

D&O Liability Insurance – Lessons Learned

By Steven Guggenheim and Katherine Henderson

Public company directors and officers (D&O) liability insurance is a unique animal. In contrast to many other types of insurance, the wording of a D&O policy is often heavily negotiated among the insured company, its insurance broker and the insurer. Indeed, given that a single public company D&O policy can generate well over a hundred thousand dollars in premiums for an insurer, insurers may compete intensely to offer companies the most attractive policy terms and enhancements. The end result of all of this negotiation and competition is a bit like evolutionary biology. D&O policies are constantly mutating – not only from insurer to insurer, but even in the terms that a single insurer may offer to different prospective insureds. Some of these mutations are positive and some have unexpectedly negative consequences. The bottom line is that the policy terms in public D&O policies can and will differ in material ways. Careful review of those terms is required, especially when a company is purchasing a D&O policy for the first time or changing insurers. Here are four lessons we've learned from reviewing hundreds of D&O policies over the past years.

Lesson Number 1: Ignore Buzz Words

Despite the great variation in D&O policies, insurers and insureds often speak as if key policy terms have standard meanings. Summaries of policy terms prepared by insurance brokers may reinforce this misperception, using buzz words to capture concepts in lieu of actual policy wording. Given the near certainty that policy terms will differ from policy to policy in critical respects, it is a mistake to rely on such summaries or descriptions of terms. In fact, there are two areas where review of actual policy language is especially important: the triggers for the conduct exclusions and the severability of the application provision.

D&O policies typically contain at least two conduct exclusions: a “dishonesty exclusion” that provides that the insurer will not pay a claim if the loss resulted from the insured acting in a deliberately dishonest way, and a separate exclusion that bars recovery for a loss that results from the insured gaining a personal profit to which he or she was not legally entitled. Establishing a threshold for when these exclusions can be triggered is essential, as the majority of lawsuits that a D&O policy covers involve either allegations of dishonesty or claims that the director or officer unjustly profited from alleged misconduct. Coverage would be meaningless if an insurer could deny coverage anytime there were allegations of wrongdoing or some document surfaced that could be construed as showing dishonesty or illegal profit on the part of an insured.

What does it mean, then, if a summary of policy terms says that the dishonesty exclusion can only be triggered by a “final adjudication?” With true final-adjudication language, the insurer only can deny coverage if there is a judgment against the insured in the underlying lawsuit that gave rise

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to the demand for coverage that establishes that the insured acted in a deliberately dishonest manner. Yet in practice, final-adjudication language for the dishonesty exclusion can mean any number of things. It might mean that the insurer does not have to rely on what happens in the underlying lawsuit to deny coverage and that it may instead initiate its own separate coverage lawsuit to prove that the insured acted dishonestly. It might allow the insurer to deny coverage if the insured enters into a settlement with a government entity such as the Securities and Exchange Commission. Or it might allow the insurer to deny coverage whenever there is a “written admission” that suggests dishonesty. This last form of final adjudication is especially problematic since what constitutes a written admission of dishonesty is clearly in the eye of the beholder and simply will invite coverage disputes. Insurers often will argue that it is better *not* to have true final-adjudication language because a lower threshold allows them to cut off coverage for the “black hats” and preserve coverage for the innocent insureds. While this contention is not without merit, a company purchasing D&O insurance must be aware of the pros and cons of the final-adjudication language offered by the insurer.

Describing a policy as having “full severability of the application” likewise hides key differences in policy language. In theory, what full severability means – or at least what it means to us – is that if there are material misrepresentations in the application for insurance, the insurer can seek to rescind the policy *only* as to those individuals who knew of the false information. In other words, the insurance application effectively is treated as if it were separately submitted by each insured, *i.e.*, severable, and the insurer must prove its case against each insured against whom it seeks to rescind. In practice, a policy provision that is described as “fully severable” can contain language that significantly dilutes the protections offered by so-called “full severability.” For example, the policy language may deem every representation in the application material (instead of requiring the insurer to prove a material misrepresentation). Or, a “fully severable” provision may allow the insurer to rescind the policy if any of the statements in the application were inaccurate, even if those statements did not materially affect the risk assumed by the insurer. Thus, once again, summaries are no substitute for actual review of policy terms.

Indeed, the most recent iteration of severability language that is making the rounds is not nearly as positive as it might seem from the description. Some insurers have been purporting to offer language that makes the D&O policy “fully non-rescindable.” This description suggests that the insurer cannot rescind the policy under any circumstances and will have to rely on the dishonesty exclusion if it wants to deny coverage to a particular insured. But while all “fully non-rescindable” policy endorsements do prevent the policy from being rescinded, those endorsements almost always contain additional language allowing the insurer to deny coverage to any insured who had knowledge of facts that were misrepresented in the application. In effect, the insurer has given up the right to rescind in exchange for a new way to deny coverage. But unlike the dishonesty exclusion, which has a trigger such as final adjudication, there is no clear trigger in the “fully non-rescindable” endorsement that specifies when an insurer can refuse coverage on the basis of misrepresentations in the application for insurance. Because of this, as well as the dearth of case law as to how such an endorsement would work in practice, the “fully non-rescindable” endorsement does not appear to be an attractive option.

Lesson Number 2: Beware the Law of Unintended Consequences

As noted, D&O insurers are often willing to agree to “enhancements” of coverage as a way of competing with rival carriers. But tweaking a D&O policy to improve it in one way can have unexpectedly negative consequences with respect to other aspects of coverage. Before agreeing to so-called “enhanced” coverage, consider the (unintended) consequences.

1. Coverage for Employees

For example, from the company’s perspective, making the definition of “Insured” as broad as possible might seem like an obvious policy enhancement. The more individuals covered under the policy, the fewer the instances in which the company, rather than the insurer, will have to shoulder the burden of paying defense costs, settlements and judgments. Along those lines, many D&O insurers are willing to expand the definition of “Insured” to cover employees and not just directors and officers under their policies.

There are, however, unintended consequences. First, employee coverage means the same amount of insurance is being spread across a much larger group, *i.e.*, not just the directors and officers as originally intended. This could, indeed, pose a negative consequence from the perspective of the company’s directors and officers, as coverage that was originally intended for them may not be available if policy limits were used up paying defense costs, settlements and judgments in lawsuits brought against employees.

Second, including employees as insureds under the policy can risk coverage under the insured-versus-insured exclusion. Under the insured-versus-insured exclusion, an insurer will not cover claims made by one insured against another. Thus, if an employee is made an insured and he or she brings a claim against the company or its directors and officers, the claim will not be covered absent an exception or carveback to the insured-versus-insured exclusion. While such exceptions can be negotiated, there is no guaranty that they will be effective, *i.e.*, that there will be coverage in the event of a suit brought by or instigated by an employee. In short, one must be aware that a broader definition of “Insured” increases the likelihood for triggering the insured-versus-insured exclusion.

2. Company Coverage

There are also unintended consequences to making a company an insured under a D&O policy. Although mainly designed to provide insurance coverage for a company’s directors and officers when the company cannot indemnify them¹ (Side A coverage) and to reimburse a company

¹ A company cannot indemnify if it is insolvent. Public policy also prohibits the company from indemnifying its directors or officers for settlements and judgments in derivative actions (lawsuits brought on behalf of the company against the directors or officers) and for judgments against directors and officers that involve violations of the federal securities laws. Even the attorneys’ fees spent defending a derivative lawsuit may not be indemnifiable if a director or officer is ultimately adjudged liable to the corporation. In those instances—that is, where the company is bankrupt or where indemnity is prohibited by law—a director would look to Side A coverage for protection.

for the cost of indemnifying its directors and officers (Side B coverage), it is now relatively typical for D&O policies also to cover securities lawsuits that are brought directly against the company itself. This latter coverage is known as Side C coverage. Because securities lawsuits normally are brought against both the directors and officers and the company, making the company an insured under the policy eliminates the need to allocate, as between the insurer and the company, who bears the cost of such litigation.

While it has obvious benefits to the company, Side C coverage also poses coverage risks for the directors and officers. As with employee coverage, Side C coverage puts the same strain upon the policy limits. If, for example, the available limits are used up in settling claims against the company, the directors and officers can be left with no insurance coverage. This can be especially problematic where the directors and officers cannot look to the company to indemnify them, either because indemnity is against public policy or because the company lacks the money to honor its indemnity obligation. Indeed, if a company is bankrupt, a bankruptcy trustee may seek to freeze the policy, claiming that the policy proceeds are an asset of the estate. Since Side C coverage is a direct benefit to the company, the presence of Side C coverage strengthens the trustee's argument that the proceeds of the policy should be treated as an asset of the bankrupt estate. The solution is not necessarily to get rid of Side C coverage—such coverage does free a company from costly disputes over allocation with its insurers. The solution is to obtain some form of Side A-only coverage for the directors and officers. This Side A coverage cannot be used by the company in settling claims and is virtually immune to claims by a bankruptcy trustee.²

3. Oral Demands as Claims

Expanding the definition of a “claim” also can create problems if it will not be clear to a decision maker within the insured company when the claim was made. For example, some policies include oral demands as claims. The advantage of this “enhancement” is that if a claim begins at the time when an oral demand is made, the insured can get insurance coverage at a much earlier point in a dispute, *i.e.*, before a lawsuit is actually filed. But the unintended consequences make this enhancement ill advised. The vague trigger for coverage creates uncertainty in relation to the requirement that the insured give timely notice to its insurer. For example, suppose that a vendor calls up a company's sales manager and indicates that it thinks the company has violated a contractual arrangement. Would this constitute an “oral demand”? What happens if the sales manager fails to tell the individual ordinarily responsible for giving notice of claims to the insurance

² A related problem regarding limits-sharing is created by the decision to include a “debtor in possession” in the definition of “Insured.” A company becomes a “debtor in possession” when it files for voluntary bankruptcy. This again is almost always offered as an enhancement to the D&O policy – it insures that a company does not lose coverage for claims brought directly against it if the company files for voluntary bankruptcy. Yet, the decision to make a debtor in possession an “Insured” has negative consequences for the company's directors and officers since it means, among other things, that the directors and officers will have to share their insurance limits with the company at a time when the company is insolvent and likely will not be able to indemnify them.

company? If notice is not given in a timely manner and the oral demand ripens into a lawsuit, there may be serious disputes over whether the insurer is excused from covering the claim because of late notice. Given the uncertainty involved in deciding when an “oral demand” is made, it is better to restrict the “claim” definition to more definitive occurrences such as the filing of lawsuits. In addition, the notice provisions in a D&O policy can be positively enhanced by providing that the company is not required to give notice of a claim until specific individuals, such as the general counsel, risk manager or chief financial officer, become aware of the claim.

4. Large Retentions

Brokers sometimes will suggest increasing the deductible or retention as a way of reducing the cost of a D&O policy. Indeed, we have seen instances where the deductible is \$10 million or \$15 million, *i.e.*, a company must go out of pocket \$10 million or \$15 million before the policy will begin paying on the claim. The problem is that while the cost of the claim (defense costs and settlements or judgments) never may actually exceed the deductible, the limits on the D&O policy are potentially implicated and the insurer therefore can demand to be involved in litigating the claim. Along these lines, although the company likely will not receive any benefit from the insurer, the insurer can require: 1) that the insured keep the insurer informed throughout the litigation, and 2) that the insured comply with the insurer’s rules, such as whom the insured may retain as counsel, when the insured may settle a claim and general litigation strategy. Any (typically small) savings that result from increasing the deductible likely are far outweighed by the probability of having to jump through hoops for the insurer on claims that never may implicate policy limits.

Lesson Number 3: If You Want It, Ask for It

As noted above, there can be intense competition amongst insurers to get new D&O liability insurance business. This is particularly the case where an initial public offering is involved. Companies should recognize that this competition among insurers can work to their benefit not just on pricing, but also on terms.

In particular, D&O insurers may be willing to compete by offering coverage that other insurers refuse. One notable example of this relates to coverage for Section 11 and Section 12 claims under the Securities Act of 1933. Because the remedy for those claims can be rescissory in nature, *i.e.*, the defendant corporation can be forced to give back money that it allegedly wrongfully obtained, some insurers have been successful in arguing that even a settlement of a Section 11 or Section 12 claim is uninsurable. *CNL Hotels & Resorts, Inc. v. Twin City Fire Insurance Co.*, No. 06-00324-CV-ORL-31-UAM, 2008 WL 3823898 (11th Cir. August 18, 2008) (“The return of money received through a violation of law, even if the actions of the recipient were innocent, constitutes a restitutionary payment, not a loss” within the policy). In response to this anti-insured case law, other insurers have been willing to expressly agree by endorsement to their D&O policies that they would *not* take that position – that they would not argue that a settlement of a Section 11 or Section 12 claim is uninsurable. Obviously, the choice between an insurer who may refuse coverage if a company is named in a Section 11 or Section 12 claim and insurer who agrees that it will not reject coverage on that basis, is an easy one.

On a going-forward basis, an area that could prove to be a differentiator for insurers offering public company D&O coverage would be to offer a defense-costs carveback in the insured-versus-insured exclusion.³ As noted above, absent exceptions, insurers will not cover suits brought by one insured against another. This insured versus insured exclusion was developed in order to prevent collusive lawsuits between insureds that effectively seek to tap into the D&O policy as a means of recovering money for the party bringing the lawsuit.⁴ If, however, the D&O policy only will pay defense costs in a suit brought by one insured against another, the risk of a collusive suit disappears. In fact, some insurers already offer such a carveback in their Side A-only D&O policies; there is no reason such a carveback should not also be extended to D&O policies offering Side B and Side C coverage.

Lesson Number 4: Look Up

With all of the heavy focus spent on negotiating primary terms, it is remarkable how often the companies that purchase D&O policies don't take the time to look up to the excess policies that sit on top of those policies. These days, a primary D&O insurer typically will not agree to cover more than \$10 million of the risk for a single company. For a company that needs \$50 million of coverage, that means there may be four or even eight excess carriers that provide the remaining \$40 million in coverage. In large part, the excess policies in the insurance tower should simply follow form (that is, adopt the exclusions and coverage provisions of the primary policy). The fact that such policies may *not* follow form can lead to a coverage dispute with the excess carrier even where there is no dispute with the primary insurer. Indeed, any language in the excess policy that speaks to an issue already addressed in the primary policy could be used by the excess insurer to argue that its policy does not follow form, giving the excess insurer a basis for denying coverage that is not available to the primary insurer.

The implications of such a dispute extend beyond the insurer whose policy does not follow form. Each excess insurer typically is only required to pay out on its policy if the insurers below it have first already paid out on their policies. Thus, a coverage dispute with a single excess insurer

³ A defense-costs carveback to the insured-versus-insured exclusion basically says that while an insurer will not cover any settlements or judgments in a lawsuit brought by one insured versus another, the insurer *will* cover the defense costs spent defending against that lawsuit.

⁴ The insured-versus-insured exclusion first arose in the mid-1980s after financial institutions attempted to recoup corporate losses arising out of underperforming loans by suing their own officers for negligence in handling the loans. See *Township of Center, Butler County, Pa. v. First Mercury Syndicate, Inc.*, 117 F.3d 115, 119 (3rd Cir. 1997) (“The exclusion arose from a wave of litigation in the mid-1980’s when corporations attempted to use their Director and Officer policies to recoup operational losses”) *Fidelity and Deposit Co. of Maryland v. Zandstra*, 756 F.Supp. 429, 431 (N.D.Cal. 1990) (“The obvious intent behind the ‘insured v. insured’ exclusion is to protect [the insurer] against collusive suits among [the insured company] and its directors and officers”); *Conklin, Inc. v. Nat’l Union Fire Ins. Co.*, No. 4-86-680, 1987 WL 108957, at *6 (D.Minn. Jan. 28, 1987) (exclusion “intended to prevent collusive or friendly lawsuits, where, for example, the insured company sues its directors or officers for their wrongful acts”); William E. Knepper & Dan A. Bailey, *Liability Of Corporate Officers and Directors* § 25-28, at 453 (6th ed. 1998) (insured-versus-insured clause intended to preclude coverage for collusive suits brought for the purpose of converting insured corporation’s D & O policy into a liquid asset).

means that every insurer above that excess insurer has a defense to coverage simply because the policy below them is refusing to pay. For example, in a \$50 million insurance tower where the primary policy insures the first \$5 million and the excess insurer with the coverage dispute insures the next \$5 million, the insurers holding the remaining \$40 million in coverage all potentially can refuse to pay out on their policies until such time, if ever, that the first excess carrier pays out on its policy. Thus, excess policies must be reviewed carefully to ensure that they do not give any excess insurer a right to deny coverage that the primary insurer does not have.

If there is a coverage dispute with an excess carrier or the primary insurer, then the exhaustion language in the excess policy may prove critical to resolving that dispute. The exhaustion language governs when the excess insurer is obligated to pay on its policy.

The California Court of Appeal's recent decision in *Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London*, 161 Cal. App. 4th 184 (2008) underscores the significance of exhaustion language in an excess policy. *Qualcomm* was a lawsuit brought by the eponymous company against its excess insurer, Lloyd's of London. After Qualcomm apparently had incurred approximately \$30 million in defense and settlement expenses related to a series of stock-option lawsuits, the company reached a settlement of its coverage disputes with its primary insurer. The settlement provided that the primary insurer would pay \$16 million of the \$20 million primary insurance policy in exchange for a full release of any further claims under that policy.

Qualcomm then turned to its excess carrier, Lloyd's, for coverage. Qualcomm argued, among other things, that even though it had settled for \$4 million less than the full amount of the primary policy, the company itself had paid an additional \$4 million of loss that otherwise would be covered under the policies. Therefore, Lloyd's was not being asked to pay under its policy any earlier than it had bargained for; in other words, \$20 million had been paid out by a combination of the primary insurer and Qualcomm before Lloyd's was asked to contribute anything towards settlement or defense costs.

Lloyd's refused coverage based on the following exhaustion provision in the excess policy:

Underwriters shall be liable only after the insurers under each of the Underlying policies have paid or have been held liable to pay the full amount of the Underlying Limit of Liability.

Lloyd's argued that coverage had not been triggered because the underlying primary policy had not been exhausted. Exhaustion, Lloyd's argued, required that the primary insurer, and no one else, actually have paid the entire \$20 million policy limit of the underlying policy in order for its obligation to be triggered under the excess policy. The court agreed. Relying on the above language, the Court of Appeal held that in a policy containing the above language, an insured that settles an insurance dispute with its primary insurer whereby the primary insurer pays less than the full limits of its policy effectively forfeits all coverage from the excess carrier.

To avoid the *Qualcomm* result, excess policies should contain exhaustion language that provides that coverage is available if either the underlying insurer *or* the insured pays loss within the

primary policy limits. This type of provision will allow an insured the freedom to settle a claim with one insurer without risking coverage on the layers above it. Such a provision also will protect the excess coverage in the event that one of the underlying insurers goes bankrupt and cannot pay its full limits. Most D&O insurers offer some variant of this language as an endorsement to their policies, though as with everything about D&O, the language differences can be significant.