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THE ROLE OF CORPORATE COUNSEL IN STRATEGIC RISK MANAGEMENT

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Imagine if the shareholders of your company received the following letter.

> *"Dear Stockholder:*
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> *"As you know, we have expended hundreds of millions of dollars of your money correcting the Y2K problem. Our property insurer is very concerned that the policy they provide to us might be interpreted as covering those and other expenses and, therefore, wishes to expressly exclude them. [We] seek your guidance on the three alternatives available to us:*
>
> *"A) Willingly accept the imposition of exclusions at this time as we would not want you to benefit in any way from a court decision which might be unfavorable to insurers.*
>
> *"B) Tacitly accept the imposition of the exclusions at this time and wait and see how current litigation turns out. (Please keep in mind that if current litigation results in a determination adverse to insurers, the tacit acceptance of the exclusion at this time may be interpreted as indicating our concurrence with the insurer's position and this may preclude the assertion of a claim in the future.)*
>
> *"C) Take the insurer's recent assertion of the need to add exclusions to the policy as an alert to the potential application of insurance and place the insurer on notice of a claim, so that we may attempt to protect and preserve whatever rights and remedies may be available to you.*
>
> *"(If you choose A or B, you may also be interested in receiving information on another type of insurance, directors and officers liability.)"*[1]

The above letter actually appeared as an editorial in a major insurance magazine last fall and illustrates why corporate counsel should play an active role in a company's strategic risk management.

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[1] W. Kelly, *Y2K In Court? It's Up to the Stockholders*, National Underwriter (October 25, 1999).

For the most of this century, risk management has been thought of as a cost of doing business. In other words, companies thought of risk as the art of managing liabilities and taking steps, usually through insurance, to transfer risk.. Moreover, outside opinion on risk transfer was often limited to advice received from insurance broker or agent who would owe duties of loyalty to both the broker and to the insurance company. Even worse, corporate counsel did not participate in the design of the risk transfer solution and many times were playing "catch up" with more experienced insurer counsel.

This pattern has played out once again in the context of Year 2000 insurance claims. While many corporate counsel have participated in Year 2000 planning for the last two to three years, few corporate counsel were knowledgeable about the insurance aspects of the Year 2000 problem. Consequently, most corporate policyholders were forced to accept policy exclusions for Year 2000 matters without the knowledge of the company's lawyers. These exclusions were also imposed before many companies realized that their broadly written property policies potentially covered Year 2000 remediation expenses. Now many policyholders are struggling to decide whether to put their carriers on notice for Year 2000 losses, in part because corporate counsel has been "out of the loop" and because the insurance industry has steadfastly reported to brokers and to corporate financial people that no coverage exists.[2]

Smart companies are now moving away from the traditional "cost of risk" approach to thinking about risk management strategically. Instead of worrying about how much premium a company may pay in a given year, companies are using a multi-disciplined approach aimed at producing products and services that have a market value far exceeding the competition. This multi-disciplined approach is designed to acquire knowledge, apply knowledge, and refresh knowledge so that a company can take risk and reap the higher rewards that come with risk.

Lawyers have an important role to play in this new multi-disciplined approach. The purpose of this article is to explain one aspect of that role – presenting and managing insurance claims. The first section of this article gives an overview of the various kinds of insurance that corporate counsel should be familiar with. The second section of the article teaches corporate counsel how to read and analyze an insurance policy. The third section of the article discusses the mechanics of tendering an insurance claim to the insurance company and setting the stage for successful negotiations. The fourth and final section of the article presents techniques for overcoming impasse in settlement negotiations.

Types of Insurance

Every corporate counsel should have a general understanding of four types of insurance coverage: (i) commercial general liability policies; (ii) special liability policies; (iii) first-party policies; and (iv) transportation-related policies. Commercial general liability (CGL) insurance is the most commonly held type of business insurance and it is designed to provide policyholders with coverage for all forms of third-party liability. In particular, CGL insurance provides

[2] In recent months, policyholders have begun to catch up as evidenced by the increasing number of coverage cases being filed by a range of policyholders (school districts to Fortune 500 companies) to recoup the cost of remediating computer systems for Year 2000 problems.

coverage for liabilities to third parties, who have, through the policyholder's negligence, suffered bodily injury or property damage.

CGL insurance became available in the early 1940s when the insurance industry combined several forms of liability insurance (elevators, products, premises etc.) into a single, standard form, all-risk policy. Initially, the CGL policy covered liability for bodily injury or property damage caused by an accident. In the mid-1960s, the insurance industry broadened the concept of accident into an occurrence. Under an occurrence form of CGL insurance, coverage is dependent on whether injury to the third party occurred during the policy period. In the mid-1980s, CGL policies were amended to offer this type of insurance on a "claims-made" basis. Unlike an occurrence policy that looks at time of injury, "claims-made" insurance is triggered by the assertion of a claim against the policyholder during the policy term.

Special liability policies are another form of liability coverage. This category of insurance includes directors and officers liability (D&O), the delivery of professional services (E&O), and the risks arising from employment practices. D&O insurance provides two kinds of liability coverage for claims made by third parties against directors and officers for their wrongful acts. The first kind of D&O coverage provides coverage to directors and officers in circumstances when their company is not obligated to indemnify them. The second kind of D&O coverage provides reimbursement to the company for amounts expended to indemnify directors and officers.

E&O insurance provides coverage to a wide group of professionals (accountants, lawyers, doctors, etc.) for liability arising from their performance of professional services. The typical policy responds to claims which are caused by an "act, error or omission" inherent to the policyholder's professional practice. Employment liability insurance consists of workers' compensation insurance and liability insurance designed to protect businesses against employment-related liabilities not covered by workers' compensation. The latter kind of employment practices liability insurance typically covers discrimination, harassment, wrongful termination, failure to employ or promote, breach of employment contract, misrepresentation, defamation, negligent evaluation, invasion of privacy, wrongful infliction of emotional distress, and retaliation.

In contrast to liability insurance, which covers damage to third parties, property insurance protects a policyholder from damage to or loss of its own property, including expenses incurred to prevent a covered loss. Additionally, property insurance covers consequential loss from physical damage such as business interruption. The most important distinction with regard to property insurance is the scope of coverage. An "all risk" property policy covers all causes of property loss except those causes which are specifically excluded. A "named perils" policy limits coverage to property damage which arises from specific causes enumerated in the policy (e.g., fire). A typical extension of both kinds of insurance is "business interruption" coverage which covers the right to continue operations when damage to the policyholder's property occurs.

Depending on the type of business, corporations may also have some specialized form of property coverage. One specialized form of coverage is boiler and machinery coverage, which is

intended to cover breakdowns of machinery, electrical equipment and pressurized vessels such as boilers and refrigerators. A second form of coverage is fidelity coverage, which is purchased by the financial industry to insure against internal and external crime. Other specialized coverages include "inland marine," which insures against the threat of damage to movable property, and multi-peril policies which cover matters such as valuable papers and construction of buildings.

The final category of insurance is transportation. A major category of transportation insurance is marine insurance, which is the oldest known type of insurance. First party marine insurance consists of two types: (i) hull insurance which covers the ship or vessel and (ii) cargo insurance which covers the goods carried on board of the vessel. The other major category of transportation insurance is aviation. Like marine insurance, aviation insurance covers first party risks to the aircraft, hull insurance, and third party claims arising out of the use of aircraft.

Analyzing An Insurance Policy

Insurance policies are divided into five major sections: (i) policy declarations; (ii) insuring clauses; (iii) exclusions; (iv) conditions; and (v) endorsements. The first four sections and accompanying legal rules for policy interpretation are explained below. The fifth section of the policy known as "endorsements" are simply addendums to the policy which modify preceding sections and tailor the policy to the policyholder's specific circumstances.

The first page of an insurance policy is the policy declarations or "dec. page." The "dec. page" identifies the policyholder and the insurer and specifies the term of the policy. The "dec. page" will also describe the amount of coverage available under the policy regardless of the number of insureds covered under the policy, the number of claims made, or the number of claimants. The amount of coverage is defined by the policy limits and may be capped by an aggregate limit, which defines the maximum amount payable under the policy regardless of the number of losses. The last item on the "dec. page" is a description of the coverages purchased by the policyholder.

Learning how to read a "dec. page" is crucial because sometimes neither the policyholder nor the insurer can find a complete copy of the policy. However, by using the "dec. page," or other comparable evidence, both sides can reconstruct the coverage. Indeed, because the language of most insurance policies is standardized, knowledge of the identity of the parties to the insurance contract, the policy period, the policy limits, and the type of coverage will constitute sufficient proof of the insurance policy.[3] Other forms of oral or documentary evidence of these material terms may also suffice.

The second section of the policy contains the insuring clauses which describe more completely who and what the policy covers. The identity of the insureds are defined in provisions entitled "named" and "additional insureds." When the policyholder is a large corporation, the definition of the "named insured" is important because frequently subsidiaries and other related business interests are covered under the policy. Other parties may become "additional insureds" under the policy because of contractual relationships. For example, a

[3] See e.g., *United States Fidelity & Guar. Co. v. Thomas Solvent Co.*, 683 F. Supp. 1139 (W.D. Mich. 1988).

subcontractor may add a general contractor as an additional insured under its policy. Additional insureds are typically added through endorsements which appear at the end of the policy.

The other important insuring clauses are the insuring agreements. Insuring agreements are generally entitled "Coverages" and they represent the heart of the insurance policy. Liability policies contain two important coverages: (i) coverage for the cost of legal representation and (ii) coverage for settlements or judgments. These coverages are known respectively as the duty to defend and the duty to indemnify. Of the two, the duty to defend provides broader coverage.

Indemnification coverage for liability will depend on whether the policyholder can prove that injury or a claim occurred during the policy period. In most jurisdictions, however, defense coverage provisions have been interpreted as requiring coverage if the allegations against the policyholder raise the possibility of indemnity coverage.[4] The determination of whether defense coverage exists is made immediately upon tender of the claim to the insurer and must be provided except upon a showing by the insurer that even if the allegations were proved to be true, there is no legal or factual possibility of indemnity coverage.[5] An insurer must also provide complete defense coverage for multiple claims so long as a single claim is potentially covered.[6]

After the policyholder determines that it is a covered insured and that its loss falls within one of the insuring coverages, the exclusions to coverage should be analyzed. This paradigm is consistent with the way courts have allocated responsibility on questions of coverage. The policyholder bears the burden of proving that a loss is covered and the insurer bears the burden of proving that exclusions limit or eliminate coverage.[7] Because the purpose of insurance contracts is to provide coverage, exclusions must be clear and specific as to what is excluded. If exclusions fail to meet this standard, they are construed narrowly to maximize coverage.[8]

The final section of the policies contains the conditions which set forth duties of the policyholder and the insurance company. Because these duties may impact coverage, interpretation of them often gives rise to coverage disputes. For example, the parties may debate whether the policyholder gave the insurer timely notice, and if not, whether the insurer was harmed by late notice. The most recent debate is whether a policyholder's duty to mitigate damages under property or liability policies should compel an insurance company to pay the costs of identifying and correcting Year 2000 problems to avoid property damage or harm to third parties.

Two other principles of contract interpretation deserve mention. Because many policy provisions and terms contain standardized wording drafted by the insurance industry, courts tend

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[4] 1. R. Long, *The Law of Liability Insurance*, § 4682 (1979).

[5] 7C Appleman & Appleman, *Insurance Law and Practice*, § 4683 (1976).

[6] See e.g., *Babcock & Wilcox Co. v. Parsons Corp.*, 430 F.2d 531 (8th Cir. 1970).

[7] A. Windt, *Insurance Claims and Disputes,* § 9.01 (2d. ed. 1988).

[8] 13 Appleman & Appleman, *Insurance Law and Practice,* §7405 (1976)

to construe ambiguities against insurance companies who, because of their bargaining position and experience, can better avoid ambiguities.[9] Additionally, most jurisdictions interpret ambiguities in accordance with the objectively reasonable expectations of the policyholder.[10]

Presenting & Managing the Claim

Tendering and managing an insurance claim can be an intimidating process. If the policyholder's liability arises from the operations of a predecessor company, several different insurance programs and numerous insurers could be affected by the claim. Even if defense coverage is provided, issues may arise regarding who should represent the policyholder and how much the insurance company should pay in legal fees. Questions also arise about how to manage the claim toward settlement if litigation occurs.

Presenting and managing a claim begins with understanding the policyholder's burden. Regardless of the type of coverage or claim, a policyholder's prima facie case for coverage contains four elements: (i) showing the existence of an insurance policy; (ii) establishing that the loss is covered under the policy; (iii) proving that the insurance policy has been breached; and (iv) establishing the amount of loss or damages. Simply put, handling an insurance claim is nothing more than handling a contract claim. In other words, insurance coverage cases are contract cases and the key issue is whether the loss is covered.

This simple perspective is important to successfully managing an insurance claim. Getting insurance claims favorably settled while preserving relationships requires perspective and active management of the settlement process which begins with giving notice of the claim. Giving notice raises three questions. When do you notify the insurer? Which insurers do you notify? What do you send in the notice?

Notice is considered timely if a reasonable businessperson would consider the notice timely. If notice is considered late, most jurisdictions will permit the claim to proceed unless the insurer can prove either that late notice increased its financial exposure or impaired the insurer's ability to meet its coverage obligations. The important thing for a policyholder to do is act in a manner consistent with what a reasonable insurer would have done in similar circumstances.[11]

With respect to the scope of notice, the general rule of thumb is to give notice to all potentially applicable coverage. Excess carriers up to the limits potentially involved in the matter should receive notice. Additionally, the question of predecessor coverage should be examined if the matter involves an acquired company. The notice letter should identify all known policy numbers and use the phrase "any other applicable policy" to prevent an issue later that notice was incomplete. Notice should be sent by certified mail, with return receipt requested to provide proof of notice.

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[9] Id. at § 7403
[10] Id.
[11] See e.g. *Commercial Union Ins. Co. v. International Flavors 7 Fragrances, Inc.*, 822 F.2d 267 (2d Cir. 1987).

Within a reasonable time after receiving notice of a claim, an insurer must make one of three determinations: (i) accept the claim for coverage; (ii) accept coverage under reservation of rights; or (iii) deny coverage. Obviously, if the insurer accepts the claim, then the process should go smoothly. More often than not, however, the claim will fall into a gray area and the insurer will feel compelled to reserve its rights to decline coverage or simply decline coverage right away.

The issue of legal representation under liability policies presents the first opportunity for policyholders and insurers to settle their differences, at least until the underlying claim against the policyholder is resolved. If an insurer accepts coverage but reserves its right to disclaim coverage, the policyholder may be able to control the selection of defense counsel. A policyholder's right to select counsel will depend on the degree to which there is a factual overlap between the underlying claim against the policyholder and the insurer's coverage reservations.

Policyholders have several incentives to try to work out an accommodation. Coverage reservations naturally breed suspicion about whether the insurer is truly interested in defending the policyholder or protecting its economic interests. If the policyholder appoints counsel, there may be disputes about the reasonableness or necessity of certain defense strategy and associated legal costs.

Cases involving repetitive claims or multiple carriers represent another compelling reason for a meaningful dialogue. Often a policyholder will be sued many times for progressive injuries that took place over many policy periods. In these situations, several carriers will have a duty to defend the policyholder. To avoid conflict over how much each carrier should contribute to the defense and to facilitate prompt reimbursement of defense costs, a written agreement between the policyholder and insurers regarding management and funding of the policyholder's defense should be pursued.

Declination of coverage presents different management challenges. If the policyholder disagrees with the insurer, the declination becomes tantamount to a breach of contract. How should the breach be resolved? Are there alternatives to litigation which may become time consuming and expensive for both parties?

The best model for resolving coverage disputes before litigation is the Prelitigation Protocol for Environmental Insurance Coverage Claims developed by two bi-partisan committees of the American Bar Association.[12] The protocol provides a framework and a methodology for conducting principled discussions. The first objective of the Protocol is to create a safe environment for settlement discussions through a mutual agreement to reserve rights, claims and defenses, keep information and communication confidential, toll statute of limitations and other time-based defenses, and refrain from filing suit.

The second element of the Protocol is designed to limit the information exchange to key information that addresses critical facts and that can be produced without undue expense or

[12] The Prelitigation Protocol For Environmental Insurance Coverage Claims is available onb the Internet at www.abanet.org/litigation/committee/insurance/envprot.html.

delay. The Protocol encourages policyholders to present sufficient information to explain the claim and the relevant insurance policies. Likewise, insurers are encouraged to provide sufficient information to explain the basis of coverage defenses and their view of the relevant insurance.

The third, and most important element of the Protocol, is a face-to-face business meeting between decision-makers from both parties within 30 days from completion of the initial information exchange. In the end, there is no substitute for creating relations built on mutual trust and respect as early as possible rather than letting the process deteriorate into litigation-oriented interaction which produces suspicion and hostility. Good relations at the outset also gives the parties greater flexibility to pick the right technique for dispute resolution, which could range from mediation to mini-trials.

This is not to diminish the role of litigation. At times, there may be no choice for either side but to pursue litigation, particularly when the claim involves a novel issue of policy interpretation. The lesson to be learned from previous insurance coverage wars is that equal time and attention should be given to litigation and to settlement. For every litigation plan and strategy, there should be a settlement plan and strategy. Settlement discussions should be initiated after notice is given and pursued at all critical junctures including at the time of information exchange, receipt of the insurer's coverage assessment, and before litigation is filed. If litigation is necessary, settlement discussions should occur at regular intervals, particularly before and after discovery, motion practice and trial.

If litigation is pursued, the choice of forum and choice of law may shape the settlement process more than any other factors. The typical coverage dispute does not involve a federal question. Therefore, insurance disputes are resolved by the common and statutory law of each of the fifty states. As one might expect, interpretation of policy wording varies from state to state. Moreover, states use different legal standards to resolve conflicts-of-law disputes. Consequently, the choice-of-forum may dramatically affect the choice-of-law analysis.

When settlement occurs, two factors will largely shape the terms of the agreement. The first factor concerns the scope of the policyholder's release of coverage rights. Generally, the more the policyholder gives up in the way of coverage rights, the greater the recovery. The second factor is the amount of monetary payment which may be affected by the type of payment. Payment options include immediate cash payment, periodic payments, and coverage-in-place settlements. Focus on these two factors coupled with strong management of the claim process gives the policyholder the best opportunity to reach a fair and cost-effective settlement.

Overcoming Settlement Impasse

What if you do all the right things in tendering and managing the insurance claim, but still reach impasse? One common point of impasse is an inability to analyze and communicate effectively the value of the claim. Another common obstacle is trying to get the settlement process rolling with multiple carriers, each of whom may want to avoid being the first insurer to

settle. Additionally, the parties may be unable to focus on the same facts, issues, and law so that they can see what divides them.

Environmental claims illustrate well the problems inherent in trying to value an insurance claim. Frequently, it will take years before a policyholder's liability and the cost of site remediation is resolved. Additionally, there may be threat of future claims or that the remedy could fail. The way to deal with these uncertainties is to develop a methodology for capturing and documenting all possible values.

Through experience, policyholders and insurers have learned to analyze three separate values when dealing with an environmental claim. The first value is past costs, which is a matter of accurately accounting for relevant out-of-pocket and in-kind expenditures. Relevant costs may include investigation costs, remedy design and implementation costs, consultant costs for technical, analytical, and regulatory assistance, settlement costs, and legal costs.

The second environmental insurance claim value is the value associated with future known cleanup costs. These costs will include the capital and operation and maintenance ("O&M") costs. For a typical ground water pump and treat remedy, capital costs are incurred for installing the wells, pumps, piping system, and treatment equipment. O&M costs include the costs of running the treatment system, monitoring remedial effectiveness, and maintaining/replacing equipment. Since the operating life of a ground water remediation system is often 20 to 30 years, O&M costs can represent a substantial portion of future costs.

The third component value for an environmental insurance claim is the estimation of contingent cleanup costs. Contingent cleanup costs are costs that may occur if "things go wrong." Some technologies are prone to cost overruns. Despite careful site assessments, additional "hot spots" or new contaminants may be found at a site already in remediation. The value for these contingencies is obtained by multiplying the cost to respond to the event by the probability that it will occur. For example, a $1 million contingency that has a 50% probability of occurring will give rise to contingency value of $500,000.

The point to be gleaned from this discussion is that the solution to valuation problems is good methodology which can be communicated clearly. Taking such an approach helps ensure that the parties will evaluate the objective merits of the insurance claim and attack the problem, not each other.

Working together becomes problematic when the policyholder has multiple insurers, each of whom does not want to be the carrier that settles first. The Los Angeles Superior Court has developed a solution to this common problem called the "double-blind" model, which it uses in mandatory settlement conferences.[13] Under the "double-blind" model, the policyholder prepares a statement of claim facts, which is presented to the court and to the insurers. The policyholder then provides the court with a coverage chart and a confidential objective and detailed coverage

[13] The "double-blind" model was developed by the Honorable Frederick J. Lower, Acting Supervision Judge for the Los Angeles County Superior Count and has been used successfully in such cases as *In Re Lincoln Memorial Litigation*, Case No. BC 133643.

analysis of each policy under which it believes an insurer should pay. This coverage analysis is not shared with the insurance companies.

Following submission of the policyholder's coverage analysis, the court meets with policyholder's counsel to establish a total settlement demand, which is not disclosed to any of the insurers. Thereafter, each insurer provides the court with its own confidential, objective, and detailed analysis of coverage. At this point, a second blind is erected, as each insurer's coverage analysis is not disclosed to the policyholder or to fellow insurers.

After reviewing the submissions of all the parties, the court meets with insurers on an individual basis to develop a response to the policyholder's total settlement demand. Again, confidentiality is the key, as only the court knows the individual amounts offered by the insurers and the policyholder's total demand. The point of the exercise is to establish an environment where each party can evaluate the merits of their individual position free from worry and concern about what other parties may do.

The final technique for overcoming impasse is mastering the diagnostic tools used in resolving impasses. For most negotiators, the difficulty lies in trying to define the impasse. The first solution is to simply observe. Imagine yourself in the settlement meeting going to a lookout point where you can see both sides. If you have trouble with this kind of imagery, take a second negotiator to the meeting whose responsibility it is to watch body language and listen carefully. Alternatively, play "20 questions" with the insurance company representative. Ask, ask, and ask until you are sure that you completely understand the insurance company's position.

Once you can state the positions of both parties clearly and succinctly, you are now able to define the impasse and break it down to component parts. Doing so will have several advantages. You will be separating the people from the impasse. More importantly, you will be moving the discussion to objective appraisal of the facts, policy wording and the law.

After the impasse is defined, bridges of understanding and respect can be built. The key to bridge building is giving reasons why each party should move closer together. Perhaps, the policyholder will be able absorb the risk of future losses so that the insurance company has finality. Similarly, the insurance company may be motivated to settle in order to avoid the risk of adverse precedent. Whatever the case, the goal is to define the positions, identify the underlying interests, then find commonality between respective interests.

Conclusion

The successful companies of the future will be those that employ strategic risk management. These companies will no longer be dependent on insurance companies or brokers for risk management advice. Instead, they will rely on multiple disciplines including corporate counsel. By communicating frequently with the company's financial professionals responsible for taking and transferring risk, these attorneys can help improve the company's bottom line. An important step in this direction is mastering the fundamentals of presenting and negotiating an insurance claim.

About the Author

Mark Siwik is Senior Counsel with Risk International, a national consulting firm specializing in helping corporate policyholders interface with brokers, underwriters, and insurer claim representatives. Mark counsels commercial policyholders on insurance claims and acts as their settlement representative. Before joining Risk International, Mark practiced insurance coverage law and was a partner with the Ohio law firm of Brouse McDowell.

Mark has lectured and written frequently on a variety of topics, including insurance coverage, professionalism, and individual and organizational development of lawyers and law firms. His first book, *Success Briefs for Lawyers: A Collection of Inspirational Essays on the Practice of Law*, will be published in the spring of 2000.

Mark is a member of the American Bar Association, Ohio State Bar Association, Akron Bar Association and the American Corporate Counsel Association. He is the former Chair of the Ohio State Bar Association's Law Office Automation & Technology Committee. The Akron Bar Association has twice honored Mark for his leadership.

In 1985, Mark received his B.A. in Political Science, Summa Cum Laude from the University of Akron. In 1988, he received his law degree from the University of Cincinnati where he was a member of the Order of Coif and Order of the Barristers. From 1988 until 1990, Mark clerked for the Honorable John M. Manos of the United States District Court for the Northern District of Ohio.