



INSURANCE LITIGATION NEWS

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MULTIPLE INSUREDS

Homeowners coverage not barred by exclusion for intentional acts

Minkler v. Safeco Insurance Co., No. S174016, 2010 WL 2402973 (Cal. June 17, 2010).

A policy provision excluding coverage for the intentional acts of an insured did not preclude coverage for a negligent-supervision claim against a homeowner even though the claim arose from another insured's intentional acts, the California Supreme Court has held.

Answering a certified question from the 9th U.S. Circuit Court of Appeals, California's highest court said the "intentional acts" exclusion did not apply to the homeowner in light of a policy provision stating the insurance applied "separately to each insured."

(See *MULTIPLE INSUREDS* on page 5)

ADDITIONAL INSURED

Supplier's insurer had no duty to defend power plant contractor

Federal Insurance Co. v. American Home Assurance Co., No. B216147, 2010 WL 1667665 (Cal. Ct. App., 2d Dist. Apr. 27, 2010).

The insurer for a construction project supplier had no duty to defend the project's general contractor in an arbitration proceeding seeking damages for alleged construction problems, a California appeals panel has ruled.

(California prohibits courts and parties from citing or relying on unpublished opinions in any action or proceeding, except in limited circumstances specified by California Rules of Court 8.1115a & b.)

The general contractor's carrier failed to produce evidence establishing that it qualified as an additional insured under the supplier's policy, the 2nd District Court of Appeal said.

According to the appellate panel's opinion, Dearborn Industrial Generation hired Duke/Fluor Daniel in 1998 as the engineering and construction

(See *ADDITIONAL INSUREDS* on page 6)

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DUTY TO DEFEND

Insurer back on hook for contribution claim involving defect suit

Clarendon America Insurance Co. v. North American Capacity Insurance Co., No. E048176, 2010 WL 2377835 (Cal. Ct. App., 4th Dist. June 15, 2010).

A California appeals panel has revived an insurance company's action seeking contribution from another insurer for amounts spent in defending a home developer in a construction-defect lawsuit.

(California prohibits courts and parties from citing or relying on unpublished opinions in any action or proceeding, except in limited circumstances specified by California Rules of Court 8.1115a & b.)

The 4th District Court of Appeal's decision overturns a ruling that because the developer had not met the self-insured retention for each of the eight homes covered by North American Capacity Insurance Co.'s policy, North American's duty to defend never arose.

Instead, the appeals court held, a potential for coverage under North American's policy existed because the developer may have had a reasonable expectation that the SIR applied only once to the defect suit as a whole.

Consequently, Clarendon Insurance Co. is entitled to proceed with its contribution claim against North American, the panel concluded, reversing a grant of summary judgment for North American.

According to the opinion, Clarendon, which insured developer Tanamera Homes & Resort Communities LLC from November 2000 through November 2002, defended the developer in a construction-defect action brought by the owners of 43 homes.

North American, Tanamera's carrier after the Clarendon policy expired, refused to defend Tanamera, contending its duty to defend never arose because Tanamera did not satisfy the \$25,000 "per claim" SIR in its policy.

According to North American, the \$25,000 SIR applied to each of the eight allegedly defective homes that had been completed after the effective date of its policy. Thus, North American said, its duty to defend did not arise until Tanamera had paid \$200,000 in defense or settlement of the defect case.

Clarendon sued North American seeking an equitable share of sums it expended in defending Tanamera, contending that North American's duty to defend arose once Tanamera satisfied a single \$25,000 SIR.

The trial court sided with North American and granted it summary judgment.

The 4th District Court of Appeal reversed.

Although the SIR endorsement in North American's policy provided that the SIR applied to "each and every claim," nowhere in the policy was the term "claim" defined, the appeals panel said.

After examining other policy provisions, the court concluded the term was susceptible to two different meanings: It could be understood as referring to either the underlying construction-defect lawsuit as a whole (Clarendon's argument) or to the multiple demands for payment asserted in that suit (North American's position).

Because North American was the moving party, it had the burden of showing there was no possibility of coverage, the court said. To meet this burden, North American had to show that Tanamera could not have had an "objectively reasonable expectation" that the \$25,000 "per claim" SIR would apply only once to the defect suit, the panel said.

North American failed to meet this burden, the court said.

Indeed, the appeals court said, it is "questionable" whether any reasonable insured would have agreed to pay a \$404,000 premium for a policy with a \$2 million aggregate limit if it had expected to have to pay SIRs potentially totaling millions of dollars for the multiple properties it was developing.

See Croskey, Heeseaman, Popik & Imre, CAL. PRAC. GUIDE: INSURANCE LITIGATION (The Rutter Group 2009):

15:296; 15:885.2 (action for equitable indemnity or contribution)

7:500-502.2; 7:502.5-503; 12:205 (duty to defend)

7:677 (duty to defend among multiple insurers)

7:378; 7:384 (self-insured retention)

HEALTH BENEFITS

Same-sex couples sue California, IRS for health benefits

Dragovich et al. v. U.S. Department of the Treasury et al., No. 10-1564, *complaint filed* (N.D. Cal. Apr. 13, 2010).

Three homosexual couples have gone to court to force California to make long-term health care benefits available to same-sex spouses and partners of state government workers.

The class-action lawsuit, filed by the Legal Aid Society's Employment Law Center on behalf of the couples, says the state and the federal government are violating their civil rights by barring same-sex partners from receiving coverage under the state's tax-protected long-term-care plan.

"Families headed by same-sex partners are singled out for exclusion and denied without basis an important tool of financial planning," the complaint charges.

Named defendants in the suit include the California Public Employees' Retirement System, the U.S. Treasury and the Internal Revenue Service.

According to suit, filed in the U.S. District Court for the Northern District of California, federal law permits states to offer tax-protected long-term care plans to state employees and family members, including children, siblings, parents and other extended family members.

However, the only family members excluded under these plans are same-sex spouses and registered domestic partners, the suit says.

CalPERS allegedly told the plaintiffs it could lose its federal tax-exempt status if it provided coverage for same-sex partners.

This exclusion, the complaint alleges, is unconstitutional and discriminatory.

"As couples in legally recognized, committed relationships, the plaintiffs are entitled to respect for their fundamental liberty and privacy interests in marital and familial relationships, and the full and equal protection of the law," the complaint says.

The class seeks an injunction ordering CalPERS to open its long-term-care program "on an equal basis" to California public employees with same-sex spouses and domestic partners.

See Croskey, Heeseaman, Popik & Imre, CAL. PRAC. GUIDE: INSURANCE LITIGATION (The Rutter Group 2009):

15:112; 15:137.1-139; 15:139.5 (pleadings, complaint in class actions)

13:197.2 (pleading requirements)

1:62-62.2; 6:700 (health insurance)

PROPERTY DAMAGE

California wildfire victims sue insurer for underpayment

Ibarra et al. v. Chartis U.S. Inc. et al., No. BC438394, *complaint filed* (Cal. Super. Ct., L.A. County May 24, 2010).

California residents whose mobile homes were destroyed in a 2008 wildfire have filed a class-action lawsuit against their insurer, claiming they paid for but did not receive full coverage of their property losses.

The class, represented by Carlos Ibarra and eight other named plaintiffs, is made up of 382 people who lost their mobile homes in the fire and more than 120,000 other Californians who bought similar mobile home insurance from defendant New Hampshire Insurance Co. in the past four years.

According to the suit, a wildfire swept through the Oakridge Mobile Home Park in Sylmar, Calif., in November 2008.

The suit alleges NHIC, a wholly owned subsidiary of Chartis U.S. Inc. (formerly AIG), which covered many of the homeowners, refused to provide the policyholders with guaranteed replacement cost coverage or with coverage up to the appraised value of the property plus an additional percentage.

Replacement cost coverage pays the entire cost of replacing the lost real and personal property with equivalent buildings and goods, without deductions for age or depreciation.

Class members say they paid additional premiums for this top-of-the-line coverage from at least 2005. The extra coverage also included a percentage of the value of other structures on the property, personal property, additional living expenses, and building code upgrades and debris clearance, known as the "BCD float."

But NHIC has refused to honor those obligations, according to the suit, and its conduct has been "oppressive and despicable" in obfuscating, delaying and underpaying claims.

The plaintiffs allege NHIC raised the premium rate by 9.5 percent in 2007. When the rate increase went into effect, the company eliminated guaranteed replacement cost coverage and put the homeowners into different, less comprehensive coverage categories, the suit says. It also dropped the BCD float provision.

NHIC also violated state law by changing the policies without informing the policyholders within 45 days, they claim.

After the wildfire NHIC engaged in deceptive practices by attempting to change some declarations pages to make it appear that replacement cost coverage had never been included in the policies, the complaint alleges. Some policyholders say they now have three different declarations pages as a result.

The named plaintiffs say NHIC has paid them only a third or quarter of their actual losses from the fire and refused to remove debris. As a result, they have never

been able to clear their property, rebuild and move back into their old neighborhood, the suit says.

The complaint alleges unlawful, unfair or fraudulent practices; bad faith; and breach of contract against NHIC and Chartis, as well as several related insurance companies, officers and underwriters.

See Croskey, Heeseman, Popik & Imre, CAL. PRAC. GUIDE: INSURANCE LITIGATION (The Rutter Group 2009):

15:112; 15:137.1-139; 15:139.5 (pleadings, complaint in class actions)

13:197.2 (pleading requirements)

1:56-60.1; 6:200 (fire, property and marine insurance)

6:281.10-281.13; 6:281.15; 6:281.20 ("actual cash value" defined)

3:116-117; 6:282-287; 6:287.5-287.9; 6:287.11-287.13 ("replacement cost" coverage)

THEFT

Judge tosses policy assignee's burglary claim for lack of jurisdiction

McColm v. Foremost Insurance Co., No. C 09-04132 SI, 2010 WL 1691681 (N.D. Cal. Apr. 23, 2010).

A California federal judge has dismissed a lawsuit alleging an insurer underpaid benefits following a home burglary because the plaintiff failed to plead the jurisdictional minimum of \$75,000.

However, U.S. District Judge Susan Illston of the Northern District of California refused to strike the plaintiff's claim for bad faith, finding that such a cause of action is available under state law even though the plaintiff, an assignee, was not a party to the insurance contract.

Patricia McColm sued Foremost Insurance Co. as an assignee of her father, a Foremost policyholder who had passed away.

McColm claimed that in September 2002 her father's home was burglarized, resulting in damage to the dwelling and the theft of personal property.

She said Foremost conducted an inspection but only reimbursed her under the homeowners policy for repairs to a damaged door.

She asserted causes of action for breach of contract and bad faith, seeking punitive and emotional-distress damages.

Foremost moved to dismiss.

First, Judge Illston dismissed the case for lack of subject matter jurisdiction.

While diversity of citizenship exists because McColm lives in California and Foremost is based in Michigan, McColm fell short of showing that the amount in controversy exceeds the jurisdictional minimum of \$75,000, the judge said.

She noted that McColm's complaint states that damages are greater than \$10,000.

McColm said that figure is a typographical error and that the correct value is \$100,000.

As the only other figure included in the complaint is the \$25,008 policy limit for theft, Judge Illston dismissed the complaint with leave to amend.

The judge also granted Foremost's request to strike McColm's claims for punitive damages and damages for emotional distress.

As an assignee McColm cannot maintain such claims under California law, she said.

In contrast Judge Illston refused to strike McColm's bad-faith claim.

While an insurance carrier generally does not owe a third party a duty of good faith, the judge said the rule is different when the third party is an assignee.

Citing *Essex Insurance Co. v. Five Star Dye House*, 137 P.3d 192 (Cal. 2006), she said such a cause of action is available.

In *Essex* the state Supreme Court held that assignment of a bad-faith action against an insurer for wrongfully withholding policy benefits entitles the assignee to seek recovery of attorney fees.

The judge stressed that McColm will be barred from proceeding with her bad-faith claim if she is unable to amend her complaint to meet the minimum amount in controversy.

Judge Illston also rejected Foremost's request that McColm post \$20,000 for its attorney fees and court costs because the litigant allegedly has a history of filing frivolous lawsuits.

The judge said the insurer can renew its motion if McColm successfully amends her complaint.

See Croskey, Heeseman, Popik & Imre, CAL. PRAC. GUIDE: INSURANCE LITIGATION (The Rutter Group 2009):

6:2030-2031; 6:2031.5-2032; 6:2035-2041 (property loss and theft coverage)
12:13-26; 12:49-54 (bad faith)

12:910-914 (denials based on arbitrary or unreasonable standards)

12:8; 12:636.5; 15:13-14; 15:31; 15:145-147 (third party actions as assignee of insured's claims)

(MULTIPLE INSUREDS continued from page 1)

Consequently, the exclusion did not preclude coverage for claims that a mother negligently failed to prevent her son, an additional insured, from sexually molesting a minor, the Supreme Court said.

According to the opinion, Scott Minkler sued Betty Schwartz and her adult son David, alleging David had sexually molested him over a period of several years while serving as Minkler's Little League coach.

The complaint included a claim against Betty Schwartz for negligent supervision, based on allegations that the acts occurred in Betty's home and that she failed to stop her son from molesting Minkler.

Betty Schwartz maintained a homeowners policy with Safeco Insurance Co. that covered David as an additional insured.

Safeco denied coverage for Minkler's claims against both Betty and David, citing the policy's intentional-acts exclusion.

However, the policy also contained a "severability" clause providing that "this insurance applies separately to each insured."

Minkler settled with Betty and, after Betty assigned her claims against Safeco to him, he sued Safeco, contending that the severability clause rendered the intentional-acts exclusion ineffective with respect to Betty's coverage.

The lower court dismissed the suit, and Minkler appealed to the 9th Circuit.

The Court of Appeals, in turn, sought the California Supreme Court's advice on the effect, under state law, of a severability clause on an intentional-acts exclusion in a policy covering multiple insureds.

The state high court found that the severability clause, read together with the intentional-acts exclusion, created an ambiguity as to whether the exclusion extended to all insureds or just to the particular insured who committed the intentional acts.

Consequently, under state insurance principles, the policy had to be construed in accordance with the reasonable expectations of the insured seeking coverage, the court said.

In this case, it determined, it was reasonable for Betty to expect coverage despite the intentional acts of another

insured, so long as her own conduct did not fall under the intentional-acts exclusion.

Thus, the Supreme Court held that given the policy's severability clause, the intentional-acts exclusion did not bar coverage for the claims that Betty acted negligently by failing to prevent David's intentional acts.

See Croskey, Heeseman, Popik & Imre, CAL. PRAC. GUIDE: INSURANCE LITIGATION (The Rutter Group 2009):

1:13; 3:27-29; 3:31-32; 6:3; 7:60-61; 7:239-242; 7:242.5-243 ("intentional acts" limitation)

7:320-326.5 (vicarious liability for coinsured's intentional acts)

7:315-319; 7:319.6; 7:1808-1809; 7:1942.3 (others' intentional acts)

5:149.3 (severability of coverage in homeowners insurance)

(ADDITIONAL INSUREDS continued from page 1)

contractor for a power plant construction project in Dearborn, Mich.

In 2001 Dearborn Industrial sued Duke in an arbitration proceeding, alleging extensive design and construction problems with the project.

Duke notified its liability insurer, Federal Insurance Co., of the arbitration. Federal, in turn, asked American Home Assurance Co., the liability carrier for one of Duke's suppliers, Thermal Engineering International, to defend Duke in the arbitration case.

Federal contended that Duke qualified as an additional insured under American Home's policy because, according to Federal, some of the underlying allegations about design and construction defects involved components Thermal had supplied.

American Home refused, saying there was no potential for coverage based on the facts known at that time.

Dearborn eventually obtained an arbitration award against Duke.

Federal later sued American Home in a California state court for reimbursement of the costs it incurred in defending Duke, asserting that American Home breached its duty to defend Duke as an additional insured.

The trial court denied Federal's summary judgment motion and entered judgment in American Home's favor. The Court of Appeal affirmed.

The appeals panel said Thermal's policy conferred "additional insured" status on a company only if Thermal was contractually obligated to furnish insurance to that company.

The purchase order agreement between Duke and Thermal contained a provision requiring Thermal to provide Duke with additional-insured coverage only if Thermal's employees entered the project site to supply the required parts.

But Federal cited no evidence showing that Thermal's employees had ever entered the project site, the panel said.

Instead, Federal contended only that there was a "possibility" that Thermal had entered the project site "at some point."

As the moving party, Federal had the burden of producing evidence "reasonably supporting" a finding that Thermal had entered the project site in connection with the purchase order agreement, the panel said.

The mere possibility of entry was not sufficient to meet this burden, and thus not sufficient to establish Duke's status as an additional insured under Thermal's policy, the panel concluded.

See Croskey, Heeseman, Popik & Imre, CAL. PRAC. GUIDE: INSURANCE LITIGATION (The Rutter Group 2009):

7:500-502.2; 7:502.5-503; 12:205 (duty to defend)

7:514.5-514.6; 7:564; 7:631.2; 7:1409.10 (additional insured)

COMMENTARY

D&O insurance in bankruptcy settings — what directors and officers really need to know

By Paul A Ferrillo, Esq.

For directors and officers of both public and private companies that face insolvency scenarios or potential restructurings (both in and out of court), directors and officers liability insurance really takes on a completely different personality. In bankruptcy, a D&O policy really needs to be “bulletproof” to the greatest extent possible since it is one of the only things that can be relied upon to protect directors and officers from suits aimed (at least potentially) at their personal assets. This article focuses on D&O insurance issues in corporate reorganization and bankruptcy settings and identifies what issues should be of importance to companies and their directors and officers when thinking about how their D&O policies should work.

D&O policy issues in bankruptcy

A primary D&O policy form should address several important issues to protect directors and officers from potential catastrophe when faced with lawsuits and claims in insolvency and bankruptcy settings.

Side A coverage/non-rescindable Side A endorsements

There are generally two basic insuring clauses in the “insuring agreements” of any D&O policy. “Side A” coverage is for “non-indemnifiable” loss: loss (the definition of which generally includes defense costs, judgments and settlements) that a corporation is “unable to advance” or to “pay on behalf of” a director or officer (the corporation itself is not an insured under the Side A coverage provisions of the typical D&O policy).

Side B coverage is “corporate reimbursement” coverage, either for defense costs paid in excess of the policy’s self-insured retention/deductible or for securities claims (like a suit brought under Section 10(b) of the 1934 Securities Exchange Act) made directly against the corporation.

There are generally few situations where a corporation (organized in Delaware) would be unable to advance defense costs or to indemnify a director or officer for the settlement of a claim. One easily identifiable situation is for the settlement of a shareholder derivative action, where, under Delaware law, a corporation (for which a suit is brought on behalf of against the corporation’s directors and officers) cannot indemnify a director for a settlement of such action. Shareholder derivative settlements are thus thought by some to be the general utility of Side A coverage. But not really.

Duty vs. Reality

The key is understanding really what “unable to advance” means. Here, “unable to advance” means bankruptcy or insolvency, two situations where a corporation, despite being potentially obligated to advance and indemnify under its bylaws or certificate of incorporation, simply doesn’t have the cash let alone to pay a director or officer’s defense costs (or the retention of the policy), but also to fund the settlement of litigation.

Further, if the corporation files for Chapter 11, the cash it has on hand is not really “the corporation’s” any longer. It’s the “estate’s” cash, and it is there for the benefit of the corporation’s creditors and other related bankruptcy constituencies. The payment of defense costs for claims (for example, lawsuits) arising from pre-bankruptcy-filing conduct is probably no longer likely, feasible or permissible (a corporation’s creditors generally show little sympathy for the board and management of a corporation filing for bankruptcy).

Bankruptcy is where the rubber meets the road for Side A coverage. It generally obligates a carrier to directly pay a director or officer’s defense costs and directly fund litigation settlements (subject to the policy’s other terms, conditions and exclusions), without any need to satisfy the policy’s self-insured retention.

To prevent policy-rescission-type arguments in Chapter 11 settings (that is, in situations where directors and officers likely will have to rely on the D&O policy as their primary indemnification source), for an additional premium, many carriers offer something called a “non-rescindable Side A” endorsement. Simply put, with this endorsement, coverage under Side A provisions of the policy (as set forth above) will generally not be rescindable as to the insured persons under the policy. This endorsement is obviously critical and will likely require a carrier to immediately start advancing defense costs to the individual insureds.

Full severability of the application for coverage

The mantra “full severability” goes hand in hand with the need to protect innocent directors and officers in the event a corporation’s books and records are later found to be materially misstated. “Full severability” means the following, in the literal sense: the knowledge of the person signing the application for D&O coverage

is not imputed to any other insured for the purposes of determining coverage under the policy.

In a fraud-based bankruptcy triggered upon the discovery that a company's financial statements were materially misstated, the inclusion of a full severability clause should prevent coverage from being rescinded as to any director or officer who was unaware that the company's financial statements were misstated.

'Priority of payments' provisions

A "priority of payments" clause of a D&O policy creates a clear path that allows for the contemporaneous payment of a director or officer's defense costs in a restructuring setting, where the Side A provision of a D&O policy is triggered. Under a priority-of-payments clause, payments under the policy's Side A coverage provisions generally get paid first, before any other entity related payment.

Under clear case law, a priority-of-payments clause gives a director or officer a direct contractual right to access the D&O policy for the payment of defense costs and expenses (and judgments and settlements), regardless of whether the policy's proceeds are found to be an asset of the estate.

Presumptive indemnification clauses/ advancement of defense costs

Most D&O policies have provisions called "presumptive indemnification" clauses. They mandate that "indemnification" of a director or officer's defense costs is "presumed" under most circumstances. That makes sense because most D&O policies also have deductibles that must be exhausted prior to the policy's reimbursement obligations are triggered.

A well-thought-out D&O policy should provide that bankruptcy (or "financial impairment," as some policies say) is an exception to the presumptive-indemnification clause, meaning not only that indemnification is not presumed, but that the policy deductible goes away too. An additional safeguard would be a clause that states that upon a bankruptcy filing the policy will "automatically" advance defense costs.

'Change of control' provisions/tail coverage

Most D&O policies have provisions that detail what constitutes a "change in control" and what happens to coverage under the D&O policy when a change in control happens. A change of control is generally defined by two events:

- A change in management control (in general, a greater than 50 percent change of voting control at the board level); or

- The sale of all or substantially all the assets of the corporation to another party (or parties).

If the change-of-control provision is triggered, two important things happen. First, the debtor's D&O policy terminates as to coverage for claims (lawsuits) arising from "post-change-in-control" wrongful acts. In short, that means following a change in control, new coverage needs to be put in place for the reorganized debtor, its board and management.

More importantly, for outgoing management and directors, the "tail" coverage of the policy begins. The "tail" of the policy is the period following the policy's termination (when the policy expires, or when there is a change in control) in which an insured is entitled to report claims to the insurer based upon conduct occurring prior to the policy's termination. Many D&O policies provide one year of tail coverage. More than one year of tail coverage is normally preferable, given many state statutes of limitations, so thought should be given to pre-negotiating such a longer period as soon as practicable during the policy renewal cycle.

'Insured vs. insured' carve-out

Given the nature of bankruptcy proceedings, the "insured vs. insured" exclusion (which would exclude coverage for claims where one insured under the policy sues another insured) often comes into play and can potentially wreak havoc on claims scenarios aimed at directors and officers. Here, good drafting again can help prevent problems down the road. A "carve-out" from the insured-vs.-insured exclusion for bankruptcy-related claims should carve out claims brought not only by the debtor in possession, but also by creditors, bondholders, and equity and other bankruptcy-formed constituencies to which bankruptcy-related claims may be assigned by the debtor in a reorganization plan or pursuant to a bankruptcy court order.

See Croskey, Heeseman, Popik & Imre, CAL. PRAC. GUIDE: INSURANCE LITIGATION (The Rutter Group 2009):

1:78-81; 7:1550-1559; 7:1559.5-1559.6; 7:1944 (directors and officers [D&O] liability insurance)

7:1582; 15:1177- 178 (effect of bankruptcy on insured corporation)

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