

Q & A from the ACC webinar held April 22, 2010:

## **“What Do You Mean We’re Not Covered?” – Avoiding the Latest D&O Insurance Issues**

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To view this webinar, click [here](#).

### **Q: What is your experience as to a subpoena becoming the basis for a claim?**

**A:** Depending on the nature of the subpoena, the D&O policy language, and the applicable state’s insurance law, a subpoena may be considered a “circumstance” which could give rise to a claim covered under the policy, or may itself be considered a covered “claim.”

D&O policies are triggered by a “claim” first made against an insured during the policy period for a wrongful act. Most policies provide that, if the insured notifies the insurer during the policy period of circumstances which could give rise to a claim against the insured, and such a claim is later asserted after expiration of the policy period, the insurer will deem the claim to have been first made during the policy period. This provision is important because it might be difficult or impossible for the insured to purchase future policies that would cover claims arising out of the known, past circumstances.

Thus, an insured should promptly notify the insurer if the insured receives a grand jury subpoena or other governmental investigative subpoena, or a discovery subpoena in a civil suit where the insured might ultimately have to contribute to a settlement or judgment. In most cases, the notice will serve to establish which policy period must respond to any ultimate liability.

A related issue, though, is whether the subpoena triggers the D&O insurer’s duty to begin defending its insured. Some courts recognize that, as a practical matter, certain types of subpoenas or information requests to the insured give rise to an immediate need for a defense, and that a prompt defense ultimately benefits the insurer’s interests. Therefore, according to this view, the subpoena triggers the insurer’s defense duty regardless of whether it constitutes a “claim.”

Other courts hold that the insurer’s defense duty is triggered only by a “claim,” and then decide whether a subpoena falls within the policy’s definition of “claim.” Many policies define “claim” to include a civil “proceeding” commenced by a complaint or “similar pleading;” a civil administrative or regulatory “proceeding” commenced by a notice of charges, order, or “similar document;” of a criminal “proceeding” commenced by the return of an indictment, infor-

mation or “similar document.” Courts are split as to whether subpoenas fall within this definition.

If a D&O insurer denies its duty to defend its insured against a subpoena, the insured's best approach is to object to the insurer's denial, pay for a defense lawyer, keep the insurer regularly advised of defense activities, send the insurer copies of defense bills as they are received, and ultimately sue the insurer for reimbursement if a negotiated settlement fails.

**Q: Do you recommend sending a notice of circumstances letter prior to renewal that lists the risk factors in the “K”?**

**A:** As noted above, most policies allow the insured to pull potential future claims into the current policy by notifying the insurer during the policy period of “circumstances” which could give rise to a future claim against the insured. It wouldn't hurt to attach and reference your company's 10-K in your annual notice of circumstances letter, but your D&O insurance policy may require more than a mere listing of risk factors to pull related future claims into the policy period.

Many D&O insurers have language in their policies to avoid getting “laundry listed” by their insureds at the end of the policy period. The sample Chubb policy provided during the webinar, for example, requires specifics about the circumstances which could give rise to a future claim, including the nature of any alleged wrongful acts and alleged or potential damage, the names of all potential claimants and all actual or potential defendants, and the manner in which such insured first became aware of the circumstances. Thus, it's usually best to enhance the listed risk factors with enough detail to show that your company has a reasonable belief the factors might result in a future claim.

It's especially important to provide this detail if your company is planning to switch insurers. A future insurer might deny coverage of any claims arising out of the risk factors described in the insured's past 10-K's, arguing that those claims were highly likely to occur (in view of the past risk factors) and are thus uninsurable. Although the merits of such an argument are debatable, the insured can reduce the chance of a coverage dispute and potential gap in coverage by notifying its current insurer during the policy period of the risk factors listed in the insured's 10-K, along with any required details.

**Q: One of the most significant challenges we face each year in connection with the renewal of our D&O policies is that the actual policies are not issued until several months into the actual policy term. What is the industry doing to correct this problem and what can the insureds do to get final policies shortly after renewal?**

**A:** You are not alone – this is a common complaint of insureds. Some insurers and brokers are becoming more automated and making the actual policies available via the internet, to help reduce paper and speed delivery. But this practice is not yet uniform. Some states have statutes or regulations requiring insurers to deliver the policy within a specified time, but without fines or private enforcement such laws are ineffective.

The insured might take several steps to address this problem. First, as an interim measure, the insured should insist that the broker immediately provide the specimen forms that will make up the policy, and describe in a letter any variation from those forms (including any endorsements) that will be contained in the policy ultimately issued. Second, the insured should repeatedly demand delivery of the policy through frequent, documented contacts with the broker and insurer, and seek help from the state insurance commissioner if those actions don't work.

It's been suggested that, if an insured has an agreement to compensate the broker for its services, the agreement should specify that the compensation will not be paid before delivery of the actual policy, and that late delivery of the policy will result in a specified deduction from the broker's compensation. However, the insured should be cautious about employing this approach, because it could lead to the insurer cancelling the policy for non-payment. The insured must make certain that the insurer has received its premium payments in full and the policy is in good standing.

**Q: Are the terms of insurance really that negotiable?**

**A:** The terms of many D&O insurance policy provisions absolutely are negotiable and, especially in a soft market, can sometimes be negotiated without an increase in premiums. Thus, it's important that your company and its broker keep abreast of the most favorable language available in the market. The Betterley Report, Side A D&O (published biennially by Betterley Risk Consultants (<http://betterley.com>)), and the web sites of the various D&O insurers, are helpful resources for staying up to date.

Before you purchase or renew a D&O policy, make sure your broker specializes in D&O insurance, or consults with a specialist about the most protective language available in the market. Policy terms can be broadened both in general and as to the various insureds involved – the corporation, directors, officers, and management. Negotiating the broadest policy possible up front helps to smooth the negotiation with the insurer when a complex claim against those various insureds arises.

**Q: Have you had situations where some allegations are for covered items, some are not, and the carrier says that they have to apportion between the two types (so for example one allegation of a complaint is just a breach of contract)? If so, have they been successful in apportioning that, and on what basis?**

**A:** D&O insurers typically assert a purported right to apportionment in their reservation of rights letter. An insurer's degree of success on this defense depends on the applicable state's insurance law, and whether the insurer is seeking apportionment of defense costs, a settlement, or a judgment.

In most states, an insurer must defend all claims against its insured if any one claim is potentially covered, so the insurer cannot apportion its costs of defense between covered and non-covered claims. Nevertheless, where an insurer has a duty only to reimburse its insured's defense costs (rather than to both conduct and pay for the defense), some states allow the insurer to deny coverage of any defense costs that are not reasonably related to covered parties or claims. Thus, in the example above (where a complaint contains a

breach of contract claim), all defense costs would be covered if they are all reasonably related to covered claims, even if they are also related to the breach of contract claim.

As to settlements, a number of states have applied two different rules where claims were asserted against both an uninsured corporation and its insured directors and officers:

- Under the “relative exposure” rule, D&O insurers are allowed to apportion the settlement based on the relative exposure of the insured and uninsured parties;
- Under the “larger settlement” rule, D&O insurers are allowed to deny coverage only to the extent that the uninsured party’s liability exposure resulted in a larger settlement payment.

The increased usage of entity coverage and severability clauses in D&O policies, however, has diminished the relevance of these apportionment rules, and whether these rules would be applied to apportionment between covered and non-covered claims (rather than parties) is an open question.

Nevertheless, given the risk of apportionment, it’s important to pay careful attention to the wording of any settlement of a D&O claim. Avoid language that would support an argument that the settlement was based in whole or in part on a non-covered claim or the exposure of a non-covered party, and be prepared to show that the non-covered claims and parties had no effect on the amount of the settlement.

The wording of a judgment, of course, is less controllable than the wording of a settlement. If a verdict or judgment clearly apportions damages among covered and non-covered claims or parties, it’s likely that a court will apply that same apportionment to insurance coverage for the judgment.