

# LOWENSTEIN SANDLER PC CLIENT ALERT

## INSURANCE LAW

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### RECENT COURT DECISIONS ADDRESS KEY COVERAGE ISSUES UNDER D&O POLICIES: Interrelated Acts, Notice, Insured v. Insured Exclusion

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**This Alert discusses three recent court decisions addressing insurance coverage under directors and officers insurance policies. Many policyholders rely on this coverage, not realizing that while its general structure may be clear, it is full of numerous pitfalls. This Alert discusses some of those pitfalls in an effort to help policyholders avoid them and ensure that they have adequate coverage.**

#### **I. First Trenton Indemnity Co. v. River Imaging, P.A. (N.J. App. Div. August 11, 2009)**

In *First Trenton*, the New Jersey Appellate Division addressed three important insurance law issues, and resolved each in favor of the insured. The underlying fact pattern is highly complex; indeed, the caption alone is over three pages long.

##### A. INTERRELATED ACTS

*First Trenton* concerned a claims-made directors and officers ("D&O") insurance policy. All claims-made policies contain an "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 that time of the earlier claim, and not under the current policy. Insurance companies try to apply this provision even when the relationship back is extremely attenuated.

In *First Trenton*, a medical diagnostic company and its officers and directors ("the Insureds"), were originally sued in 1999 in an action entitled *Gajarawala v. Vernon*. This was a breach of contract case brought by two employed doctors. The Appellate Division noted that one of the 27 allegations in *Gajarawala* alleged billing by the Insureds for services that were either not performed or improperly billed.

In 2001-2, 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 Insureds placed their D&O insurer, Zurich American Insurance Company, on notice. Zurich denied coverage, claiming that the 2001-2 suits by the insurance companies against the Insureds related back to the *Gajarawala* 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 the allegation of fraudulent billing in *Gajarawala*, but held that this single allegation was "a peripheral component" of the *Gajarawala* complaint. The court adopted a "substantial overlap" test. Pursuant to that test, the court found that the *Gajarawala* case and the 2001-2 complaints were "distinguishable on the basis of (1) the parties involved, (2) the factual allegations, and (3) the claims advanced." This decision establishes a favorable standard for insureds on an issue for which little guidance existed previously.

##### B. PUBLIC POLICY

The insurers also asserted that since the claims against the Insureds alleged Medicare fraud, public policy militated against insurance coverage. Insurers are increasingly using this "public policy" argument. The court rejected this argument for two reasons. First, the court noted that the underlying complaint alleged "intentional, reckless or negligent" conduct, and that it knew

of no public policy prohibition against insurance coverage for reckless or negligent conduct. Second, the court noted that the insurance policies contained numerous exclusions upon which the insurers could rely if there was ultimately a finding that the Insureds had engaged in fraud.

### C. ALLOCATION OF DEFENSE COSTS

The complaint against the Insureds included a mix of potentially covered and non-covered claims. Zurich denied coverage in its entirety and did not seek to allocate defense costs. As a result, the court, having found coverage, placed the burden on Zurich to allocate defense costs between covered and non-covered claims. The court noted that pursuant to *Hebela v. Healthcare Ins. Co.*, 370 N.J. Super. 260 (App. Div. 2004), attorneys' fees fall into three categories: those clearly related solely to covered causes of action, those clearly related to uncovered causes of action, and those that relate both to covered and uncovered causes of action. *Hebela* established that the insurer is responsible for this last category and that when the insurer fails to defend, it must provide a method of allocation. The court found that Zurich had failed to meet its burden of demonstrating a basis for allocation, and was therefore responsible for all of the attorneys' fees. *Hebela* and now *First Trenton* provide a policyholder friendly standard for the vexing problem of allocation.

## II. **Admiral Insurance Co. v SONICblue Inc., 2009WL 1308905 (N.D.Cal. May 11, 2009)**

### A. NOTICE

This case 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." Policyholders often are unaware that informal notices, such as letters, might constitute "claims" that they need to notice to their insurer. In *Admiral*, the court addressed in detail six different letters that the insured received, analyzing each to determine if it required notice to the D&O insurer.

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 non-monetary 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.

The insured didn't fare as well as with the two other 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."

This case does not provide a convenient bright line test for policyholders. 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. INTERRELATED ACTS

*Admiral* concerned claims by two different groups of note holders arising from the same transaction. The court held that the two claims were not interrelated. "Unrelated investors, with unique investment objectives, in situations in which 'importantly, the Wrongful Acts alleged by the two clients [a]re different' have been deemed unrelated." [Case cites omitted.] Nationally, the caselaw on this issue is very confused, and the combination of decisions in *First Trenton* and *Admiral* is very helpful in clarifying the circumstances under which a court will find that claims are not interrelated.

**III. Biltmore Associates v. Twin City Fire Insurance Company, N. CV-05-04220-FJM (9th Cir. July 10, 2009)**

THE INSURED V. INSURED EXCLUSION AND BANKRUPTCY

This case 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.

CONCLUSION

Anecdotally, when an insurance expert retained by Travelers was questioned by the policyholder about coverage for asbestos claims, he replied that there was no coverage because the Travelers umbrella was full of holes. This is certainly true of directors and officers liability insurance policies. Every

company, and its directors and officers, should carefully review and negotiate the wording of these policies and consult an attorney if there is even a possibility that a claim might exist.

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- October 2, 2009** Crittenden Insurance Coverage Forum, Philadelphia, PA, panelist, "Media, Technology and Privacy: Negotiating Coverage for New Risks"
- October 16, 2009** Annual Meeting, Association of Intellectual Property Lawyers of America, Washington, D.C., panelist, "Intellectual Property and Cyber-Insurance"
- March 2010** ABA Insurance Coverage Litigation Committee Conference, Tucson, AZ, panelist, "The Insurance Broker and Coverage Disputes: Emerging Issues"

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