BARNES & THORNBURG LLP

CORPORATE POLICYHOLDER

Volume 1

Risk. Recover. Repeat.

IN THIS ISSUE:

LETTER FROM THE PUBLISHER

Dear Readers,

We are pleased to share this inaugural issue of Corporate Policyholder magazine, a publication of the Barnes & Thornburg Insurance Recovery Practice Group. Our publication is devoted to the challenges facing businesses, public entities and not-for-profits in mitigating and transferring risk, principally through insurance. Maximizing the value of insurance policies and getting claims paid is what we do. This magazine is the journal of our practice, written for insurance professionals responsible for the all-important insurance recovery function inside and outside U.S. companies.

The corporate landscape has never been more saturated with risk than it is today. Corporate America is closely watching the unfolding changes in the regulatory and trade environment in order to understand what look like fundamental shifts in how assets can be protected from threats, and how risk can be transferred through insurance programs.

For instance, the issue of hacking has never been as prominent in our conversations – whether in business or politics. Data security gets more complex every day, and the bad guys seem at times to always be a step ahead of the good guys. As a result, companies need careful review and deployment of their cyber insurance and data security policies to protect themselves from losses caused by hackers. In this issue, we report on a key case involving a well-known restaurant chain, its liability to its merchant processor over fraudulent credit card transactions, and the refusal of its cyber insurer to cover the loss – a wake-up call for any business that accepts credit cards at a point of sale.

Another topic our authors tackle is the scope of insurance coverage for ever-expanding liabilities of officers and directors when a shareholder sues derivatively in the name of their company for alleged mismanagement. Policies of yesteryear do not always respond to such claims. In this issue, we offer guidance to board members and senior managers about what losses the company is and is not permitted to indemnify, and how this distinction drives insurance coverage in derivative actions.

Data security gets more complex every day, and the bad guys seem at times to always be a step ahead of the good guys.

The primary conduit for the flow of information from policyholder to carrier is the application for insurance. Being transparent in this process without giving the underwriter an excuse for refusing to write coverage can be a delicate balancing act. The pitfalls, and strategies for avoiding them, are the subject of an article in this edition.

It is a minefield out there for American business. Careful attention to insurance policies. Building relationships with insurance counsel and brokers. Broad review of your risks. These are the important tasks that must be undertaken by all successful businesses today. We hope Corporate Policyholder magazine – the result of collaboration among our excellent team at Barnes & Thornburg – can help.

Insurance Recovery and Counseling Practice Group
Barnes & Thornburg LLP

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WHO GETS COVERAGE?

Cyber Insurance and Credit Card Risks: Will Coverage Apply After the *P.F. Chang's* Denial?

By Scott Godes & Devin Stone

When a retailer or merchant purchases a broad cyber insurance policy to cover hacks or breaches of its point of sale systems, it could be forgiven for thinking that its insurance policy would cover the costs of fraudulent charges and card replacement costs – which can represent the majority of damages generally incurred in a payment card incident – demanded by the payment processor or the card brands. But one recent decision in the Federal District Court of Arizona has held that certain cyber insurance policies do not provide coverage for those damages. *P.F. Chang's China Bistro, Inc. v. Federal Ins. Co.*, 2016 WL 3055111 (D. Ariz. May 31, 2016), *appeal dismissed pursuant to settlement*, No. 16-16141, Dkt. 15 (9th Cir. Jan. 27, 2017). Now more than ever, it is important for a retailer to make sure its cyber insurance policy covers the most significant forms of damages that stem from data breaches.

WHAT LOSSES SHOULD CYBER INSURANCE COVER FOR RETAILERS?

In the specific context of cyberattacks involving payment card numbers, retailers buying cyber insurance should consider whether the insurance policy provides financial protection for the following losses:

Retailers' purported obligations in the payment card landscape

Merchants typically do not process credit card payments on their own. They usually contract with third-party "servicers" who handle the credit card transactions by acting as an intermediary with credit-card-issuing banks. In turn, the servicers contract with the major credit card brands like Visa and MasterCard in order to process the appropriate credit cards. (Other card brands often contract directly with the retailer.) As part of those servicer/association contracts between the processors and the card brands, the third-party servicing companies agree to indemnify the credit card associations for certain fees and assessments resulting from a payment card information theft. Indemnity kicks in even if the incident was at the retailer level, and not on the processor's systems.

These payments include reimbursement for fraudulent charges resulting from the incident and the cost of issuing new credit cards to individuals whose payment card information was compromised, or was at risk of being compromised, as part of the cyberattack. The processors then frequently demand indemnification from the retailers/merchants for the fraudulent charges and card replacement costs. Rather than demand payment, processors often take the money from the retailer by diverting funds to a reserve account that otherwise would go to the retailer for each sale.

1. **Breach response and investigation:** Costs of forensic investigators including Payment Card Industry Forensic Investigators (PFIs), public relations firms, consumer notification letters, complying with regulatory investigations and other matters, and credit monitoring

2. **Class actions:** Defense costs (and settlement costs, if appropriate) for consumer and issuing bank class actions

3. **Fraudulent charges and payment card replacement costs:** Liabilities to payment card brands and payment card processors that issued payment cards for (a) fraudulent charges card purportedly calculated as resulting from the cyberattack, (b) operational reimbursement/costs to reissue cards, and (c) case management fees

4. **Fines and penalties:** Liabilities (one time or on a monthly basis) imposed due to a finding of non-compliance with payment card industry data security standards (PCI DSS compliance) and regulatory liabilities.

Often, category No. 3 accounts for the lion's share of the total damages associated with a data breach. Thus, it is crucial to have a cyber insurance policy that will cover those losses in full.

Does cyber insurance cover amounts owed to card brands?

The *P.F. Chang's* decision is a red flag to cyber insurance buyers. The court ruled that although some costs were covered, such as losses in category No. 1, liabilities to the card brands and processor (category No. 3) were not. If insurance carriers rely upon this decision, claims adjusters will deny coverage under cyber insurance policies for this category of damages, unless the policy clearly provides such coverage.

In *P.F. Chang's*, the company entered into an agreement with a payment card processor to process payment card transactions. Chang's used point of sale devices to send payment card information to a clearinghouse, after which the processor would credit Chang's account for the amount of the payment. The contract with the processor provided that if there was a cyberattack, Chang's agreed to reimburse the processor for "fees," "fines," "penalties," or "assessments" imposed on the processor by the payment card associations. Thus, Chang's agreed to compensate the processor for any category No. 3 damages incurred as a result of a cyberattack.

To protect itself against losses resulting from a cyberattack, Chang's had purchased a cyber insurance policy from Chubb. Chang's suffered a cyberattack on June 10, 2014, that compromised approximately 60,000 payment card numbers. As a result of the incident, MasterCard imposed assessments on the processor totaling more than $1.7 million – the majority of which consisted of a "fraud recovery assessment" for the costs of notifying affected individuals and delivering new credit cards. Chang's then sought indemnification from Chubb under its cyber insurance policy.

The first insuring clause of the Chubb policy, which should have provided coverage for category No. 2 losses (third-party liability), covered loss arising out of a "privacy injury" defined as "injury sustained or allegedly sustained by a Person because of actual or potential unauthorized access to such Person's Record, or exceeding access to such Person's Record." Chang's asserted that the liabilities to the card brands and processor were within the scope of this third-party liability coverage.

The *P.F. Chang's* court disagreed. It found that such coverage did not apply because the processor did not sustain a privacy injury itself. The court chose not to focus on whether there was injury *because of* access to a person's record. Rather, it focused on the "such person's record" language and noted that the processor's records were not accessed in the cyberattack. Thus, because the processor's records were not compromised, the processor could not have suffered a privacy injury, and coverage did not apply.

This part of the decision should be seen as in conflict with other third-party liability coverage decisions finding that the claimant need not be the party that suffered the loss. There are numerous decisions interpreting liability insurance policies with similar "because of" language, and holding that the use of "because of" means the claimant itself did not have to suffer the disputed injury. It is not clear whether the policyholder asserted that the "because of" language should have governed the inquiry here.

The second insuring agreement in the Chubb cyber insurance policy provided coverage for notification costs, losses that could fit into category No. 1. The court ruled that as a matter of law that the costs of card replacements fell within the second insuring agreement. The court also ruled that Chang's might be able to prove that the MasterCard management fee was a form of extra expense under the Chubb cyber insurance policy, but that it could not decide the issue on a motion for summary judgment.

The *P.F. Chang's* court also held that two exclusions barred recovery for fees passed through the processor. The policy excluded "liability assumed by any Insured under any contract or agreement" and "costs or expenses incurred to perform any obligation assumed by, on behalf of, or with the consent of any Insured." The *P.F. Chang's* court found that those exclusions effectively "bar coverage for contractual obligations an insured assumes with a third-party outside of the Policy." The *P.F. Chang's* court decided that amounts owed to the processor and

THE POLICY EXCLUDED "LIABILITY ASSUMED BY ANY INSURED UNDER ANY CONTRACT OR AGREEMENT" AND "COSTS OR EXPENSES INCURRED TO PERFORM ANY OBLIGATION ASSUMED BY, ON BEHALF OF, OR WITH THE CONSENT OF ANY INSURED."

card brands were liabilities assumed under contract, and, therefore, subject to those exclusions.

The court rejected Chang's arguments that the losses should be seen as a form of equitable subrogation or based on the claim that Chang's would have been liable for the fees regardless of the contractual assumptions. The court also rejected Chang's reasonable-expectation argument that because the reason retailers buy cyber insurance is to get coverage for such fees/assessments, the court's interpretation of the policy would negate the benefit of the bargain. Given that Chang's was paying hundreds of thousands of dollars per year for the cyber policy, it is easy to understand why it would have believed that it was receiving coverage for what generally represents the largest category of damages following a cyberattack. That said, the court explained that the record was devoid of any evidence that Chang's expected the cyber insurance policy to provide such coverage.

Ultimately, the parties settled their dispute during a mediation while Chang's appeal to the U.S. Court of Appeals for the Ninth Circuit was pending.

Although it is an unpublished opinion from a single court, with an appeal that was dismissed by stipulation, *P.F. Chang's* represents a stark reminder that a best practice is to review cyber insurance policies with an eye toward the known expected damages that result from a data breach. What was at issue here was a cyber policy that could be mistaken for insurance covering fraudulent charges and payment card replacement costs that are passed down by credit card issuers through the processors – but the court held that it wasn't.

Buy a cyber insurance policy carefully in the wake of the *P.F. Chang's* decision

Under *P.F. Chang's*, the policy form sold by Chubb does not cover an insured retailer's indemnification liability to a processor arising from a theft of the processor's data where the retailer is the portal through which the theft occurs. Yet this unpublished decision – correct or not – provides a roadmap for buying policies that cover a retailer's most significant damages exposure.

First, brokers and underwriters should explain whether the cyber insurance policy provides specific coverage for so-called "PCI" (payment card industry) losses. The insurance company may be able to provide a policy with a definition of loss or damages to include specifically those amounts owed for operational fraud, operational reimbursement, and other amounts owed under a merchant services agreement. Certain cyber insurance policies include this language within their definitions of loss or damages in the basic third-party liability insuring agreement. Other cyber insurance policies include a coverage section specific to PCI losses. Another alternative that certain insurance companies provide is to have so-called PCI coverage added by endorsement, specifically referring to amounts owed under a merchant services agreement.

Second, if the cyber insurance policy provides some form of PCI coverage, policyholders should be aware of any sublimits on the coverage. A sublimit means that less than the full policy limit is available for particular losses.

Third, policyholders should make certain that exclusions for liabilities assumed under contract either are deleted or have exceptions for liabilities under merchant services agreements. If the policy Chubb sold *P.F. Chang's* had included an exception for such instances, the policyholder's liability to MasterCard might have been covered in the eyes of the Arizona court.

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Insuring Directors' And Officers' Liability In Shareholder Derivative Litigation

What Is Side A D&O Coverage Really Worth?

By David E. Wood and Joshua Rosenberg

A derivative action is a liability claim brought by a corporation's shareholders in the name of the company, often against its directors and officers. At heart, derivative actions allow shareholders to redress damage allegedly done to the corporation by directors or officers. With mergers, acquisitions and regulatory investigations expected to increase in 2018, derivative actions present significant exposure for corporate managers and this exposure can be aggravated by the fact that, in many cases, a corporation cannot or may not indemnify its directors and officers for the cost of settling a derivative action.

Under Delaware law, a corporation's statutory indemnification rights are described in Section 145 of Title 8 of the Delaware Code. Section 145(a) applies to direct actions, while Section 145(b) addresses a corporation's right to indemnify its directors and officers in connection with a derivative action. Unlike Section 145(a), Section 145(b) is silent regarding a corporation's right to indemnify a director or officer for the cost of settling of a derivative action. This silence has led certain courts and secondary sources to conclude that Section 145(b) precludes indemnification of directors or officers for the cost of settling a derivative action.

The rationale most often cited for this prohibition is the circularity that results from indemnification because the corporation would, in effect, be paying itself for an injury caused to it by the very directors or officers it would be indemnifying. To alleviate this concern, Section 145(g) authorizes a corporation to purchase directors and officers (D&O) insurance to fill the indemnification gap.

However, statutory amendments in several states in the mid-to-late 1980s and 1990s allowed for indemnification of directors and officers, to one extent or another, for the cost of settling a derivative action. New York amended its indemnification statute in 1986 to permit indemnification of amounts paid to settle a derivative action where court approval is obtained. *N.Y. Bus. Corp. Law § 722, subsec. (c).* Similarly, in 1987, California amended its indemnification statute to bar indemnification of amounts paid to settle a derivative action "without court approval." *Cal. Gen. Corp. Law § 317, subsec. (c)(2).*

Additionally, the Model Business Corporation Act was amended to permit indemnification of amounts paid to settle derivative actions if court approval is obtained.

Side A covers the personal liability of the individual directors and officers when the corporation is not permitted or is financially unable to indemnify them for a claim against them arising from execution of their duties.

2 Model Bus. Corp. Act Annotated, §§ 8.51, subsec. (d)(1), 8.54, subsec. (a)(3). Several states have adopted all, or substantially all, of the Model Act as their general corporation statute and, therefore, they would fall within the broader category of states that allow a corporation to indemnify its directors and officers, in certain situations, for the cost of settling a derivative action.

The three sides of D&O insurance and what each means

Generally, D&O insurance policies have three insuring agreements – known as Side A, Side B and Side C – which define the carrier's promises to its policyholders. Side A covers the personal liability of the individual directors and officers when the corporation is not permitted or is financially unable to indemnify them for a claim against them arising from execution of their duties. Where the corporation is permitted and able to indemnify its directors and officers, Side B covers the losses sustained by them (defense expenses, settlements and judgments) to the extent that the company indemnifies them. When purchased, Side C coverage, a newer form of coverage that emerged in the 1990s, protects the company itself from securities litigation in which it is named as a defendant.

For corporate directors and officers, an important piece of a D&O policy is Side A, representing the final bulwark against claims of liability against them personally. When their company can't indemnify them, Side A is their only source of protection for their personal assets. As such, it is critical that corporations, directors and officers understand how a derivative action will be routed through their D&O program.

The language of D&O policies is not standardized like other types of liability insurance, but many have common characteristics. Several popular forms define Side A coverage by what it is not – it is not Side B coverage. As stated, Side B covers the corporation's cost of indemnifying its officers or directors. Typical policy language provides that an insurer will pay losses for which the corporation "has indemnified or is permitted or required to indemnify an Insured Person [D&Os] pursuant to law or contract or the charter, bylaws, operation agreement or similar documents" of the corporation.

Most D&O policies state that the corporation is presumed to have indemnified its directors and officers to the fullest extent allowable by law, even if the corporation doesn't actually do so. This means that as long as the company can (i.e., is legally permitted to) indemnify, Side B – and not Side A – applies to the claim. If the corporation doesn't have the money to indemnify its directors and officers for a loss, but is legally permitted to do so, Side B would still apply. Side B offers no help to the directors and officers of an insolvent corporation.

This is where Side A comes in. Side A coverage – which should not be rescindable under any circumstances and should be subject to no self-insured retention – applies even if the corporation would be legally permitted to indemnify them, so long as it lacks the financial means to do so. Although Side A and Side B often share primary and lower-level excess limits, many companies buy a stand-alone Side A policy that sits on top of the shared-limits Side A/B coverage, written by a different insurer (or tower of insurers) subject to separate limits available only to the individual insureds. This coverage is triggered when the corporation legally cannot indemnify them. Policies and courts alike describe the type of loss covered by Side A as "non-indemnifiable" because coverage is triggered when a corporation is precluded or unable to indemnify its corporate managers for certain kinds of loss.

When does each type of coverage apply?

Most states recognize the internal affairs doctrine, a choice-of-law rule under which the "internal affairs" of a corporation are to be resolved in accordance with the laws of the state of its incorporation. Generally, a corporation's power to indemnify its directors and officers constitutes an "internal affair" subject to application of the doctrine. Accordingly, a Delaware corporation, bound by Section 145(b), would not be "permitted or required" by law to indemnify its directors and officers for a settlement of a shareholder derivative action. Only Side A coverage would likely be available to cover such a settlement. However, given that several other jurisdictions permit indemnification for amounts paid to settle a derivative action, triggering Side A coverage in these states may turn on a corporation's internal bylaws or agreements with individual directors and officers regarding indemnification.

However, most D&O policies are drafted with presumptive indemnity, i.e., requiring, in one way or another, the corporation to indemnify directors and officers whenever it is legally permitted to do so. This may come in the form of provisions stating that if a corporation is legally permitted to indemnify its directors and officers, its bylaws or governing documents will be deemed to require such indemnification. Alternatively, a policy may contain subrogation provisions unique to Side A coverage, that allow an insurer to subrogate to the rights of the insured directors and officers and sue the corporation for its failure to indemnify.

Either way, D&O policies generally make clear that Side B covers the corporation's indemnification obligation to its directors and officers, and Side A covers the directors and officers when the company is legally prohibited from meeting these obligations. In states like Delaware that bar a corporation from indemnifying directors and officers for a settlement of a derivative action, this prohibition against indemnity triggers Side A – even if (in most instances) the corporation is otherwise permitted to indemnify directors and officers for other losses, like their cost of defending themselves in the same lawsuit.

Takeaway:

Understand your policy's limitations

When confronting a derivative action, corporations and corporate managers must be mindful of the give-and-take between their respective indemnification rights and obligations, and the triggering mechanisms in their D&O insurance program.

It is deeply unsettling for a corporation to decline to indemnify its directors and officers in a settlement of a derivative action, on the ground that this kind of loss, in this kind of litigation, cannot legally be indemnified. Yet doing so clears a path under Delaware law to trigger and gain the benefit of Side A coverage (and possibly avoid a second derivative action premised on wrongful indemnification). That said, not every company is incorporated in Delaware, so companies should remember that their indemnification responsibilities primarily flow from the law of the state of their incorporation. A clear understanding of the pros and cons of indemnifying losses in shareholder derivative actions is essential to successfully navigating the maze presented by the Side A pieces of a D&O insurance program.

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TRYING AND WINNING AN INSURANCE COVERAGE CASE

By Andy Detherage

Few insurance coverage lawsuits go to trial. This is because the meaning of insurance policy provisions typically is a question of law for the court to decide on dispositive motion, before a jury is empaneled. However, significant liability and damages issues can remain for trial, even after court rulings on the meaning of policy language. Moreover, when coverage cannot be decided strictly as a matter of contract interpretation, the only way to resolve a coverage dispute is to try the case.

Experience teaches three significant keys to success in trying an insurance coverage case: (1) start trial preparation at the very beginning of the case; (2) choose and test trial themes; and (3) make a complex insurance case understandable to the jury.

The importance of trial preparation

Every trial lawyer knows that preparation is the key to winning trials. To be successful at trial of an insurance coverage action, the attorney must begin preparing for trial at the start, and litigate with trial in mind – rather than focusing only on motions concerning the meaning of policy language.

The policyholder must understand what it has to prove in order to recover, and how it will bear its burden of proof to a jury. The critical witnesses and the documents central to the case must be identified early. If a witness is important, preparation for his or her deposition should be driven by the trial themes and key documents. In this kind of litigation, there is no such thing as a traditional "discovery deposition" – all depositions should be considered trial testimony. In most cases, the deposition should be videotaped, allowing the policyholder to replay important testimony for the jury. To make this tactic effective, the witness's testimony should address the trial themes even though the deposition is taken long – sometimes years – before trial.

Likewise, the policyholder must understand which documents will be harmful and decide how to deal with them. The insured must know what jury instructions can be expected, what experts are necessary, and what kind of expert testimony will be allowed and excluded. All of these tasks have to be done before the important depositions are taken. A critical instruction or a few key documents can change the approach with a witness examination or a trial theme. Waiting to do this important work until late

in discovery or after discovery has closed can result in testimony that is less useful – or even useless – at trial.

Policyholders also must anticipate and preempt the procedural tactics insurance companies use to gain a litigation advantage. For instance, where the policyholder sues for policy benefits and for insurance bad faith (defined in most states as some form of wrongful claim-handling by the carrier), the carrier may ask the court to bifurcate the case so that coverage issues are decided first, before discovery or motion practice about bad faith. Rarely is this in the policyholder's interest, because discovery of the insurer's claim file (which the carrier will argue is relevant only to bad faith) may reveal admissions in electronic file notes or emails to excess carriers.

Another tactic in property damage and loss cases is an insurer request to require an appraisal in order to avoid a jury trial, on the ground that the policy requires an appraisal of the amount of loss. Insurers try to substitute appraisals for jury trials on issues of liability and damages beyond the scope of the appraisal provision. An insurer may also try for an appraisal to avoid a jury when appraisal is not available, such as (in many states) if the insurer denies coverage. Even where an appraisal is available, it typically cannot address liability and coverage issues. This is an example of the great lengths to which insurance companies will go to escape jury trials – which is why juries are the preferred fact-finder in most cases. This is particularly so in large loss matters, where the harm to the policyholder of a carrier's refusal to pay is underscored by the amount in controversy.

A critical part of trial preparation is to anticipate the often-formidable threat presented by the witnesses, expert and percipient, on which the carrier relies. Insurer witnesses are professionals. As insurance company employees and experts, they litigate coverage for a living. Typically, these witnesses have testified in many depositions and trials and can be difficult to cross-examine. It is important to prepare for depositions of these witnesses as if preparing for cross-examination at trial. Policyholder witnesses should be prepared with the same considerations in mind. Many policyholders try to do too much with individual witnesses. The message to each witness should be to "stay in your lane" and avoid trying to testify about matters outside the assigned subject matter. This keeps testimony focused, and prevents effective cross-examination on topics beyond the witness's knowledge and expertise.

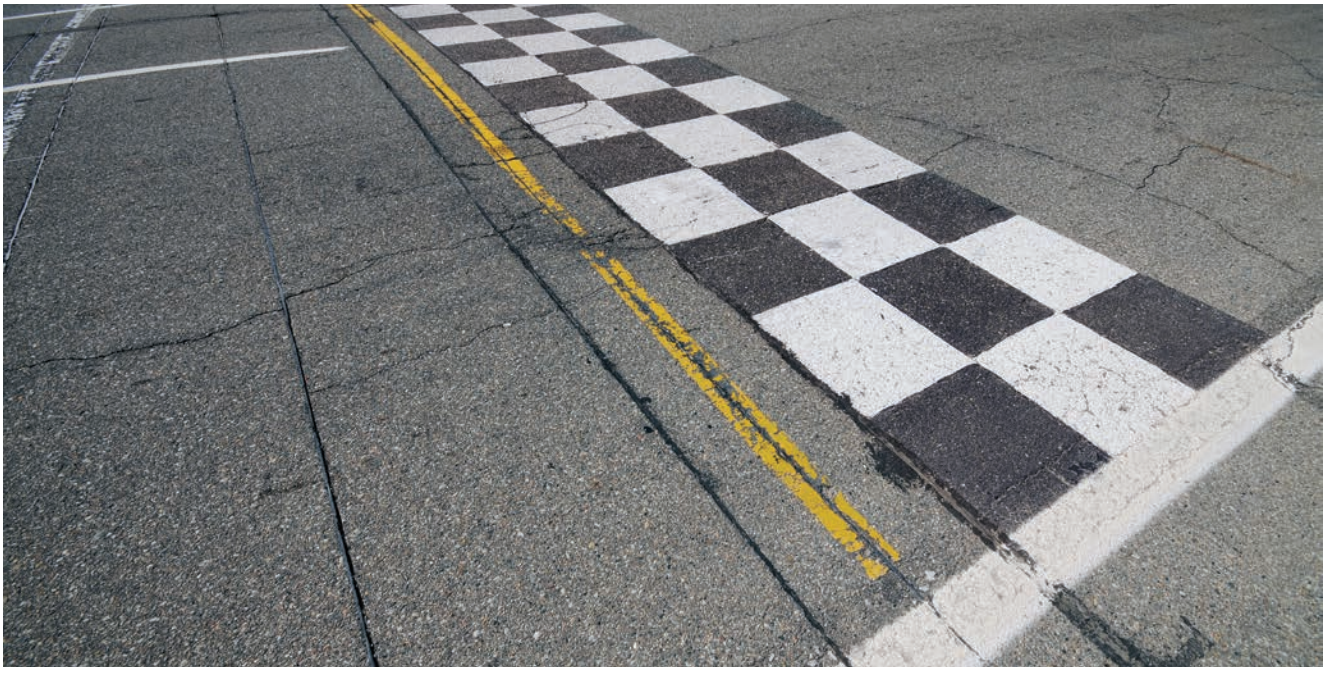
Choosing and testing trial themes

Trial themes should be identified and developed beginning with drafting the complaint, so they can be refined as discovery progresses. The trial team should challenge these themes internally, to anticipate the insurance company's arguments and mold the evidence to rebut them. Professional jury researchers can be useful in bringing different voices and viewpoints to the table to test the themes of both the policyholder and the insurance carrier. This can be done early in the case and does not always have to wait until the eve of trial.

Theme-testing for trials includes mock trials, focus groups and presentations by percipient witnesses and experts. This testing should be done in the jurisdiction where the trial will be held, or in an appropriate surrogate venue, to replicate the experiential, socioeconomic and educational conditions of the likely jury pool. Every jury research technique has strengths and weaknesses that must be considered in order to produce a balanced assessment of the risks and benefits of presenting the case in a certain way. For example, while a mock jury's interpretation of the evidence can help trial counsel develop themes that resonate with actual jurors, predicting perceptions and behavior is an art, not a science. Often, a combination of techniques produces a more thorough and effective overall result.

Theme-testing also can help identify and correct for biases of the trial lawyers. Even themes policyholder counsel thinks are obvious (e.g., everyone dislikes insurance companies, insurers never pay claims, etc.) often vary among jurisdictions and are not always accurate. Likewise, mistakes in the manner in which a witness is presented – for example, putting a maintenance worker in a business suit or failing to warm up a witness who appears quiet or distanced – can make the difference between the jury trusting the witness or rejecting the witness's testimony.

At trial, it is essential to present themes that will resonate, repeating and developing them consistently from voir dire to opening statement, to witness examinations and cross-examinations, and through closing argument. Thematic consistency allows the jury to more easily understand the policyholder's case, and helps to maintain their trust.



Making the complex case understandable to the jury

Insurance cases look mind-numbingly complex to lay juries – and to many judges as well. The key to winning an insurance coverage trial is to make the policyholder's argument understandable to juries and judges, through witnesses they identify or sympathize with. Policyholders must tell a compelling story that moves along quickly. Presenting too many witnesses or exhibits, or giving presentations that last too long, can be fatal to the policyholder's case.

Several tactics can help make an insurance case understandable:

- Choose the right storytellers
- Present only the key evidence – leave out the minutia
- Use graphics to explain and illustrate the evidence
- Ensure witnesses stay on topic and within their lanes
- Use experts able to make complicated topics sound simple

Using Rule 1006 summaries, charts and graphs[1] instead of numerous exhibits or long repetitive testimony is particularly crucial. Juries expect trial counsel to respect their time. Summaries allow for an efficient and effective presentation of voluminous information that would otherwise put the jury to sleep.

In the end, all of these tactics help do one thing: They simplify the coverage case for the jury and the court in a way that invites agreement with the policyholder.

Conclusion

Trials are about preparation, credibility, and endurance. A policyholder must win in all three categories in order to win at trial. This means preparing to try the case from the earliest stage of litigation.

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[1] Federal Rule of Evidence 1006 provides: "The proponent may use a summary, chart, or calculation to prove the content of voluminous writings, recordings, or photographs that cannot be conveniently examined in court. The proponent must make the originals or duplicates available for examination or copying, or both, by other parties at a reasonable time and place. And the court may order the proponent to produce them in court."

PAYBACK

Can Settlements Of False Claims Act Claims Be Covered Under D&O Policies?

By John L. Corbett

In recent years, corporations have seen a dramatic upswing in claims alleging violation of the federal False Claims Act (FCA). Dating from the Civil War, the FCA at one time was a sporadically used civil law that made government contractors liable for fraudulent claims on the government. After the law was reformed in the 1980s to make it easier for individuals to sue on behalf of the government, employees and shareholders of corporations transacting with the federal government began viewing it as a powerful whistleblower statute.

With the increase in lawsuits alleging violations of the FCA, insurance companies have become more aggressive in denying outright any obligation to pay settlements of FCA claims on the grounds that they seek uninsured restitution or disgorgement. Contrary to what insurance companies may claim, however, the FCA provides for relief in the form of damages and civil penalties, not restitution or disgorgement. Fines and penalties imposed under the FCA nearly doubled from 2015 to 2016, so insurance companies have every incentive to chip away at coverage for FCA settlements.

Some D&O policies cover False Claims Act claims

Most corporations purchase directors' and officers' liability (D&O) insurance policies with the thought of protecting against the risk of securities-related litigation and shareholder derivative lawsuits. They might not be thinking about whether such policies insure against FCA claims. This is understandable, because the history of D&O policies is closely intertwined with the enactment of the modern securities regulatory regime and developments in securities litigation. However, while modern D&O policies have an emphasis on securities-related claims, they can be written broadly enough to permit coverage of unrelated areas of corporate exposure.

For example, D&O policies cover claims for "Wrongful Acts," which are usually defined to include "any act, error, omission, breach of duty, misstatement or misleading statement" by the corporation or its directors, officers or employees. That language is broad enough to encompass virtually any act or omission, including fraudulent or dishonest conduct or actions which are not related to corporate governance, mergers and acquisitions or the marketing of securities. While D&O policies separately contain exclusions for fraudulent or dishonest conduct, generally those exclusions apply only where there has been a final judgment in the underlying litigation establishing that the policyholder actually engaged in excluded conduct. That means allegations of fraudulent or dishonest conduct under the FCA are not necessarily barriers to coverage, as long as the case settles before trial.

Even though conduct in relation to an FCA claim may qualify as a covered "wrongful act," insurance companies sometimes deny coverage on a theory that an FCA settlement is nothing more than a return of money obtained improperly, and not "loss" covered by the policy. Here's their rationale: Many D&O policies specifically exclude restitution and disgorgement from covered "loss." Even where the policy does not do so, the laws of many states prohibit insurance companies from covering such relief on the grounds that being required to return something that does not belong to the policyholder cannot be an insurable loss.

The purpose of the FCA seems to fit within this paradigm; after all, the point of that law is to address situations where contractors wrongfully obtain payment from the federal government. Indeed, defense attorneys reporting to the insurance company often loosely characterize relief sought under the FCA as restitution or disgorgement.

Policyholders should not be deceived by any of this. The FCA provides for two forms of relief – treble damages and civil penalties – with the former making up the lion's share of a defendant's liability exposure under the statute. Courts interpreting the FCA have been clear that it is not a restitution or disgorgement statute. Following a detailed analysis of the history and text of the FCA, the Southern District of New York concluded that the statute "expressly provides for civil penalties and damages alone – and not for restitution." *United States ex rel. Taylor v. Gabelli* (S.D.N.Y. Nov. 3, 2005) 2005 U.S. Dist. LEXIS 26821, *40. Nor does the FCA provide for disgorgement of profits, another restitutionary remedy aimed at depriving a defendant of unjust enrichment. (*Id.* at *49.) Rather, courts have characterized the treble damages available under the FCA as compensatory in nature, which would place such relief squarely within the D&O definition of "loss."

How insurance companies view the FCA

Even though the FCA is not a restitution or disgorgement statute, insurance companies may still insist that a portion of the policyholder's exposure in an FCA claim is still not covered. Many D&O policies expressly exclude coverage of punitive damages, while many states prohibit insuring punitive damages even where the policy purports to cover them. Some courts have suggested that the portion of treble damages under the FCA beyond actual damages is punitive in nature. See *United States v. Bickel* (C.D. Ill. Feb. 22, 2006) 2006 U.S. Dist. LEXIS 29665, *7. Some policies go a step further and exclude from coverage "the multiplied portion of multiple damages," which could exclude coverage of those damages regardless of whether they are deemed punitive under applicable law. Finally, many D&O policies expressly exclude "civil fines and penalties," potentially defeating coverage of the FCA's civil penalties, which usually make up a relatively small portion of the policyholder's exposure. If any of these limitations on coverage applies, the insurer may point to the policy's allocation provision in an effort to reduce the amount of defense costs and settlement funds it must pay.

Many D&O policies contain a provision under which a settlement is allocated between covered and non-covered portions based on the "relative legal exposure" of the covered and non-covered claims. Under this method, the portion of the settlement allocated to non-covered loss is determined by how much consideration of that liability exposure motivated settlement. Normally, this method is notoriously imprecise and heavily fact-based, and insurance companies sometimes use the specter of litigating allocation as a bludgeon for obtaining a discount on what they contribute to a settlement or defense costs. Policyholders are spared the brunt of this problem for FCA claims, because the FCA is relatively clear about how damages and civil penalties are assessed. Nonetheless, both policy language and public policy will determine to what extent the insurance company can allocate an FCA settlement to non-insured loss.

Policyholders need not accept assertions by insurance companies that their D&O policies simply do not cover settlements of FCA claims. In highly regulated industries where companies routinely do business with the federal government, FCA liability based on some internal mistake or rogue employee can be a cost of doing business, and D&O carriers selling policies in this space should anticipate legitimate claims for coverage arising from this exposure.

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INTERVIEW WITH MELANIE D. MARGOLIN

Deputy General Counsel of the Americas, Global Litigation, Cummins Inc.

Nearly 100 years ago, Clessie Cummins founded Cummins Inc. and focused on the newly discovered diesel engine. Thirty years later, Cummins was an industry leader with its Series N engines that powered more than half the North American heavy-duty truck market. Today, Cummins has grown into a Fortune 200 company, but it is true to its roots, and still headquartered in Columbus, Indiana. Its products are sold in nearly 200 countries around the globe, and it has annual sales of approximately $20 billion.

Melanie D. Margolin is Deputy General Counsel of the Americas, Global Litigation and also for Power Systems, one of four Cummins business units. After earning her undergraduate degree at the University of Illinois Urbana-Champaign, she received her law degree in 1997 from the DePaul University College of Law. After working in Chicago, she returned to her home state of Indiana in 2000 and worked in one AmLaw 150 law firm until joining Cummins in 2013 to develop and lead the Global Litigation program.

She agreed to an interview with Corporate Policyholder to talk about insurance coverage and how Cummins' attorneys work with insurance companies throughout the world.

CP: What aspect of your job interests you the most?

Margolin: First, I love the fact that it's a global company. I start most days with a 7 a.m. call with someone from Australia, or Europe or China, or one of the other countries where we do business. I end most days with a 7 p.m. call with someone around the world who is just starting the day. Second, I really like being on the Power Systems leadership team. I am in there as a lawyer, but our business unit president encourages people to wear all sorts of hats and be a fulsome leader when on that leadership team. So, I get a chance to develop strategy, weigh in on product portfolios and help make the big overarching decisions. Finally, it's almost impossible to work for Cummins and not talk about how great

> We pride ourselves on doing the right thing. Everyone is looking at every problem from that cornerstone value.

our mission, vision and values are. We pride ourselves on doing the right thing. Everyone is looking at every problem from that cornerstone value. It is incredible to work for a company where everyone from the shop floor employees to the Cummins leadership team all share the same values and know that as Cummins, we must do the right thing.

CP: Describe your greatest accomplishments at Cummins.

Margolin: First, developing the global litigation strategy was a key accomplishment. We reduced litigation fees. We reduced financial accruals and reserves. And, we reduced material matters we had to report to the board. Second, I have hired, trained and developed a top-notch group of global litigators. Working with these talented lawyers was how we accomplished those things. And finally, I've really been able to go in and partner with the business on the front end of issues. I know our customers. I know how we get our products to market. I sit on our leadership teams so I can counsel our commercial and technical teams on the front end and we are getting good results. I'm very proud of what I have accomplished here. I am always happy to talk with others about how we do these things because I think in many ways, our legal function has best practices that are terrific to share.

CP: How does insurance fit into your life? Is it on your radar screen every day?

Margolin: I wasn't three days into the job when our global risk team set time on my calendar. What you insure and how you insure it is very different in foreign countries from what you do in the States, and even the state-by-state practices are different. I learned a tremendous amount about our policies, our deductibles and retentions, and our practices. So, we set up the litigation group to act as the legal partner with the global risk team. If the risk team is placing insurance, or has policies up for renewals, or is going to send out an RFP for cyber security or other specialized insurance, for instance – all of that goes through my global litigation team from a risk mitigation perspective.

CP: Can you tell us about Cummins' experience in making claims under its insurance policies?

Margolin: My overall view is that Cummins has a strong claims history. We have had a strong partnership with our brokers and insurers. But times change and high-stakes litigation is happening all the time. We are in a highly regulated industry, especially in the emissions and other technology fields. It can put our insurers in a precarious position. They have to be cautious. We have had a couple of high-stakes claims which creates a built-in tension. You have this relationship with your insurers in which it's their job to evaluate if there is coverage and see if you are willing to blink in your demand that they cover you.

CP: Is there tension with your insurance companies over settlement vs. taking a case to trial?

Margolin: We often have different views on taking it to trial. We have had a few tense interactions with our insurers about this. We go out and have meetings with them when there is a material insured case. We are extremely transparent. We talk about our values, brand reputation, commitment to the customers, what a PR nightmare it might be for us to have to try an injury case or quality-related matter. They run us through their practices and procedures and try to convince us that their way is the only way to do it. We try to show them that we do it the right way. We have found that kind of transparency and hands-on approach gives us a good result.

We just settled something this week and there was some really good dialogue before we all reached a conclusion together. That isn't to say the dialogue is all flowery or friendly. But we stay in the room and keep talking until we are all on the same page.

CP: What about people who think Cummins is a large company with deep pockets and an easy mark?

Margolin: You see a lot of demands even pre-suit. They just think Cummins is a $19 billion company. "Surely they would rather write a check than fight this off." I think we are very fortunate across our peer group because we have less of that kind of litigation than most. I draw that back to good mitigation practices, taking care of the customers at the front end and making sure you stand behind your brand. You mitigate these types of risk by using good practices and making sure you treat your customers like partners. I really believe that. But at the end of the day, if we need to take a stand, we will. We will always do what is right, but if we are not at fault, we will defend ourselves.

CP: How deeply do you get involved in matters such as the choice of panel defense counsel?

Margolin: We at Cummins have a really specific list of law firms that we use. We had been using 75 law firms and brought it down to 26. We have different categories of firms separated by practice areas. When you have panel counsel like this, your lawyers know your business. That has been good for us. Where you have some rub with the insurer is that they have a list too and often it does not match ours. When we have a big claim, they are happy to use our counsel, but then as it gets closer to resolution, they want their counsel to come in and eventually try the case. This is where corporations have more of a voice than they often know. We have been successful in allowing counsel for the insurance company to be in second position at trial, with our lawyer in lead position. When you let the insurance company's attorney onto the trial team, that lawyer ends up being a voice to the insurer that they trust, and that lawyer can impact how the insurer sees the case. We have been really successful at getting everyone to roll in the same direction. This is an area where people should be more attentive. They can make the process more cooperative, without just rolling over or filing bad faith claims.

CP: Who manages the defense of a lawsuit that is covered by insurance?

Margolin: There are a couple of trigger points. Workers' Comp is managed out of house. All other lawsuits come in through our Legal Department paralegals who open new files. We assign those to in-house lawyers who choose outside counsel for lawsuits. Claims are not necessarily handled by outside counsel. My team is made up of all trial lawyers. They know how to manage cases. And we get rid of a lot of pre-suit claims in-house.

"We have found that kind of transparency and hands-on approach gives us a good result."

CP: Who manages litigation covered by insurance, and negotiates disputes with carriers as a claim unfolds?

Margolin: We don't have many disputes with our carriers. That's because we work to keep things less adversarial. At times, we have been out of alignment about some case that Cummins felt needed to be resolved, and the insurance companies didn't. When that's happened, everyone brought counsel for a sit down. We met and just said "Let's figure out the coverage." I always start by thinking about solutions, and for me the process is about driving those solutions. I know insurers are not afraid to fight. But they are a little taken aback when they set a meeting at a big New York firm and this entourage from Indiana shows up and wants to simply talk openly and honestly and work it out.

CP: Does this change when it is high-stakes litigation against the company?

Margolin: I always try to keep it collaborative. But I have had no choice but to get a little bit aggressive with our carriers at times. I have a job to protect Cummins and they have a job to try not to provide coverage if the policy excludes it. In those cases, I just lay out exactly what we are prepared to do. That is the language they understand. I am always weighing our brand reputation and trying to get the insurers to see that we are different from Smith company or Jones international. We are Cummins and we have a well-known reputation on which our business is built. Until the insurer understands that, it can get contentious at times. But again, this is the built-in tension that is supposed to exist — a checks and balances system of sorts.

CP: How often do you report to senior management about status of the case, liability and damages evaluation, settlement opportunities, and the availability of insurance?

Margolin: We do a quarterly litigation report. Any claims seeking more than $250,000 go to the business leaders throughout the company, the controller and the auditors. We also report material matters to the board. We also do case reviews and write up our opinions on various matters. No case is settled until the president of the business unit signs off with his or her finance director who has to be on board with what we want to offer. The business units actually pay for any settlement that is achieved, so it is critical that they understand the options and help determine the value of the matter.

CP: How often is Cummins a plaintiff, rather than a defendant?

Margolin: We seldom are the plaintiff. I can count on fewer than five fingers the times when we have initiated an action in my time here. The reason is based on all the other things we have discussed. We are not going to sue a customer or a partner like an insurer unless we absolutely have to. Very rarely do we act as the plaintiff, because we have great mitigation practices and relationships with our stakeholders.

CP: Finally, can you describe what it's like to be a plaintiff in a dispute with an insurance company? Is bringing in a big check a satisfying experience?

Margolin: What is satisfying is when the carriers do not want to settle a lawsuit filed against us, but we work to get them turned around resulting in a good resolution of the whole issue. Since I've been here, we have not had to sue our carrier, and the carriers have worked with us to share in the financial burden of large litigation.

CP: Thank you for your time. You really seem to love your job.

Margolin: I do love my job. It's because of the culture and integrity of the people at this company.

"I always start by thinking about solutions, and for me the process is about driving those solutions."

THE FINE LINE:

HOW CANDID CAN OR SHOULD INDEPENDENT DEFENSE COUNSEL BE WITH A LIABILITY INSURER IN CALIFORNIA WITH RESPECT TO PRIVILEGED INFORMATION?

By Matthew B. O'Hanlon and Ethan W. Craig

Under many liability insurance policies, the insurer has a duty to defend a lawsuit against its policyholder that is satisfied by hiring, paying and directing a lawyer on its defense panel (panel counsel) to protect the insured. In some states, certain conflicts of interest between an insurer and an insured give the policyholder a right to be defended by independent counsel (i.e., a lawyer who, unlike panel counsel, is not hand-selected by the insurer and who is instead chosen by the policyholder).

Behind the right to independent counsel is the acknowledgment that when a carrier warns the insured that it will deny coverage if the facts of the lawsuit against the insured turn out a certain way, there is a risk that panel defense counsel could defend the case in a way that defeats or limits coverage to the insurer's benefit of avoiding payment.

In California and other states where panel defense counsel jointly represents both the policyholder and the carrier (called "tripartite states"), this creates a conflict of interest that must be resolved in order for panel defense counsel to accept the engagement. (Tripartite states include, on one ground or another, Alabama, Alaska, Illinois, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Minnesota, Mississippi, New Jersey, New York, Oklahoma, Pennsylvania, Rhode Island and Texas.) Different states use different tests for determining whether a conflict exists, and employ different remedies for disposing of it. In tripartite states, courts have held that the insurer's desire to appoint its panel counsel of choice and control the defense of the case must yield to its obligation to defend its policyholder in a way that does not prejudice the insured's right to coverage.

When panel counsel has a conflict created by a carrier's reservation of rights, thereby triggering the right to independent counsel, this creates a practical challenge. Independent defense counsel needs to be able to share his or her opinion about the likelihood of liability with the insurance company so the insurer will settle the case for the client-insured. Similarly, the insurance company wants independent counsel to cooperate in a way that satisfies the policyholder's duty of cooperation under the policy. Yet, unlike panel counsel in the tripartite relationship, independent counsel does not have an attorney-client relationship with the insurer. Further, disclosure of independent counsel's confidential communications with the insured could invade the attorney-client privilege that exists between independent counsel and the client-insured.

How does independent counsel meet the duty to cooperate and get the carrier to settle – while protecting the client-insured's interests – by making sure that whatever the outcome, it will be covered?

A California statute acknowledges this problem, but does not solve it. The right to independent counsel codified in California Civil Code Section 2860 requires that the lawyer and the insured share certain information with the insurer by disclosing to the insurer "all information concerning the action except privileged materials relevant to coverage disputes, and timely to inform and consult with the insurer on all matters relating to the action."

Taken at face value, the statute hypothetically imposes a statutory duty on insureds to share all information with insurers regarding the underlying lawsuit except "privileged materials relevant to coverage disputes." Case law interpreting Section 2860(d), however, has recognized that insureds have no obligation to share privileged information between them and their independent lawyers with insurers as a condition for coverage under the subject policy. Accordingly, insureds can fulfill their duty to cooperate with their carrier, despite withholding privileged information and documents between the insured and independent counsel that is relevant to coverage, by "informing and consulting" with the carrier on issues relevant to liability and damages. Where to draw the line on how and what privileged information and/or documents to share can be difficult, and independent counsel must protect the insured's interest by controlling the flow of information in an attempt to maximize coverage.

The *Cumis* Decision States When the Insured Has the Right to Independent Counsel

Section 2860 represents the codification of the seminal decision reached in *San Diego Navy Federal Credit Union, et al. v. Cumis Ins. Society, Inc.*, 162 Cal. App. 3d 358 (1984), which first established the rule in California that an insurer must provide independent counsel to an insured when it reserves rights in a certain way.

Under the holding in *Cumis*, an insurer must pay for independent counsel for an insured when the insurer has a duty to defend, but reserves its right under specified circumstances to assert the lack of coverage, depending on the outcome at trial. *Id.* at 361. When allegations against the insured arguably do not fall within the scope of coverage under a policy, an insurer will often defend the insured under a reservation of the right to deny coverage later if there is a non-covered result. *Id.*

These "opposing poles of interest" – *i.e.*, the insurer's desire for litigation to result in a non-covered claim versus the insured's desire for a ruling that liability is covered under the policy – place any lawyer appointed by the insurer to defend the insured in the unenviable position of attempting to represent multiple clients with differing interests. *Id.* at 364-67. The *Cumis* court reasoned that when this conflict of interest gives panel counsel the ability to manipulate defense of the case toward a non-covered outcome – even if panel counsel does not actually do so – then "the insured has a right to independent counsel paid for by the insurer." *Id.*

To What Extent Must the Policyholder Share Privileged Information and Documents With the Carrier?

When an insurer must provide independent counsel to defend an insured, the policyholder still has a duty to share information with the carrier pursuant to the duty of cooperation. Section 2860(d) provides in pertinent part as follows:

> When independent counsel has been selected by the insured, it shall be the duty of that counsel and the insured to disclose to the insurer all information concerning the action except privileged materials relevant to coverage disputes, and timely to inform and consult with the insurer on all matters relating to the action.

On its face, the statute imposes a duty on insureds to share all information with their insurers regarding the underlying lawsuit, whether privileged or unprivileged, except for "privileged materials *relevant to coverage disputes*." (Emphasis added.) Insurance companies sometimes assert that this means the policyholder must disclose to the carrier *all* privileged communications between independent counsel and the insured, save only privileged communications having to do with coverage disputes.

To protect the insured that "informs and consults" with the carrier in assessing liability and damages, Section 2860(d) specifically states that this does not waive the privilege as to third parties (like the underlying plaintiff). *See* Cal. Civ. Code § Section 2860(d) ("[a]ny information disclosed by the insured or by independent counsel is not a waiver of the privilege as to any other party.") The carrier may point to this language as proof of its right to review, under the auspices of the policyholder's duty to cooperate, all privileged materials unless they address the specifics of insurance coverage. This would include, for example, independent counsel's advice to the insured regarding how the case should be defended to preserve insurance coverage – advice that should be protected from disclosure to the insurer to the fullest extent possible.

Does an insured's duty to cooperate – which Section 2860 does not abrogate – override the attorney-client privilege, requiring insureds essentially to waive the privilege in order to comply with the insurance policy? Clearly not. With respect to the attorney-client privilege, California law has held that such cooperation clauses do not constitute a contractual waiver of the attorney-client privilege. *See Rockwell Internat. Corp. v. Superior Court*, 26 Cal. App. 4th 1255, 1264 (1994). Case law has also made clear that insurers may not employ cooperation clauses to elicit information for purposes of denying coverage. Instead, the point of a cooperation clause is to facilitate the defense of a case, not to fish for information supporting a coverage denial. *See, e.g., Martin v. Travelers Indem. Co.*, 450 F.2d 542, 553 (5th Cir. 1971) ("Cooperation clauses are intended to guarantee to insurers the right to prepare adequately their defenses on questions of substantive liability…. We know of no case in which the insured's duty of assistance and cooperation has been used to force a putative insured to divulge to the insurer every jot and tittle of information which may aid the insurer in defeating his claim for coverage, but which in no way hinders the insurer's ability to provide the insured with a proper defense"). Accordingly, insureds may fulfill their duty to cooperate while at the same time shielding privileged information between themselves and independent counsel from insurers.

Courts interpreting Section 2860(d) agree, holding that insureds have no obligation to share privileged information with their insurers. Instead, based on "a recognition of the *tensions* in the relationship between insured and carrier (when the carrier reserves its rights) [,]" courts have held that "Section 2860 clearly does not create a duty to share with the carrier communications between [the insured] and its Cumis counsel that are privileged." *First Pac. Networks, Inc. v. Atl. Mut. Ins. Co.*, 163 F.R.D. 574, 579 (N.D. Cal. 1995) (emphasis added and internal citations omitted). Instead, "the insured and its independent counsel retain fully the right to communicate between themselves in private – and to shield those communications from the carrier." *Id.*; *see also Assurance Co. of Am. v. Haven*, 32 Cal. App. 4th 78, 90 (1995) ("the duties specified in Civil Code section 2860 that *Cumis* counsel owes the insurer are limited to the duties to disclose, inform, consult and cooperate regarding nonprivileged information").

CONCLUSION: WHERE AND HOW TO DRAW THE LINE?

Section 2860(d) creates important protections for insureds forced to mount a defense to a lawsuit while at the same time faced with a reservation of rights which gives rise to a conflict that prevents an insurer from controlling the defense. While information-sharing can be important to persuading the carrier to settle a case, insurers cannot force insureds to divulge privileged communications between the insured and independent counsel as a condition of coverage. The challenge is where to draw the line between information relevant to coverage that the insured may withhold and information relevant to liability and damages that independent counsel must and should disclose to the carrier to get the litigation resolved with insurer funds.

Independent counsel's job is to make sure that the case is defended in a way that, in good faith, maximizes coverage for claims alleged against the insured. One way to do this would be for independent counsel to withhold from the carrier information suggesting a non-covered liability on the ground that the information is relevant to coverage. This tactic seems fair. Section 2860 and the *Cumis* decision acknowledge that panel counsel is actually or potentially biased in favor of the carrier, and that this bias is cured by the appointment of independent counsel to counteract it. The carrier should not expect non-partisan views of liability and damages from a defense lawyer hired to represent the policyholder alone. If the carrier wants an unbiased view of liability and damages, it has the right to associate into defense of the lawsuit by hiring counsel loyal solely to the insurance company.

So how candid should independent counsel be with a liability insurer when defending the policyholder from liability that might or might not ultimately prove to be covered? The answer is simple: Consistent always with good faith, independent counsel should be as candid with the carrier to the extent necessary to persuade the insurance company to resolve the litigation in the manner most favorable to the insured. This is the result Section 2860 was enacted to accomplish.

While information-sharing can be important to persuading the carrier to settle a case, insurers cannot force insureds to divulge privileged communications between the insured and independent counsel as a condition of coverage.

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TELL ALL

MAKING A CASE FOR MORE DIALOGUE IN THE INSURANCE APPLICATION PROCESS

By Christopher Lynch

Do nothing secretly; for Time sees and hears all things, and discloses all. – Sophocles

Keeping secrets during the insurance application process is a bad idea. A policyholder who responds to application questions with incomplete or evasive answers to try to save a few dollars in premiums risks losing coverage altogether when those secrets are revealed. Conversely, by providing the underwriter with the information she needs to properly assess the risk, a policyholder is more likely to receive an insurance policy that meets its coverage needs. It behooves the parties to try to make the application process a cooperative exchange of information.

But even among well-intentioned parties, a potential for disconnect exists. Each side looks at the information exchange from a different perspective. The policyholder knows the people, property or business to be insured, but may not know what type of information the underwriter needs to assess the risk. The underwriter knows the type of information she needs to assess the risk, but may know little about the people, property or business to be insured. Striking the correct balance of responsibilities in the information exchange can be difficult.

How did we get here? How disclosure obligations evolved

Nearly 100 years ago, the United States Supreme Court characterized insurance policies as traditionally being contracts "uberrimae fidei" (utmost good faith) in *Stipcich v. Metro. Life Ins. Co.*, 277 U.S. 311, 316 (1928). Under that view, the burden of disclosure fell primarily on the applicant, who was required to voluntarily disclose all known facts that materially affected the risk being insured regardless of whether the underwriter made a specific inquiry into such facts.

Uberrimae fidei made sense when the insurance industry was in its infancy. When asked to insure a ship that might be half a world away, underwriters sitting in a London coffeehouse in the 1700s were completely dependent on the candor of the applicants' disclosures. They had no other way to obtain information about the thing they were being asked to insure. Indeed, in many United States jurisdictions, uberrimae fidei is still the law with respect to marine insurance, as Thomas J. Schoenbaum demonstrates in "Admiralty and Maritime Law." But in other lines of coverage, as insurers' sophistication and technology have evolved, legislators and courts have put more responsibility on the underwriter.

Subject to a variety of limitations, most states still permit an insurer to avoid coverage upon showing that a misrepresentation in, or an omission from, an insurance application was "material" to the risk. Material in this context has been defined as information that would increase the insurer's exposure to the risk insured against or affect an underwriter's decision to issue coverage, the premiums, or the terms of coverage. If the information is material, only a minority of states require the insurer to also show that the policyholder acted with intent to deceive the insurer, in order to deny coverage based on a misrepresentation in the application.

In a departure from uberrimae fidei, however, most states limit a policyholder's obligation to voluntarily disclose information. The prevailing rule in the United States is that, absent fraud, a policyholder has no duty to disclose information not specifically asked for in the application. But that rule is not universal and is subject to exceptions and qualifications.

California, for example, historically required a policyholder to disclose private information it considers material to the risk, even if the underwriter did not specifically ask for the information in the application, creating an affirmative duty of disclosure to the carrier. See Cal. Ins. Code § 332, cf. *Gen. Acc. Fire & Life Assur. Corp., Ltd., of Perth, Scotland, v. Indus. Acc. Comm'n* (Cal. 1925) 237 P. 33, 37 ("an applicant is bound to disclose a fact material to the risk, even though no specific inquiry is made on that subject"). This duty has been relaxed in more recent case law. *Maryland Cas. Co. v. Nat'l Am. Ins. Co.* (Cal.App. 1996) 56 Cal. Rptr. 2d 498, 504 ("[W]here ... the insurer fails to question the insured, the latter cannot be said to have concealed facts so as to void the policy unless they are facts which he [or she] knows, or which a reasonable [person] should have known, to be material to the risk and unless he [or she] does so for the purpose of obtaining insurance which could not have been obtained after a disclosure of such facts.") (Internal quotations omitted.).

In practice, it can be difficult to distinguish between a failure to volunteer information and a misrepresentation by concealment. The distinction can be particularly blurry where the insured knows, or should know, that the omitted information would affect the underwriter's decisions, where the policy contains provisions concerning the effect of a non-disclosure of information, or where the application makes a catchall request for all information the policyholder knows is material to the risk. In short, despite evolving legal standards, the scope of a policyholder's disclosure obligations is still often unclear.

Just the right amount of disclosure

An eight-year study of insurance disclosure obligations in the United Kingdom (the birthplace of uberrimae fidei), identified a number of problems stemming from the lack of clarity as to a policyholder's disclosure obligations, including:

- A disproportionate burden on medium and large commercial policyholders – which tend to have more information and greater decentralization – to identify information that might be material to the underwriter;
- "Data-dumping" – i.e., the submission of large volumes of information to the underwriter no matter how trivial it might be;
- The creation of a "market for lemons" by encouraging unscrupulous insurers to take shortcuts in the underwriting process so they can charge low-rate premiums and undercut their competition; and
- Post-claim underwriting by the insurer to try to avoid its coverage obligations.

England's solution to these issues was to enact the Insurance Act of 2015, a sweeping statutory reform that replaced the strict uberrimae fidei disclosure rules with a duty of "fair presentation." Under that new standard, the policyholder fulfills its obligations by either disclosing all material circumstances known to it or by at least disclosing "sufficient information to put a prudent insurer on notice that it needs to make further enquiries for the purpose of revealing those material circumstances." As explained by the English and Scottish Law Commissions "Insurance Contract Law" (July 2014), the intent behind this change was to encourage a dialogue between the parties:

> We think this should be central to the duty of disclosure. Good disclosure requires co-operation from both sides. The policyholder knows the facts; the insurer knows which facts are relevant. To provide an effective and efficient process, we think that insurers should see their role as assessing what they are told and asking further questions as appropriate.

Because insurance law in the United States is exclusively a creature of state law, interstate insurance regulation and a uniform disclosure standard is unlikely in the United States any time soon. But in keeping with the spirit of the English reforms, there are things the parties can do to improve the information exchange.

Perhaps the most important initial step an underwriter can take is to issue a detailed application. By asking questions on an application, the underwriter helps identify the information she needs to assess the risk. Once the application is returned, the underwriter should assess the information and ask further questions when necessary.

A policyholder, typically through or with the assistance of a broker, can also facilitate a dialogue. For starters, policyholders should be aware of the significance of the application process. Incomplete or erroneous answers in an application may invite a coverage dispute, regardless of the applicant's intent. When it's not clear what information the underwriter is looking for, the broker should seek clarification from the underwriter. And even when the policyholder and broker think all requested information has been provided, it is usually a good idea to ask the underwriter whether she needs any additional information. Even if they don't elicit a response, such inquiries can make it more difficult for the insurer to later try to avoid its coverage obligations based on information that was not provided during the application process.

There is no magic panacea to prevent deceitful policyholders or unscrupulous underwriters from trying to take advantage of an information disconnect. But where the parties are well-intentioned, engaging in a dialogue can help ensure that the insurance application process is a cooperative information exchange that results in the policyholder getting the coverage it needs.

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CLOSE YOUR M&A DEAL CONFIDENTLY BY FUNDING POST-CLOSING LIABILITIES THROUGH INSURANCE

By Carrie M. Raver

When a company merges with another entity and becomes a single entity, or where a company is acquired by another organization, it is critical that both parties understand their insurance programs to ensure that transactional risks are properly covered. Companies sometimes do not give adequate consideration to the possibility of future claims following a merger or sale, and do not place into the deal a funding mechanism for post-closing claims. This article offers some ideas to consider when planning an insurance solution to such claims as part of due diligence.

Tail policies cover actions taken before the closing

If you sit on the board of a company, the completion of an M&A deal does not insulate you from being sued for actions you took on behalf of the seller before it was acquired. A once-celebrated M&A deal might become a nightmare for former directors and officers long after a merger or acquisition closes. Directors' and officers' (D&O) "tail" or "run-off" insurance can help provide coverage to a selling company's board members for pre-closing conduct for years following the closing of an M&A deal.

D&O insurance is particularly important to a company's senior executives because it covers management and, at times, the corporation from claims made against them arising from the performance of their corporate duties. D&O insurance is written on a "claims made" basis. This means it covers claims asserted against the policyholder and reported to the insurer during the policy period, based

on allegedly wrongful conduct occurring while the policy was in effect. A D&O policy can extend coverage for current claims arising from pre-policy wrongful acts back into the past, via a carefully delineated "retroactive date." So if a lawsuit is filed against a director or officer in 2017 concerning acts that happened in 2013, a 2017 D&O policy with a retroactive date of January 1, 2013, would respond to the claim.

A gap in coverage can follow a merger or acquisition if the seller's D&O policy expires at closing, and the closing is the retroactive date for the buyer's D&O policy. D&O insurers generally are not willing to cover post-closing claims based on pre-closing activities over which its insureds have no control, so buying past-acts D&O coverage from the buyer's carrier usually is not an option. But the D&O policy for the seller, which does control pre-closing conduct, often includes a provision allowing the seller to purchase an extended discovery period (sometimes called a "tail" or run-off policy) bridging the gap by covering post-closing claims against the seller's directors and officers based on their pre-closing activities. The length of the tail policy can be subject to negotiation to meet or exceed the statutes of limitations for claims that arise out of a merger or sale, such as negligent or intentional misrepresentation.

Run-off policy extension premiums are typically issued on a non-refundable, non-cancellable basis. This prohibits third parties from trying to challenge or cancel the tail coverage and deprive former executives of the selling company of their insurance protection.

The buying company may not assume the seller entity's duty to indemnify claims against directors and officers arising from pre-closing acts, so the purchase of a tail policy is an important term of the deal to which the parties must agree. Another important feature of a run-off policy is that it be available to respond to a post-closing claim by the buyer against the seller's directors and officers for misstatements of fact made during due diligence. If such D&O tail coverage – without an exclusion of claims by the buyer against the seller's directors and officers – is unavailable, an M&A policy may be the only alternative available to cover buyer losses caused by misstatements by the seller. (More about this kind of coverage below.)

Almost universally, publicly owned companies have D&O insurance in place when a change of control or ownership occurs. This is the policy to which the tail is attached, which becomes effective at the time of the closing. Directors and officers of a selling company may well intend their D&O insurance to serve in the nature of a hold-back for post-closing claims by the buyer for misrepresentations in connection with the sale, and may well show this intent by having their broker buy the best tail coverage available.

Yet D&O coverage usually is not purchased solely to protect value in a transaction – at least not overtly. The same often cannot be said for privately held companies. Private companies do not always have D&O coverage. A private company may decide to buy D&O insurance for the first time during negotiation of a merger or sale. Underwriters may be uncomfortable writing a new D&O policy under these circumstances.

A selling company will want to have its insurance broker place the tail policy. Although this broker is about to

lose a client, he or she is in the best position to secure the best terms and limits of liability for a tail policy favorable to the seller's directors and officers with whom the broker has relationships and to whom the broker is loyal. Management should resist any suggestion that the buyer's broker place the coverage because this person is loyal to the buyer.

Representations and warranties policies are critical

A standard feature of most M&A transactions is that the parties make certain representations of fact to one another – called "representations and warranties" – on which they rely to price and close the deal. Representations and warranties insurance (RWI) is written specifically to cover losses arising from unintentional and/or unknown breaches of representations and warranties made by the parties to the transaction. RWI may be used to fund indemnification obligations arising from such breaches.

While RWI is available to buyers and sellers alike, the great majority of RWI policies purchased in the United States are buy-side policies. A buy-side RWI policy provides a buyer with coverage in the event of a misstatement or misrepresentation of fact made by the seller in the course of the deal. A buy-side policy is purchased by the buyer and provides first-party coverage which allows the buyer to seek recovery directly from the insurer for losses arising from a seller's breach of its representations and warranties. It allows a buyer to avoid making claims against officers of a merged-out or acquired company who may remain in key management roles. Buy-side coverage also allows a buyer to avoid the disruption of its normal business operations that results from an indemnification claim. Moreover, a prospective buyer may employ RWI as a hedge against the risk of mispricing the deal to distinguish itself from other buyers in a competitive bidding situation.

RWI is issued on a claims-made basis, and does not cover breaches of representations and warranties where the breach is known to exist prior to the inception of the policy. (However, buy-side RWI should cover undisclosed breaches known by the seller). RWI may be structured to cover specific representations and warranties within the purchase and sale agreement, or it may provide blanket coverage.

Buyer should inherit seller's insurance coverage

Insurance policies often contain anti-assignment clauses which prohibit the assignment of the policies, or rights under the policies, without the consent of the insurer.

As a general matter, a merged-out or acquired company's rights under its insurance policies often automatically vest in the surviving company by operation of the relevant state merger statute, notwithstanding the anti-assignment provisions of any policy. In the absence of a statutory merger however, courts are divided regarding whether anti-assignment provisions are enforceable. The majority rule holds that post-loss assignments of insurance rights are permitted without consent of the insurer, despite the existence of an anti-assignment clause. The minority rule is that post-loss insurance rights cannot be transferred without insurer consent where the claim is not yet liquidated, i.e., not yet due under the policy or not yet reduced to a sum certain. It is important that parties to a transaction anticipate which state's law applies to an assignment of rights under insurance policies they intend to follow the buyer after closing.

Conclusion: Insurance can be a valuable hedge against risk in a sale or merger

Thinking about coverage for post-transaction claims, and whether the seller's insurance policies will transfer to the buyer post-closing, should be a key component of every due diligence checklist. Not thinking strategically about insurance when negotiating a merger or sale can be a missed opportunity to monetize risk associated with a deal and shift it to an insurance carrier's balance sheet.

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CASE SUMMARIES

STAYING UP TO DATE ON INSURANCE POLICY LAW IS CRITICAL. HERE ARE A FEW SIGNIFICANT INSURANCE CASES DECIDED RECENTLY.

Re-Litigation Limited in Construction Case

***FountainCourt Homeowners' Assn. v. FountainCourt Development, LLC* (2016) 360 Ore. 341**

In *FountainCourt*, the Oregon Supreme Court ruled that, where a judgment in an underlying action does not establish that an insurance policy exclusion applies, the insurer may not subsequently re-litigate the applicability of that exclusion. The case arose out of a judgment against an insured subcontractor in a construction defect case finding it liable for "physical damage." The insurer refused to pay the judgment on the grounds that the judgment did not resolve whether the insured was liable for non-covered defective workmanship. The plaintiff, now a judgment creditor, brought a garnishment action against the insurer to collect policy proceeds.

The Oregon Supreme Court sided with the subcontractor, holding that, because the judgment was for "physical damage" rather than faulty workmanship, the insurer was prohibited from further litigating whether the faulty workmanship exclusion may apply. This is an important victory for policyholders, because it limits the ability of insurance companies to re-litigate the facts of the underlying case after judgment. This gives insureds some measure of finality in their insurance coverage, and limits the ability of insurers to obtain effective discounts on their policy obligations by keeping open the specter of ongoing coverage litigation long after the underlying case has been adjudicated.

Does a 'Possible Violations' Letter Trigger Coverage?

***MusclePharm Corp. v. Liberty Ins. Underwriters, Inc.* (D. Colo. Aug. 4, 2016) Case No. 15-cv-00555-REB-KMT**

In *MusclePharm*, the District of Colorado ruled that a directors' and officers' policy did not cover an insured's costs of implementing an investigation in response to a letter from the government referring to "possible violations" of law. The insured had received a letter from the Securities and Exchange Commission directing it to undertake a private investigation to determine whether certain illegal acts or practices were taking place. The letter stated that the SEC had "information that tends to show" various "possible violation[s]" of federal securities laws. MusclePharm sought coverage under its D&O policy on the premise that this letter was a "Claim" alleging "Wrongful Acts," therefore triggering coverage for the company's expense of responding.

The District Court ruled against the insured, determining that there was no "Claim" because there was no allegation of a "Wrongful Act" in the SEC letter. It concluded that an allegation of a "Wrongful Act" "must involve a positive assertion that the implicated error or omission is believed to have actually occurred," and that the letter's references to "possible violation[s]" that "may have" occurred was equivocal and did not amount to an affirmative assertion of wrongdoing.

This ruling highlights the fact that policyholders may be exposed to court decisions holding that some D&O policy forms are not written broadly enough to provide sufficient coverage to companies responding to informal governmental investigations. While many coverage claims focus on whether the policy has been triggered by a "Claim," this case demonstrates that insurers may also deny coverage on the basis that no "Wrongful Acts" have been alleged. As these kinds of investigations become increasingly commonplace, policyholders can sometimes negotiate better policy language or obtain coverage specifically geared to informal investigation response costs.

Devil in the Details in Computer Fraud Cases

***Apache Corp. v. Great American Ins. Co.* (5th Cir. Oct. 18 2016) 2016 U.S. App. LEXIS 18748**

In *Apache*, the Fifth Circuit narrowly construed a computer fraud provision in a crime protection insurance policy. The insured, an oil production company, did business with many different vendors. In this instance, the insured's accounts receivable department received a phone call stating that a vendor's payment information had been changed, a request which was followed up by an email and verified by the insured via a phone call to the number in the email. A $7 million payment was sent according to the new payment instructions. In fact, the phone call, email and phone number were part of a fraudulent scheme to steal the insured's money. The actual vendor did not receive the payment, and the insured brought a claim under the computer fraud provision of its crime policy. That provision applied to loss of money "resulting directly from the use of any computer to fraudulently cause a transfer" of that money. The insurer denied that claim, and Apache sued.

The Fifth Circuit held that the claim was not covered under the computer fraud provision. It concluded that, although the email was "part of the [fraudulent] scheme," it was "merely incidental to the occurrence of the authorized transfer of money" and therefore the transfer was not the

"direct result" of computer use. The court reasoned that "to interpret the computer-fraud provision as reaching any fraudulent scheme in which an email was part of the process would… convert the computer-fraud provision to one for general fraud." This decision underscores the fact that crime policies often cover far less than what policyholders may be led to believe, and the importance of carefully assessing a broad range of perils when shopping for crime policies.

How Far Can One Go in Marketing Claims?

***Education Affiliates, Inc. v. Fed. Ins. Co.* (D. Md. July 28, 2016) 2016 U.S. Dist. LEXIS 99137**

In *Education Affiliates,* the District of Maryland ruled that professional services exclusion in a professional liability policy does not permit directors' and officers' liability insurers to deny coverage for claims that happen to relate tangentially to professional services. The case arose from an underlying claim against a for-profit university in which plaintiffs alleged that its promotional activities misrepresented prospective students' job prospects upon graduation. The university tendered the claim to its D&O insurer, and the insurer denied coverage on the grounds that claims regarding the marketing of professional services fell within the scope of the policy's professional services exclusion. That exclusion applied to conduct "in connection with the rendering of, or actual or alleged failure to render, any professional services for others."

The District Court ruled in favor of the insured. It noted that if marketing of professional services can be conflated with the professional services themselves, given the fact that "the plaintiffs' core business is the rendering of educative services to others," the policy would offer nothing but illusory coverage – an outcome to be avoided under principles of policy interpretation. This case is an important win for policyholders, as it emphasizes that insurance companies may not use professional services exclusions as a way of undermining the coverage purchased by the policyholder.

When Does Coverage Begin?

***Nalder v. United Automobile Ins. Co.* (9th Cir. June 1, 2016) 824 F.3d 854**

Generally, an insurance company's policy limit serves as its maximum liability in connection with a given claim against its policyholder. The best-known exception to this rule is where the insurance company refuses to settle a claim against its policyholder within policy limits that it knows could exceed limits, and the claim eventually results in a judgment against the policyholder in an amount greater than these limits. Under these circumstances, the insurance company is liable for the entire judgment, regardless of policy limits. Some states articulate this rule in terms of bad faith: if the carrier declines to settle an excess-of-limits exposure within limits when it has the chance, the policy limit is waived based on a bad faith breach of the duty to settle. Where the bad faith requirement applies, it can act as a high bar to any excess recovery against the insurance company.

One case before the Ninth Circuit Court of Appeals is using basic contract law to directly challenge the view that an excess recovery is limited to instances where the insurance company has acted in bad faith. *Nalder* arose out of an incident where Lewis, the policyholder, seriously injured Nalder in an automobile accident. Lewis' insurance company (UAIC) refused to pay Nalder's $15,000 policy-limits demand, arguing that Lewis was late on paying a renewal premium and therefore was not covered at the time of the accident. Nalder sued Lewis, and UAIC refused to defend him. Nalder obtained a $3.5 million default judgment.

Nalder and Lewis then sued UAIC. The District Court of Nevada held that UAIC wrongly refused to defend Lewis, but that it had not done so in bad faith due to ambiguities in the policy. The District Court ordered UAIC to pay the judgment – but only up to the $15,000 limits of its policy. Nalder and Lewis appealed to the Ninth Circuit seeking payment from UAIC for the entire $3.5 million judgment amount. They pointed to the decision of a different federal District Court in Nevada holding that a party breaching a contract is liable for all consequential losses flowing from the breach, and that there is no special rule for insurance companies to the contrary.

While insurance disputes often land in federal court based on diversity of citizenship of the parties, insurance law is expressly limited to the states under the federal McCarran-Ferguson Act of 1945. Rather than decide the excess judgment issue based on a prediction of how the Nevada Supreme Court might rule, the Ninth Circuit in *Nalder* certified to the Nevada Supreme Court (meaning it asked the Court to decide) this question: Is an insurance company that wrongly, but in good faith, refuses to defend its policyholder liable for all losses consequential to that breach, such as default judgments, regardless of policy limits? Briefing before the Nevada Supreme Court commenced in early November 2016.

If the Nevada Supreme Court rules in favor of the policyholder and judgment debtor, its decision would raise the financial stakes of an insurance company's refusal to defend its insured. It would greatly enhance the policyholder's leverage in getting its insurance company to defend and settle cases with high excess liability exposure, because the policyholder would only need to demonstrate the existence of coverage to prevail, regardless of the insurance company's motivation for its conduct. On the other hand, if the court decides in favor of the carrier, it will be easy for an insurance company doing business in Nevada to deny a duty to defend based on a real or perceived coverage dispute.

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