WHAT HOSPITALITY LAWYERS NEED TO KNOW ABOUT INSURANCE

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David E. Wood specializes in insurance policy enforcement under business insurance programs, devoting his practice to evaluating business insurance claims and prosecuting insurance recovery litigation. He graduated from Williams College in 1979 with an A.B. degree *cum laude*, and received his Juris Doctor degree from the University of California, Hastings College of Law in 1985.

Practice Summary

The policyholders Mr. Wood typically serves include *Fortune 1000* corporations and corporate directors and officers, with special emphasis on construction, financial services and technology risks. Representative clients include Turner Construction Company, Ford Motor Credit, Granite Construction Incorporated, Insight Enterprises, Inc., East-West Bank and Computer Sciences Corporation in the United States, and Aecon Group, Inc. in Canada.

Professional Honors

Mr. Wood holds the "AV" rating for professional skill and ethics conferred by *Martindale-Hubbell*. Chosen by 60,000 of his peers, and based on the independent research of *Law and Politics* magazine, he was named one of the top Southern California lawyers in 2007.

Professional Activities

Mr. Wood is quoted frequently in national media on significant insurance matters including *CNBC* Television (November 5, 2005, insurance broker liability), *Bloomberg* Radio (September 27, 2002, World Trade Center coverage litigation), *USA Today* (June 15, 2002, insurance recovery*), Financial Week* (October 26, 2008, federal regulation of the insurance industry), *Forbes* (November 15, 2004, contingent commission scandal at Marsh), and *Forbes.com* (June 14, 2007, insurance recovery trends). Mr. Wood is a frequent speaker before professional organizations like the Association of Corporate Counsel, the Society of Corporate Secretaries and Governance Professionals, Mealey's, the International Risk Management Institute, the Risk & Insurance Management Society, and the Center for International Legal Studies.

Professional Publications

Mr. Wood has published articles for trade and legal publications including *D&O Advisor, The John Liner Review, The National Law Journal, Risk Management Magazine, California Lawyer,* San Francisco *Recorder,* and *Risk & Insurance Magazine,* to name but a few.

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I. INTRODUCTION

The risks faced by the hospitality industry are difficult to quantify because so many of them are unique to each business and business model. For example, a public company operating casinos in Las Vegas and Macau has a vastly different risk profile than a private company operating casual diners in the Mid-Atlantic region. But notwithstanding these differences, many companies confront similar threads of risk.

A frequent topic for discussion among almost all hospitality companies is the risk associated with food, beverage and premises liability. Most hospitality companies also face a disproportionate amount of employment-related risks, either in the form of wage and hour, harassment or discrimination related claims. Companies engaged in property development also face construction-related risks such as claims for delay, business interruption, property damage or bodily injury. As the economic cycle turns, the potential for loss associated with these risks increases: a higher ratio of alcohol to food sales means more alcohol-related liability; more lay-offs and fewer opportunities for laid-off employees means more employment-related liability; financing problems and contractor defaults mean more development liability.

Other risks threatening hospitality companies have been exacerbated by the rapid and dramatic downward shift in the economy in recent months. Management liability in the insolvency context is a risk few officers and directors considered this time last year. Lawsuits and government investigations surrounding declines in stock values are also far more prevalent now. As cash becomes tight for everyone during down-cycles, employee fraud and theft is both perpetrated and discovered at higher rates. Hospitality lawyers should expect to see more of these types of claims in the future.

The severe market dislocations of the past year are also changing the insurance market. The biggest news on this front is the near-failure and government bailout of AIG, the world's largest insurer. Many other significant insurers have posted large losses in recent quarters as a result of bad investments and increased claims payouts. Conventional wisdom suggests that these losses would result in a sharp hardening of the insurance market, with increased premiums, tightened policy terms and an increased rate of claim delays or denials. However, although some reports indicate a tightening, other reports indicate the opposite – the insurance market is remaining soft on account of a fight for AIG's market share and general deflationary trends.

As the insurance market floats in uncertainty, the operating environment for hospitality companies is unequivocally challenging. Competition is up, restaurant sales are down, occupancy rates are declining and lenders are withdrawing credit from the market. Scaled back development, store closures, stock declines and general downsizing are resulting in a spate of hospitality company disputes with lenders, builders, landlords, tenants, employees and shareholders. As margins tighten across the board, careful buying of new insurance and utilization of existing insurance can mean the difference between remaining profitable or succumbing to the unprecedented challenges of today's market.

This is not a Chicken Little scenario – most hospitality companies carry insurance for these risks. However, maintaining the right type of coverage – although obviously a very important first step – is in many cases insufficient to fully protect companies.

First, quality of coverage matters greatly, as policies of all types vary from policy to policy. Stated differently, insurance policies should not be viewed as commodities, as differing terms change dramatically the effective scope of coverage provided.

Second, once a company has the right types of high-quality coverage, there must also be proper execution to maximize the value of those insurance assets. To this end, it is important that all players – from the front-line management to corporate office risk managers to outside counsel – understand the importance of insurance and their role in ensuring that the appropriate steps are taken when a covered risk presents itself.

This article addresses some of the insurance-related issues and common pitfalls that arise in the context of the hospitality industry. It is intended as a summary to allow companies and their outside lawyers to identify issues for implementing appropriate insurance-related practices and procedures. Insurance is a highly specialized area and companies should consult their experienced commercial insurance broker or outside insurance counsel with specific questions.

II. INSURING HOSPITALITY INDUSTRY RISKS

A. Food, Beverage & Premises Liability

Hospitality companies face food, beverage and premises liability claims as a matter of course. These claims are largely unavoidable, even with the most prudent of operations. Most frequently, these claims involve relatively minor bodily injuries to customers from "slip and fall" accidents, inadvertent objects or material in food, or alcohol-related intentional torts. Occasionally, these types of risks will result in very serious injury or death to customers. Less frequently yet, hospitality companies will be involved in large-scale tragedies such as hotel or venue fires, in which case large numbers of claimants have been injured and the collective damages are high.

These types of risks generally do not give rise to difficult insurance issues, as they are risks well within the contemplation of the parties and occur frequently enough that the parties quickly identify and work out drafting problems. Further, in most cases, these risks are clearly within the scope of coverage under commercial general liability policies barring allegations of particularly egregious, intentional conduct on the part of the insured. There are, however, some caveats.

Most notably, most standard form commercial general liability policies issued hospitality companies contain an exclusion for alcohol-related liability. For this reason, most companies buy enhanced coverage specifically covering that risk. The coverage available under these endorsements or separate policies is typically subject to a sublimit in the primary policy, which in some cases can be significantly lower than the amount of coverage available for other risks. Umbrella policies are frequently intended to backfill against liability in excess of the alcohol-related sublimit.

However, umbrella carriers are frequently reluctant to "step down" to cover such risk, either because the language requiring that is not clear or when other insurance – such as the homeowner's or auto policy of the primary tortfeasor – is potentially available to cover the risk. In many cases these inter-insurer disputes harm the insured, in that they prolong litigation, increase overall defense costs and increase the risk that a bad case makes it to a trial in which a large adverse judgment is awarded.

Inter-insurer disputes also frequently occur when a significant bodily injury claim involves multiple defendants. For example, hotels frequently require convention exhibitors to execute indemnity agreements and add the hotel as an additional insured under the exhibitor's insurance policies. If the staging from a temporary exhibit falls and injures attendees, the hotel should in theory be protected from liability by both the indemnity agreement and exhibitor's insurance. In practice, however, the exhibitor's insurer will point out the often less than clear contract language to demand that the hotel's insurer provide primary insurance to the hotel, resulting in increased losses for the hotel or its insurer.

In many cases inter-insurer disputes result from a lack of attention to "other insurance" clauses. For example, because the standard "excess only" language is included in almost every commercial general liability policy, the competing clauses will often cancel each other out and require the insurers to both pay in contribution to the loss. *See, e.g.,* Lumbermens Mut. Cas. Co. v. Allstate Ins. Co., 51 N.Y.2d 651, 656-657 (1980); Carmel Development Co. v. RLI Ins. Co. (2005) 126 Cal.App.4th 502, 513-514. However, through proper structuring of the underlying contractual insurance and indemnity provisions the risk of inter-insurer disputes can be minimized, as – in aggregate – the various provisions clearly allocate to one insurer the primary coverage obligation. *See, e.g.,* Nat'l Union Fire Ins. Co. v. Landmark Am. Ins. Co., 2006 U.S.Dist.LEXIS 68485, *9-10 (N.D. Cal., September 13, 2006).

B. Employment-Related Liability

Hospitality companies tend to be involved in employment practices liability suits more frequently than businesses of similar sizes in other industries. This enhanced risk is often attributed to the nature of the business and characteristics of employees. Namely, hospitality companies actively seek to recruit friendly and outgoing people, who often work in a social environment. Add to that late hours, friendly interaction with patrons and after-work socializing by employees, all of which is often mixed with alcohol consumption, and it does not take a wild imagination to realize the potential for employment-related liability claims. In addition to workplace claims brought about by the uniqueness of the hospitality business, there are also the general employment issues all businesses face such as improper classification claims, wage and hour claims and claims brought about by broad reductions in the workforce.

Employment practices liability policies ("EPLI") are the primary source of coverage for these types of risks. Unfortunately, EPLI coverage is typically not well understood, primarily because it is subject to tremendous variations in the scope of coverage offered from one insurer to the next. For example, most policies are written with a duty to defend, yet others provide that the insured retains control of the defense. Almost all provide for defense costs within limits, i.e., so

called burning-limits policies. Most EPLI policies contain exclusions for claims alleging violations of wage-and-hour laws, unpaid compensation or benefits due, but a significant portion of EPLI policies will provide defense costs coverage for those claims subject to a separate sublimit. These differences, which represent only a few of the ways in which polices can vary, can result in very significant differences in the effective amount of coverage available should an employment claim be filed.

1. Coverage For Wage-And-Hour Claims

Traditionally, insurers offered liability coverage for discrimination actions but not wage-and-hour suits. That has changed over the recent years, with more carriers providing defense costs coverage for claims alleging violations of wage-and-hour laws while still providing full coverage for discrimination claims. However, while the distinction makes sense from an economic perspective (insurers do not believe they should pay what is tantamount to unpaid employee compensation), real world employment lawsuits frequently blur the line.

Plaintiffs attorneys are financially incentivized to bring, whenever possible, class litigation. A frequently employed strategy is to use small, individual claims as gateway litigation to discover facts which might support a subsequent class action. Consistent with this is the tactic of making broad and varied allegations and claims, aimed primarily at increasing the scope of potentially discoverable information. This often leads to wage-and-hour claims being added to what otherwise might be a pure discrimination or wrongful termination suit. Mixed actions involving covered claims (e.g., discrimination or wrongful termination) and non-covered claims (e.g., wage-and-hour) frequently lead to substantial and often expensive coverage disputes.

Relying on exclusions for wage-and-hour claims, insurers will often take the position that the wage-and-hour claims are predominant and the claim is not covered. Although case law addressing these issues in the context of EPLI coverage is scant (*see, e.g.*, SWH Corp. v. Select Ins. Co. (2006) 2006 Cal. App. Unpub. LEXIS 8694 [not certified for publication]), it is well established in many jurisdictions that the presence of an excluded risk, even if that risk predominates, does not preclude defense costs coverage for third-party suits. *See, e.g.*, Liberty Mut. Ins. Co. v. Metro Life Ins. Co., 260 F.3d 54 (1st Cir. 2001) Krusinski Constr. Co. v. Northbrook Prop. & Cas. Ins. Co., 326 Ill.App.3d 210 (2001); Palermo v. Fireman's Fund Ins. Co., 42 Mass.App.Ct. 283 (1997); Horace Mann Ins. Co. v. Barbara B. (1993) 4 Cal.4th 1076.

Alternatively, insurers will focus on the wage-and-hour claims and insist on an allocation of defense costs between those incurred in connection with the covered versus allegedly non-covered claims. Although allocations on a current basis might be appropriate where the insured is controlling its own defense, they generally are not permissible when the policy contains a duty to defend. *See, e.g.*, Raychem Corp. v. Federal Ins. Co., 853 F.Supp. 1170 (N.D. Cal 1994); Commer. Capital Bankcorp, Inc. v. St. Paul Mercury Ins. Co., 419 F.Supp.2d 1173 (C.D. Cal. 2006); SL Indus., Inc. v. Am. Motorists Ins. Co., 128 N.J. 188 (N.J. 1992); Shoshone First Bank v. Pac. Employers Ins. Co., 2 P.3d 510 (Wyo. 2000); Riley Stoker Corp. v. Fidelity & Guar. Ins. Underwriters, 26 F.3d 581 (5th Cir. 1994); Buss v. Superior Court (1997) 16 Cal.4th 35 [addressing, generally, the right to allocation (or lack thereof) in a variety of factual contexts].

Tensions concerning the mixed character of an action typically persist throughout the pendency of the underlying case, and become particularly acute as the case nears trial. If they believe the only potential for significant liability is on non-covered wage-and-hour claims, insurers will often refuse to contribute significant funds to a settlement and push the case towards trial. Insureds, on the other hand, frequently want to resolve the litigation with as much of the settlement allocated to the covered portion of the risk.

The ability of the insured to resolve this tension depends on numerous factors, principally whether the insured is in control of the litigation. When the policy does not contain a duty to defend, and the insured is represented by counsel of its own choosing, the insured can often structure the facts and settlement to maximize the portion allocable to covered loss. However, when the insurer is controlling the defense with counsel appointed by the insurer, it becomes more difficult to resolve the litigation on terms favorable to the insured. Many jurisdictions – including California, Illinois, New York, and Florida – provide some right for the insured to retain independent counsel, which in many cases can tip the balance of power in the insured's favor. San Diego Federal Credit Union v. Cumis Ins. Soc'y, Inc. (1984) 162 Cal. App. 3d 358; Maryland Mut. Cas. Co. v. Peppers, 355 N.E.2d 24 (Ill. 1976); New York State Urban Dev. Corp. v. VSL Corp., 738 F.2d 61 (2nd Cir. 1984); Nationwide Mut. Fire Ins. Co. v. Beville, 825 So.2d 999 (Fla. 4th Dist. Ct. App. 2002).

In those states which do not provide a right to independent counsel, like Washington and Hawaii, or where the right to independent counsel has not been addressed, like Nevada, the insured typically must rely on the insurer and insurer-appointed defense counsel to fulfill their respective obligations to the insured or resort to the various post-litigation remedies. Tank v. State Farm Fire and Cas. Co., 715 P.2d 1133 (Wash. 1986); Finley v. Home Ins. Co., 975 P.2d 1145 (Haw. 1998).

2. Claims-Made-And-Reported Issues.

For the hospitality lawyer, however, the single most important aspect of EPLI coverage to understand is that it is almost always, if not always, written on a claims-made-and-reported basis. As the name implies, claims-made-and-reported policies generally require that the third-party claim be made against the policyholder and reported to the insurer within the policy period. The failure to timely report a claim or pre-claim circumstances can, and frequently does, result in a loss of coverage for the insured.

The concept of claims-made-and-reported policies, as outlined above, is relatively simple – the insured gets sued and reports it during the policy year, and the claim is covered. Unfortunately, it often times is more complex. There are several ways by which an insurer attempts to effectuate its intent to only cover claims made-and-reported during the policy period:

1) EPLI insuring agreements typically provide that coverage is available only for claims first made and reported during the policy year, which in most circumstances is a one-year period. Related claims will typically be aggregated and treated as a single claim made or reported at the time the earliest related claim

was made or reported. The defined scope of the terms "claim" and "related claim" varies significantly between policy forms.

2) EPLI policies will almost always contain an exclusion barring coverage for prior claims. These exclusions vary significantly, with some policies excluding coverage for claims made against the insured in prior policy periods while others bar coverage only for claims reported by the insured in prior policy periods. Related claims are typically aggregated and treated as a single claim for purposes of these exclusions.

3) EPLI policies will almost always contain an exclusion or otherwise limit coverage for actual or alleged wrongful acts which pre-date a specified "retroactive date," which is usually the date from which the insured first procured and continuously maintained EPLI coverage. Under these provisions, a claim first-made-and-reported during the policy period will not be covered if the alleged wrongful acts pre-date the retroactive date.

4) EPLI policies will almost have various provisions concerning pre-claim circumstances, i.e., some act, fact or circumstance which could give rise to a claim in the future. Most policies will ***allow*** for the reporting of pre-claim circumstances, such that if a claim later arises from those circumstances it will be subject to coverage under the policy period in which notice of the pre-claim circumstances were provided. However, other policies will ***require*** reporting of pre-claim circumstances and also exclude coverage for pre-claim circumstances known by the insured before the inception of the policy. This can be express or by defining "claim" so broadly as to include what might ordinarily be considered pre-claim circumstances.

5) Prior to binding coverage, EPLI insurers will request that the insured "laundry list" all known claims or acts, facts and circumstances which give rise to a claim. The insurer will then issue the EPLI policy with a specific exclusion for all listed items and a general exclusion for all unlisted items known by the insured but not disclosed.

Coverage disputes frequently arise from the myriad interactions between the above provisions. A very common fact pattern giving rise to an EPLI coverage dispute is when an appreciably long time period elapses between an employment dispute and the filing of a lawsuit.

For example, an employee complains of on-the-job harassment by a co-worker. Management believes the alleged harassment is frivolous, but diligently responds and takes preventative measures. The preventative measures fail and the alleged harassment continues, but the employee remains quiet until six months later. At this point, the employee refuses to return to work, citing the allegedly hostile work environment. Management offers to transfer the employee or make other accommodations, but to no avail – the employee only wants a severance package, the demand for which is communicated in an email. Management still regards as frivolous the alleged harassment, does not believe severance is due and eventually terminates the

employee for failing to report to work. Nothing happens for another nine months, at which point the now-former employee sues the employer.

From an insurance perspective, at the time suit is actually filed it has been fifteen months since the employer first became aware of pre-claim circumstances and at least nine months since the claim was first made, possibly longer depending on how broadly "claim" is defined. When the employer requests coverage for the lawsuit under its current and expired EPLI policies, both insurers decline coverage. The claim is declined under the expired policy on grounds that the claim was not ***reported*** during that policy period, while it is declined under the current policy because it was not ***made*** during that policy period.

The conventional response to avoid these problems is to report all pre-claim circumstances, which many insureds are reluctant to do out of concern for over-reporting of claims. Typically, however, the risk associated with not reporting a potential claim and losing coverage outweighs the risk of over-reporting and facing higher premiums.

C. Development Liability

In recent years hospitality companies have become active in property development, capitalizing on favorable capital market trends and consumer demand for luxury resorts, hybrid developments and condominium-hotels. These projects were structured in a wide variety of ways, with hospitality companies sitting in a range of capacities including project owners, developers, joint-venture partners, property managers, landlords, lessees and sales agents. The specific contracting structures utilized also varied greatly as compared to prior development cycles, with some projects bid under a traditional general contractor and architect structure, others with a contractor or architect-led design-build structure, and others still with a multi-prime structure.

Although each particular project and contracting structure presents different challenges with respect to risk transfer and management, the fundamental insurance and contractual risk transfer issues remain fairly constant. Project development liability typically involves three types of risk, which are not necessarily mutually exclusive:

1) Property loss during the construction phase, which traditionally is regarded as subject to coverage under builder's risk policies;

2) Property damage and bodily injury both during and after construction, which traditionally is regarded as subject to coverage under commercial general liability policies; and

3) Damages resulting from a delay in completion, which could be covered under professional liability policies, if available, or commercial general liability policies, if there is a property damage or bodily injury component to the delay.

All of the above risks are typically transferred *via* contractual indemnity provisions from the owner, developer, contractor or other up-contract party to down-contract parties like

subcontractors. Down-contract counter-party risk frequently diminishes the value of contractual indemnification. To help offset this risk, subcontractors historically were required to provide surety bonds providing up-contract parties from protection against payment or completion defaults. Market changes have diminished the use of surety bonds on private projects bid in the past eight years, resulting in enhanced risk from contractor defaults.

A second tool frequently used to limit the counter-party risk is additional insured endorsements, under which the owner, developer or contractor will be added as an insured under the contractor or subcontractor's insurance policy. These typically are available only for commercial general liability policies and builder's risk policies, and therefore typically provide coverage only for property loss, property damage and bodily injury. Occasionally, contracts will require that design-team members add as insureds under their professional liability policies the owner, developer or contractor. While this can add some protection for frequently uninsured delay-related risks, exclusions barring coverage for a suit by one insured against another can prevent the aggrieved party from recovering funds under the design-team member's professional liability policy.

Even when parties properly structure contractual indemnity agreements and insurance provisions, inter-insurer disputes are common. Take, for example, a hypothetical hospitality company that acts as a developer and operator of a condominium-hotel. Per the construction documents, the hospitality company is to be broadly indemnified by and added as an additional insured under the insurance policies of the contractor, designer and all subcontractors.

After the condominium portion of the development is sold, it is discovered that a deficiency in the glass and steel curtain wall permits rain entry and causes damage to the units. The condominium owners sue the hospitality company, who in turn seeks defense and indemnity from the construction team and their insurers. The construction team, in whole or in part, disclaims responsibility, a position usually advanced by insurance defense counsel appointed by their insurers.

On the coverage claim, the construction team's insurers also stonewall the developer, asserting a variety of defenses ranging from a lack of completed operations coverage to a purported lack of evidence demonstrating wrongdoing on the part of their insured. In these situations, the hospitality company and its insurer end up wedged between the plaintiffs and the construction team, incurring significant legal fees simultaneously defending and prosecuting claims.

Seeking to avoid the scenario outlined above, many projects now utilize wrap insurance, which is intended to cover under a single insurance program the entire project and all interested parties. This insurance program can be procured and controlled by the owner (owner controlled insurance program, or OCIP) or the contractor (contractor controlled insurance program, or CCIP). Either way, wrap policies are intended to foster cooperation among the implicated parties, as there is supposed to be less incentive to push blame to other parties and their separate insurers.

This, however, is not always the case. Even when there is an OCIP or CCIP in place, most parties involved in the project still maintain their own portfolio of insurance policies. Disputes

frequently arise between wrap and portfolio insurers about which policy or policies were intended to be primary, the result of which being that neither will pay to get the case settled.

A final development coverage issue worth mentioning is that raised by recent suits alleging various misrepresentations in the sales of units in condominium-hotels, most notably in Las Vegas. Commercial general liability policies provide coverage for – in addition to bodily injury and property damage – personal injury and advertising injury. The latter two prongs might, in certain circumstances and under certain policies, provide coverage for these types of actions. Hospitality companies involved in suits such as this should carefully screen their CGL policies and plaintiffs' allegations for any language or facts that might create a potential for coverage.

D. Management Liability In The Insolvency Context

Recent experience suggests that the individual directors and officers of a bankrupt company face unprecedented risks of liability. Bankruptcy trustees, stakeholder committees and government agencies have become increasingly active in post-petition proceedings against directors, officers and any other party perceived as responsible for the company's failure or reorganization. Directors & Officers liability insurance ("D&O") is the principal source of protection for a company's former directors and officers. This is because, with the possibility of corporate indemnification foreclosed in most cases by the bankruptcy filing, the former directors and officers risk the loss of personal assets in the event D&O coverage does not apply. When a company voluntarily enters or is forced into bankruptcy, usually it is no longer allowed to indemnify its officers and directors for their personal exposure to losses suffered while performing their duties (even if it had the financial ability to do so).

Modern D&O policies typically contain at least three kinds of coverage:

1) "Side A" coverage, which provides liability coverage payable directly to the individual insureds for covered claims when indemnification is not permitted or not available due to insolvency. Side A covers only the liabilities of directors and officers – it does not cover liabilities of the corporation.

2) "Side B" coverage, which reimburses the insured entity for loss incurred fulfilling its indemnification obligations to individual insureds. Side B covers the corporation only to the extent that it indemnifies directors and officers for their liabilities. It does not cover the corporation's own liabilities – only those of the officers and directors.

3) "Side C" coverage, which provides direct coverage to the insured entity for its own wrongful acts. Entity coverage is typically limited to "securities claims" in policies issued to public companies, but it is often broader in policies issued to private companies or non-profit organizations. Side C does not cover securities claim liabilities of the directors or officers. They receive this coverage under Side A and Side B.

When a company enters bankruptcy, all litigation against it (and performance of certain obligations) is automatically stayed under the Bankruptcy Code. The idea is to preserve any pending claims against "property of the estate" of the bankrupt corporation. The Bankruptcy Code defines "property of the estate" broadly, as "all legal and equitable interests of the debtor in property as of the commencement of the case." The automatic stay protects the debtor and creditors from the dissipation of estate property.

In many cases, distressed companies and their directors and officers are already involved in litigation at the time the company enters bankruptcy. The automatic stay precludes further action against the entity, but in most cases has little direct impact on the directors and officers against whom the litigation is proceeding. When the directors and officers seek post-petition coverage under Side A of the company's D&O policy, those efforts may be opposed by the bankruptcy trustee, debtor-in-possession, creditors, or other parties looking to preserve the policy limits for their own claims. Often times, insurers themselves will attempt to use the bankruptcy proceedings to justify a delay or withholding of payments under the D&O policy. In most cases the interested parties will argue that, because the D&O policy and its proceeds are "property of the estate," the automatic stay precludes the insurer from advancing or paying policy proceeds to insureds or underlying claimants.

After an insured entity enters bankruptcy, individual insureds' requests that the insurer provide coverage under Side A present two issues: (1) whether the automatic stay bars insurers from making payments to or on the behalf of individual insureds; and (2) if so, whether reasons exist for the court to lift the stay to allow coverage for the directors and officers.

The first involves analysis of whether the policy proceeds (as distinguished from the policy itself, which almost always is considered an asset of the estate) are an asset of the estate. Although courts have not adopted a uniform approach, there appears to be an emerging consensus that, under typical factual circumstances, the bankrupt entity has no actual interest in the D&O policy proceeds because its exposure for direct or indemnification claims was hypothetical. The following guidelines were offered by the court in In re Allied Digital Tech. Corp., 306 B.R. 505, 511-512 (Bankr. D. Del. 2004):

1) When the policy provides only direct coverage to a debtor under Side C, the proceeds of the policy are property of the estate;

2) When the policy provides only direct coverage to individual insureds under Side A, the proceeds are not property of the estate;

3) When the policy provides direct coverage to individual insureds under Side A, and indemnification coverage under Side B or direct coverage under Side C to the bankrupt entity, the proceeds are property of the estate "if depletion of the proceeds would have an adverse effect on the estate to the extent the policy actually protects the estate's other assets from diminution" by providing indemnification coverage for a pending claim; and

4) When the policy provides the entity with coverage under Side B or Side C, but the covered loss "either has not occurred, is hypothetical, or speculative," the proceeds are not property of the bankruptcy estate.

Even if the court determines that D&O policy proceeds are property of the estate, the court can lift the automatic stay to permit the insurer to provide coverage under Side A. The disparate factual circumstances impacting this analysis are vast, but typically the courts attempt to balance (where possible) the competing interests of the individual insureds who have a right to the protection afforded them by their D&O policies and those of the bankruptcy representative who seeks to preserve the assets of the estate.

However, the mere availability of insurance coverage to individual insureds under applicable bankruptcy law does not guarantee that coverage will be afforded those persons. Often times the nature of the claims being asserted against the former directors and officers create coverage issues, especially when being asserted by the bankruptcy trustee or debtor-in-possession.

Claims against former directors and officers of a bankrupt company – the claims for which coverage is sought – will almost invariably involve allegations of intentional conduct such as fraud and will seek relief in the form of disgorgement of allegedly ill-gotten gains. Insurers will often take the position that these claims are either not covered in the first instance, or specifically barred from coverage under the so-called conduct exclusions. If these claims are asserted by a bankruptcy trustee or the debtor-in-possession, insurers will often argue that coverage is barred under the "insured v. insured" exclusion. If the above-cited coverage issues do not entirely defeat coverage, insurers typically will selectively decline coverage for the purportedly non-covered claims, and propose a method for "allocating" fees, costs and settlements incurred in connection with the covered and non-covered claims, respectively.

Where an insurer that successfully allocates part of the loss to the insureds, this means it has just shifted some portion of the cost of defending and settling a lawsuit back to the individual directors and officers – a catastrophe for them, which the company almost certainly never intended when it bought the D&O policy pre-petition. A company can work through challenging economic times only if it has well-protected officers and directors. Planning for and avoiding such a calamity as post-petition allocation is a *sine qua non* to attracting and keeping capable management and Board members.

E. Public Company Liability

Public hospitality companies generally face the traditional risks being a listed company carries. Securities-related litigation typically is at the top of the list for public company risks. Government investigations and proceedings are also a serious risk, especially considering that we are at the leading edge of what many believe will be increased regulatory activity in the coming years. A third common source of public company liability is litigation brought by employees under Employee Retirement Income Security Act (ERISA) or similar laws governing employee stock option plans. Indeed, stock-drop ERISA litigation has become an increasingly popular lawsuit vehicle for the plaintiffs' bar in recent years.

D&O and fiduciary liability insurance are the types of insurance intended to respond to these risks. Both types of policies vary widely with respect to policy terms and effective scopes of coverage, with seemingly slight variations in policy language resulting in dramatic swings in the available scope of coverage. Although there are numerous provisions which can impact coverage, the relative quality and usefulness of coverage often is a function of a core set of policy provisions, addressed as follows:

1. D&O Policies.

a. Definition of Claim

D&O policies typically provide coverage for "loss" arising from "claims" first made during the policy period against an "insured" for a "wrongful act," with each of these terms usually defined. As D&O insurers strive to meet the demands of the market, the types of matters for which coverage is provided has been expanded. This typically is reflected in the definition of "claim," which in recent years has been expanded from covering primarily civil lawsuits to also include government investigations, administrative proceedings and regulatory civil and criminal actions.

Many times a regulatory body such as the SEC will commence an investigation by requesting that the company turn over a large volume of documents. Companies, wishing to be cooperative and responsive, will in response commence an internal investigation and begin providing large volumes of documents. Legal fee burn-rates in connection with these investigations can easily run into the seven-figures per month range, as many companies implicated in the stock options backdating inquiries learned.

At a certain point in the informal investigation, the SEC will issue a formal order of investigation and concurrently subpoena a scope of documents similar to that previously requested. The investigation at this point is considered "formal," while prior to this point it was considered "informal" by most insurers. If the SEC decides to pursue the matter further, the next step is some form of enforcement action, at which point most insurers will agree that the matter is a "proceeding" in insurance vernacular.

Many D&O insurers define "claim" to include a "formal investigation" and "administrative or civil regulatory proceeding." Many companies believe that this provides coverage for the entire sequence of events outlined above. However, not all is always as it seems in the D&O insurance world. Take, for example, the following language from the definition of "claim" used by a particular insurer:

> Claim includes "a formal civil administrative or civil regulatory proceeding commenced by the filing of a notice of charges or similar document or by the entry of a formal order of investigation or similar document."

This language defines "Claim" to include a "proceeding," which includes a "proceeding commenced by . . . the entry of a formal order of investigation." The reference to a "proceeding . . . commenced by . . . the entry of a formal order of investigation" implies that a "formal

investigation" is also a "proceeding." However, the insurer which drafted this language has taken the opposite view, arguing that an "investigation" (whether formal or informal) is not a "proceeding" and coverage is available only for a "proceeding." Am. Ctr. for Int'l Labor Solidarity v. Fed. Ins. Co., 518 F. Supp. 2d 163 (D.D.C., 2007); Nat'l Stock Exch. v. Fed. Ins. Co., 2007 U.S. Dist. LEXIS 23876 (N.D. Ill. March 30, 2007). Although the insurer did not prevail on this argument in the courts, it represents how slight variations in policy language can mean the difference between a paid claim and litigation.

A second problem that frequently arises is the distinction between a "formal investigation," which is usually covered, and an "informal investigation," which is rarely covered. In the timeline outlined above, the distinction between when the investigation changed from informal to formal is largely artificial from the standpoint of the insured.

First, the insured was in the hot seat from the time it received the first communication from the SEC, irrespective of whether it was formal or informal. Second, the work done in connection with the informal investigation was identical in scope to the work done in connection with the formal investigation. Finally, on account of the degree to which investigative work is front-loaded, more fees were incurred during the time the investigation was informal than formal.

The ability of the insured to recover these purportedly pre-claim fees depends on a variety of factors, most importantly whether the policy provides – as some do – that "loss" does not include fees incurred in connection with a matter that was not yet a claim. Insureds need to closely scrutinize the definition of "claim" proposed by the insurer to ensure that they actually receive the scope of government investigation coverage intended.

b. Conduct Exclusions.

As addressed above, D&O policies typically provide coverage for "loss" arising from "claims" first made during the policy period against an "insured" for a "wrongful act." "Wrongful act" is typically defined broadly and encompasses about every type of imaginable conduct. All D&O policies will, however, exclude fraud or other intentionally wrongful conduct at least in part, with some policies providing no coverage for such claims and others providing coverage for "defense costs" incurred defending such claims. Further, all D&O policies will either not include, or specifically exclude, in whole or in part, coverage for claims alleging that an insured gained some benefit to which he or she was not entitled. The exclusions for fraud and improper benefits are often referred to as "conduct exclusions."

The specific language by which fraud or other intentionally wrongful conduct is excluded under a policy is critical to examine. Many policies exclude coverage for fraud, but only if and until there is an "actual adjudication" that the insured committed such acts. Express language to this effect has been watered down in many policies, with coverage excluded for fraud "in fact," which – while arguably requiring an "in fact" determination of fraud, thereby providing the same amount of coverage as the first example listed above – creates unnecessary ambiguity to the ultimate detriment of the policyholder. A third iteration of the fraud exclusion commonly found in D&O policies excludes coverage for any "actual or alleged" fraud, effectively acting as an absolute fraud exclusion. With the soft insurance market of recent years, it is less common for

the improper benefit exclusion to be issued with unfavorable "in fact" or "actual or alleged" language, but some policies do contain that language.

These distinctions may seem immaterial, but they are not. Whether a company has coverage requiring an "actual adjudication" of prohibited conduct (the first iteration, and the most favorable to the policyholder) often determines whether the insured or the insurer pays the bulk of the defense expenses in a costly lawsuit. It should be noted that, although defense costs coverage may be afforded for claims alleging excluded conduct, coverage is not available for an adverse judgment in or settlement of such claims unless it can be justified on a "cost of defense" basis.

Responding to the prevalence of "actual adjudication" language in recent D&O policies, insurers have adopted a different argument to obtain the same end. Most if not all policies except from the definition of "Loss" certain items of financial detriment, including ill-gotten gains or damages attributable to intentionally wrongful conduct. In other words, the same types of detriment excluded by the conduct exclusions, but for which defense cost coverage should apply. However, to circumvent the "actual adjudication" language in the conduct exclusions, insurers will argue that the remedies sought are not included within the definition of "Loss" and, therefore, that no coverage is available. This is, in effect, a loophole that should be addressed at the time of renewal.

Bear in mind that having high-quality D&O insurance, with "adjudication in fact" language or something similar, sometimes can cause unexpected trouble. A corporation purchasing D&O insurance wants to ensure that its directors and officers receive the broadest possible coverage in the event of a claim, so that if one of them is accused of fraud, he or she will be entitled to corporate indemnity and insurance coverage alike, unless and until a fraud is proven. This viewpoint assumes the good faith of the officer or director, and the corporation's desire to protect him or her against unfair and unprovable allegations. However, there are unfortunately instances when the alleged conduct is true and deplorable – as is the case with a rogue director or officer. The innocent directors and officers do not want the limits of their D&O coverage exhausted by the cost of defending someone they feel has committed inexcusable wrongs.

One way of balancing the corporation's interest in providing broad insurance coverage for fraud, and its desire to preserve D&O policy limits against erosion by a rogue director or officer, is to soften the "actual adjudication" language of conduct exclusions by adding the concept of an admission. Therefore, unless there has been an actual adjudication that an insured committed excluded conduct, or the insured has admitted the excluded conduct orally or in writing, the director or officer receives interim-funding of defense expenses. This gives the company a chance to use the results of its internal investigation – which may include documents and witness interviews reflecting admissions of misconduct by the rogue – to cut off coverage for the rogue's defense expenses and preserve limits for non-culpable officers and directors.

c. Severability.

Severability provisions, which prevent one insured's conduct or knowledge from being imputed to other insureds, have, historically, applied only to applications for insurance. It is, however,

now increasingly common for D&O policies to sever exclusions triggered by knowledge or conduct so that one bad actor does not defeat coverage for all insureds. For example, when an exclusion for fraud is "severed," the knowledge or participation in a fraud by one insured would not bar coverage for all insureds. The common types of exclusions which can be severed are those for fraud or other intentionally wrongful conduct, improper benefits and knowledge-based exclusions such as those which bar coverage for claims arising from known, wrongful acts which took place before the policy incepted.

Just as important are traditional severability provisions which apply to insurance applications. In most jurisdictions in the United States, an insurer is entitled to void or rescind a policy if the insured makes a material misrepresentation or misstatement in the application for coverage, on which the insurer relied in issuing the policy, on the terms it provided, and at the price it did. Often times the misrepresentation on which rescission is based need not be intentional; a simple mistake will do.

The better severability provisions split the application for Side A and Side B coverage, on one hand, and Side C coverage on the other. Under these types of severability provisions, no statement or knowledge of any individual insured is imputed to any other individual insured for purposes of coverage under Side A or Side B. Thus, if the Chief Financial Officer knows of, for example, a potential claim not disclosed in the application, that knowledge will not be imputed to defeat other individual insureds' claims for coverage should that potential claim mature into an actual claim. For Side C coverage, knowledge of senior officers (typically the Chief Financial Officer, General Counsel, Corporate Risk Manager, President, Chief Executive Officer) is imputed to the entity for purposes of determining whether information given on the application is accurate. Thus, for example, a Regional Manager's knowledge of accounting irregularities that result in a securities claim will not defeat coverage for the entity.

Although severability provisions are important in the context of solvent, going concerns, they are especially important in the bankruptcy context in which allegations of mismanagement, fraud and malfeasance are levied with particular fervor.

d. Allocation Provisions.

D&O policies, unlike other types of policies, typically permit an insurer to selectively deny coverage for certain claims. *See, e.g.*, Continental Casualty Co. v. Board of Education of Charles County, 302 Md. 516, 489 A.2d 536 (Md. 1985); Raychem Corp. v. Federal Ins. Co., 853 F.Supp. 1170 (N.D. Cal 1994); Commer. Capital Bankcorp, Inc. v. St. Paul Mercury Ins. Co., 419 F.Supp.2d 1173 (C.D. Cal. 2006). An insurer which does that will propose an allocation between covered and non-covered claims or covered and non-covered parties, under which the insurer will pay only a portion for the claim, leaving the insured responsible for the balance.

The method by which this allocation is made can have substantial effect on the amount of coverage available to the insured. In general, courts interpret D&O policies to obligate the insurer to pay defense costs that are "reasonably related" to the defense of the insured claims and settlements or judgments according to the "larger settlement rule," whereby allocation is appropriate only if the amount of the settlement is increased by virtue of the uninsured claims.

Raychem, *supra*, 853 F.Supp. 1170; Caterpillar v. Great Am. Ins. Co., 62 F.3d 955 (7th Cir. 1995); Corning v. Nat'l Union Fire Ins. Co., 257 F.3d 484 (6th Cir. 2001); Nordstrom, Inc. v. Chubb & Son, Inc., 54 F.3d 1424 (9th Cir. 1995).

To avoid these rules of interpretation, many insurers include allocation provisions which purport to require allocation under a "relative exposure" theory. Although the enforceability of these "relative exposure" allocation provisions is questionable, they are not favorable to the insured and should be avoided, if possible.

2. Fiduciary Liability Policies

Fiduciary liability policies (FLI) can be viewed as an extension of D&O coverage to fill the gap left by ERISA exclusions found in most D&O policies. They can also be viewed as an enhanced hybrid of EPLI, D&O and employee benefits administration coverage (which is different from EPLI coverage, and often issued as an endorsement to commercial general liability policies). Because of the similarities to D&O and EPLI policies, many of the same issues addressed above apply equally to FLI policies. For example, the issues concerning claims-made-and-reported provisions apply equally to FLI policies, but typically come up less frequently than with EPLI policies. FLI policies have conduct exclusions, severability provisions and allocation provisions, implicating the same issues discussed above in the context of D&O policies.

Likely the most problematic FLI coverage issue is one of scope, as many policies contain what could be construed as exclusions for what is often the greatest risk – stock drop ERISA litigation. In the wake of Enron, Worldcom and the large market declines in 2001, plaintiffs' firms began pursuing actions on behalf of employees who allege that their public company employers breached fiduciary duties under ERISA by investing employee benefits plan funds in company stock. Plaintiffs in these actions typically allege damages equivalent to the loss in value of employee plans invested in company stock following some adverse event or news release.

Many FLI policies contain exclusions for changes in the price or value of securities. A typical exclusion to this effect bars coverage for any claim "based upon, arising from, or in consequence of any actual or alleged change in the price or value of any securities" of an insured entity. Although there are no reported cases addressing whether an exclusion such as this would bar coverage for a stock drop ERISA case, many insurers contend that it does. To avoid an unexpected declination of coverage for this type of litigation, insureds should request that exclusions to this effect be removed.

F. Property Loss

1. Traditional Property Policies

Property insurance, unlike third-party liability insurance, is intended to compensate the insured for first-party loss caused by a covered event. Coverage is available for a broad variety of property including buildings, equipment and cash, while the loss-causing event can be natural forces, such as fires or floods, or the result of human acts such as employee theft or terrorism. Business interruption losses resulting from a covered cause frequently constitute a significant

portion of the amounts claimed for coverage following a large property loss claim. Builder's risk policies are important for hospitality companies operating as developers, but that is separately discussed in the Development section above.

Hospitality companies routinely have property insurance claims which run the entire spectrum from hurricane damage to employee theft. The recent terrorist attack in Mumbai, India should serve as a reminder that hospitality companies face a significant risk of terrorism-related losses, especially when operating in international markets. Procuring the right types of property insurance can be complex, especially with large companies operating a variety of businesses in numerous markets.

For example, terrorism-related coverage can vary from state-to-state within the United States, with policies issued for operations in some states providing coverage for all fire that results from terrorism, while other states permit policies to be issued with exclusions for fire resulting from terrorism. These issues are, however, primarily a broker function with which most hospitality lawyers are never confronted. Nevertheless, the complexity of and dollar amounts associated with these issues underscore the importance of securing the services of a sophisticated insurance broker with experience handling large commercial accounts.

Although hospitality lawyers generally play a very limited role in purchasing coverage, they are very often some of the earliest responders when an event occurs which gives rise to a property insurance claim. Given that most property claims involve some dramatic event, there is an element of triage involved in the response whereby the items viewed as higher priority our addressed first. Most frequently the mitigation of risk and resumption of business are the highest priority items for the insured, while structuring and preparing the insurance claim typically is viewed as a lower priority item.

Insurance companies, however, typically respond quickly to large property claims, immediately focusing on how to use potential coverage issues to mitigate their losses. This asymmetry in focus often permits insurers to develop the factual record in a manner most favorable to their coverage positions, to the detriment of the insured. It is critical, therefore, that the insured quickly identify potential coverage issues and ensure that the facts implicated by those issues are developed fairly and properly. This is especially true when the evidence of damage is available only for a short period of time, as is this case when demolition and reconstruction efforts are started shortly after the loss.

Using a recent example, Hurricane Katrina resulted in large property losses for businesses in Louisiana and Mississippi. Insurers moved quickly and immediately began developing facts tending to show that damage was resulted from an excluded cause, flood, while ignoring evidence tending to show that the damage was actually caused by a covered cause, wind or wind-driven rain. Being first out of the gate on this issue provided many insurers with a tremendous advantage, effectively forcing insureds to either accept a reduced value for their claim or incur the cost of hiring independent loss experts and attorneys to rebut the incorrect factual assessments and legal conclusions first made by the insurers. Unable to make up the lost ground, many insureds accepted a compromised value for their claim.

Even when there are no coverage issues *per se*, property claims frequently involve disputes over valuation of the damaged or lost property. Insureds generally bear the burden to prove the value of lost or damaged property. In many cases, insureds will have detailed records to demonstrate the value of the lost or damaged property, especially when that property is tangible and evidence of it remains after the loss. Extensively cataloguing and documenting the specific property damaged after a loss serves as an important backstop to any deficiencies in pre-loss record-keeping.

2. Commercial Crime Policies

In other cases, especially cases involving financial-oriented loss caused by employee dishonesty or fraud, demonstrating the value of the losses incurred can be very difficult. This is because, in these cases, the dishonest employee typically will make an extensive effort to delete or alter the company's records to hide the existence of the fraud. The company's own records, therefore, will provide no or incomplete evidence of the value of the property lost, depending on the dishonest employee's level of sophistication. Compounding this problem is when the dishonesty or theft has been ongoing for several years, as evidence demonstrating the extent of the fraud may have been destroyed in the normal course of business. This, combined with myriad complex and ambiguous coverage provisions, makes claims under commercial crime policies among the most difficult under which to achieve insurance recoveries as evidenced by loss payout ratios on these policies dramatically below other lines of property insurance.

Notwithstanding the difficulties of pursuing such claims, a creative and rapid response aimed at identifying implicated parties and preserving evidence can improve significantly the rate of recovery under a commercial crime policy. The degree to which financial transactions are conducted electronically has in many cases made easier the recovery of evidence supporting claims under commercial crime policies.

Specifically, dishonest employees will often go to great lengths to cover their tracks in the company's records, but will leave available large amounts of evidence on their personal computers or other paper files. First-responder attorneys should actively seek court orders or other means to preserve evidence in the possession of implicated employees. Equally important is identifying potential coverage issues to ensure that facts are developed properly and presented to the insurer in a manner consistent with the scope of coverage provided by the commercial crime policy.

III. CONCLUSION

After years of favorable conditions and robust growth, many hospitality companies have been hit hard by the rapid change in the market. This difficult operating environment could become worse if, as is typical in down economies, litigation picks up and the insurance market hardens. So far this has not happened, and maybe it never does during this cycle.

Maybe lawyers have finally become so expensive that parties would rather resolve disputes amicably than resort to litigation. Maybe insurance companies have learned that cyclically

alienating customers through sharp premium increases and overly aggressive claims-handling is not a good long-term approach to business. Maybe. Or maybe not.

A central premise of insurance is that companies do not have to decide exactly what will happen. Rather, they buy insurance planning for the worse, while simultaneously hoping for the best. Corporate insurance is not a commodity, and an effective insurance program requires both planning and execution on the part of both in-house and outside counsel. Learning about and remaining aware of insurance issues is central to maximizing your client or company's insurance assets.

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