



20 WAYS TO IMPROVE DIRECTORS AND OFFICERS LIABILITY COVERAGE OR PRACTICES

by Bob Bregman & Sean Jordan

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Directors and officers (D&O) liability insurance is a complicated line of coverage that requires special expertise. Understanding the proper application of D&O coverage forms and keeping abreast of developments that affect the D&O insurance field can be challenging.

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Presented in [Figure 1](#) is a list of 20 D&O practice tips featured in this special report. They were previously featured in *D&O Compass* and were chosen by the authors based on their importance, timeliness, and practicality. These tips were also edited and updated for this special report. For ease of reference, these tips have been assigned categories, and you can link to each tip from the list.

About the Authors

[Bob Bregman](#), CPCU, MLIS, RPLU, and [Sean Jordan](#), CPCU, MLIS, work with the editorial department of [International Risk Management Institute, Inc.](#) (IRMI). Mr. Bregman has been the primary author and editor of the [IRMI professional and management liability publication library](#) for nearly 30 years. Mr. Jordan contributes material to several IRMI references, including *Employment Practices Liability Consultant (EPLiC)*, *Professional Liability Insurance*, and *D&O MAPS*.

Figure 1 Twenty D&O Practice Tips

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D&O Coverage Basics

1. Sort through Side A Coverage Alternatives

The concept of Side A D&O coverage is not new. However, the reemergence of such policies has generated considerable interest. The key point is to first examine and then distinguish between the various forms in which Side A coverage is currently provided.

First, a Side A policy can be written as “pure” excess coverage over a primary D&O policy. In this instance, the Side A policy provides excess limits if the limit available under the primary policy is exhausted. Alternatively, a Side A policy can be written on an umbrella or difference-in-conditions (DIC) basis. Accordingly, in addition to providing excess limits, the policy will “drop down” (1) in the event the Side A coverage provided by the primary policy con-

tains an exclusion precluding coverage in a given claim situation (e.g., an exclusion for claims caused by financial restatements) that is not likewise excluded by the Side A policy, (2) if the primary policy is rescinded by the insurer, or (3) if a court rules that the proceeds of the primary policy belong to the bankruptcy estate of the corporate organization rather than to the individual directors and officers.

The point to recognize is that use of the term “Side A coverage” connotes anything BUT a monolithic, “one-size-fits-all” product.

Second, regardless of whether a Side A policy is written on a “pure” excess basis or provides broader umbrella/DIC coverage, there is yet another important available variation: Side A coverage can be written to apply to all of the organization’s directors and officers or to only its outside directors. (One argument for covering the latter but not the former is that outside directors require a greater level of protection since, given the nature of their position, they are further removed from the organization’s inner workings as compared to inside directors.)

Finally, although rarely, Side A policies can be written as primary coverage, leaving the Side B exposure self-insured. The rationale for this approach is that only Coverage A is truly necessary to protect the directors and officers. This is because the coverage afforded by Coverage B (corporate reimbursement) can be self-insured by the corporate organization (in theory, at least), whereas the coverage offered by Coverage A cannot, since it applies only to claims for which the organization is not legally obligated or is financially unable to provide indemnification.

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The point to recognize is that use of the term “Side A coverage” connotes anything BUT a monolithic, “one-size-fits-all” product.

2. Negotiate Side C Retention Provisions

Two special rules usually apply to the retention provision when a claim is made under Side C (entity securities coverage) of a D&O policy. In this D&O coverage tip, we explain the logic behind these two important differences.

First, unlike the retention provision in the corporate reimbursement coverage section (Side B) of the policy, whereby both defense and indemnity are subject to the retention, under the entity securities coverage section, the retention typically applies only to defense costs but not to indemnity payments. Assume an insured’s retention under the entity securities coverage section is \$1 million. If, for example, a securities claim is settled for \$5 million in indemnity and \$750,000 in defense costs, the insured pays the \$750,000 expended for defense and the insurer would make the \$5 million indemnity payment. Only the \$750,000 in defense costs, but not the \$5 million indemnity payment, is subject to the retention. In effect, when it is clear that claim allegations are valid and must therefore be settled rather than contested, this approach provides incentive for the insured to conclude the claim on an expedited basis, hopefully for less than \$750,000 in defense costs. At the same time, this benefits the insurer, since an accelerated settlement offer is likely to reduce the amount of its indemnity payment.

Second, if it is ultimately determined (usually in the form of a summary judgment dismissal by a court) that the insured is not liable for a securities claim, no retention would apply to either

defense or indemnity payments. Again, this is in contrast to the approach used under the corporate reimbursement coverage section of the policy, whereby the retention applies to both defense costs and indemnity payments. Thus, in the scenario above, if \$1 million was expended in defending the claim but no indemnity payment was made, the \$1 million in defense costs would not be subject to the retention and the defense costs would be paid by the insurer on a first-dollar basis. This approach gives the insureds an incentive to vigorously defend meritless claims; if successful in doing so, waiver of the retention is the insured’s reward. It also helps the insurer, because by virtue of the insured’s successfully contesting the claim and earning a dismissal, the insurer does not have to make an indemnity payment.

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Many, but not all, D&O policy forms contain these two special retention provisions for securities claims. However, given the win-win nature of this approach for both the insured and the insurer, policyholders should request such provisions if they are not already found within their current form.

3. Carefully Craft D&O Policy Severability Language

The outcome of a case involving Cutter & Buck and Genesis Insurance Company demonstrates the importance of obtaining “full” severability within a D&O policy. See *Cutter & Buck, Inc. v. Genesis Ins. Co.*, 306 F. Supp. 2d 988 (W.D. Wash. 2004).

But there was one critical exception: knowledge possessed by a signer of the application was imputable to innocent insureds, which is exactly what transpired in this situation.

In 2000, Cutter & Buck's former chief financial officer (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 highly questionable 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 Co. responded by rescinding coverage on the basis of the insured's misrepresentation of material facts on its D&O coverage application. The application was signed by the former CFO, who eventually pleaded guilty to fraud charges.

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The policy'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 is exactly what transpired in this situation.

The judge found that Genesis was correct in rescinding coverage. This was because the wording of the policy'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 innocent directors and officers.

The bottom line: a D&O policy's severability provision should be written so that (1) an insurer can only rescind coverage as respects an individual who has actual knowledge of material facts and (2) knowledge of one insured cannot be imputed to other insureds who do not possess such knowledge. Had the Cutter & Buck severability provision been written in this manner, the insurer's argument for rescission would have been much more difficult to make.

4. The Importance of a D&O Policy's Definition of "Claim"

Although it looks like a clear-cut issue, the manner in which a D&O policy form defines the term "claim," so as to trigger coverage, is not as straightforward as it may appear. While there is similarity regarding D&O policy definitions of "claim," insurers' approach to this issue is anything but uniform.

Ideally, a definition of "claim" should trigger an insurer's obligation to defend and/or pay for

the cost of (1) criminal proceedings, (2) claims containing written demands for both monetary and nonmonetary relief, and (3) administrative investigations requiring a formal and/or an informal proceeding. Many, but not all, D&O policies' definitions of "claim" encompass all three of these important elements.

A policy form should unambiguously state that the defense of criminal proceedings falls within its definition of "claim." The need for such coverage is apparent given the high percentage of securities class action claims that have also involved criminal prosecutions. Moreover, defense coverage for actions seeking nonmonetary relief should also be pro-

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vided within a policy's "claim" definition. In addition, there needs to be coverage for the costs of administrative hearings and investigations.

5. Check Dispute Resolution Provisions Carefully

No one expects to become embroiled in a claim dispute with his or her D&O insurer, but the possibility is far from remote. A Towers Watson D&O survey conducted in 2012 revealed that 21 percent of insureds were "dissatisfied" with their insurer's claims-handling process.

Given the reality of potential coverage disputes with a D&O insurer, it is wise to carefully check the dispute resolution provisions in the policies you buy or sell. Most such provisions

address this possibility by means of “alternative dispute resolution” (ADR) provisions.

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Among the points that demand particular scrutiny in any ADR provision are the following.

- **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 most 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 a handful of 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.

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- **Binding.** Are the results of the arbitration binding? Under most, but not all, policies, 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.
- **Law.** Is the controlling law stipulated? Again, assuming the policyholder 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. In ad-

dition to their own costs, provisions requiring the insureds to pay the insurers' costs 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.

6. Watch Renewal Dates When Reporting Claims

Because some D&O policies are written on a claims-made and reported basis, particular care must be taken when the insured receives a claim around the date of the policy's renewal/expiration date. Coverage can be lost if you don't immediately report the claim before the policy period expires or within the extended reporting period.

In *Westrec Marina Mgmt., Inc. v. Arrowood Indem. Co.*, 163 Cal. App. 4th 1387, 78 Cal. Rptr. 3d 264 (Ct. App. 2d Dist. 2008), the insured received a claim letter from an attorney on June 24, 2003, 7 days before a claims-made and reported D&O policy was scheduled to renew with the same insurer on July 1, 2003. When the insured ignored the letter, the attorney filed suit on December 19, 2003. The insured gave the D&O insurer notice of the suit on January 30, 2004, which was within the second D&O policy's term.

However, the court held there was no coverage under either D&O policy. First, the court held that the June 24, 2003, letter qualified as a "claim," even though the attorney did not specify an amount the claimant would have accepted in settlement.

Second, the court held that the lawsuit filed on December 19, 2003, arose out of the same facts as the June 24, 2003, letter, and that, therefore, the lawsuit would be deemed a part of a “single claim.”

Third, the terms of the D&O policies only covered claims first made during the policy period and reported within 30 days after the expiration of the policy. In other words, the claim had to be “first made” and reported in the same policy period (or within 30 days thereafter) for coverage to apply. Here the claim was “first made” in the June 24, 2003, letter, during the insurer’s first policy period, but was reported 6 months later on January 30, 2004, during the insurer’s second policy period. Thus, neither policy was triggered.

When you receive a demand letter, it is very important to be aware of the renewal date of a claims-made and reported policy, as the *Westrec Marina* case demonstrates. If the demand letter is received early in the policy period, there may be time to wait and see whether or not the matter ripens into litigation. But if the demand letter is received near the time when the claims-made and reported policy is about to expire, the insured does not have the luxury of waiting a few months to see how the claim develops; rather, the claim must be reported to the insurer immediately.

7. Maintain Coverage Continuity

Potential coverage problems can result when retroactive dates are advanced in D&O policy renewals. When a retroactive date is advanced, a coverage gap will result. And advancement is much more likely to occur when an underwriter provides coverage for a new, rather than a renewal, account. This is because new

underwriters are sometimes reluctant to afford coverage for periods during which they did not insure a given risk (i.e., prior acts).

Continuity disruption is an especially acute problem in D&O insurance, where most programs involve multiple excess coverage layers. If, for example, an excess insurer is unable to offer the same limit as in previous years, the entire “tower” of excess coverage above it becomes nonconcurrent if retro dates are advanced in higher-layer policies. Of course, coverage continuity can be maintained, but only if the insured remains with the same insurer each year and with the same policy limit in the overall “tower” of coverage.

Unfortunately, hard markets have a way of upsetting the all-important continuity of a D&O program. This most often happens when, in a capacity crunch, insurers can’t provide the same policy limits as they did in previous years. Peter R. Taffae, managing director of Executive Perils, a Los Angeles wholesale broker, had this take on the problem: “I look at the carrier’s capacity during the last hard market. Then, regardless of the insurer’s increased capacity in succeeding years, I still use this same hard market limit when building a program.”

As an example, consider an insurer that, during the hard market of 2002, wrote a \$15 million layer, excess of a \$15 million primary policy for an insured. Mr. Taffae advises that this insurer should continue to occupy the \$15 million layer excess of the \$15 million primary policy in all subsequent years, even if the market softens and the insurer’s capacity increases. That way, if a hard market ever returns, he can be sure that that insurer will still be willing to write at least that minimum of \$15 million in coverage at that layer. “We should learn from the past to mini-

mize problems in the future. In previous hard markets, I remember \$200 million D&O programs having to be rewritten midterm due to loss of reinsurance,” he said.

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“Putting together a program this way takes more effort on the front end,” he commented. “But even in the tightest markets, I’ve always been able to retain the same program structure and achieve the ultimate goal of maintaining coverage continuity.”

8. Ensure ERP Provisions Cover “Notice of Circumstances”

A key variable within the extended reporting periods (ERPs) found in D&O liability policy 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 are covered by the ERP.

More specifically, under a substantial minority of D&O policy forms, a formal claim (i.e., receipt of an actual lawsuit) must first be made against an insured before coverage is triggered. In contrast, under most, although not all, policies if an insured reports a set of circumstances that could later produce a claim, coverage becomes immediately available under the ERP. If, at a later date, those circumstances do mature into a formal claim, coverage will be provided.

Let’s look at a concrete example of how these two versions of the ERP provision differ. Com-

pany “A’s” D&O policy expires on January 1, 2017, at which time the company buys a 1-year ERP, effective on that date. On August 1, 2017, “A” becomes aware of circumstances that have not yet materialized, but could potentially materialize, into a formal claim. Under most insurers’ ERP wording, the report of such circumstances would immediately trigger coverage. However, as already noted, under a considerable number of other insurers’ ERP wordings, no coverage would apply until the organization has actually had a formal claim made against it.

In the latter situation, Company “A” would be compelled to purchase another ERP at the expiration of the current 1-year ERP, if the potential claim had not yet been made against the company but was expected in the future. Under these circumstances, the advantage of having an ERP that is triggered by notice of circumstances—rather than an actual claim—is apparent.

This drawback is compounded by the fact that some insurers’ forms allow insureds to purchase only a single 1-year ERP provision, a situation that would have been especially disadvantageous for the insured in this scenario noted above. Moreover, even if an additional 1-year ERP were offered by the insurer in this instance, given the looming claim, the ERP would be extremely costly.

The need to purchase an ERP most frequently occurs when a company is acquired by another. This is because the acquiring firm’s D&O policy will not cover claims resulting from wrongful acts that took place prior to the acquisition. In such cases, an ERP that covers circumstances—in addition to formal claims—is especially valuable.

The takeaway: First, determine whether your D&O form's ERP provision includes favorable "notice of circumstances" language. If not, attempt to negotiate such an extension. And since the majority of, although by no means all, insurers' forms include such wording, you will be on firm ground in making this request.

9. Beware the Multiple Meanings of "Entity Coverage"

When referring to the concept of "entity coverage," it is important to understand that the manner in which such coverage actually functions depends upon the type of policy being considered. The nature of the entity coverage provided under a D&O form written for a publicly held firm varies considerably from that found within policies covering both nonprofit and privately held organizations.

Under corporate D&O forms, entity coverage applies only to claims involving securities issued by the corporate entity. The most familiar claims to which entity coverage applies are shareholder class action suits alleging that management's errors or omissions caused a drop in the corporation's share price and ultimately a loss to the shareholders.

In contrast, under D&O forms written for nonprofits and privately held organizations, entity coverage is truly that—the corporate entity is covered for all types of claims (unless excluded), including those involving securities issued by the organization. (Admittedly, the securities exposure is minimal for privately held firms and nonexistent for nonprofits.)

The fact that the entity coverage within nonprofit and private company D&O forms is not restricted to securities-related claims creates a

strong selling point for such policies. While there is no limit to the kinds of scenarios under which these entities could be named in a non-securities lawsuit, representative claims might include allegations that the entity did one of the following.

- Breached a contract to supply or buy certain goods or services
- Used a preacquisition due diligence process as a ruse to gain information about a competitor
- Hired away several of a competitor's key personnel, who then revealed their former employer's trade secrets

While none of these types of claims against the company would be covered under the entity coverage found within a D&O policy written for a publicly held company, they would be covered by a policy written for a nonprofit or privately held company.

D&O Defense Provisions

10. Understand D&O Policy Defense Provisions

There are two distinct types of defense provisions contained within D&O policy forms: duty to defend provisions and non-duty to defend provisions. The differences between the two are considerable and can significantly affect the manner in which a claim is handled—and ultimately resolved—under a policy.

Neither of these two defense provisions is necessarily superior to the other. Rather, the insured should select a policy containing the

particular provision that is better suited to its internal corporate structure and individual needs.

Duty to defend provisions rest within the insurer's (rather than the insured's) responsibility for defending claims and managing the litigation process. Among the most important aspects of managing claims is selecting defense counsel. While duty to defend policies give insurers considerable control over the litigation process, they are nevertheless beneficial for many insureds. This is especially true for smaller organizations and nonprofit firms that lack both the experience and internal legal staff required to manage complex litigation.

Non-duty to defend (also known as "duty to pay") provisions require only that the insurer pay, as incurred, defense costs, judgments, and settlements. In contrast to duty to defend provisions, they place responsibility for managing a D&O claim within the province of the insured. (However, it should be mentioned that even most non-duty to defend wording allows the insurer to have final approval over the insured's choice of defense counsel.) Non-duty to defend policies are most often selected by larger organizations because they have more experience in handling complex litigation as well as internal legal staff to do so.

One final note: duty to defend and non-duty to defend provisions are not generally an option to be selected within a single policy form. Rather, policies are most often written with either one provision or the other. Accordingly, the insured should select among D&O policy forms containing the particular defense provision better suited to its individual needs.

11. Analyze Variations between Counsel Selection Provisions

In contrast to commercial general liability (CGL) policies, the D&O forms used to insure large and medium-sized public corporations do not require the insurer to defend the insured in connection with potentially covered claims. Rather, it is nearly always the obligation of the insured to hire an attorney to defend such claims.

Therefore, when buying or selling D&O insurance, it is a good practice to determine whether the D&O policy mandates use of panel counsel for certain types of litigation.

Despite the lack of the insurer's duty to defend claims, some policies nevertheless require the insured to select counsel from a "panel counsel" list provided by the insurer. In some instances, the insured must select from this list only for securities claims, while under other forms, panel counsel must be utilized for all types of litigation. Since insurers may or may not be flexible in allowing the insured to retain counsel not included on the panel counsel list, it is best to negotiate this item before purchasing the policy.

Therefore, when buying or selling D&O insurance, it is a good practice to determine whether the D&O policy mandates use of panel counsel for certain types of litigation. If it does, it may be possible to negotiate with the insurer to add the firm of the insured's choosing. One final caveat: although an insurer may be amenable to such an arrangement, it may place a limit on the per-hour billing rate charged by this firm, based on the fact that panel counsel

often agrees to reduced fees for their work in conjunction with certain insurers.

12. Evaluate Coverage Provisions Addressing Reimbursement for Noncovered Defense Costs

In the event it is ultimately determined that a claim is not covered by a D&O policy, most insurers' forms give the insurer the right to seek reimbursement from the insured for defense costs expended on the insured's behalf. For example, the majority of policies require the insurer to defend until "a final, nonappealable adjudication." If at the time of "final adjudication" an insured is found to have acted with criminal intent in causing a claim, the provisions found in most D&O forms state that an insurer is entitled to seek reimbursement of defense monies paid on the insured's behalf.

One even less favorable (and fortunately less common) variation of this provision states that not only does an insurer have the right to seek reimbursement of noncovered defense costs but, in addition, indicates that an insured's failure to reimburse such costs reduces remaining available limits under the policy.

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. However, an argument can also be made that prohibiting an insurer from seeking reimbursement of noncovered defense costs also benefits an insurer. This is because a statement in the policy that the insurer has the right to reimbursement under these circumstances puts the insured and the insurer in an adversarial position during the process of defending a

claim, which is ultimately detrimental to both parties.

Admittedly, it is difficult to negotiate a provision barring an insurer from seeking recoupment of noncovered defense costs. Nevertheless, insureds should resist policy provisions stating that remaining policy limits are reduced to the extent that such reimbursement is not made by the insured.

13. Treat Your D&O Insurer as a Business Partner in Claim Settlements

It is important for insureds to respect the contractual right of a D&O insurer to consent to any and all settlement deals. Ignoring the insurers may jeopardize your coverage. In one case, Bear Stearns tried to force its primary and excess D&O insurers to accept an unapproved settlement, despite clear policy language requiring it to first obtain their consent.

In *Vigilant Ins. Co. v. Bear Stearns Cos., Inc.*, 10 N.Y.3d 170 (2008), the D&O policy contained a provision stating as follows.

The Insured [Bear Stearns] agrees not to settle any Claim, incur any Defense Costs or otherwise assume any contractual obligation or admit any liability with respect to any Claim in excess of a settlement authority threshold of \$5,000,000 without the Insurer's consent, which shall not be unreasonably withheld.

Further, the D&O policy stipulated that "[t]he insurer shall not be liable for any settlement, Defense Costs, assumed obligation or admission to which it has not consented." These provisions were incorporated into the follow form excess layers providing up to \$40 million in coverage.

Despite this clear language, Bear Stearns did not obtain the consent of its D&O insurers before it agreed to pay \$80 million to settle charges by the Securities and Exchange Commission (SEC), National Association of Security Dealers (NASD), and the New York Stock Exchange (NYSE) that its stock analysts made buy recommendations to support Bear's investment banking business. The New York Court of Appeals (the state's highest court) held that Bear Stearns forfeited its right to collect \$40 million in D&O coverage because of that mistake.

However, where the directors and officers have agreed to a policy provision giving the D&O insurer the contractual right to consent to a settlement, the D&O insurer must be treated as a full business partner in the decision to settle a claim rather than as merely the ATM that funds the settlement.

Being accustomed to complete authority over their corporations, perhaps many directors and officers feel that they can likewise exercise complete authority over the disposition of a D&O claim. However, where the directors and officers have agreed to a policy provision giving the D&O insurer the contractual right to consent to a settlement, the D&O insurer must be treated as a full business partner in the decision to settle a claim rather than as merely the ATM that funds the settlement.

14. Recognize the Importance of Duty To Defend Forms with "All Allegations" Defense Coverage

Under a duty to defend policy, the insurer is obligated to defend all of the allegations in a lawsuit,

as long as at least one such allegation is covered by the policy. The following scenario illustrates this point. A former employee with 20 years of service is terminated by a private company. At the time, she owned a considerable amount of stock in the organization. Her lawsuit against her former employer's directors and officers alleges that (1) she was forced to sell her company stock at far less than its true value at the time of termination (i.e., a minority shareholder claim), (2) the company illegally prevented her from working in the same industry for a competitor firm by obtaining a restraining order (i.e., a claim of tortious interference with contract), and (3) the company owes her unpaid overtime wages (i.e., a wage-and-hour claim).

Although damages arising from the first two allegations are covered by the standard private company policy form, the wage-and-hour claim is excluded. However, since coverage exists for allegations 1 and 2, an insurer, under a duty to defend policy, must also defend the wage-and-hour claim (although it would not be liable for any potential damages). In contrast, under a non-duty to defend policy, the insurer would only be obligated to pay the costs of defending counts 1 and 2, but not count 3.

(There are two drawbacks associated with duty to defend policies. First, they place control of the litigation process within the insurer's discretion, and, second, they authorize the insurer, rather than the insured, the right to select defense counsel. Despite these disadvantages, for the typical private company that has less experience in managing complex litigation than the average public company, this is not really problematic and may, in fact, be a better approach.)

Although private company forms are almost universally written on a duty to defend basis,

this is not the case with public company directors and officers policies, a number of which are only available on a non-duty to defend basis.

D&O Exclusions

15. The Importance of Severability Wording in Conduct Exclusions

A decision by the Fifth Circuit Court of Appeals illustrates how coverage under a D&O policy can literally turn on a single word.

In *TIG Specialty Ins. Co. v. PinkMonkey.com, Inc.*, 375 F.3d 365 (5th Cir. 2004), the court held that a personal profit exclusion found within the insureds' D&O policy applied not only to one director that obtained profits illegally but to innocent directors, as well. Thus, the Fifth Circuit's ruling had the effect of barring coverage for directors that did not receive an illegal profit or gain. The actual exclusion reads as follows: "This insurance does not apply to ... Any Claim based upon, arising from, or in consequence of an Insured having gained in fact any personal profit, remuneration, or advantage to which such Insured was not legally entitled."

To avoid such results, insureds should add a severability clause to their D&O policy applicable to each conduct exclusion it contains.

In this case, the court ruled that the exclusion applied when "any" insured had obtained an illegal profit. And since one insured did, in fact, do so, such wording also precluded coverage for those insureds that did not obtain an illegal profit. However, the court noted that coverage

would have been available to the innocent directors had the exclusion stated that it applied when "the" insured—rather than "an" insured—obtained an illegal profit.

It is possible that the court's decision did not reflect the intention of the insurer and likely it did not reflect the intention of the insured. The Fifth Circuit's holding relies on a strict interpretation of the exclusion, one with which circuit courts in other jurisdictions may not necessarily concur. But the larger point is to prevent such an interpretation from precluding coverage in the future. To avoid such results, insureds should add a severability clause to their D&O policy applicable to each conduct exclusion it contains. The clause would state something to this effect: "In determining the applicability of this exclusion, the Wrongful Acts of one Insured Person shall not be imputed to any other Insured Person."

16. Negotiate To Remove the Prior and Pending Litigation Exclusion in Renewal Policies

Nearly all D&O policy forms exclude claims arising from litigation that was pending prior to the inception of the policy. For example, assume litigation against a corporation—rather than individual directors—was pending prior to the inception of a policy. If the lawsuit is amended after inception of the policy to name the organization's directors and officers, the prior and pending litigation (PPL) exclusion would preclude coverage. 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.

Despite an insurer's understandable rationale for mandating this exclusion in an initial policy, insureds should attempt to negotiate its removal in renewal policies. The advantage of obtaining this concession is apparent in the following scenario. Assume an organization's initial D&O insurance policy is written with a January 1, 2017, to January 1, 2018, term and contains a PPL exclusion. If the insured negotiates removal of the PPL exclusion in its January 1, 2018, to January 1, 2019, renewal policy, the insured will have coverage for litigation that was pending prior to the initial policy's inception date, in this instance January 1, 2017.

The insured is not without leverage in requesting removal of the PPL exclusion in such instances. First, in the example above, a claim that develops from an incident that took place prior to January 1, 2017, is far enough removed in time to be considered fortuitous. Second, if an incumbent insurer agrees to delete the exclusion, the insured will have additional incentive to remain with that insurer rather than seek a replacement.

17. Beware of the Bodily Injury and Property Damage Exclusion

The purpose of the bodily injury and property damage (BI/PD) liability exclusion in D&O forms is to avoid an overlap in coverage between an insured's D&O policy and its CGL policy. There are, however, two distinct versions of this exclusion. Preferably, the BI/PD liability 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 version, "based upon, arising out of, or in any way related to" should be avoided. This is because such wording could eliminate coverage not only for claims by persons suffering bodily injury or property damage (a CGL exposure), but also with respect to secondary claims by stockholders who sustain financial loss resulting from the bodily injury or property damage of others (e.g., shareholders in an oil company suffer financial losses when a major refinery is blown up by terrorists). Such secondary claims are not covered under a CGL policy, thus creating a gap in coverage if this wording is included.

Preferably, the BI/PD 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."

D&O insurers have not added terrorism exclusions to D&O forms. Nevertheless, a BI/PD liability exclusion using the "based upon, arising out of, or in any way related to" wording could have the unintentional effect of precluding coverage for acts of terrorism.

18. Watch for Exclusions Relating to Certain Corporate Activities

It is not unusual for underwriters to impose D&O policy exclusions for specified corporate activities. In most instances, such exclusions find their way into policies by means of standard or manuscript endorsements. However, in some unusual instances, these restrictions are also included within regular policy forms. Either way, they can eliminate coverage for

significant D&O exposures. The following are several of the most important types of such exclusions.

- **Claims from Going Private/Leveraged Buyouts.** Given the rise in 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.
- **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 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.
- **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. Under-

writers 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.

19. Address the Major Shareholder Exclusion in Private Company D&O Policies

The major shareholder exclusion is one of the major drawbacks inherent in private company D&O liability insurance policy forms. This is because the exclusion typically precludes coverage when a claim is brought by a shareholder who owns at least 15 percent of the company’s stock. Under some policies’ versions of this exclusion, the exclusionary ownership threshold is an even more unfavorable (for the insured) 10 percent and is occasionally as low as 5 percent.

The potential coverage constraints imposed by the exclusion are illustrated in an article titled “A Company Copes with Backlash Against the Raise That Roared” by Patricia Cohen (July 31, 2015, *New York Times*). The piece described a lawsuit brought by Lucas Price against his brother Dan Price, the founder and chief executive officer of Gravity Payments, due to “long-standing differences.” The article did not mention whether a D&O policy was in place. But because the *New York Times* piece stated that

“Lucas Price owns about 30 percent of their company,” even if one exists, it is likely that a major shareholder exclusion would preclude coverage for the ongoing lawsuit.

Despite the exclusion’s legitimate purposes, namely to eliminate coverage for (1) litigation driven more by “infighting” than by true managerial malfeasance and (2) claims that involve collusion, the major shareholder exclusion is an especially thorny problem for privately held businesses. In the vast majority of public companies, it is unusual to have a single individual holding more than 15 percent of the company’s stock. This is not the case when it comes to private firms, where owners routinely hold 15 percent to 100 percent of all shares.

In addition to the specific ownership percentage, there are two other key variables associated with the various insurers’ wording of this exclusion. The first is whether or not the exclusion applies *only* if a major shareholder *also* sits on the company’s board of directors, while the second variable is whether coverage applies—despite the exclusion—if the alleged wrongful act took place *before* the plaintiff became a major shareholder, regardless of *when* the claim is made against the insured.

The takeaways: negotiate for (1) the highest possible ownership share as a threshold percentage (i.e., a policy with a 15 percent threshold is more favorable than one with a 10 percent threshold), (2) a provision stating that the exclusion applies *only* if the major shareholder-claimant *also* sits on the company’s board of directors, and (3) wording that excepts (and thus covers) claims by major shareholders, provided the wrongful act that gave rise to the claim took place prior to the time the claimant became a major shareholder.

Excess D&O Coverage

20. Avoid Strict Exhaustion Requirements in Excess D&O Policies

Exhaustion of primary coverage is an important condition precedent that must occur before excess D&O coverage applies. Yet, excess insurers use significantly different policy language to define “exhaustion.” Such differences can exert a considerable effect on the outcome of claim situations, often to the detriment of insureds.

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 against AIG for \$16 million. 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 \$8.6 million in excess coverage from Lloyd’s.

Unfortunately for the insured, 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 case] have paid or have been held liable to pay the full amount of the Underlying Limit of Liability.”

Based upon such wording, 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) 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, and because there was no court judgment, AIG was never "held liable" to pay anything. Since the terms of the strict exhaustion provision were not fulfilled, the court held that Qualcomm forfeited \$8.6 million in excess coverage.

The real problem in the *Qualcomm* case was that the exhaustion provision was restrictive in that it did not specify that *either* the insured corporation *or* the insured directors and officers (in addition to the insurer) were permitted to pay a portion of the underlying limit. Rather, 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.

There are other configurations of policy language regarding exhaustion of primary cover-

age that would have better suited the insured in the *Qualcomm* case.

For example, a leading excess D&O policy includes an exhaustion provision condition that reads: "... liability 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 Company 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 more favorable language, the "Insured Company" and "Insured Persons" have the independent right to contribute payment toward the underlying limit, which the excess insurer will deem to be satisfied as long as the full amount is paid by any combination of the three listed parties.

Agents and brokers should read the exhaustion provision before recommending an excess D&O policy. If the language specifies that only the primary insurer can pay the underlying limit, it may be wise to negotiate a more liberal exhaustion provision, one that gives the insured the contractual right to absorb a portion of settlement costs without forfeiting excess coverage.



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International Risk Management Institute, Inc.
12222 Merit Drive, Suite 1600 • Dallas, TX 75251 • (972) 960-7693 • www.IRMI.com

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