Bloomberg Law Reports® Insurance Law

Insurance Aftershocks of the Financial Crisis: New Coverage Issues in a Brave New World

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The financial crisis that has unfolded since mid-2008 has brought public attention to a range of financial risks that previously were treated as esoteric and safely ignored. In the aftermath of an economic earthquake, we now understand that the risks were as varied as the instruments, arrangements and obligations that make up the financial markets themselves. Corporate executives and financial professionals have been accused of investing corporate or client funds in unduly risky assets. Indeed, some investment vehicles—like the Madoff and Stanford assets—have been exposed as Ponzi schemes. Corporations, directors, officers, and agents are being investigated or sued for making false representations, misleading statements, or material omissions in public filings about the nature and risks of corporate transactions. Banks have suffered breathtaking losses from derivative instruments backed by subprime debt. No doubt, the aftershocks will continue to be felt in the months and years ahead.

Of course, there are insurance coverage policies for each of these exposures. Directors and Officers (D&O) policies cover liability claims alleging "wrongful acts" by "covered individuals" acting as directors and officers of corporations, and sometimes the resulting corporate liabilities. Professional liability or errors and omissions (E&O) policies may cover claims of professional negligence in managing invested assets. Crime and fidelity coverage covers corporate losses from insider fraud, forgery, computer crimes and embezzlement. The world of "credit default swaps" has resulted in a new awareness of the role played by special monoline coverages, which cover institutional debtor defaults. General and excess liability coverage may come into play, and homeowners policies may cover individual investors for certain financial losses.[1]

However, the sheer newness and variety of these exposures have created emergent areas of coverage disputes. Policyholders, of course, contend that their often substantial losses are insured. In contrast, insurers often contend that risks, which in retrospect were unwise, were misrepresented or concealed when the insurance was being written. In an

environment in which investors, market regulators and criminal prosecutors allege fraud and malfeasance, insurers may also argue that losses are outside the scope of coverage or excluded as wrongful acts. Key to understanding the present insurance climate are three issues likely to cut across the landscape in the months ahead: misrepresentation, timing limitations, and insured persons/loss. We examine each of these below.

I. Accusations of Misrepresentation

When policyholders claim coverage for a type of loss that is truly new or unanticipated, insurers may argue that the risk was never properly presented at the stage of contract formation. Under the doctrine of rescission, the policy may be voided because misleading information was provided or crucial information was withheld from the insurer. Claims of material misrepresentation were briefly a mainstay of long-tail asbestos and environmental coverage claims in the 1980s, when insurers contended that their policyholders knew but withheld crucial information about the risks from their industrial processes or products. More often, however, rescission has generally been a 'throw-away' defense that does not drive litigation. However, past experience in the D&O arena and early signs from the current crisis suggest that arguments over rescission may once again become real battlegrounds.

In arguing rescission, insurers generally contend that the policyholder failed to disclose material information at the underwriting stage. Recently, for example, in *J.P. Morgan Chase & Co. v. AIU Insurance Co.*, No. 601904/06, 2009 NY Slip Op 30652[U], 2009 BL 70104 (Sup. Ct. Mar. 2, 2009), the Bankers Professional Liability policyholder was exposed at the time of renewal for losses arising from the Enron meltdown. The policy renewal was specifically conditioned on the policyholder providing notice of any potential Enron exposure claims under the prior policy. *Id.*, at 4. The policyholder had issued public statements detailing its Enron exposures. *Id.* at 2. Nevertheless, when the policyholder afterward submitted coverage claims for lawsuits filed against it concerning those matters under the renewal policies, its insurer refused coverage, claiming that the policyholder had withheld material information during the policy renewal. *Id.* at 6.

The court, in contrast, held that there was no triable issue of rescission for three reasons. First, the employees compiling the information in response to the insurer's renewal process inquiries showed no intent to deceive the insurer and were not aware of the professional malfeasance alleged in the underlying actions. *J.P. Morgan Chase* at 13, 15 & n.8. Second, the Second Circuit had upheld the dismissal of substantially similar claims based on the same allegations. *Id.* at 13, 15 & n.8. Third, the insurer failed to make the policyholder's written representations a formal, warranted part of the application. *Id.* at 6, 8–10.

Significantly, the court also found the insurer was estopped from asserting misrepresentation by the policyholder because it had continued to collect premiums, even after becoming aware of the exposure in 2002, but waited until the Enron claims arose in 2006 to try to rescind the policies. *Id.* at 17.

Similar arguments have emerged in the context of monoline insurance, a specialized coverage used to guarantee payments of principal and interest under structured finance bonds, collateralized debt obligations, and asset-backed securities. The subprime mortgage meltdown led major monoline insurers to file lawsuits to recover or avoid payment under their policies. Monoline insurer MBIA sued Merrill Lynch for $5.7 billion in damages and rescission of credit default swap agreements. *MBIA Insurance Corp. v. Merrill Lynch, Pierce, Fenner & Smith Inc.*, No. 09601324 (N.Y. Sup. Ct.) (Complaint). In its $1 billion suit against J.P. Morgan Chase, monoline insurer Ambac claims the policyholder breached contractual and fiduciary duties to the insurer by making improper investments in subprime mortgage-backed securities. *Ambac Assurance UK Ltd. v. J. P. Morgan Investment Management., Inc.*, No. 650259 (N.Y. Sup. Ct.) (Complaint). Both actions turn on allegations that the policyholder misled the insurer about the scope of the insured risk. In *Merrill Lynch*, the insurer claims the policyholder failed to disclose the qualitative risk it assumed in acting as surety for poor credit default risks. In *J.P. Morgan Chase*, the insurer's claims turn, at least implicitly, on the contention that the policyholder failed to apprise the insurer adequately of the risks it would be assuming.

Based on historical patterns, insurers may be rowing against the current in pressing arguments for rescission. In other insurance contexts, courts ordinarily have placed the burden on insurers to make reasonable inquiry before insuring a risk. This is especially true for insurers who offer specialized coverage—such as D&O, E&O, or monoline insurance—because it implies a more specialized understanding and appreciation of emerging trends relating to the class of risk they have undertaken to insure. *UST Private Equity Investors Fund, Inc. v. Salomon Smith Barney*, 288 A.D.2d 87, 88 (N.Y. App. Div. 2001).

Certain Underwriters at Lloyd's v. Milberg LLP, recently decided by the United States District Court for the Southern District of New York, reinforces the premise that the insurer shares responsibility for investigating existing claims before accepting premiums for new coverage, and raises the bar for successful rescission defenses. No. 08 Civ. 7522 (LAP) (S.D.N.Y. Sept. 30, 2009). The *Milberg* court granted the policyholder's motion to dismiss because the insurer failed to file its rescission lawsuit within New York's six-year statute of limitations for fraud. *Id.* at 27. In so ruling, the court emphasized that the insurer should not have awaited

the outcome of the underlying criminal investigation, begun in 2002, but should have conducted its own fraud investigation, and was not entitled to leverage its own delay as a basis for tolling the limitations period.

New fact patterns like those emerging from the financial crisis create an incentive for insurers to consider arguments of rescission, because the unexpected is sometimes difficult to distinguish from the concealed. On the other hand, courts may view such arguments as instances of twenty-twenty hindsight, and instead apply what may be described as the "insurance corollary" to the business judgment rule. Just as there is a presumption that the judgments of corporate directors and officers, no matter how flawed in retrospect, were intended in good faith to generate corporate profits, so courts may apply a presumption that policyholders sought profit, not loss, in conducting their business. Though in hindsight these business decisions may have been costly misjudgments, in most cases courts probably will not find that prospective policyholders intentionally misled their insurers at the underwriting stage, but rather that they made bad business judgments.

II. Timing Limitations Under Claims-Made Policies

The global financial crisis has already generated disputes over policy timing provisions. Timely notice is particularly critical under *claims-made* policies (D&O, E&O, and some general liability) which are triggered when a third party makes a claim against the policyholder who calls on the policy in effect when the claim is made.[2] *Claims-made-and-reported* policies add the additional requirement that the claim be reported to the insurer within a specific time frame.[3] Coverage may be further restricted to only those claims relating to acts that occur after a specified date, known as the retroactive date.

The 2007 collapse of a California-based securities broker-dealer produced several rulings addressing late notice and retroactive dates. In *Illinois Union Insurance Co. v. Brookstreet Securities Corp.* (*Brookstreet*), the court rejected as untimely those claims that the policyholder received but failed to turn over to the insurer before the policy expired, and those claims that the policyholder's former clients made after the policy period.[4] No. SACV07-01095-CJC (RNBx), 4, 6–13, (C.D. Cal. Nov. 20, 2009). The court strictly enforced the policy's claims-made-and-reported language by rejecting coverage for claims reported during the policy period, but not within the requisite 30 days. *Id.* at 13–15. The court also dismissed the policyholder's argument that the insurer suffered no prejudice by the delay (one as short as two weeks), upholding the maxim that the notice-prejudice rule does not apply to claims-made-and-reported policies. *Id.* at 14 (citing *World Health & Education Foundation v. Carolina Casualty Insurance Co.*, 612 F. Supp. 2d 1089, 1096 (N.D. Cal.

2009); *Root v. American Equity Specialty Insurance Co.*, 130 Cal. App. 4th 926, 929, 937, 947 (Cal. Ct. App. 2005)); *see Zuckerman*, 495 A.2d at 406. In addition, the court refused to permit an equitable excusal. *Brookstreet*, 2009 BL 262394 at 14 (citing *Root*, 130 Cal. App. 4th at 929).

In a separate ruling, the *Brookstreet* court addressed another timing dispute, rejecting the assertion that a September 10, 2002 retroactive date prevented coverage for claims involving investment activity dating back to 1996. *Illinois Union Insurance Co. v. Brookstreet Securities Corp.*No. SACV 07-01095-CJC (RNBx) at 4–5 (C.D. Cal. Nov. 18, 2009). The insurer contended that such activity formed a single interrelated wrongful act that predated the policy's retroactive date, thereby precluding coverage.[5] *Id.* at 4. The court disagreed, finding "genuine issues of material fact [preventing summary judgment] as to whether the acts after September 10, 2002 were interrelated with those occurring before that date." *Id.* at 5. Rather, the court recognized that a reasonable jury could conclude that each "unauthorized trade" was a separate and distinct act, preserving the possibility of coverage for those acts that post-dated the retroactive date.[6] *Id.* at 5.

The *Brookstreet* rulings are instructive for policyholders and insurers alike. They underscore the significance of giving timely notice and reaffirm the critical need for policyholders to immediately review all insurance policies and determine any timing limitations. Though not addressed in *Brookstreet*, insurers must also act promptly to raise late notice as a defense, or risk waiver.[7] Especially for claims spanning several years of activity, arguments based on retroactive dates both for and against coverage must be considered.

III. Insured Persons and Loss

Insurance coverage disputes emanating from the financial meltdown also involve challenges to which individuals qualify as "Insureds" and disputes as to what constitutes a cognizable and covered "Loss." Notably, though an insurer may raise such defenses at the outset, courts have repeatedly supported policyholders' right to the advancement of defense costs. *Julio & Sons Co. v. Travelers Casualty & Surety Co. of America*, 591 F. Supp. 2d 651 (S.D.N.Y. 2008) (applying Texas law); *Federal Insurance Co. v. Kozlowski*, 792 N.Y.S.2d 397 (N.Y. App. Div. 2005).

Policyholders and insurers will undoubtedly contend with the issue of which individuals among a company's current and former directors, trustees and officers, general counsel, comptrollers, managers, employees, committee members, volunteers, and faculty qualify as Insureds.[8] Particularly with general liability policies which often do not define the term

"officer," a proper coverage analysis relies not only on the policy definition of "Insured" but also considers state law as well as articles of incorporation, bylaws, and shareholders and/or board meeting minutes.[9]

In addition, other policy definitions may be implicated. For example, a recent decision involving the alleged Stanford Financial Ponzi scheme demonstrates how the definition of "Professional Services" played a role in determining coverage for allegations against a broker for signing off on certain "safety and soundness" letters. *Endurance American Specialty Insurance Co. v. Brown, Miclette & Britt, Inc.*, No. H-09-2307, 2010 BL 81 at 4–6 (S.D. Tex. Jan. 4, 2010). The court found that such activity constituted risk management and loss control consulting sufficient to trigger coverage under the E&O policy at issue.

The determination of who is insured under a D&O policy may also depend on whether the alleged wrongful acts were committed by an individual acting in an official capacity.[10] Even if committed in an official capacity, an insurer may argue that the very accusation of a breach of fiduciary duty negates coverage altogether, for it constitutes an assertion that the individual necessarily acted beyond the scope of his or her official duties. *See, e.g.*, *Farr v. Farm Bureau Insurance Co. of Nebraska*, 61 F.3d 677, 680–81 (8th Cir. 1995).

In one recent case, a court denied defense costs coverage for a Securities and Exchange Commission investigation because the letter initiating the investigation only named the company, not an insured director or officer. *Hansen Natural Corp. v. St. Paul Mercury Insurance Co.*, No. CV 08-5067-VBF at 18–19 (C.D. Cal. Apr. 9, 2009). The court reasoned that the instigating SEC letter, directed to the associate general counsel, did not explicitly provide that "the term 'Hansen' included present and former directors." *Id.* at 19.

When it comes to defining what qualifies as covered losses, most D&O and E&O policies typically define "Loss" to include "damages, judgments, settlements and defense costs" incurred by the policyholder due to covered claims. Often the definition of loss specifically excepts fines, penalties, punitive or multiplied damages, and anything uninsurable as a matter of the law under which the policy is construed.

A frequently litigated aspect of the definition of Loss is whether the policyholder is "legally obligated to pay" damages. A line of cases has established that an insurer is not obligated to cover disgorgement, restitution, or other types of improper gain. *See, e.g.*, *Vigilant Insurance Co. v. Bear Stearns Cos. Inc.*, 814 N.Y.S.2d 566 (N.Y. Sup. Ct. N.Y. County 2006), *as amended*, 824 N.Y.S.2d 91 (N.Y. App. Div. 2006) (*Bear Stearns*). Nevertheless, a

policyholder may rebut the assertion that the relief sought does not constitute loss by demonstrating that at least some portion of the settlement or judgment encompasses covered damages. *National Union Fire Insurance Co. v. Ambassador Group, Inc.*, 556 N.Y.S.2d 549 (N.Y. App. Div. 1990). For example, in *Bear Stearns*, the policyholder successfully argued that only the "portion of the settlement attributable to disgorgement [which] actually represented ill-gotten gains or improperly acquired funds," was uncovered. *Bear Stearns*, 824 N.Y.S.2d at 94. The court also found that amounts attributable to independent research or investor education fell unquestionably within the policy's definition of loss.

Conclusion

The financial crisis will surely spawn a host of insurance coverage issues, including many that defy neat categorization. The shifts are tectonic. The authors expect to see an emphasis on alleged misrepresentations at the underwriting stage as well as disputes over timing limitations and whether certain individuals and types of loss are, in fact, covered by a given insurance policy. Though other policy-specific issues are certain to emerge as well, these issues are already apparent.

It is clear that the financial crisis, which has shaken markets and altered so much terrain for investors, has also altered the landscape for insurance. For insurers, rescission defenses, arguments that claims were not made in a timely manner, and arguments that certain individuals and losses are not covered by the policy, are now more readily available. As a result, policyholders are well-advised to reexamine existing coverage to avoid loopholes, and to consider carefully all the coverages that may be applicable for every loss. It is key for both sides to take note of these shifts—which are likely have a substantial impact on insurance litigation—so that both sides may take stock of how their footing will be affected in such litigation.

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[1] *See, e.g.*, *Horowitz v. AIG International Group, Inc.*, Case No. 09-CV-7312 (S.D.N.Y. Aug. 19, 2009).

[2] Claims-made policies differ from occurrence policies (most general liability) which are triggered by the date of the alleged injury or damage. *See Weyerhaeuser Co. v. Commercial Union Insurance Co.*, 15 P.3d 115, 129 n. 12 (Wash. 2000); *Zuckerman v. Nat'l Union Fire Insurance Co.*, 495 A.2d 395, 398–400 (N.J. 1985).

[3] *See Nat'l Union Fire Insurance Co. v. Baker & McKenzie*, 997 F.2d 305, 306 (7th Cir. 1993).

[4] Timing issues often involve consideration of several policy definitions. The *Brookstreet*

court relied on the definition of "Claim" to find that a claimant's e-mail during the policy period did not meet the policy's definition of claim because it did not include a demand for money damages. *Brookstreet*, at 8–9.

[5] Arguments on retroactive dates often turn on the concept of "interrelatedness," defined by some (including Brookstreet's) policies as "all Wrongful Acts that have as a common nexus any fact, circumstance, situation, event, transaction, cause or series of related facts, circumstances, situations, events, transactions or causes." *Illinois Union Insurance Co. v. Brookstreet Securities Corp.* No. 8:07-CV-01095-CJC-RNB, at 2.

[6] *See Ball v. NCRIC, Inc.*, 120 Fed. App'x. 965, 970–73 (4th Cir. 2005); *Coregis Insurance Co. v. Blancato*, 75 F. Supp. 2d 319, 321–22 (S.D.N.Y. 1999).

[7] *See Estee Lauder Inc. v. OneBeacon Insurance Group, LLC*, 873 N.Y.S.2d 592 (N.Y. App. Div. 2009).

[8] *See, e.g.*, *Guillory v. Aetna Insurance Co.*, 415 F.2d 650 (5th Cir. 1969) (holding that employee was insured executive officer under general liability policy even though he had not formally been appointed because he held managerial responsibilities).

[9] For example, the designation of "officer" in an employment agreement was insufficient evidence of the individual's status as an insured where the company's board of directors had not formally appointed the individual. *Kealy v. Carolina Casualty Insurance Co.* No. CV-05-0911-PHX-FJM, 2007 BL 245087 at 4 (D. Ariz. Jan. 16, 2007).

[10] *See, e.g.*, *Homebank of Arkansas v. Kansas Bankers Surety Co.* No. 4:06cv001670 SWW, 2008 BL 143739 at 8–9 (E.D. Ark. July 7, 2008); *Wolfes v. Burlington Insurance Co.* Nos. C-07-00696 RMW/C-07-04657 RMW, at 6–9 (N.D. Cal. May 7, 2008).