Insurance Law

Disrupting Insurance Is Hard: How to Make It Easier (Or at Least Less Hard)

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BY JOHN PRUITT AND ED STELZER

Insurance is a mature business that developed over the centuries to serve important social needs. Insurance policies can be long-term contracts involving promises lasting several decades, and insurers have long promoted themselves as offering financial strength and stability. States, in turn, have passed laws to regulate market practices and solvency to ensure that insurers' promises are made fairly, that the products they sell match those promises and that they have adequate financial resources to meet them.

Perhaps because of this, the insurance business is perceived as stodgy, beholden to inefficient legacy distribution systems and practices, overly regulated and resistant to change. And perhaps because of that, there is now a thriving ecosystem of individuals and enterprises—in industry parlance, "Insuretech"—devoted to developing innovative applications of technology to improve, modernize or, in some cases, disrupt insurance.

This ecosystem includes technology startups, venture capital (VC) funds, insurer-backed VC funds, brick and mortar insurers, agents and brokers, accelerators, incubators and, more recently, regulators. Insuretech offers many opportunities and can be sorted into three principal areas of focus:

• **Better customer experience.** New technologies have radically changed consumer expectations for customer interface. Think Amazon. Consumers want an easy and quick purchase, preferably from a mobile device. They want instant price comparisons and prompt delivery. They don't want intermediaries. Yet none of these are attributes of traditional distribution channels for insurance. Captive or independent agents and brokers are often small businesses with rudimentary office technology. New technologies and apps offer ways to improve insurance buying and claims to be more in line with raised expectations.

There is now a thriving ecosystem of individuals and enterprises—in industry parlance, "Insuretech"—devoted to developing **innovative applications of technology** to improve, modernize or, in some cases, disrupt insurance.

• **"Big data."** Insurance is and always has been data-driven. The availability today of massive amounts of information that can be sorted and analyzed through enhanced computing offers insurers the capability to price risks more accurately, target sales at more profitable risks and deploy capital to where it can be put to its best use. Many tech start-ups are focused on data analytics, risk modeling and algorithmic underwriting. Better data also can be used for claims processing and fraud detection.

• **Business process improvements.** Insuretech offers myriad ways to improve business processes, including back-office activities the customer never sees. The insurance industry is considered very inefficient when judged on the portion of total premiums actually used to pay losses. Much of this inefficiency is due to the fact that the business is highly intermediated, with one or multiple insurance producers in the chain each taking a commission. Those costs might not be avoidable if insurers still want a flow of the business controlled by intermediaries. So lowering costs through technology-driven improvements to back-office administration is very attractive.

Regulations Matter

The focus is on regulation because some see it as an area where the new and the old come into conflict, which can be a drag on the pace of change. Regulations that matter for Insuretech include:

• **Licensing.** Entities that engage in the transaction of an insurance business in a state are required to be licensed as an insurer in that state. Licensing is also required for those who solicit, negotiate or sell insurance on behalf of another, or those who investigate, adjust and settle insurance claims. Because insurance is regulated at the state level, whether a new and different product is *insurance,* or whether a new and different way of offering a product is *selling insurance,* is a state-specific test. Further, it is not always obvious that an activity constitutes licensable activities. For example, it's normal business practice for compensation for a service or product to be tied to the amount of revenues generated. But in an insurance context, regulators will ask if such compensation is a *commission* for the sale of insurance that only a licensed agent or broker can receive.

• **Data security and privacy**. This is a rapidly developing area, and the driving force for giving consumers greater rights over their personal data may be outside the insurance industry, as seen by the recent enactment of California's Consumer Privacy Act or the Illinois Biometric Information Act. However, data security and privacy are particularly relevant for insurers because they capture and use personal history, and medical and behavior information for underwriting and claims far beyond what other businesses do.

Regulators have already begun to implement rules that address what insurers (and other involved third parties) are doing to safeguard that information. In 2016, the New York Department of Financial Services (NYDFS) adopted a cybersecurity regulation, *Cybersecurity Requirements for Financial Services Companies*, 23 NYCRR Part 500. In 2017, the National Association of Insurance Commissioners (NAIC) adopted an *Insurance Data Security Model Law,* which substantially tracks the New York regulation. These new rules require insurance licensees to maintain an information security program based on a cybersecurity risk assessment subject to board of directors' oversight, evaluate and address cybersecurity risks posed by third-party service providers, establish a written incident response plan, and investigate and provide notice to state insurance departments regarding cybersecurity events.

Regarding privacy, the relevant rules in the United States largely consist of rules adopted during the 1990s and 2000s to implement the » Page 12

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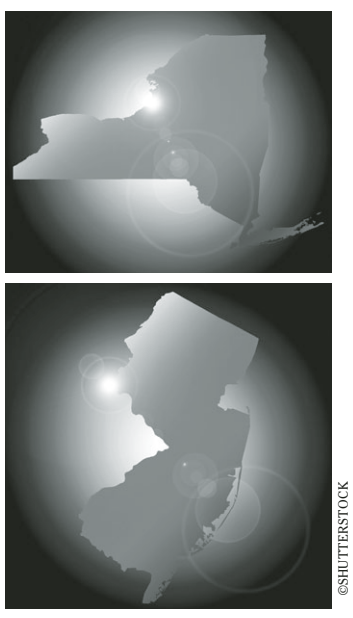
Allocation of Long-Tail Losses In New York And New Jersey



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BY MARK GARBOWSKI AND ROBERT M. HORKOVICH

For more than 20 years, insurance companies, policyholders, and their counsel, in both New York and New Jersey, have shared a mutual understanding regarding at least one issue concerning the allocation of long-tail losses among multiple policy years. Based on two leading cases decided in the 1990s, the rule and practice has been that losses are not allocated to policyholders in periods when insurance was not available for purchase. As a matter of practice, this has most commonly come into play in disputes involving insurance coverage for asbestos and environmental liabilities, as coverage for both types of claims became unavailable generally around 1985-86.

That common understanding changed earlier this year, when both the New York Court of Appeals and the New Jersey Supreme Court heard appeals where this seemingly settled issue was raised anew. The New York court upended the established rule, without creating a new universal rule in its place, leaving exactly what coverage gets applied to what year in doubt. In New Jersey, the court affirmed and even extended the longstanding rule. In this article, we first briefly will summarize each ruling and how it fits into each state's body of insurance coverage law. Then, we will offer analysis and suggestions for handling such cases in the future.

New York

In *Keyspan Gas E. Corp. v Munich Reins. Am.*, 31 N.Y.3d 51, 59-60 (N.Y. 2018), the Court of Appeals decided what was, for it, an issue of first impression: whether New York would adopt the "unavailability rule" which provides that a policyholder bears the risk for periods of time when it elected not to purchase available insurance, but not for those years when insurance was unavailable.

Previously, the guidance on New York law came from the Second Circuit, which decided that both Texas and New York would adopt the unavailability rule in *Stonewall Ins. Co. v. Asbestos Claims Mgmt.*, 73 F.3d 1178, 1203 (2d Cir. 1995). In *Keyspan*, the Court of Appeals acknowledged the *Stonewall* decision as one of several courts that adopted the unavailability rule, but did not discuss its longstanding effect on New York law, including the certainty it gave to parties and practitioners, and gave it no apparent deference.

In rejecting *Stonewall,* however, the court did not announce a replacement rule. Instead, the court decided the issue based upon its reading of the policy language at issue in the *Keyspan* case, making clear that the rule it announced was for those policies, and to a degree, for policies with similar language. It held that under the policy language before it, the unavailability rule is inconsistent with a judicially created pro rata approach to allocation.

This language-based approach is consistent with the approach that New York's highest court has taken with respect to insurance allocation issues. Most states have adopted some variation of either (1) the "all sums" allocation approach, which allows a policyholder to collect its total liability under any policy in effect during the periods that the damage occurred, up to the policy limits, or (2) the "pro rata" approach, which spreads the loss to all years in which damage took place. New York is all but unique in applying both methods, depending on the specific policy language in each case. In fact, the expectation that a state would adopt a single method was so commonly accepted, that from the time the Court of Appeals applied a pro rata method in *Consol. Edison Co. of N.Y. v. Allstate Ins. Co.*, 98 N.Y.2d 208 (2002), until it finally applied an all sums method 14 years later in *Matter of Viking Pump*, 27 N.Y.3d 244 (2016), many parties incorrectly assumed that the pro rata method was of universal application under New York law.

In *Viking Pump*, however, the court clarified that in *Consolidated Edison* "we did not adopt a strict rule mandating either pro rata or all sums allocation because insurance contracts, like other agreements, should 'be enforced as written,' and 'parties to an insurance arrangement may generally "contract as they wish and the courts will enforce their agreements without passing on the substance of them."'" *Viking Pump*, 27 N.Y.3d at 257. This approach also guided the court when it decided that the unavailability rule does not apply to the policies at issue in *Keyspan*.

New Jersey

In contrast, when the New Jersey Supreme Court addressed allocation and the application of the unavailability rule in *Cont'l Ins. Co. v. Honeywell Int'l*, 188 A.3d 297 (N.J. 2018), it was revisiting an issue that had previously been decided by that court. *Honeywell* primarily was a choice-of-law decision, in which the New Jersey court decided to apply New Jersey law over the potentially applicable Michigan law.

The New Jersey Supreme Court earlier had adopted its own variation of » Page 12

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Debunking the Myth That The First Dep't Has Rung the Death Knell On the Insurability of Disgorgement

BY MIKAELA WHITMAN

Whether there is insurance coverage for restitution or disgorgement of purported "ill-gotten gains" under Directors and Officers and other professional liability policies (collectively here, D&O policies) has become a pervasive issue in jurisdictions across the country. The increased filings in recent years of consumer and securities class actions, breach of fiduciary duty actions, SEC enforcement actions, and appraisal actions, has added renewed vigor to this judicial debate. Two recent decisions from the U.S. Supreme Court and the First Department in New York, both discussed below, add an important new dimension to this issue and D&O policyholders should not be caught unaware.

What Is the 'Disgorgement Defense'?

A standard D&O policy defines "Loss" as the total amount an insured becomes legally obligated to pay on account of a claim made against it for "Wrongful Acts," including but not limited to damages, judgments, settlements, costs, and defense expenses. The definition of "Loss" typically goes on to state that "Loss" will not include: (1) fines or penalties imposed by law, or (2) matters uninsurable by law.

Insurers will often argue that, even though the scope of covered "Loss" is defined using broad, undefined terms such as "damages," or "settlements," public policy prevents the insurers from indemnifying *any* payment labeled as "disgorgement" or "restitution" because these payments are by nature, penalties, and uninsurable by law. In response, policyholders contend that the payment of damages and settlements was the precise reason for their purchase of liability insurance, and not only are they entitled to the policy benefits, but to so limit the policy would render the coverage itself, illusory.

Particularly since the Seventh Circuit's infamous decision on this issue in *Level Three Communications v. Federal Insurance Co.*, 272 F.3d 908 (7th Cir. 2001), courts have grappled with how to resolve this question of coverage for disgorgement. A recent number of cases have chiseled away at the position that "disgorgement" or "restitution" is not, in any circum- » Page 12

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Inside

INSURANCE LAW: Angela Turturro, Sections Editor | Agnieszka Czuj, Design

Do Unto Others—**Reciprocity** Through the Lens Of **Insurance Regulation**

BY DAN RABINOWITZ

The uneven effects of laws across boundaries, when applied to persons or activities having nexuses to multiple jurisdictions, can often be neutralized by reciprocity—treating a non-resident in a particular jurisdiction the same way that a resident of that jurisdiction would be treated under identical circumstances by the laws of the non-resident's home jurisdiction. In a regulated industry such as insurance, trends in reciprocity, including among the 50 states but also between the U.S. and other nations, can reflect broader political developments and illuminate consequential public policy debates in a key sector of the economy.

An insurer "domiciled" (incorporated) in one state can be licensed to carry on business not only in that state but in as many as 49 others and will be subject to the laws of each state in which it is so licensed. Many states have adopted insurance laws imposing reciprocal treatment with respect to specified matters on insurers domiciled elsewhere but doing business in the adopting state. Some instructive examples include:

Holding company act regulation. In virtually all states, a licensed insurer controlled by another entity (e.g., a holding company) must register as a controlled insurer and must observe certain ongoing reporting requirements. However, under the model "insurance holding company act" governing these requirements (issued by the National Association of Insurance Commissioners, or NAIC, a standard-setting body), where the insurer's domiciliary state has a substantially equivalent law, registration in that state will suffice and will obviate the need for reporting in the non-domiciliary state. (New York, whose holding company act differs in certain respects from the NAIC model, remains a key exception to this general rule. A controlled insurer licensed in New York must register with and report holding company information annually to the New York Superintendent of Financial Services even where the insurer is domiciled in a state with a similar law.)

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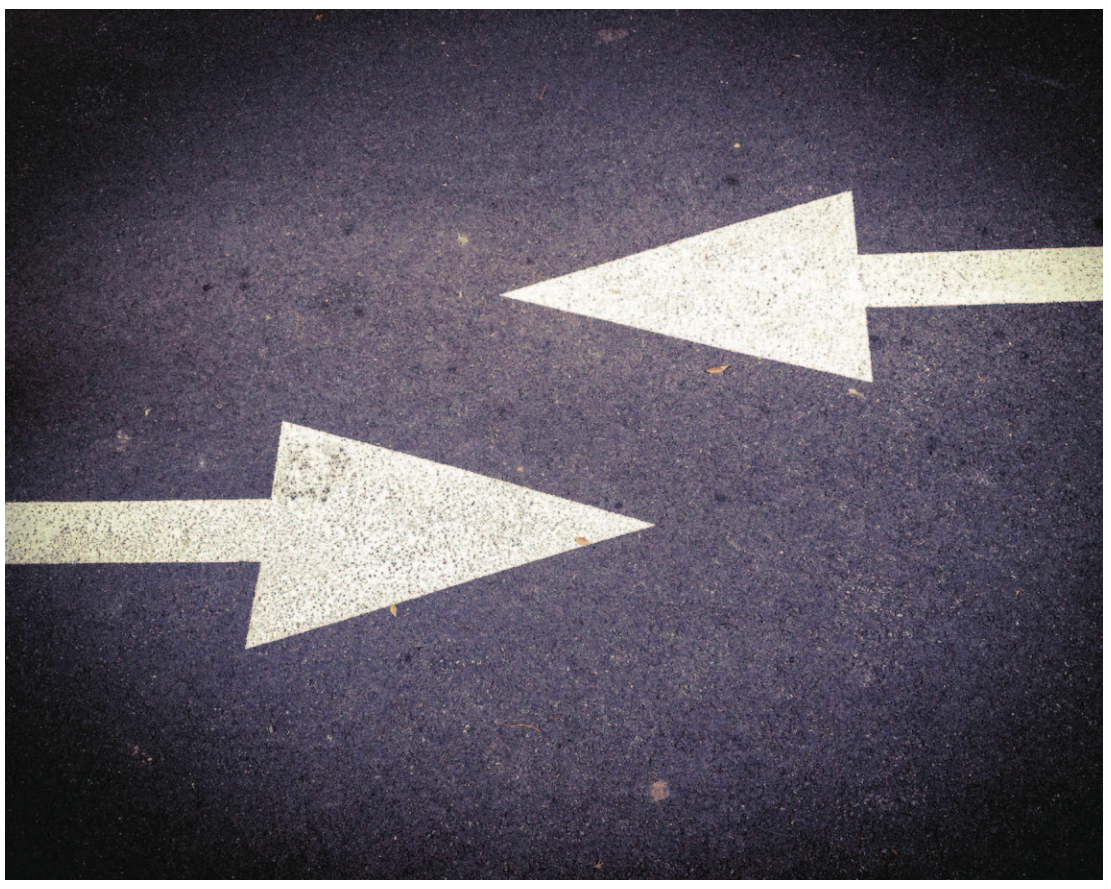
Investments. State laws regulate the types and amounts of portfolio investments that insurers may make with the assets supporting outstanding policies and surplus. Typically these requirements are imposed only on domestic insurers, as in the NAIC model investment law. However, the laws of some prominent insurance jurisdictions, including New York, Delaware and South Carolina, do subject a "foreign" insurer (that is, an insurer domiciled in another state) to the state's investment laws unless it is subject to "substantially similar" laws in its domiciliary state.

Credit for reinsurance. Reinsurance is essentially a transaction in which an insurer cedes some of the risks it has underwritten to another carrier. In order to recognize the financial effect of reinsurance on its balance sheet—that is, to receive financial statement "credit" for the transfer of the insurance liabilities to the reinsurer—the ceding insurer must observe certain state laws prescribing conditions on such reinsurance. In general, under these rules, where an assuming reinsurer does not meet certain criteria, it must post collateral in favor of the ceding company in order for the ceding company to receive credit. Concepts of reciprocity can be seen in at least two aspects of credit-for-insurance regulation:

- On the one hand, the NAIC model law on credit for reinsurance permits a ceding insurer to claim credit where the assuming insurer is domiciled in a state that "employs standards regarding credit for reinsurance substantially similar to those" applicable in the ceding company's state. (The assuming insurer must meet other technical requirements as well, including submission to examination authority of the ceding company's domiciliary state.)
- On the other hand, reciprocity historically did not always apply in the application of reinsurance rules to foreign insurers. Prior to the Dodd-Frank reforms discussed below, some states applied their reinsurance rules extraterritorially, that is, even to ceding insurers domiciled elsewhere. This was particularly visible in the large and influential states of New York (whose credit for reinsurance regulations, prior to 2011 amendments, did not distinguish between domiciled and non-domiciled insurers) and California (where a provision of the insurance code arguably gives the California regulator authority to approve certain acquisitions involving non-California domiciled insurers).



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Developments over the period 2010-2017—bookended by the Dodd-Frank Wall Street Reform and Consumer Protection Act, at one end, and the U.S./EU "Covered Agreement," on the other—illustrate efforts to incorporate additional reciprocity into these areas of insurance regulation. Key developments included the following:

Domiciliary control of credit for reinsurance regulation. In addition to its more visible provisions affecting banks, Dodd-Frank effectively ended the long-arm reach of state reinsurance laws. The statute prohibits any state but the domiciliary state from regulating reinsurance terms and conditions such as collateral requirements. (California and New York both responded to this development in 2011 by limiting the regulator's authority over non-domestic insurers.)

U.S./EU "Covered Agreement." Dodd-Frank also authorized the Executive Branch to negotiate and enter into "Covered Agreements," defined as an agreement with other countries that "achieves a level of protection for insurance or reinsurance consumers that is substantially equivalent to the level achieved under State" regulation. In its final days in January 2017, the Obama Administration announced that it had entered into such a Covered Agreement with the European Union, which, among other things, required each jurisdiction to impose credit-for-reinsurance standards (including collateral requirements) no less favorable to the other's reinsurers than the other's laws applied to the former's reinsurers. The agreement requires each jurisdiction to harmonize its rules to this reciprocity principle within five years.

> In a regulated industry such as insurance, **trends in reciprocity,** including among the 50 states but also between the U.S. and other nations, can reflect broader political developments and illuminate consequential public policy debates in a key sector of the economy.

Group supervision. Over this period at the NAIC, amendments to the insurance holding company act and other aspects of supervision of insurance groups (affiliated companies) also reflected a doubling-down on reciprocity. The NAIC imposed new requirements on insurers within groups to file "enterprise risk" reports (identifying the insurer's group-wide risks) and "own risk and solvency assessments" (self-examinations on the amount of required capital across the group). These measures required insurers or their groups to file these reports principally with the "lead" state, that is, the jurisdiction of domicile of the most consequential insurer in the group, even if other insurers in the group were domiciled elsewhere.

Three developments since roughly the end of the 2010-2017 period illustrate a possible check on reciprocity principles, however.

Policy statement on U.S./EU reciprocity. The Trump Administration adopted the U.S./EU Covered Agreement in September 2017 but, in its announcement doing so, emphasized the primacy of state insurance regulation in the U.S. and seemed to contrast it against "expansive EU reporting requirements". While not repudiating the concept of reciprocity, the policy statement suggested that promoting U.S. interests would not take a back seat to any international aspiration of equal treatment. The statement in particular also noted certain limits of the Covered Agreement, such as its inapplicability to existing reinsurance contracts.

Requiring consensus positions on IAIS reforms. Similarly, under a broader regulatory-reform bill enacted by Congress and signed by President Trump in May 2018, the Executive Branch and the Federal Reserve are required, before taking a position with respect to certain international insurance proposals, to "achieve consensus positions with" state regulators through the NAIC. The most proximate concern of this provision is the ongoing effort by the International Association of Insurance Supervisors (a global consortium of regulators) to formulate uniform capital standards for insurance groups straddling national boundaries. The legislation reflects the Administration's policy position (generally aligned with that of the NAIC) disfavoring the perceived encroachment of international rules—even reciprocal ones—on U.S. insurance business.

Codifying U.S./EU reciprocity in state law. The NAIC is in the process of conforming its model credit for reinsurance law to the U.S./EU Covered Agreement. A draft model amendment released by the NAIC in June 2018 and currently under discussion specifies that credit will be allowed where the assuming insurer is domiciled in a "Reciprocal Jurisdiction" (generally, a jurisdiction that is a party to a Covered Agreement) and certain other conditions are met. Some of these other conditions, however, arguably hinge on the regulator's discretion, including financial requirements. As of this writing the draft has attracted criticism in part because of the perception that, by empowering the local regulator to adopt additional conditions for credit, the model does not achieve true reciprocity. The draft is subject to additional discussion and ultimate adoption at the NAIC, and then it would have to be adopted in any given state in order to be effective.

Conclusion

This cross-section of reciprocity issues illustrates the push and pull of individual jurisdictions' policy preferences—and protection of local actors—against a backdrop of increasing globalization of the insurance and reinsurance sector. The extent to which a jurisdiction chooses to "do unto others" as it would have done unto it, on these and related matters, will be a key indicator of how policymakers navigate this globalization in coming years and decades.

Data Breach Risk Management: Keeping Up With Evolving Cyber Liability Insurance

BY NADIRA K. KIRKLAND

Just as cyber threats are continually evolving, so are cyber liability insurance policies. With data breaches a common occurrence, many companies are focusing on their IT systems, but tend to overlook the insurance aspects. When preparing for and responding to a cyber event, having comprehensive insurance coverage is critical. Personnel responsible for detecting, reporting and responding to cyber events and privacy violations should also have a thorough understanding of the coverages provided under their cyber policies and how those policies are triggered, well before an incident occurs.

The Evolution Begins

In the past, companies and businesses have sought coverage under traditional types of policies, such as property or commercial general liability (CGL) policies. However, there has been extensive litigation over when and in what circumstances a CGL policy covers a data breach claim. Beginning in 2001, CGL policies began excluding "electronic data" from coverage, and in 2014 additional exclusions emerged in CGL policies that were designed to eliminate coverage for cyber-related damages.

About 25 years ago, technology companies bought errors and omissions (E&O) insurance with the Y2K threat. Over time, E&O policies were extended to include unauthorized access to a client system, destruction of data or a virus impacting a customer's system. The technology coverage, often called "network security" or "Internet liability," was an add-on to the existing policy. Five to 10 years ago, these "network security" policies expanded into the privacy space by providing clear coverage for breaches of confidential information. Once coverage expanded, financial institutions, retailers and other companies holding considerable consumer data, but who were not providing the type of technology services that would warrant buying E&O insurance, took notice and began looking into stand-alone policies.

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Lots of Jargon, But Four Common Components

The term "cyber" coverage can vary with companies and groups. Generally, cyber liability insurance covers financial losses that result from data breaches and other cyber events. Many policies include first-party, third-party or both coverages. First-party coverages apply to losses sustained by the company directly. First-party coverages are often subject to a deductible. Third-party coverages apply to claims against the company by people who have been injured as a result of the company's actions or inactions. Virtually all cyber liability policies are claims-made.

Although various insurance companies use different names and terminologies, cyber coverage insurance is some combination of basically four components: E&O, media liability, network security and privacy. These categories are sometimes conflated or further divided into other subparts.

As noted above, E&O covers claims arising from errors in the performance of services, which can include technology services such as software consulting or more traditional professional services such as attorneys, medical personnel and financial planners. This is a first-party claim.

Media liability is a third-party claim pertaining to advertising injury such as infringement of domain name, intellectual property, copyright/trademark infringement and defamation, libel and slander. Due to the presence of businesses on the Internet, companies have seen this coverage migrate from their general liability policy to being bundled into a media component in a cyber policy or even a separate media liability policy.

Network security is both a first- and third-party claim. A failure of network security can lead to many different exposures, including a consumer data breach, destruction of data, virus transmission and cyber extortion. Network security coverage can also apply to trade secrets or improper access to information contained in patent applications.

Privacy is also a first- and third-party claim. It includes the wrongful collection of personally identifiable information (PII), which usually pertains to medical, health and financial records. PII is defined in some regulations/statutes but there is not a standardized definition, especially in the United States, so insurers may specifically define PII depending on the company's business model.

> Cyber liability insurance will not exonerate a company from maintaining a high level of overall security and does not take away the need to conduct the appropriate due diligence when dealing with outside vendors, but it can act as a source of funds and resources in the aftermath of an incident.

Cyber coverage includes some of the following first-party costs when a security failure or data breach occurs:

- Legal advice to determine notification and regulatory obligations
- Notification costs
- Forensic investigation of the breach
- Offering credit monitoring to customers as a result
- Public relations expenses (also referred to as Crisis Management)
- Business interruption, loss of profits and extra expense during the time that your network was down (property policies cover income losses and extra expenses that result from an interruption in business operations caused by physical damage to the covered property, which does not include electronic data)

Cyber coverage includes some of the following common third-party costs:

- Legal defense
- Cost of responding to regulatory inquiries
- Settlements, damages and judgments related to the breach
- Liability to banks for re-issuing credit cards
- Breach related fines imposed by the state or federal government. With the European Union's General Data Protection (GDPR) wide range of mandates and steep fines, some violations of GDPR may not be covered.

Cyber liability insurance has more comprehensive coverage than a CGL or standard E&O policy; however, cyber liability insurance *does not cover*:

- Loss of future revenue
- Reputational harm
- Diminished value of intellectual property
- Costs to improve internal technology systems

Insurance frequently excludes losses or claims attributable to intentionally dishonest or criminal acts, breach of contract, theft of trade secrets, unfair trade practices and employment practices and cyber liability insurance is no exception. A determination that a loss arose out of an intentional act might eliminate coverage. Also, the cyber liability policy could exclude coverage for failure to meet certain security rule requirements and failure of a third-party or cloud vendor to protect any data entrusted to it.

Claims-Made Policy

Understanding the terms of the insurance policy is just as important as understanding when it is "triggered." Cyber insurance is claims made and the policy will have a discovery trigger. This means the policy can be used when the insured first discovers the event, regardless of when the act or acts causing or contributing to the loss occurred as long as the claim is made during the policy period. This is very important in cyber liability insurance because some companies do not immediately know when there has been a breach. The Ponemon Institute found that in 2017, it took an organization an average of 191 days to learn that a data breach had occurred. (Ponemon Institute Research Report, 2017 Cost of Data Breach Study, June 2017.)

The Evolution Continues

Any organization that stores and maintains customer information or collects online payment information, or uses the cloud, should consider adding cyber insurance to its budget. Also considering the proliferation of devices that now connect to business networks in a vastly global space, there are simply more opportunities for malicious access to an organization's assets.

Cyber liability insurance will not exonerate a company from maintaining a high level of overall security and does not take away the need to conduct the appropriate due diligence when dealing with outside vendors, but it can act as a source of funds and resources in the aftermath of an incident. Knowing how the cyber liability policy is positioned within other insurance coverages and understanding how to engage each one is important. In performing a cyber incident exercise, a review of how the insurance would or would not have been triggered would highlight any potential gaps in coverage. Since cyber liability insurance does not have a standard risk coverage form and terms and language vary from insurer to insurer and policy to policy, it is imperative to speak with the broker to obtain an understanding of what is covered in the policy and individualized offering to meet the company's business model and goals.

The next wave of cyber liability insurance may address different gaps as technology continues to dictate the market and access to more data and information.

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Allocation

« Continued from page 9

pro rata, which takes into account not just the number of years over which damage occurs, but also accounts proportionally for the amount of coverage purchased in each applicable year, applying the loss to available coverage without burdening the policyholder, in *Owens-Illinois v. United Ins. Co.*, 138 N.J. 437 (1994). In that case, New Jersey also adopted the unavailability rule. In *Honeywell*, the certain excess insurance companies argued that the unavailability rule should not protect companies that continue to manufacture dangerous products after the insurance industry stops selling policies to cover such dangerous substances. In this case, the policyholder did not stop manufacturing the relevant product until 2001. The New Jersey Supreme Court refused to create this exception to the unavailability rule, and no losses were allocated after polices became impossible to purchase.

Strategies Going Forward

The fact that New York and New Jersey now have different approaches to the unavailability exception creates both problems and opportunities for those involved in coverage disputes. In addition, New York's willingness to impose both all sums and pro rata allocation further complicates matters. Before filing an action, and even before one's opponent might possibly file an action against your client, one should determine, whether New York and/or New Jersey law might apply, and if there is a chance that New York law applies, whether pro rata or all sums allocation is more likely to be imposed under New York law.

Honeywell sheds some light on the choice of law issue as applied in New Jersey. Here, the manufacturer of the relevant products was a company whose primary contacts were with Michigan, but whose successor was a New Jersey company following a corporate acquisition. The court acknowledged that the parties could not have anticipated the application of New Jersey law when the insurance policies were sold, but ruled that Michigan no longer had any ongoing interest in the dispute and applied New Jersey law.

> The New York court **upended the established rule,** without creating a new universal rule in its place, leaving exactly what coverage gets applied to what year in doubt.

Similar to New Jersey, New York has dropped the old lex loci "place of contracting" standard in favor of a more flexible governmental interests standard. In practice, this sometimes has meant the New York courts rely heavily on a policyholder's principal place of business, *Steadfast Ins. Co. v. Sentinel Real Estate Corp.*, 283 A.D.2d 44 (1st Dept. 2001), though this is not uniformly applied, as in *Davis & Partners, LLC v. QBE Ins.*, 113 A.D.3d 544, 545 (1st Dep't 2014), where multiple contacts in New York were deemed to outweigh the fact that the policyholder's principal place of business was in New Jersey.

In most instances, one does well to remember that courts in any state are both more likely to apply their local law, and more comfortable doing so.

Once you determine that application of New York or New Jersey law is likely, the substantive allocation work begins. Under New Jersey law, as noted, a variant of pro rated allocation is used, which relies upon the amount of coverage purchased every year as a significant element. Calculating the allocation under this scheme can get complicated, especially if the parties do not agree on the full scope of all policies in all years. In some instances, where policies are hard to locate, it can be necessary to estimate the amount of coverage purchased in the missing policies in order to determine amounts allocated to policies in-hand.

Under New York law, one must get deep into the review of policy language to decide which allocation scheme should be applied. The key language is usually found in "Other Insurance" or "Non-Cumulation" sections, but can also be found in the basic Insuring Agreement clause, or definitions of Bodily Injury or Property Damage. If there is any ground to support "all sums," policyholders almost certainly should argue for it, especially with the loss of universal application of an unavailability rule in pro rata cases. Counsel also should be aware that New York has not yet determined how to handle some common complicating factors, including insurance programs where the language of some policies suggest all sums, while others lean to pro rata.

Despite the contrasting approaches by New York and New Jersey, handling insurance allocation disputes in both requires both ample basic preparation and creative problem solving.

Disrupting

« Continued from page 9

Health Insurance Portability and Accountability Act (HIPAA), the Fair Credit Reporting Act (FCRA) and the Gramm-Leach-Bliley Act (GLB). However, adoption of comprehensive data privacy rules like the European Union's General Data Protection Regulation (GDPR), which empowers consumers as data owners, could have far-reaching consequences on an insurer's ability to utilize data to transform underwriting.

• **Unfair discrimination.** Regulators grapple with whether algorithmic underwriting and the use of data analytics result in unfair discrimination in underwriting risks. States have broad prohibitions on discrimination based on various protected classifications (age, race, creed, color, religion, sex, sexual orientation, national origin, ancestry, etc.) but they also prohibit *unfair discrimination* in rates, terms and conditions. In practice that means rates, terms and conditions that are not justified by sound actuarial principles. Some consumer advocates have voiced objections to predictive analytics and the new risk classifications made possible by today's enhanced analytics on the basis that they have a disparate impact on minority and low-income communities and that there are inherent biases built into the models and the historical data they use. The industry's response has been that a disparate impact analysis has no application to insurance underwriting given the legal requirement to base underwriting on actuarial principles. The conversation nonetheless has made regulators alert to a need to understand "blackbox" models to evaluate whether they produce an actuarially supportable relationship to risk or whether any improper biases are present in the data or methodologies.

> Remember that regulators do not think about the world in the same way as entrepreneurs. **Catchphrases like "disruption" or "transformative"** will likely not move the needle unless presented in a balanced way.

What Should Innovators Do?

The industry wants to innovate and move fast. It is trying to adopt the so-called Silicon Valley mindset of building an MVP (Minimum Viable Product) and iterating over time to "get it right." Unlike most start-up environments, where today you can try to "build it" to see if "they will come," in highly regulated industries like insurance, you can't just build it. You need to know that what you build is something that can be sold or used legally within the regulatory framework.

More often than not, a new idea, technology or platform is presented, and the *law is silent* or at least unclear. Industry wants to get it right, but feels hamstrung by a lack of guidance from regulators. So, what can an innovator do?

For new and different insurance propositions, *give consideration to connecting with applicable regulators early and often.* Regulators have spoken out to encourage this participation, and companies are doing this already. For example, Lemonade—an Insuretech start-up that built a new insurance company to sell renters' insurance exclusively online—approached regulators directly in certain states to grant a license under existing laws and, in Florida, worked together with regulators to change the underlying statute. See generally Bradley Tusk, *The Fixer* (2018), ch. 21.

If an approach is made, innovators should be *thoughtful about which jurisdiction they are considering.* A decision to be in a particular market should first and foremost be driven by business considerations—market demographics, physical hazards, available distribution channels, culture and where the principals are already located. But considering the regulatory environment is appropriate too. Different regulators may have different motivations and different concerns. Some may be more receptive to certain types of innovation over others. Local concerns and needs could further drive the issue.

Last, when presenting a proposition to a regulator, *don't present something that's only half-way thought through. Use common sense.* Be specific about the proposition, what regulation currently is implicated and how you would like it applied. This requires planning and good advice. Remember that regulators do not think about the world in the same way as entrepreneurs. Catchphrases like "disruption" or "transformative" will likely not move the needle unless presented in a balanced way.

Disgorgement

« Continued from page 9

stance, covered by insurance. See, e.g., *Burks v. XL Specialty Ins. Co.*, 2015 WL 6949610 (Tex. App. Nov. 10, 2015) (reasoning that the settlement of a claim seeking restitution was not necessarily uninsurable as a matter of law in the absence of an express finding that the settlement amount, in fact, represented the return of ill-gotten gain); *U.S. Bank Nat'l Assoc. v. Indian Harbor Ins. Co.*, 68 F. Supp. 3d 1044, 1050 (D. Minn. 2014) (holding that under Delaware law restitution payments were not uninsurable); *Cohen v. Lovitt & Touche*, 308 P.3d 1196, 1200 (Ariz. Ct. App. 2013) (rejecting assertion that state public policy law prohibits insurance coverage for restitutionary payments); *In re TIAA-CREF Insurance Appeals*, 2018 WL 3620873 (Del. Sup. Ct. July 30, 2018) (applying New York law) (finding that there was no evidence that settlement payment labeled as disgorgement triggered any public policy concerns).

However, and as discussed in greater detail below, a potential set-back to policyholder's arguments occurred on Sept. 20, 2018, when a New York Appellate Court overruled *J.P. Morgan Securities Inc. v. Vigilante Ins. Co.*, 57 Misc.3d 171, 177 (Sup. Ct. N.Y. Ctny. 2017), and held that SEC disgorgement is a "penalty," which does not fall within the policies definition of "Loss" because it excludes "fines or penalties imposed by law." *J.P. Morgan Securities v. Vigilante Ins. Co.*, 2018 WL 4494692, *3 (1st Dep't Sept. 20, 2018).

The New York Supreme Court: 'J.P. Morgan Securities Inc. v. Vigilante Insurance Co.', 57 Misc.3d 171 (Sup. Ct. N.Y. Ctny. 2017)

In 2003, the SEC and NYSE conducted investigations against Bear Stearns for possible violations of federal securities laws regarding the alleged facilitation of late trading and market timing by certain customers. *J.P. Morgan*, 57 Misc.3d at 176. Following the investigations, the SEC told Bear Stearns that it intended to formally charge Bear Stearns with violations of federal securities laws. Id. Bear Stearns disputed the proposed charges but the parties settled the claims with no admissions of wrongdoing by Bear Stearns. Id. As part of the settlement, Bear Stearns agreed to pay $250 million, of which $160 million was labeled disgorgement and $90 million was labeled as a penalty. Id.

Bear Stearns' insurer refused to pay for its defense costs or any part of the settlement. Soon thereafter, in 2009 plaintiffs J.P. Morgan Securities and J.P. Morgan Clearing (formerly known as Bear Stearns entities), filed an insurance coverage lawsuit in New York state court seeking a declaration that pursuant to a primary professional liability policy, which sat below excess follow-form policies, plaintiffs' insurers were obligated to indemnify Bear Stearns for the non-penalty portion of the SEC settlement—namely, the disgorgement payment—defense costs and pre-judgment interests. Id. at 177. The insurers denied coverage on multiple grounds, including, that SEC disgorgement payments are an uninsurable penalty and not a "Loss" covered by the policy. Id.

The lengthy coverage battle, ended in the Supreme Court with the trial court's a pivotal decision on April 17, 2017. The trial court held that based on the policy's broad definition of "Loss,", the settlement payment, labeled as disgorgement, was a covered "Loss" that represented the gains of third parties, not Bear Stearns. Id. at 179. The trial court also held that any public policy argument barring loss arising out of intentionally harmful conduct was not applicable because there was no evidence that Bear Stearns purposely intended to cause injury. Id. at 186.

The insurers appealed the trial court's April 17, 2017, decision. Shortly after the trial court's ruling, in June 2017, the U.S. Supreme Court issued its decision in *Kokesh v. Securities and Exchange Commission*, 137 U.S. S. Ct. 1635 (2017), which would pave the way for the insurer's arguments.

> The First Department's ruling in 'J.P. Morgan' **establishes New York precedent** for the insurability of SEC disgorgement payments while 'Kokesh' raises the broader question regarding the **scope of insurability for any disgorgement payments** in the future.

The U.S. Supreme Court: 'Kokesh v. SEC,' 137 S.Ct. 1635 (2017)

In 2009, the SEC brought an enforcement action against Charles Kokesh, alleging that he violated various securities laws by concealing the misappropriation of $34.9 million from various development companies. Id. at 1638. The SEC sought monetary civil penalties, disgorgement, and an injunction barring Kokesh from future securities violations. Id. After a jury found Kokesh guilty of the misappropriation, the District Court of New Mexico imposed the penalties sought by the SEC and determined that because disgorgement was not a "penalty" within the meaning of 28 U.S.C. §2462, the applicable five-year statute of limitations did not apply and disgorgement actions "in the securities-enforcement context" must be commenced within five years of the date the claim accrues. Id. at 1641. The U.S. Court of Appeals for the Tenth Circuit affirmed the district court's opinion, confirmed that SEC disgorgement is not a penalty, and further found that disgorgement is not a forfeiture. Id. The SEC appealed the Tenth Circuit's ruling to the U.S. Supreme Court.

On June 5, 2017, the Supreme Court reversed the Tenth Circuit's decision and held that, "[d]isgorgement, as it is applied in SEC enforcement proceedings, operates as a penalty under §2462," and "any claim for disgorgement in an SEC enforcement action must be commenced within the five years of the date the claim accrued." Id. at 1645. In its analysis, the Supreme Court considered and determined: (1) SEC disgorgement is imposed by the courts as a consequence for violating a wrong to the public, rather than an individual; (2) SEC disgorgement is imposed for punitive purposes, not remedial; and (3) often, SEC disgorgement is not compensatory and operates to deter, not compensate—the hallmarks of a penalty. Id. at 1644.

The First Department: 'J.P. Morgan Securities v. Vigilante Insurance Co.', 2018 WL 4494692, *3 (1st Dep't Sept. 20, 2018)

On Sept. 20, 2018, the First Department became one of, if not the first, court to hold that *Kokesh*'s finding that SEC disgorgement is a penalty, "applies with equal force" to insurance coverage actions. *J.P. Morgan*, 2018 WL 4494692 at *3 (finding that *Kokesh's* holding applies with "equal force to the issue of whether the disgorgement paid by Bear Stearns, even if representing third-party gains, was a "Loss" within the meaning of the policy and whether public policy bars insurance companies from indemnifying insureds paying SEC disgorgement.").

In the appeal of the trial court's April 17, 2017 decision, the First Department considered whether "SEC disgorgement is an uninsurable penalty and not a "Loss" covered by the policy." *J.P. Morgan,* 2018 WL 4494692, at *3. In a unanimous opinion, the First Department found that the *Kokesh* decision "provided the missing precedent, establishing that disgorgement is a penalty, whether it is linked to the wrongdoer's gains or gains that went to others." Id. at *5. The First Department reasoned that the trial court's opinion granting coverage could not stand because SEC disgorgement is a "penalty," and does not fall within the policies definition of "Loss" which excludes "fines or penalties imposed by law." Id. In reaching this conclusion, Associate Justice Richard Andrias wrote:

> In both instances disgorgement is a punitive sanction intended to deter. To allow a wrongdoer to pass on its loss emanating from the disgorgement payment to the insurer, thereby shielding the wrongdoer from the consequences of its deliberate malfeasance, undermines this goal and "violate[s] the fundamental principle that no one should be permitted to take advantage of his own wrong."

Id. at *3 (internal quotation marks omitted).

Policyholder Considerations

The First Department's ruling in *J.P. Morgan* establishes New York precedent for the insurability of SEC disgorgement payments while *Kokesh* raises the broader question regarding the scope of insurability for any disgorgement payments in the future. However, in the face of these decisions, policyholders should also take the following into consideration:

First, it is currently unknown whether other courts and jurisdictions will agree with *J.P. Morgan* and find that *Kokesh*'s holding applies "with equal force" to insurance coverage actions. Indeed, Justice Sotomayor cautioned courts that nothing in the *Kokesh* decision should be interpreted as an opinion on "whether courts have properly applied disgorgement principles in this context. The sole question presented in this case [*Kokesh*] is whether disgorgement, as applied in SEC enforcement actions, is subject to §2462's limitation period." *Kokesh,* 137 S.Ct. 1635, at n.3. Thus, it remains to be seen if the First Department's application of *Kokesh* is merely an outlier, or the ringleader. In addition, *J.P. Morgan* is still subject to an application for appeal and could be overturned by the Court of Appeals.

Second, *Kokesh* held that SEC disgorgement is a "penalty," imposed as a sanction for violating public laws and is imposed for punitive reasons. *Kokesh*, 137 S.Ct. at 1638. Applying *Kokesh*, *J.P. Morgan* did not hold that all forms of disgorgement are uninsurable but rather, only that "SEC disgorgement," which has been determined as a matter of law to be a penalty, is uninsurable. Therefore, *J.P. Morgan* holds, at most, that this specific type of disgorgement is uninsurable.

Third, since *J.P. Morgan* is limited to an analysis of the insurability of "SEC disgorgement," and not the insurability of *all* payments that happen to be labeled as "disgorgement," D&O policyholders should pay close attention to both the nature of the claims (i.e., fiduciary duty claims, class actions, securities enforcement actions) and the specific type of damages sought. In illustration, the Delaware Supreme Court, applying New York law, recently distinguished the trial court's decision in *J.P. Morgan* and similar cases that "involve regulatory proceedings which resulted in settlements ordering the insured to pay disgorgement damages." *In re TIAA-CREF Insurance Appeals*, 2018 WL 3620873, at * 2 (Del. Sup. Ct. July 30, 2018). In *TIAA-CREF*, settlement payments labeled as disgorgement were made in connection with civil ERISA class actions where defendant TIAA consistently denied liability, defended the civil class actions, there was no finding of wrongdoing by the court, and the ill-gotten gains were not necessarily in the hands of the policyholder. Id. at *2. Therefore, the court's review of the nature of these settlement payments, even though they were labeled as such, did not represent disgorgement. Id.