

Recent D&O Insurance Cases of Note

Published by
The Lowenstein Sandler
Insurance Group

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ATTORNEYS AT LAW

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Introduction

Directors and Officers insurance is constantly in a state of flux. Policies issued by different insurers are not identical, and seemingly minor differences in wording can have an enormous impact on coverage. Usually without notifying the insured, insurers add endorsements to policies that can eliminate or modify coverage. Each case law victory by policyholders leads to revisions to the D&O policy by insurers who attempt to reverse the favorable holding by the court.

This case law review captures current D&O insurance coverage case law in 2010. It illuminates gaps and traps in coverage and advises on mechanisms to avoid these pitfalls.

D&O insurance is supposed to provide directors and officers with an umbrella against liability. However, that umbrella is full of holes. This review helps companies identify and patch those holes.

RECENT D&O INSURANCE CASES OF NOTE

I WHAT IS A CLAIM?/NOTICE

A. Always Give Notice

Admiral Insurance Co. v SONICblue Inc., 2009 WL 1308905 (N.D.Cal. May 11, 2009) primarily addresses the complex and, for the insured, potentially fatal issue of notice in the context of claims-made policies.

In the context of general liability claims, most jurisdictions will only deny coverage because of late notice if the insurer can show it was prejudiced by the late notice. However, under claims-made policies such as D&O and EPLI policies, almost all jurisdictions deny coverage for late notice without any need for a showing of prejudice by the insurer. This creates a particular problem for policyholders because the insured must report "claims," and the policies offer broad, expansive definitions of claim, such as "written notice of a demand for monetary or non-monetary relief."

In *Admiral*, the court first held that two letters to the insured in 2002 from one group of noteholders *were not* claims. These letters "express[ed] concerns about the company's financial state and future prospects," but did not "even allude to the possibility of damages or nonmonetary relief." The court next held that two letters dated December 12, 2003 from the same noteholders *were* claims because they contained "specific demands for monetary relief." The insured did not give notice of the 2002 letters but did give notice of the December 12, 2003 letters.

A second group of noteholders sent a letter to the insured on November 14, 2002 in which they expressly "reserve[d] all their claims and rights with respect to the careless and inappropriate sales of [certain] shares that have already occurred." The insured did not give notice of this letter. The court did not find that this letter was a "claim," but did find that the insured should have reasonably expected that the matters discussed in the letter could give rise to a claim, and therefore required notice.

Finally, the court addressed a letter from the State of Wisconsin Investment Board, which demanded access to certain information from the insured so that the State could "investigate possible waste, mismanagement, or breaches of fiduciary duties in connection with the recent offering..." The court found that the insured should have given notice of this letter because it described a breach of fiduciary duty and demanded that the directors and officers "take action to cure the breach."

Policyholders often are unaware that informal notices, such as letters, might constitute "claims" that they need to notice to their insurer. This case does not provide a convenient bright line test for policyholders but the lesson to be learned is that even informal notices can be claims that the company must report. Practically, the only way for a policyholder fully to protect itself is to provide notice as broadly as possible.

B. Is it a Claim

Definitions of 'Claim' differ markedly among insurance policies, and a broker must use his or her best efforts to confirm that its client has the most favorable definition. One major battleground is whether different types of government subpoenas constitute a 'claim.'

In *Jemmco Partners v. Executive Risk Indemnity, Inc.*, Docket No. L-486-07 (N.J Superior Ct., filed March 22, 2007), Jemmco, a hedge fund, received subpoenas seeking documents from the SEC, the Commodities Futures Trading Commission (CFTC), and a grand jury. The subpoenas involved market timing and late trading.

Jemmco was insured under a D&O policy which provided coverage against 'claims.' 'Claims' was defined in pertinent part as: (a) "any civil proceeding in a court of law or equity including any mediation or alternative dispute resolution ordered or sponsored by such court"; (b) "any criminal proceeding in a court of law"; and (d) "any administrative or regulatory proceeding commenced by the filing of a notice of charges, formal investigative order, or similar document."

Jemmco provided notice of the subpoenas to its insurer and the insurer denied coverage, arguing that the subpoenas related to other parties and mutual funds, and not Jemmco, and therefore were not "claims" as defined in the policy. Jemmco sued for coverage, taking the position that the grand jury proceedings were criminal proceedings in a court of law, falling within subsection (b) of the definition of a claim.

The court found that the grand jury proceeding was a criminal proceeding, and that the SEC and CFTC matters were administrative or regulatory proceedings. Next, the court addressed the subsection (d)'s requirement that regulatory proceedings be commenced by 'the filing of a notice of charges, formal investigative order or similar document.' The court found sufficient an affidavit from Jemmco's attorney stating that he had seen the formal investigative orders, which were not public, when he met with lawyers for the SEC and CFTC.

The court then noted that the policy's definition of 'claim' required that the claim be against an insured 'for a wrongful act,' and found that there were disputed issues of fact as to whether the subpoenas asserted such 'wrongful acts' by the insured. The court noted that a subpoena, unlike a complaint or an indictment, does not 'allege particular conduct or make accusations.' *Jemmco Transcript* at 37. The court stated that it was unwilling to find that a document such as a complaint or indictment was necessary for a subpoena to be a claim. It said that a subpoena with a target letter would be sufficient, and that other circumstances or notices may also qualify.

See also *Diamond Glass Companies v. Twin City Fire Insurance Company*, No. 06-CV-13105 (S.D.N.Y. Aug. 18, 2008) (grand jury subpoena seeking documents and testimony not a claim); *Ace American Insurance Company v. Ascend One Corporation*, No. 1:06-cv-03371-CCB (D. Md. Aug. 7, 2008) (finding that subpoena and investigative demands were claims).

II INSURED'S DUTY TO COOPERATE

In *Vigilant Insur. Co., et al. v. The Bear Stearns Companies, Inc.*, 2008 WL 65620 (N.Y. Mar. 13, 2008), the New York Court of Appeals ruled that Bear Stearns Companies, Inc., was not entitled to insurance for its \$80 million settlement with the Securities and Exchange Commission, the National Association of Securities Dealers, and the New York Stock Exchange, because it failed to obtain its insurers' consent to the settlement.

In early 2002, the SEC, NASD and NYSE, along with state attorneys general, initiated a joint investigation into the practices of research analysts at various financial services firms, focusing on the potential conflicts of interest arising from the relationship between the analysts' research functions and investment banking objectives. Bear Stearns, a financial services firm, was among the companies investigated.

On December 20, 2002, Bear Stearns signed a settlement-in-principle with the SEC, NASD and NYSE to settle the claims. On April 21, 2003, Bear Stearns consented to be permanently enjoined from violating a number of NASD and NYSE rules and agreed to pay a total of \$80 million to fully resolve the pending regulatory claims. The settlement was allocated \$25 million as a penalty, \$25 million in disgorgement, \$25 million for independent research and \$5 million for investor education. Three days after executing the settlement agreement, Bear Stearns sent letters to its insurers requesting their consent to the settlement.

Bear Stearns' primary professional liability insurance policy, issued by Vigilant Insurance Company (the "Policy"), provided \$10 million in coverage for losses resulting from claims against the insured for its "wrongful acts." The Policy attached in excess of a \$10 million self-insured retention. In addition, Bear Stearns had another \$40 million in follow form excess coverage. The Policy required Bear Stearns to obtain the consent of its insurers prior to agreeing to settle any claim in excess of \$5 million.

The insurers denied coverage for the settlement on a number of grounds and brought a declaratory judgment action in the state supreme court. First, they argued that the insured had breached the policy provision obligating it to obtain the insurers' consent before entering into the settlement. They also denied on the basis of the investment banking exclusion in the policy and argued that certain portions of the settlement did not constitute covered "losses."

The insurers moved for summary judgment. The state supreme court found an issue of fact as to when the settlement became final and, therefore, whether Bear Stearns breached the provision obligating it to obtain the consent of the insurers prior to settlement. The Appellate Division agreed that an issue of fact existed as to whether Bear Stearns had breached the policy obligation to obtain consent to settlement. The insurers appealed, raising a number of objections to the Appellate Division order. In particular, the insurers argued that Bear Stearns resolved and finalized the settlement of the case when it executed the settlement-in-principle in December 2002, or, at the latest, when it signed the consent agreement in April 2003, without advising the insurers.

The Court of Appeals noted that in the April 2003 settlement agreement, Bear Stearns agreed to pay \$80 million and to be permanently enjoined from violating certain NASD and NYSE rules in order to resolve all the pending regulatory claims against it. The court also noted that in that agreement, Bear Stearns acknowledged that the SEC could present a final judgment to the federal court for signature and entry without further notice to the company, evidencing Bear Stearns' intention to settle the matter fully at that time. Moreover, Bear Stearns did not provide that the settlement was subject to its insurers' approval. Thus, even though the federal court did not approve the settlement until October 2003, the court determined that the parties had fully resolved the claim in April 2003. Since Bear Stearns had failed to obtain insurer approval of the settlement prior to that date, as required by the terms of the Policy, the court held that Bear Stearns was barred from recovering the settlement proceeds from the insurers.

Unfortunately, in the exigency of litigation, insurance can become an afterthought. Lapses most frequently occur in the notice process, and late notice of a claim often forecloses coverage. However, all insurance policies require the cooperation of the insured, and many policies require the insurers' consent to settlement, or even to litigation decisions. The adversarial posture that often exists between companies and their insurers can also cause a company to avoid keeping its insurer informed or not seek its approval. Insurance management is an essential component of any litigation strategy.

III RESCISSION

A. Platte River v. Baptist Health

In *Platte River Ins. Co. v. Baptist Health*, 2009 WL 2015102 (E.D. Ark. Apr. 17, 2009), the insured Baptist Health ("BH"), a non-profit organization operating hospitals in Arkansas, sought coverage for claims brought against it after its adoption of an Economic Conflict of Interest Policy ("ECOI Policy").

The insurer, Platte River Insurance Company ("Platte River"), disclaimed coverage on the grounds of BH's alleged prior knowledge of circumstances that could give rise to a claim. The ECOI Policy provided that no physician who directly or indirectly acquires or holds an ownership or investment interest in a competing hospital shall be eligible to apply for initial or renewed appointment or clinical privileges in the professional staff of any Baptist Health hospital. This practice is also known as economic credentialing.

Prior to the adoption of the ECOI Policy, BH's CEO commissioned a project to research ECOI policies. The research was in response to a request by the Office of the Inspector General of Health and Human Services for comments regarding the legality of economic credentialing. The research discovered that several hospitals had been defendants in cases challenging their ECOI policies. BH retained outside counsel to draft its own ECOI policy in order to avoid violation of anti-kickback or anti-trust laws. A month before formally adopting the ECOI policy, BH's CEO testified at a Federal Trade Commission hearing concerning economic credentialing. At the hearing, a doctor for a competing institution voiced his concerns about the potential risk to BH by adopting an ECOI policy. At about the same time, a member of the board of trustees sent a

letter to BH's CEO expressing his concerns regarding the legality of adopting an ECOI policy. He believed that the ECOI policy would trigger a suit against BH. BH formally adopted its ECOI policy in May 2003.

Upon the expiration of its policy with Executive Risk Indemnity Insurance ("ERII") in October 2003, BH's broker submitted a renewal application with another insurer. The application stated: No Entity nor any individual proposed for coverage is aware of any fact, circumstance, situation, transaction, event, act, error or omission which they knew or should reasonable have known may result in a claim that may fall within the scope of the proposed insurance, except as follows. If answer is "None," so state: BH replied "None." BH also included a copy of the ECOI policy in its submission to the underwriter.

The underwriter reviewed the application but would later testify that she did not recall evaluating any of the risks associated with the ECOI policy. After providing a quote to BH, the underwriter provided an additional application which asked:

Does anyone for whom insurance is intended have any knowledge or information of any act, error, omission, fact or circumstance which may give rise to a Claim which may fall within the scope of the proposed insurance?

BH responded "No."

Further, both applications contained prior knowledge exclusions. The latter provided that the statements in the application were material to the acceptance of risk and were relied upon by the underwriter. Coverage was ultimately bound in December 2003.

BH was first sued because of its adoption of the ECOI Policy in February 2004. Two years later, the insurer notified BH that it had become aware of issues regarding prior knowledge. Subsequently, the insurer denied coverage for any suit relating to the ECOI policies and filed an action seeking declaratory judgment. The insurer moved for summary judgment seeking rescission on the basis of the alleged misrepresentations in the applications. The insurer also argued that the prior knowledge exclusions in the applications were incorporated into the policy and barred coverage.

The court granted the insurer's motion for summary judgment. First, the court found that the applications were incorporated into the policy. The opinion found that BH understood that its statements in the applications were material to the acceptance of the risk. The court rejected BH's arguments that the questions on the applications were ambiguous, particularly where both: (1) requested any facts or circumstances which "may result in a claim." and (2) were followed by clear language providing that any claim resulting from knowledge of such facts and circumstances would be excluded from coverage.

Additionally, the court rejected BH's argument that the question one of the applications was subject to a subjective interpretation. Although the question did not explicitly contain any "reasonable person" language, the question did not call for an answer based upon personal belief or interpretation. It called for disclosure of "any" knowledge of information, which the court found triggered an objective standard of foreseeability. The court found that BH was aware of

such facts and circumstances particularly where it knew other hospitals had been sued and where it already identified physicians that would be affected by its adoption of the ECOI Policy. Moreover, even if there were no misrepresentations, the court found that the prior knowledge exclusions included in the applications would have barred coverage because BH had knowledge of facts which a reasonable person would have foreseen would give rise to a claim.

B. J.P. Morgan v. Twin City

In *JP Morgan Chase & Co. v. Twin City Fire Ins. Co.*, Index No. 601904/06, (N.Y. Sup. Ct. N.Y. Cty. Mar. 3, 2009), JP Morgan Chase (“JPMC”) sought coverage for losses related to services it provided to Enron. JPMC held excess insurance policies with Twin City for the periods 1997-2001 and 2001-2002. In the fall of 2001, JPMC issued a press release detailing losses associated to its exposure to Enron. On the day before the 1997-2001 policy was to expire, JPMC placed Twin City on notice of “circumstances that might give rise to a claim” but asserted that it had “no actual knowledge” of any “Wrongful Acts” as defined in the policy. The next day, Twin City issued a binder for \$10 million in coverage for 2001-02. Subsequently, JPMC was named as a defendant in several actions by Enron. Twin City refused coverage for Enron related losses under the 1997-2001 policy. JPMC brought suit against Twin City and Twin City counterclaimed. In the counterclaim, Twin City sought rescission of the 2001-2002 policy because JPMC alleged concealment of information regarding the full extent of its exposure to Enron, which it claimed tainted its decision to renew coverage. The insurer also asserted various other claims, including, *inter alia*, common law fraud and breach of contract. The court found that Twin City did not meet its burden on summary judgment as to rescission. Twin City did not present any evidence that its underwriters had actually relied upon statements in the Notice or Press Release. The court further noted that these items were not made part of the renewal packet that was submitted to the insurer in lieu of a more formal application. Despite the insurer’s assertions that its underwriters were concerned about the Enron situation in November 2001, the underwriters could not recall even reading the notice prior to issuing the binder for 01-02.

Moreover, the court did not find any evidence that JPMC deliberately misled the insurers. The insurer’s only evidence of concealment was a statement by the insured’s broker that the insured’s relationship with Enron would not have a “material impact.” The insurer pointed to testimony from its underwriters that it had conversations with the JPMC’s broker regarding the underwriter’s concerns about exposure to Enron-related losses. The court rejected this evidence and held that “Twin City must provide more than simply its own suspicions that JPMC intended to mislead Twin City, and that Twin City’s underwriters actually relied upon the statements contained therein.”

Further, the court held that Twin City had waived its right to assert rescission. JPMC had fully disclosed in a press release the extent of its exposure to Enron. Thus, Twin City was aware of the potential misrepresentation between December 2001 and fall of 2002. Yet, Twin City did not assert its right to rescind the policy until JPMC filed suit in 2006. Additionally, Twin City retained JPMC’s premiums during the entire period. The court reasoned that where the insurer had accepted and retained the premiums with knowledge of the alleged misrepresentations, rescission would be unreasonable as a matter of law.

The client must rely on its broker to obtain the broadest possible protection against rescission when drafting an insurance policy. Many D&O policies are now non-rescindable, and directors can purchase special 'Side A' coverage that is non-rescindable.

IV. EXCESS D&O INSURANCE

Many corporations, even the smallest concerns, are aware of the need for substantial directors and officers' liability insurance to protect their officers and directors from the risk of liability while managing the affairs of the company. However, even when the company buys excess insurance on top of the primary policy to ensure adequate limits to cover both defense expenses and settlements/judgments, an issue may arise as to whether the excess insurer's obligations are triggered if the primary insurer pays less than its full limits in a settlement where the company steps in to pay the gap left by the primary insurer's refusal to cover certain of the claims.

Where a company steps in to fill the "gap" left by the primary insurer, the excess carrier may assert that its limits are not triggered, thereby blocking a potential settlement of a large claim by making the excess limits unavailable to the company. Two recent cases demonstrate that this is a very real risk for policyholders since courts are willing to take the excess insurer's side on this issue.

In *Comerica Inc. v. Zurich Am. Ins. Co.*, 498 F. Supp. 2d 1019 (E.D. Mich. July 27, 2007), Comerica entered into a settlement of several securities class action lawsuits for a total amount of \$21 million. Comerica's primary carrier disputed coverage on some of the claims and ultimately agreed to pay \$14 million of its \$20 million limit towards the settlement. Comerica sought coverage from its excess insurer for the \$1 million excess of the "gap" it would fill in the settlement amount with its own money, as well as in excess of \$2 million in additional legal fees. The excess insurer refused to pay, arguing that the underlying policy hadn't been exhausted, relying upon language in its policy that coverage was not triggered until "after all such 'Underlying Insurance' has been reduced or exhausted by payments for losses." The court came out in favor of the excess insurer, holding that the language in the excess policy was unambiguous and coverage was only triggered by the full payment of limits by the underlying insurance, and that the insured stepping in to fill that gap was not what the excess carrier contracted for.

Similarly, in *Qualcomm, Inc. v. Certain Underwriters at Lloyd's London*, 73 Cal. Rptr. 3d 770 (Cal. App. Mar. 25, 2008), the California Court of Appeal affirmed the dismissal of a complaint by Qualcomm against its excess D&O insurer because the primary insurer did not pay the full limits of its policy. In that case, Qualcomm gave the primary insurer a full policy release in exchange for payment by the primary carrier of \$16 million of its \$20 million limits in resolving a class action lawsuit and various individual lawsuits by employees and former employees related to their asserted right to unvested company stock options. Qualcomm then sued its excess D&O insurer for its unreimbursed defense expenses for the class action and employee lawsuits totaling over \$12 million.

Qualcomm's excess policy stated that the excess insurer "shall be liable only after the insurers under each of the Underlying Policies *have paid... the full amount* of the Underlying Limit of

Liability." The court again held that the relevant policy clause unambiguous, stating that there could be no other reasonable interpretation of that language, other than that the primary carrier would have to make a full payment of its entire limit before coverage was triggered.

Excess insurers may use the holdings in *Qualcomm* and *Comerica* to argue that they are entitled to the benefit of the language they bargained for regarding exhaustion of underlying limits, and that the language is intended to prevent settlement between an insured and underlying insurer, thereby shifting risk to excess insurers that attach at higher levels at a lower premium. The potential risk of forfeiture of excess coverage is real after *Comerica* and *Qualcomm* and policyholders would be well-served to negotiate specific language insuring that their excess policies drop down in instances when the insured is called upon to fill the gap in settlement.

V. CONSTRUING EXCLUSIONS: IN FACT, ARISING OUT OF

Exclusions come in a variety of sizes, from extremely broad to very narrow. An exclusion may apply to

'Any claim based upon, arising out of, attributable to, or directly or indirectly resulting from' intellectual property

'Any claim arising out' of intellectual property

'Any claim for' intellectual property infringement

Any claim for intellectual property infringement 'in fact'

Any claim resulting in a finding of intellectual property infringement 'by final adjudication.'

Obviously for the policyholder, negotiating the policy to obtain the narrowest exclusionary language is critical. Except for the 'final adjudication' language, the other formulations leave the client exposed.

"Arising out of..."

In *Sealed Air Corporation v. Royal Indemnity Co.*, 196 N.J.Super. 601 (App.Div. 2008), a class action asserted that Sealed Air, in connection with a complex financial transaction, had misrepresented its potential exposure to asbestos claims, resulting in an inflated price for its stock. The company's D&O policy provided coverage for securities actions. However, the policy excluded any claim based on, arising out of, or in any way involving' the release of pollutants, an exclusion invoked by Royal to deny coverage.

The court found that 'the securities holders' complaint has its roots in securities fraud and misrepresentation, not pollution.' In examining the exclusionary language, the court found that 'based on' and 'arising out of' required a substantial nexus. The court noted that "'in any way involving" is facially extremely inclusive.' However, the court read that phrase in conjunction

with 'based upon' and 'arising out of' to require a 'more direct causal relationship between the pollution and the harm.'

The court relied heavily on the basic rules of insurance policy construction to support its position. Readers should note that other courts have construed similar language more broadly to deny coverage.

"In fact"

In *Westport Insurance Corp. v. Hanft & Knight, P.C.*, 523 F.Supp. 444 (M.D.Pa. 2007), the complaint alleged that the lawyer had personally profited by obtaining loans through false representations. The exclusion at issue excluded "any claim based upon, arising out of, attributable to, or directly or indirectly resulting from any Insured having gained in fact any personal profit or advantage to which he or she was not legally entitled." The insured asserted that this exclusion did not apply because the factfinder in the underlying action had made no factual finding of wrongful personal profit, and cited several cases to this effect. The court, however, held that "the allegations and evidence presented by the underlying complaint make clear that the [insured] procured the loan based on 'fraudulent representations'..." Thus, the court could itself find, based upon the available evidence, that the insured had 'in fact' personally profited."

Virginia Mason Medical Center v. Executive Risk Indemnity Co., WL 3473683 (W.D.Wash. 2007) discussed a similar exclusion and reached a similar conclusion. Here too, the insurer argued that the allegations set forth in the underlying complaint established that the insured had gained remuneration to which it was not legally entitled. The court disagreed, applied a standard requiring an objective basis before coverage was foreclosed, and explained that this objective basis could be a factual finding in either the underlying case or the coverage case, or an admission by the insured. However, the court then proceeded to hold that the underlying complaint could provide an objective basis, but the allegations in the underlying complaint in the case before it were not sufficient in and of themselves to demonstrate an illegal profit, and that the insurer had not presented any further evidence to support its claim.

Thus, the 'in fact' language in an exclusion provides the insured with little comfort.

VI. INTERRELATED ACTS EXCLUSION

First Trenton Indemnity Co. v. River Imaging, P.A. (N.J. App. Div. August 11, 2009) involved a series of lawsuits filed against a medical diagnostic company and its officers and directors ("the Insureds"). The first lawsuit was a breach of contract action in which one of the 27 allegations in the lawsuit alleged billing by the Insureds for services that were either not performed or improperly billed.

Later, three insurance companies sued the Insureds for recovery of personal injury protection benefits that they had paid, alleging that the Insureds had fraudulently obtained payment of the benefits as a result of several statutory violations and by fraudulently overbilling.

The insured had a D&O policy which contained a standard "interrelated acts" exclusion stating that if the claim made by the Insured "relates back" to an earlier claim, coverage only exists under the policy in effect at the time of the earlier claim, and not under the current policy.

The Insureds placed their D&O insurer, Zurich American Insurance Company, on notice of the insurance company lawsuits and Zurich denied coverage, claiming that these subsequent lawsuits related back to the breach of contract case.

The trial court denied Zurich's motion for summary judgment on this issue. On appeal, the court held that even though the interrelated acts provision was not listed as an exclusion, it served that function. As a result, Zurich had the burden of proof as to its applicability.

The court noted that while there was an allegation of fraudulent billing in the breach of contract action, this single allegation was "a peripheral component" of the complaint. The court adopted a "substantial overlap" test. Pursuant to that test, the court found that the breach of contract case and the subsequent insurance company lawsuits were "distinguishable on the basis of (1) the parties involved, (2) the factual allegations, and (3) the claims advanced."

Insurance companies often try to apply the inter-related acts provision, even when the relationship back is extremely attenuated. This decision establishes a favorable standard for insureds on an issue for which little guidance existed previously.

VII. BANKRUPTCY/INSURED V. INSURED EXCLUSION

A. Biltmore v. Twin City

Biltmore Associates v. Twin City Fire Insurance Company, N. CV-05- 04220-FJM (9th Cir. July 10, 2009) concerns the crucial issue of application of the "insured v. insured" exclusion in the bankruptcy setting.

The debtor in possession asserted that its directors and officers had looted the company. As part of the reorganization, the debtor in possession assigned its claims against its directors and officers to the Creditors Trust, whose trustee then sued the company's directors and officers.

The court denied coverage on the basis of the "insured v. insured" exclusion, finding that "a post bankruptcy debtor in possession acts in the same capacity as the pre-bankruptcy debtor for the purposes of directors and officers liability insurance." The court held that since the debtor and its directors and officers were all insureds under the D&O policy, the "insured v. insured" exclusion barred coverage. The court found that the assignment of the claim by the debtor in possession to the creditors committee did not change this result, since the creditors committee was still pursuing the claim of the debtor.

Courts in many states have addressed the application of the "insured v. insured" exclusion to claims by debtors in possession, creditor's committees, and trustees. The resulting case law is wildly inconsistent. Companies should try to endorse their D&O policies to explicitly exempt such claims from the operation of the insured v insured exclusion.

B. Westchester

In *Westchester Fire Ins. Co. v. Wallerich*, 563 F.3d 707 (8th Cir. 2009), the Eighth Circuit considered the proper application of an “insured v. insured” in the bankruptcy context.

The D&O policy issued by Westchester covered the directors and officers of an LLC created to develop properties for commercial and residential use. One of the officer/directors, Mark Fayette, and his wife, Shayna Fayette (an investor in, but not employed by, the LLC), filed a lawsuit alleging breach of various fiduciary duties in connection with management and auction of properties held by the LLC. The insureds, who held various director and officer positions within the LLC, timely notified the insurer of the suit and sought coverage for their defense. The insurer initially refused a defense, but upon reconsideration, agreed to defend subject to a reservation of rights, including “the right to seek reimbursement of defense expenses in the event that a court found that Westchester had no duty to defend the insureds.”

The insurer filed a declaratory judgment seeking a determination of whether the D&O policy obligated it to provide coverage. The insurer also argued that it was entitled to reimbursement of fees and costs incurred in defending the Fayette suit. The insured ultimately moved for summary judgment on the grounds that the “insured v. insured” exclusion precluded coverage.

The district court granted in part the insurer’s motion for summary judgment, finding that the “insured v. insured” exclusion applied because Mark Fayette was a party in the underlying lawsuit against the other insureds. However, the district court found that Shayna Fayette was not an insured within the meaning of the policy. The policy’s General Terms and Conditions provided that:

The . . . spouses . . . of natural persons who are **Insureds** shall be considered **Insureds** under this **Policy**; provided, however, coverage is afforded to such . . . spouses . . . only for a **Claim** arising solely out of their status as such and, in the case of a spouse . . . where the **Claim** seeks damages from marital community property, jointly held property or property transferred from the natural person who is an **Insured** to the spouse

(emphasis in original). Further, the “insured v. insured” exclusion provided that:

Insurer shall not be liable for **Loss** under this Coverage Section on account of any **Claim** . . . brought or maintained by, on behalf of, in the right of, or at the direction of any **Insured** in any capacity

(emphasis in original).

The insurer appealed the district court’s ruling that Shayna Fayette was not an insured. The insurer was particularly concerned that the Fayette’s could merely dismiss their complaint and re-file in Shayna Fayette’s name alone. The Eighth Circuit found that the policy language was not ambiguous and that Shayna Fayette was an insured under the policy. Because Shayna Fayette was the spouse of Mark Fayette, himself a director and officer who met the definition of “Insured,” the court found that she was also an “Insured”. Accordingly, the court held that the Insurer had no duty to defend because of the “insured v. insured” exclusion.

However, in a dissenting opinion, one judge argued that Shayna Fayette was not an insured because the language in the clause limited the instances where a spouse can be an insured to instances where a claim is brought against a spouse in that capacity and where the claim seeks damages from marital community property. Because the Fayette's suit did not fall under this definition, Judge Bye reasoned that the exclusion did not apply. Judge Bye opined, "[i]t is incongruous to construe the phrase '[t]he . . . spouses . . . of natural persons who are **Insureds** shall be considered **Insureds** under this **Policy**' independent of the limited grant of coverage which immediately follows it." (emphasis in original).

While insurance companies have narrowed somewhat the scope of this exclusion, it still is a frequent coverage obstacle. Moreover, courts in different states construe this exclusion differently. Once again, the broker needs to obtain the narrowest possible language here, including an endorsement that the exclusion does not apply to bankruptcy trustees or creditor committees.

VIII. INADEQUATE CONSIDERATION EXCLUSION

In *Delta Financial Corp. v. Westchester Surplus Lines*, 398 B.R. 382 (Bankr. D. Del. 2008), the insured company engaged in a transaction with its noteholders in which the noteholders were to receive cash flow certificates with a value of \$153,000,000. However, the certificates turned out to have a value of only about \$43,000,000, resulting in litigation. When the company turned to its Director's and Officer's Liability policy, the insurer denied coverage on the basis of an 'inadequate consideration' exclusion which stated, in pertinent part, that there was no coverage for claims 'based on . . . actual or proposed payment of the Company of allegedly inadequate or excessive consideration in connection with the purchase of securities issued by any company.' The court upheld the insurer's disclaimer.

The 'inadequate consideration exclusion' is one of numerous new exclusions that the insurance industry is adding that sharply reduce coverage, and which often pass unnoticed by insurance brokers and consultants. The policyholder does have two remedies for new exclusions. In most states, the insurer on a renewal must advise the policyholder of any reductions in coverage. The broker has a similar duty to advise its client of any changes to the policy. Both insurers and brokers often fail in these duties.

IX. BUMP UP EXCLUSION

Directors and officers insurance policies are full of holes and do not provide coverage for many basic corporate exposures. *Genzyme Corp. v. Federal Ins. Co.*, 2009 WL 3101025, civ. Action no. 08cv10988-NG (D. Mass. Sept. 28, 2009) demonstrates the prevalence of the insurers' defense that many settlement payments do not constitute "loss" under the D&O policy but rather are restitutionary payments that are not covered.

On September 28, 2009, the United States District Court for the District of Massachusetts dismissed a lawsuit filed by Genzyme Corporation ("Genzyme") seeking insurance coverage from Federal Insurance Company (the "Insurer") under its D&O insurance policy (the "Policy") for a settlement of a shareholder class action. In determining that there was no insurance

coverage for the settlement, the Court relied primarily upon the definition of "Loss" in the Policy and a "Bump-Up exclusion" in the Policy, which relieved the insurer of liability for any "inadequate or excessive consideration in connection with [the] purchase of securities."

Genzyme is a biotechnology company. It had sold a series of "tracking stock" designed to track the performance of certain business divisions of the company. From December 2000 through June 2003, three series of Genzyme tracking stock were outstanding; specifically, the Biosurgery, Molecular Oncology and General Divisions. On May 8, 2003, Genzyme announced that it was going to exercise the optional exchange provisions in its Articles of Organization, which would effectively eliminate the corporation's tracking stocks by exchanging all outstanding Biosurgery Division and Molecular Oncology Division shares for common stock in the General Division. Shareholders holding stock in the Biosurgery and Molecular Oncology Divisions were compensated as part of this share exchange based upon the current market value of their stock as compared to the value of the common stock of the company.

A number of shareholder lawsuits were filed against Genzyme and its officers and directors as a result of this share exchange, and these shareholders were certified as a class on August 6, 2007. While the complaint contained seven counts, it primarily alleged that Genzyme and its officers and directors conspired to depress the market value of outstanding Biosurgery Division stock in order to exchange it for common stock at a rate that would result in a profit for the General Division shareholders - including Genzyme's top officers and directors - at the expense of Biosurgery Division shareholders. Genzyme agreed to settle the class claims by making a one-time payment of \$64 million.

Genzyme sued the Insurer for coverage under its D&O Policy. The Court determined that Genzyme did not have coverage for the settlement payment as a result of two key terms in the Policy - an exclusion from the definition of a covered "Loss" for "matters uninsurable under the law" and a "Bump-Up" exclusion¹ which provided, in pertinent part, that:

[The Insurer] shall not be liable ... for that part of Loss ... which is based upon, arising from, or in consequence of the actual or proposed payment by any Insured Organization of allegedly inadequate or excessive consideration in connection with its purchase of securities issued by any Insured Organization.

As an initial matter, the Court determined that the settlement payment was uninsurable under Massachusetts law for reasons of public policy. The Insurer cited abundant case law supporting the notion that an insured does not incur an insurable "loss" when he is merely forced to disgorge money or other property to which he is not entitled (i.e., an "ill-gotten gain"). *See, e.g., Level 3 Communications, Inc. v. Federal Ins. Co.*, 272 F.3d 908 (7th Cir. 2001). Genzyme argued that the settlement payment was not restitutionary in nature since the company did not receive any benefit from the share exchange.

¹ According to the Insurer, this exclusion is apparently referred to in the insurance industry as a "bump-up" exclusion because it is used to describe litigation seeking to increase or "bump-up" the consideration paid for security.

The Court sided with the Insurer, stating that while the company itself did not profit from the transaction, it did effectively benefit one class of shareholders at the expense of another class of shareholders, and the settlement was designed to redress this imbalance. The Court was concerned that requiring coverage under these circumstances would transform insurance policies into "profit centers" for companies, stating "[e]veryone would win, except for the insurance company forced to bear the loss of paying off the disgruntled shareholders." *See* decision at *8.

The Court then turned to the Bump-Up exclusion in the Policy. Genzyme argued that the share exchange did not involve an actual "purchase" of securities since it was a share exchange and therefore the exclusion was inapplicable. The Court relied upon the dictionary definition of "purchase" which includes an exchange for something of equivalent value, and found that the share exchange was in fact a "purchase" as that term was used in the Policy. Accordingly, the Court held that the exclusion was an absolute bar to coverage under Insuring Clause 3 - coverage for securities claims brought against the entity.

Genzyme further argued that even if it was barred from recovering for securities claims brought against it as a result of the Bump-Up exclusion, it was still entitled to reimbursement for the money it paid to indemnify its directors and officers, since the settlement was a global resolution of the claims in the underlying lawsuit. The Court disagreed, stating that no court has "split the baby" in this manner where coverage for claims against the entity were barred, since companies can only act through their directors and officers. Moreover, the Court was concerned that permitting this type of distinction with regard to a global settlement would permit companies to structure settlements in a manner to maximize coverage under the indemnification provisions of a D&O policy where the payment was in fact restitutionary in nature.

This decision to deny coverage for settlement payments made to shareholders was largely driven by public policy concerns. The Court was very keenly attuned to the risk that providing coverage for these types of shareholder settlements would encourage fraud and chicanery by insured corporations. The decision also has far-reaching impact beyond D&O policies containing a bump-up exclusion since the Court relied upon the disgorgement/restitution exclusion as an independent basis for barring coverage. In doing that, the Court expanded that exclusion to include a stock redistribution or recalibration. This was a novel analysis of an exclusion found in nearly every D&O policy and may give insurers ammunition to go farther afield in their denials of coverage on the basis of this exclusion, in situations where, as in Genzyme, the company itself did not profit from the underlying transaction. Accordingly, insureds may need to argue that the judge's creative recalibration analysis is restricted to the specific and unusual circumstances of the Genzyme case and should not be broadly applied.

X. INTENTIONAL CONDUCT EXCLUSION

In *Greenwich Ins. Co. v. Media Breakaway, LLC et al.*, 2009 U.S. Dist. LEXIS 63454 (C.D. Cal. July 22, 2009) Greenwich filed a declaratory judgment action regarding its duty to defend and indemnify its insureds, an online marketing company and its CEO and president, for a lawsuit filed by MySpace claiming multiple violations of state and federal law for "phishing" - sending unlawful, unsolicited commercial advertisements through MySpace user accounts. MySpace was awarded over \$6 million in damages as a result of arbitration of the underlying

case. The arbitrator found for MySpace on the ground that Media Breakaway "condoned, encouraged, knew about and benefitted from the unlawful spam attacks on MySpace..."

Accordingly, the insurer argued that the damages were barred by the following exclusions in the policy for any claim made against an Insured "brought about or contributed to in fact by any: (1) intentionally dishonest, fraudulent or criminal act or omission or any willful violation of any statute, rule or law; or (2) profit or remuneration gained by any Insured to which such Insured is not legally entitled."

The Court agreed with the insurer, concluding that the exclusion for intentional conduct clearly applied to the arbitrator's findings and therefore, the claim was not covered under the policy. The Court therefore held that the insurer had no duty to defend or indemnify the insured for the action and ordered that the insured repay the defense expenses received.

XI. BAD FAITH

Acacia Research Corp. v. National Union Fire Ins. Co. of Pittsburgh, PA, Case No. CV 05-501 PSG (C.D.Ca. 2008) highlights the type of facts and circumstances that a court may find constitute bad faith on the part of an insurance carrier in denying an insured's claim as well as the damages that could result therefrom.

In *Acacia*, the plaintiffs were insured under a Directors, Officers and Corporate Liability Insurance Policy ("D&O") issued by National Union Fire Insurance Company, which provided coverage to the corporate entities as well as their respective directors and officers. Prior to the inception of this policy, the insured hired a new Vice President of Research and Development and Chief Technology Officer. He agreed that all of his inventions while in the insured's employ would be assigned to the insured. These inventions subsequently resulted in two patents, both of which were issued during the D&O policy period. Thereafter, a suit was commenced against the insured by Nanogen, Inc. ("Nanogen"), claiming that the disputed technology was wrongfully assigned.

Following the commencement of that action, the insured notified its D&O carrier of the claim. Approximately two weeks later, on or about December 15, 2000, the insurer transmitted a written acknowledgment of receipt of the claim and a representation that its preliminary coverage evaluation would be forwarded "in the near future." However, two days prior to the drafting of that correspondence, the claims handler for the insurer opined in an internal e-mail that the claim "does not appear to be covered." By March 2001, the claims handler had not taken any action other than to acknowledge receipt of the claim and request a copy of the policy. The claim was then reassigned, and thereafter the insurer requested additional information from its insured. The insured promptly responded to that request and reiterated its willingness to fully cooperate with the investigation. The insured subsequently transmitted correspondence to its insurer in April and May 2001 requesting a status of the claim but received no response.

The insurer subsequently removed that claims handler from the claims department in May 2001. However, the insurer did not reassign the claim until August 2002, by which time the insured had settled the matter directly with Nanogen. In January 2003, the new adjuster verbally represented

that the settlement was not a covered loss since the policy did not cover patent or breach of contract claims. However, that adjuster subsequently acknowledged at a deposition that there was no breach of contract exclusion contained within the policy and that he reached his opinion without sufficient information about the insured's coverage.

The insurer again reassigned the claim in May 2003. On November 3, 2003, the insurer sent its first and final coverage letter to the insured denying coverage based upon, *inter alia*, the insured's alleged failure to cooperate. On these facts, the court concluded that the insurer improperly and unreasonably withheld in bad faith benefits otherwise due to the insured under the policy. As such, the insured was entitled to all damages proximately caused by that conduct, regardless of whether they could have been anticipated. The court ordered the insurer to reimburse the insured for the amount of the settlement, defense costs and interest.

See also *Abercrombie & Fitch v. Federal Insurance Co.*, 2008 U.S. Dist. LEXIS 18597 (S. D. Ohio 2008)(court refuses to dismiss bad faith count).

XII. LITIGATION GUIDELINES

In *Abercrombie & Fitch v. Federal Insurance Co.*, Docket No. SOM L-1571-07 N.J. Law Div Nov. 13, 2009), the insurer agreed to defend the insured, but insisted on compliance with its Litigation Management Guidelines ("LMG"). At the end of the day, the insurer had failed to pay a substantial portion of the policyholder's attorneys' fees, alleging failure to comply with the LMG. The insurer asserted that the block billing by the policyholder's attorneys did not provide enough specificity to allow it to evaluate the claim. The insurer also asserted individual billing issues, such as having too many lawyers at a deposition.

The policyholder sued for bad faith. The insurer brought a motion to dismiss the bad faith count, and the insured cross-moved for a declaration that the LMG were unenforceable.

The insured asserted that the LMG were not part of the insurance policy. The court noted that while it was true that the LMG were not part of the policy, the policy stated that all payments needed the insurer's consent, which would not be unreasonably withheld. As a result, the insurer had some control over the attorneys' fees. Moreover, in its reservation of rights letter, the insurer had conditioned its agreement to defend on compliance with the LMG, and the insured did not object.

Ultimately, the court denied both motions because of fact issues. The court found that it needed to examine the impact and reasonableness of the LMG, whether they had been applied reasonably, whether the insurer should be allowed to rely on them, and the degree to which the policyholder had complied with them. The court held that:

"Whether the LMG is enforceable, and if so, to what extent, will depend on the reasonableness of defendant conditioning its consent on application of the LMG as well as on the reasonableness of the LMG's provisions and defendant's application of the guidelines. A subsidiary issue is whether the LMG or its application offend public policy."

Policyholders often struggle with the LMG, and often end up having to discount their bills. The insurers essentially want the attorney to re-write all of its bills in an effort to comply, a task that, even if possible, would be prohibitively expensive.

The *Abercrombie & Fitch* decision is an important weapon for policyholders to insist that the insurer apply the LMG reasonably. This is an issue best raised at the outset of the proceeding. Frequently, the insurer will object each month to items on the attorneys' bills as inconsistent with the LMG, and the policyholder will let the objections pile up. At the end of the underlying litigation, the policyholder is left with a significant amount of unpaid bills, little desire to institute a coverage action over them, and with little other recourse.

These cases demonstrate an increasing willingness by courts to hold insurers to their contractual promises, and to punish them for egregious violations of their fiduciary duty. Importantly, they stand for the proposition that following the submission of a claim, an insurer is obligated to timely and diligently investigate, evaluate and adjust claims in good faith. Insureds and their counsel must be cognizant of the applicable "prompt-pay" and other statutory guidelines regarding claims processing and not accept unreasonable delays or unjustifiable coverage positions by the insurer.

XIII. WHOSE MONEY IS IT ANYWAY?

Several executives of Stanford International Bank and related entities are accused of being at the center of an \$8 billion Ponzi scheme and now find themselves as defendants in a securities fraud case brought by the Securities Exchange Commission pending in the United States District Court for the Northern District of Texas entitled *SEC v. Stanford Int'l Bank*, Civ. Action No.: 3.09-CV-298-N. In that action, the SEC requested that the Court appoint a receiver to protect the assets obtained in connection with the Ponzi scheme and the Court complied with this request, freezing the defendants' assets and putting them into receivership.

One of the defendants moved the Court for an order clarifying that the \$50 million in D&O insurance policy limits obtained by the companies were outside of the receivership estate and could be used for payment of defense costs on behalf of the directors and officers. On October 9, 2009, the Court responded to the defendant's motion, noting that this was an issue of first impression for the Court.

The Court first noted that the receiver had not yet tendered any claim against the Stanford entities that might deplete the policy limits, and Lloyds of London - the D&O insurer - was adamant that any such future claim would be barred by various policy exclusions. Lloyds further maintained that the receiver would be estopped from arguing that the exclusions do not apply since he had repeatedly accused the Stanford entities of fraud. The Court noted that while it wasn't passing judgment on the availability of coverage for such claims, it did highlight to the Court that the receivership's claim to insurance proceeds was largely hypothetical.

The Court went on to state that permitting the directors and officers to access insurance proceeds was in the general interest of fairness since many of the defendants denied knowledge of the fraudulent activities and therefore should be entitled to receive the coverage that they relied upon

in the course of their employment. Thus, the Court reasoned that while the potential harm to the receivership was purely speculative, individual defendants may be unable to defend themselves in this matter if they can not access policy proceeds. Moreover, the Court noted that these assets were different from the other assets being preserved by the receiver in that there was no allegation that the insurance proceeds were potentially tainted by fraud and the Court had no duty to preserve them as such.

Thus, the Court ultimately decided that it had discretion to permit disbursement of the D&O insurance proceeds for defense costs. The Court clarified that its Order was not a coverage determination as to the right of any individual defendant to defense costs from the policy, and that Lloyds retained the ability to deny coverage under any applicable policy exclusions.

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