The Year in Review: 2017 Key D&O Insurance Coverage Decisions

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As we begin 2018, we take a moment to look back at the key 2017 insurance coverage caselaw involving perennial coverage issues for D&O insurers and policyholders.

Disgorgement

The definition of loss in most D&O insurance policies excludes amounts that are uninsurable as a matter of law. Coverage disputes often arise, particularly in the settlement context, when insurers and policyholders disagree whether settlement amounts reflect uninsurable disgorgement such that the relief is not included within the loss definition. In 2017, two federal district courts issued insurer favorable decisions on this subject.

In *Philadelphia Indemnity Insurance Company v. Sabal Insurance Group, Inc., 2017 U.S. Dist. LEXIS 159508 (S.D. Fla. Sep. 28, 2017)* ("*Sabal*") the policyholder sought coverage for settlement of a grand theft claim. The settlement agreement between the policyholder and the State of Florida resolving the grand theft claim did not state that the payments contemplated under the agreement constituted restitution. As such, the policyholder argued because there was no use of the word "restitution" in the settlement agreement, it followed that there could not be a finding that the payments contained within settlement agreement were restitutionary. The court, however, disagreed. The court noted that by definition, theft is wrongly acquiring the property of another. Therefore, payments made to resolve the claim "can only be said to disgorge the policyholder of property to which it was allegedly not legally entitled." Moreover, the court found that the language of the settlement agreement did not preclude a determination that the payments within it constituted restitution or were restitutionary in nature. The court made clear that how payments are characterized in a settlement agreement is binding only on the parties themselves and not their insurers. *Sabal* provides a good example of how at least some courts are willing to look beyond the terms of an underlying settlement agreement when analyzing whether the relief at issue constitutes uninsurable disgorgement.

In *Twin City Fire Insurance Co. v. Oceaneering International, Inc.*, 2017 U.S. Dist. LEXIS 47798 (S.D. Tex. Feb. 28, 2017), plaintiff in the underlying derivative claim alleged that members of the policyholder's board had granted themselves excessive compensation. The complaint alleged breach of fiduciary duty and unjust enrichment. The underlying plaintiff sought disgorgement for the unjust enrichment claim and damages for the alleged breaches of fiduciary duties. The D&O insurer and policyholder disputed whether any portion of the underlying derivative action's potential settlement constituted uninsurable

disgorgement. Relying on the Fifth Circuit's decision in In re TransTexas Gas Corp., 597 F.3d 298, 309 (5th Cir. 2010) (finding language stating that "loss" shall not include "matters which may be deemed uninsurable under the law pursuant to which this policy shall be construed" to be unambiguous), the court held that any settlement amounts directed at repayment of the excessive compensation is, a "disgorgement of ill-gotten gains and a restitutionary payment." Notably, the court rejected the policyholder's argument that the personal profit exclusion, which required a final adjudication, mandated coverage since no final adjudication had been issued.

What Constitutes a Claim?

The question of whether a letter or other document received by policyholder prior to the commencement of litigation constitutes a claim continues to spawn coverage litigation. In today's market, most policies define a claim to include a written demand for monetary, non-monetary or injunctive relief. When the writing demands monetary relief, it is generally accepted that the writing constitutes a claim. However, when monetary relief is not expressly demanded, whether the writing constitutes a claim is a bit murkier, and is often the subject of coverage litigation. In *Tree Top, Inc. v. Starr Indemnity & Liability Co.*, 2017 U.S. Dist. LEXIS 197375 (E.D. Wash. Nov. 21, 2017) ("*Tree Top*"), the United States District Court for the Eastern District of Washington held that a statutory notice of intent to sue seeking to enforce certain portions of California Proposition 65, which seeks to reduce the public's exposure to chemicals in consumer products by requiring warning labels on products, did not constitute a claim, because it was not a "written demand for monetary, non-monetary or injunctive relief." The notice stated the claimant "intend[ed] to bring suit in the public interest against [the insured] . . . to correct the violation occasioned by the failure to warn all customers of the exposure to lead." The insurer argued that the notice constituted a claim. In the ensuing coverage litigation, the district court held that the notice did not constitute a claim because it lacked any "explicit" demand for relief, stating that "[t]he notice does not request a settlement or direct [the insured] to take any affirmative action. It merely provides notice of [the claimant's] allegations and its intent to sue." The court also rejected the insurer's assertion that the notice contained an implied demand finding that this would require the policyholder to infer more from the notice than its plain language supports.

In contrast to the *Tree Top* Court's unwillingness to infer an implied demand, the United States District Court for the District of Colorado, in *Scottsdale Indemnity Co. v. Convercent, Inc.*, 2017 U.S. Dist. LEXIS 187939 (D. Colo. Nov. 14, 2017) ("*Convercent*"), found that a letter authored by an employee contained an implied settlement demand. In *Convercent*, the employee's letter listed the specific legal violations that he believed had occurred in relation to his termination and suggested that the parties "get together and determine if my continued employment may be mutually addressed in a manner reflective of all issues to avoid litigation." In so doing, the court found the employee was impliedly requesting a settlement of the issues he raised. Additionally, the employee warned that he would "pursue all appropriate remedies" if his recommended steps were not taken. The court further found that such a

statement should reasonably have been read as an ultimatum and a threat to engage in litigation if his requests were not met. Accordingly, the court held that the letter constituted a claim because it was a "demand for damages or other relief."

Another frequent "claim" touchpoint involves whether subpoenas constitute claims. This is an issue when the claim definition does not explicitly include subpoenas, as illustrated by the United States District Court for the Southern District of New York's decision in *Patriarch Partners, LLC v. AXIS Insurance Co.*, 2017 U.S. Dist. LEXIS 155367 (S.D.N.Y. Sep. 22, 2017) ("*Patriarch*") and the Tenth Circuit Court of Appeals' decision in *MusclePharm Corp. v. Liberty Insurance Underwriters, Inc.*, 2017 U.S. App. LEXIS 20233 (10th Cir. Oct. 17, 2017) ("*MusclePharm*").

In *Patriarch*, the district court held that subpoenas and a formal investigative order issued by the U.S. Securities & Exchange Commission ("SEC") constituted claims for purposes of an excess policy's prior and pending claims exclusion. Specifically, the prior and pending claims exclusion provided that the excess policy did not apply to "any amounts incurred by the Insureds on account of any claim or other matter based upon, arising out of or attributable to any demand, suit or other proceeding pending or order, decree, judgment or adjudication entered against any Insured…" The primary D&O policy defined a claim to include: "a written demand for monetary damages or non-monetary relief (including but not limited to injunctive relief) or a written request to toll or waive the statute of limitations" or an "Investigation of an Insured alleging a Wrongful Act." The primary policy defined the term "Investigation" to include, among other things, "an order of investigation or other investigation by the Securities and Exchange Commission . . . ." The court held that the SEC subpoena constituted a "demand" for "non-monetary relief" under the primary policy. Although the primary policy did not define the term "demand," the court found that a subpoena is a demand as it is an "imperative solicitation for that which is legally owed." The court also found that the subpoena sought non-monetary relief in the form of documents that were to be produced. Additionally, the court found that the SEC formal investigative order and its underlying investigation of Patriarch were also claims under the primary policy. The court noted that the primary policy's definition of an "Investigation" explicitly referenced "an order of investigation or other investigation by the Securities and Exchange Commission." The court further noted that the formal investigative order also alleged a "Wrongful Act" because the order stated that the SEC has information that "tends to show" that Patriarch "may have been or may be" defrauding its clients and investors "[i]n possible violation" of the securities laws. The court found that this "[s]tatement amounts to a declaration that the SEC is investigating an allegation of wrongdoing. . . ."

In contrast to *Patriarch*, in *MusclePharm*, the United States Court of Appeals for the Tenth Circuit, held that a formal investigative order issued by the SEC and related subpoenas did not constitute "Claims" alleging "Wrongful Acts" as defined under a D&O policy. The policy at issue defined a claim to include "a written demand for monetary or non-monetary relief against an Insured Person," "a formal

administrative or regulatory proceeding against an Insured Person" or "a formal criminal, administrative or regulatory proceeding against an Insured Person when such Insured Person receives a Wells Notice or target letter in connection with such investigation." The court rejected the policyholder's argument that the SEC formal investigative order and related subpoenas constituted written demands for non-monetary relief. Relying on a dictionary definition of the term "relief," the court found that through the formal investigative order and related subpoenas, the SEC sought to determine whether there would be any basis to seek monetary and/or non-monetary relief from MusclePharm. The court determined that "[By] this action, the SEC was not seeking relief, but was only gathering information." The court also found that the formal investigative order and related subpoenas did not allege a Wrongful Act. Additionally, the court rejected the policyholder's contention that the formal investigative order constituted a formal administrative or regulatory proceeding. The court held that although the formal investigative order was captioned as a proceeding, that alone did not result in its coverage under the policy. Moreover, the court concluded that "the events leading up to the SEC's issuance of Wells Notices were part of a 'regulatory investigation' and were not a 'proceeding.'"

The Insured vs. Insured Exclusion

Application of the Insured vs. Insured exclusion remained a hot-button issue in 2017 with application of the exclusion to so-called mixed actions continuing to spawn coverage litigation. In a mixed action, the plaintiffs are comprised of both insureds and uninsured parties. Courts faced with applying the exclusion to mixed actions must decide whether the presence of some insured parties permits the exclusion to serve as a complete bar to coverage. As exemplified by the United States Court of Appeals for the Eighth Circuit's decision in *Jerry's Enterprises. v. United States Specialty Insurance Co.*, 845 F.3d 883 (8th Cir. 2017) ("*Jerry's Enterprises*") and the United States District Court for the Northern District of Illinois' decision in *Vita Food Products v. Navigators Insurance Co.*, 2017 U.S. Dist. LEXIS 85257 (N.D. Ill. June 2, 2017) ("*Vita Food Products*"), how courts have addressed this issue remains a mixed bag.

In *Jerry's Enterprises*, the daughter of the insured entity's founder and her two daughters filed suit against the insured entity alleging multiple acts of misconduct by the insured entity's directors designed to lower the value of their shares. The complaint contained claims for declaratory judgment, breach of fiduciary duty, aiding and abetting tortious conduct, equitable relief under Minnesota common and statutory law, breach of contract, civil conspiracy, and preliminary and permanent injunctive relief. All claims were brought jointly by the three plaintiffs. The daughter of the insured entity's founder was a former member of the company's board of directors while her daughters were not. The insurer denied coverage for the underlying litigation on the basis of the insured vs. insured exclusion, which barred coverage for any claim "brought by or on behalf of, or in the name or right of . . . any Insured Person, unless such Claim is: (1) brought and maintained independently of, and without the solicitation, assistance or active participation of . . . any Insured Person." The Tenth Circuit determined that insured vs. exclusion applied due to the presence of a former director as an active participant. Moreover, the

court noted that the former director was the driving force of the litigation. In so holding, the court rejected the policyholder's argument that the presence of an allocation provision in the policy mandated a contrary result.

Although the Tenth Circuit refused to find that the presence of an allocation provision prevented the insured vs. insured exclusion from serving as a complete bar to coverage, the United States District Court for the Northern District of Illinois in *Vita Food Products*, held otherwise. In *Vita Food Products*, the underlying litigation was commenced by two dozen of the company's former shareholders. Two of the plaintiffs were also Vita Food Products directors. The insured vs. insured exclusion precluded coverage for any claim made against any insured "by or on behalf of the company, or any security holder of the company, or any Directors or Officers." The exclusion contained an exception, however, which provided that the "exclusion shall not apply to . . . any Claim brought by any security holder of the Company whether directly or derivatively, if the security holder bringing such Claim is acting totally independent of, and without the solicitation, assistance, active participation or intervention of any Director or Officer of the Company" (the "security holder exception"). The insurer argued that because at least some of the plaintiffs in the underlying lawsuit qualified as security holders or directors, the entire claim was barred under the insured vs. insured exclusion. The insurer further argued that the security holder exception did not save the claim because the director plaintiffs actively participated and assisted in the underlying litigation. The court held that the presence of the policy's allocation provision was a dispositive factor and rejected the insurer's argument.

Scope of the Professional Services Exclusion

The professional services exclusion precludes coverage for loss arising out of the performance of professional services. Coverage disputes most often arise involving the exclusion's scope, particularly as it applies to service companies. The United States Court of Appeals for the Eleventh Circuit's decision in *Stettin v. National Union Fire Insurance Co.*, 861 F.3d 1335 (11th Cir. 2017) ("*Stettin*") is illustrative of this issue.

In *Stettin*, the coverage litigation emanated from underlying litigation relating to a Ponzi scheme orchestrated by a Florida attorney and his law firm. The underlying litigation asserted claims against certain executives of a bank and trust company, the insured, at which the law firm maintained its accounts. The primary and excess insurers denied coverage for the underlying litigation based on the professional services exclusion, which precluded coverage for "any Claim made against any Insured alleging, arising out of, based upon, or attributable to the Organization's or any Insured's performance of or failure to perform professional services for others, or any act(s), error(s) or omission(s) relating thereto." The Eleventh Circuit Court of Appeals sustained the district court's dismissal of the coverage litigation finding that the exclusion's use of the phrase "any Insured" unambiguously expressed a contractual intent to create joint obligations. As such, the court held that the exclusion applied to

preclude coverage as to all insureds, including those bank executives who were merely responsible for internal managerial banking functions. The court further noted that the policies did not contain a severability clause and the absence of such a clause was "fatal" to the plaintiff's argument seeking to apply the exclusion to only those executives performing professional services.

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If the past is prologue, we would expect to see courts address these perennial coverage issues again in 2018. The caselaw that made this year memorable will certainly influence coverage decisions in 2018.