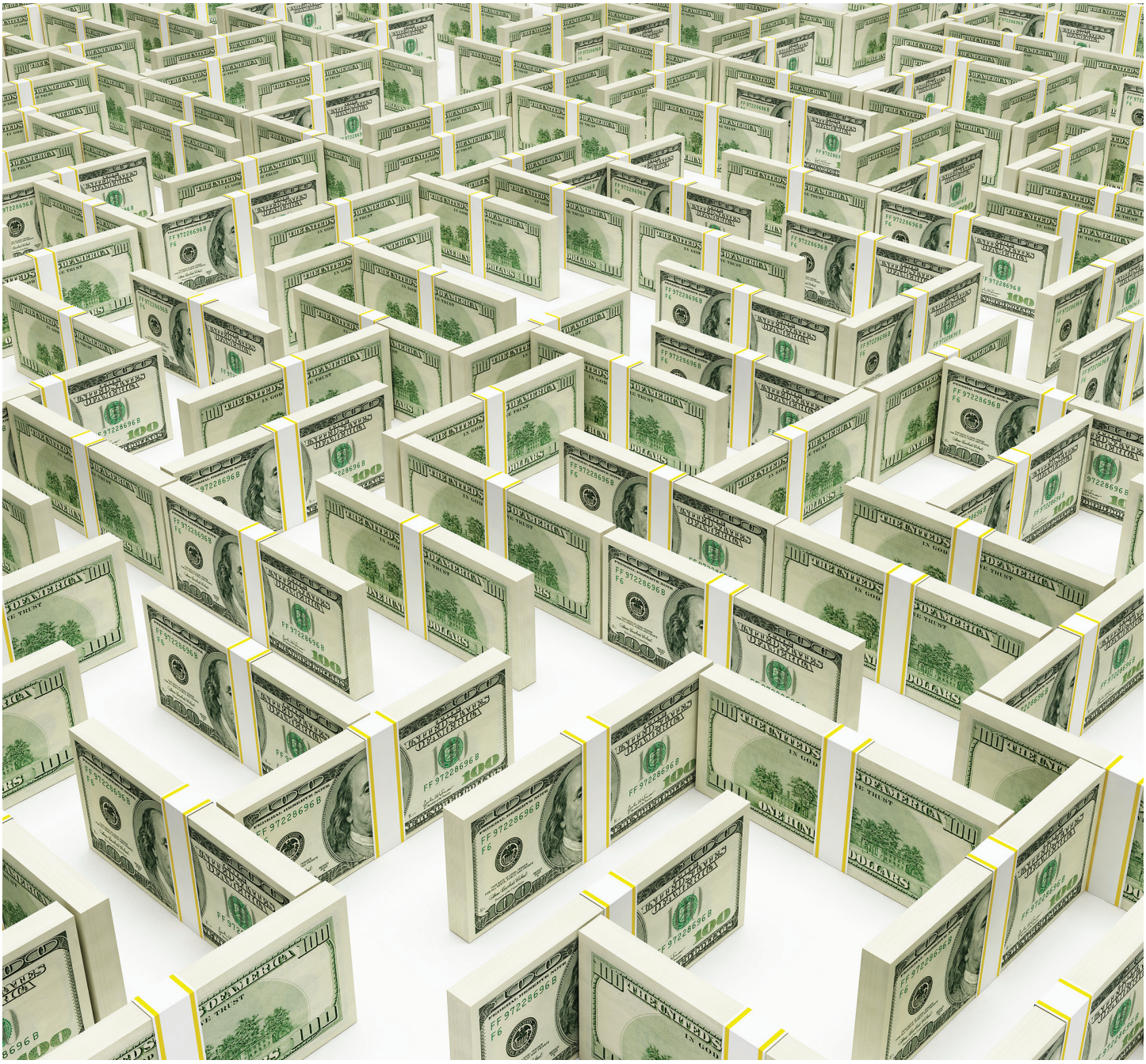
Not for the Novice

By Elizabeth Hanke and Nancy Gutzler

Bermuda Form



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Bermuda Form liability insurance can be valuable to corporate policyholders who are at risk for large bodily injury or property claims, especially those arising from their products. But the Bermuda Form is complicated, and it contains several terms and conditions that can make or break a policyholder's insurance recovery, if not properly considered. This article discusses three of the most important concepts of these policies: integrated occurrence, maintenance deductibles, and allocation of covered and uncovered costs. We will focus on best practices a policyholder can follow proactively to maximize recovery, as well as what to do if facing a Bermuda Form claim without being properly prepared.

History of the Bermuda Form

The Bermuda Form was born in the mid-1980s as a direct response to what is sometimes called the collapse of the U.S. excess liability insurance market. That collapse was due in large part to increases in long-tail, multi-year liabilities such as environmental property damage and asbestos bodily injury. For a period, certain high-risk policyholders had a difficult time getting meaningful comprehensive general liability (CGL) insurance.

The Bermuda Form is a hybrid of traditional occurrence-based policies and claims-made policies. The form provides large product manufacturers with meaningful coverage, while allowing insurers to limit their liability for occurrences that span multiple years. The coverage gets its name from the beautiful island of Bermuda, where most of the issuing insurers are based.

The first insurer to issue this type of coverage was ACE Ltd. ACE was created in 1984 by 34 corporate shareholders, who were led by Marsh & McLennan and JP Morgan. While originally formed in the Cayman Islands, ACE redomiciled in Bermuda the next year. *See* Charting Bermuda's History, November 12, 2000, *available at* http://www.businessinsurance.com. Initially, ACE wrote insurance only in excess of $100 million. However, in 1986, X.L. Insurance Co. Ltd. was formed in Barbados, with help from Marsh & McLennan and JP Morgan, to write lower-level excess liability coverage. Today, all the Bermuda markets write coverage on the form, which generally has a maximum capacity of $1 billion and self-insured retentions (SIRs) between $50 million and $100 million.

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One of the reasons policyholders choose this form of liability insurance is to secure coverage for longer tail claims. The Bermuda Form allows for reimbursement for claims made during a policy period even when part of the injury or damage occurred over many years. As the insurance industry moved away from occurrence-based coverage and towards "claims made" coverage, the Bermuda Form was created to fill the demand.

Conceptually, the policy is simple in that it provides broadly defined excess liability coverage, typically over a very large SIR. The coverage is for personal injury or property damage that takes place after the inception of the policy, and it allows a policyholder to combine multiple losses into one defined "integrated" occurrence. The integrated occurrence provides a way for a policyholder to aggregate similar claims into one policy year, even if they spill over into the years after the policy.

Integrated Occurrence

The integrated occurrence concept is one of the most appealing features of the Bermuda Form, especially for a policyholder facing many individual product liability claims. Bermuda Form policies typically sit above very large ($50 to $100 million) SIRs, such that being able to "integrate" or batch many claims into one occurrence can be the difference between reaching coverage or remaining in self-insurance. Even injuries that occur over several years can potentially be integrated into the same occurrence and allocated to one year of coverage; in this way, they behave much like an occurrence-based policy.

The following is a typical definition of an integrated occurrence in a Bermuda Form policy:

> Definition R: "Integrated Occurrence" means: an Occurrence encompassing actual or alleged Personal Injury, Property Damage, and/or Advertising Liability to two or more persons or properties which commences over a period longer than thirty (30) consecutive days which is attributable directly, indirectly or allegedly to the same actual or alleged event, condition, cause, defect, hazard and/or failure to warn as such; provided, however, that such Occurrence must be identified in a notice pursuant to Section C of Article V as an "Integrated Occurrence."

As the definition states, a policyholder must give notice or "declare" an integrated occurrence. How and when an integrated occurrence is defined and noticed to an insurer impacts the ultimate value of the occurrence and the related insurance available. Defining an integrated occurrence too broadly can have the unintended consequence of wrapping future claims into the same occurrence because they relate to the same product, even if because of a different defect. This would result in allocating these damages into the same potentially exhausted policy year. Defining the occurrence too narrowly has the opposite effect: limiting the claims included. In that case, claims may not go beyond the self-insured retention. Legal theories of product defect, related causation, and injury type typically develop over time, such that waiting to declare an integrated occurrence may

provide the policyholder with a better definition. The caveat to waiting is that Bermuda policies are still "claims made and reported"—in that the timing of when notice of an integrated occurrence can be given is limited by the specific policy language and possibly extended reporting periods. Many policies allow an integrated occurrence to be defined "retroactively."

Consider a pharmaceutical drug claim where many claims have been filed alleging three general types of injuries to have been caused by the same drug: heart attack, stroke and skin problems. If all three types of injury are part of the same integrated occurrence, the occurrence will pierce the SIR layer. But if each injury-type is considered a separate integrated occurrence, the SIR must be paid three times, and each individual occurrence may not exceed the SIR amount such that no insurance coverage is triggered. See Figure 1.

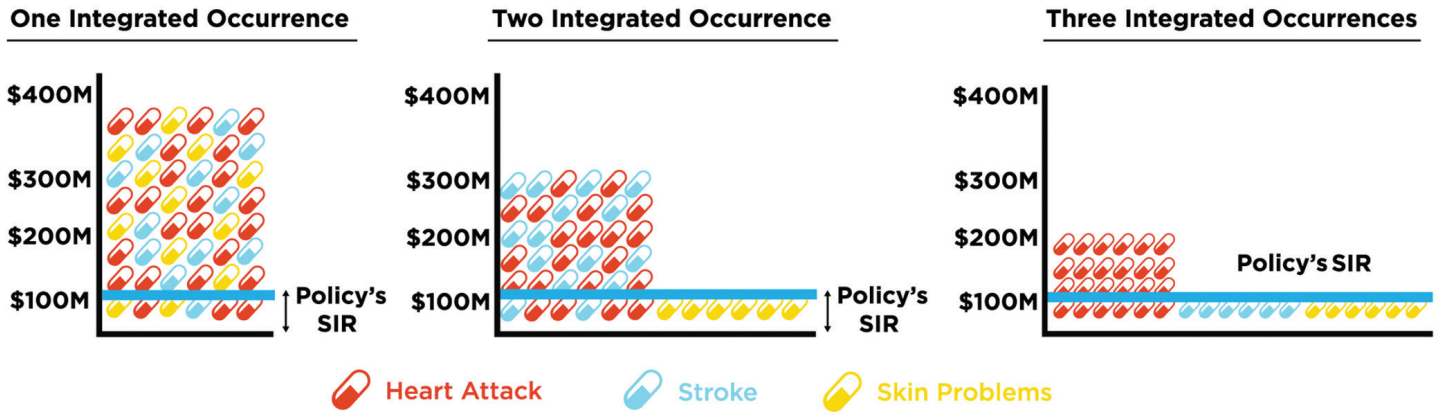
Due to the weighty implications of these decisions, having timely and accurate claims data is critical so that both policyholder and counsel can make the best decisions regarding when and how to declare an integrated occurrence. Further, if a product is distributed nationally to millions of people, the related claims will come from different jurisdictions and plaintiffs' attorneys over many years. Being able to see the data in real time allows policyholders to identify trends and facts regarding products involved, allegations of causation, and injury types. The key is having the claims data consistently captured in a single accessible location. Using a system that makes it possible to evaluate potential integrated occurrence definitions, the policyholder is able to stay ahead of the game.

In the above example, the product is the same for all three potential occurrence definitions, but the alleged injuries are can be grouped in two or three different ways. While it is common for a defendant to track a specific product as it relates to a claim, it is not as common to consistently track injury type; general allegations such as a design defect, manufacturing defect, or failure to warn; or claims that arise out of consumer protection cases. While some cases are more complex in nature, having detailed information about alleged injury and the legal theories under which a claim is being pursued can help a policyholder identify a potential integrated occurrence earlier and more clearly.

The single most useful step a defendant can take is to use universal claim numbering across all law firms and systems. When a complaint is filed, a unique reference number gets created and shared by local and national counsel for use in all defense cost and expense billing, document management, and related settlement amounts.

Defense costs associated with product liability cases can be quite high—sometimes in excess of indemnity costs. Since these costs are typically covered within policy limits on the Bermuda Form and go toward exhausting the large SIR, it is important to track them in such a way that they can be included when evaluating integrated occurrence definitions. The simplest way to do this is to track defense costs on a by-claim or by-lawsuit level. This can be more challenging than it sounds, since certain defense costs are shared between claims. For example, discovery efforts and associated costs can be used for multiple claims as National Coordinating Counsel (NCC) works up standard responses to complaints and interrogatories and creates expert witness lists that apply across claims. These costs may be covered (see below for a discussion of covered and uncovered claims) if they are tracked properly; they can also be included when valuing an integrated occurrence. The single most useful step a defendant can take is to use universal claim numbering across all law firms and systems. When a complaint is filed, a unique reference number gets created and shared by local and national counsel for use in all defense cost

Figure 1



and expense billing, document management, and related settlement amounts. Different platforms are less of a problem when claims have a consistent reference number. Shared defense costs should be tracked in a way that allows them to be allocated to related claims at a later date.

While the specific definition of an integrated occurrence and the timing around when to declare it are legal questions, having claims data available to evaluate the options is critical. The claims data should be evaluated considering the language of all of the policies in place during the time period of the potential occurrence, as well as other non-related occurrences for either different products or different allegations involving the same product.

Maintenance Deductibles

As previously mentioned, Bermuda Form insurance policies typically sit above very large SIRs. The policyholder expects to pay many millions of dollars before reaching coverage for any one occurrence, integrated or not. Further complicating the long road to coverage is the elusive "maintenance deductible." While those words do not appear anywhere in the Bermuda Form, they have become common nomenclature to describe injury, damage, or liability that was "expected or intended" by the policyholder. Paul Stanley, Queens Counsel and an expert on the Bermuda Form, wrote a paper detailing the complexities of the maintenance deductible for the ABA's Insurance Coverage Litigation Committee's 2017 annual meeting. *See* The "Maintenance Deductible" in Practice, *available at* http://www.aba.org.

The concept is derived from the definition of the occurrence in Bermuda Forms, which, like all general liability policies, exclude any injury or damage that is expected or intended by the policyholder. The idea is that there may be some level of injury that is expected as part of the ordinary features of the insured's business; such claims are excluded from coverage. Let's consider vaccines. While millions of people use them safely each year, some small percentage of the population will have a serious adverse reaction or injury and can be expected to sue. These "expected" claims would not be covered or count toward the large SIR underlying a Bermuda Form policy. The analogy used by Stanley is that the maintenance deductible is the liability-insurance version of "wear and tear"—it's not covered. While the concept makes sense intuitively, it is very difficult to measure in practice. See Figure 2

The "maintenance deductible" requires a policyholder and its carrier to compare the expected rate of something to the actual rate of something. Specifically, the policy language is [emphasis added]:

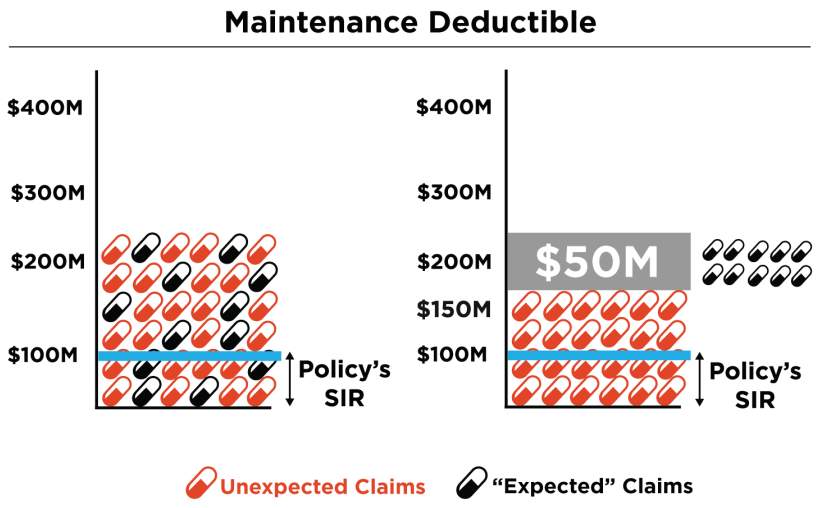
> … and which personal injury, property damage or advertising liability is neither expected nor intended by the Insured. Where certain actual or alleged personal injury, property damage or advertising liability *is expected or intended* by the Insured *or* the Insured has *historically experienced* a level or rate of actual or alleged personal injury, property damage or advertising liability associated with given products or operations and actual or alleged personal injury, property damage or advertising liability *fundamentally different in nature or vastly greater in order of magnitude occurs*, such actual or alleged personal injury, property damage or advertising liability shall not by virtue of such expectation, intent or historical experience be deemed expected or intended to the extent and only to the extent it is different or incrementally greater.

This definition gives two measures for what falls within the maintenance deductible. In the first instance, how does a policyholder determine the "rate" of historical injury? Is it based on number of claims, average severity of claims, or total amounts paid on claims? If the insured markets a product knowing that it sometimes causes injury, *e.g.*, the vaccine example, but believes it has adequately warned of the rare side effects such that it is not expecting any significant claims, then what is "expected"? If the policyholder is then sued for a failure to warn adequately, and numerous claims are filed, at what point does coverage kick in, if at all? For the second measure, the policy language alludes to whether the injury is fundamentally different in nature or vastly greater in magnitude than expected. This brings to mind more questions regarding the difficulty of measurement. How do you measure magnitude of injury? Is it simply the number of claims, or is it the severity of the injuries?

Using a simple example to illustrate the quandary: if we expect 10 claims at an average of $10,000 per claim, and we get 10 claims, but the first one is resolved for $10 million and the remaining for $5 million each, do any of the claims fall under the maintenance deductible?

This segues into the issue of timing. Using the example above, it may be some time before we realize the 10 claims received to date are greater than "expected" in dollars. A policyholder ends up shooting at a moving target in an attempt to determine if and when the claims have exceeded

Figure 2



expectations—vastly or otherwise. Once a policyholder concedes that some trivial level or rate of injury was expected, they enter into huge uncertainty as to how this provision will be applied.

As seen with the integrated occurrence issue discussed previously, accurate and timely claims data can inform a policyholder, sooner rather than later, when the quantity and/or value of claims has exceeded the "expected" threshold. Tracking additional claims details regarding the nature of the injury can also alert a policyholder early on if the nature of the claims is not what was expected. A policyholder who accumulates claims data over years and distinguishes claim, injury, and product differences is in a better position to place upper and lower boundaries on what was "expected" by looking at actual historical experiences.

Allocation of Covered and Uncovered Costs

Since Bermuda Form policies are designed to cover complex liability situations such as drug and medical devices, these types of product liability cases commonly involve claims that ultimately will be covered, as well as some that will not. Whether a claim will be considered covered or uncovered is not necessarily known when it is first filed. Policyholders and their defense counsels rarely, if ever, attempt to segregate defense and liability into "covered and uncovered" as cases are ongoing. As previously discussed, the concepts of integrated occurrence and maintenance deductibles, by definition, can divide seemingly related claims into different covered and uncovered groups. The Bermuda Form has complicated occurrence reporting requirements, including possibly extended or retroactive reporting periods. A typical policyholder will undertake a comprehensive approach to defending claims vigorously before coverage of any claim can be determined. Because an insurer cannot be called upon to pay more than it bargained for under an insurance contract, the policyholder's loss must eventually be allocated between covered and uncovered claims.

Not all Bermuda Form policies speak to the issue of allocation, but if they do, the language may look something like this:

> If liabilities, losses, costs and/or expenses are in part covered by this Policy and in part not covered by this Policy, the Insured and Company shall use their best efforts to agree upon a fair and proper allocation thereof between covered and uncovered amounts, and the Insured shall cooperate with such efforts by providing all pertinent information with respect thereto.

A policyholder who accumulates claims data over years and distinguishes claim, injury, and product differences is in a better position to place upper and lower boundaries on what was "expected" by looking at actual historical experiences.

The basic idea is that the insurer should only pay for what is covered, and the insurer and policyholder will work together to come up with a fair spilt. While the concept is clear, the determination of what is covered and not covered is not simple. By virtue of the nature of these complex claims, the data used to make such determinations is not always available, or may be subject to certain interpretations by both sides. In the absence of specific policy language, New York law will typically control a Bermuda Form arbitration. New York law generally has two methodologies: one for settlement costs and one for defense costs.

With regard to judgement and settlement costs, amounts are allocated based on the "relative exposure" or "relative fault" test. Like all things Bermuda Form, it sounds easier than it is! Determining relative exposure is a fact-intensive exercise that may require additional evidence and discovery. If what makes a claim covered or uncovered is a matter of agreeable and definable criteria, *e.g.*, in claims filed before a certain date or claims making a certain allegation, the total covered claims can be quantified by adding up those related settlements and the associated defense costs. However, in cases with multiple jurisdictions and defense firms, the data may not have been captured in a way that allows the coverage determining criteria to be applied. If the definition of "covered" involves facts not captured, or not captured consistently across claims, then the exercise of determining the total covered amount can be daunting. Of course, there is also the (likely) possibility that policyholder and insurer will disagree on the definition of "covered," making it even harder to determine coverability.

When it comes to defense costs, New York courts allocate by applying a "reasonably related" test. Under it, all defense costs that are reasonably related to defense of covered claims are covered in full, even if those costs relate to, or benefit, uncovered claims. If additional expenses are incurred that would not have been incurred but for the inclusion of the non-covered claims, then the court permits an allocation of those additional expenses if it can be done on a factual basis. The insurer has the burden to demonstrate that all or some portion of the costs were strictly in defense of an uncovered claim. As previously discussed, it is most helpful if defense costs—fees as well as expenses—are well documented and consistently maintained on a claim level from filing of the first claim or lawsuit. This allows a policyholder to respond effectively if an insurer overreaches regarding what was related solely to uncovered claims.

Best Practices

Given the complexity of the Bermuda Form and the liabilities it insures, cases can go on for many years—both in the defense and resolution of the underlying claims and any related coverage disputes. This time lag is further exacerbated by the fact that most Bermuda Form policies sit above very large SIRs. Often a policyholder does not realize they will pierce the SIR layer until the underlying litigation is well underway.

There are some proactive steps that all Bermuda Form policyholders should take to ensure they maximize coverage when they need it. It is critical to involve coverage counsel early on for guidance. If likely coverage disputes are identified early, a policyholder can collect data to value and help mitigate impact on coverage later. Setting up a tracking mechanism for Bermuda Form policy terms is critical to the process. Reporting periods for an integrated occurrence, including any extended or retroactive date options, and for general notice requirements should be known by the policyholder and anyone working on their behalf.

Keep in mind that the data needed for pursuing coverage can differ from the data needed for the underlying defense. It is time-consuming and expensive to collect data retroactively. Data protocols should be set up early. Determine who will enter and maintain the data, who will preserve it year after year, and who will coordinate collection between parties.

Multijurisdictional product liability cases can produce very large defense costs that sometimes exceed indemnity costs. It is crucial to set up defense billing systems and guidelines appropriately and consistently across all counsel. A defendant company should also utilize task billing codes along with specific guidelines for each code, track defense data on a claim or lawsuit level, and preserve electronic defense data on an ongoing basis. Having detailed defense data over the life of the underlying claim will be critical for all of the issues discussed in this article:

- Defining integrated occurrence;
- Determining maintenance deductibles;
- Allocating covered and uncovered claims and the related defense.

Ideally, a single electronic litigation billing system would capture and preserve all defense costs, including detailed time entries. If that is not the case, a policyholder or its coordinating counsel should proactively coordinate and collect the information between defense billing systems and firms. As previously mentioned, having consistent identification numbers for claims and related defense costs between systems is very powerful. Defense counsel should summarize litigation milestones to provide context for what defense counsel is doing at different points in time—either monthly, quarterly, or yearly, as appropriate. Defense expenses that benefit many claims—such as preparing initial discovery, mock jury trials, and certain aspects of trial preparation—need to be well documented. Discovery-related expenses, such as the set up and coding of documents into an electronic discovery system and associated monthly maintenance fees, are not always tied to just one "claim." If these expenses are well-documented and clearly identified, it can be shown that the costs would have been incurred, regardless of whether a claim is ultimately determined to be covered or uncovered.

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All settlements should be fully and consistently documented, including capturing the data points in a database with backup documents linked to each claim. Coverage counsel should be consulted on the level of evidence and documentation that is required for coverage. It is common in large product liability cases for defendants to enter into structured settlements that can streamline the settlement process and reduce related defense costs by providing a set of criteria that each claim must meet for settlement. It is important that the requirements for structured settlements incorporate the same level of evidence as may be required for coverage. Additionally, SIR or deductible exhaustion should be documented with the same diligence that would be used for proving exhaustion of insurance policies.

Some common data points that can be used for insurance recovery include:

- Dates
  - date of product use—all use or the most recent prior to injury, depending on the facts at issue;
  - date of loss or injury;
  - date of diagnosis;
  - date of manufacture or date of installation of product;
  - date of complaint;
  - date of death.
- Descriptive Data
  - allegations made in an underlying claim;
  - product used, including any relevant distinctions;
  - injury or loss in detail and categorized for summarizing;
  - diagnosis information including doctor, documentation of diagnosis (*i.e.*, medical records if needed);
  - doses (if applicable);
  - other relevant facts used to prove or disprove the liability of the policyholder—may also speak to whether the claim is covered or not covered.

What if a policyholder finds itself facing a claim and is not as prepared as it could have been? While it will take more effort and time, the same information can usually be compiled from existing litigation claim files and billing systems. Electronic defense billing systems can be exported and complied into one defense cost database; even if the systems are different, the data can be extracted in a universal format. If the volume of files and information is too great to review, a sampling of files can be used to extrapolate to the entire population.

Is It Worth It?

Bermuda Form policies are not for the novice, but when facing "bet the company" litigation, they can be incredibly valuable. In order to make the most of the policies, companies do best if they proactively collect data and monitor claims on a consistent basis. Of course, this is not easy or without cost. While it may seem like a lot of effort, especially for situations when an occurrence does not result in piercing the SIR, it can help maximize insurance recovery and allow a company to identify and effectively manage serious situations. Having data available to model variations in coverage positions results in more productive and informed litigation and coverage decisions.