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Maximizing executive protection under D&O policies: Common disputes and lessons learned from recent case law

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Several recent decisions have ruled on insurance issues that often affect the coverage available to company executives under directors' and officers' liability insurance policies.

The rulings — both for and against policyholders — address several common exclusions that companies and their officers and directors should consider closely when procuring or renewing D&O insurance.

> The Insured vs. Insured exclusion commonly is subject to carve outs that may bring certain types of claims back into coverage, which is where coverage disputes often arise.

This article introduces these exclusions and provides practical tips and takeaways based on recent case law to avoid surprises and maximize recovery should a claim arise.

'INSURED VS. INSURED' EXCLUSION

The "Insured vs. Insured" exclusion is commonly found in D&O policies and, as its name suggests, bars coverage for claims brought by or on behalf of one insured against another insured.

The exclusion, for instance, may eliminate coverage for claims by a company against its executives or by former or current executives against other executives of the same company.

While the exclusionary language varies widely between policies, it is intended to discourage company infighting by removing intracompany disputes from coverage and to avoid collusion between insureds who may decide to sue the company with the aim of recovering under D&O policies.

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A recent Kentucky federal decision, *Tarter v. Navigators Insurance Co.*[1] highlights the limits of one such exception to an Insured vs. Insured exclusion, which stated in relevant part:

> The Insurer will not be liable under this Coverage Part to make any payment of Loss, including Costs of Defense, in connection with any Claim made against any Insured by or on behalf of any Insured or any security holder of the Company ... unless such Claim is instigated and continued totally independent of, and totally without the solicitation of, or assistance of, or active participation of, or intervention of, any Director or Officer or the Company or any affiliate of the Company.

In *Tarter*, the company's treasurer, among others, sued the company president for allegedly exploiting his position to orchestrate a conspiracy to siphon off profits from the company.

Because both the treasurer and president were "Insured Persons" under the company D&O policy, the court held that the Insured vs. Insured exclusion eliminated coverage entirely.[2]

The president argued that the "assistance" exception to the exclusion applied because one of the underlying plaintiffs was not an insured under the policy.

Despite acknowledging well-recognized insurance interpretation principles requiring resolution of all doubts in favor of the insureds and construing exclusions strictly against the insurer, the court rejected the policyholder's argument because the treasurer was a plaintiff from the outset of the underlying action and "actively participated" in asserting the claims against the company.

The court also reiterated that, because the policy's definition of "Claim" referred to a "civil proceeding" as a whole, rather than an "individual component" of a lawsuit that forms part of the larger action, the presence of insureds on "both sides of the underlying action" negated the insurer's duty to defend any part of the lawsuit.

As a result, the court concluded that the underlying action fit within the intended purpose of the Insured vs. Insured exclusion — namely, "to preclude D&O coverage for 'suits arising out of those particularly bitter disputes that erupt when members of a corporate, as of a personal, family have a falling out and fall to quarreling.'"[3]

The court also declined to find that the policy's allocation provision, which permitted allocation of loss between both covered and uncovered matters within a single "Claim," required the insurer to

provide a defense for that portion of the underlying lawsuit asserted by non-insured plaintiffs.

Interpreting the allocation provision "in juxtaposition" with the "assistance" exception, the court reasoned, would make the exception superfluous by affording coverage for claims asserted by insureds who actively participated in the litigation.

> The Insured vs. Insured exclusion is one of the most frequently litigated provisions in private-company D&O coverage disputes.

While the court ruled against the policyholder, the outcome in other circumstances will be governed by the facts, policy language, and applicable state law at issue.

The Insured vs. Insured exclusion is one of the most frequently litigated provisions in private-company D&O coverage disputes, however, and *Tarter* exemplifies why policyholders must understand how the exclusion and any exceptions apply in practice.

Exceptions to the Insured vs. Insured exclusions include, among others, carve outs for derivative claims brought without the solicitation or assistance of any insured, claims by insured persons for employment-related conduct, claims by bankruptcy trustees, liquidators, receivers, or similar entities, and claims by former directors or officers who have not served in such capacities for several years.

While those exceptions are standard in certain policy forms, carefully crafted policies may bring larger portions of otherwise excluded claims back into coverage through endorsements or manuscript coverage specifically tailored to the company's risks.

PROFESSIONAL SERVICES EXCLUSION

The "professional services" exclusion is commonly found in private company D&O policies and even in some policies issued to publicly traded companies like banks, financial advisors, and other entities that provide professional services

The exclusion is intended to preclude claims that should be covered under errors and omissions or professional liability policies that are tailored specifically to respond to claims for rendering or failure to render professional services.

While the coordination of policies and avoidance of duplicative coverage makes sense in some instances, in practice professional services exclusions can be written so broadly as to eliminate D&O coverage for claims alleging only a tangential relationship with professional services.

In *Atlantic Healthcare LLC v. Argonaut Insurance Co.,*[4] the court took a measured approach and rejected the insurer's broad interpretation of a professional services exclusion that would have rendered large portions of D&O coverage illusory.

The underlying lawsuit, filed by the estate of a deceased patient against a nursing home and its owners, alleged that the defendants caused physical and monetary injuries by breaching various fiduciary and statutory duties.

The exclusion in the D&O policy barred coverage for loss arising out of the "rendering or failure to render professional services" and further defined "professional services" by endorsement to mean "any health care, medical care, or treatment provided to others, or any other professional services, including but not limited to" a number of medical and healthcare-related activities.

The insurer argued that it had no duty to defend the lawsuit because certain allegations related to the provision of healthcare and medical services and because the entire lawsuit concerned "the interaction between a professional healthcare facility and its residents."

The policyholder countered that those allegations were "business decisions" that the officers and directors made in handling the nursing home's affairs.

The court ruled that the professional services exclusion was ambiguous because a reasonable person may have found that it relates only to the narrower subset of health care and medical treatment services listed in the endorsement — not to the business decisions made by the facility's management at issue in the underlying litigation.

Absent extrinsic evidence to resolve the ambiguity, the court was required to construe the exclusion narrowly against the insurer and in favor of coverage.

The court also agreed that it would be inappropriate to adopt the insurer's broad interpretation to construe the exclusion to eliminate coverage for "every kind of professional service imaginable."[5]

The court rejected such a broad interpretation of the exclusion, especially where the insurer failed to establish that "every allegation" in the underlying complaint against the policyholder was for conduct captured by the professional services exclusion — a difficult burden given that the court was required to construe the exclusion narrowly.

Because the policyholder articulated a reasonable interpretation of "professional services" that was beyond the reach of the exclusion, the claim was not barred.

Even though an insurer's duty to defend is interpreted broadly and exclusions are construed narrowly,[6] policyholders should ensure that professional services exclusions are limited appropriately to avoid the risk of losing coverage for D&O claims due to ancillary references to professional services.

Particular attention should be paid to the relevant causation language, as an exclusion "for" the provision of professional services will likely be construed much more narrowly than, for example, an exclusion for claims "arising out of" the provision of professional services.

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Companies also may limit the reach of the exclusion by defining "professional services" through endorsement to include only a limited subset of activities.

The importance of modifying standard-form exclusions in this manner is greater for companies — like those in the banking, financial services, or technology sectors — that provide "professional" services that could form the basis for fiduciary claims against directors, officers, or executives.

As in *Atlantic*, however, even narrowed definitions of "professional services" can pose significant coverage issues if the enumerated activities include catchalls like "any other professional services" or if the list of activities is non-exclusive.

Understanding these key provisions and, if needed, negotiating modifications to problematic exclusions is critical to maximizing coverage.

PRIOR ACTS EXCLUSION

"Prior acts" exclusions are found in claims-made D&O policies to exclude coverage for claims against the policyholder for wrongful acts committed prior to a certain date.

In *Northrop Grumman Innovation Systems, Inc. v. Zurich American Insurance Co.*,[7] the court examined a prior acts exclusion that the insurers asserted would bar coverage for claims made under the insured's D&O policy. The named insured, Orbital ATK Inc., was created after the merger of Alliant Techsystems, Inc. and Orbital Sciences Corporation.[8]

The Alliant-Orbital merger resulted in two class-action lawsuits: one by former stockholders of Orbital Sciences challenging, among other things, proxy solicitation statements about the proposed merger (the "pre-merger claim"); and a second against OATK and certain of its executives regarding allegedly fraudulent post-merger financial reports about the value of OATK's business activities after the merger (the "post-merger claim").

In the ensuing coverage litigation, the insurer argued that there was no coverage for the post-merger claim against the policyholder because the alleged post-merger wrongful acts related back to misconduct alleged in the pre-merger claims, which predated the inception of the policy and, therefore, were barred by the prior acts exclusion.

The court disagreed. In refusing to apply the prior acts exclusion, the court explained that (i) the alleged wrongdoing against the policyholder and its management team in the post-merger claim was unrelated (not "fundamentally identical") to the misconduct alleged in the pre-merger claim, and (ii) the post-merger claim could not be related to the pre-merger claim as a matter of policy interpretation because the pre-merger claim was not a "wrongful act" under the post-merger policies.[9]

When placing and renewing D&O policies, companies must consider whether the policy contains a prior acts date that cuts off coverage for past wrongful acts, as well as a broad "interrelated claims" provision that may be used by an insurer to argue that recent alleged wrongful acts "relate back" to earlier acts allegedly occurring outside the coverage period.

In some cases, insurers may offer "full past acts" coverage without a prior acts exclusion for an additional premium.

The risk that insurers may assert prior acts defenses can heighten where, as in the Alliant-Orbital merger, corporate entities undergo transactions that leave the newly-created merger entity susceptible to claims related to pre-merger activities.

'BUMP-UP' EXCLUSION

Northrop also addresses the application of a "bump-up" exclusion, which is intended to exclude as a covered loss any consideration paid by the policyholder to increase its purchase price of a target company in response to a claim alleging that the price to acquire the target was inadequate.

The purpose behind this exclusion is to prevent the insurance company from essentially becoming an underwriter of a corporate acquisition by contributing to the purchase price of a target company through the use of D&O insurance proceeds.

In practice, however, the bump-up exclusion is often relied upon by insurers in a variety of other situations inconsistent with this narrow purpose.

In *Northrop*, the bump-up exclusion provided in relevant part:

In the event of a Claim alleging that the price or consideration paid for the acquisition or completion of the acquisition of all or substantially all the ownership interest or assets in an entity is inadequate, Loss with respect to such Claim shall not include any amount of any judgment or settlement representing the amount by which such price is effectively increased.[10]

In addition to the prior acts exclusion discussed above, the insurers argued that there was no coverage for the pre-merger claim under the bump-up exclusion.

The parties first disputed whether bump-up language is an exclusion or simply a limit on the policy's coverage grant. The court held that the bump-up provision was an exclusion, even though it was not labeled as such and was structured as an exception to the definition of "loss."

This required the insurer to carry the burden of establishing that the provision clearly excluded coverage, as opposed to being part of the policyholder's burden to demonstrate that the insuring agreement was satisfied.

The court refused to apply the bump-up exclusion for several reasons.

First, the court held that the policy language regarding the "acquisition of all or substantially all" of the assets of a company meant that the provision did not apply to mergers of equals, as was the case in the Alliant/Orbital merger.

Even though an insurer's duty to defend is interpreted broadly and exclusions are construed narrowly, policyholders should ensure that professional services exclusions are limited appropriately to avoid the risk of losing coverage for D&O claims due to ancillary references to professional services.

Second, the court held that the pre-merger claim sought damages as a result of alleged securities law violations and was not exclusively about the payment of "inadequate" consideration for an acquisition.

Rather, looking at the entire complaint, the court concluded that the pre-merger claim centered on the dissemination of an allegedly false and misleading proxy statement used to obtain approval of the merger at issue.[11]

In other words, the claim was covered because the alleged wrongdoing not only coerced the stockholders to accept inadequate consideration but also induced them to approve the merger when they otherwise would not have.

Third, the court held under the specific facts presented that the plaintiffs' claim was more in the nature of a demand for refund of the purchase price by Orbital Sciences stockholders for their overpayment, as opposed to an increase in purchase price by Alliant shareholders for an underpayment.

Given the varied wording of "bump-up" exclusions governing claims asserting inadequate consideration in a transaction, policyholders should closely compare the allegations to each element required for the exclusion to apply.

Not all disputes raised by dissatisfied shareholders following a transaction will amount to a "bump up" claim excluded by D&O coverage.

Indeed, as the *Northrop* court explained, a "federal securities class action about fabricated proxy forms is not the narrowly tailored fit" imagined by that particular bump-up exclusion. Uncertainties or lack of clarity in exclusionary language should be construed in favor of coverage.

KEY TAKEAWAYS

The recent cases discussed above highlight several common exclusions and coverage disputes for companies and their directors and officers to consider when reviewing D&O policies:

- Understand the full policy — not only the insuring agreements and exclusions, but also exceptions to exclusions or carve outs from definitions that can significantly expand or narrow coverage.
- Compare policy language and endorsements to standard-form provisions and re-evaluate on a regular basis whether modifications are necessary based on new or different exposures. Retaining experienced brokers and coverage counsel can help place, renew, and modify D&O coverage programs to mitigate risk and maximize recovery in the event of a claim.
- Provisions limiting or restricting coverage may be treated as "exclusions" subject to a more stringent burden of proof by the insurer, even if those provisions are not labeled as such or included in the "exclusions" section of the policy.
- State law can vary widely and materially impact coverage determinations. Directors and officers like those in Northrop may be afforded greater protections in Delaware, for example, than in other jurisdictions, though there can be significant variations within each state on particular issues. For those reasons, choice-of-law and forum selection provisions can affect the policyholder's ability to take advantage of favorable law.

Notes

[1] 2021 WL 149302 (E.D. Ky. Jan. 15, 2021).

[2] *Id.* at *2.

[3] *Id.* at *9.

[4] 2021 WL 266281 (S.D. Fla. Jan. 27, 2021).

[5] *Id.* at *2.

[6] *See id.* at *4 ("This Court must construe the duty to defend liberally in [the insured's] favor. If any potential for coverage exists — however slight — [the insurer] has a duty to defend.").

[7] 2021 WL 347015 (Del. Super. Feb. 2, 2021).

[8] OATK in turn was acquired by Northrop Grumman Innovation Systems, Inc. in 2018.

[9] *Id.* at *9.

[10] *Id.* at *19.

[11] *Id.* at *20.

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