

**SURVEYING THE INSURANCE LANDSCAPE:
THE CHANGING FACE OF INSURANCE LAW
IN NEW JERSEY**

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<http://www.spsk.com/profile.cfm>

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**SURVEYING THE INSURANCE LANDSCAPE: THE CHANGING
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PREFACE

The following will present a summary of recent coverage decisions, both within New Jersey, and nationwide, that are expected to impact insurance law in New Jersey. Important decisions from other jurisdictions were not included in instances where the issues addressed have already been fully explored and definitively determined by New Jersey courts.

Also presented is a brief synopsis of the Sarbanes-Oxley Act of 2002 and a short analysis of its potential impact on Directors and Officers insurance coverage in New Jersey.

PUNITIVE DAMAGES

THE DECISION:

The United States Supreme Court found that an excessive punitive damages award violated the Due Process Clause of the 14th Amendment. State Farm Mutual Automobile Insurance Co. v. Campbell, 538 U.S. 408 (2003).

THE FACTS:

The genesis of what many feel was a landmark decision was a relatively straightforward auto liability action which ultimately lead to a bad faith suit where a jury awarded \$2.6 million in compensatory damages and \$145 million in punitive damages. The compensatory award was reduced to one million dollars and the Supreme Court found that the punitive award, as compared to the compensatory award, was excessive and violated the Due Process Clause of the 14th Amendment. The Due Process Clause, in general, prohibits grossly excessive or arbitrary punishments.

The Court found the punitive to compensatory ratio, 145:1 to be excessive and, though it declined to provide a specific numerical guideline, it was held that single digit ratios are most likely to withstand due process scrutiny. In assessing the fairness of a punitive award, the Court identified three factors which should be considered:

1. The degree of reprehensibility of the defendant's conduct;
2. The disparity between the actual or potential harm suffered by the plaintiff and the punitive award; and
3. The difference between the punitive award and civil penalties authorized or imposed in comparable cases.

THE IMPORTANCE OF THE DECISION:

This decision is of enormous significance and is not only applicable to coverage litigation but to all litigation. It is expected to change the way both plaintiffs and defendants evaluate cases for settlement purposes as the specter of a gross and excessive punitive award is removed.

SUCCESSOR LIABILITY

THE DECISION:

The Supreme Court of California held that an assignment of policy benefits was invalid without the insurers' consent. Henkel Corp. v. Hartford Accident and Indemnity Co., 29 Cal. 4th 934 (2003).

THE FACTS:

Henkel, a successor corporation, brought an action against its purported insurers for their refusal to defend it in tort litigation alleging personal injuries as a result of exposure to the chemical products of a predecessor. It was undisputed that the successor corporation had in fact succeeded to all of the rights and liabilities of its predecessor.

The insurers denied coverage, citing to policy provisions which required the insurers' consent to an assignment of the policies. Henkel argued that despite the "No Assignment" clause, the benefits of the policy could be assigned without consent once the event giving rise to the liability had occurred. The Court agreed with the insurers, finding at the time of the corporate transfer, the claims of the personal injury plaintiffs had not yet become an assignable chose in action and had not been reduced to a sum of money due. The Court also found that even if enforcement of the "No Assignment" clause required a showing of an additional burden or risk not contemplated by the insurers, as was argued by Henkel, that alone was not decisive as an additional burden may arise whenever the predecessor corporation still exists or can be revived. The Court noted that if both the assignor and assignee were to assert the right to a defense, the insurer may be faced with the burden of defending both parties.

THE IMPORTANCE OF THIS DECISION:

While on its face, the "No Assignment" clause presents a plausible justification for an insurer to disclaim coverage to a successor entity where the insurer did not consent to the assignment of the policy benefits, it is rare that an insurer will ever rely on the provision in disclaiming coverage. Our experience in New Jersey has been that at most, it will be a "throw in" defense or an additional ground for disclaiming coverage.

Many insurers and most courts reason that the assignment after the loss does not require consent "for the obvious reason that the clause by its own terms ordinarily prohibits merely the assignment of the policy, as distinguished from a claim arising hereunder, and the assignment before a loss involves a transfer of a contractual relationship while the assignment after the loss is the assignment of a right to a money claim." 3 Couch on Insurance §35.7 (3d Ed. 1995). New Jersey courts have followed this reasoning. See, Flint Frozen Foods, Inc. v. Firemen's Fund Ins. Co., 12 N.J. Super. 396, 399 (Law Div. 1951), rev'd on other grounds, 8 N.J. 606 (1952) (stating, once the loss occurs, the assignment is of the loss and not the policy and thus does not require the consent of the insurer); Elat, Inc. v. Aetna Casualty and Surety Co., 280 N.J. Super. 62 (App. Div. 1995) (concluding that the "No Assignment" clause prohibits the assignment of the policy, not the claim. The purpose of the clause is to protect the insurer from insuring a different risk than intended.); see also, Caldwell Trucking PRP Group v. Spaulding Composites Co., 890 F.Supp. 1247 (D.N.J. 1995).

It remains to be seen whether the Henkel decision will change the way New Jersey courts address this issue. When considered in light of the recent and very subtle pro-insurer shift in the Appellate Division and Supreme Court, it may be an issue worth monitoring.

REIMBURSEMENT OF DEFENSE COSTS

THE DECISION:

The Court ruled that the insured does not have the right to dictate to the insurer the hourly rate that must be paid after a successful declaratory judgment action. The trial court should determine the hourly rate typically charged for similar defense work, taking into consideration that attorneys who perform such insurance defense work do so for a lower hourly rate. Also, the insurer does not have to pay attorney's fees incurred by the insured in monitoring the work of the assigned defense counsel. Under certain circumstances, the insurer may be responsible for defense costs associated with both covered and uncovered claims. Aquino v. State Farm Ins. Co., 349 N.J. Super. 402 (App. Div. 2002).

THE FACTS:

In this assault and battery case, the New Jersey Appellate Division examined the amount of counsel fees which would be owed as reimbursement of defense costs after a conflict (here, between alleged intentional and negligent conduct) which had precluded the insurer from properly assuming the defense was resolved.

Subject to an inadequate reservation of rights, Travelers Insurance Company defended its insured in a four count complaint which alleged both negligent and intentional acts. Personal counsel for the insured believed that assigned defense counsel was inadequate and successfully moved to compel his own partial substitution. The Court noted that assigned defense counsel could "not proceed with undivided loyalty to defend all four counts." Id. at 411.

It is well settled that an insurer may decline coverage where a conflict exists. In the event that coverage is determined to exist, the duty to defend will be converted to a duty to reimburse counsel fees incurred by the insured in its own defense.

In Aquino, the Court held that, under "special circumstances", an insurer may be held responsible for costs associated with the defense of both covered and non-covered claims. Id. at 413. The Court required the insurer to reimburse its insured for defense costs incurred in defending even the uncovered claims (those alleging intentional acts), citing the insurer's decision to initially undertake the defense of these claims, despite an apparent conflict. Though not specifically addressed by the Court, it is clear that the doctrines of waiver and estoppel were applied to reach this result.

The Court did not, however, allow for reimbursement of all defense costs sought by the insured's personal counsel, finding that the trial court should determine the hourly rate typically charged for similar defense work, taking into consideration, once again, that attorneys who perform such insurance defense work do so for a lower hourly rate. Also, the insurer did not have to pay attorney's fees incurred by the insured in monitoring the work of the assigned defense counsel.

THE IMPORTANCE OF THIS DECISION:

Here, the insurer undertook the entire defense, defending its insured against claims alleging both negligent and intentional conduct, without a clear reservation of rights. The lesson for insurers is to clearly and completely state all grounds upon which coverage is being disclaimed as part of its reservation of rights. While it is always preferable to have the insured sign off on the reservation of rights or non-waiver agreement, in the very least, the insured should: (1) be clearly advised as to which claims are covered and which are not; and (2) retain counsel at its own expense for the non-covered claims. Where there is an inherent conflict in defending part of a suit under such circumstances, the insurer should deny coverage. Depending on facts which may develop through the continuing litigation, the insurer may then have to reimburse its insured for defense costs incurred.

NON-CUMULATION CLAUSE

THE DECISION:

The Supreme Court of New Jersey found the “non-cumulation” clause to be invalid and in contravention of the principles espoused in its decision in Owens-Illinois v. United Ins. Co., 138 N.J. 437 (1994). Spaulding Composites Co. Inc. et al. v. Aetna Cas. & Sur. Co., 176 N.J. 25 (2003).

THE FACTS:

The Supreme Court of New Jersey examined the applicability of a “non-cumulation” clause for an environmental claim that triggered multiple consecutive policy periods. The non-cumulation clause at issue read as follows:

If the same occurrence gives rise to personal injury or property damage which occurs partly before and partly within the policy period, the “each occurrence” limit and the applicable aggregate limit of this policy shall be reduced by the amount of each payment made by the company with respect to such occurrence under a previous policy of which this policy is a replacement.

The clause operated to limit the insurer’s liability under multiple sequential CGL policies where losses related a “single” occurrence triggered multiple policies. The Supreme Court refused to enforce the clause, finding that the basis for the clause, namely, the notion of a “single occurrence with multiple year effects” was rejected by Owens-Illinois. The Court held that progressive indivisible injuries are to be “treated as an occurrence within each of the years of a CGL policy.” Id. at 44.

THE IMPORTANCE OF THE DECISION:

While clearly reiterating and confirming the rationale espoused in Owens-Illinois, especially in the environmental coverage context, the broader implications for asbestos coverage litigation must be considered. At least in New Jersey, the courts will not allow policy language to abrogate the function of the continuous trigger theory in maximizing insurance coverage for catastrophic losses, especially where there are societal implications.

ALLOCATION OF DEDUCTIBLES

THE DECISION:

The New Jersey Supreme Court determined that where there is a progressive environmental injury triggering multiple policies, the insured must satisfy the deductible for each triggered policy before it is entitled to indemnity from its insurer. Benjamin Moore & Co. v. Aetna Casualty & Surety Co., 179 N.J. 87 (2004).

THE FACTS:

Benjamin Moore filed a declaratory judgment action seeking defense and indemnity in connection with two class action lawsuits alleging bodily injury and property damage from exposure to lead containing paint. Policies over an eleven year period were triggered, each with a limit of liability of \$1 million per occurrence. Each of the policies also contained deductibles of either \$250,000 or \$500,000. Benjamin Moore argued that for what was in essence a single loss, it should only pay for a single deductible. In the alternative, Benjamin Moore argued that the deductibles should be allocated on the same basis that insurance coverage is allocated under Owens-Illinois v. United Ins. Co., 138 N.J. 437 (1994).

Under Owens-Illinois, progressive environmental injuries which cannot be scientifically attributed to a particular time period are treated as multiple occurrences, triggering all policies in effect from the first exposure to manifestation. Id. at 451. However, Owens-Illinois does not displace the basic provisions of an insurance contract so long as those provisions are not inconsistent with the methodology adopted therein. (See the Spaulding decision, above).

The Supreme Court rejected the “single occurrence” methodology, advocated by Benjamin Moore, in an attempt to avoid having to satisfy multiple deductibles. The Supreme Court found that once the amount of loss is allocated to a particular policy period, it is treated exactly as an actual loss under the policy in effect would be treated, subject to all policy provisions, limits and exclusions. The Court noted that deductibles are clear and constitute a bargained for aspect of the insurance contract. In this case, because of high deductibles (which allowed for lower premiums), an insured such as Benjamin Moore may not be indemnified at all, but as the Court noted, “Justice does not guarantee insurance coverage in every case”.

THE IMPORTANCE OF THE DECISION:

For many years, the trend in New Jersey has been to maximize available insurance coverage, sometimes regardless of and in contravention of clear policy language. In Benjamin Moore, the Court exhibited a willingness to buck that trend.

ABSOLUTE POLLUTION EXCLUSION

THE DECISION:

The New York Court of Appeals found the absolute pollution clause to be ambiguous when applied to a “non-traditional” pollution claim. Belt Painting Corp. v. TIG Ins. Co., 100 N.Y.2d 377 (2003).

THE FACTS:

The claimed personal injury resulted from the inhalation of paint or solvent fumes in an office building where the insured was painting. The Court found that despite the inclusion of “fumes” in the definition of “pollutant,” “reasonable minds can disagree as to whether the exclusion applies here.” Id. at 381. The Court went further, questioning whether the injury was caused by the “discharge, dispersal, seepage, migration, release or escape” of the fumes. Specifically, the Court questioned whether such language would apply when the fumes “drifted a short distance from the area of the insured’s intended use and allegedly caused inhalation injuries to a bystander.” Id. at 381.

THE IMPORTANCE OF THIS DECISION:

In coming to this conclusion, the Court relied on Westview Ass. v. Guarantee National Ins. Co., 95 N.Y.2d 334 (2000) where the Court held that the absolute pollution exclusion was ambiguous when applied to lead based paint. A similar result was reached by a New Jersey Appellate Court in Byrd v. Blumerich, 317 N.J. Super. 496 (App. Div. 1999) where the Court found the exclusion ambiguous when applied to a lead poisoning claim. See, Leo Haus, Inc. v. Selective Ins., 353 N.J. Super. 67 (App. Div. 2002), where the Appellate Division found that the absolute pollution exclusion was not ambiguous when applied to a claim resulting from indoor air pollution, to wit, carbon monoxide. The Haus Court found that carbon monoxide was a “pollutant” and rejected the argument that the absolute pollution exclusion should only apply to industrial pollution or outdoor contamination.

This case is part of a nationwide trend where the absolute pollution exclusion, typically found to be clear and unambiguous, is being questioned when applied in atypical, non-industrial contexts. It also remains to be seen as to whether certain contaminants, such as mold, will fall within the definition of a “pollutant”.

ALLOCATION OF DEFENSE COSTS

THE DECISION:

The Supreme Court of Connecticut addressed the allocation of defense costs among multiple years, including years where the insured was without coverage and held that the insured is responsible for defense costs allocated to uncovered years. Security Ins. Co. of Hartford v. Lumbermens Mut. Cas. Co., 264 Conn. 688 (2003).

THE FACTS:

In addressing the allocation of asbestos defense costs, the Court held that the insured is responsible for defense costs on a *pro rata* basis for years when it was without coverage, without regard to whether the insured simply could not locate the policies or chose to forego insurance. The Court rejected the insured's argument for joint and several allocation.

THE IMPORTANCE OF THIS DECISION:

Many insureds attempt to argue that each triggered policy entitles them to a full defense for a covered claim, relying on the maxim that the "duty to defend is broader than the duty to indemnify" (a tenet of insurance law that is often misused and misunderstood by both policyholders and the Courts).

The decision should confirm that for years when an insured bears the risk, it bears not only the *pro rata* portion of indemnity costs for those years, but also its *pro rata* allocable share of defense costs.

In New Jersey, the question as to how to allocate defense costs for years where the Absolute Pollution Exclusion applies (generally, 1985 or 1986 and later) was recently addressed by the Appellate Division in Champion Dyeing & Finishing Co. v. Continental Ins. Co., 355 N.J. Super. 262 (App. Div. 2002). The Appellate Division clarified the holding in Owens-Illinois and found that in years when coverage was disclaimed based upon the Absolute Pollution Exclusion, the insured could be responsible for its allocable share of defense and indemnity costs if insurance coverage such as Environmental Impairment Liability coverage, was available. The Court held that a decision not to purchase such insurance is tantamount to a decision to assume the risk. Under such circumstances, the insured will bear a *pro rata* allocation of defense costs for such uninsured periods. The inquiry as to whether the coverage was available will be objective so an insurer need not prove that a particular insured actually knew about the availability of such coverage. Champion Dyeing v. Continental Ins., 355 N.J. Super. 262 (App. Div. 2002).

EXPECTED AND INTENDED

THE DECISION:

The Appellate Court of Ohio addressed the “expected and intended” exclusion in the context of a workplace exposure case and found for the insurance company. Altwater v. Ohio Cas. Ins. Co., 2003 Ohio App. LEXIS 4296 (2003).

THE FACTS:

Plaintiff died from chronic obstructive pulmonary disease, a disease related to his exposure to silica dust in the workplace. The employer sought coverage for the claim under a CGL policy which was denied based on the “expected and intended” exclusion.

The Court, in deciding in favor of the insurer, found that proof of the insured’s actual intent to injure was not required for coverage to be precluded under the exclusion. Instead, the Court found that where the insured knew of a “substantial certainty” that harm would occur, the intent to harm will be inferred as a matter of law, thereby triggering the exclusion.

THE IMPORTANCE OF THIS DECISION:

Many courts, including those in New Jersey, require proof of a subjective intent to cause the actual injury or property damage for which coverage is sought, a high standard that is not easily met. An exception in New Jersey is allowed where the conduct of the insured is so “reprehensible” that the intent to harm may be inferred and will be the subject of an objective analysis. Voorhees v. Preferred Mut. Ins. Co., 128 N.J. 165 (1992). Even for seemingly reprehensible acts, the result is anything but predictable. See, e.g., Cumberland Mut. Fire Ins. v. Dahl, 362 N.J. Super. 91 (App. Div.), certif. denied, 178 N.J. 250 (2003) (stating that premeditated and carefully planned murder where actor’s judgment was clouded by some mental condition was not necessarily an intentional act for purposes of the exclusion).

The Ohio Appellate Court has taken the objective standard one step further, requiring not “reprehensible” conduct, but only a “substantial certainty” that harm would occur, at least in the workplace.

PROPERTY DAMAGE (COMPUTER SOFTWARE)

THE DECISION:

The Fourth Circuit Court of Appeals found that software defects and resulting computer malfunctions do not qualify as “property damage”. America Online, Inc. v. St. Paul Mercury Ins. Co., 347 F.3d 89 (4th Cir. 2003).

THE FACTS:

America Online sought insurance coverage for a series of class actions which alleged that its internet access software had defects which, in turn, caused damage to users’ existing software, operating systems and stored data. Its insurer denied coverage, asserting that the claims did not allege damage to tangible property.

The Court found that such damage did not constitute “physical damage to tangible property” and found for the insurer. The Court found that damage to data and software was more akin to damage to ideas, logic, instructions and information which do not qualify as “property damage”. The Court noted that damage to circuits, drives or other physical components of computer hardware, would be covered.

THE IMPORTANCE OF THIS DECISION:

With computer related litigation likely to grow as businesses and individuals become more reliant on electronic data storage and manipulation, insurers and policyholders would be wise to examine their insurance coverage for computer-related losses. Some policy forms specifically aver that “electronic data” is NOT tangible property. Other policy forms specifically exclude coverage for “Certain Computer-Related Losses”.

Notwithstanding the decision of the Fourth Circuit, absent clear exclusionary language, the definition of “tangible property” is sufficiently vague when applied to computer related losses to guarantee continuing litigation.

D&O COVERAGE
SARBANES-OXLEY ACT OF 2002

A treatise could be written about the impact and potential impact of the Sarbanes-Oxley Act of 2002 (“SOX” or the “Act”) on Directors and Officers (“D&O”) coverage. The following will only present a cursory overview.

THE REQUIREMENTS OF THE ACT

SOX imposes new responsibilities on directors and officers, changed reporting requirements and requires corporations to change the way they maintain records. It requires enhanced and more open public disclosures, mandatory CFO and CEO certification of financial statements, and establishes penalties and crimes for violation of the Act’s requirements. Outside directors and advisors, including law firms, face potential liability for fraud claims under federal securities laws. With these increased responsibilities and requirements, there will almost certainly be an increase in claims against directors and officers. The increased reporting requirements and strictures will create a road map for the plaintiffs’ bar pursuing litigation. SOX also gives the SEC broad powers to bring various administrative proceeding which will also trigger litigation.

THE IMPACT OF THE ACT ON COVERAGE

Directors and officers are facing increasing claims and exposures in what can be best described as a hostile environment. Even before the scandals of Enron, WorldCom, Adelphia and others surfaced and even before the passage of SOX, D&O insurance premiums were on the rise. Insurers offering D&O coverage have sought to limit exposure and losses, often through limits management. With the recent passage of SOX, premiums continue to rise. It should be noted that it is not just the books and records of large corporations that have come under tough scrutiny. Mid-market corporations are becoming increasingly the subject of securities litigation.

Bankruptcy may also operate to eliminate coverage for directors and officers. Some bankruptcy courts consider a D&O policy to be an asset of the company to be distributed among the creditors, thus barring the directors and officers from using the policy to pay defense costs.

D&O liability insurance generally covers claims against directors and officers for “wrongful acts” or omissions committed concomitantly as part of their duties. Unlike CGL policies, D&O policies may provide coverage for intentional acts or misconduct. Punitive or exemplary damages generally are not covered. D&O policies typically do not cover the corporation itself for direct claims or claims based on *respondeat superior*. As a general rule, coverage is afforded on a claims made basis.

There are generally four categories of exclusions in a D&O policy. The first is conduct exclusions which eliminate coverage for egregious wrongdoing or conduct such as fraud, dishonesty, illegal personal gains, etc. (Some policies require a final adjudication and finding of fraud before coverage is eliminated. Absent such a final adjudication, the exclusion does not apply. Insurers understandably prefer “in fact” language which allows them to make the determination of fraud.) The second category of exclusions applies to losses which are covered by other available insurance such as ERISA claims (typically covered under a fiduciary policy), and environmental, bodily injury and property damage claims (typically

covered under a general liability policy). The third category of exclusions applies to claims by one insured against another insured. The fourth category of exclusions precludes coverage for directors and officers for claims brought by regulatory agencies. Some courts have refused to enforce these types of exclusions, finding that they contravene public policy.

SOX places an increased emphasis on individual conduct. Accordingly, the first category of exclusions, those dealing with fraud, dishonesty and illegal profit, will be more important and the subject of dispute and litigation.

ONE LIKELY SCENARIO

SOX will likely lead to an increase in rescission actions. There are several reasons for this. First, rescission, if successful, allows a carrier to quickly divorce itself from what may be a very bad situation. Second, certifications regarding financials are often made a part of the insurance application. To the extent that there were misstatements in the applications, renewal applications and supporting financials, carriers may rescind or disclaim coverage. It will not go unnoticed by insurers that there has been a record rise in restatements of financial statements in recent years. Rescission does not require an intent to deceive, a mere false statement regarding a material fact upon which the insurer relied is grounds for rescission. Furthermore, the insurer has no obligation to investigate the truthfulness of the information provided as part of the application process, but must rescind as soon as practicable after learning of facts justifying rescission. Ledley v. William Penn Life Ins. Co., 138 N.J. 627 (1995); Palisades Safety & Ins. Ass'n v. Bastien, 344 N.J. Super. 319 (App.Div. 2001), aff'd, 175 N.J. 144 (2003). At least two of Enron's D&O carriers have disclaimed coverage based upon the company's financial misstatements.

The issue as to whether coverage for all can be rescinded because of the misrepresentation of one was addressed in First American Title Ins. Co. v. Lawson, 351 N.J. Super. 407 (App. Div. 2003), where the Appellate Division held that where a partner acting on behalf of his law firm made a misrepresentation on the application for insurance, coverage could be rescinded for the entire firm, including innocent partners. The Supreme Court reversed, in part, finding coverage could not be rescinded as to the innocent partner. Coverage was properly rescinded as to the defalcating partners and the firm. 175 N.J. 125 (2003). Obviously there are devils in the details.

D&O policies contain language regarding severability which addresses whether coverage for innocent officers and directors may be disclaimed or rescinded because of the wrongdoings of others. Some policies state that, with regard to applications, knowledge possessed by one insured will not be imputed to another insured. Some policies include language that knowledge of the CEO or CFO shall be imputed to all insureds. Insureds would be well advised to review their policies to determine whether they contain a severability clause.

The Sarbanes-Oxley Act of 2002, as well as the headlines and corporate scandals of the past several years, have dramatically changed the landscape for both insureds and insurers. Both groups

would be well advised to closely examine their risks and exposures to develop a cogent plan for what promises to be a bumpy ride.

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