HOW TO INSURE D&O LIABILITIES

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How to Insure D&O Liabilities
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Introduction

This course is designed to give a moderately experienced insurance person a detailed look at the key provisions contained within a corporate directors and officers (D&O) liability insurance policy and how they function within various claims scenarios. The course begins by describing the policy's three key insuring agreements and then examines the covered persons, covered organizations, and covered acts provisions. Next, it analyzes two of the policy's most important defined terms: "covered damages" and "covered losses." It continues by describing the policy's defense coverage provisions and defense procedures. The manner in which a D&O policy's limits, retentions, and coinsurance provisions apply is considered next, followed by a look at the policy's most important conditions. The course reviews the exclusions section of the policy and the claims-made coverage trigger provisions. The final chapters analyze excess D&O liability policies and provide an overview of the specialized policy forms written to cover privately held companies.

A glossary, which follows the concluding chapter, contains definitions of key words, phrases, and acronyms used in this text. Be sure to check the glossary if you are unsure of some term or have forgotten what an acronym stands for.

Upon successful completion of this course, you will be able to

1. distinguish among a corporate D&O liability policy's three major insuring agreements;
2. recognize how the covered persons, covered organizations, and covered acts provisions coordinate within these three insuring agreements;
3. identify the "covered damages" and "covered losses" definitions and recognize how they first define and then limit the scope of coverage the policy provides;
4. recognize the extent to which D&O policies provide employment practices liability (EPL) coverage and how endorsements to the forms can further expand upon the extent of such coverage;
5. recognize the scope of defense coverage provided by the D&O policies, distinguish between duty to defend and non-duty to defend policies, and recognize how these two provisions function in a claim situation;
6. recognize how a D&O policy's limits, retentions, and coinsurance provisions coordinate with the policy's three key insuring agreements;
7. identify and recognize the impact of the critical policy conditions found within D&O forms, including severability, cancellation, subrogation, other insurance, arbitration, presumptive indemnification provisions, and priority of payments provisions;
8. distinguish between "limited" and "full" severability provisions;
9. identify the major exclusions found within D&O policies, distinguishing between the different versions of the same exclusion, and recognizing the rationale for each of these exclusions;
10. given relevant information, recognize how the terms claims first made, post-policy reporting window, retroactive date, discovery provision, extended reporting, and runoff provisions relate to such triggers and apply in claim situations;

11. recognize how excess D&O liability policies are structured to interact with primary D&O coverage and how the major policy provisions function in a claim situation; and
12. identify the unique exposures of privately held organizations and how the coverage features within the policies differ from those contained in the forms designed to cover corporate/for-profit firms.

Chapter 1
The D&O Policy: Insuring Agreements

Overview

This chapter analyzes the four distinct insuring agreements found within public company D&O policy forms.

Chapter Objectives

On completion of this chapter, you should be able to

1. distinguish among Side A, Side B, Side C, and Side D coverages;
2. recognize common coverage variations and identify their advantages and disadvantages; and
3. recognize examples of claims to which each coverage applies.

The first insuring agreement—known as "Side A" coverage, also termed "directors and officers liability insurance" or "personal assets protection"—provides liability coverage for individual directors and officers of the parent corporation. The second insuring agreement—known as "Side B" coverage, also termed "corporate reimbursement insurance"—reimburses the corporation for payments it is legally obligated (or permitted) to make in indemnifying its directors and officers for liability claims made against them, protecting the balance sheet of the organization itself. The third—known as "Side C" coverage, also termed "entity coverage"—covers the corporation for claims made against it *solely* relating to the corporation's securities (i.e., shares of publicly traded stock). The fourth—known as "Side D" coverage, or "derivative investigation coverage"—pays the cost of investigations that are required when a derivative claim is made against the insured corporation.

The coverage provided by D&O policy forms is illustrated in Exhibit 1.1.

Exhibit 1.1
D&O Insuring Agreements

Side A Coverage D&O Liability Coverage or Personal Assets Protection	Side B Coverage Corporate Reimbursement Coverage	Side C Coverage Entity Securities Coverage	Side D Coverage Derivative Investigation Coverage
Covers directors and officers when the corporation does not indemnify	Covers the corporation's obligation to indemnify directors and officers	Covers the corporation as a defendant in litigation involving securities issued by the corporation	Pays the cost of investigations that are required when a derivative claim is made against the insured corporation
No retention	Large retention	Largest retention	No retention; usually subject to $250,000 sublimit
Combined, aggregate single limit for all four coverages.			

D&O Liability Coverage ("Side A")

The first insuring agreement of a D&O policy covers what is known as the "direct" or "nonindemnifiable" liability of an organization's directors and officers. If such persons are found liable to third parties—and the corporation is not legally liable for reimbursing the directors and officers and/or is financially unable to indemnify the directors and officers—this portion of the policy promises to indemnify them for claim payments and defense costs they incur as a result of such liability.

Side A is an extremely important coverage and applies in three situations: (1) when the parent organization is not legally required or able to indemnify directors and officers for a specific claim, (2) when the defendant directors and officers must pay a settlement or judgment in a shareholder derivative lawsuit (derivative claims are actions brought on behalf of a corporation against its own directors and officers, as opposed to claims brought on behalf of an individual or a group), or (3) when the corporation lacks the financial capacity to indemnify the directors and officers, which usually occurs when it is insolvent. In each of these situations, Side A of the policy provides indemnification of the corporation's directors and officers on a "direct" basis.

Side A-Only D&O Policies

Recognizing the importance of these exposures, beginning in the early part of the 2000s, insurers began to more frequently offer what are known as "Side A-only" policies. Actually, as early as 1986, Corporate Officers & Directors Assurance Ltd. (CODA) began writing policies of this type. Such policies are often written in conjunction with "primary" D&O policies (which contain both Side A and Side B coverage and frequently Side C and Side D coverage). Side A policies can provide coverage on an excess basis (excess of the corporation's primary or "ABC" D&O policy) and often cover only independent/outside directors (i.e., directors who are not employees of the company).

The most frequent intent of Side A-only policies is twofold.

- To provide excess limits in the event the limits under the primary form are exhausted by claim payments and defense costs.

- To "drop down" over primary forms in the event that an exclusion or other coverage restriction applies under the primary form.

Corporate Entity Is Not an Insured under Side A Policies

Another key point to recognize is that the parent organization is not an insured under Side A-only policies. Rather, the forms only provide coverage for the directors and officers—not for the corporate organization's obligation to indemnify such persons. In effect, Side A policies operate like D&O umbrella policies but only as respects the coverage provided by a Side A policy.

Exhibit 1.2 provides a description of the advantages provided by Side A-only coverage forms.

Exhibit 1.2
Advantages of Side A-Only Coverage Forms

Coverage Assured in Bankruptcy Situations

One of the most important advantages of a Side A-only policy is that, under a primary D&O form, there is sometimes uncertainty as to whether directors and officers have access to the proceeds of such policies in the event a company declares bankruptcy. More specifically, there have been a number of conflicting court decisions on this issue. Some decisions indicate that the proceeds of a D&O policy belong to the directors and officers. Conversely, other decisions have held that such proceeds are the property of the bankruptcy trustee (because the trustee "stands in the shoes" of the corporate entity), a holding that usually precludes reimbursement of insured directors and officers. However, since the corporate organization is not an insured under Side A-only forms (as is the case under primary D&O policies), coverage for the directors is not in doubt, even when a company is insolvent and a bankruptcy trustee seeks access to policy proceeds.

Inapplicability of Severable Warranties

Another obstacle to a director's obtaining access to primary D&O policy proceeds is the application of nonseverable warranties. This refers to a situation in which coverage for a director or officer is barred because of fraud or concealment by a corporation's CEO or CFO in providing information within the application for coverage. For example, assume a CEO knows of a situation that is likely to produce a claim. The CEO intentionally conceals such circumstances in the application for D&O coverage. Depending on the wording of the warranty provision within the primary D&O policy, coverage for the claim could be barred as to all directors and officers under the policy. This is because such warranties are not always severable, meaning that the CEO's fraudulent statements in the application will bind even directors who had no knowledge of these circumstances. However, under Side A-only policy forms, this otherwise nonseverable warranty (which ordinarily defeats coverage for nonculpable directors and officers) does not apply, meaning coverage would be available under such circumstances.

Exclusions for Financial Restatements

Yet another coverage gap is created by exclusions for coverage of claims produced by financial restatements. (A financial restatement occurs when a publicly traded corporation must make a material revision to one of its recently released earnings statements, almost always in a manner indicating that profits were lower or losses were larger than originally reported.) Again, such exclusions do not appear in Side A-only policy forms. Therefore, despite the presence of such an exclusion in a primary D&O form, coverage would nonetheless apply to directors insured by a Side A-only policy, because most types of Side A-only forms would "drop down" over the coverage gap caused by the financial restatement exclusion in the primary policy.

Exhibit 1.2
Advantages of Side A-Only Coverage Forms

Nonrescindable Policy

Side A-only forms cannot be rescinded based on fraud committed by any insureds under the policy. In contrast, under traditional D&O policies (those that cover Sides A, B, C, and sometimes D) an insurer can rescind an insurance policy when it finds that the insured has misrepresented a material fact when applying for coverage, such as providing a fraudulent financial statement with its application. (The rescission of a policy means that the policy never went into effect. Under such circumstances, an insurer must return the entire premium to the insured.)

Although coverage under a Side A policy would be denied as to an insured(s) that intentionally provided false information on an application, such coverage would still apply to other, nonculpable insureds under the policy, which is not always the case under primary policy forms.

Additional Policy Limits Available for Mega-Claim Situations

Since D&O policies are written with a combined single limit for all three insuring agreements (see Exhibit 1.1), when the corporate entity is named in mega-securities litigation (e.g., $100+ million), policy limits are usually depleted by the claim applicable to Coverage C (entity securities coverage), leaving little or no monies available for claims that also name directors and officers. However, the presence of a Side A-only policy, which contains a "dedicated" limit for directors and officers—and is not accessible by the corporate entity—solves this problem.

Limited Conduct Exclusions

Although all Side A forms are not uniform in this regard, the more favorable (for the insured) versions typically have very limited conduct exclusions for directors and officers. The exclusion, which is meant to bar coverage in scenarios in which directors and officers have had financial gains to which they were not legally entitled and/or committed fraudulent or criminal acts, only applies to clearly "deliberate" acts in the more favorable forms that commonly provide Side A-only coverage. Furthermore, the exclusion is frequently only applicable after both "final" *and* "non-appealable" adjudication establishes the improper conduct, meaning that coverage has a greater chance of existing throughout extended litigation. Lastly, the conduct exclusions in Side A-only forms frequently do not apply to defense costs, independent directors, or claims of the employment practices variety.

The Two Types of Side A-Only Coverage

There are two types of Side A-only policies: (1) those written on a pure excess basis and (2) those providing "true" umbrella coverage (also called difference-in-conditions (DIC) coverage).

- **Pure Excess Side A-Only Policies**—Such forms afford coverage on the same basis as the primary D&O policy. That is, coverage is subject to the same terms and conditions of the underlying policy(ies). The only additional coverage that "pure excess Side A-only" forms provide is limits excess of primary coverage. These forms are typically the less expensive of the two types.
- **Umbrella (DIC) Side A-Only Policies**—"Umbrella (DIC) Side A-only" policies provide "true" umbrella coverage over a primary D&O policy and are therefore subject to their own terms and conditions. Accordingly, they will "drop down" over the Side A coverage provided within the primary D&O policy in situations where the primary policy contains an exclusion or other provision that precludes coverage.

Variations within Side A-Only Coverage

There are two key variations of Side A-only coverage. First, some corporations purchase an "all Side A" program, and, second, a number of corporations purchase a Side A policy applying only to their independent/outside (i.e., nonemployee) directors.

- **"All Side A" Program**—A minority of corporations choose to purchase only Side A coverage, leaving their Side B (corporate reimbursement), Side C (entity securities), and Side D (derivative investigations) exposures self-insured. The rationale behind this approach is that, first, such companies foresee a low probability of (1) claims against their directors and officers and (2) securities claims against the corporate entity. In addition, even in the event of a claim, these organizations feel their balance sheets are strong enough to withstand whatever defense costs and claim payments may be required to respond to such claims. Accordingly, they believe the only type of coverage that is really necessary is Side A, because it applies in situations in which the corporation cannot legally indemnify the directors and officers or when the corporation cannot indemnify the directors due to its insolvency.
- **Coverage for Outside/Independent Directors Only ("IDL" Coverage)**—A second variation of Side A-only policies is those covering *only* outside/independent directors while not covering "inside" directors (i.e., directors who are also employees of the company). An argument can be made, and a number of actual claim situations have proven, that outside directors, given their lack of day-to-day contact with and control over the inner workings of the corporate organization, require a greater level of protection compared to "inside" directors and officers. Accordingly, so-called IDL (independent directors liability) policies fill this need. Such forms also serve as a recruitment tool for independent directors who want to serve on a corporate board but seek additional protection of their personal assets.

The need for IDL coverage was illustrated when a number of outside/independent directors at Enron and WorldCom were forced to contribute personal funds to securities liability settlements with shareholders, since coverage limits of Enron's corporate policies had been exhausted by claims against the company's inside directors. If IDL policies had been in effect, such coverage would have provided additional limits that could have covered the settlements and prevented the independent directors from having to resolve claims using their personal funds.

Corporate Reimbursement Coverage ("Side B")

The second insuring agreement in a D&O policy is called "Side B" or corporate reimbursement coverage. This part of the policy covers the parent company's obligation to indemnify the insured directors or officers for claim payments and defense costs associated with wrongful acts the directors or officers committed while serving in their capacity as such. The following documents typically require corporations to indemnify their directors and officers for wrongful acts.

- The organization's charter or bylaws
- Individual agreements with a director or officer as a condition of employment
- State indemnification statutes
- Common law requirements in the state of incorporation

The Corporation Is Required To Indemnify Retention Amounts

In situations in which corporations are required to indemnify directors and officers against claims from wrongful acts, the corporation is also usually required to reimburse any retention amounts that may not apply to the limits of liability under a D&O policy. For instance, if a D&O claim requires a director to expend $5 million in settlement and defense costs, the organization is required to reimburse the full $5 million, even if a $1 million policy retention applies to the corporate indemnification portion of the policy. This is important because with the exception of situations involving corporate insolvency or a derivative claim, the vast majority of D&O claims (against the directors and officers) are paid under the corporate reimbursement ("Side B" coverage) provision of the policy, rather than under Side A (D&O coverage). Thus, in the event of a claim, the corporation—not the individual directors and officers—must ultimately absorb the cost of the retention stated in the D&O policy.

Complementary Nature of the Two Insuring Agreements

The two insuring agreements, A and B, of a D&O policy are complementary. That is, if a director or officer incurs liability of a type for which the company is required to indemnify that director or officer, the D&O insurer will make the required indemnification on behalf of the company under Side B of the policy. On the other hand, when the company provides no indemnification (because it is insolvent, not legally able to indemnify, or in a derivative claim situation), the D&O policy will afford direct coverage for the director(s) or officer(s) under Side A of the policy.

One confusing factor relating to indemnification is that state law defines the types of liabilities for which a company may or may not indemnify its directors and officers. However, if the amounts a director or officer is required to pay (because of a particular wrongful act) are not indemnifiable by the company under the applicable state law, coverage may still exist under the D&O policy's other insuring agreement—the one providing *direct* coverage for the directors and officers themselves (i.e., Side A coverage).

Entity Securities Coverage ("Side C")

Coverage under Sides A and B of a D&O policy is limited to situations in which a lawsuit specifically names the organization's directors and officers (either individually or collectively). Coverage under Sides A and B will be denied if the lawsuit names only the parent organization. Instead, coverage in this situation would apply under Side C.

Side C Coverage Is Only for Securities-Related Claims

To address this "gap" in Sides A and B coverage when the corporate organization is named in a lawsuit (either alone or in conjunction with directors and officers), in the mid-1990s, insurers introduced what is known as "entity coverage." As Peter Taffae wrote in a December 21, 2009, article published on PropertyCasualty360.com ("The ABCs of D&O Insurance Clauses"), Side C can effectively trace its roots back to a US 9th Circuit Court of Appeals decision in *Nordstrom, Inc. vs. Chubb & Son, Inc.* In the decision, it was determined that "a means of differentiating the liability between directors, officers and the legal entity did not exist in securities litigation." As a result, "predetermined allocation" endorsements were introduced across the industry, specifying the liability allocation between individuals and the entity itself. From this, separate Side C coverage eventually arose.

Given the fact that a publicly traded corporate organization's single largest exposure relates to its potential liability as an issuer of securities, the public company D&O policies that provide entity coverage do so *only as respects securities claims*. Such coverage is afforded under a separate section of a D&O policy, also known as "Side C" coverage. More specifically, this section of the policy covers the corporate entity in situations in which a claimant names the corporate entity alone or names both the entity and individual directors and officers in a claim associated with securities.

An Example: A Noncovered Claim versus a Covered Claim under Side C

Assume that a claimant sues an insured corporation, alleging that the corporation had breached a contract to deliver $2 million of its product. The claimant's lawsuit cites damages resulting from the company's failure to deliver its product. There would be no coverage under Side C (or under any other portion of a corporate D&O policy form) for this type of claim. This is because Side C applies only to claims involving the securities (i.e., shares of stock) the insured corporation issued.

On the other hand, assume a situation in which a claimant brings a lawsuit alleging that poor management decisions caused the corporation to suffer a quarterly loss. Within 2 days of the announcement of this loss, shares of the company's stock have dropped in value by 50 percent. Side C of the policy would cover such a claim since it involves securities issued by the insured company.

Limits for Entity Coverage of Securities Claims

As is the case with Coverage A (D&O liability) and Coverage B (corporate reimbursement), entity securities coverage is also subject to the policy's aggregate limit. Again, it should be emphasized that claims *in any combination* under any of these four coverages (A, B, C, D) can exhaust the policy's aggregate limit. Although the rise in prevalence of Side C satisfies an important coverage need for insureds, the broader application of coverage can also lead to more rapid depletion of limits. Insureds should be sure to make their limits purchasing decisions accordingly, keeping not only the individual directors and officers in mind but also the entity itself.

Retentions for Entity Coverage

Typically, however, coverage for securities claims is generally subject to a separate, larger retention than that applicable to Coverage B (corporate reimbursement) and Coverage A (direct coverage for directors and officers, which is not subject to a retention). Coverage under Side C of a D&O policy is subject to a higher retention because securities claims against corporate entities are usually much larger than other types of claims made under Coverage B. Additionally, corporations themselves have more assets at their disposal, meaning they can tolerate a higher retention.

Allocation Issues under Entity Securities ("Side C") Coverage

One unique aspect of entity securities liability coverage is that, in a number of instances, claims will be made against the entity that

- are also made against *other parties* not covered by the policy (i.e., nondirectors and nonofficers), known as "covered versus uncovered party" allocation, and
- sometimes involve *individual allegations* that the policy does not cover (i.e., claims not involving securities) along with those that do involve securities, which is known as "covered versus uncovered claim" allocation.

In each of these two instances, an "allocation" or apportionment must be made in which the insured and the insurer determine the extent to which *each of the parties* named in a lawsuit is entitled to indemnification from the D&O policy and the extent to which each specific type of allegation comprising the claim is or is not covered by the D&O policy.

Covered versus Uncovered Party Allocation

Typically, a lawsuit names both individual directors and officers and the corporate entity. In cases in which entity coverage is not purchased, the insurer must "allocate" or apportion coverage between the corporate entity on one hand and the directors and officers on the other. It must, according to the facts surrounding the claim, determine which specific allegations pertain to individual directors and officers and which result from the acts of persons whom the policy does not insure (i.e., nondirectors/nonofficers).

Particularly corresponding with the passage of the Sarbanes-Oxley Act in 2002 (SOx), insurers have added nondirectors/nonofficers with high-level responsibilities as insureds (e.g., corporate comptrollers, senior staff attorneys, human resources managers) under Coverage C. This is because SOx expanded the personal liability of such individuals, for which coverage is now typically required in a large, publicly traded corporation. Such a coverage extension has significantly reduced the number of covered versus uncovered party allocation disputes.

Covered versus Uncovered Claim Allocation

Another type of allocation issue arises when some, but not all, of the allegations comprising a D&O claim are covered under a given policy form. For example, a single lawsuit might involve allegations of wrongful financial reporting that caused the share price of an insured's stock to nosedive, combined with allegations of damages caused by pollution. In this situation, an allocation would have to be made between the damages resulting from the former claim, which would be covered under Side C, and the latter claim, for which virtually all D&O forms exclude coverage.

Allocation Provisions in D&O Policies

Apportionment of an insurer's payment is extremely complex in both covered person/uncovered person and covered claim/uncovered claim situations. Usually, the extent (i.e., the percentage) to which a claim is covered becomes a matter of contentious negotiation between the parent organization and the insurer, rather than a function of straightforward application of policy terms.

Nevertheless, since disputes frequently result from the allocation process, D&O forms contain allocation provisions that are aimed at providing guidance as to how the allocation process will be conducted, in an effort to reduce, if not avert, such controversies.

Best Efforts Allocation Provisions

By far, the most common type of allocation provision in D&O policies is known as the "best efforts" provision, whereby both insurer and insured promise to use their "best efforts" in apportioning covered claim amounts, based on the relative legal exposures of the parties and based on the type(s) of claims made. In the event they are unable to do so, the insurer promises to advance what it considers "fair and proper" amounts, on the insured's behalf, prior to resolving the dispute. In some instances, an arbitrator is hired to make an allocation determination, although in most cases, the insured and insurer are able to negotiate allocations between themselves. (Judges, on the other hand, do not participate in allocation proceedings.)

Derivative Investigations Coverage ("Side D")

A derivative claim is a type of lawsuit brought by one or more stockholders—on behalf of the corporation—rather than on behalf of the individual stockholder. The alleged harm must be to the corporation as a whole, rather than to one or more shareholders. Therefore, any recovery in derivative suits inures to the benefit of the corporation and is therefore paid to the corporation rather than to the shareholder(s) who institute the action.

Derivative investigations associated with these claims are a part of an ever-higher proportion of D&O claims. When such investigations are called for, insureds must usually hire outside, independent counsel, as well as various accounting, financial, and regulatory experts. Such parties then assist the organization in activities such as managing document requests, responding to interrogatories, and providing depositions.

Accordingly, beginning around 2009, D&O insurers started offering investigations coverage, known as "Side D."

Limitations Associated with Side D Coverage

There are three specific drawbacks associated with investigations coverage: (1) low limits, (2) lack of excess coverage, and (3) narrow coverage scope.

Low Limits

The vast majority of insurers write Side D coverage with only a $250,000 sublimit. This means that payment of investigation costs reduces the policy's aggregate limit and is therefore not an additional limit of coverage. For example, assume a D&O policy contains a $5 million aggregate limit. Also assume that an insurer pays the full $5 million limit in conjunction with the defense and indemnity costs of various claims made during the policy period. Once the $5 million aggregate limit is exhausted, there would be no monies available to pay the costs associated with investigations—despite the policy's $250,000 sublimit.

Lack of Excess Coverage

Furthermore, virtually no excess D&O insurers will provide "drop down" coverage once the $250,000 sublimit has been exhausted, although there are rare exceptions. For example, assume that an insured expends $1.25 million in investigations expense in conjunction with a claim. Also assume that its primary D&O insurer pays the full $250,000 sublimit for such costs. Despite the fact that the insured has an excess D&O policy containing an additional $5 million limit, the excess insurer will not "drop down" and cover the remaining $1 million that the insured did not receive from its primary D&O insurer (i.e., $1.25 million total investigation expense – $250,000 paid by primary D&O insurer = $1 million not covered by excess D&O insurer).

Narrow Coverage Scope

Nearly all D&O policies' investigations expense insuring agreements state that coverage is limited to shareholder derivative demand investigations. Although the incidence of derivative claims has grown historically, the number of investigations necessitated by derivative claims is nevertheless dwarfed by those conducted at the behest of government regulatory agencies, a type of investigation that is typically not covered by "Side D."

Chapter 1 Review Questions

1. Chi Corporation's directors and officers policy has four insuring agreements. Which, if any, of these insuring agreements provides liability coverage for Chi's obligation to indemnify individual directors and officers?

    A. Side A coverage

    B. Side B coverage

    C. Side C coverage

    D. Side D coverage

2. A liability claim has been made against Tau Tea Company's directors and officers. Unless otherwise excluded, the coverage provided under Side A of Tau's directors and officers policy will directly indemnify the directors and officers for resulting claim payments under which of the following conditions?

    A. The directors and officers are found liable to third parties, and Tau is financially unable to indemnify them.

    B. The directors and officers are not found liable to third parties, but Tau is legally required to indemnify them.

    C. The directors and officers are not found liable to third parties, and Tau is financially unable to indemnify them.

    D. The directors and officers are not found liable to third parties, and Tau is not legally liable to indemnify them.

3. Rho Boat Corporation purchases a standard directors and officers policy that includes Side A, B, C, and D coverages. Now that Rho has declared bankruptcy,

    A. courts agree that the proceeds of this policy clearly belong to directors and officers.

    B. courts agree that the proceeds of this policy are the property of the bankruptcy trustee.

    C. it is uncertain whether directors and officers now have access to policy proceeds.

    D. Rho Boat Corporation fails to qualify as an insured for any of the policy's coverages.

4. Because she committed a particular wrongful act in her role as an officer of Theta Co., Amy is required to pay damages to a third party. Theta's directors and officers (D&O) policy includes coverage under Sides A, B, C, and D. However, under applicable state law, Theta Co. cannot indemnify Amy for her loss. Under these circumstances, Amy might

    A. need to absorb a large retention.

    B. receive direct coverage under Side A of Theta's D&O policy.

    C. receive direct coverage under Side B of Theta's D&O policy.

    D. receive indirect coverage under Side B of Theta's D&O policy.

5. Gamma Corporation's directors and officers policy provides Side A and Side B coverage but not Side C or Side D coverage. Allegations clearly covered by the policy are involved in a claim that names individual board members and Gamma Corporation itself as defendants. Under these circumstances,

    A. coverage will be available for the corporation but not for the individual board members.

    B. the insurer will deny the claim.

    C. the insurer will pay the claim in full.

    D. coverage will be available for the individual board members but not for the corporation.

Answers to Chapter 1 Review Questions

1.

A. This answer is incorrect. Side A covers directors and officers when the corporation does not indemnify.

B. That's correct! Side B provides corporate reimbursement coverage.

C. This answer is incorrect. Side C covers the corporation as a defendant in litigation involving securities issued by the corporation.

D. This answer is incorrect. One of the other three insuring agreements provides this desired coverage.

2.

A. That's correct! When directors and officers are found liable to third parties and Tau is financially unable to indemnify them, these circumstances are covered under Side A.

B. This answer is incorrect. Without a finding of liability, there would be no need for indemnity.

C. This answer is incorrect. Without a finding of liability, there would be no need for indemnity.

D. This answer is incorrect. Without a finding of liability, nobody is obligated to indemnify anyone.

3.

A. This answer is incorrect. Court decisions on this issue have been inconsistent.

B. This answer is incorrect. Although some courts have taken this position, other courts disagree.

C. That's correct! There is sometimes uncertainty as to whether directors and officers have access to policy proceeds in the event a company declares bankruptcy.

D. This answer is incorrect. Rho Boat's status as an insured is not affected by its bankruptcy.

4.

A. This answer is incorrect. The applicable coverage involves no retention.

B. That's correct! If the amounts a director or officer is required to pay (because of a particular wrongful act) are not indemnifiable by the company under the applicable state law, coverage may still exist under the D&O policy's Side A coverage.

C. This answer is incorrect. "Direct coverage" is provided elsewhere in the policy.

D. This answer is incorrect. In this scenario, state law precludes payment under Side B.

5.

A. This answer is incorrect. Sides A and B do not cover suits against the corporation.

B. This answer is incorrect. There is some coverage for the claim.

C. This answer is incorrect. Only part of the claim is covered.

D. That's correct! Coverage will be available for the individual board members because Sides A and B, which have been purchased, will cover the individual board members. However, Side C, which would cover the corporation, has not been purchased.

Chapter 2
Covered Acts, Persons, and Organizations under D&O Policies

Overview

This chapter examines the covered acts, covered persons, and covered organizations provisions found within corporate D&O policy forms.

Chapter Objectives

On completion of this chapter, you should be able to

1. in any given situation, identify the persons and organizations covered by a corporate D&O policy;
2. distinguish between acts that are and are not covered by a D&O policy; and
3. recognize situations requiring special handling and identify appropriate methods of handling these situations.

Covered Acts under D&O Policies

D&O policies contain a two-part wrongful act definition. The first part pertains to conduct and the second to status. Customarily, the definition encompasses the following.

1. Any actual or alleged error, misstatement, misleading statement, act, omission, or breach of duty by directors or officers while acting in their individual or collective capacities *as directors or officers*
2. Any matter claimed against them solely by reason of their being directors or officers of the company

No Coverage for Bodily Injury (BI) and Property Damage (PD)

Like most other forms of professional liability insurance (although architects and engineers, medical malpractice, and police professional liability coverages are notable exceptions), D&O coverage is not designed to treat exposures related to BI or PD, an intent reflected in the "wrongful act" definition in the policies. In fact, separate exclusions apply to BI and PD claims in virtually all D&O policies. Rather, the typical covered claims that are made against corporate directors and officers are normally based on allegations that decisions, acts, errors, or omissions of the directors and officers have lowered the value of the company's stock, compromised the company's competitive position in the industry, wasted corporate assets, caused the company to forego a significant opportunity, or otherwise injured stockholders (or others) in an economic or financial sense.

One common exception, or nuance, to this rule is the affirmative coverage for securities claims *arising out of* BI or PD.

No Entity Coverage for Employment Practices Liability (EPL)

The vast majority of public company D&O policy forms have EPL exclusions that bar entity coverage for conduct such as discrimination, wrongful termination, sexual harassment, retaliation, or other inappropriate employment conduct. Entity coverage for these exposures is typically found in either stand-alone EPL policies or some form of management liability package policy. However, many public company D&O liability forms do offer coverage for non-entity EPL exposures, such as when individual directors and officers are named in an employment-related lawsuit.

Up until about 2010, a large percentage of private company D&O policies afforded coverage for EPL claims, and for this reason, private company D&O policies were some of the last to add the EPL exclusion. However, given the eventual widespread addition of the exclusion, claims made under private company D&O policies now involve a much higher percentage of more "traditional" D&O claims (i.e., those involving economic or financial loss).

Covered Persons under D&O Policies

D&O policies are designed to automatically cover any person occupying the position of director or officer (while acting in their capacity as such) without requiring that such individuals be specifically named in the policy declarations. (Note: The corporate charter is usually the source that determines which specific positions are designated as "officers" within a corporation. A person's official title can actually be misleading as to whether or not they are an officer of a corporation. For example, the "chief administrator" of a hospital is virtually always an officer—despite not having the title of "vice president" or "chief executive officer." On the other hand, the literally hundreds of assistant vice presidents at large, national banks are generally not officers of the corporation, despite having the title of "vice president.")

Coverage Only for Acts as a Director/Officer

It should be recognized, however, that directors and officers are covered only for claims that allege wrongdoing while acting in the capacity of a director or officer. Where such acts of misconduct were not performed in such a capacity, claims under a D&O policy are not covered. For instance, often the chief counsel or senior legal person in an organization is also a corporate officer, and, in some instances, this individual sits on the corporation's board of directors. In these situations, D&O policies do not cover such persons for their acts as attorneys (e.g., for liability incurred when drafting a contract or when making a court appearance on the organization's behalf). Rather, such exposures are addressed by specialized policies designed to cover their liabilities incurred as employed lawyers, known as "employed lawyers professional liability insurance." In effect, a D&O policy would only cover the organization's chief counsel for acts that would subject nonattorneys to liability (e.g., voting to approve a merger or acquisition at a board meeting).

"Automatic" Coverage for Newly Created Directors/Officers

Almost no insurers mandate that the parent report newly created director or officer positions. This is because D&O premiums are not based upon the number of covered individuals. (D&O premiums are more closely correlated with an organization's total assets, among other factors.) Accordingly, coverage under D&O forms is said to be "automatic."

Coverage for Nondirectors/Nonofficers

When requested, underwriters will normally agree to broaden the policy to cover corporate managers with high-level responsibilities, as well as other types of employees, despite the fact that they are not technically officers (e.g., the corporate assistant treasurer or human resources manager). Addition of such persons as insureds can usually be accomplished without any additional premium. Such coverage extensions require that these nonofficers be reported to the underwriter. In some organizations, such as hospitals, officer positions are not always denoted by the term "vice president." Thus, a person who is, in

effect, the chief executive officer of a hospital may have the title "chief administrator." Under these circumstances, insureds should be sure that the policy lists, in the declarations, the person or persons for whom coverage is intended to apply.

Coverage of Nondirectors/Nonofficers for Securities Claims

As noted earlier, a number of insurers have added nondirectors/nonofficers as insureds, although only for securities claims. The need to add such persons as insureds stems from the fact that under SOx, in addition to directors and officers, in-house accounting and legal personnel (e.g., auditors, staff attorneys) also can be held liable for a number of wrongful acts, the nature of which is sometimes asserted in lawsuits, most often in those involving securities. For this reason, an increasing number of insurers are adding coverage for nondirectors/officers when they are named in securities-related lawsuits.

Coverage of Past, Present, and Future Directors and Officers

The policies intend to cover persons (only while acting in their capacity as directors or officers) who

- served as directors and officers in the past,
- currently serve, or
- will serve in the future.

Coverage of Past/Retired Directors

Coverage of past personnel is important because claims are routinely made against individuals after they have left the company but who were directors and officers at the time of an alleged wrongful act. Such coverage also ensures the full cooperation of these individuals in defending a claim, which might not be the case if they were not insureds under the policy.

Coverage of Future Directors

By covering future directors and officers, it is made clear that the insurance is not limited only to those holding director and officer positions at the inception of the policy period. This is significant because a claim may be made against an individual director or officer after he or she assumes such a position but before the parent organization has had an opportunity to notify the underwriter to this effect. One final important point: coverage of new directors requires no notification to the insurer within any specific time frame during the policy (other than notification by means of their inclusion within a renewal application).

Coverage of Subsidiary Directors and Officers

D&O liability policies cover individual directors and officers at a number of corporate levels. Accordingly, coverage automatically applies to directors and officers of

- the parent company;
- existing, majority-owned subsidiaries of the parent company; and
- newly created/acquired subsidiaries of the parent.

Directors and officers of the parent company and existing subsidiaries are automatically covered at the inception of the policy. This is because the application normally includes underwriting data pertinent to these individuals, and the premium quoted reflects the exposure they generate.

Typically, policies define the term "subsidiary" as an entity in which the parent company owns more than 50 percent of the outstanding voting stock. However, a few policies contain somewhat more liberal definitions of "subsidiary" and broaden the term to include corporations in which a subsidiary or any entity of the parent company owns 100 percent of the voting stock (even if the parent corporation does not hold a majority interest in the subsidiary).

Coverage of Directors and Officers of Foreign Subsidiaries

The directors and officers of a corporation's foreign subsidiaries do not always have the title of "director" or "officer," despite the fact that their duties, responsibilities, and legal liability exposures are similar, if not identical, to their US counterparts. Accordingly, D&O policy "insured persons" definitions sometimes provide coverage of such individuals who function as directors and officers but whose official titles may not be "director" or "officer." Organizations with foreign personnel who fall within this category should have their D&O policies endorsed accordingly if the policy's definition of "insured persons" does not afford such coverage (under what is known as a "foreign functional equivalents" provision).

Coverage of Estates, Heirs, and Legal Representatives

Virtually all of the policies also cover the estates, heirs, and legal representatives of insureds. A D&O claim is a claim against the personal assets of the individual directors and officers; therefore, such protection will be transferred to the insured's heirs, estates, or trustees if he or she dies, is declared incompetent, or files for bankruptcy.

Spousal Coverage

Insured directors and officers sometimes attempt to shield assets from potential D&O claim judgments by transferring those assets to their spouses. To counter this tactic, plaintiffs' attorneys name spouses in suit papers. Therefore, spouses also require protection under the D&O form, and insurers have responded to this need by extending insured status to the spouses and often significant others of insured directors and officers.

Coverage Applies to Spousal Status, Not to Spousal Acts

It is important to note, however, that spousal coverage does not extend protection for the wrongful act of a spouse of an insured director or officer; rather, such provisions only cover that spouse's liability as a spouse of an insured or because the spouse shares interest in property of an insured director or officer. Thus, there would be no coverage of a spouse who is not a director or officer if he or she were accused of fraud. Coverage would only apply to the nondirector/nonofficer spouse if such an allegation were also made against the spouse (for his or her corporate wrongdoing) who is a director or officer.

Spousal Coverage Definition That Includes "Domestic Partners"

An increasing percentage of insurers' forms contain a spousal coverage definition that covers "... spouses, including 'domestic partners.'" (A domestic partnership is a legal or personal relationship between two individuals who live together and share a common domestic life but are joined by neither a traditional marriage nor a civil union.) Given the increased incidence of such living arrangements, the need to provide this coverage extension has grown over time. Preferred wording, which provides the broadest possible scope of coverage, defines a domestic partner as a person qualifying as such "... under any applicable law of any jurisdiction in the world, or by common or statutory law."

Virtually all insurers cover spouses within their regular definition of "insured persons," meaning that a separate endorsement is not necessary for spousal coverage.

Coverage of Directors and Officers for Outside Activities

Recognizing that corporate directors and officers also sometimes serve on the boards of other organizations, D&O policy forms usually contain provisions designed to provide coverage for these situations, typically in provisions termed "outside position management liability" coverage. It is important to mention that this provision typically applies only when service on such boards is at the direction of the parent organization, although this is not always the case. So, for example, there would be no coverage for a director who sits on the board of his condominium association. Rather, the intent of

such provisions is to cover directors and officers who serve on nonprofit boards, usually as "representatives" of the for-profit corporation on whose board they also serve.

Under the minority of forms that do not cover the exposure from service on outside, nonprofit boards automatically, such coverage can usually be obtained by endorsement.

No Coverage for For-Profit Board Service

Coverage for service on outside boards only applies to nonprofit boards of directors. Coverage for an insured's service on for-profit boards is never provided under D&O policies. This is because service on for-profit boards generates significantly greater exposure to claim frequency and severity compared to service on nonprofit boards.

Triple Excess Coverage Application

When it applies, outside directorship liability coverage does so only on an excess basis. Specifically, such coverage is afforded excess of

1. any insurance coverage proceeds afforded to the director from the outside entity's D&O policy;
2. any indemnification the outside entity provides to the director; and
3. any indemnification provided by the parent organization (i.e., the organization covered by the D&O policy that affords outside position coverage).

"Double" versus "Triple" Excess Coverage

Most D&O forms provide outside directorship coverage only after conditions 1 and 2 above have been satisfied, known as "double excess" coverage. However, there are some forms that provide such coverage only after all three conditions above have been satisfied, known as "triple excess" coverage.

From a practical standpoint, the outside position coverage described above is of relatively little value. This is especially true when provided on a "triple excess basis." Consider the following scenario. The CEO of Company A serves on the board of nonprofit Company B. Company A's policy provides outside directorship liability coverage on a triple excess basis. Before the CEO can receive any proceeds under A's policy, the following three events would first have to transpire.

- Company B's policy limits would have to be exhausted (or coverage not apply);
- Company B would be unable to indemnify the CEO (most likely, due to insolvency); and
- Company A would be unable to indemnify the CEO, again, most likely due to its own insolvency.

Even if coverage were written on a double excess basis, the first two conditions (above) would have to occur. Accordingly, outside directorship liability coverage is usually of little practical value. This is especially true in the (increasingly uncommon) scenario that an insured is covered on a "triple excess basis."

Covered Organizations under D&O Policies

D&O policies cover a corporation's individual directors and officers (Side A) as well as the organization's obligation to indemnify these individuals (Side B). The organization is usually termed the "parent company" under the policy, although, technically, it is not an insured under a D&O form unless the policy also provides entity securities liability coverage (Side C).

Coverage of Newly Created/Acquired Entities

The scope of coverage for the directors and officers of newly created or acquired entities has liberalized significantly over time. Previously, most insurers required notification within 30 to 60 days of acquisition/creation and submission of underwriting data, sometimes imposed coverage restrictions, and frequently charged additional premium. Currently, many insurers afford automatic coverage (i.e., notification not required) if the subsidiary's assets do not exceed 10 to 25 percent (depending on the individual insurer) of the parent company's assets. When an entity is acquired with assets exceeding 25 percent of the parent organization, underwriters generally require notification within 60 days, as well as additional premium, to reflect the increased exposure created by the acquisition. (Absent notification in such instances, no coverage will apply to the new entity.) In contrast, when a new entity falls below the policy's stated asset threshold, no notice is required, other than including the new entity in details provided with the corporation's next renewal application.

Coverage Only Applies to Post-Acquisition/Creation Acts

An important aspect of this provision is that coverage only applies to wrongful acts that took place after acquisition or creation of the new entity. For the policy to cover acts that took place before the acquisition/creation, additional premium is always required. In effect, the automatic nature of the coverage provided by this provision does not apply to "prior acts."

This concept is illustrated below in Exhibit 2.1.

Exhibit 2.1
Application of Coverage for Pre- and Post-Acquisition Acts

Company A acquired Company B on June 1, 2018, at which time Company B became an insured under A's D&O policy. Following the acquisition, two separate claims were made against B, the first of which was not covered and the second of which was covered. This is illustrated below.

Claim #1

Wrongful Act	Acquisition	Claim Made
X	X	X
3/1/18	6/1/18	9/1/18

No coverage applies under Company A's policy because the wrongful act (March 1, 2018) that gave rise to the claim took place *prior to* the acquisition (June 1, 2018). This is despite the fact that the claim was made against Company B (September 1, 2018) *after* the date of the acquisition.

Claim #2

Acquisition	Wrongful Act	Claim Made
X	X	X
6/1/18	8/1/18	9/1/18

Coverage applies under Company A's policy because the wrongful act (August 1, 2018) that gave rise to the claim took place *after* the acquisition (June 1, 2018) and was made against Company B *after* (September 1, 2018) the date of the acquisition.

Automatic Coverage Termination Provisions in Largescale Mergers/Consolidations

Virtually all D&O policies include provisions that immediately turn the policy into "runoff" coverage until the expiration date in the event another company acquires the majority of the insured organization's assets. This allows the insured to report claims for a given amount of time in the event of a merger or consolidation. Provisions of this kind override the normal cancellation notice requirements discussed later in this section of the course.

Coverage Excluded for Wrongful Acts after the Acquisition

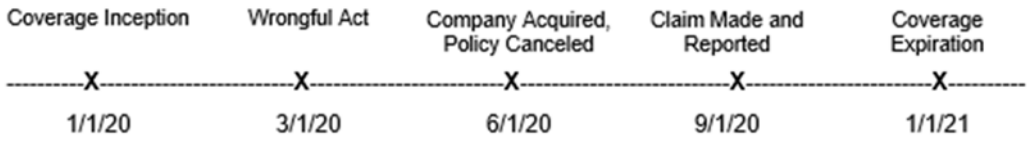
These provisions preclude coverage for wrongful acts taking place after the date of acquisition, which, in theory, is not a problem. This is because coverage should only be required in conjunction with the wrongful acts that took place before the organization ceased to exist. For example, Organization B acquires Organization A, whose D&O policy term is January 1, 2020–2021, on October 1, 2020. Organization A's D&O coverage under the policy automatically terminates with respect to claims from any wrongful act that takes place *after* that date. Accordingly, however, A will still have coverage for wrongful acts that took place *prior* to that date, as long as they are made against the insured and reported to the insurer prior to the end of its current policy period (January 1, 2020–2021). Thus, cancellation of coverage applies only to acts that take place after the acquisition but not to claims made against the insured and reported to the insurer prior to January 1, 2021. In effect, the insured will have extended reporting coverage (a concept discussed in Chapter 9 of this course) as to any acts that took place prior to October 1, 2020, *and* are reported to the insurer prior to January 1, 2021.

As to acts taking place after the acquisition, Organization A will presumably have coverage under Organization B's D&O policy.

These concepts are illustrated below in Exhibit 2.2.

Exhibit 2.2
Application of Change of Control Provision
When Acquired Company's Policy Is Canceled

Company A acquired Company B on June 1, 2020, at which time B's policy was automatically canceled. A claim is made against B on September 1, 2020, that arose from a wrongful act that took place on March 1, 2020, and is also reported to the insurer on that date. Coverage applies to this claim under B's policy because the wrongful act that gave rise to the claim took place during the term of B's policy (March 1, 2020–2021) and before the policy was canceled. This is illustrated below.



Activating a Discovery Provision

Another means to obtain coverage of acts prior to an acquisition would be for the acquired company to activate its D&O policy's discovery provision (also known as an "awareness clause" or "notice of potential claim provision," discussed in more detail in Chapter 9 of this course). Under a discovery provision, coverage will be afforded for any incidents or circumstances that could give rise to a claim (regardless of how far in the future such claims are actually made against the insured), provided the insurer is notified of such incidents prior to policy termination.

Chapter 2 Review Questions

1. Alice Blue is an officer of Aqua Marine Corporation, but her name is not listed in Aqua's directors and officers policy declarations. Therefore,
    A. Alice is covered for any claims alleging wrongful acts.
    B. Alice is covered for all claims related to her association with Aqua Marine but not for personal activities.
    C. Alice is covered for claims that allege wrongdoing in her capacity as a corporate officer.
    D. Alice is not covered.
2. Directors and officers (D&O) policies are intended to cover all the following persons, except
    A. current directors and officers.
    B. deceased directors and officers.
    C. past directors and officers.
    D. directors and officers added after the policy period begins.
3. Rainbow International, Inc., has offices around the world, many of which are staffed by a corporate officer who might or might not have an official title that reflects his or her actual status. To provide appropriate coverage for these officers, Rainbow's directors and officers policy should be endorsed accordingly unless the policy's definition of insured persons includes a(n)
    A. exclusion for officers outside the continental United States.
    B. extraterritorial provision.
    C. foreign functional equivalents provision.
    D. foreign flag waiver.
4. Grownup Toy Company creates a subsidiary known as Child Toy Company. Child's assets equal approximately 40 percent of Grownup's assets. Under the terms of a typical directors and officers policy, Grownup, the parent company,
    A. receives automatic coverage for the new entity with no additional premium.
    B. receives automatic coverage subject to additional premium following a year-end audit.
    C. should notify the underwriter only when completing a renewal application.
    D. should notify the underwriter within 60 days and pay an additional premium.
5. Paper Company's directors and officers (D&O) policy term ran from March 1, 2016, to March 1, 2017. Paper Company acquired Rock Company on August 1, 2016, and Rock's own D&O policy was automatically canceled at that time. A claim was made against Rock on November 1, 2016, on account of a wrongful act on May 1, 2016, that was immediately reported to the insurer. What is the coverage situation with respect to this claim?
    A. Coverage applies under both Paper's policy and Rock's policy, subject to both policies' combined limits.
    B. Coverage applies under Paper's policy.
    C. Coverage applies under Rock's policy.
    D. No coverage applies.

Answers to Chapter 2 Review Questions

1.

A. This answer is incorrect. Coverage applies only to Alice's acts as a corporate officer.

B. This answer is incorrect. Alice may perform business-related acts that have nothing to do with her role as a corporate officer.

C. That's correct! Directors and officers are automatically covered for claims that allege wrongdoing while acting in the capacity of a director or officer.

D. This answer is incorrect. Alice is a covered person.

2.

A. This answer is incorrect. D&O policies are designed to automatically cover any person occupying the position of director or officer.

B. That's correct! Deceased directors and officers are no longer subject to D&O claims. Many policies do, however, cover the estates, heirs, and legal representatives of insureds.

C. This answer is incorrect. D&O policies intend to cover persons who served as directors and officers in the past.

D. This answer is incorrect. Directors and officers need not be identified by name for coverage to apply; moreover, automatic coverage applies to newly created D&O positions.

3.

A. This answer is incorrect. An exclusion would preclude, not provide, coverage.

B. This answer is incorrect. The issue is not where coverage applies (territorially) but to whom it applies.

C. That's correct! A foreign functional equivalents provision provides coverage to foreign personnel who have officers' duties and exposures if not officer titles.

D. This answer is incorrect. Waving the flag of the country one resides in may be a smart move, but this is not something referred to in the definitions of a D&O policy.

4.

A. This answer is incorrect. Underwriters frequently charge an additional premium.

B. This answer is incorrect. Child's assets are too large to qualify Child for automatic coverage.

C. This answer is incorrect. The underwriter should be notified within the time frame specified in the policy.

D. That's correct! When an entity is acquired with assets exceeding 25 percent of the parent organization, underwriters generally require notification within 60 days, as well as additional premium, to reflect the increased exposure created by the acquisition.

5.

A. This answer is incorrect. Only one policy applies.

B. This answer is incorrect. When the wrongful act occurred, Paper's policy did not cover Rock.

C. That's correct! The wrongful act took place during the term of Rock's policy and before the policy was canceled.

D. This answer is incorrect. Unless some other provision precludes coverage, the claim is covered under at least one policy.

Chapter 3
Two Key Definitions: “Claim” and “Damages”

Overview

This chapter analyzes two key definitions included within public company D&O policies: “claim” and “damages.”

Chapter Objectives

On completion of this chapter, you should be able to

1. recognize the types of events that trigger a “claim” under a typical D&O policy,
2. recognize why a broad definition of “claim” is desirable,
3. identify the types of damages covered and not covered by a D&O policy, and
4. recognize the purpose of “most favorable jurisdiction” provisions.

Definition of “Claim”

The manner in which the policies define the term “claim” is an important coverage issue. The broadest possible definition is ideal because such a definition tends to accelerate the trigger of coverage under a D&O policy form, which is usually advantageous from the insured’s standpoint. Although the exact definitions of “claim” vary from policy to policy, the following are events that trigger a “claim” under the typical D&O policy.

Civil Proceeding Commenced by the Service of a Complaint

A civil proceeding commenced by the service of a complaint is actually a type of written demand for monetary or nonmonetary relief.

Criminal Proceeding Commenced by an Indictment

A criminal indictment also triggers coverage under a D&O policy. This is important because, at times, corporate directors and officers are indicted for criminal offenses, prior to the time in which civil complaints are filed against them. (Note: The policies exclude coverage for damages alleged in conjunction with criminal acts. However, the policies state that defense coverage is provided when an insured is criminally charged and that defense coverage continues until “final adjudication,” meaning the point at which the insured director/officer is acquitted, convicted, or pleads guilty, or the claim is settled.)

Administrative or Arbitration Proceeding Against Any Insured Person

Administrative or regulatory agencies frequently file complaints against directors and officers; thus, it is important for such actions to trigger coverage. In addition, requests for arbitration are brought against insureds, often under the terms of a D&O policy, usually in the event of a coverage dispute. (This issue

will be addressed in more detail under the heading of "Arbitration Provisions," discussed in Chapter 7 of this course.)

Civil, Criminal, Administrative, or Regulatory Investigations

Corporate directors and officers frequently find themselves the target of investigations, in addition to having actual claims made against them. Accordingly, it is important that such actions also fall within a D&O policy's definition of "claim." For example, in 2015, the Securities and Exchange Commission (SEC) cited 112 accounting and auditing enforcement actions, showing the extent of investigatory-type action.

Request for Extradition or Arrest Warrant for any Insured Person

Occasionally, legal authorities seek the extradition of a corporate director or officer from a foreign country. Under some, but not all, policy forms, such actions fall within their definitions of "claim."

Not all of the foregoing elements are contained in all D&O policy definitions of the term "claim," especially the last element, that for extradition requests. However, the broader the scope of the definition of "claim" is, the more advantageous for the insured.

Covered Damages/Covered Losses under D&O Policies

D&O policies cover amounts paid as (1) judgments or settlements and (2) expenses incurred in defending or settling an action against the insured directors and officers or covered entity. (The coverage provided by a D&O policy in connection with the defense of suits will be analyzed in Chapter 5 of this course.)

Items Excluded from "Covered Damages" Definition

The following items generally do not fall within the typical D&O policy's definition of "covered damages" or "covered losses": (1) sanctions, (2) taxes, (3) fines, (4) penalties, and (5) matters deemed uninsurable under the law where a D&O claim is made (which usually refers to coverage of punitive damages in jurisdictions where payment of punitive damages by insurance policies is not permitted). This means that even though a company's indemnification agreement permits it to reimburse directors and officers for certain types of damages awarded in conjunction with claims against them (such as punitive damages), the policy does not cover the "items excluded" portion of the company's indemnification obligation.

"Covered Damages" Limited to Payment of Monetary Damages

Standard definitions of "covered damages" and "covered loss" also preclude coverage for injunctive relief, which refers to court orders to perform certain actions or to desist from certain actions (e.g., a court may order a corporation to surrender a piece of land to another corporation or individual to whom the court has ruled the land rightfully belongs). In effect, the definitions of "covered damages" or "covered loss" are limited to the payment of monetary damages.

Coverage of Punitive Damages

Until the mid-1990s, punitive damages were almost universally excluded from coverage under D&O policy forms. There were a number of reasons for this exclusion, one being that reinsurers would not cover punitive damages. In addition, some insurers felt that affording punitive damages coverage defeated their purpose. Since punitive damages were intended to punish an insured for uncommonly egregious conduct, offering insurance coverage allowed an insured to "escape" such punishment (although coverage for punitive damages could, in some instances, be obtained by endorsement and usually required payment of significant additional premium).

However, In January 1995, Executive Re Indemnity introduced a policy containing a definition of the term "loss" that afforded an affirmative grant of coverage for punitive damages, and, shortly thereafter, a number of other insurers began to do likewise. Since that time, nearly all D&O policy forms provide coverage of punitive damages by way of most favorable jurisdiction provisions, to be discussed in more detail below.

State-Specific Prohibitions of Punitive Damages Coverage

Despite provisions granting punitive damages coverage, a number of states, including California, New York, Florida, Pennsylvania, and others, prohibit insurance coverage of punitive damages. Accordingly, even if a D&O policy does not exclude, or even affirmatively covers, punitive damages, these state-specific prohibitions can bar payment of punitive damages. (Note: Policies written in these states do not contain endorsements barring coverage of punitive damages. However, given the laws in these jurisdictions, if the insured were to insist upon payment of punitive damages, the insurer could legally refuse to cover such damages, and the insurer's coverage denial would probably be sustained in the applicable state court.)

Most Favorable Jurisdiction Provisions

Insurers have attempted to circumvent these state-specific prohibitions against coverage of punitive damages by means of what are known as "most favorable jurisdiction" provisions. Nearly all D&O policy forms are written with such a provision. To a great extent, insurers' willingness to cover punitive damages, despite state-specific prohibitions, arose from intense competition in the D&O market beginning in the late 1990s and continuing to this day.

Most favorable jurisdiction wording states that, with respect to the insurability of punitive damages, the law of the jurisdiction most favorable to the insurability of punitive damages will apply, provided the jurisdiction has a "substantial relationship" with the insured, with the insurer, or to the location where the claim is made or occurs. The "substantial relationship" criterion is considered to be met by one of the following: (1) the jurisdiction where the claim for punitive damages was made, (2) the jurisdiction where the act giving rise to the punitive damages award occurred, (3) the jurisdiction where the insured is incorporated or maintains its principal place of business, or (4) the jurisdiction where the insurer is incorporated or maintains its principal place of business.

Two Critical Caveats

First, it is important to recognize that most favorable venue wording merely modifies the existing level of coverage for punitive damages already provided by a D&O policy; it does not provide such coverage if punitive damages are otherwise excluded by a policy form. Nevertheless, if a D&O policy is written with punitive damages coverage, an endorsement providing most favorable venue wording should, of course, be requested, if wording of this kind is not already contained within the policy.

Second, the enforceability of most favorable jurisdiction wording has never been tested in court. Therefore, if an insured requests such an endorsement, no additional premium should be charged, because the actual value of the endorsement may be nil until its legality is tested in court.

When the Endorsement Is Important

Most favorable jurisdiction wording is imperative for the insured when purchasing a D&O policy

- in a state where punitive damages are not insurable and/or
- for insureds that have multistate operations and that therefore cannot predict where the claims seeking punitive damages will be brought against the insured.

Chapter 3 Review Questions

1. On reviewing his corporation's directors and officers policy, Bert Dill is alarmed by the wide range of potential incidents that appear to qualify as claims. In discussing this concern with Ted, the firm's insurance agent, Bert learns that

    A. a broad definition of "claim" creates problems, because minor incidents that fit the definition often go unreported.

    B. a broad definition of "claim" is desirable from the firm's standpoint, because it means the policy covers a broad range of incidents.

    C. the narrower the definition of claim, the broader the coverage.

    D. the narrower the definition of "claim," the more expensive the coverage.

2. Harry Buns, famous owner of a string of indoor tennis courts, has just been indicted on racketeering charges. It is expected that civil complaints will soon be filed. Under the terms of Harry's typical directors and officers (D&O) policy, his insurer will provide defense coverage

    A. for damages in connection with Harry's alleged criminal acts.

    B. from the date a civil complaint is filed until the civil claim is settled.

    C. from the date of the indictment until final adjudication.

    D. only if Harry pleads guilty to the criminal charges.

3. Why is it important to an insured corporation's directors and officers that their directors and officers (D&O) policy include investigations within the policy's definition of "claim"?

    A. A claim usually leads to an investigation.

    B. A more restrictive definition postpones the coverage trigger.

    C. Corporate directors and officers frequently find themselves the target of investigations.

    D. In almost all cases, an investigation leads to an actual claim.

4. A claim against the directors and officers of Worst National Bank (WNB), who were accused of abusive lending practices, is settled when the bank agrees to take the following actions. Which of these actions does WNB's directors and officers insurance most likely cover?

    A. WNB will cease to overcharge future borrowers.

    B. WNB will issue a public apology.

    C. WNB will pay damages to borrowers who were overcharged.

    D. WNB will return property that was wrongfully seized in settlement of a debt.

5. "Our Business Is Picking Up" Waste Disposal Company (OBPU) is based in Pennsylvania, one of the states that prohibits insurance coverage of punitive damages, and it operates in a neighboring state that has no such prohibition. To improve the probability that any directors and officers (D&O) judgment for punitive damages will be paid, the insurer agrees to add a most favorable jurisdiction endorsement to OBPU's policy. The most appropriate charge for this endorsement is

    A. $0.

    B. 10 percent of the normal D&O premium.

    C. twice the normal D&O premium.

    D. set by the states.

Answers to Chapter 3 Review Questions

1.

A. This answer is incorrect. A broad definition is desirable.

B. That's correct! A broad definition results in fewer uncovered incidents.

C. This answer is incorrect. The opposite is true.

D. This answer is incorrect. Because a narrower definition encompasses fewer incidents, if anything, it deserves a lower premium.

2.

A. This answer is incorrect. D&O policies exclude coverage for damages alleged in conjunction with criminal acts.

B. This answer is incorrect. Coverage in this case begins even before the civil complaint is filed.

C. That's correct! A criminal indictment triggers defense coverage under a D&O policy, and defense coverage continues until final adjudication.

D. This answer is incorrect. Any defense coverage that is provided will terminate at the point when Harry enters a guilty plea.

3.

A. This answer is incorrect. An investigation may also lead to a claim.

B. This answer is incorrect. It is generally advantageous from the insured's standpoint to accelerate the coverage trigger.

C. That's correct! Because corporate directors and officers frequently find themselves the target of investigations, in addition to having actual claims filed against them, it is important that investigative actions also fall within a D&O policy's definition of "claim."

D. This answer is incorrect. A director or officer may be the target of an investigation that never leads to an actual claim.

4.

A. This answer is incorrect. This action requires no financial payment.

B. This answer is incorrect. No money changes hands in this case.

C. That's correct! WNB will pay damages to borrowers who were overcharged. Covered damages or covered loss refers to the payment of monetary damages.

D. This answer is incorrect. Coverage is limited to the payment of money damages.

5.

A. That's correct! The actual value of the endorsement may be nil until its legality is tested in court.

B. This answer is incorrect. That's too high a charge for a provision that might not even be enforceable.

C. This answer is incorrect. An endorsement that merely modifies the existing level of coverage should not require twice the normal premium.

D. This answer is incorrect. The states determine whether punitive damages may be covered, but insurers set the rates for coverage.

Chapter 4
Defense Coverage within D&O Policies

Overview

This chapter examines the distinct nature and operation of defense coverage provisions and procedures contained within corporate D&O policies.

Chapter Objectives

On completion of this chapter, you should be able to

1. identify the items a D&O policy includes as covered defense costs,
2. identify the party(ies) responsible for defense costs under various scenarios, and
3. recognize the implications of duty to defend versus non-duty to defend policy language.

Covered Defense Cost Items

D&O policies are very similar regarding the types of items included within the definition of "covered defense costs." Essentially, the policies cover attorney fees and investigation expenses required to defend and settle claims, as well as the costs of bonds (e.g., appeal and attachment bonds) associated with the litigation process.

Salaries of Insureds Are Not Considered "Covered Defense Costs"

The most notable component that the policies specifically exclude from the definition of "covered defense costs," however, is the salaries of directors, officers, and employees of the parent organization. In other words, the policy does not reimburse the parent corporation for the salaries of the directors and officers who are required to spend time working with defense counsel to adjudicate or settle claims. Given the high compensation levels characteristic of insureds under D&O policies, uninsured compensation losses can be substantial. This is especially true considering the complex and time-consuming nature of D&O claims.

Duty To Advance Defense Costs

Historically, D&O policies did not contain language requiring the insurer to reimburse the parent organization for defense costs until a claim had been completely resolved. However, given the substantial expense entailed in defending claims, even large, well-capitalized organizations would prefer to finance the defense of a D&O claim with some degree of insurer assistance. Consequently, nearly all D&O forms contain language making it a duty for the insurer to advance or at least reimburse defense costs as they are incurred.

Duty to advance defense cost provisions typically provide that (1) prior to advancement of such costs, the policy's retention must be satisfied; (2) any costs advanced to the insured will reduce policy limits; and (3) if it is ultimately determined that the insurer has no liability under the policy for the applicable claim, insureds are required to repay the insurer all defense costs that were advanced.

Recoupment of Uncovered Defense Costs

Where the insurer has advanced defense costs, and where the insurer has provided a defense, the issue that often arises is whether the insurer is entitled to partially or completely recoup its defense costs from the insureds—if it turns out that one or all of the claims were not, in fact, covered by the policy. An example of this would be a situation in which an insured director or officer is found guilty of having committed fraud in a criminal trial (acts typically excluded under D&O policies) and the insurer then seeks a return of the monies expended to defend the insured.

Almost all policies are silent as to whether an insurer is allowed to recoup uncovered defense costs that it has already paid on an insured's behalf. Accordingly, any provisions allowing the insurer to recoup such costs from the insured should be vigorously resisted. They obviously not only are detrimental for an insured but also are unusual and should be objected to on that basis, as well.

Barring the Insurer from Enforcing Recoupment

Ideally, wording in a D&O policy would state that the insurer is *barred* from seeking such reimbursement. Of course, this is a favorable approach for the insured. Although it is difficult to negotiate a provision barring an insurer from seeking recoupment of noncovered defense costs, attempts should be made to do so nonetheless.

Common Law Right of Recoupment: The Majority Rule

It appears that a majority of jurisdictions allow insurers to recoup uncovered defense costs even in the absence of language to that effect in the policy, especially where the insurer expressly reserves its right to seek such recoupment in an agreement made prior to advancing the defense costs. They reason that, if the insured does not object to the insurer's reservation of rights in that regard, the insured must have consented to the insurer's right to be repaid if the claims turn out to be not covered.

Some D&O policies now contain express provisions requiring the insureds to repay defense costs if a court decides that any part of them were not covered. The D&O policy at issue in *Protection Strategies, Inc. v. Starr Indem.& Liab. Co.,* (Fourth Circuit US Court of Appeals, May 27, 2015) provides an example of such a reimbursement provision.

> [i]n the event and to the extent that the Insureds shall not be entitled to payment of such Loss under the terms and conditions of this policy, such payments by the Insurer *shall be repaid to the Insurer* by the Insureds. [As cited by Leagle, Inc., emphasis added.]

No Common Law Right of Recoupment: The Minority Rule

A growing number of jurisdictions disagree with the majority rule. They read the insurer's duty to provide a defense to be more absolute. They hold that, absent language *in the policy itself* explicitly granting the insurer a right of recoupment, the insured is not required to repay defense costs even where the insurer provides a defense to the claim under a reservation of rights letter.

Duty To Defend versus Non-Duty To Defend Language

D&O policies for larger, more legalistically sophisticated insured organizations are most often written on a "non-duty to defend" (also sometimes called a "duty to pay") basis. In contrast, smaller insureds that do not have the experience or time to become closely involved in the complexities of D&O litigation generally opt for what are known as "duty to defend" policies. Insureds can usually choose between a "duty to defend" and a "non-duty to defend"/"duty to pay" form. Almost all nonprofit and private company policies are written on a duty to defend basis, while the vast majority of public company policies are written on a non-duty to defend basis.

The phrase "duty to defend" in a D&O policy expressly states that the insurer has the duty to defend any claim alleging a covered act under the policy. In contrast, other policies state that the insurer has "no duty to defend" the insured; rather, such forms indicate that "it is the duty of the insured to defend claims." Such forms only compel the insurer to pay the defense costs in connection with the insured's executing the defense of the claims.

Who Controls Defense and Settlement?

Two of the important differences between a "non-duty to defend" and a "duty to defend" policy involve (1) the right to choose defense counsel and (2) the right to control the defense of the claim. Under a "duty to defend" policy, unless specifically negotiated otherwise in the policy, the insurer has the right to choose defense counsel. In addition, under a "duty to defend" policy, the insurer typically has the absolute, unfettered right to control the defense strategy of the claim, including settlement.

Conversely, under a "non-duty to defend" policy, the insured is able to use any lawyer of its choice, subject to insurer approval (although the consent to settlement provisions of such policies state that approval will not be "unreasonably withheld"). In addition, the policyholder has the right to control the defense strategy and settlement of the claim. Accordingly, the policyholder would, for example, have the option of settling a claim (although it typically may not settle without first obtaining the insurer's consent; again, the policies state that such consent will not be "unreasonably withheld") or, on the other hand, taking it to trial.

Pros and Cons of Duty To Defend versus Duty To Pay Policies

In many instances, a duty to defend provision may benefit an insured, despite the fact that the provision reduces the extent to which the insured can exert control over the claims handling process. This is especially true if the company is inexperienced in managing the complexities of D&O litigation. On the other hand, firms that are more familiar with the details of the D&O claims handling process may prefer a D&O policy containing duty to pay/non-duty to defend language. (This is also true because there is typically no difference in cost between these two kinds of policies.) In short, the selection of duty to defend/non-duty to defend language is an organization-specific issue.

One significant benefit of duty to defend forms, as opposed to non-duty to defend policies, is availability of so-called all-allegations defense coverage under the former. Under a duty to defend policy, the insurer is obligated to defend *all* of the allegations in a lawsuit, as long as the policy covers at least one such allegation.

The following scenario illustrates this point. A former employee with 20 years of service is terminated by Company A immediately after the company imposes a widespread layoff. The layoff was precipitated by the fact that Company A has just purchased a competitor, Company B, resulting in a duplication of staff. Consequently, 10 percent of both companies' workforces are let go. The former employee, who also holds a significant amount of Company A stock, brings a lawsuit against A, alleging that (1) Company A paid too much for Company B, thus diminishing the value of her shares of stock in Company A; and (2) Company A illegally terminated her.

Although both damages and defense costs arising from the first allegation are covered by a standard D&O policy form (under Coverage C, because the claim involves the securities of the company) the wrongful termination allegation is excluded. However, under a duty to defend policy, since coverage exists for the first allegation, the insurer must also defend the wrongful termination claim (although it would not be liable for any potential damages associated with it). In contrast, under a non-duty to defend policy, the insurer would only be obligated to pay the costs of defending (and indemnifying) the insured for the first but not the second allegation.

Defense Procedures under Non-Duty To Defend Forms

Despite the fact that a policy is written on a non-duty to defend basis, a D&O insurer does, however, retain a certain amount of control over the handling of suits brought against its insureds. For instance, almost all of the policies contain what are known as cooperation clauses, which give the insurer the right to associate with the parent company and insured directors and officers in defending and negotiating the settlement of claims, even when those policies are written on a non-duty to defend basis.

However, under non-duty to defend policies, if the insured is able to settle a claim within the policy's retention, no insurer consent is generally required. In addition, the policies require insureds to provide the insurer with ongoing information concerning the details of the settlement process.

Exhibit 4.1 compares the features of duty to defend with non-duty to defend policies.

Exhibit 4.1
Duty To Defend versus Non-Duty To Defend Policies: A Comparison

	Duty To Defend	Non-Duty To Defend
Counsel Selection	Insurer	Insured (usually with insurer approval)
Control of Defense Process	Insurer	Insured (in consultation with insurer)
All-Allegations Defense Coverage?	Yes	No
Unilateral Ability To Settle Claims within Retention?	No	Usually requires consent

Chapter 4 Review Questions

1. Timeless Watch Company's directors and officers (D&O) policy had a $1 million limit and a $100,000 retention when it was presented with a D&O claim for which the policy appeared to provide coverage. Once Timeless's legal bills exceeded $100,000, the insurer advanced additional funds to support further defense costs. The insurer had advanced $75,000 in defense costs before it became clear that the insurer had no liability for this particular claim under the terms of its policy. What happens to the money spent on Timeless's defense?

    A. The insurer will give Timeless an additional $100,000 to reimburse the retention amount.

    B. Timeless must return $75,000 to the insurer.

    C. Timeless must return $100,000 to the insurer.

    D. Timeless will keep the $75,000 and use it to pay defense costs in excess of the retention.

2. Robert is concerned what might happen if an insurer unsuccessfully defends claims against a director that ultimately turn out to involve criminal acts or some other activity not covered by the directors and officers (D&O) policy. Robert is afraid the insurer would then seek to recover its defense costs from the corporation. In such a situation, the most favorable wording in a D&O policy would

    A. allow the insurer to recoup uncovered defense costs.

    B. bar the insurer from seeking reimbursement.

    C. be silent as to whether the insurer can seek reimbursement.

    D. require the insurer to seek reimbursement.

3. Selfie Camera Company has a directors and officers (D&O) policy with duty to defend language, which specifies who has the right to choose defense counsel and the right to control the defense of the claim. Therefore, if Selfie faces a D&O claim,

    A. Selfie will choose the defense counsel and control the defense of the claim.

    B. Selfie will choose the defense counsel, and the insurer will control the defense of the claim.

    C. The insurer will choose the defense counsel and control the defense of the claim.

    D. The insurer will choose the defense counsel, and Selfie will control the defense of the claim.

4. A significant benefit of duty to defend forms is that

    A. The insurer must defend all allegations in a lawsuit as long as at least one allegation is covered.

    B. The insurer must defend only the allegations that would be covered by the policy.

    C. The insurer is not obligated to defend the lawsuit unless all allegations would be covered by the policy

    D. The insured must defend all allegations, and the insurer will reimburse the insured for those allegations for which the insured is legally liable.

5. Under non-duty to defend directors and officers policies, an insured
    A. may settle a claim within the retention without the insurer's consent.
    B. may settle a claim within limits without involving the insurer.
    C. avoids any need to keep the insurer informed of the details of the settlement process.
    D. must use the insurer's defense attorneys.

Answers to Chapter 4 Review Questions

1.

A. This answer is incorrect. Timeless retains $100,000 in any case.

B. That's correct! Since it was determined that the insurer had no liability under the policy for the applicable claim, the insured is required to repay the insurer all defense costs that were advanced.

C. This answer is incorrect. The insurer did not spend $100,000 in defending Timeless. Timeless already incurred that expense using its own funds.

D. This answer is incorrect. This answer would be correct if it had been determined that the claim was covered, but in this case, it turned out that the insurer had no liability.

2.

A. This answer is incorrect. This is exactly what Robert wishes to avoid.

B. That's correct! Ideal wording in a D&O policy would state that the insurer is barred from seeking such reimbursement.

C. This answer is incorrect. A majority of jurisdictions allow insurers to recoup uncovered defense costs, even in the absence of policy language addressing this issue.

D. This answer is incorrect. Some D&O policies include a reimbursement provision of this type, which clearly is not favorable to the insured.

3.

A. This answer is incorrect. Selfie will not control the defense of the claim.

B. This answer is incorrect. Selfie will not choose the defense counsel.

C. That's correct! Unless specifically negotiated otherwise in the policy, the insurer has the right to choose defense counsel and typically also has the absolute, unfettered right to control the defense strategy of the claim.

D. This answer is incorrect. The insurer will control the defense of the claim.

4.

A. That's correct! The availability of the so-called "all-allegations defense coverage in duty to defend forms is a benefit of these forms as opposed to non-duty to defend forms.

B. This answer is incorrect. The insurer must defend all allegations as long as at least one allegation is covered.

C. This answer is incorrect. The insurer must defend all allegations as long as at least one allegation is covered

D. This answer is incorrect. The insurer must defend all allegations as long as at least one allegation is covered.

5.

A. That's correct! No insurer consent is generally required if the insured is able to settle a claim within the policy's retention.

B. This answer is incorrect. The insurer does retain a certain amount of control over the handling of suits brought against its insured.

C. This answer is incorrect. Policies require insureds to provide the insurer with ongoing information concerning the details of the settlement process.

D. This answer is incorrect. The insured may use any lawyer of its choice.

Chapter 5
Limits and Retentions under D&O Policies

Overview

Chapter 5 explains the manner in which limits and retention/deductible provisions apply within public company D&O policies.

Chapter Objectives

On completion of this chapter, you should be able to

1. recognize the relationships among limits and retentions (deductibles) provisions in corporate D&O policies; and
2. given relevant information concerning a covered D&O claim, identify the amount payable by the insurer and/or the insured.

Policy Limits

D&O policies are customarily written subject to an aggregate limit applying to losses paid under any one of the policy's insuring agreements: (1) coverage for directors/officers (Side A), (2) corporate reimbursement coverage (Side B), (3) coverage for entity securities claims (Side C), and (4) derivative investigation coverage (Side D), if applicable. In effect, the policy limit will be applied in any combination to one or more claims that are covered by one or more of these insuring agreements. Therefore, when buying D&O insurance, an insured purchases a policy with a single, aggregate limit that may be applied to claims falling within the coverage scope of all four insuring agreements.

Limits under "Packaged" or "Management Liability" Policies

A number of D&O policies (especially those written to cover privately held and nonprofit firms) are written in a "packaged" format (and are also known as "management liability policies"). Such policies also cover EPL and fiduciary liability claims. Most "package policies" afford a separate limit for each of these three exposures, while a handful are written with an aggregate limit for D&O, EPL, and fiduciary liability claims (as is the case with for-profit D&O forms).

Defense Costs within Limits

D&O insurance policies include defense costs within the policy limits, meaning that the expenditure of defense costs reduces the policy's limit of liability. (This approach contrasts with that used under commercial general liability (CGL) policies, under which defense costs do not reduce available policy limits.) Since many D&O suits involve highly complex areas of commercial and civil law, they are among the most expensive legal actions to defend. Consequently, limits should be selected not only to cover potential judgments and settlements but also in consideration of high, anticipated defense costs, as well.

Internal Insurer Claim Management Costs Do Not Reduce Policy Limits

Although the costs incurred by outside counsel engaged to defend claims made against insureds reduce policy limits, this is not the case with respect to the insurer's internal claim handling costs required to manage a claim. For example, although an insurer's claim department will review a claim, analyze coverage and liability aspects, and collaborate with and monitor the activities of outside counsel in conjunction with that claim, the implicit costs of the insurer's claim personnel will not reduce policy limits.

Lack of Coverage for First-Dollar Defense

It should also be noted that D&O policies do not afford first-dollar defense coverage. For example, even if a claim were to involve only defense costs (and no judgment or settlement amount were payable), the insured would nevertheless be required to absorb the amount of the policy's retention before the insurer would indemnify or pay defense costs on the insured's behalf.

Exhaustion of Limits Terminates Duty To Defend

Another point to recognize is that virtually all D&O policies state that, once limits have been exhausted by any combination of claim payments and defense expenditures, the insurer's duty to defend any claims against the insured ceases.

Importantly, clauses of this type apply only to situations where actual claim *payments*—rather than *reserves* set aside for pending claims—have exceeded limits.

Related Claims Provisions

Related claims provisions, also known as "interrelated claims" or "interrelated acts" provisions, apply to situations in which more than one claim results from a single wrongful act or a series of related wrongful acts.

These provisions usually state that (1) the insured receives the protection provided by the limit of coverage applicable when the *first* claim was made, rather than the *sum* of the limits that were applicable to the policy periods during which all the claims were made; and (2) only one deductible/retention applies to all the claims (a point that will be further discussed in the following pages).

An Example

Assume that on July 1, 2018, an insured officer commits a wrongful act. Three separate claims are made against the insured (in conjunction with the act) on November 1, 2018; November 1, 2019; and November 1, 2020, respectively. Also assume that a $5 million policy was in effect on the date the first claim was made and that two separate $5 million policies were also in effect on the dates the second and third claims were made. Under a related claims provision, the $5 million limit of coverage available on November 1, 2018 (i.e., the date on which the *first* policy was in effect and the *first* claim was made), is the total amount that will be available to cover *all three* claims. This is because all three claims arose from the same wrongful act. In effect, the purpose of the related claims provision is to prevent a "stacking" of policy limits.

Additionally, despite the fact that three separate claims have been made, only one self-insured retention will apply to all three claims.

Potential Bad Faith and Policy Limits Issues under Duty To Defend Policies

Whenever a policy is written with defense costs included in the limit of liability, there are potential bad faith issues for insurers to consider. For example, assume that a D&O policy is written with a $2 million limit. A corporation receives a $1 million demand. Three years later, if the insurer has already expended $1.5 million in defending the claim, the insurer would be unable to settle the claim within the policy's

limits, despite the fact that the claimant's initial demand was only $1 million (i.e., the $1 million demand plus the $1.5 million already expended on defense equals $2.5 million, which exceeds the $2 million policy limit).

Note: In the above example, the insurer might, in theory, still be able to settle the claim for, say, $500,000 or prevail with no damages award at all—thus remaining within policy limits. Such outcomes are unlikely, however.

These kinds of "shrinking limit" situations (where defense costs reduce policy limits) place a responsibility on insurers covering insureds on a duty to defend basis to keep insureds continually advised of current defense expenditure amounts so that strategic settlement decisions can be effectively made and potential bad faith claims avoided. (Normally, insurers provide insureds with quarterly statements as to defense monies expended on any given claim. In the event that insureds are not furnished with such information, they should request it from their insurer.)

Of course, under non-duty to defend policies, in which insureds control the defense process (and are therefore aware of all billings submitted to the insurer), the argument could be made that insureds are already cognizant of the extent to which policy limits have been reduced. Therefore, shrinking limits issues are less problematic under non-duty to defend policies, compared to situations in which coverage is written on a duty to defend basis.

Retentions

The corporate reimbursement coverage (Side B) and the entity securities coverage (Side C) provided by a D&O policy are subject to retentions. Direct coverage for directors and officers (Side A) and derivative investigation coverage (Side D) are typically not subject to retentions. This is, of course, advantageous for the individual directors and officers.

Retentions in Multiple Claim Situations

It is common for a single wrongful act to produce a number of claims (i.e., by different claimants). Without a policy provision to the contrary, this may cause retentions to "stack" on each other. To illustrate, if Side B of a D&O liability policy has a $500,000 per claim retention, and a single wrongful act leads to claims filed by three different persons against the insureds, the parent company could retain as much as $1.5 million of the loss payments and defense costs. To prevent such situations, anti-stacking clauses indicating that only one retention applies per wrongful act are included in virtually all D&O policies.

Even in the absence of an anti-stacking provision, nearly all courts have held that, if one or more interrelated causes are found to have resulted in all of the injuries or damages claimed, there is but one loss for the purpose of determining the applicability of retentions. Accordingly, even if a policy did not contain an anti-stacking provision, as a matter of common practice, a single retention would be applied if one wrongful act produced multiple claims (as in the example in the preceding paragraph).

Chapter 5 Review Questions

1. Pyramid Builders has a directors and officers policy that includes Coverages A, B, C, and D. What type of policy limit(s) will this policy contain?

    A. A dollar limit for Coverage A and smaller Coverage B, C, and D limits expressed as percentage of the Coverage A limit

    B. A per occurrence limit but no aggregate limit(s)

    C. A single aggregate dollar limit that applies to all four coverages

    D. The same dollar limit that applies separately to each coverage

2. EuroKay Company has a directors and officers (D&O) policy with a $1 million limit. Its insurer has spent $400,000 worth of staff time to date in defending EuroKay's first D&O claim and expects to eventually prevail. Should it lose, the amount of coverage currently available to pay covered damages is

    A. $400,000.

    B. $600,000.

    C. $1 million.

    D. $1.6 million.

3. Golden Slipper Company's directors and officers (D&O) policy has a $1 million limit and a $100,000 deductible. A series of complex D&O claims against Golden Slipper have been difficult and costly to defend. To date, Golden Slipper has paid $100,000 in defense costs and damages, and the insurer has paid $300,000 in defense costs and $200,000 in damages. The insurer has just set aside $500,000 in reserves to cover the cost of claims that are still pending. At this time,

    A. because its limits have been exhausted, the insurer has no further duty to defend Golden Slipper against D&O claims.

    B. the insurer has a duty to defend Golden Slipper until it has paid another $800,000 in damages.

    C. the insurer still has a duty to defend pending D&O claims against Golden Slipper.

    D. the policy limits are automatically increased by 25 percent.

4. Klutz Company has a directors and officers (D&O) policy with a $1 million limit and a $100,000 retention. Sixty thousand dollars in legal expenses were incurred in successfully defending its first D&O claim, and no damages were awarded to the claimant. The insurer will pay

    A. nothing.

    B. $30,000.

    C. $60,000.

    D. $100,000.

5. OpenYd Dental Supply Company has been increasing the limits on its directors and officers (D&O) policy every year. The initial policy had a $1 million limit, the second year's policy had a $2 million limit, the third policy had a $3 million limit, and the fourth policy had a $4 million limit. OpenYd has not yet settled the three D&O claims incurred since the first policy's inception. All three claims are based on a director's wrongful act during the first policy year, but the claims were not made until the second, the third, and the fourth policy year. (A separate claim was made each year.) According to the D&O policy's interrelated claims provision, what is the maximum total amount of coverage available to pay those three claims?

    A. $1 million

    B. $2 million

    C. $9 million

    D. $10 million

Answers to Chapter 5 Review Questions

1.

A. This answer is incorrect. Coverage B, C, and D limits are not expressed as a percentage of the Coverage A limit.

B. This answer is incorrect. The policy does include at least one aggregate limit.

C. That's correct! The policy has a single, aggregate limit that may be applied to claims falling within the coverage scope of all four insuring agreements.

D. This answer is incorrect. The limit does not separately apply to each coverage.

2.

A. This answer is incorrect. More than $400,000 remains available to pay covered damages.

B. This answer is incorrect. The insurer's internal claims handling costs do not reduce policy limits.

C. That's correct! The implicit costs of the insurer's claims personnel will not erode policy limits.

D. This answer is incorrect. The policy has a $1 million limit.

3.

A. This answer is incorrect. The limits have not been exhausted by actual claim payments.

B. This answer is incorrect. By the time it pays another $800,000 in damages, the insurer will have paid out much more than the policy's $1 million limit.

C. That's correct! The insurer's duty to defend does not cease until it has actually paid $1 million in damages and defense costs. Reserves don't count.

D. This answer is incorrect. Claims do not automatically increase the policy limit.

4.

A. That's correct! The insured is required to absorb the amount of the policy's retention before the insurer would indemnify or pay defense costs on the insured's behalf.

B. This answer is incorrect. The insured and the insurer do not split defense costs 50/50.

C. This answer is incorrect. Defense costs are less than the retention.

D. This answer is incorrect. One hundred thousand dollars is the retention amount, not the amount spent on this claim.

5.

A. This answer is incorrect. The amount of coverage available does not depend on the limit of coverage in force when the wrongful act took place.

B. That's correct! The insured receives the protection provided by the limit of coverage applicable during year 2 when the first claim was made.

C. This answer is incorrect. Nine million dollars is the sum of limits available during years 2, 3, and 4 combined, but these limits may not be stacked.

D. This answer is incorrect. The $1 million limit available during the year when the wrongful act occurred should not be considered.

Chapter 6
Conditions in D&O Policies

Overview

Chapter 6 addresses the conditions provisions universally found in D&O forms, which include severability, cancellation, subrogation, other insurance, arbitration, priority of payments, and presumptive indemnification provisions.

Chapter Objectives

On completion of this chapter, you should be able to evaluate the following types of conditions in D&O forms and determine whether a given provision is favorable or unfavorable to the insured:

1. severability,
2. cancellation,
3. subrogation,
4. other insurance,
5. arbitration,
6. priority of payments, and
7. presumptive indemnification.

Severability

In a D&O policy, the term "severability" means that either (1) the application for D&O coverage or (2) the exclusions within a policy apply individually to each insured, as if a separate contract of insurance were in place.

Typically, a D&O policy contains two separate severability provisions: one applying to the application and the other pertaining to the policy's exclusions.

Application Severability versus Severability of Exclusions

If, in a claim situation, an exclusion applies to one insured due to some action on the part of that insured, severability operates so that coverage is not barred as respects other insureds. For example, if an officer commits fraud and, along with him, the firm's other directors and officers are sued, the policy's fraud/dishonesty exclusion would not apply—coverage would be available—to the so-called innocent insureds. (Note: Severability provisions usually apply only to a D&O policy's conduct-related exclusions such as illegal personal profit and fraud/dishonesty and are discussed in more detail in Chapter 7.)

Similarly, assume that one director knew the application for coverage contained a material misstatement (e.g., the director knew that the company's financial statements contained intentionally inflated earnings data). This knowledge would negate coverage for that particular director. However, a severability provision stating that such knowledge was not imputable to other directors or officers would preserve coverage for these nonculpable insured persons in the event they were sued in conjunction with the misstatement within the application.

In effect, severability, as to the exclusions or the application, creates a *separate* policy and a *separate* application, respectively, so that the actions of one insured do not defeat coverage for another, innocent insured.

Why Has Severability Become Important?

Severability provisions have become increasingly important because a significant percentage of claims against insured directors and officers have involved both so-called white hat (i.e., nonculpable insureds who did not commit fraud) and black hat insureds (i.e., culpable insureds who did commit fraud).

It has become commonplace for claims to be made against persons who were guilty of willful conduct in causing claims—along with those who were innocent of any intentional wrongdoing. Usually, it is outside directors who are unaware of the fraud committed by the officers who run the company's day-to-day operations. However, absent severability of both the application for coverage and policy exclusions, coverage could otherwise be denied to these innocent insureds, since the wrongful knowledge/conduct of culpable insureds could be imputed to the innocent insureds.

Directors and Officers Should Review Applications

Although the Enron case presents the most notable example of the black hat/white hat dichotomy, many other less publicized cases have also involved intentional, wrongful conduct by some insureds occurring on a parallel basis with that of other nonculpable insureds. Even where severability provisions appear in both D&O policy forms and applications (which is usually the case), it should be an established procedure within all organizations that every insured director or officer be given a copy of the application with instructions to review it carefully so that any errors contained therein, which a plaintiff's attorney could construe as fraudulent, intentionally made statements, can be corrected.

The Two Types of Application Severability

There are two types of severability provisions found within D&O application forms: limited severability and full severability.

Limited Severability

Under a "limited" severability provision, severability will apply, and coverage will be available to the other, "innocent" insureds, unless (1) the person who signed the application had knowledge of the false application statement or (2) one of certain designated executive officers (typically the CEO or CFO) had knowledge of the false statement. Accordingly, knowledge of the false statement by the signer of the application and/or the CEO or CFO will be imputed to all insureds, and they will have no coverage. A minority of insurers' applications contain limited severability provisions, and such provisions are becoming increasingly unusual.

Full Severability

Under a "full" severability provision, which is the majority approach, knowledge of either the signer of the application or certain executive officers, such as the CEO or CFO, is not imputed to any other insureds, and, thus, such innocent persons will have coverage despite the false statement or knowledge about the false statement by such other persons.

It should be recognized, however, that a "fully severable" policy is not the same as a "nonrescindable" policy. "Full severability" should not be confused with provisions barring an insurer from rescinding a policy based upon material, fraudulent statements in an application.

An Instructive Case

Cutter & Buck, Inc. v. Genesis Ins. Co., 306 F. Supp. 2d 988 (2004), demonstrates the importance of the severability provision within a D&O application. For fiscal year 2000, Cutter & Buck's CFO accounted for a number of product "shipments" as "sales," despite the fact that distributors returned the goods in 2001. This, of course, materially overstated the company's actual revenues. In 2002, when the firm's new CFO discovered these fraudulent accounting practices, she ordered an investigation that ultimately required the company to restate its financials. A number of shareholder lawsuits against the company's directors and officers followed. Genesis Insurance Company responded by rescinding coverage, asserting that the insured CFO, who was also the signer of the D&O application and eventually pled guilty to fraud, had misrepresented material facts on the application.

The application's severability provision stated that knowledge possessed by one insured was not imputable to other insureds. *But there was one critical exception*: knowledge possessed by a signer of the application was imputable to innocent insureds, which was exactly what transpired in this situation.

The judge found that Genesis was correct in rescinding coverage on this basis. Here, the wording of the application's severability provision did not bar Genesis from rescinding coverage for all of Cutter & Buck's directors and officers because the knowledge of the CFO—who signed the application—could be imputed to others, including innocent directors and officers.

The bottom line is that severability is not just an issue for the giants of the business world. Rather, it is important for firms of all sizes to carefully address severability provisions when arranging their D&O coverage.

Cancellation

D&O policies have similar cancellation provisions, normally permitting immediate cancellation by the named insured with no advance notice. Under these circumstances, premium is returned on a short-rate basis (i.e., pro rata unearned premium, less 10 percent). If the insurer cancels, unearned premium is returned to the insured on a pro rata basis, although most policies only allow for insurer cancellation in the event of nonpayment of premium.

In the event that the insurer cancels, 30 days is usually the minimum notice period that policies require insurers to provide insureds. Note that 10 days' notice by the insurer is the minimum notice period in two situations:

- nonpayment of premium or
- failure to reimburse deductible amounts.

Although a majority of forms include cancellation notice provisions of 30 days, some insurers (i.e., most of the insurers providing coverage on admitted forms) have state amendatory endorsements attached to their policies that extend cancellation notice periods to 60 days. Alternatively, some insurers' policies include "regular" cancellation notice provisions as long as 60 days.

Noncancelable Policies with Nonrenewal Notice Requirements

Over time, D&O policies have trended toward more liberalized cancellation provisions. That is, a number of forms are written on a noncancelable basis (except that cancellation is permitted for nonpayment of premium) and with provisions requiring the insurer to provide up to 60 days' prior notice of its intention not to renew the policy.

Subrogation

Virtually all D&O liability policies contain similarly worded subrogation provisions. The policies mandate the insureds' cooperation in recovering from third parties that were responsible for causing a claim to be made against the insureds. Such provisions reinforce the fact that the insureds are not permitted to prejudice the insurer's potential rights of recovery against parties responsible for causing a loss.

Other Insurance

"Other insurance" clauses in D&O forms state that if other insurance is available, the D&O liability policy shall serve as excess insurance. A common exception is when the other D&O liability policy is specifically scheduled as excess of the policy in question.

The purpose of an "other insurance" clause is to prevent an insured from profiting as a result of a loss by collecting payment from more than one insurer. "Other insurance" clauses also preclude an insurer from profiting by escaping payment of a claim it rightfully insured.

Arbitration Provisions

A significant number of D&O forms contain provisions requiring coverage disputes between the insured and the insurer be submitted to binding arbitration, rather than allowing either party to resort to the legal system to redress the dispute. (This is known as a "mandatory" arbitration provision, although a minority of forms affords insureds the option, but not the obligation, to submit coverage disputes to arbitration.) The effect of this provision is to expedite resolution of coverage-related controversies, given the long delays inherent in the conventional US judicial process. Also important is the fact that arbitration typically reduces the cost of settling such disputes compared to utilizing the traditional court system.

Why Arbitration Favors the Insurer

Although the mandatory arbitration provision benefits both the insurer and the insured for these reasons, arbitration probably affords greater benefit to the insurer. This is because it is generally believed that arbitrators are less biased against insurance companies than are judges and juries, as evidenced by the rare incidence of astronomical arbitration awards against insurers, compared to the occasional "runaway verdict" rendered by juries.

Furthermore, insurers regularly hire arbitrators because insurers are repeatedly involved in coverage disputes. Given their continuing need for the services of arbitrators, over time, insurers are in a position to hire arbitrators "more selectively," so that eventually they begin hiring arbitrators whose previous decisions have tended to favor them. Conversely, insureds, given the rarity of their participation in the arbitration process, are not in a position to select arbitrators whose prior decisions have appeared to favor their interests. This is yet another reason why arbitration tends to favor insurers.

Check Arbitration Provisions Carefully

Although insureds should not anticipate becoming embroiled in a claim dispute with their D&O insurer, the possibility is far from remote. In fact, the 2012 Towers Watson Directors and Officers Liability Survey revealed that 21 percent of organizations were dissatisfied with their insurers' D&O claim handling services, indicating the possibility of resulting coverage disputes.

Given the reality of potential coverage disputes with a D&O insurer, it is wise for insureds to carefully check the dispute resolution provisions in D&O policies. Following are the points that demand particular scrutiny in any arbitration provision.

Mandatory or Optional?

Is arbitration mandatory in all instances, subject to demand by either party? Or, can it be entered into only at the election of the policyholder? The latter is the more favorable version for an insured, since there may be situations in which counsel for the insured does not feel that arbitration is the ideal forum for resolving a dispute. In other words, the best provisions from the insured's standpoint are those giving the insured the option but not the obligation to submit a coverage dispute to arbitration.

Preconditions to Arbitration

Do the provisions require that the insured first submit disputes to nonbinding mediation in an attempt to reach an agreement? Most do not, but some forms contain such a requirement. The problem with this approach is that, assuming each party pays its own costs, the (usually) stronger financial position of the insurer may have the effect of "wearing down" the insured, thus compelling a settlement prior to arbitration, which is not in the insured's best interests.

Binding or Not?

Are the results of the arbitration binding? Under most policies, but not all, arbitration is binding. Whether this is to the insured's or the insurer's advantage depends on the outcome of the arbitration and the facts underlying the dispute.

Venue

Does the provision state the venue in which the arbitration must take place? If so, does it favor the insurer, or does it make arbitration burdensome to the policyholder? Under some policy forms, for example, an insured may be required to appear at an arbitration in the United Kingdom, a situation that would clearly put a US insured at a disadvantage.

Controlling Law

Is the controlling law stipulated? Again, assuming the insured is an American corporation, US law in a specifically enumerated state should control the arbitration proceedings rather than the law of a country outside the United States.

Panel Composition

Is the approach for selecting the arbitration panel reasonable? Usually, the provisions call for each participant to appoint one arbitrator, both of whom choose an umpire. Sometimes there is a change from this, whereby restrictions are placed on the background and experience of the arbitrators, and these could work to the advantage of one of the parties, usually the insurer that drafted it.

Costs

How are the costs of arbitration allocated between the parties? Usually, each side must pay its own costs. Provisions requiring the insureds to pay the insurers' costs in addition to their own are to be avoided.

Given the chance that an insured will, at some time, be engaged in a claim dispute with its D&O insurer, insureds (or their representatives) should carefully analyze these points and, if any appear onerous, attempt to negotiate more favorable wording.

Priority of Payments Provision

When a corporation files a bankruptcy petition, it creates an "estate," which includes all of the property interests of the debtor corporation at the time the bankruptcy proceeding commences. One of the critical questions in such situations is whether the proceeds of a D&O policy should be treated as a part of the bankruptcy estate or whether those proceeds are the property of the individual insured directors and officers. If such proceeds are considered property of the estate, they will be subject to the bankruptcy court's jurisdiction and may not be available to pay the defense costs of the directors and officers.

Why the Provision Is Important

This issue was addressed in the bankruptcy case of World Health Alternatives, Inc., decided on June 8, 2007. In the decision, the judge ruled that the bankruptcy trustee "could not prevent the company's former directors and officers from using the D & O policy proceeds to settle claims against them," as reported by Kevin LaCroix in his June 17, 2007, post in *The D&O Diary* titled "Bankruptcy and D & O Claims Settlements."

However, not all cases, and especially not all applicable policies, are alike, meaning that the above decision does not guarantee director and officer access to D&O proceeds in all future bankruptcy scenarios. Accordingly, it is advantageous for a D&O policy to include a priority of payments provision that specifically states that such proceeds are the property of the directors and officers. A typical priority of payments provision states that payment will first be made under Coverage A (D&O liability), then under Coverage B (corporate reimbursement), and lastly, under Coverage C (entity securities). This is in keeping with the concept that the primary purpose of D&O coverage is protection for individual directors and officers, then for the corporate entity, and finally, for "other interests" such as a bankruptcy trustee.

Limitations of Priority of Payments Provisions

Priorities of payments provisions are helpful but far from ironclad. Although insureds should insist that they be included in a D&O policy, such provisions cannot be completely relied on. For one thing, federal statutes govern bankruptcy law, whereas state law is used to interpret insurance policies. Since federal law takes precedence over state law, a bankruptcy court could decide to ignore a priority of payments endorsement. Furthermore, the validity of priority of payments provisions remains legally unclear, despite the fact that they do favor the interest of insureds over those of bankruptcy trustees.

Presumptive Indemnification Provision

As noted under the "retentions" heading earlier in this course, the typical D&O policy includes a substantial self-insured retention for corporate reimbursement (Side B) coverage and entity securities (Side C) and no retention for direct (Side A) and derivative investigation (Side D) D&O coverage.

Why the Presumptive Indemnification Provision Was Introduced

At one time, corporations attempted to avoid paying the Side B retention by simply electing not to indemnify the insured directors and officers, thereby forcing the insurer to provide first dollar coverage for the directors and officers under Side A of the policy.

In response, insurers placed "presumptive indemnification" provisions in D&O policies, stating that, for the purpose of determining whether a claim is subject to the retention, the corporation will be deemed to have indemnified its directors and officers to the fullest extent permitted by law, regardless of whether the corporation does, in fact, indemnify the directors and officers.

When the Provision Does Not Apply

It is important to recognize, however, that presumptive indemnification clauses typically do not apply when insolvency prevents the corporation from meeting its indemnity obligations. Accordingly, one might think that directors and officers will also enjoy virtual first dollar coverage when the corporation has filed for bankruptcy, which, in fact, may not necessarily be the case. Rather, there are times when a currently solvent company will file for bankruptcy to forestall a potential risk of future insolvency. As a result, if a corporation files for bankruptcy but is not actually insolvent, an insurer could argue that the presumptive indemnification clause requires the insureds to assume liability for the self-insured retention.

Given this possibility, when negotiating the wording of a D&O policy (especially if there is a significant possibility of a future bankruptcy filing), the corporation should ask the insurer to use language that eliminates the presumption of indemnification on filing of bankruptcy, as well as when the corporation is insolvent.

Chapter 6 Review Questions

1. Severability provisions are important to claims against insured directors and officers that involve both white hat and black hat insureds. In connection with the directors and officers (D&O) claims against the Hollow Wienie Company, which of the following would be considered a black hat insured?

    A. Samantha Stephens, the corporate treasurer who cooked the books

    B. Frank Furter, Hollow Wienie's CEO who signed off on the financial reports but did not know they were fraudulent

    C. Hilda Broom, pilot of the corporate aircraft that transported board members

    D. Holly Moses, the personnel vice president who hired Samantha Stephens

2. Careful reading of J-Fly Company's directors and officers (D&O) policy suggests that, no matter how innocent he or she might be, no director or officer of the company is entitled to protection under the policy if the CEO or CFO knows that the insurance application contains false statements. Based on this information, it appears that J-Fly's D&O policy has

    A. a broad severability provision.

    B. a full severability provision.

    C. a limited severability provision.

    D. no severability provision.

3. A typical directors and officers (D&O) policy includes provisions that

    A. clarify the policy's relationship with other insurance and require cooperation with the insurer's subrogation efforts.

    B. permit other D&O insurance but prohibit subrogation.

    C. permit subrogation but prohibit other D&O insurance.

    D. prohibit subrogation by the insurer and prohibit other insurance covering the same exposures.

4. When comparing arbitration provisions in directors and officers policies from the standpoint of the insured,

    A. the insured should preferably pay all arbitration costs.

    B. mandatory arbitration is preferable to optional arbitration.

    C. restrictions on the composition of the arbitration panel usually favor the insurer.

    D. the venue in which the arbitration must take place is not a relevant factor.

5. Mustard Gas and Oil Company is financially stressed, possibly even headed for bankruptcy, due to competition from its major competitor, Ketchup Petroleum. Mustard is currently negotiating with its insurer over the wording of its directors and officers policy. Given Mustard's current financial situation, Mustard should attempt to negotiate contract language that

    A. eliminates the presumption of indemnification if Mustard becomes insolvent or files for bankruptcy.

    B. eliminates the presumption of indemnification if Mustard becomes insolvent but is silent on the possibility of a bankruptcy.

    C. includes a presumption of indemnification if Mustard becomes insolvent or files for bankruptcy.

    D. includes a presumption of indemnification if Mustard declares bankruptcy but does not address the possibility of Mustard's insolvency.

Answers to Chapter 6 Review Questions

1.

A. That's correct! Samantha committed the fraud.

B. This answer is incorrect. Although Frank can be held legally responsible for the financial reports, he did not commit any fraudulent acts.

C. This answer is incorrect. Hilda probably is not even an insured under the D&O policy.

D. This answer is incorrect. Unless she was a coconspirator with Samantha, Holly is guilty only of a mistake in hiring.

2.

A. This answer is incorrect. The two types of severability provisions are limited and full.

B. This answer is incorrect. Under a full severability provision, knowledge of either the application's signer or certain executive officers is not imputed to any other insureds, so innocent persons will have coverage despite a false statement or knowledge about a false statement.

C. That's correct! Under a "limited" severability provision, severability will apply and coverage will be available to the other, "innocent" insureds, unless (1) the person who signed the application had knowledge of the false application statement or (2) one of certain designated executive officers (typically the CEO or CFO) had knowledge of the false statement.

D. This answer is incorrect. The information described here is found in a severability provision.

3.

A. That's correct! Other insurance clauses state that the policy provides excess coverage (subject to one exception) and require the insured to cooperate with the insurer's third-party recovery attempts.

B. This answer is incorrect. Virtually all D&O policies permit subrogation.

C. This answer is incorrect. D&O policies usually specify that they are excess over other available insurance.

D. This answer is incorrect. These policies require the insured to cooperate with the insurer that pursues its subrogation rights.

4.

A. This answer is incorrect. Provisions requiring the insureds to pay insurers' costs in addition to their own should be avoided.

B. This answer is incorrect. Arbitration only at the election of the policyholder is the more favorable version for an insured.

C. That's correct! Restrictions on the background and experience of the arbitrators usually work to the advantage of the insurer that drafted the restrictions in the policy.

D. This answer is incorrect. Requiring arbitration proceedings in some distant location could be unduly burdensome to the policyholder.

5.

A. That’s correct! Because there is a significant possibility of a future bankruptcy filing, the corporation should ask the insurer to use language that eliminates the presumption of indemnification on filing of bankruptcy, as well as when the corporation is insolvent.

B. This answer is incorrect. The possibility of bankruptcy should also be addressed.

C. This answer is incorrect. Mustard should avoid the presumption of indemnification.

D. This answer is incorrect. The policy language should anticipate the possibilities of both bankruptcy and insolvency.

Chapter 7
Exclusions in D&O Policies

Overview

Chapter 7 examines the exclusions found within corporate D&O policies.

Chapter Objectives

On completion of this chapter, you should be able to

1. identify the types of exclusions commonly found in D&O policies,
2. identify the effect of common D&O exclusions, and
3. recognize the implications of variations in the wording of common D&O exclusions in a given situation.

Exclusions are incorporated into D&O liability policies in one of two ways: (1) They are contained within the policy form, or (2) they are added to the policy by endorsement. Both types of exclusions can have a significant effect on the scope of coverage the policies provide. Since D&O policies vary more in their exclusionary language than in any other coverage aspect, it is necessary to examine the exclusions carefully.

It is also important to note that the exclusions in a D&O form are not always contained in the policy section titled "Exclusions." They may also be contained within definitions (e.g., "loss" defined to exclude fines and penalties) as well as in the conditions section.

D&O Forms Containing Multiple Sets of Exclusions

A minority of D&O policies incorporate as many as three sets of exclusions: one set applicable to the corporate reimbursement section of the policy, a second set applicable to the coverage for directors and officers, and a third set applicable to the policy's entity securities coverage section.

It should be recognized that a corporation's bylaws and state statutes governing corporate reimbursement plans impose many of the same restrictions found in the D&O coverage exclusions. For this reason, these exclusions do not always need to be included in the set of exclusions that pertain to the corporate reimbursement coverage section. As a result, a number of D&O policies contain only a single set of exclusions that apply to the corporate reimbursement, D&O, and entity securities coverage sections (i.e., Coverages A, B, and C).

Severability Provisions in Policy Exclusions

As discussed earlier, by virtue of what are known as severability provisions, the actions of one director or officer are not normally imputed to any other directors or officers. For example, assume that a claim alleges that a group of directors and officers committed dishonest acts. If only one of these individuals was, in fact, proven guilty of the dishonesty, based upon the severability provision applying to the policy's exclusions, the innocent directors/officers would not be barred from having defense coverage available for the claim. This is because the provision states that the dishonest acts of the guilty director/officer will not be imputed to the innocent director(s) to bar coverage for these individuals.

Severability provisions are also sometimes referred to as “innocent director” or “nonimputation” clauses. (The concept of severability regarding statements made in connection with the application for a D&O policy was examined earlier in this course.)

Exclusions for Which Severability Provisions Usually Apply

Insurers typically include severability provisions with respect to the following exclusions.

- Fraud/dishonesty/conduct
- Personal profit
- Illegal payments and gratuities
- “Short swing” profits
- Return of remuneration
- Other insurance

Care should be taken to verify that severability provisions also apply to any similar kinds of exclusions that may be added to the D&O policy by endorsement.

The following pages will discuss these specific exclusions.

- Claims caused by director/officer fraud/dishonesty
- Personal profit exclusion
- Illegal payments and gratuities exclusion
- Exclusion of claims under Section 16(b) of the 1934 SEC Act (“Short Swing” Profits)
- Exclusions relating to various corporate activities
- Return of remuneration exclusion
- Prior and pending litigation exclusion
- Exclusion of losses covered by a prior policy
- Insured versus insured exclusion
- Failure to maintain insurance exclusion
- Wage and hour claim exclusion
- Employee Retirement Income Security Act (ERISA) liability exclusion
- BI/PD/personal injury (PI) exclusion
- Pollution exclusion
- Inadequate consideration (“bump up”) exclusion
- Professional services exclusion

Exclusion of Claims Caused by Dishonesty of Directors and Officers

Insuring people for their individual liability arising out of intentionally committed illegal acts is not permitted as a matter of public policy. Accordingly, D&O policies exclude coverage for dishonest, fraudulent, malicious, and criminal acts committed by insured directors and officers.

"Final Adjudication" versus "In Fact" Wording

There are two versions of the dishonesty exclusion in D&O policies. The first requires a "final adjudication" before it can be applied. This version is viewed as being more favorable to the insured because it implies that the claim has reached a definite conclusion (i.e., a settlement or a judgment).

The second version requires that the dishonesty be established "in fact," which sets up a lower standard of proof compared to the first version. This is because it does not specify that the claim has reached a final outcome.

In addition, there is a certain degree of ambiguity associated with "in fact" language compared to the "final adjudication" version of this exclusion. More specifically, if "in fact" means something less than a "final adjudication," how and when does the insurer establish that the misconduct precluded by the exclusions occurred "in fact"?

- Upon testimony or document production during the discovery phase of litigation?
- Through facts uncovered by the insurer during its own investigation?
- At trial, where, arguably, facts are established for the first time through admitted evidence?

A final problem associated with "in fact" language is the question of who determines when dishonest conduct has "in fact" occurred. Although not specified in the policy language, one insurer that has used "in fact" wording for many years has, in the past, advised its policyholders that it would not unilaterally apply these exclusions. Rather, it would seek the intervention of a third party, such as an arbitrator, to decide whether the misconduct had "in fact" taken place.

In short, given these ambiguities, "final adjudication" wording is much more favorable for the insured, compared to "in fact" wording, and should always be preferred when comparing the wording of the dishonesty exclusion. And for this reason, the use of "in fact" wording has become rarer in D&O policies over time.

Coverage for Defense

By inference, the wording of the dishonesty exclusion indicates that the D&O policy covers the cost of a successful defense against charges of dishonest conduct on the part of a director or officer. In addition, defense and indemnity coverage is available if a settlement is made without admission of liability (which is typically the case in settlement agreement language). The availability of defense coverage in these instances is critical because the majority of claim allegations made against insured directors and officers contain specific charges that dishonest conduct was responsible for causing a loss.

"Final Adjudication" Wording in Conduct Exclusions May Not Always Be Advantageous

Traditionally, and as already discussed, "final adjudication" wording is considered preferable for the insured. However, there are some occasions in which this may not be the case, such as when an insured director or officer pleads guilty to certain charges, but a D&O policy continues to provide defense because the case has not actually reached "final adjudication" yet. In a situation like this, other less culpable directors and officers are faced with a "shrinking limits" problem while defense is provided for a presumably guilty director.

Personal Profit Exclusion

Another exposure considered uninsurable involves claims that directors or officers have gained illegal personal profit or advantage to which they were not entitled. For example, an outside director may also be the owner or major stockholder of a firm that is bidding on a contract proposal offered by the parent organization. If the director's company wins the bid because it was proven that the director was privy to the bids submitted by competitor firms, a claim of illegal personal profit could be made, and if a lawsuit were filed as a result, the director would not have coverage.

"In Fact" Wording Is Preferable

The most favorable versions of this exclusion state that coverage for illegal personal profit is excluded, but only if an insured gained such profit "in fact." The implication is that the policy covers defense coverage to allegations of personal profit until it is factually established that the insured gained illegal personal profit.

Full Severability Usually—But Not Always—Applies to the Personal Profit Exclusion

In *TIG Specialty Ins. Co. v. Pinkmonkey.com, Inc.,* 375 F.3d 365 (5th Cir. 2004), the CEO personally profited from the wrongful sale of stock. However, the personal profit exclusion applied whenever "an insured" personally profited from the alleged wrongful conduct. The court held that, under such wording, coverage was precluded for all insureds, not just the culpable CEO. (It should be recognized that such severability language is unusual, although insurers do occasionally use it.)

On the other hand, had the exclusion been worded so that it applied only when "the insured" personally profited from wrongful conduct, it is likely that the court would have ruled differently, that except for the culpable CEO, coverage would apply to the other, "innocent" insureds. The lesson for insureds is that they should avoid severability language in conduct exclusions that precludes coverage when "an insured" is guilty of wrongful conduct. Instead, they should request language precluding coverage only when "the insured" has committed such acts. Language of this kind will then allow the severability provision to function as intended, whereby "innocent insureds" will not lose coverage.

Avoid "Any Willful Violation of Law" Wording

A significant minority of D&O policies contain a personal profit exclusion that is worded so that it *also* eliminates coverage for claims alleging "… any willful violation of law…."

The problem with the addition of "… any willful violation of law …" wording to the personal profit exclusion is that a number of actions by insureds may be considered willful violations of a law and yet still not give rise to criminal liability. Therefore, insureds could find themselves excluded from coverage for *civil* liability (arising, for example, from certain types of civil fraud), due to an exclusion intended to apply to *criminal* acts.

A number of industry experts believe that "any willful violation of law" wording is not a problem for the insured, provided the policy contains an exception—and thus coverage—if a final adjudication proves the insured's innocence, which most forms do. But implicit within the exception is that final adjudication is reached only *after* a trial, meaning there cannot be a covered settlement, despite the fact that only civil, rather than criminal, charges have been brought against the insured. So even with the exception, an insured will only have coverage for defense costs—but not for a settlement. Thus, even with the final adjudication exception, "any willful violation of law" wording still reduces the extent of coverage because it compels the insured to litigate, rather than settle, to obtain any insurer reimbursement. Furthermore, final adjudication wording could still bar coverage for *appeals* that result after what was originally deemed a "final" adjudication. "Final and non-appealable" wording, or similar phrasing, is more favorable for insureds.

For these reasons, and in light of the fact that only a minority of insurers use such language, insureds should negotiate to have "any willful violation of law" wording removed if it appears within their D&O policy.

Illegal Payments and Gratuities Exclusion

This exclusion is sometimes called the "payments and commissions" exclusion. It excludes claims relating to the insured's receiving or making payments that are prohibited by law.

The exclusion originated as a result of the Foreign Corrupt Practices Act of 1977, which prohibits bribes, political contributions, gratuities, and other payments to foreign or domestic officials. The Act was passed as a result of SEC investigations in the mid-1970s. Ultimately, these investigations revealed that more than 400 US corporations admitted making questionable or illegal payments in excess of $300 million to foreign government officials, politicians, and political parties. The abuses were widespread and included such acts as bribery of high foreign officials to obtain various forms of favorable action or consideration by a foreign government, as well as so-called facilitating payments made to ensure that government officials performed certain accounting and bookkeeping duties that were essential to the completion of various business deals.

However, it should be emphasized that the exclusion prohibits coverage not only for illegal payments in conjunction with the Foreign Corrupt Practices Act of 1977 but also as respects any other applicable laws.

The exclusion is typically incorporated in the text of the policy forms and is normally subject to severability provisions. Thus, if a claim of having arranged illegal payments were made against five directors and officers, but only one had actually done so, defense coverage would apply to the four innocent insureds.

Exclusion of Claims under Section 16(b) of the 1934 SEC Act ("Short Swing" Profits)

Profits made from the director or officer's personal sale of stock in his or her own company, if the stock has been held for less than 6 months (referred to as "short swing" profits), are prohibited by the Securities Exchange Act of 1934. Virtually all D&O policies exclude coverage of claims alleging violation of this rule. However, insurers usually provide coverage of defense costs when allegations of Securities Exchange Act of 1934 violations are successfully defended.

Exclusions Relating to Certain Corporate Activities

Related to exclusions pertaining to "short swing" profits are those sometimes imposed for other, specified corporate activities. In most instances, such exclusions find their way into policies by means of standard or manuscript endorsements, rather than via standard policy wording. However, in some unusual instances, these restrictions are also included within regular policy form wording. Either way, they can eliminate coverage for significant D&O exposures. Following are several of the most important types of such exclusions.

Claims from Going Private/Leveraged Buyouts

During periods of high private equity activity, such restrictions can easily find their way into D&O policies. This is especially true, since stockholders frequently allege conflicts of interest and self-dealing in claims associated with private buyouts. (In private buyouts, private equity firms purchase the shares and ultimately gain control of publicly held companies. The private equity group eventually resells the company later, hopefully for a higher price per share than the one for which it was originally acquired on the public market.)

Claims from Mergers and Acquisitions

Although these transactions do not involve a private buyout, they nevertheless create the distinct possibility that stockholders of the acquired firm will allege that they were insufficiently compensated for their shares by the acquiring firm as a part of the merger or acquisition.

Claims from Initial Public Offerings (IPOs)

Claims associated with IPOs are most often made by purchasers of the newly public shares who assert that the offering prospectus did not present a true picture of the company. Accordingly, D&O forms written for private companies (which are discussed later in this course) should be checked carefully for any restrictions or exclusions relating to claims from IPOs, since, during a policy period but well after having signed an application for coverage indicating no plan to do so, the company could decide to float a public offering of its shares. Policy forms should also be checked carefully with regard to "road show" coverage, applying to situations in which a company "tours" in order to get in front of potential investors and/or other interested parties and garner interest before an IPO.

Claims from Joint Ventures or Partnerships

At times, corporations will operate a joint venture or partnership with another organization for a short-term, time-limited business purpose. Underwriters sometimes preclude coverage for joint ventures by means of "insured" definitions within their policy form. Accordingly, such definitions should be checked and consideration given to negotiating to include the joint venture or partnership as an insured under the policy.

Although additional premium may be required to remove these types of restrictions and exclusions, it may be well worth the cost, given the high claim potential inherent in such circumstances.

Return of Remuneration Exclusion

Most D&O policy forms exclude coverage for monies paid to a director or officer without stockholders' approval. However, some D&O policies incorporate an important exception to this exclusion by making it apply only when a court has held remuneration to be illegal. If possible, the exclusion should contain wording to this effect, which would make defense coverage available until an allegation of illegal remuneration is actually proven.

Origins of the Return of Remuneration Exclusion

Originally, the exclusion of illegal remuneration was not commonly found in D&O forms since, under SEC rules, the compensation paid to directors or officers was not subject to shareholder approval. However, concern about excessive compensation of management commencing in the early 1990s has prompted a change in SEC rules, which now permit greater shareholder involvement in the setting of compensation for top executives.

This, again, is an exclusion to which severability applies in almost all policies.

Prior and Pending Litigation

Nearly all D&O policy forms exclude claims arising from litigation that was pending prior to the inception of the policy or was pending prior to the policy's "prior and pending litigation date" (a date that is normally included on the declarations page of the policy or added by endorsement). The intent of this exclusion is to avoid insuring the so-called burning building, whereby the insurer must cover claims from events that were lacking in fortuity and that sometimes provide the incentive for an insured to obtain coverage.

How the Prior and Pending Litigation Exclusion Applies

A prior and pending litigation exclusion would apply if litigation against a corporation—rather than individual directors and officers—was pending prior to the inception of a D&O policy. If the lawsuit is amended after inception of the policy, so that it now names the organization's directors and officers, the prior and pending litigation exclusion would preclude coverage for the amended version of the claim.

An Example

On July 1, 2020, a borrower on whose home XYZ Bank has foreclosed files a lawsuit alleging breach of contract against the bank. The suit alleges that the bank misrepresented the actual terms of the loan when the closing papers were signed, because the papers failed to state explicitly that after 2 years, the interest rate would jump from 3 percent to 12 percent. (Note that a D&O policy would not cover a breach of contract lawsuit against the bank because Coverage C, entity coverage, applies only to claims involving the securities of the insured corporation, or shares of the bank's stock in this example.) On January 1, 2021, the borrower amends the lawsuit to also name the bank's directors and officers. (In contrast, this claim would be covered, because coverage applies under Coverages A or B for any cause of action.) A week after receiving the suit papers, the directors and officers file the claim with their D&O insurer under their January 1, 2021–January 1, 2022, policy. However, if the bank's January 1, 2021–January 1, 2022, policy contained a prior and pending litigation exclusion, coverage will be denied since the claim arose out of a lawsuit that was pending prior to the inception of that policy (i.e., the "original" breach of contract lawsuit was filed on July 1, 2020).

Modifying the Prior and Pending Litigation Exclusion

Often, insurers will agree to modify the prior and pending litigation exclusion so that it only applies to litigation pending prior to the inception date of the present insurer's first D&O policy. Given this modification, any litigation originally initiated during the present insurer's stream of protection will not be excluded. This is a reasonably negotiable item and can usually be achieved without additional premium. This modification can be accomplished by having the policy's "prior and pending litigation date" be the same as the inception date of the current insurer's first D&O policy. Using the example in the above paragraph, if the insurer first began writing coverage for the insured on January 1, 2020, and the prior and pending litigation date on the policy was also January 1, 2020, the prior and pending litigation exclusion would not bar coverage for the claim, since the original litigation was not pending prior to January 1, 2020. On the other hand, if the prior and pending litigation date on the January 1, 2021–2022 policy described above was January 1, 2021, no coverage would have applied since the litigation actually began on July 1, 2020. As a general rule, from the insured's standpoint, the prior and pending litigation date should be as early in time as possible.

Removing the Exclusion in Renewal Policies

Insureds should also attempt to have the prior and pending litigation exclusion removed in renewal policies. The purpose of the exclusion is to avoid having the insurer cover situations that the insured knew or suspected would eventually result in a claim against the corporation's directors and officers. Accordingly, after the policy has been in force for a year, this possibility is greatly reduced if such a claim has not yet been made. Thus, at the first renewal, the insured should request that the prior and pending litigation exclusion be removed.

Exclusion of Losses Insured by a Prior Policy

Most D&O forms contain exclusions precluding coverage for claims that have already been reported under prior policies, written either by the current insurer or by a previous insurer. Such exclusions are necessary to prevent insureds from reporting a claim—for the second time—under current policies with higher limits or broader coverage provisions than those in prior years, when claims were previously reported.

For example, an insured reported a claim during the term of Insurer A's policy (January 1, 2020–2021). The policy's limit was $5 million. For the January 1, 2021–2022, term, the insured purchased a policy containing a $10 million limit from Insurer B. This exclusion prevents the insured from obtaining coverage under a policy with a higher limit (i.e., $10 million) by reporting the same claim to Insurer B if, for instance, the claim turned out to require more than Insurer A's $5 million limit.

Insured versus Insured Exclusion

Insured versus insured exclusions preclude coverage for claims made by one insured under a D&O policy against another. An example of an insured versus insured claim (that would be excluded) is one in which corporate director "A" sues corporate director "B" because of a bad business proposition that "B" advised the company to pursue, such as urging the acquisition of a subsidiary that eventually produced a significant loss for the company.

Rationales for the Exclusion

There are several rationales for the insured versus insured exclusion in D&O policy forms.

No Intent To Cover Recoupment for Bad Business Decisions

The insured versus insured exclusion was originally introduced in the 1980s, when Bank of America began suing a number of its loan officers for losses caused by imprudent extensions of credit. In response to these lawsuits, the officers then sought coverage under Bank of America's D&O liability policy. However, the bank's insurer did not intend for the policy to function as an indemnification vehicle for bad business decisions. (Insurers viewed such claims as affording coverage for "business risk," rather than for professional negligence). So in response, D&O insurers began inserting insured versus insured exclusions within their policy forms (a practice that was later extended to other kinds of professional and management liability policy forms).

Other, More Specific Insurance Coverage Available

Since many insureds also purchase stand-alone EPL coverage (or buy EPL coverage within a management liability package policy), D&O liability insurers feel that employment-related claims by one insured against another (which, for example, would preclude coverage if a CEO who is terminated sues the other directors and officers) are more appropriately covered by policies designed expressly to cover employment-related liability risks.

No Coverage Intended for "Infighting"

Yet another rationale for not covering claims made by one insured person against another is that, at times, such lawsuits are the result of "infighting" by one insured against another. For example, in an attempt to force a director to resign because of a personality conflict, the other directors sue him for negligence, alleging that he does not contribute adequately at board meetings.

Key Exception Wording

Despite the rationales for excluding claims by one insured against another, the policies contain "exception wording," which has the effect of providing coverage for certain kinds of claims in which one insured sues another insured. Under the following circumstances noted below, most but not all D&O policies "except," and therefore cover, the following claim situations.

Derivative Actions

These actions are brought by one or more stockholders on behalf of the corporation. Any recovery in a derivative suit inures to the benefit of the corporation itself as opposed to the individual shareholders who institute the action (i.e., the proceeds of a successful derivative suit are paid to the corporation). If, for example, a director or officer were to bring a derivative suit, the insured versus insured exclusion would not apply to the claim, and coverage for the claim would be available.

Employment-Related Claims

Claims by one director/officer against another are not excluded if they involve employment-related matters. For example, if an officer of a corporation sues the other officers and directors, alleging that he was wrongfully terminated, the exception to the insured versus insured exclusion would provide coverage for the officers and directors sued by the terminated director. Despite this exception, however, coverage may not always apply. This is because the majority of public company D&O policy forms contain an exclusion of coverage for employment-related claims. (The exclusion is discussed later in this chapter.)

Claims for Contribution or Indemnity

This refers to a situation in which one director or officer is sued and then, by means of another lawsuit, attempts to have other directors and officers contribute monies for his or her defense and/or payment of the claim. Most versions of the insured versus insured exclusion except coverage for these types of situations.

Claims by Bankruptcy Trustees

Bankruptcy trustees frequently make claims against directors and officers. And because bankruptcy trustees should not be considered insureds under D&O policies, most policy forms cover claims brought by bankruptcy trustees by "excepting" them from the insured versus insured exclusion.

Claims by Past Insureds

This refers to claims made by persons who have not served as a director or officer for a period of at least 5 years (provided they are not bringing the claim with the assistance of or at the urging of a person who is currently serving as a director or officer). Given the 5-year time lapse, such claims are rarely motivated by either collusion or infighting and are therefore excepted from the insured versus insured exclusion.

Claims Brought Outside the United States

The most frequent situation in which this exception applies, and coverage is afforded, would be a claim brought by a director or officer of a foreign subsidiary and filed outside the United States against the company's US directors and officers.

Whistleblower Claims

Suits brought by insureds based on any protected activity specified in a "whistleblower" law also fall within one of the exceptions to the insured versus insured exclusion and are thus covered. For example, if an insured director reported illegal activity under the whistleblower provision of the Dodd-Frank Act and was later sued by other directors and officers, coverage of the claim would still apply.

Failure To Maintain Insurance

A number of D&O policies contain an exclusion of claims alleging loss due to the failure of directors and officers to maintain property and liability insurance coverage. The following scenario illustrates the way in which a "failure to maintain insurance" exclusion could come into play in a claim situation. Assume that an organization with a large insured property schedule either has inadvertently omitted an individual property from the schedule or perhaps does not have the correct scope of property insurance coverage on this singular location (e.g., there is no coverage for flood on a given manufacturing plant). The property suffers damage and is not insured, resulting in financial loss to the organization. This loss leads to litigation alleging director/officer negligence in managing the corporation's insurance program. If the D&O policy contained a failure to maintain insurance exclusion, the D&O insurer would likely deny the claim. In fact, taken literally, the D&O insurer could deny almost any claim for which there would be insurance available, somewhere, and at some price. Since most exposures are at least somewhat insurable somewhere and for some price, the vagueness of the language of the exclusion and the eagerness of many D&O insurers to deny claims are reasons for concern regarding this language.

Katrina Disaster Underscores the Dangers of Failure To Insure Exclusions

If there were ever a time when an insured would not want a failure to maintain insurance exclusion in a D&O policy, it would be in the aftermath of a natural disaster such as Hurricane Katrina. Firms with substantial operations in the affected area were almost certain to suffer considerable PD and business interruption losses—even if insurance coverage was in place—given deductibles/retentions, coinsurance provisions, and valuation clauses that produce less than full replacement cost recoveries.

For any firms that lacked flood coverage or had inadequate or no property and/or business income policies at the time of the hurricane, lawsuits by investors could allege managerial negligence in failing to obtain appropriate coverage. Under these circumstances, a failure to maintain insurance exclusion in a D&O form could prove problematic.

Removing the Exclusion

Given the problems this exclusion could generate, insureds should present the D&O insurer with a complete schedule of insurance coverage, along with a discussion of the corporation's risk management program. Based on this material, the insured will be in a better position to negotiate the removal of the exclusion.

Exclusions for Insurance-Related Operations

A few versions of the failure to maintain insurance exclusion also contain restrictions on claims involving the insured's involvement with risk-bearing operations such as captive insurance companies and risk retention groups. Both for-profit and nonprofit organizations sometimes band together with firms in similar industries and form such risk-bearing entities. Separate coverage is required for such operations.

Employment-Related Claims Exclusion

At one time, public company D&O policies did not exclude coverage for employment-related claims such as wrongful termination, discrimination, sexual harassment, and retaliation (although they did not affirmatively cover such claims). In fact, some D&O insurers offered endorsements that specifically covered EPL exposures.

Since that time, D&O insurers have been moving away from EPL coverage extensions and toward exclusions for employment-related acts. This trend has been prompted by the fact that businesses are now likely to seek more expansive protection for these exposures under a stand-alone EPL insurance policy. Furthermore, a significant minority of public company D&O insurers have begun offering packaged

policies to their insureds, which contain separate insuring agreements for addressing EPL exposures (along with separate insuring agreements for fiduciary and, increasingly for cyber and privacy exposures).

Accordingly, insurers have added exclusions for employment-related acts within their public company D&O forms, given the fact that most insureds have obtained EPL coverage either by means of a stand-alone form or a package policy.

Wage and Hour Claims Exclusion

Most D&O policies exclude coverage for wage and hour claims. Such claims most commonly arise from an employer's alleged failure to pay overtime to employees it should have treated as nonexempt (i.e., not exempt from and thus eligible to receive overtime pay). All employees are either "exempt" or "nonexempt." Although those terms have many implications, the most important is that exempt employees (e.g., mainly professional staff employed on a salaried basis, as well as outside salespersons) need not be paid overtime. Wage and hour claims most often occur when an employee complains about not getting paid overtime to an attorney who then, after the interview, realizes that he or she may have a six-figure class action claim on his or her hands.

The exclusion of wage and hour claims first became an issue of urgent concern on July 10, 2001, when a California jury returned a $91 million verdict against a company (Farmers Insurance) that had improperly classified its claims adjusters as exempt. Numerous high-dollar settlements against a number of national companies, including Rite Aid ($25 million), U-Haul ($7.5 million), and Taco Bell ($13 million), have since followed. According to the "Trends in Wage and Hour Settlements: 2015 Update" report from NERA Economic Consulting, there were 613 wage and hour settlements between January 2007 and March 2015 for an aggregate of $3.6 billion paid out.

There is an overtime exemption for executive, administrative, professional, and outside sales employees under the Fair Labor Standards Act and most state guidelines. To be exempt, these employees must meet certain tests regarding job duties and responsibilities and be compensated "on a salary basis" at not less than stated amounts. However, such tests are often confusing. Indeed, the issue of who is an "exempt" employee is not always clear-cut.

Modifying the Exclusion

Although there is not much an insured can do about the standard wage and hour exclusion, wording should be requested that modifies the exclusion so that it does not apply to claims associated with the federal Equal Pay Act of 1963. This law, which prohibits sex-based discrimination in determining the wages of male and female employees, mandates equal pay for both sexes when work involves equal levels of skill, effort, and responsibility and does not involve the types of wage and hour claims already discussed. However, absent a clarifying endorsement to this effect, an insurer could stretch the intended scope of this exclusion so that it extends beyond prohibiting merely a garden-variety wage and hour claim and also deny coverage for a claim alleging violation of the Equal Pay Act of 1963.

ERISA Liability Exclusion

Claims are excluded under a D&O policy if they are based on a director's or officer's responsibilities as a fiduciary as defined in the federal ERISA of 1974 or similar laws. ERISA and other liability exposures associated with administration of corporate pension plans, profit sharing, and employee benefit programs are insurable under separate fiduciary liability policies (discussed in a separate course within this series). Certain variations of this exclusion also preclude coverage for benefits due under a number of federal, state, and local labor-related statutes such as the National Labor Relations Act, the Fair Labor Standards Act, the Worker Adjustment and Retraining Notification Act, and others.

BI/PD/PI Exclusion

Claims alleging the following are excluded under almost all D&O policy forms.

- BI (including sickness, disease, and death)
- PD to or loss of use of tangible property
- Libel or slander
- Emotional distress
- Other common PI perils (i.e., false arrest, assault)

The purpose of the BI/PD/PI exclusion in D&O forms is to avoid an overlap in coverage between an insured's D&O policy and its CGL policy, which is expressly designed to cover claims of this type.

Two Key Variations of the BI/PD/PI Exclusion

There are, however, two distinct versions of this exclusion. Preferably, the exclusion should be worded so that it applies only to claims "*for* bodily injury and property damage" and not "to claims *based upon, arising out of, or in any way related to* bodily injury or property damage."

The latter, "based upon, arising out of, or in any way related to" version could eliminate coverage not only for claims by persons suffering BI or PD (a CGL exposure) but also with respect to secondary claims by stockholders who sustain financial loss resulting from the BI or PD of others (e.g., shareholders in an oil company suffer financial losses after an explosion at a major refinery). Such secondary claims are not covered under a CGL policy, thus creating a gap in coverage if this wording is included.

BI/PD/PI Exclusionary Wording and Its Effect on Terrorism

D&O insurers have not added terrorism exclusions to D&O forms. Nevertheless, a BI/PD exclusion using the "based upon, arising out of, or in any way related to" wording could also have the unintentional effect of precluding coverage for acts of terrorism that cause financial loss (e.g., terrorists destroy a manufacturing plant, causing loss of revenues and a consequent drop in a corporation's share price). This example provides yet another reason to avoid the "based upon, arising out of, or in any way related to" wording of the BI/PD exclusion if possible.

Pollution Exclusion

Most pollution exclusions in D&O forms are highly restrictive and exclude coverage for all forms of pollution. In addition to PD and BI caused by pollution, the policies also preclude coverage for cleanup costs involving a pollution loss. They also eliminate coverage for penalties that might be levied against directors and officers. Such penalties could be applied when their decisions result in a violation of federal, state, or other environmental protection statutes.

"Based Upon, Arising Out of, Related to" Wording versus "For" Wording

It should also be pointed out that, like the BI/PD exclusion (discussed above), a number of insurers use language that excludes coverage "for" pollution, rather than excluding claims "based upon, arising out of, directly or indirectly resulting from, or in consequence of" pollution. For the same reasons, "for" language is preferable for the insured and should be included where possible.

Inadequate Consideration ("Bump Up") Exclusion

A substantial minority of D&O policies contain what are known as inadequate consideration or "bump up" exclusions.

Frequently, following the purchase of one corporation by another, shareholders of the acquired organization bring lawsuits alleging that the purchase price paid by the acquirer—and thus the price received by the acquiree's shareholders—was too low. In other words, such claims are based on perception of the stockholders of the acquired company that they did not receive fair compensation for the value of their shares. As a result, such lawsuits seek compensation representing the difference between what the acquirer paid and what the shareholders of the acquired company believe their shares were actually worth.

"Bump up" claims can be quite costly. If there were 5 million shares of a company outstanding at the time that it was acquired, a $30 per share "bump up" would require that the acquirer "bump up" the original price by $150 million (5 million shares × $30).

Insurers deploying this exclusion are of the opinion that the value of companies is, to a great extent, highly subjective. In effect, insurers perceive that such claims are essentially business risks and that to "second guess" the directors and officers in these situations is beyond the scope of intended coverage under a D&O policy.

Professional Services Exclusion

Professional services exclusions are steadily finding their way into D&O policies. While the majority of D&O forms do not (yet) contain them at the time of this writing, insurers are more frequently adding exclusionary endorsements that preclude coverage for claims involving the delivery of professional services, particularly with regard to private company D&O policies.

An Example: When a Professional Services Exclusion Would Apply

A pharmaceutical company X announces that it will be 6 months late in introducing its new drug for treating late-stage prostate cancer. Following the announcement, and although the drug has not yet even been offered for sale, a competitor of X files a patent infringement lawsuit against the company. A plunge in X's share price ensues shortly after the competitor's lawsuit filing. The following week, a group of X's shareholders files a securities class action stock drop claim, alleging various securities law violations. The claim alleges that the 6-month delay in the release of X's drug resulted from errors committed during the clinical trials of the drug, which were mismanaged by the company's vice president of research (a physician). The suit goes on to assert that the company's general counsel (an attorney) provided faulty legal advice in failing to recognize that the supposedly new drug infringed on existing patents for similar drugs that were already on the market. Lastly, the claim charges that the company's CFO (a certified public accountant) made erroneous projections as to the new drug's expected sales and profits.

Now, imagine the company's D&O policy contained the following professional services exclusion.

> This insurance does not apply to any liability arising from professional services incurred by:
>
> 1. The named insured;
> 2. The named insured's employees; or
> 3. Anyone for whom the named insured is responsible.
>
> Professional services means any of the following professions: medicine, law, accounting, architecture, or engineering.

Given such wording, the insurer could make a reasonable case in denying coverage for the company's vice president of research, general counsel, and CFO—a doctor, attorney, and accountant, respectively.

A More Favorable Version of the Professional Services Exclusion

Fortunately, a number of other insurers' versions of the professional services exclusion use wording that is much more favorable for insureds. Specifically, their language differs in three key respects. First, it only excludes coverage for claims arising from "services performed for others" and "for a fee." Second, the wording excepts (and thus covers) claims from "alleged violations of securities laws." Third, the language also excepts claims alleging that the insured "negligently managed or supervised such professionals."

The combined effect of these three exceptions is to exclude only claims involving the kinds of fee-driven services that are offered to third parties by a traditional professional firm, rather than those provided by professionals employed in a corporate setting, such as in the above scenario.

Furthermore, as Kevin LaCroix discussed in *The D&O Diary,* insureds in the service industry should be particularly adamant about ensuring that the exclusion contains the narrower "for" preamble, as opposed to "based upon or arising out of," a point discussed throughout this chapter. In his post on May 15, 2016, "Two Things D&O Insurers Regularly Get Wrong," he stated that "… everything a policyholder does in a service industry arises out of their performance of professional services. An exclusion with this wording threatens coverage for the most likely claims the policyholder could encounter." For this reason, service industry insureds should be sure to closely examine the wording of any applicable professional services exclusion.

Chapter 7 Review Questions

1. As with other insurance policies, exclusions in a directors and officers insurance contract commonly appear in all the following places, except

    A. the application.

    B. the conditions.

    C. the definitions.

    D. the endorsements.

2. Although Chopped Sewage Company's directors and officers (D&O) policy excludes coverage for intentionally committed illegal acts, questions remained as to whether the acts of Sam, the officer accused of a wrongful act, were intentional. Because the D&O policy's dishonesty exclusion contains final adjudication wording, which of the following describes the earliest point at which the insurer can deny coverage for Sam based on the exclusion?

    A. A document produced during the discovery phase suggests Sam intended to commit fraud.

    B. An appeals court upholds the trial court's finding that Sam intentionally committed a crime.

    C. At Sam's trial, the plaintiff introduces evidence establishing the facts.

    D. The insurer's investigation uncovers a witness to a conversation in which Sam described his plans to commit the fraudulent act.

3. Missing Lynx Company's directors and officers policy excludes coverage whenever "an insured" personally profits from the alleged wrongful conduct. From the standpoint of an insured, the major problem with this wording is that

    A. it conflicts with the severability provision and creates an ambiguity.

    B. it precludes coverage for all insureds, even those who are not culpable.

    C. the exclusion fails to clarify who is an insured.

    D. the party that profits from the alleged conduct is the party that needs the coverage.

4. Exceptions to the insured versus insured exclusion in a directors and officers (D&O) policy normally provide coverage for all the following situations, except:

    A. A bankruptcy trustee sues corporate directors and officers.

    B. A director seeks indemnification from another director for expenses resulting from a lawsuit against the first director.

    C. A former director, who left the board 10 years ago but is still a major stockholder, sues current directors.

    D. A corporation sues its officers for making bad decisions.

5. Noah Sark Ferry Corporation stock became worthless when passengers' injury and death claims exceeded corporate assets after the ferry capsized during a storm. The ferry and vehicles aboard the ferry were also destroyed. Shareholders sued corporate president and boat captain Noah Sark for a wrongful act arising out of bad management, alleging that the boat should not have been sailing when a severe storm was predicted. The corporation's directors and officers (D&O) policy precludes coverage for claims based upon, arising out of, or in any way related to bodily injury (BI) or property damage (PD). In this case, the D&O claim

    A. is covered because it alleges a wrongful act that is not related to BI or PD.

    B. is covered because it is based on the stockholders' emotional distress.

    C. is not covered because it is related to the BI to passengers and the PD to their vehicles.

    D. is not covered because devaluation of corporate stock is a form of PD.

Answers to Chapter 7 Review Questions

1.

A. That's correct! Exclusions and/or other options may be selected in an application, but they become effective when they appear as part of the contract language.

B. This answer is incorrect. Although not generally worded as exclusions, the policy conditions often include provisions that preclude coverage in certain situations.

C. This answer is incorrect. In defining key terms, the definitions exclude coverage for some situations.

D. This answer is incorrect. Many endorsements are designed to exclude coverage for some situations.

2.

A. This answer is incorrect. The document is merely evidence.

B. That's correct! The earliest point at which the insurer can deny coverage for Sam based on the exclusion is when the final adjudication verdict establishes Sam's intent as a legal fact.

C. This answer is incorrect. No matter what the plaintiff may say, evidence is not conclusive until the court reaches a verdict.

D. This answer is incorrect. Even if the witness's testimony is valid, planning to commit fraud is not the same as a legal determination that the person has committed fraud.

3.

A. This answer is incorrect. The major problem relates to this wording's potential effect on innocent insureds.

B. That's correct! Courts have held that such wording precludes coverage for all insureds, not just the culpable one.

C. This answer is incorrect. Other policy provisions, normally definitions or part of the insuring agreement, should specify who is an insured. That is not the role of an exclusion.

D. This answer is incorrect. The party that actually profits from wrongful conduct does not deserve coverage.

4.

A. This answer is incorrect. Claims by bankruptcy trustees are covered by excepting them from the insured versus insured exclusions.

B. This answer is incorrect. Most exclusions except coverage for situations in which one director or officer is sued and then sues other directors and officers to get them to contribute monies for his or her defense and/or payment of the claim.

C. This answer is incorrect. Claims by past insureds who have not served as directors or officers for at least 5 years are excepted; such claims are rarely motivated by collusion or infighting.

D. That's correct! The D&O policy does not intend to protect a corporation against bad business decisions.

5.

A. This answer is incorrect. The claim is, in fact, related to BI and PD.

B. This answer is incorrect. The claim is an attempt to recover the stockholders' financial loss.

C. That's correct! The D&O claim is not covered because this secondary claim is clearly related to the BI/PD claim.

D. This answer is incorrect. Loss in value of intangible property does not qualify as PD.

Chapter 8
Coverage Triggers in D&O Policies

Overview

Chapter 8 explains the nature of D&O policy coverage triggers. It begins by discussing how they function and describes the key terms associated with claims-made coverage triggers (i.e., retroactive dates, discovery provisions, and extended reporting provisions).

Chapter Objectives

On completion of this chapter, you should be able to

1. identify what must take place to trigger coverage under a claims-made policy,
2. recognize the meaning of terms associated with claims-made D&O coverage,
3. recognize the effect of common variations in D&O policies' claims-made provisions, and
4. given relevant case information, determine whether D&O coverage has been triggered.

Operation of Claims-Made Coverage Triggers

Virtually all of the major insurers' policy forms are written on a claims-made basis. To be covered under a claims-made policy, a claim must be

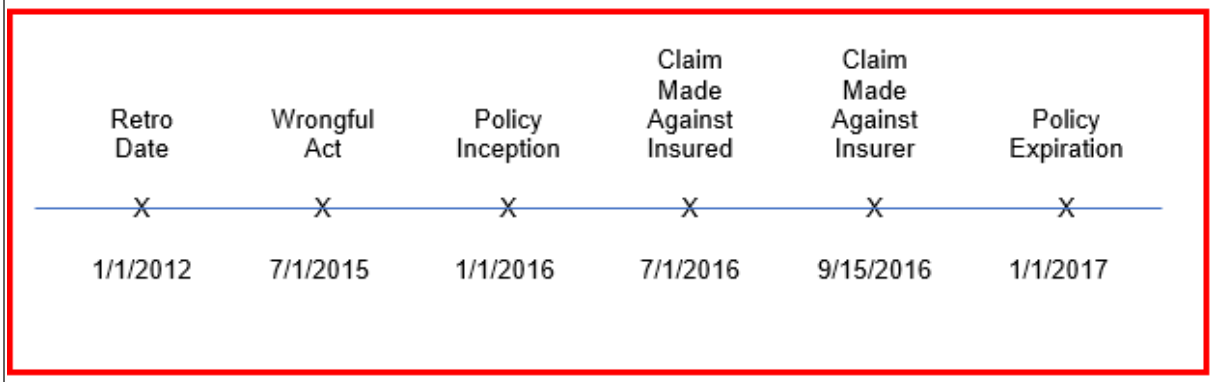
1. *first made* against an insured during the policy period,
2. resulting from a wrongful act that took place on or after the policy's *retroactive date*, and
3. *reported to the insurer* prior to the expiration of the policy (or within 30 to 60 days following expiration).

The italicized terms will be explained in the pages that follow.

Operation of a claims-made coverage trigger is illustrated in Exhibit 8.1.

Exhibit 8.1
How a Claims-Made Policy Functions

Policy Period: 1/1/16–1/1/17
Retro Date: 1/1/12
Wrongful Act: 7/1/15
Claim Made Against Insured: 7/1/16
Claim Reported to Insurer: 9/15/16



In this example, coverage applies because (1) the claim was first made against the insured during the January 1, 2016–2017, policy period, (2) the wrongful act took place after the policy's January 1, 2012, retroactive date, and (3) the claim was reported to the insurer prior to policy expiration. Had the wrongful act taken place prior to the policy's January 1, 2012, retroactive date, coverage would not have applied. Similarly, there would have been no coverage had the claim been made against the insured prior to January 1, 2016, or after January 1, 2017. Lastly, there would have been no coverage had the claim been reported to the insurer after the policy expiration date of January 1, 2017 (although in actual practice, most policy forms contain either a 30 or 60 day post-policy reporting "window" allowing the insured to report the claim to the insurer within 30/60 days after the date the policy expires).

The Significance of "First Made" Language

Use of the term "first made" is significant because it indicates that coverage will apply only when the claim has not previously been made in conjunction with (1) a prior policy written by the current insurer or (2) a policy written by a different insurer, covering the insured prior to the current policy.

Claims-Made and Reported Policies

Under a minority of D&O policies, coverage applies only if the claim is both first made against the insured and reported to the insurer during the policy period. This is known as a "claims-made and reported" policy. For example, under such a policy with a January 1, 2020–2021, term, no coverage would apply unless a claim was both made against the insured during the policy period and also reported to the insurer prior to January 1, 2021.

Claims-Made Policies and Reported Policies with Post-Policy Reporting "Windows"

In contrast, nearly all forms provide what are known as post-policy claim reporting "windows," under which claims made against the insured during the policy period can be reported to the insurer for either 30 or 60 days (depending upon the insurer) after expiration of the policy.

D&O forms containing post-policy reporting "windows" are preferable to claims-made and reported policies. This is because some circumstances could render it impossible for an insured to report a claim made late in a policy period.

An Example

If a summons is delivered to an insured CEO's office late in the day that a policy expires, the insured may be unable to notify the insurer within the policy period. This case may be especially true if he or she was not in the office that day or if the summons was served late in the day at the start of a long, holiday weekend, as a result of which the insurer's office had closed earlier than usual. Under such circumstances, a claims-made policy that contains a 30-day or, preferably for the insured, a 60-day post-policy reporting window is advantageous compared to a claims-made and reported policy because it allows an insured to report a claim to the insurer after the term of coverage has expired.

Retroactive Dates

Retroactive dates in D&O liability policies state that, for coverage to apply, the wrongful act giving rise to a claim must have taken place on or after the retroactive date. Thus, retroactive dates preclude coverage for claims stemming from acts that took place prior to a policy's retroactive date.

Purposes of Retroactive Dates

Retroactive dates have the effect of excluding coverage for possible wrongful acts committed in conjunction with some known event (i.e., known to the insured) that took place prior to policy inception. They also preclude coverage for wrongful acts that transpired in the distant past—even if unknown to the insured.

Retroactive dates are generally included in D&O liability policies for organizations that are buying coverage for the first time. This is because underwriters are reluctant to offer "full prior acts coverage" (i.e., policies without retroactive dates) under such circumstances. Their concern is that the insured's sudden desire to obtain a policy may have been prompted by the need to obtain coverage for circumstances they suspect could produce a claim in the future. For example, if a company began doing business on January 1, 2010, but did not seek to buy D&O liability coverage until January 1, 2020, an underwriter could have the impression that the company now expects a claim to be made against it shortly, since the business operated for 10 years without purchasing D&O liability coverage.

"Full Prior Acts": Coverage without a Retroactive Date

However, if a firm already has a D&O policy in place and then seeks coverage with a new insurer, inclusion of a retroactive date by the new insurer should be resisted unless there is a specific underwriting reason, such as a complete change in the company's operating management and board of directors. By eliminating a retroactive date, a policy will provide what is known as "full prior acts coverage" for all acts, going back to when the organization was founded/incepted.

Retro Date Should Be No Earlier Than the Insured's First D&O Policy Inception

Ideally, an insured will have a policy written with full prior acts (i.e., no retroactive date) coverage. But at the very least, an insured should always require an insurer to offer a policy with a retroactive date that coincides with the date on which it first began buying D&O coverage (known as "prior acts" coverage), even if that date precedes the date on which its current insurer first began writing coverage. If an insured's retroactive date does not coincide with the date on which it first began buying coverage, a coverage gap will result since there will be no coverage for wrongful acts that took place between the inception date of the insured's first D&O policy ever purchased and the retroactive date of the new insurer's policy.

Always Resist Retroactive Date Advancements When Replacing Coverage

At times, underwriters seek an "advanced" retroactive date when writing coverage for a new account. This has the effect of limiting the coverage they are willing to provide to the start of the period of time this new insurer will be on the account. This approach is detrimental for an insured because it provides no coverage for acts that took place from the inception date of its first policy to the inception date of the new insurer's policy. Accordingly, D&O insureds and their agents/brokers should always resist such advancements, even if additional premium is required to achieve "prior acts" coverage.

Option Backdating Claims Illustrate the Importance of Retroactive Dates

The wave of option backdating claims that surfaced in the summer of 2006 illustrates the potential problems that can result from retroactive dates in D&O policies. (Option backdating occurs when a stock option exercise date is set prior to the date on which the option was granted and at a lower exercise price than the current market price of the company's stock. Directors and officers are frequently compensated by means of option grants, in addition to salary.) Option backdating is not illegal if the backdating is clearly communicated to stockholders and if earnings reports and tax payments properly reflect the effect of the backdating. However, a number of lawsuits against corporate directors and officers have alleged illegal option backdating in which these conditions were not met.

Many of these claims related to option grants that were made during the mid-to-late 1990s, in some cases as many as 10 years earlier. So unless the retroactive date on an insured corporation's current D&O policy form—the one under which an options backdating claim was being made—is earlier in time than the alleged wrongful acts associated with these options grants, no coverage will be available.

For example, assume that improper options grants (i.e., the "wrongful acts") were alleged to have been made in 2007. Unless the insured's current D&O policy contains a retroactive date of January 1, 2007 (or earlier), no coverage would apply, despite the fact that the claim was made against the insured during the term of the policy presently in force.

As these circumstances illustrate, retroactive dates present potential coverage problems because D&O claims have a way of "popping up" despite the fact that the alleged wrongful conduct giving rise to the claim took place many years earlier, as was the case with these option backdating claims.

Retroactive Date Issues in Policies for IPOs

One error is often made when structuring D&O coverage for companies making IPOs of their shares of stock to the public. Specifically, policies for such companies are sometimes written with a retroactive date coinciding with the date on which the company first began selling shares to the public. This is normally the date on which such firms are considered "public companies." There are two coverage gaps created under this scenario.

No Coverage for Operations Prior to the IPO

First, by setting the retro date as the date on which the company begins selling shares to the public, it eliminates coverage for any claims that resulted from acts committed prior to that time. Few companies begin as publicly traded firms. More typically, they first achieve success as privately held companies and then, some years later, begin selling shares to the public, most often because of the firm's need to raise capital so it can expand its already successful operations.

No Coverage for Prospectus-Related Claims

Second, by setting a retroactive date coincident with the date on which it begins selling shares to the public, it will eliminate coverage for claims relating to the firm's prospectus. (A prospectus provides details about the company's history and operations, including detailed financial data, and is intended to serve as an inducement for people to buy shares of stock in the company.) This is because an IPO offering

prospectus is always prepared prior to the date on which shares are offered. Thus, any alleged wrongful act associated with the prospectus (i.e., allegations by investors that the prospectus misrepresented the company's financial condition) would have necessarily taken place prior to the retro date and, as a result, would not be covered. Admittedly, a retro date coincident with the date on which the firm went public will likely produce a lower premium compared, for example, to one coinciding with its inception. However, given the relatively high risk associated with IPOs, any premium savings achieved in this manner are probably not worth it.

Accordingly, if a company begins offering shares to the public and, as a result, seeks to buy D&O coverage for the first time, the policy's retroactive date should coincide with the date on which the firm initially "opened its doors," even if this was a number of years prior to becoming or beginning the process of becoming a public corporation. This will also allow for coverage for "road show" activities (alluded to earlier in this course), in which private companies essentially go on a tour in order to garner investor interest in an upcoming IPO.

Discovery Provisions

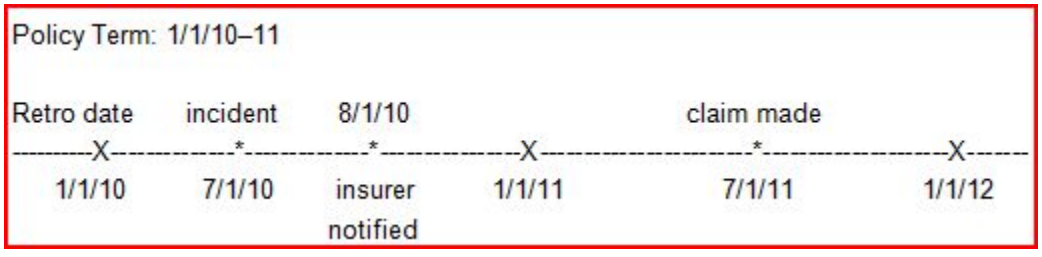
Circumstances often arise under which it is probable that an act, error, or omission will eventually cause a claim to be made against insured directors/officers—despite the fact that litigation may not be initiated for some time. Accordingly, virtually all D&O policies provide, by means of what are called "discovery provisions" (also known as "incident reporting provisions" or "notice of potential claim provisions"), that if the insured advises the insurer of "incidents" or "potential claims" during the policy, any claims arising out of such "incidents" will be considered to have been "made" during that policy period.

An Example

A corporation announces that it did not meet its quarterly earnings target and, as a result, receives negative commentary in the financial press. During the next week, the company's share price drops by 20 percent. This chain of events could be considered an "incident," reportable under a D&O policy's discovery provision. While no claims have yet been received, there is a strong possibility that shareholder class action lawsuits will follow.

When such notice is provided to the insurer, coverage for these claims will apply regardless of how long after the policy under which they were reported has expired. Exhibit 8.2 illustrates the operation of a discovery provision.

Exhibit 8.2
How a Discovery Provision Functions



In this example, coverage applies because the insured notified the insurer of an "incident" on August 1, 2010. Although the claim associated with the incident was not made against the insured until after the January 1, 2010–2011, policy had expired, coverage applies nonetheless because the insurer was notified of the incident under the policy's discovery provision. Although the claim was made against the insured in this example 7 months *after* the policy expired, as long as the "incident" that gave rise to the claim is reported to the insurer during the policy period, regardless of how far in the future a claim is eventually made, coverage will apply.

Extended Reporting Provisions

Extended reporting periods (ERPs), which are also known as extended discovery or "tail" provisions and are included in D&O policies, give an insured the right to present claims after a policy has expired or been canceled. Exhibit 8.3 illustrates how an ERP provision functions.

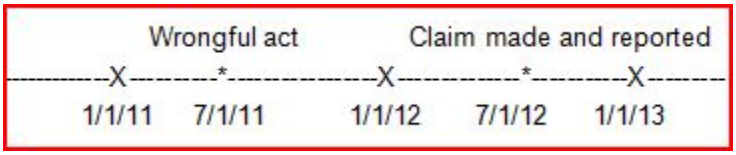
Exhibit 8.3
How an ERP Functions

Insurer A's Policy Term: January 1, 2011–2012

Insured buys an ERP from Insurer A with a term of January 1, 2012–2013

Wrongful Act: July 1, 2011

Claim Made and Reported: July 1, 2012



Coverage applies under the ERP because the wrongful act took place during Insurer A's January 1, 2011–2012, policy term *and* a claim associated with the act was made and reported during the term of Insurer A's January 1, 2012–2013, ERP. One final, key point regarding ERPs: No coverage would have applied in this example if *both* the wrongful act took place *and* the claim were reported during the January 1, 2012–2013, ERP period. Rather, the wrongful act must take place during the expired/canceled policy period for coverage to apply during the ERP.

ERPs Do Not Reinstate Remaining Policy Limits

ERPs do not, however, increase or reinstate the policy's limit of liability. Thus, coverage during an ERP is always subject to available remaining limits.

No Coverage for Wrongful Acts during the ERP

Nor do ERPs cover claims from wrongful acts that took place during the ERP. In effect, ERPs only extend the time period during which wrongful acts that took place during the expired (or in some instances, canceled) policy can be reported to the insurer. For coverage to apply under an ERP, the alleged wrongful act giving rise to the claim must have taken place on or after the retroactive date, if any, of the policy and before the policy's termination date. Thus, ERPs do not afford coverage for an act or omission that took place during the ERP itself, despite the fact that such a claim is reported during the ERP.

Discovery Provisions versus ERPs

Although these two provisions are often confused, the difference is straightforward. Discovery provisions allow insureds to obtain coverage for *incidents* that are reported *during* the policy period. In contrast, ERPs provide coverage for *claims* that are reported *after* a policy period has expired.

Key Variations between ERP Provisions

There are several important variations in the way that different D&O insurers write the key provisions associated with ERPs. These differences are described in the following paragraphs.

Availability

The vast majority of D&O forms permit the insured to purchase an ERP if cancellation/nonrenewal is at the insured's *or* the insurer's election. This is known as a two-way or bilateral tail. Clearly, D&O policy forms that contain bilateral ERPs are preferable to those offering only a one-way tail provision, which would only apply in the event of cancellation or nonrenewal at the behest of the insurer. The latter should be vigorously resisted when negotiating coverage with an insurer. Fortunately, very few D&O insurers offer policies containing one-way tail provisions.

Coverage for "Notice of Circumstances" during ERP

A key variation between the ERPs in D&O forms is whether a report of circumstances that have the potential to result—but have not yet resulted—in a formal claim against the insured is covered by an ERP. In effect, under some insurers' ERP wording, the policy's discovery provision (discussed earlier in this section) is operative, whereas in others, it is not.

Case in point: A D&O policy expires on January 1, 2020, at which time the insured firm buys a 1-year ERP. On August 1, 2020, the insured firm becomes aware of circumstances (from a wrongful act that took place during the expired policy) that could potentially materialize into a formal claim but have not yet. Under some insurers' policies, the report of such circumstances would trigger coverage. However, under other insurers' ERP wording, no coverage would apply until the insured has a formal claim made against it, even if these circumstances are reported to the insurer during the ERP.

Given the situation in the above scenario, the insured would be compelled to purchase (if available) another ERP at the expiration of the current ERP, if the potential claim had not yet been made against the firm but was expected at some point. In this situation, the advantage of having a policy's discovery provision that is operative during the ERP provision is apparent.

Duration

In most instances, D&O insurers offer ERPs of 1 year in duration, although in some cases, ERPs of longer durations are offered as well. Multiple duration options (e.g., 1 year, 2 years, 3 years) are often available under D&O policies written for privately held and nonprofit organizations. However, publicly traded companies are not usually offered anything other than a 1-year option.

Premium Charge

In nearly all instances, the policies state the premium charge for the ERP option. This is typically done by indicating that the ERP will cost a fixed percentage of the expiring policy's premium, normally 100 to 200 percent, depending upon the individual policy, for a 1-year ERP.

Time in Which To Elect

The majority of D&O policies allow the insured up to 30 days following nonrenewal, expiration, or cancellation to purchase the ERP. A few allow as long as 60 days in which to make this election, which is, of course, preferable since it is beneficial to maximize the time period in which the insured can make this election.

Runoff Policies

As an alternative to an ERP, there are certain circumstances under which insureds should consider purchasing a runoff policy.

Runoff Policies versus ERPs

Like ERPs, runoff policies also permit an insured to report claims (that resulted from wrongful acts taking place during prior policy periods) for a specified period of time in the future. In contrast, the use of runoff policies is typically restricted to situations in which another organization merges with or acquires an insured, rather than when the insured replaces coverage with another insurer, as is usually the case when an ERP is purchased. Like ERPs, runoff policies are usually offered on a 1-year basis. However, unlike ERPs, they are typically offered on a renewable basis, with a decreasing premium for each subsequent 1-year renewal period.

Chapter 8 Review Questions

1. To be covered by a claims-made directors and officers insurance policy, a claim must meet all the following criteria, except
    A. that it was first made against an insured during the policy period.
    B. that it results from a wrongful act that occurred during the policy period.
    C. that it is reported to the insurer prior to the policy's expiration (or within 30 to 60 days following expiration).
    D. that it results from a wrongful act that occurred on or after the retroactive date.
2. Under a directors and officers policy with a post-policy reporting window, a claim first reported to the insurer after the policy period ends
    A. is covered if it is reported while a 30- or 60-day post-policy reporting window is open.
    B. is covered if it is reported while a 30- or 60-day post-policy reporting window is closed.
    C. is covered if the wrongful act takes place within 30 or 60 days of the policy period.
    D. is never covered.
3. The provisions in a directors and officers policy that give the insured a right to present claims after a policy has terminated are referred to in several ways. These include all of the following, except
    A. extended discovery provisions.
    B. extended reporting periods.
    C. nose coverage.
    D. tail provisions.
4. Claims would be covered under a directors and officers policy with an extended reporting period (ERP) for an alleged wrongful act that occurred
    A. after the policy's termination date but during the ERP.
    B. after the retroactive date and before the policy's termination date.
    C. after the retroactive date and during the ERP.
    D. before the retroactive date.
5. As regards the decision whether to purchase coverage for an optional extended reporting period (ERP), a typical directors and officers policy
    A. permits the insured to activate ERP coverage during a 1-year period following the policy's termination.
    B. stipulates the premium that will be charged and requires the insured to declare during the policy period its intention to purchase or forgo ERP coverage.
    C. stipulates the premium that will be charged and the time period following nonrenewal, expiration, or cancellation during which the ERP may be elected.
    D. stipulates the time period following nonrenewal, expiration, or cancellation during which the insurer must quote the ERP premium and the insured may elect whether to purchase the ERP.

Answers to Chapter 8 Review Questions

1.

A. This answer is incorrect. To trigger coverage, a claim must first be made during the policy period.

B. That's correct! The alleged wrongful act need not take place during the policy period so long as other criteria are met.

C. This answer is incorrect. To trigger coverage, a claim must be made during the policy period or any post-policy reporting window (the window is typically 30 or 60 days wide).

D. This answer is incorrect. Acts occurring prior to the retro date are not covered.

2.

A. That's correct! Claims made against the insured during the policy period can be reported to the insurer for either 30 or 60 days (depending upon the insurer) after expiration of the policy.

B. This answer is incorrect. The claim will not go through a window that is closed.

C. This answer is incorrect. The act must take place before the policy period ends.

D. This answer is incorrect. Coverage for an otherwise covered claim may be triggered if the claim is reported during a short time period after the policy period concludes.

3.

A. This answer is incorrect. Extended reporting periods are also known as extended discovery provisions.

B. This answer is incorrect. Extended reporting periods give an insured the right to present claims after a policy has expired or been canceled.

C. That's correct! Coverage attached to the back end of the policy term is sometimes referred to as tail coverage. As a metaphorical contrast, retroactive dates or other appendages at the front end of the policy period are occasionally referred to as nose provisions.

D. This answer is incorrect. Because this type of coverage is attached to the back end of a policy term in much the same way as a tail is attached to the back end of an animal, the insurance appendage is sometimes referred to as tail coverage.

4.

A. This answer is incorrect. There is no coverage for wrongful acts during the ERP.

B. That's correct! Coverage applies to wrongful acts that took place on or after the policy's retroactive date and before the policy's termination date.

C. This answer is incorrect. Only part of this statement is correct.

D. This answer is incorrect. Wrongful acts occurring before the retro date are never covered.

5.

A. This answer is incorrect. A 30- to 60-day time period is typical.

B. This answer is incorrect. The stipulation may be made after the policy terminates.

C. That's correct! Nearly all policies indicate the specific ERP option's premium charge as a fixed percentage of the expiring policy's premium and allow the insured 30 (sometimes 60) days to elect coverage.

D. This answer is incorrect. Nearly all policies indicate what the ERP premium charge will be; there is no need to wait for a quote.

Chapter 9
Excess D&O Insurance Policies

Overview

Chapter 9 explains the nature and function of excess D&O policies.

Chapter Objectives

On completion of this chapter, you should be able to

1. identify the function of excess D&O policies,
2. recognize the essential features of quota share excess D&O programs,
3. distinguish between follow form excess D&O policies and independent or stand-alone D&O policies,
4. recognize the consequences under various scenarios of failing to maintain underlying insurance, and
5. identify the role of integrated excess policies.

Excess D&O policies are used in situations when an insured requires higher limits than any single D&O insurer may be willing to provide. In such situations, insureds obtain a primary D&O policy and then proceed to build excess "layers" of coverage above the primary policy until a sufficient limit has been obtained. A layered D&O program is illustrated in Exhibit 9.1.

Exhibit 9.1
A Layered D&O Program

Layer	Insurer
$15 million primary policy	A
$15 million 1st excess layer ($15 million excess of $15 million)	B
$15 million 2nd excess layer ($15 million excess of $30 million)	C
$15 million 3rd excess layer ($15 million excess of $45 million)	D
$20 million 4th excess layer ($20 million excess of $60 million)	E
$20 million 5th excess layer ($20 million excess of $80 million)	
Total Limits: $100 million	

Quota Share Excess D&O Programs

Use of quota share arrangements among excess D&O insurers has grown in frequency over time. Unlike the example provided in Exhibit 9.1 above (where only one insurer provided all of the coverage within each excess layer), the quota share approach involves the assumption of a given layer of excess coverage by more than one insurer. Under such arrangements, participating insurers provide policies that afford a specific percentage of coverage within a particular layer. Exhibit 9.2 illustrates a quota share D&O program.

Exhibit 9.2
Enron's Quota Share D&O Program

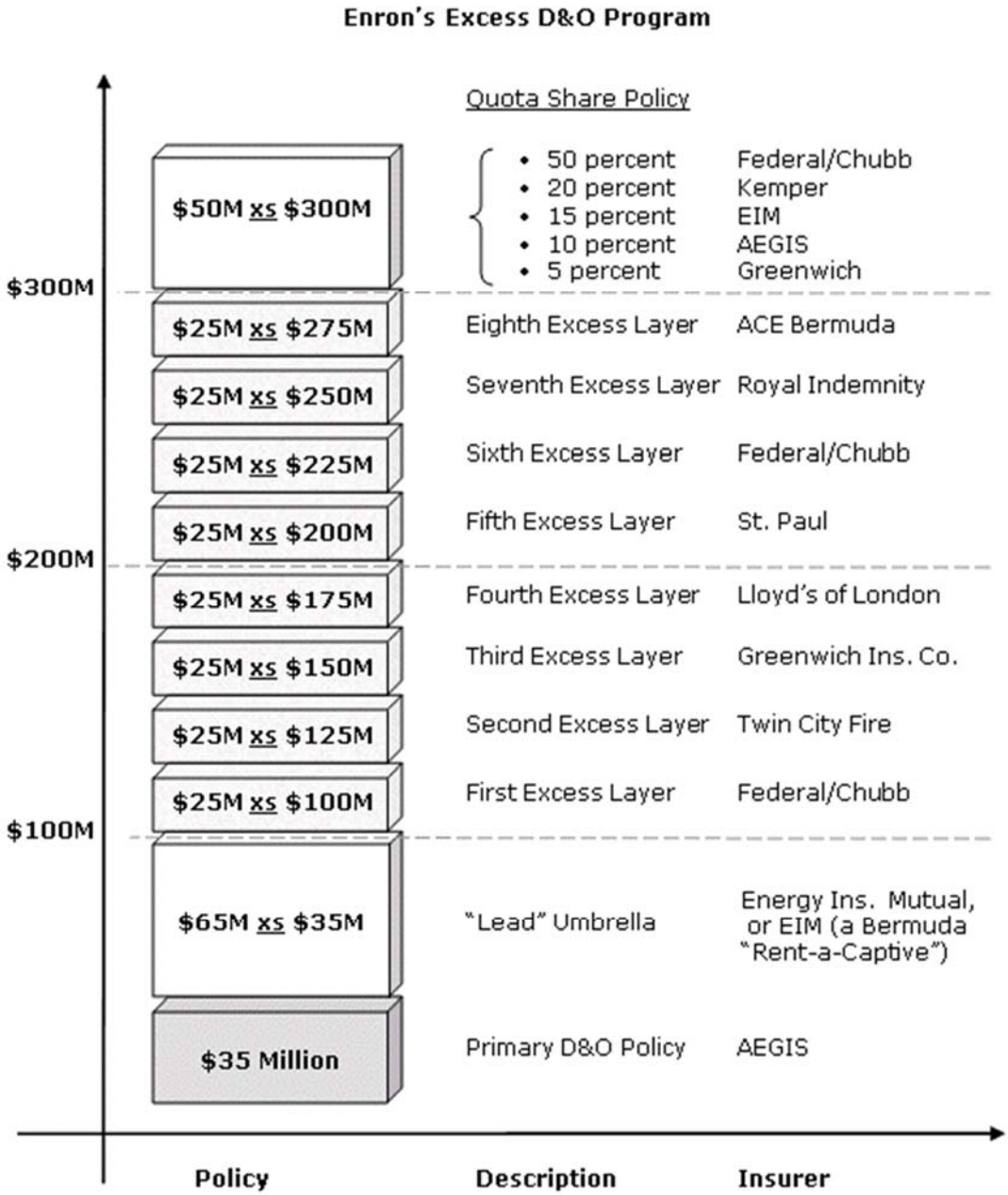


Exhibit 9.2 provides an example of a quota share excess D&O program. Specifically, it depicts Enron's D&O program that provided a total of $350 million of coverage at the time of its financial collapse in late 2001. Note that the $50 million layer of coverage, excess of $300 million, is afforded under a quota share arrangement, in which five different insurers are participating in various percentages to provide a total of $50 million of coverage. If, for example, there was a $25 million loss within this $50 million layer, each of the five insurers would contribute its respective percentage, as noted in Exhibit 9.2. So, for example, since Federal provided 50 percent of the coverage within this layer, in the event of a $25 million loss, it would pay 50 percent, or $12.5 million.

Coverage under Excess D&O Policies: Two Basic Types

There are two basic types of excess D&O insurance policies.

- Follow form policies
- Independent or "stand-alone" excess policies

Follow form policies are much more common. Over time, "stand-alone" excess policies have generally become less available.

Follow Form Excess D&O Policies

These policies adopt the coverage provisions of the underlying policy or policies. This usually includes such matters as insuring agreements, conditions, exclusions, and other key coverage provisions. The insuring agreements state that, unless endorsed, the coverage provided by the excess D&O policy will not be broader than that afforded by the form immediately below it in the "tower" of coverage.

Independent or "Stand-Alone" Excess D&O Policies

These excess policies have their own complete sets of coverage agreements, definitions, and exclusions. However, as already noted, since the late 1990s, such policies are rarely written. Rather, following form excess policies are by far more common.

Underlying Limits of Liability Definition

The manner in which an excess D&O policy defines "underlying limits of liability" is important in understanding how excess D&O policies function. Typically, the "underlying limits of liability" are defined as the sum of (1) the primary D&O policy limits, (2) any retention applicable under the primary D&O policy, and (3) all limits available under any underlying excess policies.

Limit of Liability Provision

The manner in which D&O excess policies define the term "limit of liability" is also important in the functioning of excess D&O policies.

This provision states that the excess D&O insurer will pay losses that exceed the "underlying limit of liability." This means that the excess insurer is not liable until each of the underlying insurers has paid the full amount of the "underlying limits of liability" (as defined in their policies). Finally, the provision indicates that if underlying limits are reduced or exhausted, the policy will pay excess of these reduced or exhausted limits but only after the retention applicable to the primary policy has been satisfied.

Exhaustion/Depletion of Underlying Limits Provision

All excess D&O policies contain a provision stating that the underlying policies must be exhausted before the excess insurer has any liability for payment of loss.

There are four rationales underlying this type of provision.

1. To ensure that the excess insurer is not being requested to drop down to assume loss that it did not bargain to accept.
2. To be sure that the professional claims department and/or counsel of the primary insurer has evaluated the claim, analyzing such issues as coverage, allocation, and the application of exclusions. (Although these findings may not be binding on the excess insurer, excess insurers generally rely on the work done by the primary insurer.)
3. To be certain that its place in the queues of insurers is not violated, an insurer will not be forced to pay a loss when there is an insurer having a greater obligation to pay the loss still available to the insureds.
4. In the case of "duty to defend" policies, to avoid a premature demand for defense of a claim. (However, this is not applicable to most D&O claim situations, since the majority of D&O policies written with excess coverage do not involve a duty to defend.)

Strict versus Liberal Exhaustion of Limits Provisions: A Case Study

Excess insurers use different policy language to define "exhaustion"—some of which is worse for the insured than others.

Facts of the Case

In *Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London*, 161 Cal. App. 4th 184, 73 Cal. Rptr. 3d 770 (Ct. App. 4th Dist. 2008), employees sued Qualcomm over issues related to their stock options. Qualcomm settled the stock option litigation, incurring $28.6 million in defense and indemnity costs.

Qualcomm had a $20 million primary D&O policy with AIG and an excess D&O policy with Lloyd's. Qualcomm settled its coverage claim under the AIG policy for $16 million. This was the most AIG agreed to pay as respects the claim. Since Qualcomm was willing to absorb the next $4 million in costs between the $16 million AIG settlement and the $20 million attachment point of the excess coverage, it only sought excess coverage for about $8.6 million from Lloyd's. (Note: According to what Qualcomm *thought* were the terms of the Lloyd's excess policy, that policy would not afford coverage until $20 million had been paid out within the primary layer—whether by the primary insurer and/or by Qualcomm. In effect, Qualcomm believed that it needed to self-insure the $4 million settlement "gap" so it could access the Lloyd's excess policy.)

Unfortunately for Qualcomm, the Lloyd's excess policy had a very strict exhaustion provision that read, "Underwriters shall be liable only after the insurers under each of the Underlying Policies [the AIG policy, in this instance] have paid or have been held liable to pay the full amount of the Underlying Limit of Liability."

The Court's Ruling

The appellate court held that Qualcomm was not entitled to excess coverage. Nothing in the Lloyd's exhaustion provision was ambiguous. It clearly required either that (1) AIG "has paid" the full amount of the $20 million primary limit or (2) that AIG has been "held liable to pay" the full amount of the $20 million underlying limit. Neither of those events occurred. AIG actually paid only $16 million out of its $20 million underlying limit. AIG was not "held liable" by a judge or jury. Even reading the phrase "held liable to pay" as meaning being obligated to pay under a settlement, in this case, the settlement only

required AIG to pay $16 million out of the $20 million underlying limit. Since the terms of the strict exhaustion provision were not fulfilled, the court held that Qualcomm forfeited around $8.6 million in excess coverage.

The real problem in the Qualcomm case was that the exhaustion provision restricted who was allowed to pay the underlying limit. The plain terms of the Lloyd's policy said that only *the underlying insurer* was allowed to pay. This language simply did not grant the insured a contractual right to absorb any portion of the settlement costs within the primary layer.

A Better Alternative

There are other, more liberal, versions of policy language regarding exhaustion of primary coverage that would have better suited the insured in the Qualcomm case. Specifically, some excess D&O policies expressly permit the insured to pay a portion of the underlying limit. For example, one popular excess D&O insurer's policy contains an exhaustion provision condition that reads, "[L]iability for any covered Loss with respect to Claims first made in each Policy Year shall attach to the Insurer only after [1] the insurers of the Underlying Policies, [2] *the Insured* and/or [3] the Insured Persons shall have paid, in the applicable legal currency, the full amount of the Underlying Limit for such Policy Year." Under this language, the "Insured" has the right to contribute payment toward the underlying limit, which the excess insurer will deem satisfied as long as the full amount is paid by any combination of the three listed parties.

The Lesson of the Case

If the language specifies that only the primary insurer can pay the underlying limit, it is wise to negotiate a more liberal exhaustion provision giving the insured the contractual right to absorb a portion of settlement costs without forfeiting excess coverage.

Maintenance of Underlying Policies Provision

Of utmost importance to an excess insurer are (1) the existence of the underlying insurance and (2) the solvency of the underlying insurers. The purpose of this provision is to protect the excess insurer in the event that any of the underlying insurers' policies expire or are canceled yet not replaced with comparable coverage. In such instances, and in the absence of the maintenance of underlying insurance provision, an affected excess insurer would otherwise be liable for loss that these underlying policies would no longer cover. However, since the excess insurer's premium was predicated on the existence of a specific amount of underlying coverage, it would be inequitable for the excess insurer to bear such loss.

Two Versions of the Maintenance of Underlying Policies Provision

There are two versions of the maintenance of underlying insurance provision.

Restrictive Version

Under the restrictive version, if an underlying policy is canceled or its limits are otherwise impaired (e.g., by means of insurer insolvency), the excess policy above it automatically terminates. In the example discussed above, assume the primary insurer writing the $5 million of coverage becomes insolvent and is no longer able to pay claims. The first excess policy above it provides an additional $10 million limit, but the form contains a restrictive version of the maintenance of underlying limits provision. In this situation, the $10 million excess policy would automatically terminate, and the insured would have neither primary coverage nor the coverage under the first excess policy available.

Favorable Version

In contrast, under the favorable version of the maintenance of underlying insurance provision found within excess D&O policy forms, if an underlying policy is canceled or its limits become impaired (in this instance, by the primary insurer's insolvency), the excess policy above it will not automatically terminate. Rather, the excess policy applies as if the policyholder were self-insured for the underlying layer (i.e., the excess policy will not "drop down"). In the previous claim example, if the primary insurer became insolvent, the first excess insurer's policy would remain in force, subject to a $6 million self-insured retention ($5 million policy limit + $1 million retention).

Implications of the Maintenance of Underlying Insurance Provision

Given the significant functional difference between the favorable and restrictive versions of the maintenance of underlying provisions, it is a critical point of differentiation between excess D&O policies. Accordingly, when putting together an excess D&O program, the restrictive version of the maintenance of underlying limits provision should be avoided. If it cannot, such policy(ies) should be placed as high as possible in the insured's "tower of coverage."

A follow form excess policy adopts the exclusions in the immediately underlying policy. Accordingly, in the example that has been used throughout this section on excess D&O policies, the second excess D&O policy would adopt any additional exclusions found in the first excess D&O policy, and the first excess policy would adopt any additional exclusions found in the primary policy.

If an excess D&O policy contains additional exclusions, this would be to the insured's disadvantage. Accordingly, such policies should be avoided whenever possible. If, however, this cannot be arranged, such policies should be placed on the top layer of an excess D&O program to minimize the probability of involving that policy in a claim situation. Otherwise, insurers providing higher layers of excess coverage would probably automatically adopt these added exclusions.

"Blended" or "Integrated" Excess Policies

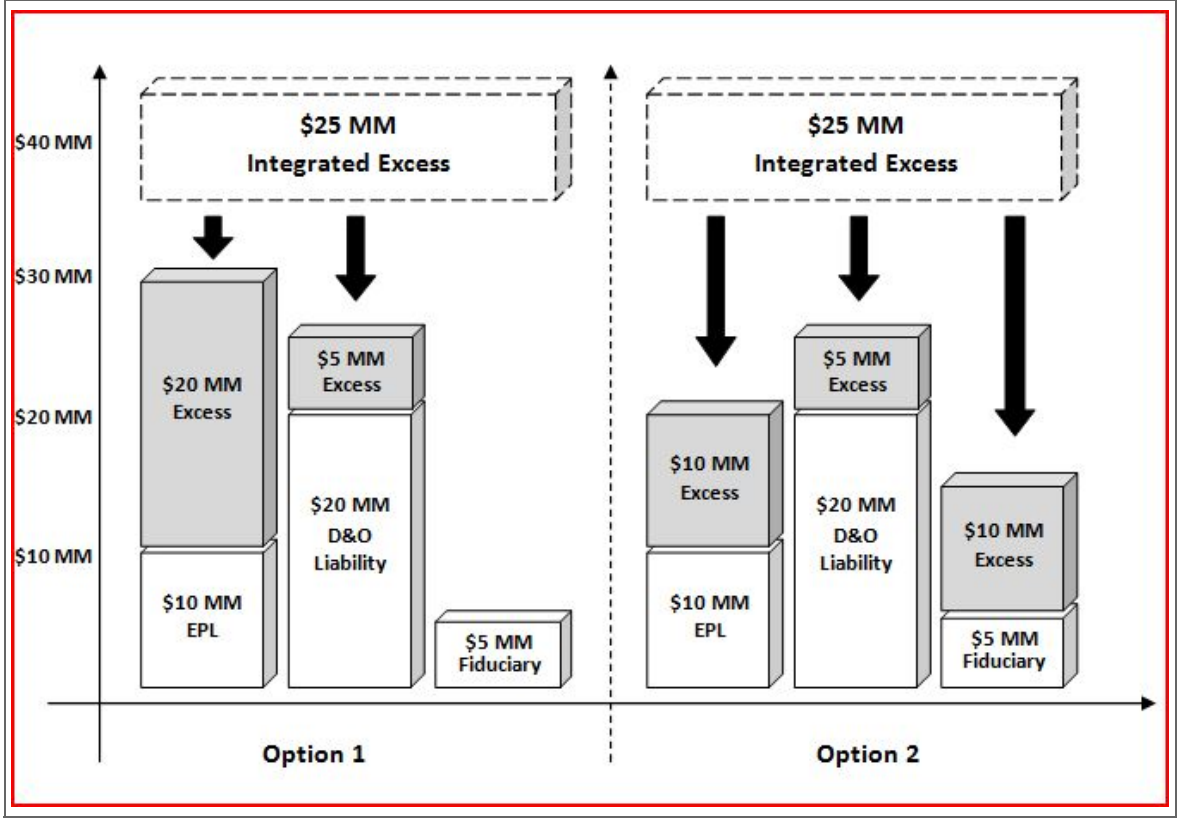
In addition to excess D&O policies, which apply to a single type of coverage, a number of insurers offer what are known as "blended" or "integrated" excess policies that apply as excess coverage over a variety of claims-made policies. These policies include D&O liability, EPL, and fiduciary liability.

Blended excess policies are written with a single aggregate policy limit for all coverages combined. The terms and conditions of such forms are generally similar to those found in excess D&O forms, except for those changes required to accommodate multiple coverages.

Under blended excess policies, if losses other than D&O losses exhaust the aggregate policy limit, there will be no coverage left for D&O claims other than what is available in underlying policies. On the other hand, for the same amount of total premium dollars that might be paid for individual excess policies, a much higher aggregate limit for the entire group of coverages will probably be available under a blended excess policy.

The question then becomes whether it is better to have a rigid wall around the D&O policy to protect only the directors and officers or to have the flexibility to apply the excess coverage where it is needed when other types of losses (i.e., employment practices, fiduciary, or crime) occur. Exhibit 9.3 illustrates the manner in which integrated excess policies function.

Exhibit 9.3
Operation of an Integrated Excess Policy



In this diagram, an aggregate limit of $25 million in coverage is provided under the integrated excess policy. The policy functions exactly like an umbrella policy, providing $25 million in excess coverage over the three underlying policies—in any combination—whenever any of the limits of any of the underlying policies is exhausted.

Two Examples

In Option 1 shown on the left, the insured has allocated $20 million of the excess coverage to apply over the EPL policy to cover a very large EPL claim, which leaves only $5 million of the aggregate limit available, which can be applied over the other policies, such as the D&O policy. In Option 2 shown on the right, the insured has allocated $10 million of the excess coverage to the EPL policy, $5 million of the excess coverage to the D&O policy, and $10 million of the excess coverage to the fiduciary liability policy.

In a like manner, the insured has the flexibility to use the $25 million aggregate limit in any fashion to respond to large claims filed under any of the three underlying policies.

Notices Required To Be Given to the Excess Insurer

Most excess policies contain some sort of "Required Notices" provision, which calls for the insured to notify the excess insurer of certain key events. Below are five events to which these provisions typically apply.

- Cancellation of any underlying insurance
- Change in the terms, conditions, limitations, or exclusions of the "followed" policy
- Any notice of claim or any "incident" that might give rise to a claim under the underlying insurance
- Any claim payment or settlement offer the insured intends to make, even if the amount does not impact the excess insurer's layer of coverage
- Any additional or return premiums, due or returned by the underlying insurers

Chapter 9 Review Questions

1. Wedding Cake Company has a quota share excess directors and officers (D&O) program, a program in which
    A. each insurer is entirely responsible for its own layer of coverage.
    B. gaps between the various layers require filling.
    C. more than one insurer shares a layer of coverage.
    D. only one layer of coverage applies.
2. Toadstool, Inc., has an unusual excess directors and officers (D&O) policy that does not rely on the provisions in underlying policies but rather has its own complete set of coverage agreements, definitions, exclusions, and other provisions. Toadstool's excess policy is a(n)
    A. dependent excess policy.
    B. follow form excess policy.
    C. secondary excess policy.
    D. stand-alone excess policy.
3. Pancake Company is comparing the maintenance of underlying insurance provisions in excess directors and officers policies from two insurers. Policy A says that if an underlying policy is canceled, the excess policy applies as if the policyholder were self-insured for the underlying layer. Policy B says the excess policy terminates if an underlying policy is canceled. From the policyholder's standpoint,
    A. both policies are acceptable since both include drop down coverage.
    B. Policy A is preferable.
    C. Policy B is preferable.
    D. neither policy is acceptable.
4. What is the major difference between an excess directors and officers (D&O) policy and an integrated excess policy?
    A. The integrated excess policy can provide excess coverage over occurrence policies, while an excess D&O policy provides excess coverage only over claims-made policies.
    B. The integrated excess policy provides excess coverage over several underlying claims-made policies.
    C. The integrated excess policy provides excess coverage over several underlying occurrence policies.
    D. The limits of an integrated excess policy are not diluted by employment practices liability or fiduciary liability claims.

5. Centipede Shoe Company, which sells its product in the United States, recently purchased an integrated excess policy to supplement the protection available under its existing directors and officers (D&O) policy and other management liability policies. This policy includes a typical "required notices" provision that requires Centipede to report certain key events to the insurer. Which one of the following events that occur during the year while this excess policy is in force would not require a report?

    A. An exclusionary endorsement was added to Centipede's existing D&O policy.

    B. Centipede began selling sneakers in New Mexico.

    C. Centipede issued a financial restatement that might lead to D&O claims.

    D. The insurer that issued Centipede's D&O policy discovered a calculation error and refunded a portion of the premium Centipede had paid.

Answers to Chapter 9 Review Questions

1.

A. This answer is incorrect. More than one insurer might be involved in a given layer.

B. This answer is incorrect. A properly structured program will have no coverage gaps.

C. That's correct! A quote share excess D&O program is a program in which more than one insurer shares a layer of coverage.

D. This answer is incorrect. Wedding Cake's program involves multiple layers.

2.

A. This answer is incorrect. Toadstool's policy is independent of other policies.

B. This answer is incorrect. A follow form policy relies on provisions in underlying policies.

C. This answer is incorrect. All excess policies are secondary to underlying primary coverages.

D. That's correct! Independent or stand-alone excess D&O policies have their own complete sets of coverage agreements, definitions, and exclusions; these policies are currently uncommon.

3.

A. This answer is incorrect. Neither version provides first-dollar coverage if the underlying coverage is canceled.

B. That's correct! The policyholder will still have excess coverage if an underlying policy is canceled.

C. This answer is incorrect. Policy B is more likely to be canceled midterm.

D. This answer is incorrect. One of these two versions is clearly preferable.

4.

A. This answer is incorrect. The integrated excess policy provides excess coverage over claims-made policies.

B. That's correct! Blended or integrated excess policies apply as excess coverage over a variety of claims-made policies, including D&O, employment practices liability, and fiduciary liability.

C. This answer is incorrect. The integrated excess policy provides excess coverage over claims-made policies.

D. This answer is incorrect. Under blended excess policies, losses other than D&O losses can exhaust the aggregate policy limit.

5.

A. This answer is incorrect. The insurer should be notified of any change in the exclusions of the followed policy.

B. That's correct! Expanding its market to an additional state would not require notification to the excess insurer.

C. This answer is incorrect. The insurer should be notified of any incident that might give rise to a claim under the underlying insurance.

D. This answer is incorrect. This transaction is probably innocuous, but the insurer should still be notified of any additional or return premiums due or returned by the underlying insurers.

Chapter 10
D&O Insurance for Privately Held Companies

Overview

Chapter 10 examines the distinct policy forms that are available to cover the exposures faced by privately held companies.

Chapter Objectives

On completion of this chapter, you should be able to

1. identify the typical policy features that distinguish private company D&O forms from those offered to publicly traded organizations.

Distinctive Aspects of Private Company D&O Coverage Forms

There are several key differences between the two kinds of forms written to cover privately held companies and publicly traded organizations. These differences are discussed below.

Packaged Approach

The vast majority of D&O coverage written for privately held firms is made available on a so-called package basis. That is, in addition to offering standard D&O coverage, nearly all of the policies also provide coverage for EPL, fiduciary, and crime exposures, all of which many privately held companies are highly susceptible to. In addition, some policies designed for private companies also afford the option to purchase kidnap/ransom coverage (also termed "special crime" coverage) and miscellaneous professional liability insurance (covering corporate accountants and attorneys, for example).

It should be noted, however, that many particularly large private companies likely will not have the option of utilizing a packaged format. Private companies with more than 250 employees or more than $100 million in annual sales generally must use an unbundled approach.

Exhibit 10.1 details some of the general advantages of covering private company exposures in a packaged format.

Exhibit 10.1 Advantages of a Packaged Approach	
Lower premium	Insureds can expect an approximate 5 percent discount for each line of coverage when they buy more than one type of policy within a packaged format, compared to purchasing three separate policies.
Ease of Administration	Package policies require only a single application, rather than multiple applications, a fact that reduces an insured's administrative effort. This approach also benefits a private company insured because the person handling the administration process need only deal with one insurer and review a single insurance policy after the insurer issues it.
Common Policy Provisions	The three major coverage lines (D&O, EPL, and fiduciary) are almost always subject to a set of "common" policy provisions (e.g., cancellation, notice of claim requirements). This has the effect of minimizing potential coverage disputes and coverage gaps.
Unified Claims Management	When buying a package policy, the claims handling process is streamlined, reimbursements to the insured will follow more quickly, and coverage disputes will be minimized, compared to claim situations involving multiple insurers.

Flexibility in Limits and Retentions

Another advantage of the package format is that (in contrast to what is made available by insurers of publicly held companies) most writers of private company D&O policies offer a great deal of flexibility in the selection of limits and retentions for the various coverages. Insurers usually offer either separate or combined limits for each of these different types of coverage as well as either separate or combined retentions for each of them.

For example, under a typical package approach, an insured could elect a combined single limit applying to D&O, employment practices, and fiduciary liability coverage. Or the insured could select a separate limit for each of these coverages. The same can usually be said for the selection of retentions for each of these coverages. That is, the insured could opt for a separate retention for each type of coverage or a single retention annual aggregate for all coverages.

Broad "Insured Persons" Coverage

Unlike corporate D&O policies, whereby only directors and officers are "insured persons," private company policies cover a much broader range of individuals. Specifically, employees (both full- and part-time) are also insureds under the forms.

Broad Entity Coverage

Unlike insurers of publicly held companies, insurers who write privately held firms provide entity coverage for all kinds of claims—not just those involving securities. Moreover, entity coverage is automatic under D&O policies for private companies, whereas, under corporate D&O forms, entity coverage always requires payment of additional premium to purchase Coverage C.

Duty To Defend

Virtually all D&O policies for private companies are written on a duty to defend basis. In contrast, the vast majority of forms written for publicly traded firms state that the insurer has no duty to defend, only a duty to pay defense costs and make indemnity payments.

However, the duty to defend approach is usually better suited to privately held firms because they tend to be smaller and less familiar with the complexities of D&O litigation. It is usually best to allow the insurer to manage and control the litigation process when private companies are involved, compared with the larger, publicly traded companies that tend to have sizeable legal staffs and are more comfortable controlling the litigation process associated with D&O claims.

Liberal Cancellation and Nonrenewal Provisions

The cancellation and nonrenewal provisions in private company D&O policies tend to be more liberal than those found in their for-profit counterparts. Specifically, a majority of such forms are written on a noncancelable basis (except for nonpayment of premium). In contrast, a significant number of for-profit D&O forms require only 30 to 60 days' notice prior to cancellation.

In addition, most private company forms require the insurer to provide 30 to 60 days' notice prior to nonrenewing, compared to corporate D&O insurers whose forms generally do not require any prior notice of nonrenewal.

Broad ERPs

The ERPs found in private company D&O forms are usually somewhat broader than those made available by corporate D&O writers. For example, private company forms typically offer ERPs of 1 year for a maximum of 125 percent of the expiring premium and in some cases as low as 50 percent of the expiring premium. Conversely, corporate D&O insurers' ERP premiums are usually a minimum of 100 percent of expiring premium and can be as high as 200 percent of the expiring premium. In addition, insurers of privately held companies frequently offer ERPs of more than 1 year and for as long a period as 5 years.

Key Provisions in Private Company D&O Policy Forms (and How To Modify Them)

This section will discuss six of the most important provisions found in private company D&O forms and how they should be written to maximize coverage for the insured.

Exhibit 10.2 lists the provisions that will be discussed.

Exhibit 10.2
Key Provisions in Private Company D&O Policies

- Insured versus Insured Exclusion
- Major Shareholder Exclusion
- Family Exclusion
- Increased Coverage Limits for Directors and Officers
- Breach of Contract Exclusion
- Securities Claim Exclusion

Insured versus Insured Exclusion

As discussed previously, the insured versus insured exclusion eliminates coverage for claims by one insured against another. There is one important reason why the insured versus insured exclusion is especially problematic in private company D&O policies. Unlike D&O policies written to cover public companies, whereby only directors and officers are insureds, private company D&O forms cover "everyone" who is associated with the company (e.g., employees, managers, stockholders, volunteers). Thus, a claim made by any of the broad range of insureds would be excluded by the "insured versus insured exclusion." As a consequence, a number of "garden variety" claims will be excluded by a private company D&O policy, unless the insured versus exclusion is modified. Such claims most notably include EPL claims and whistleblower claims. This is because most claims of both types are usually brought *by* employees *against* directors and officers.

Given this situation, the insured versus insured exclusion should be modified so that it excepts, and thus covers, employment claims and whistleblower claims. Wording should also be modified so as to not preclude claims involving (a) retired directors and officers, (b) employees, and (c) bankruptcy trustees.

Major Shareholder Exclusion

The major shareholder exclusion eliminates coverage for claims brought by persons who own a certain percentage (or more) of the total outstanding shares of a privately held company. Specifically, the exclusionary threshold typically ranges from a low of 5 percent to a high of 15 percent.

Unlike most types of exclusions, which are found within "regular" policy wording, the major shareholder exclusion is almost always added as an exclusionary endorsement.

Interestingly, the major shareholder exclusion is one of the only significant restrictions found within private company D&O policies that is *not* also contained within the D&O forms written to cover publicly traded companies. Public company D&O policies generally do not contain a major shareholder exclusion because the vast majority of publicly held businesses are so large that (usually) no one person owns 5 percent or more of its shares. In contrast, with private companies, a single individual almost always owns more than 5 percent of its shares. In fact, it is not uncommon for one person to own *all* the shares of a private company.

Given the fact that the major shareholder exclusion could potentially eliminate coverage for numerous claims, insureds should first attempt to have the exclusion removed. Alternatively, underwriters may be amenable to increasing the threshold percentage, either from 5 percent to 10 percent or from 10 percent to 15 percent. Although these changes usually require payment of additional premium, insureds should weigh the benefits against the costs and consider requesting such modifications.

Family Exclusion

The family exclusion precludes claims made by one family member/owner against another family member/owner. Again, like the insured versus insured exclusion, the intent of the family exclusion is to preclude coverage for claims involving either collusion or infighting. However, there are foreseeable situations in which this exclusion could operate to eliminate coverage where neither of these events is occurring. Most often, this happens where, for example, a son sues a father, alleging mismanagement of the family business. In such a situation, neither collusion nor infighting is the source of the claim, and, thus, the claim should be covered.

The most effective means of modifying the family exclusion is to request that only claims from members of the *same generation* should be excluded. The effect of this modification would therefore be to allow coverage if, for instance, a son were to sue a grandfather, or a daughter were to sue a father. In addition, the exclusion should not apply and coverage should be provided where ownership of the plaintiff's shares of stock are held in a family trust.

In the latter instance, it is likely that the younger generation will not have control of the business and yet may be suing to prevent gross mismanagement of a family business, a scenario that is different from the possibility of collusion or infighting that underwriters attempt to avoid with this exclusion.

Increased Coverage Limits for Directors and Officers

Although "everyone" is an insured under a private company D&O policy, it is apparent that not everyone at most private companies has the same level of exposure. Therefore, it is usually prudent to secure additional coverage limits for a private company's directors and officers. Accordingly, insurers of privately held companies allow such businesses to buy separate and additional limits that apply only to the company's directors and officers.

For example, assume a private company D&O policy is written with a $1 million aggregate limit. Consideration should be given to buying an additional "dedicated" limit applying only to directors and officers of $1 million or perhaps $2 million.

Breach of Contract Exclusion

Despite the expansive nature of private company D&O policies, one important "gap" is the exclusion for breach of contracts. The rationale for this exclusion is that the underwriters only intend to cover claims involving duties imposed by law, such as the common law duties of diligence, obedience, and loyalty, which are required of a corporation's directors and officers. In contrast, the breach of a contract is considered to involve the breach of a personal, voluntarily assumed obligation and is therefore excluded by many private company D&O policy forms.

The breach of contract exclusion should use "for" language; meaning the exclusion should only apply "for breach of contract." However, a number of private company D&O forms employ the more expansive "arising out of, or in any way related or attributable to breach of contract" wording. This language could be used by an insurer to exclude coverage for an excessive range of claim scenarios. On the other hand, an insurer would have a much more difficult time denying coverage if a private company D&O policy used "for" breach of contract language.

An Example

A private company's D&O policy is written with a breach of contract exclusion that uses a preamble precluding coverage "arising out of, or in any way related or attributable to breach of contract." The company is sued by a bank that alleges the company has defaulted on a loan. Under these circumstances, the insurer will have a much better chance of being able to deny coverage for the claim, rather than if the breach of contract exclusion were written with the more favorable (for the insured) "for breach of contract" preamble.

Securities Claims Exclusion

A number of private company D&O forms exclude coverage for securities claims. The rationale for the exclusion is that because private companies do not usually issue securities to the public, such firms have no exposure to securities claims. However, private companies do in fact have a securities claims exposure. Although they do not issue *equity securities* to the public, larger privately held companies sometimes issue *debt securities* (i.e., bonds) to the public. In addition, private firms occasionally issue equity securities to small groups of private investors in what are known as *private placements.* Furthermore, although private companies are not required to register private placements or debt securities with the SEC, they are still required to comply with US securities laws.

Given this clear exposure to securities litigation, the securities exclusion should contain three specific modifications.

Coverage for Exempt Securities Offerings

First, the exclusion should "except," *and thus cover,* claims involving securities that are exempt from registration under the Securities Act of 1933. This is necessary because, even though private companies need not register bond issues or private placements with the SEC, such companies still have an exposure from these activities because private firms must nevertheless comply with US securities laws.

Coverage for Failure To Go Public

Second, the securities exclusion should be modified so that it includes coverage for claims alleging "failure to go public." This wording is also necessary because individuals are often induced to invest in a private company based on the assurance that the organization will "go public" in the near future. This provides a significant incentive for investors, because a public stock offering usually brings with it substantial return for the original owners of such a company. However, numerous lawsuits alleging "securities fraud" have been filed because the private company never offered its shares to the public.

Coverage for Offerings of Securities

Third, the securities exclusion should provide that if the insured decides to offer shares to the public (and thus convert from a privately held to a publicly held business), the insured can notify the insurer 30 days prior to the public offering and receive a proposal for coverage of claims arising from the public offering. It should be noted that the insurer will have the right to impose additional terms and conditions and charge extra premium for such coverage and will not be *obligated* to provide an actual quotation.

Chapter 10 Review Questions

1. Paper Clips, Inc., a privately held office supplies store, wants to purchase a package policy that includes directors and officers, employment practices liability, and fiduciary liability coverage. Under a typical packaged approach, Paper Clips would have any of the following options, except

    A. combined single limit for all coverages.

    B. separate limits for each coverage.

    C. separate retention for each coverage.

    D. waiver of underlying insurance.

2. The officers of Fox Hole, a private company, are reluctant to inform their insurer of a possible directors and officers (D&O) claim for fear their policy will be canceled. If their policy is like most D&O policies written on private companies, the insurer

    A. cannot cancel the policy except for nonpayment of premium.

    B. may cancel the policy only if the policyholder gives notice of a potential claim.

    C. must provide 30 to 60 days' notice prior to cancellation.

    D. may cancel the policy for any reason.

3. Peter Piper picked a bad time to reveal that Hunton Peck, treasurer of the Pickled Pepper Company that employed Peter, had been cooking the books. Pickled Pepper's directors and officers (D&O) policy will provide no coverage for any resulting claims unless the insured versus insured exclusion has been modified

    A. to cover cooking claims.

    B. to cover garden-variety claims.

    C. to except employment claims.

    D. to except whistleblower claims and claims involving employees.

4. All shares in the Dump Hotel corporation are owned by members of the Dump family: Donna Dump, Ivan Dump, Erica Dump, and Fanny Dump. What exclusion that is often added to directors and officers (D&O) policies on privately held companies should be eliminated from the Dump policy, if possible, because it could effectively eliminate coverage for numerous claims the Dump D&O policy might otherwise cover?

    A. Exclusion "for breach of contract"

    B. Major shareholder exclusion

    C. Wage and hour claims exclusion

    D. War exclusion

5. Kau Pi Company, an upper-crust commercial bakery, is a privately owned corporation whose business is rapidly expanding. Like many other directors and officers (D&O) policies on private companies, Kau Pi's D&O policy excludes coverage for securities claims. Which one of the following modifications to this endorsement should Kau Pi not request?

    A. A major shareholder exclusion

    B. An exception for claims involving securities exempt from registration under the Securities Act of 1933

    C. An inclusion of coverage for claims alleging failure to go public

    D. Coverage if the insured decides to offer shares to the public

Answers to Chapter 10 Review Questions

1.

A. This answer is incorrect. Insurers usually offer combined limits.

B. This answer is incorrect. Insurers usually offer separate limits for each type of coverage.

C. This answer is incorrect. The insured is usually offered a selection of separate retentions for each coverage or a single retention annual aggregate for all coverages.

D. That's correct! Under a typical packaged policy, Paper Clips would not have the option of a waiver of underlying insurance.

2.

A. That's correct! A majority of private company D&O policies are written on a noncancelable basis, except that the insurer may cancel for nonpayment of premium.

B. This answer is incorrect. The policy may only be canceled for a different reason.

C. This answer is incorrect. Public company forms generally do not require any prior notice.

D. This answer is incorrect. The permissible reasons for cancellation are very limited.

3.

A. This answer is incorrect. Cooking per se does not generally lead to D&O claims.

B. This answer is incorrect. Garden-variety is a broad, nonspecific term. The exclusion should be modified to except specific types of garden-variety claims.

C. This answer is incorrect. Although Peter Piper was an employee, the underlying complaint did not involve an employment practice.

D. That's correct! The exclusion should be modified to except, and therefore cover, whistleblower claims. The wording should also be modified so as not to preclude claims that involve employees such as Piper.

4.

A. This answer is incorrect. "For" language is a better approach to this exclusion than other wording that is commonly used.

B. That's correct! A major shareholder exclusion would eliminate coverage for claims brought by persons who own more than some percentage, usually between 5 and 15 percent of the company. This provision would preclude coverage for claims brought by one if not all of the Dump family members.

C. This answer is incorrect. Most D&O policies have this exclusion, and there is nothing unique about the Dump corporation that makes it a problem. However, any business in the hospitality industry should be careful to avoid violation of the Fair Labor Standards Act and other guidelines.

D. This answer is incorrect. Although the Dump relatives could fight with one another, a family feud would not trigger a typical war exclusion.

5.

A. That’s correct! A major shareholder exclusion might eliminate coverage for many claims that would otherwise be covered.

B. This answer is incorrect. Even though private companies like Kau Pi need not register bond issues or private placements with the Securities and Exchange Commission, they still have an exposure from these activities.

C. This answer is incorrect. Numerous lawsuits alleging securities fraud have been filed because a private company never offered its shares to the public.

D. This answer is incorrect. The securities exclusion should provide that, if Kau Pi decides to convert from a privately held to a publicly held business, the insured can notify the insurer 30 days prior to the public offering and receive a proposal for coverage of claims arising from the public offering; the insurer is therefore obligated to provide an actual quotation.

Glossary

1934 SEC Act—See Securities Exchange Act.

Allocation—(1) The assignment to individual policies of the obligation to defend or indemnify an insured when injury or damage has occurred during a succession of policy periods. (2) The determination of which elements of defense costs must be paid by the insurer and which elements may be subject to reimbursement by the insured, depending on covered and noncovered elements of the suit or claim brought against the insured. Some courts have ruled that an insurer is not obligated to pay the cost of defending noncovered elements of a claim.

arbitration—Referral of a dispute to an impartial third party chosen by the parties in the dispute who agree in advance to abide by the arbitrator's award issued after a hearing at which both parties have a chance to be heard.

arbitration clause—Language providing a means of resolving differences between a reinsurer and the reinsured (or an insurer and an insured) without litigation. Usually, each party appoints an arbiter. The two arbiters select a third, or an umpire, and a majority decision of the three becomes binding on the parties in the arbitration proceedings.

bad faith—A term describing blatantly unfair conduct that exceeds mere negligence by an insurance company. For example, a bad faith claim may arise if an auto liability insurer arbitrarily refuses to settle a claim within policy limits, where an insured's liability is incontrovertible. Bad faith damages, also known as extracontractual damages, are often substantial. They frequently exceed the limits of the insurance policy that is the subject of the claim.

best efforts allocation provisions—Both insurer and insured promise to use their "best efforts" in apportioning covered claim amounts, based on the relative legal exposures of the parties and based on the type(s) of claims made.

claims-made and reported policy—A type of claims-made policy in which a claim must be both made against the insured and reported to the insurer during the policy period for coverage to apply. Claims-made and reported policies are unfavorable from the insured's standpoint because it is sometimes difficult to report a claim to an insurer during a policy period if the claim is made late in that policy period. However, more liberal versions of claims-made and reported policies provide post-policy "windows," which allow insureds to report claims to the insurer within 30 to 60 days following policy expiration.

claims-made policy—A policy providing coverage that is triggered when a claim is made against the insured during the policy period, regardless of when the wrongful act that gave rise to the claim took place. (The one exception is when a retroactive date is applicable to a claims-made policy. In such instances, the wrongful act that gave rise to the claim must have taken place on or after the retroactive date.) Most professional, errors and omissions (E&O), directors and officers (D&O), and employment practices liability insurance (EPLI) is written as claims-made policies.

coinsurance (in D&O insurance)—In a directors and officers (D&O) policy, the coinsurance provision is similar to the co-payment provisions found in medical insurance coverage, in which the policy will pay only a specified portion (typically 80 to 95 percent) of each loss in excess of the dollar amount deductible.

corporate reimbursement coverage—Coverage under a directors and officers (D&O) liability policy covering the corporate organization's obligation to indemnify its directors and officers for claims resulting from their acts in conjunction with the organization. This obligation is usually stated in either the corporate charter or the corporate bylaws and in some cases is mandated by state statute. The coverage provided by this section of a D&O policy is also referred to as "Side B" coverage.

D&O—directors and officers

D&O policy—See Directors and officers liability insurance.

defense within limits—A liability policy provision according to which amounts paid by the insurer to defend the insured against a claim or suit reduce the policy's applicable limit of insurance. General liability policies are ordinarily not subject to such a provision, although the standard commercial general liability (CGL) policy provides for defense of the named insured's indemnitee "within limits" when the named insured has a contractual obligation to provide such a defense. Defense within limits is more common in professional liability policies.

derivative lawsuit—A type of lawsuit brought by one or more stockholders, on behalf of the corporation, alleging financial loss to the organization. The alleged harm must be to the corporation as a whole, such as the diminishing of the corporation's assets, for shareholders to pursue an action derivatively. Any recovery in such suits inures to the benefit of the corporation itself as opposed to the shareholders who institute the action.

directors and officers (D&O) liability insurance—A type of liability insurance covering directors and officers for claims made against them while serving on a board of directors and/or as an officer. D&O liability insurance can be written to cover the directors and officers of for-profit businesses, privately held firms, not-for-profit organizations, and educational institutions. In effect, the policies function as "management errors and omissions liability insurance," covering claims resulting from managerial decisions that have adverse financial consequences. The policies contain "shrinking limits" provisions, meaning that defense costs—which are often a substantial part of a claim—reduce the policy's limits. This approach contrasts with commercial general liability (CGL) policies, in which defense is covered in addition to policy limits. Other distinctive features of D&O policies are that they (a) are written on a claims-made basis, (b) usually contain no explicit duty to defend the insureds (when covering for-profit businesses), and (c) cover monetary damages but exclude bodily injury (BI) and property damage (PD).

discovery provision—Provisions that permit insureds to report incidents or circumstances that may result in claims in the future, found mainly in professional liability insurance policies written with claims-made coverage triggers. Discovery provisions, which are also known as "awareness" or "notice of potential claim" provisions, allow an insured to lock in coverage for such events so that coverage will apply under the current claims-made policy, regardless of how far in the future a claim is eventually made in conjunction with the incident that has been reported.

duty to defend—A term used to describe an insurer's obligation to provide an insured with defense to claims made under a liability insurance policy. As a general rule, an insured need only establish that there is potential for coverage under a policy to give rise to the insurer's duty to defend. Therefore, the duty to defend may exist even where coverage is in doubt and ultimately does not apply. Implicit in this rule is the principle that an insurer's duty to defend an insured is broader than its duty to indemnify. Moreover, an insurer may owe a duty to defend its insured against a claim in which ultimately no damages are awarded, and any doubt as to whether the facts support a duty to defend is usually resolved in the insured's favor.

With respect to directors and officers (D&O) and employment practices liability insurance (EPLI) policies, policies containing explicit "duty to defend" wording obligate an insurer to assume control of the claim defense process, including selecting counsel and paying legal bills. In contrast, non-duty to defend (or duty to pay) policies require only that the insurer reimburse the insured for funds expended by the insured in defending a claim.

employment practices liability insurance (EPLI)—A type of liability insurance covering wrongful acts arising from the employment process. The most frequent types of claims covered under such policies include wrongful termination, discrimination, sexual harassment, and retaliation. In addition, the policies cover claims from a variety of other types of inappropriate workplace conduct, including (but not limited to) employment-related defamation, invasion of privacy, failure to promote, deprivation of a career opportunity, and negligent evaluation. The policies cover directors and officers, management personnel, and employees as insureds. The most common exclusions are for bodily injury (BI), property damage (PD), and intentional/dishonest acts. EPLI policies are written on a claims-made basis. The forms contain "shrinking limits" provisions, meaning that insurer payment of defense costs—which are often a substantial part of a claim—reduces the policy's limits. This approach contrasts with commercial general liability (CGL) policies, in which defense is covered in addition to policy limits. Although EPLI is available as a stand-alone coverage, it is also frequently sold as part of a management liability package policy. In addition to providing directors and officers (D&O) and fiduciary liability insurance, management liability package policies afford the option to cover employment practices liability (EPL).

entity coverage—Affords direct coverage of the insured organization under a directors and officers (D&O) liability policy. Typically, corporate D&O forms only reimburse the insured organization when it is legally obligated to indemnify corporate officers and directors for their acts on behalf of the organization. However, if a lawsuit specifically names the insured organization as a defendant, the standard D&O policy does not provide coverage. Entity coverage, which until recent years was only provided under D&O policies written for nonprofit organizations and healthcare institutions, is designed to cover the organization directly in addition to its directors and officers. A number of corporate D&O forms will now provide an entity coverage endorsement for an additional premium.

EPL—employment practices liability.

EPLI—See Employment practices liability insurance.

ERP—See Extended reporting period.

extended reporting period (ERP)—A designated time period after a claims-made policy has expired during which a claim may be made and coverage triggered as if the claim had been made during the policy period.

extradition—The process by which one country transfers a suspected or convicted criminal to another country.

final adjudication—The point at which the insured director/officer is acquitted or convicted or the claim is settled.

financial restatement—A publicly traded corporation's material revision to one of its recently released earning statements, usually in a manner indicating that profits were lower or losses were larger than originally reported.

first-dollar defense coverage—A coverage feature of some liability policies in which retentions do not apply to defense costs, even if no indemnity payments are made in conjunction with a claim. Thus, if an insurer were to expend $10,000 on defense of a claim and nothing for indemnity, the insured would not be required to pay any out-of-pocket costs for defense.

first-made language—Policy wording to the effect that coverage will apply only when the claim has not previously been made in connection with a prior policy written by the current insurer or a different insurer.

full prior acts coverage—A type of claims-made liability policy that does not contain a retroactive date and therefore covers claims arising from acts that took place at any time prior to the inception date of the policy—regardless of how far in the past. For example, assume that an insured has a claims-made policy that includes a January 1, 2000, retroactive date and a January 1, 2010–2011, term. If a claim is made against the insured on July 1, 2010, and the claim arose from a wrongful act that took place on January 1, 1998, there would be no coverage under the policy. This is because the wrongful act took place prior to the January 1, 2000, retroactive date. Now assume that another insured has a policy written with the same January 1, 2010–2011, policy term, but the policy contains no retroactive date. If a claim were made against the insured on July 1, 2010, from a wrongful act that took place on January 1, 1998, coverage would apply because the absence of a retroactive date means that, regardless of how far in the past a wrongful act giving rise to a claim took place, the claim will be covered (as long as it is made against the insured during the policy period). Full prior acts coverage is most likely to be granted when an applicant already has coverage in place at the time it submits an application. On the other hand, underwriters generally do not provide full prior acts coverage to insureds that have not previously purchased liability insurance. This is because underwriters sometimes believe that an applicant's desire to buy coverage at this juncture may be motivated by the applicant's intention to report a claim under the new policy.

full severability provision—Provision in a directors and officers (D&O) policy application that knowledge of either the signer of the application or certain executive officers is not imputed to any other insureds, and, thus, such innocent persons will have coverage despite the application's false statement or knowledge about the false statement.

IDL coverage—A variation on Side A-only policies providing directors and officers (D&O) liability coverage for independent directors only.

initial public offering (IPO)—The process of selling stock in a corporation for the first time to the general public. IPOs are handled by investment banking firms, which study the corporation's financial situation and then decide how many shares of stock should be sold and at what price. Individual investors are sometimes shut out of IPOs because investment bankers typically dole out IPO shares to institutional customers, such as mutual funds, pension funds, banks, and insurance companies. Accordingly, IPOs have received particular attention in recent years because class action lawsuits against corporate directors and officers have arisen in conjunction with the way in which the IPOs were allocated among various parties. Such claims are known as IPO laddering claims.

integrated excess policies—Excess insurance policies that can apply as additional coverage over one or more different types of primary liability policies, which are usually, but not always, written on a claims-made basis. Integrated excess policies are also known as "flexible excess" policies and most often apply as excess coverage over directors and officers (D&O), employment practices liability (EPL), and fiduciary liability policies. Integrated excess policies are written with a single, aggregate limit for all of the underlying coverages to which the policy applies.

intentional torts—A category civil wrongs resulting from an intentional act by the wrongdoer (tortfeasor).

IPO—See Initial public offering.

limited severability provision—A provision in an application for directors and officers (D&O) liability insurance stating that knowledge possessed by any insured persons, other than the signer of the application or certain executive officers (usually the CEO, COO, and CFO), will not be imputed to other insureds in a claim situation. For example, if an insured were aware that a coverage application contained false financial data, this knowledge—which would ordinarily bar coverage in a claim situation—will not be attributed to any other insureds who did not know that the financial statements were false. As a result, these so-called innocent insureds will have coverage under the policy. However, if either the signer of the application or one of the three executive officers had knowledge of the false data, their knowledge would be attributed to the innocent insureds, and coverage would be barred for the "innocent insureds" as well. A limited severability provision is much less favorable for insureds, compared to a full severability provision. However, only a minority of insurers' application forms contain limited severability provisions.

management liability insurance—Insurance that covers exposures faced by directors, officers, managers, and business entities that arise from governance, finance, benefits, and management activities (also called "executive liability insurance"). This includes (1) directors and officers (D&O) liability insurance, (2) employment practices liability (EPL) insurance, (3) fiduciary liability insurance, and (4) "special crime" insurance (covering kidnap, ransom, and extortion exposures). These coverages may be written as stand-alone insurance policies or combined into a single, "package" policy. Management liability "package" policies usually contain a set of common conditions applying to all of the coverage lines purchased. In most cases, an insured must select a minimum of two types of coverage to be eligible to purchase a management liability "package" policy. This arrangement offers meaningful premium discounts because much of the same data is needed to underwrite employment practices, D&O, fiduciary, and special crime coverages. Management liability "package" policies are usually available only to privately held firms, not-for-profit organizations, and small publicly traded companies (i.e., those with annual sales of under $25 million). Large publicly traded firms generally purchase stand-alone policies.

Management Liability Insurance Specialist (MLIS®)—An insurance certification identifying an individual who has satisfactorily completed seven examinations covering various aspects of management liability exposures and insurance. The program emphasizes insurance policies written to cover directors and officers (D&O), fiduciary, and employment practices liability (EPL). In addition, there is considerable material addressing claims-made coverage triggers, legal issues, underwriting methods, claims management, and loss control techniques. The program is administered by the International Risk Management Institute, Inc. (IRMI), of Dallas, Texas.

most favorable venue wording—A provision found within some directors and officers (D&O), professional, and employment practices liability (EPL) policies stating that, with respect to the insurability of punitive damages, the law of the jurisdiction most favorable to the insurability of punitive damages will apply, provided the jurisdiction meets one of the following criteria. It is the jurisdiction where (a) the punitive damages were awarded, (b) the act giving rise to the punitive damages award occurred, (c) the insured is incorporated or maintains its principal place of business, or (d) the insurer is incorporated or maintains its principal place of business. When this provision is included within a policy that affirmatively covers (or does not exclude) punitive damages, it provides assurance that such damages will be covered by the insurer, despite the fact that covering punitive damages is contrary to law in certain jurisdictions (e.g., California). Most favored venue wording merely modifies the existing level of coverage for punitive damages already provided by a policy. Such wording does not provide coverage if the policy otherwise excludes punitive damages. It is also important to recognize that the validity of this provision has not been tested in court.

non-duty to defend—See Duty to defend.

personal injury (PI)—Under general liability coverage, a category of insurable offenses that produce harm other than bodily injury (BI). As covered by the commercial general liability (CGL) policy, PI includes false arrest, detention, or imprisonment; malicious prosecution; wrongful eviction; slander; libel; and invasion of privacy. Also addressed in the homeowners policy. Under umbrella liability insurance, a broad category of insurable offenses that includes both BI and the offenses defined as "personal injury" in CGL policies.

privately held corporation—A type of corporation whose shares are not for sale to the public. Rather, the shares of privately held companies are usually owned by a small group of persons—often, although not always, family members and/or senior executives and managers of the company. Unlike publicly held corporations, the shares of stock in privately held corporations are not listed on the major stock exchanges.

punitive damages—Damages in excess of those required to compensate the plaintiff for the wrong done, which are imposed in order to punish the defendant because of the particularly wanton or willful nature of his or her wrongdoing. Also called "exemplary damages." Although the standard commercial general liability (CGL) policy and business auto policy (BAP) contain no punitive damage exclusion, many umbrella and excess liability policies contain such an exclusion.

quota share excess directors and officers (D&O) programs—An approach involving the assumption of a given layer of excess coverage by more than one insurer.

retention—(1) Assumption of risk of loss by means of noninsurance, self-insurance, or deductibles. Retention can be intentional or, when exposures are not identified, unintentional. (2) In reinsurance, the net amount of risk the ceding company keeps for its own account.

retroactive date—A provision found in many (although not all) claims-made policies that eliminates coverage for claims produced by wrongful acts that took place prior to a specified date, even if the claim is first made during the policy period.

For example, a January 1, 2010, retroactive date in a policy written with a January 1, 2010–2011, term, would bar coverage for claims resulting from wrongful acts that took place prior to January 1, 2010, even if claims (resulting from such acts) are made against the insured during the January 1, 2010–2011, policy period.

There are two purposes of retroactive dates: (1) to eliminate coverage for situations or incidents known to insureds that have the potential to give rise to claims in the future and (2) to preclude coverage for "stale" claims that arise from events far in the past, even if such events are unknown to the insured. In the former case, the retroactive date preserves the principle of "fortuity"—that is, the insurer should not be called upon to cover the so-called burning building. In the latter instance, the retroactive date makes policies more affordable by precluding coverage for events that, while insurable, are remote in time.

Securities Exchange Act of 1934—The Act and its accompanying rules were enacted to protect investors in connection with the trading of securities already issued and outstanding. The most important components of the Act are Section 10(b) and Securities and Exchange Commission (SEC) Rule 10b-5, which prohibits manipulative or deceptive acts in connection with the purchase or sale of a security. Corporate directors and officers are frequently the targets of lawsuits brought under these antifraud provisions.

severability of interests clause—A policy provision clarifying that, except with respect to the coverage limits, insurance applies to each insured as though a separate policy were issued to each. Thus, a policy containing such a clause will cover a claim made by one insured against another insured.

severability provision in directors and officers (D&O) applications—A provision in an application for D&O liability insurance stating that knowledge of material, false statements in the application that is possessed by one insured will not be imputed to other insured(s). For example, if one insured was aware that a coverage application contained false financial data, this knowledge—which would ordinarily bar coverage—will not be attributed to any other insureds who had no knowledge that the financial statements were false. As a result, these so-called innocent insureds will have coverage under the policy. Most D&O insurers offer what is known as a "full severability provision" within their application forms, which is advantageous for insureds. However, a significant minority of insurers use what is known as a limited severability provision, which is not nearly as favorable for policyholders.

Side A coverage—The section of coverage under a directors and officers (D&O) liability insurance policy affording "direct" coverage of an organization's directors and officers. This portion of the policy provides direct indemnification to the directors and officers for acts for which the corporate organization is not legally required to indemnify the directors and officers.

Side A-only coverage—A directors and officers (D&O) liability policy that provides only "direct" coverage of the directors and officers but does not cover the corporation's legal obligation to indemnify the directors and officers (known as Side B or corporate reimbursement coverage). Side A-only forms are written on either an excess or umbrella basis over a primary D&O policy. When written on an excess basis, they provide additional limits if a claim exhausts the coverage available under the primary form. When written on an umbrella basis, Side A-only policies afford broader coverage than the underlying, primary D&O policy, as well as additional limits.

Side B coverage—Another term for what is known as the "Corporate Reimbursement Coverage" section of a directors and officers (D&O) liability policy.

Side C coverage—Another term for what is known as the "Entity Securities Coverage" section of a directors and officers (D&O) liability policy.

subrogation: The assignment to an insurer by terms of the policy or by law, after payment of a loss, of the rights of the insured to recover the amount of the loss from one legally liable for it.

subrogation provision—A provision in an insurance policy addressing whether the insured has the right to waive its recovery rights against another party that may have been responsible for loss covered under the policy. In standard commercial policies, the subrogation provision is called "Transfer of Rights of Recovery Against Others to Us."

underlying coverage—With respect to any given policy of excess insurance, the coverage in place on the same risk that will respond to loss before the excess policy is called on to pay any portion of the claim.

wage and hours claim—An assertion by an employee-plaintiff that his or her employer has failed to pay overtime wages owed to the employee. Within the past several years, a number of high-profile, high-dollar wage and hour claims have been filed on a class action basis, a fact that has vastly increased the dollar amount payable under such lawsuits. Given the magnitude of this exposure, most employment practices liability insurance (EPLI) policies specifically exclude coverage for wage and hour claims.

warranty—(1) A guarantee of the performance of a product. Product warranties are included within the definition of the named insured's product in general liability policies. (2) A statement of fact given to an insurer by the insured concerning the insured risk, which, if untrue, will void the policy.