KAMIL VOJNAR

SUBPRIME FALLOUT

PART ONE

Insurance Coverage Battles

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While the nation's widely known mortgage lenders and issuers of mortgage-backed securities (MBS) are already facing government investigations and numerous lawsuits, the nature of these actions—and the defendants facing them—are expanding every day. Actions have already been filed against subprime lenders, brokers, appraisers, loan issuers, homebuilders, investment funds, bond raters and public companies who invested in MBS. Allegations run the gamut from breach of fiduciary duty, negligent misrepresentation, common law fraud and breach of contract claims to claims of discrimination, civil conspiracy and violations of the Securities Acts of 1933 and 1934, and the Employee Retirement Income Security Act (ERISA).

As varying claims emerge and the number of defendants increases, companies and individuals facing potential liability will look to their insurers for protection. Given the enormous exposure for the insurance industry and the complex factual setting relating to the securitization of subprime loans, there inevitably will be a large number of disputes about the availability of insurance. Because of the size of the claims, many will end up in litigation or arbitration. Some of the most impacted coverages will be directors and officers insurance, errors and omissions insurance, fiduciary liability insurance and commercial general liability insurance. The following are the questions every company should ask.

When Does a Claim Arise?

Most D&O, E&O and fiduciary liability policies are claims made policies requiring a claim during the policy period to trigger the policy obligations. There is a wide variety of definitions of "claim," but most require a written demand or document be presented to the insured. The securities class actions, derivative actions and ERISA actions arising out of the subprime crisis will constitute claims. The most common disputes will be whether inquiries from governmental entities or customers constitute claims.

The first place to look to determine whether an investigation or customer complaint constitutes a claim is the specific definition of claim in the policy. If that does not provide clarity, one should look at the case law. Importantly, the facts of any action must be carefully analyzed. For example, in *National Stock Exchange v. Federal Insurance Company*, the court held that an SEC "Order Directing Private Investigation and Designating Officer to Take Testimony"

issued to the company was a claim against individuals because the definition of "company" was broad and included directors and officers.

Is a Wrongful Act Alleged?

D&O, E&O and fiduciary liability policies also require that a "wrongful act" be alleged. One definition of "wrongful act" in D&O and E&O policies is "an actual or alleged breach of duty, neglect, error, misstatement, misleading statement, omission or act." A typical definition of "wrongful act" in fiduciary liability policies is a "breach of responsibilities, obligations or duties imposed upon the fiduciaries of any plan by ERISA or the common law or statutory law of any jurisdiction governing such plan."

Insurers have reserved rights with respect to whether certain subprime cases allege wrongful acts. The insurers have raised issues such as whether the policies cover intentional acts, whether the alleged acts were done in the individual's insured capacity and whether the conditional language of investigative orders (e.g., "may have" committed) constitutes a wrongful act. Each of these defenses should be relatively easy to overcome. These policies unequivocally cover intentional acts. Although whether an act is performed in an individual's insured capacity is an issue that will depend upon the facts of the particular claim, the vast majority of subprime cases allege claims arising out of conduct taking place in an insured capacity. Finally, the conditional language of an investigative order should be sufficient to constitute a wrongful act.

Do the Actions Seek Loss?

Many of the relevant policies require there to be "loss," which is generally defined as the "total amount which any insured becomes legally obligated to pay on account of each claim...made against them for wrongful acts...including, but not limited to, damages, judgments, settlements and defense costs." One of the battlegrounds will be whether subprime lawsuits and investigations seek loss.

Insurance companies have asserted that a number of the claims seek restitutionary damages or disgorgement, and that such remedies do not constitute loss within the meaning of the insurance policies. This view has found support in a number of court decisions that could be important because SEC actions typically couch the relief sought as restitution or disgorgement of profits—not as "damages."

On the other hand, other courts have been reluctant to construe loss narrowly. Most recently, in *Virginia Mason Medical Center v. Executive Risk Indemnity, Inc.*, a federal court in Washington state rejected an insurer's attempt to characterize a settlement as uncovered, stating that "restitution remedy is awarded at the conclusion of litigation once culpability is allocated, while a settlement is a negotiated bargain between two parties who have foregone the right to a finding of culpability." In doing so, the court also pointed out a distinction that could be vital to the subprime cases: "A restitution remedy is distinct from a damages remedy because '[r]estitution measures the remedy by the defendant's gain and seeks to force disgorgement of that gain while '[t]he stated goal of the damages remedy is compensation of the plaintiff for legally recognized losses.'"

Thus, with respect to the loss issue, two critical issues may be whether the case is settled or tried; and the methodology used by the plaintiffs to demonstrate damages allegedly due.

When Does the Duty to Reimburse Defense Costs Arise?

Many D&O and E&O policies are not typical "duty to defend" policies and, instead, require the reimbursement of defense costs. Although insurers sometimes take the position that the duty to reimburse defense costs can wait until the final determination of the underlying claim, the vast majority of courts that have considered the issue have held that the duty to reimburse is judged by the duty to defend standard. Specifically, the duty to pay defense costs arises if there is any potential that the claim may be covered.

Some policies also have a duty to advance defense costs subject to the insurer's right to seek reimbursement of the advanced fees if future events warrant it. Courts have held the insurers have the obligation to advance, even if the insurer has coverage defenses.

Must the Insured Comply with Litigation and Billing Guidelines?

This is an area of constant irritation for many policyholders. Litigation and billing guidelines are not referred to in the insurance policies, but insurers usually insist upon compliance with the guidelines. The guidelines often address a wide range of topics, from reporting requirements, to the need for preapproval for research or specific case activity. The policyholders often find themselves caught between disgruntled defense counsel whose bills are not being fully or promptly paid and the insurers who are funding a large portion of the defense.

Policyholders should be aware that many ethics opinions have been issued by state bar associations holding that certain guidelines improperly interfere with an attorney's duty to represent his or her client. In most situations, the issues that arise can be resolved through negotiation with the insurer.

Do Personal Conduct Exclusions Apply?

D&O policies have exclusions for dishonesty, fraud and illegal profit. These exclusions may come into play because the subprime cases usually allege fraud and dishonesty, as well as illegal profit. There are several important points to remember about these exclusions. First, most policies require a judicial finding that the conduct in fact occurred or a

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"final adjudication" that the conduct occurred. Because the vast majority of cases settle without such judicial finding or adjudication, these exclusions should not be a major obstacle to coverage. Second, the assertion of these exclusions as a defense without an adjudication of the conduct, will not excuse an insurer from its defense obligations. Finally, the burden is on the insurers to prove the exclusions apply.

Do the Claims Allege Professional Services?

There have been an increasing number of lawsuits in the subprime crisis that allege professional negligence. This means an increasing number of claims will be made under E&O policies. The critical question will be whether the insured was engaged in professional services. Insurers have reserved rights with respect to several E&O claims relating to the subprime crisis on this basis. A court reviewing this issue will focus on the policy definition of "professional services" (if one exists) and the nature of the risk insured. Courts usually focus on the nature of the business of the insured to determine whether something is a professional service.

Has There Been Proper Notice?

Many of the potentially applicable policies are claims made policies that require not only a claim during the policy period, but the reporting of the claim during the policy period. The vast majority of courts will strictly enforce the requirement that notice be given within the policy period.

In addition, many policies allow a policyholder to report circumstances that might give rise to a claim and, if a claim arises later, the claim will be deemed to have been made during the policy period. Mere suspicion of a claim will not suffice. In fact, at least one recent court has required a good deal of specification in reporting notice of potential claim circumstances. Notice of potential claim circumstances may be particularly important if the policyholder is facing policy expiration.

Will Insurers Assert a Rescission Defense?

Rescission is a defense that relates to misrepresentations in the application for coverage. Although the requirements for rescission vary from state to state, most states require a material misrepresentation or omission, reliance by the insurer, and a return of the premium. Courts have refused to allow a rescission defense if the misrepresentations were not part of the application or if there was a severability clause in the policy.

In *In Re HealthSouth Corp. Ins. Litigation*, several insurers sought to rescind coverage under D&O policies and fiduciary liability policies for the former officers and directors of HealthSouth. The insurer relied, in part, on guilty pleas entered by former HealthSouth officers who admitted that they participated in a scheme to alter the company's financial reports.

The court held that severability clauses in the policies precluded rescission as to all insureds regardless of their involvement in the alleged fraud. The court rejected Federal Insurance Company's attempt to rely on representations contained in HealthSouth's financial statements, finding that if the insurers could rescind coverage because of misstatements in HealthSouth's SEC filings, without showing that the individual insured knew of the misstatement, then coverage "would be totally illusory."

Do CGL Policies Provide Any Coverage for These Claims?

In order to fall with the coverage of CGL policies, there must be "bodily injury," "property damage," "advertising injury" or "personal injury." Subprime claims may allege mental anguish and discrimination. Both claims could fall within the coverage of a CGL policy. Mental anguish should fall within the definition of "bodily injury" or "personal injury." Further, claims of discrimination in lending should be covered.

What is the Role of the Insurer in Subprime Claim Settlement?

Nearly every insurance policy requires the policyholder to cooperate with the insurer in the defense and settlement of claims. Policyholders should keep the insurers informed of developments in the defense of claims. Some courts have held that the policyholder's duty to cooperate only applies if the insurer is defending without a reservation of rights. Moreover, in the event of a breach of the cooperation clause, the majority of courts require an insurer to be prejudiced before the insurer will be excused from providing coverage.

Nevertheless, policyholders should work with insurers involved in the defense of a matter to ensure reasonable requests for information are answered and the insurer's consent to any proposed settlement is sought before the settlement is entered into. Failure to seek an insurer's consent to settlement prior to agreeing on a settlement, even an "agreement in principle," may lead to a forfeiture of coverage.

Will the Venue for Litigation Affect the Outcome?

Venue could be the most important factor. All insurance law is state specific. In view of the absence of choice-of-law provisions in many policies, the choice of a venue for an action will impact the law applied to interpret the insurance policies. Policyholders should give careful consideration of the potentially applicable law on the key issues prior to filing suit.

The choice of venue may also impact how quickly a case is decided. In some jurisdictions, cases are handled by more than one judge, resulting in steep learning curves for each judge reviewing pretrial motions and in a trial judge not well-versed about the case history. ■

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