The Subprime Meltdown

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Unprecedented banking and financial company failures and hastily arranged buyouts by regulators to avoid insolvencies have left the financial markets reeling. The Federal Reserve and the Treasury Department formulated bailouts of companies once thought solid. Congress wrangled with the $700 billion rescue package to avert further disaster. Stockholders of once-steady entities such as Washington Mutual, Wachovia, or AIG find investments lost, and some on the brink of retirement discover that their nest eggs have shrunk by 25 percent or more. As the affected masses search for people to blame and assets to tap, suits against directors, officers, accountants, and even loan agents and appraisers continue to mount.

Given the more than $230 billion in write-downs from the subprime mortgage crisis in the first half of 2008, an inevitable barrage of litigation ensued. During the first three months of 2008 alone, 170 subprime-related lawsuits were filed in Federal Court. Nearly half of these suits were filed in New York and California. One half of the lawsuits involved putative class actions by borrowers versus lenders and mortgage brokers alleging (among other things) discriminatory lending practices, improper charges, and inadequate disclosures.

In January 2008, Bear Stearns estimated that directors and officers (D&O) insurers may face $9 billion in claim-related costs. Bear Stearns' own officers and directors were subject to a suit against them, which was filed within hours of the announced bailout sale to J. P. Morgan (*Eastside Holdings, Inc. v. Bear Stearns*). Other subprime-related securities lawsuits have been brought against AIG, Citigroup E-Trade Financial Corp., HSBC Holdings, Movies Company, Toll Brothers, and Washington Mutual, Inc. Of the many cases filed in the past year, almost all of them name individual directors or officers as defendants.

But are the insurers taking note of the burgeoning litigation? Have the underwriters anticipated such claims with policy language that excludes claims arising out of fraud, dishonest acts, or improper personal profit? Are claim professionals ready to investigate the facts to make the proper coverage determinations? Will other insurers face the same fate as AIG?

When faced with a D&O claim made against a director or an officer of a Fortune 500, a small privately held firm, or an errors and omissions (E&O) claim against a loan broker, insurers must be prepared to apply policy language and investigate the facts. This can be accomplished by answering simple questions.

Does the Policy Language Limit Coverage?

D&O and E&O policies contain "dishonesty exclusions." The related policy language may resemble the following: a) The gaining of any profit, remuneration, or advantage to which the insured was not legally entitled; or b) any criminal or deliberately fraudulent act, error or omission by an insured, if evidenced by any judgment, final adjudication, alternative dispute resolution proceeding, or a document or written statement by an insured.

Many policies do not include the qualifying phrase, “or a document or a written statement by an insured.” Instead, numerous policies contain language that the exclusion only applies, “if a judgment or other final adjudication adverse to the insured establishes such act, omission, or willful violation.”

A secondary issue arises where the policy provides that no fact pertaining to, knowledge possessed by, or conduct by any insured individual shall be imputed to any other insured individual. Essentially, this means that if one director or officer commits a wrongful act resulting in an illegal profit, then the innocent directors or officers are not subject to a loss of coverage.

An insurance company may be defending D&O litigation — or reimbursing an insured for the defense and potential indemnity payments in litigation — until there is a final adjudication establishing the application of the dishonesty exclusion.

Many D&O policies also contain language excluding “personal profit.” The language usually states that such losses are excluded arising out of the gaining “in fact” of any personal profit or advantage to which the insured is not legally entitled.

Some courts have interpreted this “in-fact” requirement as meaning a final adjudication. (*PMI Mortgage Ins. Co. v. American International Specialty Lines Ins. Co*). In *PMI Mortgage* , the insurance company was required to reimburse an insured’s defense costs and amounts paid to settle an underlying D&O lawsuit brought about by consumers against a mortgage insurer, even though the allegations of the complaint sought recovery of profit to which the insured was not legally entitled. During the trial, the insurer could not produce evidence of the coverage action to establish that the insured paid a settlement amount allocated to an excluded personal profit. Other jurisdictions have not required a final adjudication to satisfy the “in-fact” requirement.

Therefore, the application of the exclusions related to dishonest acts or personal profit require that the insurer alter the evidence to establish that defense and indemnity reimbursement sought by the insured is excluded. Depending on the policy language, this may require a final adjudication in the underlying action against the insured. Waiting for the underlying action to go to final judgment could be a costly proposition for an insurer. As such, the claim professional needs to investigate to obtain the evidence to determine if the insurer can establish “in fact” an illegal personal profit or establish in a separate declaratory relief action that the dishonesty exclusion applies.

What Lies Beneath

An insurer’s investigation entails a thorough analysis of the operations of its insured. This begins with a complete review of the underwriting materials from the company and documents from the insurance agent or surplus lines broker that contain all the facts about the insured’s operations.

Next, the claim professional will need to analyze the laws governing the particular industry. If there is an

allegation of predatory lending practices, then the professional will need to determine what, if any, regulations the insured has allegedly violated. One should also consider the common industry practice as to the application of fees or the duties of disclosure. Do the damages seek excluded fines and penalties? What is the maximum penalty and how is this calculated? The claim professional needs to be able — at an early stage — to allocate the potentially sought damages to amounts covered under a policy, and to amounts excluded as the product of a dishonest act, a personal profit, or a fine or penalty.

Insurers must not overlook easy information sources, such as a company web site or company marketing material for a closely held company like a local mortgage broker. For a large enterprise, pay attention to annual reports or other publicly filed documents. Interviews of company employees may fill in the gaps where documents leave off. Depending on the complexity of the case and on the policy limits exposure, carriers should also consider forensic accounting experts to assist in understanding the exposure. It may be prudent to ask the expert to assist in a damage analysis for the potential application of policy exclusions to a settlement demand, settlement payment, or a judgment against an insured.

Duty of the Insurer

The insurer needs to respond to a tender from a policyholder in an expeditious manner. Some state-specific claim regulations establish time periods that a carrier must follow when responding to an insured and making an initial coverage determination. Preliminarily, the insurance company's response will depend on whether the policy is a straight reimbursement policy and if the policy contains a "duty-to-defend" provision.

Where the policy contains a duty to defend — as is often the case in D&O policies specifically tailored to closely held companies — the insurer would do best to defend while it investigates the claim. A letter specifically tailored to set forth the coverage position of the insurance company should be formulated. This should include the pertinent exclusions, the conditions and provisions of the policy, the definition of loss, and the requirements that the underlying suit must seek damages as opposed to fines or penalties. The carrier can then request the insured's cooperation in providing information, books, records, and other documents from the company that relate to the underlying suit. It can also ensure that its employees are available for interviews and can opt to correspond with its insured via coverage counsel. This will insulate the insurance company through the attorney/client privilege from the thoughts, comments, and opinions of its coverage counsel. It is important to note that the nature and extent of the attorney/client privilege varies from jurisdiction.

In limited circumstances, depending upon the lack of cooperation from the policyholder, it may be necessary to file a specifically tailored complaint for declaratory relief. When the policyholder will not communicate with the insurer, the only remaining option may be seeking court assistance. Filing a declaratory relief action allows the carrier to obtain facts through the litigation process where the policyholder was unwilling or unable to provide the necessary documentation for the carrier to determine coverage. The carrier does not want to be in a position where there is a demand to indemnify from the policyholder for a questionably covered claim, and the carrier has no facts to evaluate its coverage or to challenge the demand.

The Power of Exclusion

The impact of a subprime crisis on insurance companies will likely be minimized by the effect of exclusions based on the fraud of the insured — whether the dishonest-acts exclusion or the personal-profit exclusion applies. Insurers have drafted this language anticipating E&O and D&O claims. However, the need for a final adjudication of the facts to apply the exclusions requires the insurer to be vigilant in its investigation from the onset.

The insurer will be required to either wait for the conclusion of an expensive underlying action or be prepared to litigate coverage in a coverage action. The insurer will then need to establish the evidence to allocate the damages sought to the exclusion. A thorough and early investigation will allow the insurer to meaningfully discuss apportionment of loss with its insured while underlying action proceeds along, rather than wait until the insured settles or faces a final judgment that may or may not be sufficiently particular to allow the application of exclusion.

Finally, conducting a thorough investigation will permit an insurer to properly reserve the losses and allow actuaries to price premiums moving forward to maintain the financial solvency of the insurance company.

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