

Chapter 10

Directors' and Officers' Liability Insurance

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10.1 Amended Complaints as Separate Claims

10.1.1 Community Foundation for Jewish Education v Federal Insurance Co., 2001 U.S. App. Lexis 13764 (7th Cir. June 12, 2001)

Beginning in 1993, the Community Foundation for Jewish Education and the Board of Jewish Education of Metropolitan Chicago were parties to five interlocking three-year contracts under which, among other things, the Foundation performed operating and management services for the Board. On March 18, 1997, after the operating agreements expired, the Board sued the Foundation, alleging that the Foundation had failed to repay two loans as required in one of the contracts.

On May 6, 1997, less than two months after the Board's complaint was filed, the Foundation applied for a claims-made directors' and officers' policy. The Foundation did not disclose its litigation with the Board as part of its application for insurance and it did not seek coverage for the action at that time. Federal Insurance Company issued a three-year policy beginning June 30, 1997.

On November 20, 1997, the Board amended its complaint to add allegations that the Foundation had breached all five of its operating agreements and that the Foundation had committed various business torts. On May 7, 1998, the Board filed a second amended complaint that alleged a conspiracy between the Foundation and a newly added defendant.

The Foundation then submitted the claim to Federal for insurance coverage, asserting that the new tort and contract allegations constituted a separate claim first made during Federal's policy period. Federal disclaimed coverage, arguing that the entire lawsuit was a single claim for which no coverage was available because the claim had been first made – i.e., the original complaint was filed – before the inception date of the policy. The Foundation filed an action against Federal and the U.S. District Court for the Northern District of Illinois held that the amended complaint did not constitute a separate claim first made during the policy period.

The Seventh Circuit affirmed, noting that the definition of "claim" in Federal's policy included "a suit" and reasoning that because a "suit begins in federal court with the filing of a complaint," an amendment of the complaint made within the policy period does not constitute a new suit or claim. Furthermore, the Court found that the wording of Federal's policy compelled the reader to conclude that "once that first claim is made, subsequent variations of the same claim do not qualify as new claims." However, the Court did distinguish this ruling from cases where "the insured is brought into the litigation for the first time through the amended complaint." Because such a claim is "obviously new to that entity," it could constitute a claim first made under the provisions of the policy in effect when the entity is added as a party to the litigation.

10.2 Interpretation of Tax Penalties as Loss

10.2.1 Mortenson v. National Union Fire Insurance Co., 249 F.3d 667 (7th Cir. 2001)

National Union issued a directors' and officers' insurance policy to Opelika Manufacturing Company, whose president was Lee Mortenson. Both before and during his tenure, the company failed to pay payroll taxes. When the IRS brought an action against Mortenson, the parties agreed to settle for \$900,000. Mortenson then submitted the claim to National Union, which denied coverage.

National Union pointed to its policy provision excluding "fines or penalties imposed by law or other matters which may be deemed uninsurable under the law pursuant to which this policy shall be construed." National Union argued that the IRS sued Mortenson under a statute that would make him liable for a penalty equal to the total amount of tax, and that any settlement of such an action therefore would be excluded from coverage.

Mortenson argued that because the policy does not define "penalty," the term is ambiguous and must be interpreted in his favor. In addition, Mortenson argued that the amount he agreed to pay in settlement did not constitute a penalty because "the aim is to collect taxes rather than to punish the willfully delinquent person," as demonstrated by the fact that the IRS had never used "the statute to collect more than the actual amount of unpaid tax." Further, Mortenson argued that the correct definition of "penalty" for the purposes of the policy in question "is a punishment for deliberate wrongdoing, of which the willfulness required for liability under § 6672 (a) is... a pale shadow."

The Seventh Circuit disagreed, stating tersely that "penalties are frequently imposed for conduct well short of wrongdoing." According to the court, the statute in question imposes "the civil counterpart of a fine," and is thus encompassed within the "fines or penalties" provision in the policy. The court also stated that although it was probable "that insurance against the penalty in § 6672 (a) is against public policy because it encourages the nonpayment of payroll taxes," there was no need to decide that issue.

10.3 Interpretation of the Duty of Good Faith and Fair Dealing

10.3.1 American Medical International, Inc. v. National Union Fire Insurance Co., 244 F.3d 715 (9th Cir. 2001)

National Union issued an excess directors' and officers' policy to American Medical International. The primary insurer was Harbor Insurance Company. The policies did not provide coverage for claims against AMI for its own actual or alleged misconduct.

In 1988, several prospective purchasers approached AMI, which established a special committee to evaluate the bids. AMI ultimately accepted an offer from First Boston Corporation. Soon thereafter, a number of shareholders filed class actions against the board,

alleging misconduct in the sale. A former director named Pearce, whose offer to purchase AMI had been rejected, filed a cross-claim against AMI and one fellow director.

In due course, Harbor paid most of its policy proceeds to settle the shareholder actions. However, Harbor refused to settle the cross-claims by Pearce against AMI and the individual director. Among other limitations on coverage, Harbor's policy contained an "insured vs. insured" exclusion. In addition, the definition of "wrongful acts" specifically excluded allegations that directors or officers "attempted to prevent the acquisition of the corporation." AMI gave Harbor a full policy release, even though Harbor failed to exhaust its full \$10 million limit of liability.

AMI continued to press National Union for funds to settle Pearce's cross-claims. Instead, National Union entered into a "Mary Carter" agreement with Pearce. National Union guaranteed him payment of its full policy limit of \$5 million, in exchange for which Pearce released the individual director but continued his suit against AMI. Pearce agreed that any amount he won from AMI would be deducted dollar for dollar from National Union's contribution. During jury deliberations, AMI settled with Pearce for \$16 million, which relieved National Union of any obligation to pay Pearce at all.

AMI filed suit against National Union, claiming breach of contract and breach of the implied covenant of good faith and fair dealing. The trial court agreed and awarded AMI \$12 million. National Union appealed.

The Ninth Circuit reversed, noting that "where there is no coverage of any kind under an insurance contract, the insured may not hold the insurer liable for the breach of the implied covenant of good faith and fair dealing." In this case, the policy did not provide coverage for losses, including defense costs, resulting from allegations against AMI. According to the court, once Pearce released the individual insured, it was no longer possible for AMI to suffer losses covered by the policy.

The court also addressed the "insured vs. insured" exclusion. The court summarily dismissed AMI's argument that the exclusion should not apply since Pearce brought his action as a former director rather than "in his capacity as a director." According to the court, the policy's explicit reference to the term "past director" means that the exclusion "does not really contemplate capacity at all, since a past director has no official role as such."

10.4 Interpretation of "Official Capacity" and "Personal Profit"

10.4.1 *Cincinnati Insurance Co. v. Irwin Co.*, No. C-000107, C-000120 (Ohio Ct. App., Dec 22, 2000)

Irwin Company is a closely-held corporation that issues stock to its employees. Under the company's informal "buy-back" policy, several officers and directors purchased employees' stock for approximately \$20 per share. Unknown to the selling shareholders, the officers and directors had been negotiating a "strategic alliance" with the American Tool Company. The officers and directors eventually ended up selling their shares for \$83 to \$107 per share. Shortly thereafter, the selling shareholders, alleging that they had been duped, instigated lawsuits against the officers and directors, which were promptly settled for more than \$1 million.

Irwin Company's D&O insurer, Cincinnati Insurance Co., denied coverage for the claim. The trial court concluded that the claims were not covered, and on appeal, the Ohio Supreme Court affirmed, noting that the settlements were reached by the officers and directors not in their official capacities but rather their personal capacity. According to the court, 1) there "was no prior corporate approval for the purchase of the treasury stock" at below market value; 2) the "settlement amounts were allocated" according to "the number of Irwin shares owned by the appellant officers and directors, and not upon their relative liabilities for actions taken as officers and directors;" and 3) the settlement amount represented "a return of the personal profit that was realized" from the transaction in question.

10.5 Collusive Settlement

10.5.1 *Continental Casualty Co. v. Hempel, et al.*, 2001 U.S. App. LEXIS 2757 (9th Cir. Feb. 22, 2001)

Continental Casualty Company (among other carriers) insured Frank O. Westerfield, an attorney for an annuity trust. Westerfield had been sued by Charles Hempel for various causes of action arising out of Westerfield's alleged breaches of duty in allowing the executor to misappropriate trust assets. Westerfield and Hempel entered into a settlement to which Westerfield's other insurers contributed. Continental refused to participate, however, in part because it asserted coverage defenses based on allegations of fraud in the underlying complaint.

Under the terms of the settlement agreement, Westerfield assigned to Hempel his claims against any insurer unwilling to contribute to the settlement. In exchange, Hempel agreed not to execute any judgment against Westerfield and to pay him ten percent of Hempel's recovery from Continental.

The underlying case went to trial, but Westerfield's attorney was "instructed by the parties not to exert any effort at all in defending Westerfield." The court entered a judgment against Westerfield in the amount of \$26 million. Hempel then pursued Westerfield's claims against Continental for coverage.

Continental filed an action for declaratory relief and was granted a declaration of no coverage because the settlement agreement had been collusive. On appeal, the court stated that while an insured whose insurer has refused to defend him does have the right to enter into a settlement agreement, the terms of the settlement agreement must nonetheless be reasonable. In this case, the settlement led directly to a \$26 million stipulated judgment that was "wildly out of proportion" to Hempel's actual damages. Furthermore, it did not comport with Hempel's original settlement demand of \$5.5 million.

The court went on to state that the problem with a stipulated or consent judgment coupled with a covenant not to execute is that, while these settlement packages offer substantial protection for defendants whose insurers have wrongfully refused to defend them, there is still "high potential for fraud or collusion." The lack of any personal exposure to damages gives the insured no incentive whatsoever to defend against the claims asserted. Any settlement the court finds to be "the product of fraud or collusion at the expense of a nonparticipating insurer would release that insurer from any obligation under the settlement."

10.6 Restitution Is Not An Insurable Loss

10.6.1 Level 3 Communications, Inc. v. Federal Insurance Company, 272 F.3d 908 (7th Cir. 2001)

Federal Insurance Company issued a directors' and officers' policy to Level 3 Communications. The policy did not include entity coverage for securities claims. In the underlying litigation, the plaintiffs alleged that they had sold shares in their corporation to Level 3 only because of fraudulent representations that Level 3 had made. Plaintiffs sought to rescind the transaction and recover their shares or, alternatively, the monetary value of the shares. Level 3 settled the action by agreeing to pay plaintiffs \$11.8 million.

Federal argued that the settlement was not a "Loss" covered by the policy. The policy defined Loss as "the total amount which any Insured Person becomes legally obligated to pay . . . including, but not limited to . . . settlements." As the court characterized Federal's argument:

It's as if . . . Level 3 had stolen cash from Pompliano and the other shareholders and had been forced to return it and were now asking the insurance company to pick up the tab. Federal continues that a D&O policy is designed to cover only losses that injure the insured, not ones that result from returning stolen property, and that if such an insurance policy did insure a thief against the cost to him of disgorging the proceeds of the theft it would be against public policy and so would be unenforceable.

The Seventh Circuit agreed, holding that a "loss" within the meaning of an insurance contract does not include the restoration of an ill-gotten gain. In this case, because the shareholders sought damages based on the difference in the value of the stock between the sales and the trial date, the court found that the "settlement thus served to deprive the insured of the net benefit of its unlawful acts." Accordingly, the court found that this "restitution" did not constitute an insured loss.

Implications for Securities Fraud Cases

The Seventh Circuit acknowledged that plaintiffs did not characterize their alleged damages as "disgorgement" or "restitution." Rather, they sought the difference between the value of the stock at the time of trial and the price they had received for the stock from Level 3. Nevertheless, the court found that, even though plaintiffs were seeking "standard damages relief in securities fraud claims," the damages sought were restitutionary in nature.

[The underlying litigation] seeks to deprive the defendant of the net benefit of the unlawful act, the value of the unlawfully obtained stock minus the cost to the defendant of obtaining the stock. It is equivalent to seeking to impress a constructive trust on the property in favor of the rightful owner. How the claim or judgment order or settlement is worded is irrelevant. An insured incurs no loss within the meaning of the insurance contract by being compelled to return property that it had stolen, even if a more polite word than "stolen" is used to characterize the claim for the property's return.

The court's interpretation may have particular implications for actions brought under Section 14 of the Securities Exchange Act of 1934, which provides for rescission or rescissory damages, and Section 12 of the Securities Act of 1933, which provides for the recovery of "consideration paid for such security . . ."

When Damages Would Be Loss

The Seventh Circuit anticipated the potential reaction to its interpretation of "loss" by demonstrating "that the D&O policy would not be rendered illusory" by its holding:

An example [of covered loss] would be a fraudulent statement by a corporate officer that inflated the price of the corporation's stock without conferring any measurable benefit on the corporation. Or suppose that unbeknownst to Level 3 the officer had stolen property for its benefit and, not knowing this, Level 3 defended against a suit seeking the return of the property and incurred heavy legal expenses in that defense. Those expenses would be a loss to the company not offset by any benefit to it, unlike the "expense" that consists simply of the value of the stolen property, a wash. . . . All that the plaintiffs in the underlying suit obtained was the amount they received in settlement of their claim against Level 3, and that amount was part of Level 3's gain from its officers' misbehavior.

10.7 Interpretation of "Binding Adjudication of Liability"

10.7.1 JB Oxford Holdings, Inc. v. Certain Underwriters at Lloyd's, 2001 Cal. App. LEXIS 911 (Cal. Ct. App. 2001)

Certain Underwriters at Lloyd's issued a claims-made directors' and officers' insurance policy to JB Oxford. The policy included coverage for "Loss sustained by the Company resulting from any Securities Action Claim first made during the [Policy] Period against the Company for a Wrongful Act." The policy defined a "Securities Action Claim" as including a judicial or administrative proceeding in which the Insureds "may be subjected to a binding adjudication of liability for damages or other relief" for violations of securities laws. The policy also contained an exclusion for claims "brought by or on behalf of any governmental or regulatory agency."

During the policy period, the SEC initiated an investigation and the Justice Department initiated a parallel grand jury investigation to determine whether JB Oxford and at least two of its officers and directors had filed misleading statements with the SEC and engaged in stock price manipulation. Both the SEC and Justice Department served subpoenas as part of their respective investigations.

The company sought indemnity from Lloyd's for the costs incurred in responding to the subpoenas. Lloyd's declined coverage, arguing that the subpoenas did not constitute a proceeding that can result in a "binding adjudication of liability for damages or other relief" and that processing of the subpoenas did not equate with coverage for "claims" or "securities action claims." In addition, Lloyd's relied on a government/regulatory agency exclusion set forth in the policy. JB Oxford filed a complaint against Lloyd's for breach of contract. The trial court found

that the subpoenas issued in connection with the governmental investigations did meet the definition of “Claim” but agreed with Lloyd’s that the government/regulatory agency exclusion applied to preclude coverage.

On appeal, the court distinguished between the “investigative” and “adjudicatory” functions of the SEC, and further noted that a grand jury’s role is explicitly investigatory. The proceedings for which JB Oxford sought coverage could not result in “a binding adjudication of liability,” because liability could result only from actual adjudicative proceedings initiated after the investigations were concluded. Accordingly, the court disagreed with the trial court, finding that neither the grand jury investigation nor the SEC investigation constituted a Claim.

10.8 The Notice Requirement, Definition of “Claim” and Grounds for Rescission

10.8.1 St. Paul Reinsurance Company v. Williams & Montgomery, Ltd, 2001 U.S. Dist. LEXIS 16871 (N.D. Ill. 2001)

St Paul and CNA issued claims-made Employment Practices Liability Insurance policies to the law firm of Williams & Montgomery for the policy period from May 1998 to May 1999.

At the end of March 1999, the insured law firm fired five partners, four of whom immediately sent the firm a letter stating that they were owed money and requesting that the firm “preserve all evidence related to this dispute.” On April 23, 1999, the firm submitted its application to renew the policies for the period from May 1999 to May 2000. According to the court, the application asked whether there had been any unreported “change in the status of any EPL claims or circumstances.” The firm responded “No.” Its managing partner signed the application. The policies were renewed.

On April 29, 1999, the fifth fired partner sent a letter to the firm demanding an accounting and payment of amounts owed to her. The firm failed to report this demand to its insurers. In June 1999, the five fired partners filed two lawsuits. The firm undertook its own defense of the lawsuits but did not provide notice to its insurers until October 15, 1999.

The insurers filed an action for declaratory judgment. They argued that the policies precluded coverage for claims that “arise from a Circumstance of which any Insured has knowledge prior to the inception date of this policy.” The insurers also contended that the insured breached the notice provision of the policy, which required a claim to be reported within thirty days of “the complaint or demand received by your management . . . or a written or oral demand of any kind following employment related or third party action which may result in a claim under this policy.” Finally, the insurers sought rescission of the 1999-2000 policy because the firm had made a material misrepresentation in the application for insurance that affected the risk assumed by the Insurers under that policy. On a motion for summary judgment, the court agreed in all respects with the insurance companies.

Late Notice

The court stated that the firm’s notification to the insurers more than two and a half months after the lawsuits were filed and six months after the demand letters was a “clear violation” of the policy’s notice provisions. The court rejected the assertion that an insurer is required to show

that it was prejudiced by any reporting delay. The court flatly held that under Illinois law, a “showing of prejudice is only required in instances involving an occurrence policy.”

Plaintiffs in this case are not required to show the Court they have been harmed by Defendant's failure to report the claim within thirty days. Plaintiffs only have to show Defendant did not follow the condition precedent to indemnification, i.e. the notice requirement. Additionally, the Court finds it is irrelevant whether or not Defendant received a liability claim under the 1998-1999 Policy or the 1999-2000 Policy. Regardless of whether Defendant should have reported either the claim or a change in circumstances while the 1998-1999 Policy was still in effect, or within thirty days of the June lawsuit filing, it violated the notice requirement and liability does not attach.

Definition of Claim

The court also rejected the law firm's assertion that there was no claim against it until the five partners filed their lawsuits. The firm characterized the “demand letters” it received in April 1999 as “negotiations” rather than actual “claims.” The court cited to “well-established law” that “the common definition of a claim is a demand for money.” The fired partners had written letters to the firm seeking the amounts they believed they were owed. Accordingly, the court found that all the demand letters, and even a newspaper article in which the partners asserted that they were owed money “qualify as claims.”

(With regard to the newspaper article, the court appears to have recognized that it may have gone too far in characterizing the newspaper article itself as a claim. The opinion immediately goes on to say that it was “enough to put an insured on notice of an impending claim” and should have been reported as such under the 1998-1999 policy.)

Material Misrepresentation

The insurers argued that they were entitled to rescind the 1999-2000 policy based on the application's failure to disclose that five terminated partners were demanding compensation from the insured. The court granted summary judgment for the insurers on this issue, stating that in Illinois, an insurer seeking to rescind a policy on the basis of an inaccurate or incomplete application does not have to show both actual intent to deceive and materiality of the misrepresentation; it satisfies its burden with a showing of either. In this case, the court stated that it did not have to determine whether the omission from the application was intentional. It found that the nondisclosure was material because it prevented the insurer from assessing its risk. The court relied in part on a letter from the insurer's underwriter indicating that either the policy would not have been renewed or, at the very least, the premiums would have risen had the underwriter been able to properly assess its risk at the time of application.

The court also noted that the law firm violated its “good faith duty requirement” to disclose all relevant facts that may affect its policy terms:

The applicant cannot pick and choose what to tell his insurer, or take it upon itself to determine whether the information it holds regarding a change in circumstances or conditions that may lead to a future claim are material.

With regard to whether the law firm knew of any change in circumstances or any claims pending, the court applied an objective standard. It found that the letters and the newspaper

article (which quoted the managing partner) demonstrated that the firm had enough information to know the terminated partners were making claims for money. Therefore, the court said, the firm “had adequate knowledge a liability lawsuit against them was a very real possibility.”

10.9 Allocation

10.9.1 *Owens Corning v. National Union Fire Insurance Co.*, 257 F.3d 484 (6th Cir. 2001)

Owens Corning settled a shareholder class action lawsuit brought against itself and its directors and officers. The action alleged misrepresentations in the company's financial statements regarding the company's reserves and charges to earnings with respect to contingent asbestos liabilities.

The directors and officers were insured by a claims-made policy issued by National Union. The policy did not provide entity coverage for claims made directly against Owens Corning. National Union argued that the policy required an allocation between those amounts attributable to allegations against the directors (covered) and to allegations against the corporation (not covered). The policy did not set forth a method for such allocation except that the parties agreed to “use their best efforts” to reach a “fair and proper allocation of the amounts as between the Company and the Insureds.”

The district court applied the “larger settlement” rule, which allows allocation “where that settlement is larger because of the activities of uninsured persons who were sued or persons who were not sued but whose actions may have contributed to the suit.” Based on the “larger settlement” rule, the district court found that Owens Corning's corporate activities did not make the settlement larger than it would otherwise have been, and found that the policy did not therefore require any allocation.

On appeal, the Sixth Circuit preliminarily noted that the PSLRA “sharply limited joint and several liability in shareholder actions, possibly altering the rationale behind the rule.” In this case, however, the settlement preceded the PSLRA regime. Accordingly, the Sixth Circuit framed the issue as whether or not to apply the “larger settlement” rule rather than “its rival, the ‘relative exposure’ rule.” That rule allocates a settlement based on comparing the potential exposure of the uninsured and insured defendants had the litigation proceeded.

The court decided that Ohio law favored the “larger settlement” rule, because it favors coverage. “Allocation is in effect a partial exclusion of the insurer's liability” and “an exclusion from liability must be clear and exact in order to be given effect.” In the absence of clear policy language requiring an assessment of “relative potential liability,” the court held that the “larger settlement” rule governed National Union's policy. The court also agreed with the lower court that Owens Corning had shown that the directors had been sued in all counts in the shareholder action and there no separate claims attributable solely to other corporate employees or to the corporation.

10.10 Uninsurable Willful Conduct

10.10.1 *California Amplifier, Inc. v. RLI Insurance Co.*, 94 Cal. App. 4th 102 (Cal. Ct. App. 2001)

RLI issued an excess directors' and officers' liability policy to California Amplifier. During the policy period, Cal Amp's shareholders sued the corporation and its officers, alleging that they made false and misleading statements to inflate the price of Cal Amp's stock. The class action suit was brought under the state securities statutes rather than federal securities law. The defendants settled and sought coverage under their insurance policies.

The primary carrier contributed to the settlement, but RLI denied coverage. The insureds then sued RLI for breach of contract and bad faith. The trial court agreed with the insurer that the settlement was uninsurable under California Insurance Code Section 533, which provides that "an insurer is not liable for a loss caused by the willful act of the insured."

On appeal, the court examined the requirement for liability under California Corporation Code Sections 25400 and 25500. Section 25400, subdivision (d), makes it unlawful for any person selling or offering securities to make false or misleading statements "which he knew or had reasonable ground to believe" were false or misleading "for the purpose of inducing the purchase or sale of such security." According to the court, one element of the statute – "knew or had reasonable ground to believe" – can be satisfied by a showing of recklessness, but the other – "for the purpose of inducing" – requires "a specific intent to affect the price of a security." Such specific intent, according to the court, constitutes "willful conduct."

In addition, the court found that Section 25500 of the Corporation Code, which authorizes private causes of action, limits liability for damages to a person who "willfully participates in any act or transaction in violation of Section 25400."

The most reasonable interpretation of the phrase "willfully participates" is to limit section 25500 liability to situations where there is an intent to defraud through a knowingly false statement. Only persons who willfully, not merely recklessly, violate section 25400, subdivision (d) can be liable for damages.

The court then turned to the interpretation of "willful act" under the Insurance Code, and defined it as "an act deliberately done for the express purpose of causing damage or intentionally performed with knowledge that damage is highly probable or substantially certain to result." Because Section 25500 liability required the insureds to make a false or misleading statement for the purpose of inducing the purchase or sale of stock, the court found that the conduct constituted an uninsurable "willful act" and affirmed judgment of no coverage.

10.11 Interpretation of the Exclusions for “Deliberate Fraud,” “Illegal Profit or Advantage” and “Insured vs. Insured”

10.11.1 *Alstrin, et al., v. St Paul Mercury Insurance Co., et al., 2002* U.S. Dist. LEXIS 719 (D. Del. 2002)

Cole Taylor Financial Group filed for reorganization under Chapter 11. The directors and officers of a CTFG sought coverage from National Union under a D&O insurance policy for liabilities arising from shareholder class actions alleging violations of the federal securities laws, and for claims filed against them by CTFG’s Estate Representative for fraudulent conveyance and breach of fiduciary duty. National Union’s policy went into effect on February 12, 1997. At that time, CTFG already had a D&O primary policy issued by St. Paul, which was set to expire on July 31, 1997. The National Union policy and the St. Paul policy overlapped for approximately 5 1/2 months from February to July.

National Union asserted coverage defenses based on four policy exclusions. The court rejected them all.

Fraud Exclusion

Exclusion 4(c) excludes claims “arising out of, based upon or attributable to the committing in fact of any criminal or deliberate fraud.” The insureds contended that this provision does not apply to securities fraud, because the policy expressly provides coverage for “Securities Claims” and an exclusion cannot override an explicit grant of coverage.

National Union argued that the policy can cover Securities Claims without covering “deliberate fraud” because recklessness and negligence, respectively, are sufficient for findings of liability under Sections 10(b) and 14(a) of the 1934 Act. Moreover, National Union argued, there must be a judicial determination of deliberate fraud before the exclusion applies, such that coverage would be available for, at a minimum, defense costs incurred in connection with a Securities Claim.

The court disagreed, finding that the exclusion as National Union interpreted it would render coverage for Securities Claims illusory. The court found support for its opinion in a number of cases analyzing policies that provide coverage for intentional torts, such as defamation or false arrest, but also contain exclusions for intentional conduct. “In such circumstances, courts have almost universally held that the exclusion does not apply.”

In essence, National Union is suggesting that where the policy states that it provides coverage for securities claims under the '33 and '34 Acts, it actually only provides coverage for those claims that are based on reckless or negligent behavior. The fact that some limited amount of coverage might survive the intentional act exclusion is not sufficient grounds to apply an exclusion that is irreconcilable with the coverage grant itself, because no one purchasing a policy that provides coverage for securities claims under the '33 and '34 Acts would intend to purchase such restricted coverage.

The court also stated that the “reasonable expectations” of policyholders would not accord with “such limited coverage from a policy that purports to cover all types of securities

fraud claims.” The court therefore held that the “deliberate fraud” exclusion did not apply to Securities Claims.

Illegal Profit or Advantage

Exclusion 4(a) of National Union’s policy excludes claims “arising out of, based upon or attributable to the gaining in fact of any profit or advantage to which an insured was not legally entitled.” The insureds argued that the class action plaintiffs did not allege any specific illegal profit or gain. National Union responded by pointing to the complaint’s allegations that the defendants’ false or misleading representations “inflated the price of Reliance’s common stock and the value of the defendant’s personal holdings, and permitted defendants to protect and enhance their executive positions and substantially increase their compensation.”

The court held that to preclude coverage, Exclusion 4(a) required the complaint to allege that any profit or gain was itself illegal, and that plaintiffs must seek disgorgement of such illegal profit or gain:

Exclusion 4(a), by its terms, requires a profit or gain that is illegal; not an illegal act that produces a profit or gain to the insured as a by-product. This exclusion, therefore, would be applicable in cases of theft, such as insider trading, but is inapplicable to illegalities such as securities misrepresentation to which a private gain might be incidental. . . . Almost all securities fraud complaints will allege that the defendants did what they did in order to benefit themselves in some way. If such an allegation were sufficient to invoke the protections of 4(a), the broad coverage for “Securities Claims” provided by the National Union policy would be rendered valueless by this exclusion.

Insured vs. Insured Exclusion

Exclusion 4(i) of National Union’s policy excluded from coverage any claim made against an Insured “which is brought by any Insured or by the Company” The Estate Representative argued that exclusion 4(i) does not apply to bar coverage for his claims because he is not the “Insured” within the meaning of exclusion 4(i).

The court agreed, stating that under Bankruptcy Rule 2012(a), once the Estate Representative was appointed, “the debtor-in possession” ceases to exist. The court adopted the reasoning of the Southern District of Ohio in *In re Buckeye Countrymark, Inc.*, 251 B.R. 835 (S.D. Ohio 2000), which involved an even broader exclusion for claims brought “by or on behalf of” one insured against another:

the very purpose of the ‘insured v. insured’ exclusion does not apply to adversarial claims brought by the Trustee against the Debtor’s directors and officers and managers. The intent behind the ‘insured v. insured’ exclusion in a [D&O] Policy is to protect the insurance companies against collusive suits between the insured corporation and its insured officers and directors. [citation omitted] When the plaintiff is not the corporation but a bankruptcy trustee acting as a genuinely adverse party to the defendant officers and directors, there is no threat of collusion.

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In the *Alstrin* case, the court found no collusion between the Estate Representative and the directors and officers, and further held that the Estate's claims were asserted on behalf of the Debtor's creditors and not on behalf of the Debtor itself.

With this decision, the court joins the growing ranks of jurisdictions that have ruled that the “insured vs. insured” exclusion does not preclude coverage for an action brought by a bankruptcy trustee against the debtor’s officers and directors.

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