

Directors and Officers Liability and Insurance Coverage

By Irene C. Warshauer

I. Introduction

Directors' and Officers' ("D&O") Liability insurance protects senior management of the policyholder against claims alleging Wrongful Acts committed in their capacity as officers or directors. There are a growing number of specialized insurance policies available to insure particular employees of the corporate policyholder or certain types of corporate activities. Insurance designed to cover specialized corporate activity or particular employees can include policies to protect against claims arising in the context of employment practices, providing professional services, trading securities, or serving as a fiduciary of employee benefit plans. The most common are Errors and Omissions (E&O) policies which protect the corporation and generally its employees from liability arising out of a Wrongful Act committed in connection with rendering a professional service.

Because specialized business insurance, like the D&O policy, is designed to have a limited scope, assertion of claims under that policy frequently, if not inevitably, leads to coverage disputes. Insurance Companies already are familiar with the types of insurance issues that will arise when a D&O or E&O claim is submitted, but policyholders are not. Therefore, it can be particularly helpful for a corporate policyholder to familiarize itself with the difficulties often faced by its others who have submitted claims. Some problems can, with planning and proper advocacy, be avoided, others cannot. Policyholders should be aware of those problems that cannot be avoided so that their cost can be calculated into the cost of the policy.

II.D&O Liability Policies

Under a D&O insurance policy, the insurance company agrees to indemnify, or pay on behalf of, the directors or officers all “Loss” that those individuals become legally obligated to pay for a “Wrongful Act” committed in their capacity as officers and directors.¹ This promise, referred to as Coverage A, protects only the individual directors and officers. It does not protect the corporate policyholder.

Under Coverage B, the insurance company agrees to reimburse the corporate policyholder for all Loss that the company is required to pay as indemnity, or has paid to legally indemnify, the directors or officers for a claim alleging a Wrongful Act. Coverage B does not insure claims brought directly against the corporation.

Recently, some D&O policies in the United States also include limited “Entity Coverage.” Under such an agreement, the insurance company agrees to reimburse the corporate policyholder for liability arising out of certain types of claims made against the corporation, such as claims brought by investors under the securities laws, or for employee liabilities. Entity Coverage will reduce the limits available to protect the individual officers and directors.

III. The Types of Claims Covered by a D&O Policy

Prior to the 1970’s, D&O claims, even in the United States, were relatively uncommon. Now, according to the most recent Wyatt Survey, 30% of the survey participants experienced one or more claims against their officers and directors over a nine year period. Moreover, in the United States, D&O claims often are significant. The average defense costs

¹ “Loss” is defined in the policies and generally includes any amounts paid in judgment or settlement, as well as the costs of defense. “Wrongful Act” generally is defined to include any negligent act, error or omission, or breach of duty committed by the directors or officers in the discharge of their duties and solely in their capacity as directors and officers.

presently is \$1 million. For those claims in which an indemnity payment was made, the average indemnity payment was \$5.24 million.

Almost half of all D&O claims are brought by shareholders as derivative or class actions against directors and officers. These claims allege failure to disclose events which caused adverse corporate financial performance as well as merger, acquisition and divestiture activities which have an impact on corporate stock. Claims based upon improper disclosure and financial reporting are the most frequent. These claims, often brought under the federal securities laws, represent the most serious threat facing directors and officers, because of the amount of damages demanded, and the complexity and resulting cost of a defense.²

The second largest group of claimants (25%) are employees alleging discrimination or wrongful termination. Claims against directors and officers based upon employment practices are increasing. The remainder of D&O claims include suits brought by customers and clients (15%); by competitors (6%); by the Government (2%), particularly claims asserted by regulatory agencies (such as the Resolution Trust Corporation, Federal Deposit Insurance Corporation and the Federal Savings and Loan Insurance Corporation against banks), and miscellaneous claims brought by other third parties (5%).

IV. E&O Liability Policies

The E&O policy protects the insured against liability arising from a “negligent act, error or omission in the performance of the insured’s professional service.” In more

² Of current interest in the United States is the impact that the Private Securities Litigation Reform Act of 1995, Pub. L. No. 104-67, 109 Stat. 737 (1995) (the “Reform Act”) will have on the frequency and severity of D&O shareholders’ claims. The Reform Act was designed to discourage speculative securities fraud lawsuits. So far, there has not been any decline in filings of security class action cases in federal courts and state court filing have increased. Policyholders and insurance companies hope that, if the Reform Act is interpreted aggressively, more suits will be dismissed at the pleading stage, without defendants and their insurers bearing the costs of defense, or settlements.

common terms, it provides protection against claims of malpractice. Unlike a D&O policy, an E&O policy generally protects the corporate policyholder as well as its employees. It is critical to any corporate entity who sells services, such as insurance brokers, installers of computers or high technology devices.

V. Coverage Issues Under D&O and E&O Policies

Unfortunately, the submission of a D&O claim often generates some form of coverage dispute between the corporate policyholder and the insurance company. Such disputes arise out of the language in the D&O policy, as well as the claims handling practices of insurance companies. Although less frequent, coverage disputes are not uncommon under an E&O policy, particularly if the claim is significant.

The consequence is that policyholders have to expend significant money to defend themselves, with no certainty of ultimate reimbursement from their insurance companies. The psychological strain can be agonizing. Once a claim has been filed, many policyholders quickly learn that the quality of their insurance coverage largely depends upon the quality of their insurance company's claims handling practices.³ Indeed, insurance companies increasingly represent that their claims handling is pro-policyholder in their marketing of policies. Unfortunately, this is not always the case.

³ See Eugene R. Anderson, Laura Jones and Joshua Gold, Directors' And Officers' Insurance: Choose Your Insurance Company Wisely, Inside, Sept. 1996, at 19.

A. The Policy Language

1. “Director” and “Officer” Capacity

D&O policies provide insurance only for liabilities which result from Wrongful Acts committed by the covered individuals acting in their capacity as officers and directors. Frequently, insurance companies reserve their right to deny coverage on the grounds that the Wrongful Acts were not committed in the defined capacity. They may argue that the individual was acting to advance his or her own particular interest, or was acting in the capacity of a lesser employee. For instance, during a labor strike, senior management frequently performs tasks usually handled by lower level employees. Insurance companies argue that any resulting liability arising out of that conduct was not committed in the capacity as an officer and director. Similarly, a suit brought against an officer of a brokerage company by a customer, may result in the insurance company denying coverage on the ground that the Wrongful Act was committed while rendering professional services, rather than in the capacity as an officer of director. Indeed, any suit brought by a customer or client against a director or officer is likely to trigger this defense to coverage.

2. The Definition of a Claim

The definition of “claim” is important both for a determination as to which policy will apply, and the determination as to the extent of coverage. D&O and E&O policies typically provide coverage for claims that are made against directors or officers during the period of the policy. Thus, they are referred to as claims-made policies. Some policies have a “double anchor” and require that the claim be made and reported to the insurance company during the policy period. Under a policy with either a double or single anchor, the relevant time for

determining whether a policy must respond, or is “triggered,” is the date of the claim and not the date of the Wrongful Act from which the claim arises.

Some policies define “claim” to mean a formal judicial or administrative proceeding. Other policies define “claim” to include a less formal written demand for damages. Still other policies contain no definition. Regardless of the definition, there can be a disagreement as to what the term “claims” means in practice. Disagreements of this type may be particularly prevalent when the “claims” take the form of governmental administrative actions rather than private lawsuits for damages.

In Abifadel v. Cigna Ins. Co., 9 Cal. Rptr. 2d 910 (Cal. Ct. App. 1992), the policyholder argued that demands by minority shareholders and threats to sue a director, constituted claims. In rejecting that argument, the court stated that, “in defining claims, the law focuses on the claimant’s formal demand for service or payment and does not recognize a request for an explanation, the expression of dissatisfaction or disappointment, mere complaining, or the lodging of a grievance as a claim.” Id. at 920. The court distinguished a “claim” from a “potential claim,” reasoning that there must be a distinction between the two. The court stated that “a claim is not threatened action, accusation of misconduct, or mere notice of an intention to hold an insured responsible for a wrongful act.” Id. at 920-21.⁴

Most courts in the United States hold that a formal proceeding is not required. For instance, in John Hancock Health Plan of Penn. Inc. v. Lexington Ins. Co., 1989 WL 106992, *4 (E.D. Penn. Sept. 12, 1989) the court held that a lawsuit was not needed to trigger a claim under policy. Similarly, in Polychron v. Crum & Forster Inc. Co., 916 F.2d 461, 463 (8th Cir. 1990), the court reasoned that the definition of a “claim” is broader than “cause of action.” Thus,

⁴ See also FDIC v. Booth, 83 F.3d 670, 676 (5th Cir. 1996). (Correspondence from a governmental agency threatening action is not a “claim”).

it held that a grand jury subpoena, directed to a bank regarding documents relating to the bank president's conduct, constituted a claim under the policy.

A related issue is whether multiple claims will be treated as a single claim for purposes of coverage. D&O policies typically provide that when claims arise out of the same Wrongful Act or interrelated Wrongful Acts, they will be treated as one claim and will be deemed to have been made at the time of the first such claim. The effect of treating multiple claims as one claim and assigning them to a single policy is to limit coverage to the aggregate limit of the single policy in question. If the claims are treated separately and assigned to several policies, more coverage may be available. On the other hand, multiple deductibles or retentions may have to be satisfied.

Accordingly, disputes often arise as to whether the Wrongful Acts involved in multiple claims are identical or interrelated. Most of the cases that have addressed this issue in the D&O context involve suits stemming from bank failures. In almost every case, the courts have refused to aggregate claims.

First, courts find the relevant policy language ambiguous. Under well accepted rules of construction applied in the United States, ambiguous policy language is construed against the insurance company. In McCuen v. American Cas. Co., 946 F.2d 1401, 1407-08 (8th Cir. 1991), the directors and officers were sued in an underlying action for breach of fiduciary duty and negligent management of a savings and loan. In the coverage action, the insurance company argued that there were three claims under the policy because there were three borrowers. The policyholder argued that there were seventeen separate loans and therefore seventeen separate claims. The court found that the policy was ambiguous, held that the

ambiguity should be resolved in favor of coverage and found that there were seventeen separate claims.

Similarly, in Stauth v. Federal Insurance Co., No. CIV96-1825-M (W.D. Okla. Nov. 12, 1997), a wholesale grocery store in Oklahoma City, Oklahoma, Fleming Cos., was faced with two lawsuits. One suit, brought in 1993 was filed by a competitor which alleged that Fleming had engaged in illegal price fixing. The other suit, a class action brought in 1996 by the company's shareholders, alleged that the company and its directors and officers failed to disclose material information about the 1993 suit. The insurance companies that had issued directors and officers liability insurance policies to Fleming, argued that Fleming was entitled to insurance coverage under only the 1993 insurance policy, which had lower limits of liability, because the 1993 and 1996 events were "interrelated wrongful acts."

The 1993 policy provided that:

All such causally connected errors, statements, acts, omissions, neglects or breaches of duty or other such matters committed or attempted by . . . one or more insured persons shall be deemed interrelated Wrongful Acts.

The policyholder argued that the wrongful acts alleged in the two lawsuits were not "causally connected" and, therefore, the policies in both years applied.

The Stauth court found that the wrongful acts alleged in the two lawsuits were not interrelated. Although it discussed case law on the subject of "interrelated acts," the only analytical theme that ties those decisions together was that the policyholder prevailed when application of the policy language to a particular fact situation was ambiguous.

A second approach involves a determination as to whether the underlying losses resulted from more than one independent business decision or separate acts of negligence. If so, the losses support separate claims.

In Atlantic Permanent Fed. Sav. & Loan v. American Cas. Co., 839 F.2d 212, 219-20 (4th Cir.), cert. denied, 486 U.S. 1056 (1988), the court found that claims arising from nine loan transactions comprised a single loss because they arose from a series of interrelated acts — “the planning and carrying out of [the S&L’s] home improvement loan program.” The insurance company had argued that there were multiple losses so that it could deduct multiple retentions. The court also reasoned that it should also construe ambiguities in the policy against the insurance company.

In another context, Polychron v. Crum & Forster Ins. Co., 916 F.2d 461 (8th Cir. 1990) involved a grand jury investigation in Eastern District of Arkansas. The court found that the investigation constituted a claim during the policy period. The court found that the subsequent indictment, which occurred after the policy expired, was part of the same claim as the investigation, and thus covered by the policy.

3. Notice of Claim

Late notice is a common problem in coverage disputes and one that should never occur. Most claims-made policies require that the policyholder give notice of claims as soon as practicable. Typically, a director or officer, or the corporation and its employee allegedly guilty of malpractice, is so shocked by the underlying claim and concerned about defense of that claim, that insurance is overlooked. Failure to report a claim during the policy period may result in a forfeiture of coverage under any policy. Courts are even more likely to find forfeiture in the case of a claims-made policy, which is only triggered by a claim properly noticed during the policy period.

In Brumfield v. Shelton, 831 F. Supp. 562 (E.D. La. 1993), the policyholder was sued in connection with security purchases made for an employee stock ownership plan

(“ESOP”) by a former trustee. The new trustee of the ESOP brought a lawsuit against several parties, including the insurance company which sold the fiduciary liability policy.

In the insurance coverage lawsuit, the federal trial court agreed with the insurance company’s position that the policyholder failed to give sufficient or timely notice. The policyholder had first given notice of the lawsuit to the correct insurance company, but under a D&O policy rather than the fiduciary liability policy. The court refused to find that notice under the D&O policy constituted timely notice under the fiduciary liability policy. *Id.* at 565. The policyholder then furnished notice in writing under the fiduciary liability policy, but did so eight hours after the policy had expired. The court ruled that providing notice eight hours after policy expiration was a violation of the policy’s strict notice provisions. The court also ruled against the policyholder’s contention that the insurance company was not prejudiced by the delay in giving notice. *Id.* at 566.

The Brumfield case is a prime example of the harsh consequences that can befall a policyholder who fails to abide strictly by the policy’s notice provisions. Although the insurance company did in fact receive notice of the lawsuit and its surrounding facts in a timely fashion, coverage was still rejected because the policyholder failed to reference the fiduciary liability policy.

Strict construction of Notice provisions may also bar coverage for subsequent litigation related to a claim prior to inception of the claims-made policy. For instance, in Ameriwood Industries International Corp. v. Amer. Cas. Co., 840 F.Supp. 1143, 1152 (W.D. Mich 1993), insurance was denied even though a subsequent amended complaint was filed which included different claims against different individuals and notice was promptly given on the amended complaint.

Whenever a claim is filed, whatever kind of claim it might be, one of the immediate and necessary responses must be - is there insurance? As the unfortunate policyholder found out in Brumfield, it is also important to recognize that a claim or lawsuit can potentially trigger coverage under many separate lines of coverage: general liability policies; D&O insurance; errors and omissions insurance; as well as a number of other specialized business policies. Notice must be given promptly and to all possible insurance companies under all possible lines of coverage.

4. Notice of Circumstance

Most D&O and some policies give the policyholder the right to submit notices of Wrongful Acts or circumstances that could give rise to a claim in the future. If such notice is given, and a claim is later made arising out of those Wrongful Acts or circumstances, the policy typically provides that the claim will be deemed to have been made during the policy period in which notice is given.

D&O Policies generally require that the notice of circumstances be in writing, and give details regarding the acts, dates, and persons involved. The degree of specificity required is unclear. A notice which states only that various of the company's activities might result in a claim, can have the effect of converting a claims-made policy into an occurrence policy. On the other hand, policyholders often are reluctant to describe circumstances which might give rise to a claim because such disclosure can be self-fulfilling, encouraging third parties to bring a claim against the officers and directors. Such disclosures must also be consistent with any public filings the policyholder must make, including those with the SEC. If the insurance company believes that the notice of circumstances is insufficient, the insurance company must inform the

policyholder within a reasonable time, or risk waiver of a right to assert inadequate notice as a defense if and when a claim is ultimately filed.

The problems regarding notice of circumstances do not end with the level of detail required. D&O policies typically have an exclusion for claims that arise out of Wrongful Acts or circumstances that have been noticed under a prior policy. Accordingly, while notice of circumstances may lock in coverage under the pending policy, it may also oust coverage under future policies.

Although this issue may not create a problem when coverage is renewed with the same insurance company, it is critical when a policyholder seeks to change insurance companies. Typically, each insurance company will argue that the other insurance company should pay if a claim is subsequently brought. The earlier insurance company will argue that the claim came in after its policy expired, and that the notice of Wrongful Acts was not sufficiently specific to comply with the requirements of the policy. The subsequent D&O insurance company will take the position that the notice of Wrongful Acts was adequate and that the exclusion in its policy is therefore applicable. If both positions are sustained, the result is no coverage for the claim.

To minimize the problems created by the policy language where the “Wrongful Act” happens in one policy period and the actual claim is filed later, a policyholder should do the following: (1) provide actual notice under the first insurance policy for the specific purpose of locking in coverage (as the Brumfield policyholder found out, courts have been hostile towards attempts to prove “constructive” notice); (2) although no particular words must be used to provide proper notice, be as specific as possible as to the circumstances involved and (3) at the time of the negotiations with the new insurance company, obtain an agreement that, if the first

insurance company is successful at avoiding coverage on the grounds that the notice of circumstances was insufficient, the second insurance company will accept the claim.

5. Exclusions

In the typical D&O policy, there can be two paragraphs containing the coverage provisions and two pages of exclusions in the pre-printed form, with additional exclusions added by endorsement. Often it is easier to tell what is not covered than what is. Narrowing the scope of coverage increases the chances that disputes between policyholder and insurance company will arise.

For instance, in the United States, D&O policies increasingly exclude any liability arising out of or related to the provision of professional services, because the policyholder can purchase an E&O policy. There are Securities Act policies to fill the hole created by Securities Act D&O exclusions, and Fiduciary policies to fill the hole created by D&O ERISA Act exclusions. Most D&O policies exclude claims for liability arising out of property damage or bodily injury. This type of liability is intended to be covered by the comprehensive general liability policies purchased by the corporation.

There also are exclusions for liabilities for which there may not be alternative coverage. D&O policies sold in the United States generally have an exclusion for claims by regulatory agencies or claims seeking environmental damage. Typical of all D&O policies are exclusions for claims brought by the company or by other officers, and directors (Insured v. Insured exclusion); fines or penalties; and liabilities arising out of the fraud or self-dealing of the directors and officers, if such wrongful conduct is established.

Although the hole created by some of these exclusions may be partially filled through the purchase of more specialized policies, often the fit is not exact between the insurance

excluded, and the insurance provided by the specialized policy. There is a danger that the apparently seamless protection that the corporate policyholder intended to buy for its officers and directors has holes which can grow large when a claim is submitted.

The above are simply examples of the many exclusions which can abound in a D&O policy. The consequence is that: (i) application of the exclusions can raise ambiguities, which create coverage disputes and problems in claims handling; (ii) the policies may be construed to provide less coverage than the policyholder expected; (iii) coverage disputes may arise in connection with the relationship between different types of policies; and (iv) a lawsuit or claim may have some aspects which are excluded and others which are not, leading to problems of allocation. Obviously, to the extent possible, policyholders should seek to limit the number of exclusions at the time the policy is purchased. If and when coverage is denied, a policyholder should be armed with the law and an effective advocate to limit the scope of the exclusions as applied to the facts of his or her case.

6. Defense Costs

D&O and E&O policies differ from comprehensive general liability (“CGL”) policies with respect to the defense obligation in several ways:

1. There is no “duty to defend” imposed upon the insurance company. The insurance company has only a duty to reimburse for defense costs. Thus, the policyholder generally chooses the defense counsel (sometimes with the approval of the insurance company), and runs the defense of the case.
2. Defense costs are deducted from the limits of the policy. Defense costs are not in addition to the limits.

3. The scope of the duty to reimburse for defense costs generally is co-extensive with the duty to indemnify. In contrast, under a CGL policy, the duty to defend extends to claims that are only “potentially” covered by the policy.
4. Traditionally, insurance companies argue that, as a matter of timing, reimbursement for defense costs occurs only at the time when the underlying claim is resolved.

At least two aspects of the defense obligation have been the subject of significant litigation. First, it is typical for the insurance company to contend that the amount of defense costs are unreasonable. For instance, they will argue that too many lawyers worked on the case, or a particular motion should have been made. Thus, a number of criticisms of the defense strategy can be expected, with the benefit of the insurance company’s hindsight.

Policyholders can anticipate these arguments and blunt their impact in a number of ways. Insurance companies generally have defense cost guidelines. Policyholders should read these guidelines before deciding to purchase a policy from a particular insurance company and negotiate any necessary modifications. Policyholders must also make sure that its defense counsel comply with those guidelines. The policyholder should be aware that the hourly rates and other provisions in the defense cost guidelines are often quite restrictive, and may want to advise the insurance company that the appropriate standard is the hourly rates and conditions that counsel for insurance companies use in coverage litigation or when the insurance company is a defendant.

Policyholders also should regularly provide its insurance company with defense counsel’s billing statements, and otherwise inform, and seek the participation of, the insurance company in defense of the claim. Whether or not the insurance company actually assists in the

defense is beside the point. The goal is to give the insurance company the opportunity to object from the earliest possible date and to ask for changes in defense practices if the insurance company deems it necessary. To the extent that the insurance company is silent, it arguably has waived the right to object at a later date.

The second issue that has been the subject of litigation is the issue of “advancement” of defense costs: Whether an insurance company must reimburse for defense costs on an ongoing basis or wait until the claim is resolved. Many courts have found that the policy language is ambiguous on the question of when defense costs must be paid. Okada v. MGIC Indem. Corp., 823 F.2d 276 (9th Cir. 1986). McCuen v. American Cas. Co., 946 F.2d 1401 (8th Cir 1991). If the language is ambiguous, the policyholder should prevail. Even if the insurance policy does not expressly require the insurance company to fund the officer’s or director’s defense on an on-going basis, some insurance companies will do so if asked (or pressed). Wayne County Neighborhood Legal Serv. v. National Union Fire Ins. Co., 971 F.2d 1 (6th Cir. 1992). A few courts have required insurance companies to advance directors’ and officers’ defense costs, notwithstanding insurance policy provisions. See, e.g., National Union Fire Ins. Co. of Pittsburgh, Pa v. Brown, 787 F. Supp 1424 (S.D. Fla. 1991), aff’d, 963 F.2d 385 (11th Cir. 1992).

Accordingly, policyholders should seek contemporaneous payment of defense costs, regardless of the possible ambiguity in the policy language. Moreover, given the currently soft market, policyholders should try to negotiate policy provisions that clearly require advancement of defense costs under both Coverage A and Coverage B.

7. **Miscellaneous Policy Provisions.**

a. **Choice of Forum and Choice of Law Provisions**

Policyholders should try to avoid policies that require arbitration of any dispute arising under, or in connection with, an insurance policy. Arbitration, generally, is a forum which favors the insurance company.⁵ Although many D&O forms contain such a provision, the insurance company may delete that provision as part of the negotiations at the time of sale. The policyholder should be aware that the inability to bring an action in a court of law may reduce its leverage in a subsequent dispute with the insurance company over claims. The parties can always agree to arbitrate a particular claim at a later time.

Similarly, policies which require the application of a particular law or require litigation in a particular forum should be avoided. From the perspective of the policyholder, these clauses spell trouble. That is why the insurance companies insert such provisions into their policies. A policyholder is much better off if the policy is silent in this regard. The selection of forum at the time a coverage action is commenced can be critical to a successful resolution of the dispute.

b. **Subrogation Clause**

Subrogation is the right by which an insurance company, having made payment to the policyholder, may sue other responsible parties to recoup its payment. Frequently policies explicitly preserve that right and provide that the policyholder will do nothing to interfere with the insurance companies' subrogation rights. Often the subrogation action will be brought or

⁵ See Irene C. Warshauer, ADR and Insurance Coverage Dispute Resolution, U.S. Insurance Report, Spring/Summer 1998 at 1; David Garfield Roland, Arbitration--A Good Idea That Does Not Work, Ins. Advocate, June 8, 1996, at 23; Roger Parloff, Kaiser Arbitration: Waiting For Judge Godot?, Am. Law., July 1996, at 84; Lorelie S. Masters, Arbitration Clauses In Liability Policies: A Ticket To Ride?, John Liner Rev., Winter 1996, at 33; Margaret A. Jacobs, Policies Requiring Arbitration Challenged, Wall St. J., Oct. 16, 1995, at B5.

threatened against third parties closely aligned with the policyholder, such as its accountants or attorneys. Such an action can seriously disrupt the policyholder's business. At the point at which the insurance company is asked to reimburse for an underlying covered claim, the insurance company may offer to forego its subrogation rights, but only if the policyholder accepts less than what is due under the policy.

At the time the insurance policy is purchased, the policyholder may be able to buy back the insurance company's subrogation rights for a relative small amount of additional premium. This will eliminate the potential future problems caused by the insurance company's attempt to recoup its payment through a subrogation action, or to reduce its payment under the policy by selling its subrogation rights at a time when the policyholder is in no position to bargain.

c. The Hammer Clause

Many policies provide that the insurance company has the right to settle a claim with the policyholder's consent but that, if the policyholder does not consent, the insurance company's liability is "capped" by the amount for which the insurance company could have settled the claim, plus defense costs incurred as of that date.

Cases against officers and directors or claims which allege malpractice often involve "reputational" factors.⁶ Officers, directors and professionals want to preserve their reputations by fighting certain lawsuits rather than settling. For this reason, among others, defense costs can run high. Some insurance policies include a settlement provision permitting the policyholder to refuse to consent to a settlement. This type of policy, however, also may expressly limit the insurance company's liability in the event of a subsequent judgment in excess

of the amount for which the insurance company claims the case could have been settled. A typical clause provides that:

The insurance company shall not settle any claim without the written consent of the insured. If however, the insured shall refuse to consent to any settlement recommended by the insurance company and shall elect to contest the claim or continue any legal proceeding in connection with such claim, then the insurance company's liability for the claim shall not exceed the amount for which the claim would have been settled, plus the cost and expenses incurred, with its consent, up to the date of such refusal.⁷

Even without a settlement clause, some insurance companies view the insured's reputational predicament as an opportunity to limit their costs of defense and indemnification by pressing the policyholder for permission to settle the claim quickly. Thus, the insurance company recommends an early settlement offer. The policyholder balks and the insurance company then contends that its responsibility is capped at, or limited to, the amount of the settlement it suggested. The insurance company knows of the policyholder's reputational concerns and that the policyholder would prefer to litigate the merits of the claim as opposed to offering a settlement. Ergo, the cap.

B. Allocation

The issue of allocation is a frequent source of contention between policyholders and D&O insurance companies. It is almost inevitable when an insurance policy, such as the policy sold to protect officers and directors, provides only a limited range of coverage. Insurance companies routinely argue that they are entitled to apportion the costs of defense, and

⁶ See Martin Minkowitz, State Law Limitations And Insurance Regulations Affecting Directors' And Officers' Policies, in Directors And Officers Liability Insurance 1988, at 29, 67 (PLI Com. L. & Prac. No.454, 1988).

⁷ Allen D. Windt, Insurance Claims And Disputes: Representation Of Insurance Companies and Insureds 5.03 n.22 (2d ed. 1982).

settlement or judgment between insured and uninsured parties or claims in the underlying lawsuit.

For instance, although claims against the corporation are not covered under most D&O policies, both the corporation and the individuals are alleged to have committed the same wrongful acts, and the claims will be defended and settled jointly. By allocating these costs between those covered under the D&O policy (e.g., the officer) and those who are not (e.g., the corporation), the insurance company attempts to reduce greatly its exposure.

Allocation issues can occur at two points in time. First, there is the allocation of defense costs and expenses during the time the underlying claims against the officers are pending.⁸ Second, there is the allocation of indemnity payments at the time of any settlement or judgment. When a D&O policy makes no reference to issues of allocation, insurance companies regularly attempt to allocate costs of defense and indemnity on an arbitrary 50-50 basis. This is true even where little or no investigation of the surrounding facts has taken place. Most policyholders can negotiate a far more favorable percentage. Allocation is an example of the potential for insurance company claims handling to erode the scope and quality of D&O insurance coverage.

Several courts have refused to rule in favor of insurance company attempts to limit insurance through allocation.⁹ In Harbor Ins. Co. v. Continental Bank Corp., 922 F.2d 357 (7th Cir. 1990), the Seventh Circuit held that: “To allow insurance companies an allocation between the director’s liability and the corporation’s derivative liability for the director’s acts

⁸ See Eugene R. Anderson and Randy Paar, What’s Wrong With D&O Insurance?, Risk Mgmt., Jan. 1995, at 29.

⁹ See, e.g., Nordstrom, Inc. v. Chubb & Son, Inc., 54 F.3d 1424 (9th Cir. 1995); Safeway Stores, Inc. v. National Union Fire Ins. Co. of Pittsburgh, Pa., 64 F.3d 1282 (9th Cir. 1995); Caterpillar, Inc. v. Great Am. Ins. Co., 62 F.3d 955 (7th Cir. 1995). See also Bruce D. Celebrezze and Katherine Cranston Potter, Allocation Cases Expand D&O Cover, Nat’l Underwriter, Nov. 13, 1995, at 3.

would rob the [policyholder] of the insurance protection that it sought and bought.” Id. at 368. In Stauth (discussed earlier) allocation was an issue because the policy only provided insurance for the individual officers and directors, but not for the corporate defendant. The court rejected the insurance companies’ allocation argument and held, consistent with recent precedent, that the insurance companies had to pay the entire amount, unless defense or liability payments were increased as a result of the presence of uninsured parties or entities in the lawsuits. Insurance companies had to indemnify for the entire loss except for the increased cost or settlement that resulted from the presence of the uninsured parties.

Referred to as the “larger settlement rule,” this rule recognizes that the principal wrongdoers, as alleged, are the insured officers and directors. One of the reasons why courts have adopted the “larger settlement rule” is their determination that the D&O policies were ambiguous on the allocation issue.

Most insurance companies selling D&O insurance, have responded to this line of authority by including policy provisions which explicitly set forth an allocation formula. Alternatively, insurance companies avoid the allocation issue by selling “entity coverage,” insurance for the corporation as well as the officers and directors, for the most frequently asserted claims. Despite the recent cases ruling in favor of policyholders, D&O insurance companies continue to try and impose allocation upon their policyholders when the policy language is ambiguous.¹⁰

The leading case on the issue of allocation of defense costs is Continental Cas. Co. v. Board of Educ., 489 A.2d 536, 544 (Md. 1985). There, the court held that defense costs “reasonably related” to the defense of the covered claims should be covered by the policy, even

¹⁰ See Dave Lenckus, D&O Insurer Loss On Allocations Is Third Straight, Business Ins., Sept. 4, 1995, at 1, 27.

if those services and expenses would also be of use in defending the non-covered claims. The “reasonably related” standard of Continental also has been applied to allocation between covered and non-covered parties. Nodavey Valley Beach v. Continental Cas. Co., 715 F. Supp. 1458, 1460-61 (W.D. Mo. 1989), aff’d 916 F.2d 1362 (8th Cir. 1990). As a fallback position, policyholders can argue for pro rata allocation, as usually, several officers and directors are named as defendants as opposed to the lone corporation.

C. The Claims Process

Upon the submission of a D&O claim, the insurance company will typically issue a Reservation of Rights (“ROR”) letter that will raise all possible defenses to coverage.¹¹ Generally, one or more of the policy language issues discussed above will be raised. The insurance company also will argue that some or all of the liability alleged in the underlying claim is attributable to uncovered claims or the conduct of uncovered parties.¹² As already noted, when the underlying case is resolved and the claim is presented to the D&O insurance company for payment, the insurance company may also contend that the defense costs were excessive or that the case was not properly litigated.

Frequently, claims against officers and directors include allegations of fraud or self-dealing. Thus, the insurance company may argue that, to the extent that the directors and

¹¹ ROR letters are long, strongly termed statements advancing the insurance company’s position as to why insurance coverage may be denied or substantially reduced. They usually recite the very same facts the policyholder presented when the claim was filed. ROR letters often quote extensively from the policy and list the insurance policy exclusions that the insurance company contends are potentially applicable to the claim. One insurance company executive has described them as obscure and, at times, overly-inclusive.

Frequently, such letters also include a clause--or more appropriately, a trap--binding the policyholder to the insurance company’s claims handling methods and arguments. Typically, after laying out the grounds for the potential denial of insurance coverage, the ROR letter provides the following:

Unless the insurance company receives written notice to the contrary within ten days of this letter, the insurance company shall assume that the policyholder agrees to its handling of this matter with a full reservation of rights, and the insurance company shall proceed accordingly.

officers were acting with a selfish or fraudulent intent, any resulting liability is within one of these exclusions. Sometimes insurance companies use allegations of a director's or officer's intentional misconduct to deny insurance coverage in its entirety, even if minimal information exists to support such allegations.¹³ This can happen even when other allegations contained in the very same lawsuit bring the policyholder's claim within the scope of coverage.¹⁴ Accordingly, there are times in which the insurance company adopts the positions of the underlying claimant and attempts to make a case against the policyholder. The result is that a policyholder must battle two adversaries, one of whom is the insurance company to whom it paid premiums.

At some point, the insurance company may also try to deny insurance on the grounds that certain facts were not fully disclosed on the insurance application. Such applications generally contain broad and generalized questions that are difficult to answer, such as: "Are you aware of any circumstances which might give rise to a claim?" Obviously, in hindsight, after a claim has been filed, it is easy for an insurance company to find circumstances that it will contend should have been described on the application.

For instance, in Harristown Development Corp. v. International Insurance Co., 1988 U.S. Dist LEXIS 12791 (Pa.D.C. 1988), the insurance company denied the policyholder's claim, arguing that coverage was void because there were misstatements made on the application for the D&O policy. Interestingly, this rationale for denying the policyholder's claim came years after the claim was initially filed with the insurance company. In the interim period, the

¹² See, e.g., *Northwest Airlines, Inc. v. Federal Ins. Co.*, 32 F.2d 349 (8th Cir. 1994). Cf., *Continental Cas. Co. v. Board Of Educ. of Charles County, Md.*, 489 A.2d 536 (Ct. App. Md. 1985).

¹³ See, e.g., *Harbor Ins. Co. v. Continental Bank Corp.*, 922 F.2d 357, 359-60 (1990).

¹⁴ See, e.g., *American Home Assurance Co. v. Port Authority of New York and New Jersey*, 412 N.Y.S.2d 605 (A.D. 1st Dept. 1979); *Eaton v. D'Amato*, 581 F. Supp. 743, 750 (D.D.C. 1980); *Anglo-American Ins. Co. v. Molin*, 673 A.2d 986 (Pa.Cmwlt. 1996).

policyholder continued to renew its policy and pay premiums to the insurance company for the D&O coverage.

The policyholder sued the insurance company to secure coverage under the D&O policy. The court ultimately found in favor of the policyholder, concluding that there were no misrepresentations on the application that would void insurance coverage. Nevertheless, the Harristown Development litigation is indicative of the practice of some insurance companies to comb through insurance applications for either misstatements or “incomplete” answers to insurance application questions in an effort to defeat insurance coverage for covered claims.

The lesson is that merely answering the questions on the insurance application may not be sufficient to prevent a subsequent claim by the insurance company that additional information should have been disclosed. A policyholder may be well advised to ask the insurance company, in writing, if there is anything else it wants to know. The policyholder may be able to offer the insurance company access to certain corporate files so that the insurance company can make its own determination of the materiality of the information. The policyholder may also invite the underwriter to interview representatives of the policyholder. A policyholder should make sure that there is a memo to the file that accurately describes what it offered the insurance company and what occurred at the interview, including the offer to provide additional information.

Insurance companies also have an obligation to sell insurance suitable for the purposes being sought. See Clark-Peterson Co. v. Indep. Ins. Assoc., Ltd., 492 N.W.2d 675 (Iowa 1992). Accordingly, clearly communicating the nature of the policyholder’s business and the reasons for purchasing insurance may help on subsequent interpretive issues in the event that a claim for insurance is subsequently denied. A policyholder should also try to obtain a

description from the insurance company of the type of claims covered by the policy, as well as any promotional information that is available. An insurance company will be more expansive in interpreting its policy at the time of sale, than at the time that a claim is made.

The current vogue among insurance companies is to “manage policyholder’s expectations” about the problems which are likely to arise in claims handling by what is referred to as a “Pre-Claim Meeting.” At this sit-down, the insurance company explains all of the difficulties which are likely to arise when a D&O claim is submitted. What is most interesting about this procedure is the insistence of many insurance companies that the “Pre-Claim Meeting” should happen only after the premium check has been received. It is the policyholder’s obligation to make sure that this meeting is not just “Pre-Claim” but also “Pre-Premium.” The problems of pursuing a claim under a D&O policy are part of the costs of the policy, and the policyholder should be aware of those costs before it buys the product. A policyholder cannot afford to be surprised by its insurance company at the same time it is defending against an underlying claims.

Insurance companies are not all alike. Choosing an insurance company based solely on the amount of the premium is a mistake, particularly if the insurance company has a policy of aggressively denying claims. For instance, the president and chief underwriting officer for Aetna’s D&O company warned of the perils of blindly buying D&O insurance policies from just any insurance company. “Assuming that policies or insurance companies are interchangeable could be a costly mistake for the [policyholder].”¹⁵ Policyholders shopping for D&O insurance must do their homework and investigate the claims handling histories of the insurance companies under consideration. This means speaking with a number of insurance brokers and colleagues in order to evaluate the quality of an insurance company under consideration.

D. Settlement of the Underlying Claim

Whenever there is a dispute over the scope of insurance coverage, the policyholder often must defend or settle the underlying case without the help of its insurance company. If the underlying case is resolved by settlement, a question will arise as to the extent that the non-participating insurance company is bound by the settlement. After the policyholder settles the underlying claim and brings an action against its insurance company for the amount of the settlement, the insurance company will often contend that the policyholder was not liable to the underlying claimant or that the settlement was unreasonable. Thus, the insurance company tries to force the policyholder to relitigate the underlying case and to prove its own underlying liability in the coverage action.

A recent pro-policyholder case which discussed this issue is Vitkus v. Beatrice Co., 127 F.3d 936 (10th Cir. 1997), which arose out of the Silverardo Savings and Loan debacle. In Vitkus, the policyholder agreed to a non-binding settlement with the Federal Deposit Insurance Corporation as a result of the actions of one of the policyholder's officers, Richard Vitkus. The entire underlying lawsuit was settled for \$26.5 million, of which \$10 million was allocated to Richard Vitkus.

The policyholder's directors and officers (D&O) liability insurance policy provided insurance coverage for a "loss" which was described as "any amount which the Insureds are legally obligated to pay for a claim . . . and shall include damages, judgments, [and] settlements . . ." The questions for the federal appellate court were whether the policyholder was "legally obligated" to pay the settlement, and whether the amount and allocation between defendants of the settlement amount was binding on the insurance company, who had denied coverage and had not participated in the settlement negotiations.

¹⁵ Stephen Sills, Shopping The D&O Market, Risk Mgmt., July 1995, at 65.

The Vitkus court first held that a “settlement” was a sum which the policyholder was “legally obligated to pay.” The court aptly noted that to decide that otherwise would eviscerate the protection of all policyholders, and would undermine the public policy in favor of settlements.

The court also ruled that the D&O policy was required to indemnify the entire \$10 million allocated to cover the liability of Richard Vitkus in the underlying settlement. The court admitted that it was not convinced that \$10 million accurately reflected the Vitkus’ share of liability for the Silverado debacle, however, it held that:

Actual liability . . . is not our guide in evaluating whether a settlement allocation is enforceable. It would be wholly impractical to charge the district court with trying the Silverado litigation after a successful settlement in order to ascertain Vitkus’ and the other settling parties relative culpabilities.

This ruling is an important rejection of the argument that the policyholder must retry the underlying claim in order to obtain coverage. The Vitkus court ruled that all that the policyholder must show is that “the settlement allocation reasonably reflected [the policyholder’s] potential exposure in the underlying litigation.”

In conclusion, the court held that: “Where a reluctant insurer fails to participate in an insured’s settlement discussions, and the insured becomes party to a global settlement agreement, the insured may be indemnified for any amount of the total settlement package for which it can establish a reasonable anticipation of liability.”

VI. Conclusion

Policyholders should be aware that while liability insurance is usually essential, and specialized business insurance is becoming more common, insurance coverage problems frequently develop upon filing a claim with their insurance company. Too frequently, insurance companies battle their policyholders at the worst of possible times in an effort to delay insurance

coverage for sizeable claims. Risk managers must understand that an insurance policy has value only if the insurance company pays when a covered claim is submitted. By developing a fundamental understanding of their liability insurance policies and the insurance claims process, as well as adopting a willingness to fight for the contractual rights that it purchased, policyholders can place themselves in a stronger position to secure insurance coverage for their claims.