clear idea of which law firm to choose, he or she can contact the insurer for recommendations. In essence, the insurer and insured have mutual interests in defeating the claim, despite the potential conflict of interest between them. The choice of defense counsel is critical, as some firms are more knowledgeable and more aggressive in trying to get a claim dismissed than others. Particularly in the current environment, in which the judiciary is more open to dismissals than in the past, it is important to look for these characteristics in choosing D&O attorneys. A development to note is that one insurance company is assembling a national panel of approved attorneys from which it would like its insureds to choose — a step that has sparked debate within the industry.

Another consideration during the defense counsel selection process is that the company may likely have an uninsured exposure, entailing allocation of expenses and the company's payment of some defense costs. In order for general and defense counsel to act effectively in the claim process, the risk manager must ensure that they understand allocation. Allocation occurs for two reasons. First, a D&O policy covers allegations such as misrepresentation or mismanagement, while it does not cover such allegations as fraud, dishonesty and insider trading. If the suit includes allegations that are not covered in the policy, there will be an allocation of defense expenses between covered and non-covered allegations.

"Most allocation case law recognizes an insurer's right to allocate between covered and non-covered parties."

Secondly, directors and officers are typically sued along with the corporation. Because D&O insurance covers the liability of the directors and officers, but not of the corporation, there will be an allocation of defense and settlement costs based on the percentage of liability attributable to each, the insured and the uninsured parties in the claim. If one law firm represents both the corporation (uninsured party) and its directors and officers (insured parties), then defense costs must be allocated between covered and non-covered parties. If the corporation retains a separate firm to represent the entity, then no allocation must occur. It is a more efficient and effective strategy to present a united front by having the same counsel defend both the corporation and named individuals. However, an insurance company will object if it discerns an effort to circumvent the original intention of the coverage by having the firm hired to defend the directors and officers do all the preparation and filing of the same papers for the corporation as well.

Certainly, allocation is the source of the most frequent and complicated disputes between the insured and the insurance company. Whether participating directly in negotiations or working behind the scenes, an effective risk manager will advise the general counsel about what to expect in these negotiations.

Most existing allocation case law recognizes an insurer's right to allocate between covered and non-covered parties and allegations. However, most policy language gives no guidance in resolving allocation issues. Frequently, an allocation is reached using a combination of several accepted methods. The "relative exposure" method recognizes the exposure and benefit relative to different defendants, while the "group pro-ration" method recognizes that various groups of defendants may have differing liabilities. A good approach to allocation should consider legal issues (including the standards of liability and defenses for different defendants), fac-

tual issues (such as degrees of fault or insider trading) and practical issues (such as relative benefit and exposure, coverage issues and resources).

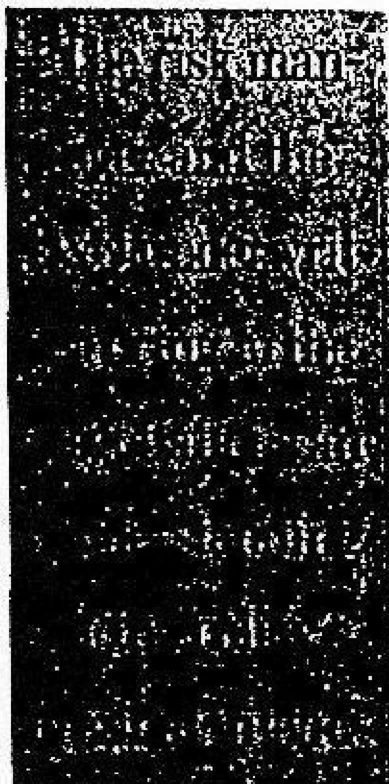
Coverage disputes are much less frequent than allocation disputes, because coverages are usually spelled out quite clearly in the policy. Occasionally, coverage disputes concerning capacity will occur: that is, was the director or officer acting in his or her official capacity when the allegation occurred? This question might arise, for example, in a leveraged buyout scenario in which the directors and officers seeking to buy the company are sued in their capacities as buyers. In another instance, a plant manager who is not an officer of the company may be sued in an employment case. Sometimes disputes over capacity can be avoided altogether by ensuring at the time of policy purchase or renewal that the definition of insured persons is amended to include such additional positions. Similarly, negotiating advancement of defense costs when purchasing a policy can prevent that issue from arising at the time of a claim.

PREPARING DEFENSE COUNSEL

Allocation is the source of the most complicated negotiations between insurer and insured. Negotiations typically involve the selected defense attorneys, but a risk manager should remain actively involved. Frequently, negotiations occur simultaneously with the plaintiffs and with the insurance company's monitoring counsel in a give-and-take process among the three parties. Again, the company's representatives can act most effectively if armed with a thorough knowledge of the allocation process.

The risk manager should inform the defense lawyers that the insurer will allocate defense expenses first, then apply the deductible. Usually, settling the allocation first with the insurer benefits both insurer and insured — it enables them to determine accurately the uninsured portion of any settlement and to concentrate on negotiating a satisfactory settlement with the plaintiff. Defense counsel should be prepared to present the insurance company with a settlement strategy and to get the insurer's consent to settle, a step that many policies require.

These and other negotiations in the claim process focus attention on the quality of the insurer/insured relationship and the quality of the communication between them, in effecting an outcome satisfactory to all parties. According to Claudia Mastrapasqua, a vice president in the Financial Group of Johnson & Higgins' New York branch and a former risk manager who has experienced the D&O claims process, the



risk manager and the D&O underwriter should work in concert with in-house and outside counsel. They bring to the process an understanding of the policy's original intent. "But more importantly, a risk manager has developed over time a valuable, non-adversarial business relationship with an insurance company underwriter that flavors the tone of the negotiation. That relationship can not only enhance the information flow in the negotiation process, but also facilitate the ultimate settlement," she says.

During negotiations, the risk manager is in a position to emphasize the importance of the long-term insurer/

insured relationship and thus should play a proactive role in ensuring that the parties are communicating well to preserve that relationship. Furthermore, "brokers can assist risk managers by enriching their expertise — particularly giving them a broader overview of how recent case law has been resolved and perhaps some practical advice based on their experience," notes Virginia Kolstad, vice president of risk management for First Bank System in Minneapolis.

Finally, the mention of the term "monitoring counsel" in regard to claims negotiations points up another important area in which the risk manager can well serve the needs of defense counsel. Because of the complexity of the D&O claim, the risk manager should be prepared from the start of the claim process to deal with a law firm hired by the insurer, rather than directly with a company representative. A relatively small group of law firms does monitoring work for all the insurance companies. Risk managers who do their homework will get a "read" on the reputation for cooperation and fairness of the firm representing the insurance company in order to prepare general counsel and defense counsel for what they can expect in dealing with the monitoring firm.

In fact, no one likes surprises, least of all, the risk manager, who is thrust into the spotlight if a D&O lawsuit arises. Some of what occurs in the claim process will indicate the quality of the risk manager's previous preparation of senior management about D&O coverage. Even if management shows little interest, it is in the risk manager's best interests to pursue this education process. It has been suggested that at every renewal, the risk manager should take the opportunity to communicate the parameters of this coverage, which is so different from traditional insurance.

Yet, if a D&O suit does occur, the chances for its successful resolution will also increase if the risk manager takes the opportunity to serve as an active advisor. No one else can bring to this process the knowledge of insurance that is essential to achieving the goals for which the company purchases D&O coverage in the first place. RM

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Kirk L. Jensen and Sanford Victor, Update on D&O Coverage, The Journal of Corporate Board (July/August 1995) at 15.

Update On D&O Coverage

By Kirk L. Jensen and Sanford Victor

Ten years ago, a directors and officers liability insurance crisis hit America's boardrooms. Premiums soared, when coverage was to be had at all. Today, new liabilities, coverage limits, and some surprises for ex-directors are making D&O concerns as urgent as ever.

In the early 1980s, an explosion of claims against corporate directors and officers caught the insurance industry off guard. Their premium base for directors and officers (D&O) coverage was inadequate to respond to such unanticipated losses. Reinsurers were even less prepared for what was turning into a catastrophic situation.

The marketplace deteriorated rapidly. A large number of insurers and reinsurers withdrew, and those remaining offered far less dollar protection under more restrictive terms. At the same time, rates increased dramatically.

The D&O crisis led to legislation making indemnification and defense easier. But the quality of coverage today varies widely, and many restrictive provisions still exist.

For insurance buyers, it was an extremely "hard" market. While the demand for coverage was increasing, its availability on acceptable terms diminished rapidly. The ensuing crisis led to legislation making it easier for corporations to indemnify their executives and provide them with added defenses against claims.

Corporations banded together to form their own insuring facilities. At the same time, with the prospect of much higher premiums as an incentive, the market began to rebound. It took time, but, to a large extent, the market cycle reversed itself.

Although the pricing of D&O liability coverage remained high, "quality" coverage again was to be found. Insurers weathering the storm began offering coverage on a more liberal "risk-taking" basis. New insurers entered the marketplace, at times competing vigorously.

Where do matters stand today on D&O liability coverage? What lessons were learned from the past? What are some of the important current issues?

Today, insurance continues to be a valuable source of personal protection. The driving force for maintaining coverage is the personal exposures directors face if their corporation is prohibited from indemnifying them, unwilling to do so, or becomes financially insolvent. Unfortunately, these situations are not uncommon.

While "quality" insurance is available, the level of quality varies from one policy to another. This variation can be substantial. During the "hard" market, severely restrictive provisions were introduced and some of these underwriting concerns still exist.

"Pollution" is one example. Insurers have paid—and are likely to continue to pay—substantial sums arising from this exposure. Many insurers contend that they are being forced to pay for environmental problems with insurance policies that never anticipated such exposures.

In an effort to avoid this liability, insurers have added a "pollution" exclusion to many policies—whether or not there is a particular rationale for it. D&O policies are no exception. The difference between D&O and other coverages is that the market's insistence on the exclusion is driven less by claims activity to date than by fear of future, unknown problems.

The risk of "mismanagement" and securities law violation claims against directors for pollution is a very real one. An article in *The Business Lawyer* notes that the "aggressive enforcement of environmental laws probably will increase in the 1990s and 'environmental due diligence' is a phrase that will

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grow increasingly familiar to attorneys representing both public issuers and investors."

In a D&O policy, an "absolute" pollution exclusion applies to security holder claims arising out of pollution problems. This exclusion essentially eliminates protection for pollution-related claims. Most policies now contain this exclusion. The good news is that there is often a way to fill this gap. But there is a cost attached to doing so, and not every company decides to remedy this coverage deficiency.

The insurance "gap" created by a pollution exclusion is usually obvious and widely understood. Less obvious will be other restrictive terms, such as a broad bodily injury/property damage or professional services exclusion. Both of these may exclude mismanagement and securities claims against your board.

The quality of D&O coverage available today varies widely, and the potential harm caused by restrictive terms is not immediately obvious. However, the insurance market for D&O coverage is highly competitive. Buyers who understand the important differences between the various insurance policies will be able to negotiate better coverage.

At times, this means locating insurers offering special products—more of which are available today than in the past. A good example of such a product is coverage that protects directors and officers when they are not indemnified, but provides no coverage for standard indemnification.

Another major D&O development is greater emphasis on non-traditional approaches to coverage. Historically, buyers covered their risks by obtaining a conventional insurance policy. On top of this, a premium was paid to transfer certain elements of risk to an insurer up to a certain dollar amount or limit.

Cost and other considerations have intensified the debate on whether there is a more effective way to manage this exposure. Among proposed alternatives are those perceived as more "business-like," with parties striving to establish longer-term relationships. One example would be "quasi-financing" arrangements with the potential for return of a portion of the premium based upon claims history. This is the D&O equivalent of an auto insurance "good driver" rebate. These arrangements can result in less shifting of risk, but coverage that is broader in scope and less costly in the absence of claims.

Companies should seek insurers willing to "stay the course" and to honor their coverage commitments. Coverage for directors after they leave the board is also proving vital.

As competitive markets vie for business, innovation is the order of the day. An ACE *D&O Report* notes that in "many respects, one's ability to improve an existing insurance program today is limited only by one's imagination."

As companies sort through the issues, they need to keep two points in mind. They should maintain coverage with insurers having both the will and the ability to "stay the course" and honor their commitments when the coverage is needed. D&O claims often give rise to complex issues. An insurer that is an ally and can provide help in the defense, and when appropriate, claims disposition is all important. Quality coverage with a quality insurer is paramount. The current focus on building long-term relationships to better manage risk may help with that effort.

While D&O insurance has long been viewed as an urgent need for public corporations in the United States, that view has not been shared abroad. Even though the coverage has been available to foreign corporations, many saw little value in purchasing it, particularly when there was a limited claims history. That attitude is changing fast, though, partly due to new exposures from the trading of American Depository Receipts on U.S. exchanges.

Along with assuring sound coverage for current directors, it is vital that coverage be maintained after these directors have left the board. Increased merger and acquisition activity has stirred interest, but these are not the only reasons that former directors still need insurance protection.

D&O policies generally provide coverage to directors and officers for claims made against them during the policy period. Corporations then receive indemnification for these claims. The terms "directors" and "officers" almost always include former direc-

tors and officers. A former director means not only those who leave the board after inception of the policy, but those who left even before the policy began.

Just because directors leave a corporation, their claims exposure is not ended. Former directors may have even more need for quality coverage than your current board members.

Former directors have an acute need for ongoing D&O insurance coverage. Just because directors leave a corporation, their exposure to potential claims is not ended. They still run the risk of claims asserted by shareholders, regulators, employees, customers, or others for alleged "wrongful acts" committed during their tenure. Different types of claims have different statutes of limitations, and no one can say definitely when a former director's or officer's risk becomes nil.

Potential exposures continue for years, and even a stale claim can generate defense costs in litigation over the statute of limitations. Claims against former directors are not simply an abstract and academic issue. For example, people with long-ended bank board affiliations have found themselves pursued years later by regulators.

Some D&O policies provide coverage to subsidiaries divested prior to the inception of the policy. Others cover only subsidiaries divested during the policy period. In either case, the directors and officers of the former subsidiary are covered only for "wrongful acts" committed while the former subsidiary was held. For those directors, the D&O policy of the former parent becomes, in effect, a run-off policy. This means that it only offers coverage for claims alleging acts prior to a particular date. For example, divestiture of a subsidiary through spin-off of the subsidiary to the public.

Former directors may have even more need for quality insurance protection than your current board members. The company's broad discretion in these matters is an acute problem for former directors. Their coverage depends on the ex-directors' relationship with current management.

Generally, directors first turn to the company for advancement of defense costs and ultimate indemnification. The corporation, however, may have the discretion not to advance expenses or indemnify. Under Delaware law, for example, a corporation is required to indemnify directors only in cases of a successful defense. Most cases, however, are not defended, but are settled. Moreover, the statute says nothing about mandatory advancement of expenses. This obviously presents real problems for a director receiving sizable bills from a law firm every month.

In Search Of Liability Reform

Do Reform Proposals Go Far Enough?

Does the Republican "Contract with America" or pending securities legislation provide serious relief from liability abuse? Not according to the Center for the Study of American Business (CSAB) in St. Louis, Missouri. CSAB Adjunct Fellow William H. Lash III finds that Congress has been unduly swayed by federal and state regulators fearing an "economic apocalypse where millions of fleeced investors withdraw from securities markets that fail to adequately protect them."

The CSAB study urges Congress to concentrate on the economic and legal realities of securities litigation, where attorneys finance frivolous "strike suits." Some of the plaintiffs in these cases have as little as two shares of stock in the corporation. The result has been unprecedented levels of fear in corporate America, and a siphoning off of precious financial resources.

Several elements are suggested in the CSAB study for serious corporate liability reform:

- ☐ Institute a "loser pays" court costs provision to deter groundless suits.
- ☐ Require a meaningful investment by plaintiffs in strike suits. A sound target would be one percent of the firm's outstanding securities or $10,000 worth of securities subject to the dispute.
- ☐ Require specific allegations of actual company fraud or recklessness.
- ☐ Abolish RICO liability for securities suits. The original intent of the statute was organized crime—not corporate boards.
- ☐ Limit the number of lawsuits that may be sought by professional plaintiffs to five cases in a three-year period.
- ☐ Require the SEC to adopt improved "safe harbor" rules for companies making forward-looking statements.

The need for D&O insurance for former directors is usually most acute after an acquisition, in which the corporation is either merged out of existence or becomes a subsidiary of another corporation. In such situations, directors of the "target" corporation may all at once find themselves *former* directors. Their old corporation is in the hands of new management that will make its own decisions regarding indemnification of the old team.

The target board is often the subject of litigation regarding its approval of the merger. For these reasons, merger agreements often require the acquiring company to indemnify former directors and officers of the target and to maintain D&O "tail" insurance. Especially important is coverage for claims alleging "wrongful acts" committed prior to the acquisition.

Coverage and indemnification for former directors is usually negotiated in advance, with three to six years of coverage the norm. Yet there is no guarantee that a director will not be sued more than six years after departure.

For those who stay on and find themselves directors of a subsidiary with a new parent, coverage for claims alleging ongoing, post-merger "wrongful acts" will be under the new parent D&O policy. Great care must be taken in structuring and coordinating the run-off and on-going coverages to avoid surprise gaps between the policies.

The acquiring company's obligations to indemnify former directors and to maintain D&O insurance for their benefit is generally negotiated in advance and set forth in the merger agreement. Such transactions are the product of the negotiation process, but three to six years seems to be the norm. However, there is no guarantee that a former director or officer will not be sued—even more than six years after leaving a corporation—for alleged "wrongful acts."

Irrespective of insurance and indemnification protection in a merger agreement, any director of a target corporation should be aware of common D&O policy provisions that may be triggered when the company is acquired. These apply whether a director departs when the transaction is consummated or stays on.

The takeover provisions automatically convert the policy to run-off. This also modifies the policy to exclude coverage for "wrongful act" claims after the takeover. Some policies may be more draconian and slash all coverage upon the takeover transaction.

The transaction triggering the conversion to run-off coverage can be an act other than a merger or acquisition of the insured corporation into a new parent. Other possibilities include: consolidation of the insured company with another firm to start a new entity; sale of all or most of the corporate assets; or acquisition of majority voting power by a new entity.

In short, underwriters, through widely different wordings, seek to exclude coverage for ongoing acts after a fundamental change in corporate structure or ownership. The change itself constitutes a fundamental alteration in the risk as originally reviewed and underwritten.

After run-off D&O coverage is triggered, directors may face further restrictions on what is covered. In a merger, if the acquiring company does not purchase new run-off coverage, coverage will expire when that policy expires. The policy's conversion to run-off status may also automatically cut the policy's discovery clause. This halts the insured corporation's option to buy run-off coverage. This coverage is usually offered for a period of one year following the cancellation or non-renewal of a policy.

For directors who stay on after a triggering transaction, the conversion to run-off coverage is even trickier. The run-off policy will not cover alleged "wrongful acts" after the date of the transaction. Your directors will therefore need protection from other sources for their ongoing acts. The acquiring entity will need to purchase coverage. However, with other triggers, such as a sale of substantially all corporate assets, there may be no such protection.

D&O insurance is a valuable source of protection for directors both during their tenure and after their departure. However, complex coverage and liability issues can be involved, and the scope of coverage often varies. This is a particularly opportune time for the informed buyer to negotiate quality terms. ■

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Shopping the D&O market.(directors' and officers' liability insurance)(includ related article on evaluation of D&O coverage)
Stephen **Sills**

Despite strong demand, excess capacity for directors' and officers' liability insurance and strong insurer competition (known as a "soft" market in insurance circles) continue to make the mid-1990s a perfectly pillowy time for most D&O purchasers. Unfortunately, the idea that you can't get a free lunch applies with equal force to the D&O industry as it does everywhere else. One consequence of the prevailing market is the emergence of key qualitative contrasts among D&O policies and the coverage they offer. D&O insurance is one area where the quality of a policy's coverage generally outweights the quantity.

MARKET-DRIVEN COVERAGE

Speaking from the insurer's viewpoint, it is evident that the D&O selection process has increasingly become a number-crunching affair. Not surprisingly, the first number crunched is usually the policy premium. Due to renewed aggressiveness among carriers in the United States and a strengthening of the Lloyd's of London syndicates, insured businesses in almost every industrial and commercial sector have seen their annual D&O premiums stabilize, or even decrease slightly, over the past few years. For the time being, it seems that risk managers, their fellow officers and board members can rest easy, secure in the knowledge that policies with adequate limits, reasonable deductibles and stable premiums will be available at the next renewal date.

Or will they? Fierce bidding for the company's D&O business may be a boon for the opportunistic risk manager, but it can set a trap for the unwary. Too often, comparing two, three or more D&O quotes results in an apples to apples analysis that focuses only on financially quantifiable differences such as policy limits, deductibles and premiums. Assuming that policies (or insurance companies) are interchangeable could be a costly mistake for a corporation.

There are significant disparities among various insurers' D&O policy forms. These subtle differences in policy definitions, exclusions and conditions can dramatically affect the scope of coverage. Also, a D&O carrier's claims-handling philosophy may be affected by a need to control costs. An insurer's responsiveness when a claim is made will

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not be apparent from the face of the policy, but it is a factor that needs to be assessed.

THE "DECLARATIONS PAGE" MINDSET

There are any number of reasons why management might tend to adopt the "declarations page mentality" that often seems to drive the D&O selection process. Certainly, large dollar amounts in the declaration's Limits of Liability box, accompanied by reasonably affordable deductibles, will convey to management a sense of personal and corporate security, particularly as seven-figure settlements seem to have become the rule in modern securities litigation. The other declarations page figure, the policy's premium, will also be an important selection criterion--if not the preeminent one.

Although D&O premium costs have moderated in recent years, the coverage remains a significant expense for most corporations. The Wyatt Company, a nationally known insurance research firm, conducts an annual D&O survey of approximately 1,200 U.S. for-profit corporations. The Wyatt Survey's 1994 results showed a median annual combined premium cost of $248,000 for primary and excess D&O coverage. Large corporations and those in riskier business segments often pay a significant multiple of that amount. At these magnitudes, prudent managers cannot afford to ignore premium competitiveness as they evaluate D&O coverage plans. Even if the need for dependable liability insurance were not by itself a sufficient reason to scrutinize the quality of D&O coverage, the substantial premiums make it imperative that management understands exactly what coverage those premium dollars are--and are not--buying.

Unquestionably, the biggest obstacle to performing a qualitative analysis of competing D&O programs is the highly technical nature of policy differences. Indeed, a valid assessment of any D&O policy's coverage will usually require the assistance of an experienced risk manager or broker who is well versed in the subtle language differences scattered among a dozen or more carefully drafted pages of definitions, exclusions and conditions. The best of such experts will be able to take these issues beyond the realm of theory and hypothesis to create valid, real-world scenarios that demonstrate policy differences. Though difficult, this work needs to be done. Expert analysis of the policy language will provide a clear picture of the policy's coverage and value.

Unlike other liability policies, such as workers' compensation or comprehensive general liability insurance, D&O addresses types of risk with relatively low frequency but high severity. The Wyatt Survey shows that, overall, only one in four of the insured corporations responding had made any D&O claim during the nine-year period ending in 1994 (although larger companies can expect a somewhat higher frequency). Conversely, claims tend to be severe, with payments averaging $4.62 million, a figure that rises to over $7.5 million for governmental and

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shareholder claims paid during the surveyed period. The generally infrequent but costly character of D&O claims has obvious and important implications for the issue of coverage quality. Because of the potential severity of exposures, every company needs to know going into the relationship exactly what its D&O carrier will provide in terms of coverage and claims handling.

COVERAGE DEFINITIONS AND EXCLUSIONS

No general discussion of D&O quality can possibly touch on all of the issues that arise when comparing policy language. Many coverage quality concerns will involve the policy's definitions section and the exclusions. For example, consider the term "claim" as it is often defined in D&O insurance policies. It might be supposed that, for so basic an insurance concept, there would be a fairly consistent approach to the kinds of facts and circumstances that constitute a D&O "claim." Not so. Many major D&O companies' policy forms define "claim" inconsistently: Some forms cover any written demand for money damages; others require the commencement of a judicial or administrative proceeding; still others specify that there be a "formal" proceeding. These language discrepancies will have varying significance under the facts and circumstances of a given exposure. Similar differences will be apparent throughout the competing policies' definitions of terms including "loss," covered "defense cost," "wrongful act" and "notice of claim or potential claim."

Typical coverage exclusions rule out claims that arise from fraudulent or illegal acts and from "insured versus insured" situations, as well as any losses involving bodily or emotional injury, property damage and environmental hazards. There are additional industry-specific coverage exclusions, such as regulatory exclusions for banks and nuclear loss exclusions for utilities. Here again, every D&O purchaser and risk management professional must critically examine the policy wording to assess the impact of an exclusion on the company's particular exposures. For example, a public utility company with ownership interests in a nuclear plant would need to carefully determine how the D&O policy's nuclear damage exclusion would affect a regulatory action brought against management as a result of a plant accident.

CLAIMS HANDLING

Another important factor to be considered in the D&O arena is claims handling. Unfortunately, this aspect of coverage quality cannot be discerned from the policy's language. Each insurance company's claims handling is a product of its financial ability to pay and its claims philosophy. Careful D&O applicants will usually investigate the underwriter's ability to pay because insurer financial information is relatively easy to obtain. But checking the insurer's ratings is only the first step in assuring satisfactory results should the company have to make a D&O claim.

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D&O insurers have different claims-handling philosophies that can markedly affect the quality of coverage. The Wyatt Survey indicates that roughly one in five D&O claims involves some payment dispute. Each dispute will involve its own facts and circumstances, and there are no guarantees that every claim with a given insurer will be handled in the same manner.

Claims-handling patterns ought to be investigated in the D&O selection process, since a carrier's institutional approach to handling and paying D&O claims can materially affect the insured company's financial recovery. This is doubly true where the carrier has an historical tendency to litigate claims disputes with insureds.

Although claims-paying philosophy is the ultimate intangible in the mix of D&O insurance variables, an experienced D&O broker should have an informed opinion of the relative strengths and weaknesses of competing carriers. A broker should also be able to provide some relevant comment on the insurer's claims-handling procedures. Even for claims where coverage and payment amounts are not disputed, the insured's satisfaction and comfort level will depend on the professionalism, experience and proactivity of the claims manager assigned to the case.

ALLOCATION -- THE TOUGH ISSUE

It's likely that every corporate officer involved in evaluating D&O coverage quality will eventually wrestle with the question of "allocation," one of the most controversial issues in the D&O arena. Allocation refers to the need to apportion coverage when both insured and uninsured parties are the subject of the claim. The issue most often comes up when a settlement discharges the liability of all defendants, including the insureds (directors and officers) and an uninsured party (the corporation). Over the years, D&O insurers have taken the position that only part of the settlement is properly allocatable to the reimbursement of executives, with the remainder attributable to the corporation's uninsured liability. Although the process is necessary to prevent the D&O carrier from becoming the unintended insurer of corporate obligations and liabilities, dividing responsibility for a loss frequently involves difficult factual and legal determinations.

Allocation disputes were cited as the cause of almost half of the claims-related disputes reported in the 1994 Wyatt Survey. Many insureds and carriers have litigated the issue over the past several years. Recent court decisions have found full unallocated coverage under several D&O policies, even when a settlement discharges both corporate and executive liability (for example, Nordstrom, Inc. v. Chubb & Son, decided in April 1995). At this writing, the majority of federal appeals courts have not definitively addressed this difficult issue. Although the state of the law is best described as unsettled, the D&O industry appears to have lost ground on allocation and some

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changes in this area are to be anticipated. To the extent that courts are unwilling to recognize the boundary between D&O insurance and full corporate entity coverage, the industry will have no choice but to adapt its policy language, exclusions and pricing to reflect the increased exposure.

FUTURE TRENDS

While it is always risky to prognosticate publicly in such matters, a continuation of the unfavorable trend in allocation cases will spawn significant responses from D&O underwriters. These responses will probably include explicit grants of direct corporate liability coverage in at least some areas (with a significant charge for the corporate coverage), new policy language to address the findings in cases like Nordstrom or combinations of such approaches.

Because D&O markets are cyclical, the current competitive environment may eventually give way to another scenario. There are signs of renewed life in one particularly hazardous arena, mergers and acquisitions, as well as new exposures that are emerging in areas such as employment law and trade practices regulation. These increases in D&O risk, together with reduced market capacity as a result of consolidations within the property/casualty industry, could lead to a firming of the market.

Beyond the merits of the allocation issue and its ultimate resolution, the lessons for D&O consumers ought to be clear. An insurance policy is diminished as a product if the claims-handling practices of the insurer are based on contention and delay, rather than on a commitment to resolve difficult issues (including allocation) reasonably and fairly. Risk managers and brokers responsible for evaluating D&O coverage quality need to check the carrier's claims-handling references. There is no better way to enhance the probabilities of a satisfactory outcome should a claim arise.

Although it may seem ironic, the soft market of the 1990s has actually made selecting D&O coverage harder. Where ten years ago risk managers could feel they'd done their job just to obtain any coverage at all (let alone at a reasonable price), today's insurance professional needs to do his or her homework. In order to assess qualitative variances in the coverages under consideration, the risk manager must become familiar with the nuances of policy language, the relative financial strengths and claims-paying philosophies of the carriers and the hot issues within the D&O industry. Ultimately, the goal is to present management with a policy that provides not only enough coverage, but enough of the right coverage.

RELATED ARTICLE: ASKING THE RIGHT QUESTIONS

An evaluation of coverage quality will start with a review of the existing policy. Pay special attention to any D&O exposures unique to your company or industry. Listed below are general questions to answer

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as you evaluate your D&O coverage needs.

Is there coverage for shareholder suits arising from excluded losses? The single most critical D&O exposure for a publicly held corporation remains shareholder-initiated lawsuits. Management needs to understand precisely what coverage a policy affords when a shareholder claim derives wholly or in part from policy-excluded activities.

What happens when insured officers are sued for fraud and the case settles without a determination of fraud? It depends. Virtually every D&O policy excludes coverage for fraudulent or dishonest acts. But differences in the language can cause divergent results when a fraud claim is settled before trial. Subtle wording in the exclusory language can create either a presumption of honesty (i.e., provide coverage unless there is an actual finding of fraud) or the opposite. The effect on the company's litigation strategy and, ultimately, its coverage can be dramatic.

What is "insured versus insured" and how does it affect coverage? The policy's insured-versus-insured exclusion must be carefully analyzed to ensure coverage for shareholder derivative actions. In these cases, the plaintiff theoretically asserts the rights of the corporation (an insured party) against officers or directors. Since judgments and settlements of derivative actions are normally non-indemnifiable, D&O insurance is management's principal line of defense in these claims. Additional areas of concern are wrongful termination or other employment-related suits by former officers, which may be excluded under the insured-versus-insured provisions.

When are defense costs paid? Legal bills, expert witness fees and court costs often comprise the major expenses associated with defending a D&O claim. Policies generally include such costs within the "loss" concept but diverge on the timing of payment. Since a claim can take several years to reach settlement or judgment, it will be important to know whether the company's policy will reimburse expenses as they are incurred. Some pay defense cost reimbursements only when the litigation is completed.

What happens to D&O coverage if the company is acquired, goes public or files for bankruptcy? Policy implications for coverage in the event of future corporate changes need to be considered. Management needs to know what potions will be available should fundamental corporate changes occur. To be sure, these are just a few of the general coverage questions to be addressed. Depending on the insured company's business, industry profile, regulatory environment and the demographics of its stockholders, creditors, customers and employees, additional D&O issues will certainly suggest themselves. The point to remember is that the answers to these questions may well determine whether a D&O policy--even one with a very large limit of liability--provides even $1 of coverage for those risks the insured corporation is most likely to encounter.

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