

“HOT TOPICS IN D&O CLAIMS HANDLING AND COVERAGE”

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June 8, 2006

I. WHO IS INSURED BY A D&O POLICY

D&O insurance is designed primarily for the protection of individual directors and officers of corporations. While most state regulations and corporate charters and by-laws require a corporation to indemnify its individual directors and officers from many liabilities arising from their actions on behalf of the corporation, D&O insurance provides comfort to the directors and officers that they may be protected even if the corporation can not or will not indemnify them.

As a result of the corporation's indemnification obligations, D&O Policies typically contain at least two coverage parts commonly known as “Side A” and “Side B.” Side A is direct insurance of the individual directors and officers and typically carries a small (if any) retention to be paid by the Insureds before the Insurer is obligated to pay. Side A is only triggered if the corporation does not provide indemnification to the individual directors and officers. Side B applies when the corporation does indemnify the directors and officers. Typically, the retention is far larger than Side A as it is being paid by the Corporation and the Corporation is only looking for insurance with respect to significant exposures.

D&O insurance today often provides additional coverage, such as for securities fraud suits against the corporate entity and employment practices liability. As a

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result, individual directors and officers may be surprised to learn that the insurance they understood was purchased for their benefit may be eroded or even exhausted by claims against the corporate entity and/or is not readily available to them in the event of the corporation's bankruptcy. This may be alleviated when the D&O policies, such as the Enron D&O policies, have a "priority of payments" provision entitling the individual directors and officers to a priority interest, ahead of the debtor corporation, to amounts payable under the policy.

II. WHAT TYPES OF RISKS ARE INSURED AND PROCEDURAL REQUIREMENTS LIMITING COVERAGE

D&O policies typically tie coverage to "Loss" from a "Claim" made against an Insured during the "Policy Period" alleging "Wrongful Acts." Also important for understanding the type of risks insured are: provisions concerning who has the responsibility for defending a Claim; when a Claim must be reported; and when the potential for a future Claim may be reported.

A. Defense Obligation

While there are exceptions to this rule, particularly for smaller companies, large company D&O policies typically do not impose on the Insurer a "duty to defend." Thus, the Insured has both the right and the obligation to select defense counsel and control the defense of the litigation. However, most policies require that: (a) no expenses be incurred without the Insurer's consent (an area also relevant to the timeliness of notice of the Claim to the Insurer discussed below); and (b) the expenses be "reasonable." The reasonableness requirement is intended to afford the Insurer some control over the rates charged by counsel selected by the Insured as well as some control over the strategy choices made in the conduct of the litigation. Some Insurers also afford financial incentives to Insureds who accept the carriers' recommended counsel.

A related issue is whether a policy's coverage wording states that the Insurer shall "indemnify" the Insured or shall "pay on behalf of" the Insured. While other terms may be used, or this issue may be expressly addressed in the Policy, it is worth noting that a policy providing "indemnification" may be deemed to permit the Insurer to require that the Insured pay all defense fees and even any settlement until the litigation is fully resolved at which time the Insurer and Insured can address amounts for the Insurer to "indemnify." The term "pay on behalf of" is typically interpreted to require the Insurer to begin paying defense fees directly as they are incurred and once the Policy's retention has been satisfied by the Insured.

Typically included within the scope of corporate indemnification are expenses, judgments, fines and settlements that directors and officers reasonably incur in actions against them by reason of their being directors or officers but, again, only if they act in “good faith” and in a manner they reasonably believe to be “in or not opposed to the best interests of the corporation.” *See, e.g.*, Del. CPL §145. These statutes also authorize corporations to advance the litigation expenses their directors and officers incur in such actions, and in practice, corporations routinely advance such expenses. The ability of corporations to advance defense expense, like providing broad indemnification rights, is considered to be critical to a corporation’s ability to attract qualified people to serve in management, especially given the substantial expense of defending director and officer litigation. Advancing litigation expenses also helps the corporation promote a common representation and coordinated defense. Generally, advancement can be conditioned upon the recipient’s undertaking to reimburse the corporation if the recipient ultimately is not entitled to indemnification or upon any other conditions the corporation requires, including the retention of counsel the corporation selects. However, advancement is not indemnification, but a loan in anticipation of indemnification.

B. Definition of “Claim”

Most policies today provide a detailed definition attempting to clarify what comprises a covered “Claim.” Such definition typically addresses whether a simple demand for compensation triggers coverage or whether there must be a formal lawsuit filed in a court or other forum. Similarly, the definition of Claim may expressly address whether or not a regulatory or criminal investigation is covered and what level of investigation will trigger coverage (i.e., the commencement of a formal or informal investigation or the filing of formal charges and/or an indictment). To fully evaluate this definition in a particular regulatory environment, it may be necessary to analyze the statutory authority upon which the regulator is proceeding.

Coverage for government investigations is sometimes analyzed in the context of the definition of “Claim.” There appears to be somewhat of a split of opinion among the courts as to whether a claims-made policy is triggered by the commencement of a governmental or regulatory investigation.

Several courts have held that a grand jury or similar governmental investigation is a “claim” under a professional liability policy and, therefore, the investigation triggers coverage for the cost of the defense of the insured. *See Polychron v.*

Crum & Forster Ins. Co., 916 F.2d 461 (8th Cir. 1990) (Where the term “claim” is not defined, a grand jury subpoena and investigation were found to be “claims” under a D&O policy, and legal fees incurred in connection with responding were covered “loss.”); *Minuteman International Inc. v. Great American Insurance Co.*, 2004 WL 603482 (N.D. Ill. 2004) (Court held SEC investigation commenced by an order and subpoenas was a “claim” under D&O policy as it was a proceeding seeking “relief.”); *Richardson Electronics, Ltd. v. Federal Ins. Co.*, 120 F.Supp.2d 698 (N.D. Ill. 2000) (Justice Department’s antitrust investigation of insured corporation was a “claim” and thus, within coverage of claims-made executive risk insurance policy, even though no demand was made for money; investigation could not be characterized as mere request for information.). However, several other courts appear to have held that governmental or regulatory investigations are not sufficient to trigger coverage under a claims-made policy. See, e.g., *MGIC Indemnity Corp. v. Home State Savings Ass’n.*, 797 F.2d 285 (6th Cir. 1986) (Amounts paid by bank in plea agreement resulting from grand jury investigation not covered “loss” as no “claim” was made against officers; court interpreted undefined term “claim” as requiring a demand for payment of “some discreet amount of money owed to the claimant on account of the alleged wrongdoing” in order to trigger coverage under the policy); *Foster v. Summit Medical Systems, Inc.*, 610 N.W.2d 350 (Minn. Ct. App. 2000) (SEC investigation was not claim for “relief” and did not trigger coverage under claims made policy; policy’s definition of “claim” required that insured could be “subject to a binding adjudication”); *Resolution Trust Corp. v. Ayo*, 1992 WL 245552 (E.D. La. 1992) (Regulatory agency’s report to bank criticizing bank and demanding corrective action did not trigger policy; court interpreted undefined term “claim” to mean “one seeking the payment of money”); *Center for Blood Research, Inc. v. Coregis Ins. Co.*, 305 F.3d 38 (1st Cir. 2002) (Subpoena issued by U.S. District Attorney seeking records from insured did not trigger policy; policy’s definition of “claim” required that insured could be “subject to a binding adjudication” and there was no indication insured was anything more than custodian of the records sought); *St. Paul Mercury Ins. Co. v. Foster*, 268 F.Supp.2d 1035 (C.D. Ill. 2003) (Request for information pursuant to ERISA from attorney on behalf of insured’s clients was not a “claim”; policy defined “claim” as requiring a written demand for monetary damages)

C. Definition of “Wrongful Act”

The definition of Wrongful Act is typically very broad and includes any “actual or alleged act, error or omission.” However, there is typically a limiting requirement that the conduct in issue be “in the capacity as a director or officer.” Thus, one must consider whether the director or officer is sued in that capacity or some other.

Additionally, if the officer is sued for service on one company’s board (particularly a not-for-profit) and is serving there at the behest of an employer, both companies’ insurance should be reviewed. Directors serving on a board at the request of their primary employer should consider whether their primary employer’s coverage provides “outside director” coverage. This could be important in the event that one company’s insurance is not sufficient or, for some other reason, not available.

Related term definitions such as “Interrelated Wrongful Acts” or “Related Wrongful Acts” (i.e., the same or related facts, series of related facts, circumstances, situations, transactions or events) are often used in policies to indicate when several different lawsuits may nonetheless be sufficiently related to constitute a single Claim. Correspondingly, courts have recognized that a single lawsuit may be comprised of more than one Claim because the alleged wrongdoing is not sufficiently related. The relationship among the alleged Wrongful Acts may be determinative of issues such as whether: (a) a single retention or multiple retentions apply; (b) a single limit of liability or multiple limits of liability are potentially available; or (c) coverage relates back to a prior policy period.

There have been a number of decisions in the past few months that have attempted to clarify the application of interrelated claim provisions for purposes of determining whether two separate claims may be deemed to arise out of the same or interrelated circumstances, so as to have been first made at the time that the earlier of the claims was first brought. Most recently, the Honorable Loretta A. Preska in *Eric Zahler v. Twin City Fire Ins. Co. et al.*, 2006 WL 846352 (S.D.N.Y. March 31, 2006), granted judgment on the pleadings to Greenwich Insurance Company and held that the wrongful acts alleged in an ERISA lawsuit were interrelated to the wrongful acts alleged in an earlier securities action. As such, the ERISA claim was deemed first made within Twin City’s coverage period, and prior to the inception of Greenwich’s coverage period. In her opinion,

J. Preska reasoned that the bargained-for language in the claims-made policy at issue clearly and unambiguously indicated that the ERISA claim was interrelated to the securities claim, as each action alleged a class period that commenced immediately after the publication of allegedly misleading statements with respect to the expansion of telecommunications services provided by the defendants, which adversely affected the value of the defendant company's stock. The Court noted that the factual similarities between the two actions rendered them "related claims," notwithstanding the fact that the two lawsuits entailed different parties who sought relief under distinct statutory frameworks.

The *Zahler* decision relied on *Seneca Ins. Co. v. Kemper Ins. Co.*, 133 Fed.Appx. 770 (2nd Cir. May 27, 2005), wherein the Court of Appeals for the Second Circuit issued a Summary Order affirming the dismissal of a complaint brought by Seneca against Kemper Insurance Company based on the application of an interrelated wrongful acts clause. Specifically, the Second Circuit relied on district court precedent in using the "sufficient factual nexus" test to conclude that the claims at issue were "neither factually or legally distinct" and arose from "numerous logically connected facts and circumstances" such that they could be deemed made at the time of the earlier claim, and prior to the inception of Kemper's policy period.

While *Seneca* and *Zahler* have been the latest decisions on this topic, they are the progeny of several other decisions within the Second Circuit, as well as other jurisdictions, which hold that two claims based on interrelated wrongful acts that share a sufficient factual nexus may be deemed a single claim which is made when the earlier of such claims was first noticed. *Zunenshine v. Executive Risk Indemnity, Inc.*, 1998 WL 483475 at *3-4 (S.D.N.Y. 17, 1998), aff'd 182 F.3d 902 (2nd Cir. June 29, 1999) (unpublished disposition), 1998 WL 483475 (the interpretation of "prior notice" exclusions in "claims made" insurance policies governed by New York law turns on whether there is a "sufficient factual nexus" between the respective claims); *Home Ins. Co. of Illinois v. Spectrum Info. Technologies*, 930 F.Supp. 825 (E.D.N.Y. 1996) (application of a clause that excludes claims for loss noticed under a prior policy depends on whether there was a sufficient factual nexus between the interrelated claims at issue); *WFS Financial, Inc. v. Progressive Casualty Ins. Co.*, Case No. EDCV 04-976-VAP at p. 11 (C.D.Ca. March 30, 2005) ("[C]laims against the insured arising out of interrelated wrongful acts 'shall be deemed to be first made on the date the earliest of such claims was first made, regardless of whether such date is before or during the Policy Period'." (emphasis in original).) *Highwoods Props., Inc. v.*

Executive Risk Indem. Inc., No. 04-2406 (8th Cir. May 11, 2005) (unpublished) (two lawsuits filed against the insured company based on the breach of fiduciary duty in connection with the company's merger, and the securities fraud in connection with the same merger, respectively, were deemed to arise out of interrelated wrongful acts because they were "grounded in actions taken by the defendants in relation to the [merger].")

D. Definition of "Loss"

The definition of Loss typically outlines the nature of the items that the Insurer is agreeing to cover. Although, as noted above, different policies may address this in different ways, the definition of Loss typically includes defense costs incurred in connection with a covered Claim as well as any resulting settlement or judgment. Of course, the coverage is limited to the policy's stated limits of liability.

The "Loss" definition also typically sets forth limitations or exclusions on the coverage not separately set forth in the Policy's separate list of exclusions. Thus, the definition of Loss may reveal whether coverage is afforded for matters such as taxes, fines and penalties, the multiplied portion of multiplied damages, disgorgement, and the salaries and benefits of employees of the Insured entity. The definition of "Loss" often also contains a catch-all exclusion for matters for which coverage is prohibited as a matter of law. In this regard, for example, some state laws expressly prohibit coverage for punitive damages as a matter of public policy.

There is also a growing body of case law that certain losses are "uninsurable" regardless of the wording of the insurance policy. This case law essentially holds that the remedies of "disgorgement" or return of "ill-gotten gains" are not insurable losses as the remedy requires the return of something that should not have been had in the first place. See *Vigilant Ins. Co. v. Credit Suisse First Boston*, 10 A.D.3d 528, 528, 782 N.Y.S.2d 19, 20 (1st Dep't 2004); *Reliance Group Holdings, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 188 A.D.2d 47, 55, 594 N.Y.S.2d 20, 24 (1st Dep't 1993); *Level 3 Commc'ns, Inc. v. Federal Ins. Co.*, 272 F.3d 908, 911 (7th Cir. 2001).

One example of this developing case law is that in cases under Section 11 of the Securities Act of 1933 (material misrepresentations in a prospectus offering securities) the remedy that a corporation must return to shareholders amounts that

they would not have paid to the corporation but-for the misrepresentation, is such an uninsurable disgorgement. *See Reliance Group Holdings, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 188 A.D.2d 47, 55, 594 N.Y.S.2d 20, 24 (1st Dep't 1993).

The SEC has also specifically designated settlement amounts as constituting disgorgement and has prohibited corporate or insurance indemnification of settlement amounts. In *Credit Suisse*, the court held that an insured “[can]not recover through its insurers the amount of the settlement with [securities regulators] which represented the disgorgement of funds improperly acquired.” *Credit Suisse*, 10 A.D.3d at 528, 782 N.Y.S.2d at 20. The investment bank in *Credit Suisse* had settled a governmental investigation by entering into a consent agreement with the SEC and other regulators that required the “disgorgement” of improperly obtained funds. The court rejected the investment bank’s argument that its disgorgement was insurable under its professional liability policies. On appeal, the court affirmed the lower court’s reasoning that “[t]o rule in CSFB’s favor would allow CSFB to pass the burden of this kind of settlement to its insurers. This result would defeat the purpose of the Final Judgment and the policy behind disgorgement.” *Vigilant Ins. Co. v. Credit Suisse First Boston Corp.*, No. 600854/2002, 2003 WL 24009803, at *4 (N.Y. Co. Sup. Ct. July 8, 2003).

This rule prohibiting the insuring of disgorgement payments is based on well-established public policy considerations. In *Bank of the West v. Superior Court of Contra Costa County*, a case relied in *Reliance*, the court explained:

When the law requires a wrongdoer to disgorge money or property acquired through a violation of the law, to permit the wrongdoer to transfer the cost of disgorgement to an insurer would eliminate the incentive for obeying the law. Otherwise, the wrongdoer would retain the proceeds of his illegal acts, merely shifting his loss to an insurer.

2 Cal.4th 1254, 1269, 833 P.2d 545, 555 (1992).

E. Definition of “Defense Fees and Costs”

Whether or not included in the definition of Loss, defense fees and costs typically serve to reduce the available limits of liability. This is in contrast with a typical

comprehensive general liability policy where defense costs are usually in addition to the limits of liability available to settle claims or pay judgments.

Covered defense fees and costs are also typically limited to “reasonable” defense costs incurred with the consent of the Insurer. This provision provides a basis for an Insurer to negotiate fee rates with defense counsel selected by the Insured, to audit itemized cost invoices and to participate in defense strategy including whether/who to retain as an expert and whether/when to file motions. Courts have addressed many aspects of attorney fee issues including what should be considered the reasonable “prevailing” fee schedules in an area and whether or not it is reasonable for attorneys to bill in quarter hour as opposed to tenth of an hour increments.

Advancement of defense costs under D&O policies has become a hot topic, particularly in the context of company insolvencies, as the insureds and their insurers struggle to strike a balance between often competing concerns. If, because of insolvency, a company cannot meet its indemnification obligations, directors and officers will look to their D&O policies to advance their defense costs. Most D&O policies allow for advancement of defense costs, prior to the final disposition of a claim, subject to an undertaking by the director or officer, whose defense costs are being advanced, that the director or officer will repay any amounts advanced, if it is ultimately agreed or established that the carrier has no liability to that director or officer for that claim.

Recent case law suggests that courts are more reluctant to permit a carrier to stop advancing defense costs before a final decision on coverage issues where the company to which the D&O policy was issued is insolvent. *See, e.g., In re Worldcom, Inc. Securities Litig.*, 354 F.Supp.2d 455 (S.D.N.Y. 2005) (with respect to D&O policy of an insolvent entity, holding that carrier was required to advance defense costs during pendency of rescission action); *Associated Elec. & Gas Ins. Servs., Ltd. v. Rigas*, 382 F.Supp.2d 684 (E.D. Pa. 2004) (same). In *Great American Ins. Co. v. Gross, et al.*, 2005 WL 1048752 (E.D. Va., May 3, 2005), the court granted a motion for preliminary injunction, obligating the insurer to continue to advance defense costs to two officers of an insolvent insurance company who had pled guilty to insurance fraud in a related criminal investigation, notwithstanding the insurer’s assertion of the fraud exclusion. The court appeared to base its decision in that case on its view that the guilty pleas concerned narrower grounds than those alleged in the underlying litigation and on the officers’ argument that they could not defend the underlying actions, absent the insurer’s continued advancement of defense costs. The court did not appear to

be concerned by the inconsistency in the officers' argument that, while they lacked the resources to fund their own defense, the insurer could recoup any amounts that were later determined not to be owed under the policy.

In contrast, in *Gaon v. Twin City Fire Ins. Co.*, No. 1:05-CV-04477-KMW (S.D.N.Y. Jun. 3, 2005), the U.S. District Court for the Southern District of New York denied a motion for preliminary injunction that would have required the D&O carrier of a bankrupt corporation to advance defense costs to two former officers of the corporation. The carrier had denied coverage as a result of a misrepresentation in the application process. Among other things, as in *Great American Ins. Co. v. Gross*, the former officers argued that they would be irreparably harmed if they were not awarded defense costs because they would be unable to fund the ongoing litigation, whereas the carrier would not be harmed by advancing defense costs because it was obligated to do so under the policy and the officers would agree to repay the defense costs if the court ultimately determined that there was no coverage. In denying the officers' motion for preliminary injunction, the court noted that if the officers could not afford the defense costs now, then they likely could not repay the carrier at a later time and concluded that, even assuming the officers would suffer irreparable harm, that factor alone was not sufficient to support issuance of the requested injunction. *See also National Union Fire Ins. Co. of Pittsburgh v. Ambassador Group, Inc. (In re Ambassador Group, Inc. Litig.)*, 1991 WL 110033784 (E.D.N.Y. Feb. 27, 1991) (denying request by directors of collapsed insurance company for payment of legal fees pending determination of carrier's liability under a D&O policy, while noting "if, as the Ambassadors Directors contend, they do not have funds available to finance their own defense, then any advances made for legal costs will surely be irrecoverable").

F. Requirement of Allocation

As noted above, a single lawsuit may involve components that are covered Claims and components that are not. Allocation issues may arise where a suit: (a) alleges both covered and uncovered causes of action; (b) alleges misconduct by an individual in both Insured and uninsured capacities (i.e., outside directors who also face exposure as outside counsel); (c) asserts claims against Insureds as well as individuals or entities who are not entitled to coverage; or (d) alleges separate acts committed at separate times, some of which are outside of time-based coverage limitations (see the discussion of "Retroactive Dates" below). Depending on the applicable Policy's definition of "Claim," allocation issues may also arise where a single defense counsel is representing an Insured with respect

to both a civil suit and response to a parallel civil or criminal inquiry or investigation. In these situations, defense counsel, Insureds and Insurers may consider whether counsel's work in connection with the informal investigation somehow assists the defense of the civil suit.

Often, allocation disputes are resolved by negotiation. Nonetheless, litigation of these issues has resulted in various judicially created rules such as the "reasonable relationship" test for allocating defense costs, and the "relative exposure" and "larger settlement" rules for allocating judgments and settlements. *See In re Warner Communications Sec. Litig.*, 618 F. Supp. 735, *aff'd*, 798 F.2d 35 (2d Cir. 1986) (Settlement and allocation of the settlement amount was reasonable and appropriate where the potential exposure of the corporation was significantly greater than the potential exposure of the individual defendants and the settlement reflected this difference). To determine allocation based on relative exposure, which is the potential liability of the parties at the time of settlement, there may be limited discovery into areas protected by attorney-client privilege and the work product doctrine. Discovery is limited to either testimonial or documentary evidence, must be directed toward determining the potential liability of the parties at the time of settlement and will be subject to an in camera review to prevent disclosure of privileged material that is not relevant to the allocation issue. *See Safeway Stores v. National Union Fire Ins. Co.*, No. C-88-3440-DLJ, 1993 U.S. Dist. LEXIS 2006 (Feb. 4, 1993).

Many D&O policies also contain clauses expressly addressing allocation. These may contain pre-determined allocation amounts (i.e., some specified percentage of defense costs will be deemed covered in the event of a suit against directors and officers and the corporate entity where the policy does not provide direct coverage to the entity), requirements that parties use "best efforts" to negotiate allocation, or provisions for prompt arbitration of allocation disputes.

G. Requirement that a Claim be Made During the Policy Period

As noted above, the event triggering coverage under a D&O Policy is a "Claim" first made during the Policy Period. Sometimes, but not always, the Policy is specific about whether the filing of a suit or the receipt of service of a suit determines when the "Claim" is "first made." Further, some D&O policies permit Insureds to have an increased level of control over this issue by granting coverage for Claim "reported" to the Insurer during the Policy Period subject to certain conditions as to when a Claim must be reported.

Further, many policies provide a restriction on coverage based on when the alleged Wrongful Acts occurred. Often, this restriction is in the form of a “Retroactive Date” listed either in the Declarations or a specific exclusion. Thus, a Claim made during a Policy Period may nonetheless not be afforded coverage because it is based on conduct prior to a specified date. This type of limitation is typically seen where the Insured has changed insurers or has significantly increased the dollar amount of a policy’s limit of liability from one period to another. Any policyholder considering changing to a new insurance provider which requires such a coverage limitation should consider whether to provide its former carrier with what is often referred to as a “laundry list” of all known circumstances that might potentially result in future lawsuits.

Note that this is similar to the “interrelated” or “related” wrongful acts issue discussed above. Courts have upheld carrier denials of coverage based on the conclusion that continuing acts commenced prior to a Retroactive Date limitation and continued after that date nonetheless constitute a single series of acts incepting prior to the policy’s coverage. *See Gateway Group Advantage, Inc. v. McCarthy*, 300 F.Supp.2d 236 (D. Mass. 2003) (holding that prior acts exclusion precluded coverage for a claim that arose out of acts that occurred after retroactive date but that were related to acts that occurred prior to retroactive date).

H. Requirement Concerning Reporting of Claims

Many policies require that any Claim be reported to the Insurer in writing “as soon as practicable.” Others include a limitation that the report be as soon as practicable but “no later than” some specific time after the end of the policy period.

The meaning of the phrase “as soon as practicable” is far from clear. Some courts have held that an Insurer has a heavy burden to show that it has been prejudiced as a result of late notice in order to support a denial of coverage on that basis. *See Friedland v. Travelers Indemnity Co.*, 105 P.3d 639 (Colo., 2005) (holding that insurer must demonstrate that late notice prejudiced its “significant interests”). Other courts do not require any prejudice, just a showing of late notice. *See Argo Corp. v. Greater New York Mutua. Ins. Co.*, 4 N.Y.3d 332 (2005) (concluding that insurance carrier need not show prejudice before denying coverage for late notice). Certainly, this issue is related to the need for the Insurer’s consent to settlement discussed below. When looking at judicial opinions on this issue, one should pay close attention to whether a court is addressing a claims-made policy

(such as a D&O policy) as distinct from an occurrence-based policy (such as most general liability policies).

D&O policies also often contain some type of an “extended reporting period” or “optional extension period” that can be purchased for additional premium in the event of termination of the policy. Such provisions should be read carefully as they usually are not an extension of the Policy in its entirety. Rather, while such provisions extend the period during which a Claim can be made and still be eligible for coverage, the extension is granted only for those Claims alleging Wrongful Acts committed prior to the termination of the original Policy Period (as opposed to Wrongful Acts committed during the extension period).

Where a company has more than one layer of insurance, it should be noted that requirements concerning Claim reporting typically do not “follow form” to the primary. Thus, the timing and method for notifying excess Insurers may differ for each policy. Many consider it “best practices” to notify all carriers in a potentially applicable tower of insurance at once.

I. Reporting of Circumstances that Might Lead to a Claim

Most D&O policies contain a permissive provision that entitles an Insured to give notice of circumstances that might someday result in a Claim, despite the fact that no Claim has yet been asserted. This provides the Insured with an opportunity to secure coverage under the D&O policy in effect at the time the circumstances are discovered and reported even if no Claim is made for years.

The proper focus of a court’s inquiry into the sufficiency of notice of a potential claim is whether the insured has objectively complied with the notice provision, and not whether the insurer has subjectively drawn inferences that potential claims exist from the materials submitted by the insured. Therefore, an insured providing information of potential claims, without any details concerning the potential claims’ circumstances and reasons for anticipating them, is usually considered insufficient notice. *California Union Ins. Co. v. American Diversified Sav. Co.*, 914 F.2d 1271 (9th Cir. 1991), *cert. denied sub. nom., Sahni v. Harbor Ins. Co.*, 111 S.Ct. 966 (1991) (Annual reports, proxy materials, and letters to insured bank from broker asserting that certain aspects of the Bank’s financial condition were making it hard for the broker to obtain adequate insurance, did not constitute notice of a potential claim against the bank).

Although these provisions are typically permissive, an insured should be wary of failing to give notice of circumstances that might eventually result in a Claim. As noted above, some policies have restrictions limiting coverage to Wrongful Acts occurring after a certain date. Thus, failure to give notice of potential claim circumstances creates a risk that a subsequently commenced Claim may be excluded from coverage under a subsequent policy based on the time that the Wrongful Acts occurred. On the other hand, Insureds are often wary of providing notice of potential claim circumstances and the possible impact of such notice on future premiums.

A separate issue is the reporting of potential claims in the application process for new or renewal insurance. D&O policy applications often ask the applicant to make a specific representation that, at the time of the application, the applicant is not aware of any circumstances that might lead to a Claim. If the applicant is not honest, most state insurance laws deem that dishonesty to be insurance fraud and provide that the insurance policy may be voided (or “rescinded”) by the Insurer. As detailed below, state laws vary widely with respect to when avoidance of the policy by the Insurer is allowed. In some states an Insurer is required to prove the applicant’s intent to defraud. In others, the Insurer need only show that the misrepresented information was “material” to the Insurer’s decision to issue the particular policy, regardless of the applicants’ intent. In any event, information provided in a policy application is not considered notice of circumstances sufficient to preserve coverage for future claims.

J. Availability of Other Insurance

Most D&O policies contain some type of provision indicating that the coverage afforded by the D&O policy shall only apply as excess over any other potentially applicable policy unless that other policy is expressly written as excess over the subject policy. The impact of this provision is straightforward when other policies expressly provide that they are primary regardless of any other insurance available but is not straightforward when another policy contains a similar “excess over other insurance” provision.

One example of when this can be particularly beneficial to an Insured is where one policy (for example a general liability policy) provides that it shall be primary and that defense costs are covered but do not deplete the limit of liability available for any settlement or judgment. In the event of overlapping coverage with a D&O policy that contains an excess provision, the litigation defense may be provided

by the general liability policy while the limits of both the general liability policy and the D&O policy are potentially available for any settlement or judgment.

K. Insured's Duty to Cooperate with the Insurer

While duties of cooperation exist as a matter of common law, most D&O policies expressly require the Insured to fully cooperate with the Insurer during the defense of a Claim. In *Waste Management Inc. v. International Surplus Lines Ins. Co.*, the Court held that a cooperation clause creates an obligation on the insured to “disclose all the facts within his knowledge and otherwise to aid the insurer in its determination of coverage under the policy.” 144 Ill.2d 178 (Ill. Ct. App. 1991). The court broadly held that the purpose of a cooperation clause is to enable the insurer to protect its interests. *Id.* To hold otherwise, the court found, effectively places the insurer at the mercy of the insured and severely handicaps the insurer in contesting a claim. *Id.*

Counsel representing the Insureds must nonetheless consider the risk of waiving privilege protections. While many courts have established exceptions to waivers for sharing information with carriers (particularly if a formal non-waiver or confidentiality agreement is entered) some jurisdictions are not sufficiently clear and circumstances may arise that require careful consideration. *See North River Ins. Co. v. Philadelphia Reinsurance Corp.*, 797 F.Supp. 363, 369 (D.N.J. 1992) (holding that cooperation clause does not prevent insured's expectation of confidentiality with its defense counsel); *But see Waste Management, Inc. v. International Surplus Lines Insurance Co.* 579 N.E.2d 322 (Ill. 1991) (holding that the duty to cooperate operates as a waiver of the attorney-client privilege between the insured and its counsel).

One particular area of concern is where information disclosed to an Insurer could provide a basis for determining the applicability of an exclusion. Certainly, an active concealment of relevant information could constitute insurance fraud. Nonetheless, most (but not all) judges and ethics analysts take the position that despite the duty to cooperate, defense counsel is not required to reveal work-product or attorney-client privileged materials or information to the Insurer. The exceptions to this rule focus on the Insurer-Insured “common interest,” which is also a basis for courts holding that disclosures to an Insurer by defense counsel do not result in a waiver of the attorney-client or work-product privileges.

L. Consent to Settlement

D&O Policies typically provide that neither the Insurer nor the Insured can agree to a settlement without the others' consent. Many courts have held that in the event an Insurer has denied coverage, the consent provisions do not apply and an Insured can thus settle a suit without consent and still proceed against its insurer for coverage. *See Hamilton v. Maryland Casualty Co.*, 27 Cal.4th 718 (Cal. 2002) (“the denial of coverage and a defense entitles the policyholder to make a reasonable, non-collusive settlement without the insurer’s consent and to seek reimbursement for the settlement amount in an action for breach of the covenant of good faith and fair dealing”).

Failure by either an Insurer or Insured to consent to a settlement opportunity may significantly impact that party’s exposure. For example, most policies contain provisions that when an Insured refuses to consent to a settlement recommended by the Insurer, and the ultimate Loss (judgment plus defense costs) is greater than the amount for which the suit could have been settled as recommended by the Insurer, then the Insurer’s exposure is limited to the amount of Loss at the time of the rejected settlement opportunity (defense costs and settlement amount) and the Insured must pay the balance. This shifting of exposure only occurs if there was an actual settlement opportunity (a settlement offer by the plaintiff) and a recommendation by the Insurer that the settlement be accepted. *See Security Ins. Co. of Hartford v. Schipporeit, Inc.*, 69 F.3d 1377 (7th Cir. 1995) (finding that the insurer had not recommended a settlement opportunity as required by the policy because the “proposed settlement” would not have resolved the dispute).

Similarly, if a real settlement offer exists which is within the Insurer’s limit of liability and the Insured recommends the settlement as reasonable in the circumstances of the case but the Insurer chooses to reject the offer and the case ultimately leads to a judgment for a greater amount, the Insurer may be responsible for the full amount of the judgment regardless of the Policy’s express limit of liability. *See Kransco v. American Empire Surplus Lines Ins. Co.*, 23 Cal.4th 390, (Cal. 2000) (holding that an insurer may be held liable for a judgment against the insured in excess of its policy limits where it has breached its implied covenant of good faith and fair dealing by unreasonably refusing to accept a settlement offer within the policy limits).

IV. What is Not Insured -- Policy Exclusions

Exclusions contained in a D&O policy are in many ways self-explanatory. As with the rest of the insurance contract, each exclusion should be read carefully to evaluate their meaning and significance in a particular situation. Issues to note include whether “all Loss” in connection with a certain type of Claim is covered or Defense Costs may be covered even if the ultimate liability faced is excluded. Similarly, some exclusions may apply from the outset of a case while others apply only in the event certain facts are discovered or liability is established by a “final adjudication.” The following highlights two exclusions in a D&O liability policy that are particularly significant today in connection with the high-profile corporate bankruptcies and criminal prosecutions.

A. Willful and Criminal Conduct Exclusion

Most policies today limit the applicability of the willful/criminal acts exclusion to circumstances where there has been a “final adjudication” of the intentional misconduct. Nonetheless, a particular policy’s wording and case authorities in the applicable jurisdiction(s) should be closely examined to determine whether an Insurer is bound by the outcome of the Claim against its Insured or is entitled to litigate whether or not the intentional misconduct occurred in a suit by the Insurer.²

The final adjudication requirement has been interpreted by many courts to require the Insurer to provide funding of defense fees until the applicability of the exclusion is conclusively established. This is particularly significant where the complexities of the issues and the length of the litigation indicate that a significant portion, if not all, of the applicable D&O insurance program will likely be eroded long before there is any final adjudication conclusively determining whether the Insurers are able to deny coverage.

In *Great American Insurance Co. v. Gross*, 2005 WL 1048752 (E.D. Va. May 3, 2005), the court required the D&O insurer to continue advancing defense costs to two former corporate insiders, despite their formal guilty pleas. Plaintiffs sued

² Whether or not this exclusion applies is separate from whether or not misrepresentations were made in the application for insurance such that the Insurer may seek to rescind the entire policy. The issue of rescission is discussed below.

former officers and directors of Reciprocal of America for hiding the company's financial condition from regulators, rating services and policyholders. The insurer stopped reimbursing defense costs to those officers who pled guilty but continued advancing defense costs to other directors and officers. The fraud exclusion required a final adjudication that the individual in fact committed fraudulent acts, which brought about or contributed to the claims. Because the court had not yet decided whether fraudulent conduct by the "black hat" defendants "contributed to" or "brought about" the lawsuits, the guilty pleas did not stop defense costs payments for those two defendants.

B. Insured versus Insured Exclusion

This exclusion has been described by commentators and courts as having been designed to prevent "collusive" lawsuits such that so long as there is a truly adversarial aspect to the litigation, the exclusion does not apply. Nonetheless, by its terms, the exclusion has a much broader application. Most Insurers take the position that this exclusion exists because D&O coverage is intended to provide coverage solely for third party liability and not to provide compensation to the Insured corporation itself.

Thus, when the corporation is in bankruptcy, while the coverage typically remains in effect to defend against third party claims (i.e., a claim by shareholders against the corporation's directors and officers) carriers often seek to deny coverage for an action by those standing in the shoes of the corporation seeking recovery on behalf of the corporation, such as a litigation trustee bringing claims otherwise belonging to the corporation but assigned by the debtor-in-possession. Court rulings addressing the applicability of this exclusion to such suits have not been uniform.

Prior to 1995 at least two circuit courts affirmed district court decisions finding "insured versus insured" exclusions applicable to bankruptcy trustees. *See Reliance Ins. Co. v. Weis*, 148 B.R. 575 (E.D. Mo. 1992); *aff'd*, 5 F.3d 532 (8th Cir. 1993); *National Union Fire Ins. Co. v. Olympia Holding Corp.*, No. 94-CV-2081, order issued (N.D. Ga. Sept. 14, 1995); *aff'd*, 1996 WL 33415761 (N.D. Ga. 1996), *aff'd* without opinion, 148 F.3d 1070 (11th Cir. 1998). More recent lower court decisions, however, have found that the "insured versus insured" exclusions are not applicable to bankruptcy trustees. *See In re Buckeye Countrymark, Inc.*, 251 B.R. 835 (Bankr. S.D. Ohio 2000); *In re County Seat Stores*, 280 B.R. 319 (Bankr. S.D.N.Y. 2002).

V. Additional Considerations

A. Bankruptcy of the Corporate Entity

As we discussed above, when the corporate Insured is in bankruptcy, it may be financially unable to advance defense expenses. Even if the corporate Insured in bankruptcy has sufficient assets to pay defense expenses, it must obtain bankruptcy court approval prior to making such payments. In addressing such issues, several bankruptcy courts have ruled that a D&O liability policy is property of the estate (i.e., an asset of the corporate debtor) but the “proceeds” of the policies (i.e., amounts paid by the Insurer pursuant to the policy on behalf of the Individual Ds/Os) may not be property of the estate and therefore may be paid without first seeking approval of the bankruptcy court. Many carriers consider it “best practice” to nonetheless obtain bankruptcy court approval before distributing policy proceeds to ensure that it cannot later be claimed that they made the payments improperly and at their own risk such that the payments cannot be deemed to reduce the available limits of liability under their policy.

Many courts have held that insurance policies, including D&O policies, issued to an insolvent company, are “property of the estate” of the debtor, subject to the automatic stay under Section 362 of the Bankruptcy Code. *See, e.g., MacArthur Co. v. Johns-Manville Corp. (In re Johns-Manville Corp.)*, 837 F.2d 89, 92 (2d Cir. 1988); *In re Minoco Group of Cos., Ltd.*, 799 F.2d 517, 519 (9th Cir. 1986); *In re Cybermedica, Inc.*, 280 B.R. 12, 16 (D. Mass. 2002). Although their conclusions are largely fact-driven, courts disagree as to whether the proceeds of a D&O policy, as contrasted with the policy itself, are property of the estate. Some courts have held that, if the debtor does not have a direct or immediate interest in the proceeds of a D&O policy, the proceeds are not property of the debtor’s estate. *See, e.g., Louisiana World Exposition, Inc. v. Federal Ins. Co. (In re Louisiana World Exposition, Inc.)*, 832 F.2d 1391, 1400-01 (5th Cir. 1981); *In re Youngstown Osteopathic Hosp. Ass’n.*, 271 B.R. 544, 550-51 (Bankr. N.D. Ohio 2002); *see also Houston v. Edgeworth (Matter of Edgeworth)*, 993 F.2d 51, 56 (5th Cir. 1993) (“When the debtor has no legally cognizable claim to the insurance proceeds, those proceeds are not property of the estate.”). In the context of a D&O policy, the existence of entity coverage may weigh in favor of a determination that both the policy and its proceeds are property of the estate, but the mere inclusion of entity coverage does not necessarily provide a sufficient predicate to convert the proceeds into estate property. *Ochs v. Lipson (In re First Central Fin. Corp.)*, 238 B.R. 9, 17 (Bankr. E.D.N.Y. 1999).

One way in which directors and officers may seek to protect their access to their company's D&O policy proceeds, in case of the company's insolvency, is through a priority-of-payments clause providing that the nonindemnifiable losses of individual insureds will be paid before any loss of the entity. In its simplest form, such a clause states, "In the event of Loss arising from a covered Claim, the Insurer shall first pay Loss for which coverage is provided for directors and officers." The primary intent of a priority-of-payments clause is to give priority to the individuals when the proceeds of the D&O policy are distributed: the liabilities of the individuals (the directors, officers or trustees, for example) will be recognized first and the remainder of the limit is then available for the corporation's loss.

In the Enron bankruptcy, Enron's primary D&O carrier and certain of Enron's present and former directors and officers moved for relief from the automatic stay to permit payment and/or advancement of defense costs in multiple underlying lawsuits to individual directors and officers. The motions were opposed by a number of different parties, including the Official Committee of Unsecured Creditors (the "Committee"). The Committee argued that the D&O policy provides entity coverage to Enron for the actions pending against it and that the D&O policy proceeds are property of the estate that should be preserved to satisfy the Committee's own claims against certain Enron directors and officers. In contrast, the outside directors argued that even though the D&O policies also insure the corporation, they were obtained primarily for the protection of management, and thus, the policy proceeds are not the property of the estate. In support of this argument, the outside directors relied heavily on an endorsement to Enron's primary D&O policy that provides a first-priority payment to directors and officers before any payment may be made to Enron.³

³ The policy at issue contained the following "Priority of Payments Endorsement":

(7) With respect to the ULTIMATE NET LOSS for which payment is due the INSURER shall: first, pay such CLAIM which is covered by Insuring Agreement (A)(1), and then with respects [sic] to any remaining Limits of Liability after the payment of any CLAIM made under Insuring Agreement (A)(1), at the written request of the chief executive officer of the COMPANY, either pay or withhold payment of such remaining portion of the ULTIMATE NET LOSS for which coverage is provided under this Policy.

In an oral ruling from the bench on April 11, 2002, the Bankruptcy Court sided with the outside directors, thus allowing payment by Enron's lead D&O insurer of millions of dollars to cover defense costs.

In another high-profile bankruptcy case – the Adelpia bankruptcy – the Bankruptcy Court found both the presence of indemnification and entity coverage and the lack of a priority-of-payments clause in the D&O policy at issue significant in concluding that the proceeds of the policy are assets of the debtor, subject to the automatic stay. *In re Adelpia Comm. Corp.*, 285 B.R. 580, 586-87 (Bankr. S.D.N.Y. 2002), vacated and remanded by *In re Adelpia Comm. Corp.*, 302 B.R. 439 (Bankr. S.D.N.Y. 2003). The District Court, however, held that the proceeds of the D&O policy were not yet property of *Adelpia's* bankruptcy estate because the debtor had not made any payments for which it would be entitled to indemnification coverage, because no such payments were contemplated, and because the debtor had not committed itself to payments using its entity coverage. *In re Adelpia Comm. Corp.*, 302 B.R. 439, 53-54 (Bankr. S.D.N.Y. 2003). On remand, while acknowledging its duty to comply with the District Court's "mandate," the Bankruptcy Court went to some lengths to question the soundness of the District Court's holding that the proceeds of the D&O property were not "yet" the property of the bankruptcy estate. See *In re Adelpia Comm. Corp.*, 302 B.R. 454 n.38 (Bankr. S.D.N.Y. 2003) (noting that a number of Supreme Court and Second Circuit cases hold that "property" of the estate "does not depend on whether enjoyment of the property is contingent or must be postponed" and emphasizing the fact that cases characterizing policy proceeds as property of the estate involved indemnification or entity coverage).

Open questions remain in situations where a priority of payments clause directs payment, first, to individuals insured under a D&O policy before payments to the corporation can be made but where there are varying exposures and varying defense costs among the individuals. Particularly where the policy would exhaust before the claims of the individuals can be satisfied, the question then becomes how to determine the priority of payments as among the individuals.

In a motion to lift the automatic stay to permit payment/advancement of defense costs under its D&O policy that was ultimately denied on procedural grounds, Enron argued that there was no basis for distinguishing among its directors and officers in terms of coverage rights, and regarding any concern that wrongdoers might benefit, Enron asserted that the repayment undertakings signed by each individual director and officer would insure that such individual would repay any amounts advanced if a court finally determined that their behavior did not entitle

them to coverage. In *Anglo-American Ins. Co. v. Molin*, 670 A.D. 194 (1995), the Commonwealth Court of Pennsylvania held that a carrier should not be precluded from accepting a reasonable settlement offer for fewer than all insureds, even though that settlement would exhaust coverage under the D&O policy and leave the non-settling insureds without coverage for their defense costs. See also *Millers Mut. Ins. Assoc. of Illinois v. Shell Oil Co.*, 959 S.W.2d 864 (1998) (permitting an insurer to terminate its duty to defend and indemnify an additional insured upon paying the policy limit in settlement of a claim against the named insured). In contrast, in non-D&O, non-insolvency contexts, courts have held that, where an insurer settled a claim on behalf of one insured for the full amount of a policy, it acted in bad faith with respect to the other insureds who were left exposed. See *Smoral v. Hanover Ins. Co.*, 37 A.D.2d 23 (N.Y. 1st Dep't 1971); *Shell Oil Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh*, 44 Cal.App.4th 1633, 1648 (Cal. App. 1996).

B. Rescission or Avoidance of the Policy by the Insurer

As noted above, an insurance policy is a contract. Thus, common law contract rules apply including the rule that when one party was fraudulently induced to enter the contract, that party may avoid its obligations under the contract ab initio. In addition, most states insurance regulations expressly prohibit misrepresentations in insurance applications.

D&O Insurers typically review the corporate applicant's financial statements in the application process. An issue becoming increasingly common is whether, when a corporation restates the very financial statements reviewed and relied upon by the Insurer in the application process, the restatement is an admission of a misrepresentation in the application sufficient to support rescission of the insurance policy. An Insurer's position on this issue is certainly impacted by the commencement of a civil shareholder securities fraud class action, SEC enforcement action or criminal indictment alleging fraud in the very financial statements relied on by the Insurer in making its underwriting decision.

1. Rescission

Rescission is a remedy that wipes out an existing contract and restores the parties to their situation prior to entering into the contract. In the context of insurance policies, rescission allows an insurer to void coverage ab initio and in its entirety in the face of a material misrepresentation in the insurance application and requires that the rescinding insurer refund all premiums. The justification for this

remedy is that the insurer would not have agreed to issue the policy on the terms issued if the true facts had been disclosed to the insurer, and the insurer should therefore not be required to provide coverage that was obtained under false pretenses.

The elements of rescission vary from state to state, and most states have codified the standards for rescission. *See La. Rev. Stat. Ann.* § 22:619 (West 1978 & 1994 Wupp.); *R.I. Gen. Laws* § 27-18-16 (1979); *Tex. Ins. Code* § 21.16 (Vernon 1981); *Del. Code Ann. Tit. 18*, § 2711 (1989); *Fla. Stat. Ann.* § 627.409 (1996); 215 *Ill. Comp. Stat. Ann.* 5/154 (West 1997); *Mass. Gen. Laws Ch. 175*, § 186 (1998); *Wash. Rev. Code Ann.* § 48.18.090 (West 1999). As recent cases show, judicial interpretations of rescission requirements vary by state, as well as by the terms of the insurance policy and the underlying facts. *See Federal Ins. Co. v. Kozlowski*, 18 A.D.3d 33 (N.Y. App. Div. 2005); *Associated Elec. & Gas Ins. Servs., Ltd. v. Rigas*, 2004 WL 540451 (E.D. Pa. Mar. 17, 2004); *In re HealthSouth Corp. Insurance Litigation*, 308 F. Supp.2d 1253 (N.D. Ala. 2004); *Cutter & Buck, Inc. v. Genesis Ins. Co.*, 306 F. Supp.2d 1253 (W.D. Wash. 2004); *In re Adelpia Communications*, 298 B.R. 49 (S.D.N.Y. 2003).

Generally speaking, an insurer must prove some or all of the following elements in order to rescind a policy: (1) the making of a representation; (2) the falsity of the representation; (3) the materiality of the misrepresentation; (4) the insurer's reliance on the misrepresentation in underwriting the policy; and (5) in some jurisdictions, the insured's knowledge of the representation's falsity.

The misrepresentation can be contained in the application for insurance or in publicly filed financial statements or other materials that are required to be submitted with the application. Even absent a warranty statement, if the financials are attached to an application and relied upon by the insurer, a basis for rescission may exist. In the absence of an application, however, courts may deem an insurer's claimed reliance on financial statements to be unreasonable. *See National Union Fire Ins. Co. of Pittsburgh v. Xerox Corp.*, 792 N.Y.S.2d 772 (Sup. Ct. 2004) (concluding that the insurer's purported reliance on insured's allegedly false financial statements in issuing policy was unreasonable, where financial statements were not part of any insurance application, as no such application was submitted).

Generally speaking, a misrepresentation or omission is deemed material if knowledge or ignorance of the information would have influenced the insurer's decision to underwrite the risk, and in order to prove rescission, it is generally sufficient for the insurer to establish through the testimony of its underwriters that

the insurer reasonably relied on the information furnished by the insured in underwriting the policy. Some states require the insurer to prove that the insureds either intended to deceive the insurer or had knowledge of the misrepresentation(s) or omission(s) in order to rescind coverage. In other states, an unknowing misrepresentation by the insureds may be sufficient to justify rescission if the insurer relied to its detriment upon the false information.

2. Severability

A severability provision in a D&O policy protects coverage for so-called “innocent” insureds, even if one or more other insureds misrepresented information to the insurer. With full severability, the application is deemed to be a separate application by each insured, such that no knowledge of one insured is imputed to another insured for purposes of determining coverage. Full severability is intended to preserve coverage for an “innocent” insured even if another insured knew facts that should have been but were not truthfully disclosed to the insurer during the underwriting process. With limited or partial severability, the knowledge of one individual insured is not imputed to another individual insured for purposes of the application, except that the knowledge of either the signer of the application or, alternatively, the knowledge of certain designated senior managers is imputed to the insured company and sometimes to all individual insureds.

Also significant, most policies contain a “severability” provision such that criminal conduct by one Insured does not result in application of this exclusion to other Insureds. A variation on severability is a provision that the acts of certain of the most senior executives (such as the Chief Executive Officer) may be imputed to others and/or to the entity (if entity coverage is otherwise provided) and thereby limit the severability protection.

A severability provision in a D&O policy protects coverage for so-called “innocent” insureds, even if one or more other insureds misrepresented information to the insurer. With full severability, the application is deemed to be a separate application by each insured, such that no knowledge of one insured is imputed to another insured for purposes of determining coverage. Full severability is intended to preserve coverage for an “innocent” insured even if another insured knew facts that should have been but were not truthfully disclosed to the insurer during the underwriting process. With limited or partial severability, the knowledge of one individual insured is not imputed to another individual insured for purposes of the application, except that the knowledge of

either the signer of the application or, alternatively, the knowledge of certain designated senior managers is imputed to the insured company and sometimes to all individual insureds.

In *Cutter & Buck v. Genesis Ins. Co.*, at issue was a severability provision that stated as follows:

[I]n the event that the Application, including materials submitted therewith, contains misrepresentations made with the actual intent to deceive, or contains misrepresentations which materially affect either the acceptance of the risk or the hazard assumed by the INSURER under this Policy, this Policy in its entirety shall be void and of no effect whatsoever; and provided, however, that no knowledge possessed by any DIRECTOR or OFFICER shall be imputed to any other DIRECTOR or OFFICER except for material information known to the person or persons who signed the Application. In the event that any of the particulars or statements in the Application is untrue, this Policy will be voided with respect to any DIRECTOR or OFFICER who knew of such untruth.

306 F.Supp. 2d at 1011.

The court interpreted this provision to mean that “innocent directors and officers retain coverage unless the application’s signor knows of a misrepresentation within the application, in which case even innocent directors and officers lose coverage.” *Id.* at 1012. Relying on evidence that the signor knew that the financial statements that were attached or submitted with the policy application contained false statements, the court found that the signor’s knowledge was imputed to the otherwise innocent directors and officers, and as such, the insurer had a right to rescind the policy as to all directors and officers. *Id.* at 1014.

In contrast, in *In re HealthSouth Corp. Insurance Litigation*, the severability clause provided that “no statement in the application or knowledge possessed by an Insured Person shall be imputed to any other Insured Person for the purpose of determining the availability of coverage hereunder.” 308 F. Supp.2d at 1261. A federal district court, interpreting Alabama law, determined that this clause prohibited the carrier from rescinding coverage for all directors and officers based on misrepresentation in the policy application. The court held that the severability provision effectively created separate policies for each of the insureds

and gave each insured the right to have coverage determined separately, since the representations or knowledge of insured could not be imputed to another insured. Id. at 1279-80.

This exclusion also demonstrates how an Insured's tactical decisions in a regulatory or criminal matter can affect the availability of insurance coverage. If an Insured admits wrongdoing, such an admission will likely affect insurance coverage. In the past, regulators such as the SEC were often willing to accept settlements that were carefully worded so the defendant neither admits nor denies guilt. This gentle approach seems to have disappeared with the major corporate scandals of the past few years and the SEC appears to be ever more aggressive in insisting on actual admissions of misconduct. Indeed, in several recent high profile cases, the SEC has insisted on a prohibition of the use of insurance funds to satisfy the required settlement payment.

Correspondingly, when Insureds testify in rescission or declaratory judgment actions, prosecutors may use their testimony against them in criminal prosecutions. For this reason, an Insured that faces, or may in the future face a parallel criminal prosecution, is permitted to invoke the Fifth Amendment privilege against self-incrimination in a rescission action by an Insurer. However, when an officer or director invokes the Fifth Amendment in a coverage action, the fact finder may be permitted to draw an adverse inference against the Insured, provided that such an inference is substantiated by independent evidence.

Rescission, severability and advancement of defense costs during the pendency of a rescission action present difficult issues because insureds and insurers both have legitimate but conflicting concerns regarding misrepresentations. Directors and officers, particularly outside directors, who acquire a D&O policy in good faith understandably want assurance that they will have insurance protection, even if another insured misrepresented information to the insurer in the underwriting process. Equally, insurers who relied on false information in the underwriting process want a remedy for such misrepresentation, and simply denying coverage for the insured who made the misrepresentation affords little, if any, relief, as the insurer would still be required to pay out large amounts under the policy to other insureds.

C. Compromising Coverage Disputes

In the current climate of large potential exposures (i.e., multiple billions of dollars in market cap loss from a financial restatement) and multiple suits by different plaintiff groups with different constituencies (i.e., shareholder class actions in federal and state courts, individual investor opt-out suits, bondholder suits, derivative suits, ERISA pension fund suits, SEC civil fraud actions, state attorney general suits, criminal actions, etc.) which present potential liabilities far in excess of total available insurance coverage, Insureds and Insurers are increasingly willing to consider alternatives for resolving the related coverage disputes that arise as discussed above.

Rather than embark on a long and drawn-out process to address and litigate or mediate each issue, many Insureds and Insurers have opted for a global resolution of the coverage disputes including, for example, full policy releases in exchange for a payment of something less than the total limits of liability available from each insurer or payments by the Insured to the Insurer as, effectively, increased premium to reflect the proper nature of the risk insured.

Factors that are typically considered in a global coverage resolution include: (a) the aggregate potential exposure to the Insurers; (b) the ultimate strength of potential coverage issues; (c) estimated costs of coverage litigation or other coverage dispute resolution and the likelihood of success; (d) whether the policies require coverage disputes to be addressed in a particular forum; and (e) any issues specific to only certain policies (i.e., any differences in conditions and/or potentially applicable law).

Although the negotiation and implementation of a global resolution can be complicated, when handled properly, there are benefits for both the Insurer and the Insured, including: (a) certainty for Insureds and Insurers; (b) Insureds face one less litigation front and can focus on defending and resolving the liability suits; (c) Insureds and Insurers avoid the cost of a coverage dispute; (d) Insureds receive full authority to negotiate settlement of the underlying Claims without the requirement of Insurer consent; (e) Insurers receive some savings of limits on every layer of the insurance program, which is particularly significant when coverage issues (such as rescission) suggest that the availability of insurance may be an “all or nothing” proposition; and (f) Insurers are released from further potential liability under their policies and under “bad faith” laws.



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