

ASPATORE THOUGHT LEADERSHIP

Insurance Law 2010

*Top Lawyers on Trends and Key Strategies
for the Upcoming Year*



ASPATORE

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Key Issues in D&O Liability Insurance

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Our firm handles a considerable amount of director and officer (D&O) liability insurance issues. On the front end, we counsel clients on what type of language they should procure for their policies. On the back end, we litigate and settle D&O insurance claims.

Addressing these two areas goes hand-in-hand in many respects. Difficult claims illustrate problems that can be addressed for clients on renewal; whereas, newly available policy language can address shortfalls in coverage, as illustrated by recent court opinions.

We have assisted a large number of clients, including Fortune 100 companies, and individuals who sit on the boards of those companies, with D&O insurance renewals. If our firm is asked to review a client's D&O insurance program, we conduct the review taking into account issues raised in case law, and how negotiations with carriers on similar issues are progressing. Our goal is to attempt to eliminate problems on the front end, by securing better contract language, so that clients can avoid litigation with their carrier later on.

With respect to renewals, one change we have seen is aggressive policy pricing. This scenario seems to have opened up a myriad opportunities for clients—not only to obtain a better price, but also to negotiate better policy language going forward. This current environment is creating new opportunities for those willing to bargain for better D&O policy language.

In what may be seen as a counterintuitive trend, we have also experienced more difficulties with respect to collecting defense and indemnity coverage. The cause of this trend is unclear, but it appears to be here to stay. One of the most disturbing examples of this trend is the increase in insurers who are alleging that policies should be rescinded based on alleged misrepresentations by the policyholder. This and other common reasons for denial, as well as suggested responses, are discussed in detail below.

D&O Claims and Renewal Strategies

Government Investigations

One of the largest areas of difficulty is coverage for governmental investigations. If a corporation or individual is investigated by the government, they may spend hundreds of thousands, if not millions, of dollars defending those investigations. The investigation may start with the issuance of a subpoena or a letter, and these early-stage investigations can be somewhat informal. When an individual or corporation is asked by a government agency to answer questions, or if an agency requests documents that the individual or company needs to produce, lawyers need to be hired, often at considerable expense. In this situation, some insurance carriers have denied coverage, alleging that since a lawsuit was not filed, no claim has been made.

Unfortunately, government investigations are generally front end-loaded, meaning that a great deal of money is spent in the early stages of defense. If defense counsel does its job, the best-case scenario is that the individuals, or the corporate entity, avoids further inquiry. From a coverage perspective, the insurance carrier may agree that a policyholder spent money in the context of responding to an investigation, and that these expenditures were a necessary expense, but the carrier, may, nonetheless, argue that it has no obligation to pay such defense costs because the issuance of a subpoena does not meet their interpretation of what constitutes a D&O “claim.”

Individuals and entities that are successful at convincing the government they should not be the target of an investigation can find themselves in an ironic position with respect to their D&O insurance. In essence, they are told that if they would have elected to do nothing and the government would have sued them, they would be in a better position with respect to coverage.

A number of insurers have recognized the irony of this issue, and offer language that clearly provides coverage for the early defense of government investigations. Other carriers require an endorsement to their policies broadening the definition of “Claim.” Either way, clients who ask for one of these broader definitions prior to binding can often remedy this situation

before a claim has been made, saving them a great deal of money and aggravation if a claim is made against them later.

In any event, those who face a claim without the best policy language still have recourse. Even with less than ideal policy language, carriers are often willing to pay a portion of the front-end costs of a defense and investigation if presented with proper legal arguments as to why such coverage should be provided.

Shareholder Derivative Demands

Similar arguments have been made by some carriers to avoid coverage for shareholder derivative demands. A shareholder derivative demand is a statutory requirement that must be met before a shareholder derivative lawsuit can be filed. In essence, a shareholder derivative demand letter demands that the company investigate some activity that the third party believes was improper, and instructs the company to file a lawsuit against individual directors allegedly responsible. Such a shareholder derivative demand is sent out prior to the filing of a lawsuit against a company by the third party.

Once a shareholder derivative demand is sent, an organization will typically spend considerable sums investigating and defending the claim. Because of the complexity in investigating such claims, pre-suit legal fees in excess of \$5 million are not uncommon. But, because this defense is conducted prior to the filing of an actual lawsuit, some carriers have denied coverage for such pre-suit defense costs, arguing that their defense coverage commences only after a lawsuit is filed.

Again, there are two ways to address this situation—fight with your insurance carrier afterwards, or attempt to fix the situation beforehand by negotiating a broader definition of a “Claim” in your policy. Even if the policy only covers lawsuits, pre-suit defense costs should be covered if legal work done pursuant to a shareholder derivative demand is part of the defense. This is certainly the case in jurisdictions where, pursuant to statute, pre-suit derivative demand expenditures are legally part of the defense. In these jurisdictions, this law can be articulated to carriers, and in some cases, carriers will give credence to the argument and pay all or a good portion of these early defense costs.

The easiest solution, though, is to negotiate a broader definition of claim from the start.

Personal Conduct Exclusions

One area where we are seeing improvement is in the language of personal conduct exclusions. All D&O insurance policies contain some form of personal conduct exclusions, which may include conduct related to unlawful payments to officers, criminal acts, and fraudulent acts or omissions. These exclusions have generally been tolerated because they were intended to apply only to illegal conduct, or, at a minimum, very bad conduct. Insurers have, however, struggled with how to characterize the kind of culpable conduct that should be excluded. Over the years, some carriers have expanded what they consider to be culpable conduct, to potentially exclude the very essence of what is alleged in securities fraud cases— i.e., securities related fraud.

Perhaps the leading case addressing these exclusions in the context of securities claims is *Alstrin v. St. Paul Mercury Ins. Co.*, 179 F.Supp.2d 376 (D. Del. 2002). In *Alstrin*, a series of class action lawsuits were filed against former officers and directors alleging violations of §§ 10(b), 14(a), 20(a) of the Securities Exchange Act of 1934. The policies at issue expressly covered such securities claims. Nonetheless, the carrier sought to exclude coverage for the lawsuits based on the policy's fraud and illegal profit exclusions. The policyholders argued that if these exclusions were applied to securities claims, which typically allege fraudulent or illegal conduct, coverage for virtually all securities claims would be barred, rendering the policy's express grant of coverage for such actions meaningless. The insurer, to the contrary, argued that the provisions did not render securities coverage illusory because the policy would still apply to certain types of securities violations, such as Section 11 claims, which do not require any culpability, or are premised on findings of negligence or recklessness.

The court in *Alstrin* agreed with the policyholder, reasoning that if the conduct exclusions barred coverage for securities fraud claims, coverage under the policy would be illusory:

[i]f the deliberate fraud exclusion applied to securities claims, there would be little or nothing left to that coverage. Particularly, in a D&O insurance policy, where securities fraud claims are among the most common claims filed against directors and officers, the effect of such an exclusion would be particularly devastating. No insured would expect such limited coverage from a policy that purports to cover all types of securities fraud claims.

Id. at 398. This area is certainly ripe for additional litigation.

In practice, since most lawsuits allege some sort of fraudulent or dishonest conduct, this issue can be raised with respect to virtually any D&O lawsuit.

Common policy language does not always elevate the problem. Common policy language requires an insurer to pay defense costs until such culpable conduct has been proven, but some carriers have attempted to claw back defense costs paid, once an unfavorable ruling, settlement, or plea-bargain has been entered. This defeats the purpose of providing defense coverage in the first place. Some state-of-the-art policy language prohibits this, in that it requires an insurer to pay defense costs, and prohibits the carrier from seeking reimbursement for those defense costs if it is later proven that conduct was improper.

On the positive side, some carriers have completely done away with the dishonesty portion of the exclusion, and now exclude only “deliberate fraudulent acts.” These kinds of exclusions will likely become the standard in months or years to come, but old language will persist for many unless better language is expressly requested.

Bankruptcy and Insolvency Issues

Numerous coverage issues arise out of bankruptcy and insolvency. One of the more common insolvency issues we face is what deductible applies. For example, standard primary D&O insurance products typically offer three basic types of coverage: executive liability protection, often referred to as “Side A”; corporate reimbursement, typically known as “Side B”; and securities or entity coverage, sometimes referred to as “Side C.”

Side A coverage pays the directors and officers directly for loss, including defense costs, when corporate indemnity is unavailable. Side B coverage, in contrast, reimburses the corporation, or entity, for amounts it has paid to indemnify its directors and officers. Side C coverage provides reimbursement of defense costs and indemnification for claims asserted directly against the corporation, which is often limited to securities lawsuits.

Issues arise here because the deductible for Side A coverage is typically nothing, whereas, the deductible for Side B and Side C coverage is often considerable (\$50,000 to \$500,000 is not uncommon). One might suppose there is a bright-line answer to what the deductible is for a given lawsuit, but we have found this is not always the case—and good advocacy can make the difference between a high deductible and no deductible at all, depending on how the policy is written and how the insured entities are structured.

Although not new, another insolvency-related issue that has been raised by carriers with increasing frequency in the past year are disputes related to “insured versus insured” exclusions. When an organization is in bankruptcy, a trustee may be appointed, and the trustee may bring suits for breach of duty against various individuals, including the directors and officers. Under some policies, insurers have argued that the trustee’s claims should be excluded because such claims were brought “by or on behalf of the company.” Similarly, some policies contain creditor exclusions, that insurers have argued apply to virtually any claim brought by a creditor in bankruptcy against a director or officer of the company.

Unfortunately, this is exactly the type of situation where directors and officers need to be covered. When an organization files for bankruptcy, claims are likely to follow—and the last thing an individual insured wants is a situation where his or her personal assets end up being attacked just because the insurance policy is unclear or was poorly negotiated.

Fortunately, many of these bankruptcy-related problems can be easily fixed before a claim is brought. Better policy language includes a multitude of exceptions to the insured versus insured exclusion, and one of these is an exception for trustee claims brought in bankruptcy. Similarly, creditor exclusions have no valid place in D&O policies, and can often be deleted on renewal.

Application Errors and Policy Rescission

One of the most important issues we are seeing—and it seems to be raised in increasing frequency—is the nullification of insurance due to an alleged error in the insurance application. Most directors and officers never see the application, but it can, nonetheless, prove more problematic than any policy provision or exclusion. If an application is filled out incorrectly, even if the mistake was innocent, an insurance carrier may seek to rescind the policy, defeating coverage for all officers and directors, whether they were aware of the inaccuracy or not. The rationale expressed by courts granting such rescissions is that the insurance company underwrote coverage based on representations contained in the application. Some courts have used this concept to render the insurance policy null and void.

Although the concept of rescission has no place in D&O coverage, some insurance carriers routinely deny coverage alleging that the policies should be rescinded. The impact of rescission is severe. If a policy has been rescinded, it no longer legally exists, and, as such, it cannot provide coverage to any director or officer covered under the policy. This leaves directors and officers personally exposed to mounting legal fees and securities lawsuit judgments potentially rendered against them.

It is a common misperception to believe that a carrier will limit its rescission allegations only to situations where someone acted with malicious intent. Rescission allegations can arise in situations where no one did anything wrong. A common situation is where the insurance application and the policy state that the insurer relied on public filings and statements made in the application for underwriting coverage. If information contained in a company's public filings later proves inaccurate, through a restatement of earnings or otherwise, some insurers have taken the position that the policy must be rescinded.

Policyholders have several approaches for minimizing the risk of rescission. As an initial matter, directors and officers should be wary of a policy's express incorporation of public filings into the application. To the extent an insurer requires financial statements as part of the application, such records should be limited to the proceeding year's filings.

In addition, policyholders should insist on express language providing that fraud or other inaccuracies in the application cannot be imputed to officers and directors who had no knowledge of the erroneous or untrue facts. But, even such protective language may prove inadequate to prevent forfeiture of coverage for innocent officers and directors due to the misrepresentations of others. Some courts have, for instance, determined that the intent of these severability provisions is unclear and have allowed insurers to rescind policies as to all officers and directors. Moreover, even if severability language is enforced, an insurer may still withhold coverage while it investigates the knowledge of each specific director and officer. Some carriers have also been known to file a lawsuit against directors and officers seeking a judicial determination that they possessed sufficient knowledge to justify rescission. This, of course, may have disastrous impact on any individuals relying on the carrier for the prompt advancement of defense costs.

Another method to manage the rescission risk is to bind “non-rescindable coverage.” Traditional D&O policies can, for instance, be amended or endorsed to be non-rescindable with respect to Side A coverage, and sometimes, for Sides B and C coverage as well. Also, so-called “Side A-only” non-rescindable coverage may be purchased. Directors and officers opting for Side A-only coverage are well advised to consider a comprehensive “difference in conditions” (or DIC) policy, which is designed to “drop down” and function as primary coverage where, for instance, the primary carrier has cancelled or rescinded coverage, or even where the primary insurer has simply refused to indemnify officers and directors on a timely basis.

Unfortunately, even non-rescindable coverage may not guarantee that insurance will be available for officers and directors in the event of misstatements in the application or incorporated public filings. Many policies, while purportedly “non-rescindable,” nevertheless preclude coverage through an exclusion for officers or directors who knew that facts set forth in D&O application were not truthfully or accurately disclosed. Regardless of whether the carrier rescinds the entire policy or simply “excludes” coverage, the impact, as to some officers and directors, may be the same.

In the end, there is no easy solution to the rescission concern. Although non-rescindable coverage is best, some so-called non-rescindable policies still contain language supporting rescission.

Final Thoughts

We are seeing more claims issues in recent times, and claims that we believe would have been paid in the past, are not being paid today. This may or may not be a function of current economic times and the difficulties that some insurers have faced. At the same time, we are also seeing increased regulatory scrutiny. It is too soon to tell how the Obama Administration's actions will ultimately affect policyholder disputes with insurers, but the convergence of increased regulatory scrutiny combined with positions taken by some carriers related to coverage for regulatory actions could be a recipe for concern.

We will likely continue to see a sustained high level of contentiousness with respect to the handling and processing of claims in the year ahead. Some carriers and some insurance carrier counsel have been quite aggressive in their denials. It is not uncommon to see preemptively filed lawsuits and declaratory judgment actions, even when negotiations have not completely run their course. We do not expect this to change in 2010, as an increasing number of carriers seem to be turning claims responsibilities over to litigation counsel, who may be incentivized, in this economy, to recommend litigation, rather than settlement.

The issues our clients are currently facing seem to be big-picture issues that will occur with similar frequency in 2010. We will continue to work with our clients to negotiate better policy language in the upcoming year, and fortunately, the soft market for insurance seems to be intact. Given this environment, we believe that leading carriers will continue to innovate on the underwriting side, and we will continue to negotiate better language for our clients. On the negative side, disturbing trends in claims handling can not be reversed overnight, and will likely continue until successful test cases have been decided.

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