IMA Executive Risk Solutions

Quarterly Update – 2Q2019

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Arbitration Award not Covered Due to Lack of Supplemental Notice

While this case was decided on late notice grounds, in reality it serves as a reminder to insureds to keep an insurer apprised of significant developments throughout the life of a claim.

This matter began as a wrongful termination claim that was tendered to the insured's employment practices liability insurer and accepted for coverage. The claimant, however, switched course by dismissing the lawsuit and re-filing it as an arbitration claim. After the lawsuit was dismissed, the insurer administratively closed its file and asked the insureds to update them if the matter was re-filed. The insured failed to do so until the arbitration concluded, wherein they were found liable for $334,992 in damages. Upon being advised of the arbitration award, the insurer denied coverage and took the position that the insured was obligated to provide separate notice of the arbitration filing regardless of having provided notice of the prior lawsuit.

In upholding the denial of coverage, the court relied on the policy in question, which defined a lawsuit and arbitration proceeding each as a "Claim". Moreover, the Reporting section of the policy required written notice be given for "any Claim" as soon as practicable. The court further noted the Reporting section did not mention "Related Claims" whatsoever, meaning that even if the lawsuit and arbitration proceeding were deemed a single claim under the policy, the insured was still required to provide separate notice of the arbitration proceeding. Despite finding it need not prove prejudice to deny coverage, the court found the insurer was prejudiced by not being afforded the opportunity to control the defense or participate at all, as it was entitled to per the policy's terms.

This case is a reminder to always err on the side of over-communication during the pendency of a claim to ensure coverage is not jeopardized. *Stadium Motorcars, LLC v. Federal Ins. Co.*, 2019 WL 2121111, (S.D. Tx. May 15, 2019).

Cases of Interest

Insured Entitled to Keep Settlement with Underlying Insurers Confidential (For Now)

When a claim implicates multiple layers of an insurance program, interactions between the insured and the insurers become even more complicated than in a typical claim scenario where only one policy affords coverage. This case underscores the need for an insured to have knowledgeable partners responsible for ensuring all policies are properly written and structured so as to not be in conflict during the placement process as well as throughout the life of a claim.

The insured in this case purchased multiple layers of errors and omissions (E&O) insurance. As with most insurance 'towers' of this sort, the excess layers only provided coverage upon exhaustion of the underlying policy limits. Several class actions alleging antitrust violations were filed against the insured and were tendered for coverage. As a result of a coverage dispute with the primary insurer, however, a confidential settlement was reached with some of the insurers in the tower, but not all.

After its attempts to learn the details of the settlement were rebuffed, because the agreements were deemed confidential, the second excess insurer moved for its production to be compelled by the court.

While the court refused to require the insureds to disclose the details of settlements with the underlying insurers at this juncture, it went on to hold that "if [the insurer] is correct that the exhaustion question cannot be answered without knowing what the settlement agreement provides, [the insured] bears the risk of losing this case if it insists on keeping the agreement's contents secret." The insured was, at least temporarily, allowed to keep the settlement with its underlying insurers confidential; however, it seems almost certain they will need to be disclosed in the future if the insured intends to access the limits of the non-settling excess insurers. *Homeland Insurance Co. of New York v. Health Care Service Corp. d/b/a Blue Cross Blue Shield of Illinois, et. al.*, 2019 WL 1499300 (N.D. Ill. April 3, 2019).

Cases of Interest

Courts Remain Split on Whether Subpoenas are Afforded Coverage

Courts continue to grapple with the questions of whether a subpoena (1) constitutes a "demand for non-monetary relief" and (2) qualifies as a "Claim" alleging "Wrongful Acts" as defined in the typical D&O policy.

Two recent judicial opinions exemplify this fact, with a federal trial court in Texas holding they do, while the First Circuit Court of Appeals in Massachusetts found they do not. Ultimately, the definition of "Claim" in the D&O policy will play a large (if not exclusive) role in determining whether a subpoena is covered.

The Texas case involved a Directors' and Officers' liability (D&O) policy under which coverage was sought for a *qui tam* lawsuit alleging False Claims Act violations. The Office of Inspector General issued a subpoena to the insureds demanding the production of documents. The subpoena was tendered for coverage to the D&O insurer; however, the insurer took the position that it did not meet the definition of a "Claim" under the policy. Upon the unsealing of the *qui tam* lawsuit, the insurer again denied coverage on various grounds. After dismissal of the *qui tam* suit, the insured brought this action to recover its legal fees it believed were covered under the D&O policy.

Applying Texas law, the court held the subpoena to undoubtedly be a demand for something due, thereby qualifying as a "Claim". In addition, the court held the subpoena sufficiently alleged violations of the False Claims Act to be considered Wrongful Acts.

In the second case, the coverage denial of the insurer was upheld on the basis of the claim originating prior to inception of the policy. This matter involved subpoenas issued by the Securities and Exchange Commission (SEC) investigating violations of federal securities laws. Contrary to the findings of the Texas court, this court found the "subpoenas were requests made of a party for information. They were not requests made of a court for equitable redress or benefit." The court reached this conclusion by relying on a definition of 'relief' as "the redress or benefit esp. equitable in nature (such as an injunction or specific performance) that a party asks of a court." (emphasis in original).

While these cases turn on different policy language and different state law, the lessons are clear. A broad definition of "Claim" is of utmost importance in executive liability policies, and notice to the insurer about any ongoing investigations should never be delayed. *Oceans Healthcare, LLC v. Illinois Union Ins. Co.*, 2019 WL 1437955 (E.D. Tx. March 30, 2019); *Biochemics, Inc. v. AXIS Reinsurance Co.*, 924 F.3d 633 (1st Cir. 2019).

Cases of Interest

Failure to Disclose Acquisition Discussions in Renewal Application Results in Coverage Denial

This case is presented as a stark reminder that omissions in a policy application can have disastrous results. Like many start-up companies, the insured in this case routinely engaged in a dialogue with prospective business partners on whether their interests in the company's technology were for license, re-sale or full acquisition of the company. After due diligence with the goal of acquisition had commenced, and in the process of renewing its executive liability insurance, questions on multiple applications asking whether any mergers, acquisitions or consolidations were contemplated in the next twelve months were answered in the negative. Only days after the policies incepted, a term sheet was executed and the company was acquired within two months.

A short time later, governmental investigations and litigation were initiated against the former CEO of the acquired company over fraudulent contracts that inflated revenues and payouts from the acquisition deal. The CEO sought indemnification from the successor company and, after initially denying coverage, the insurer agreed to advance defense costs until exhaustion of its $5,000,000 policy limit, while reserving the right to seek reimbursement.

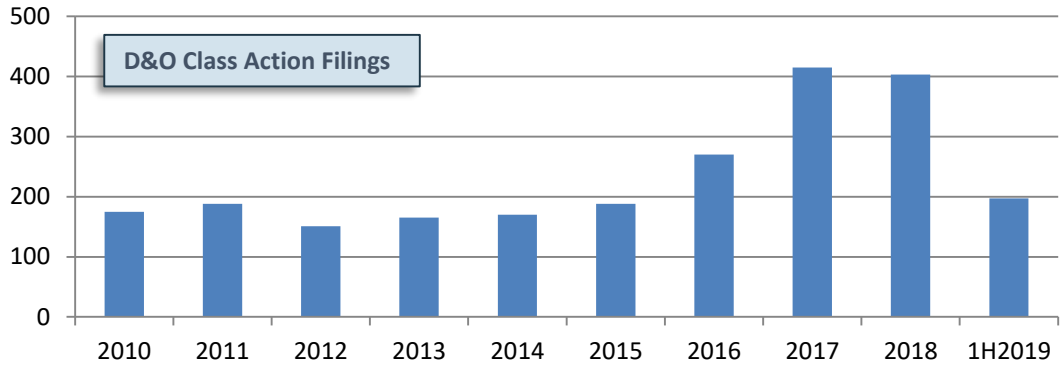
This action was then filed, wherein the insurer sought to recoup its full policy limit based on misrepresentations in the insurance application. After finding the answers in the application to be inaccurate, the questions unambiguous, and the inaccuracies to be material, the court found in favor of the insurer, requiring reimbursement of the full $5,000,000.

This case represents a particularly harsh result, given that the misrepresentations were done by the acquired company's CEO, but had the effect of depriving the successor company of coverage. We highlight it here simply as a reminder that answers provided in insurance policy applications need to be accurate and can have dire consequences if not taken seriously. *Scottsdale Insurance Co. v. CSC Agility Platform, Inc., et. al.,* 2019 WL 1452910 (C.D. Cal. February 4, 2019)

D&O Filings, Settlements and Other Developments

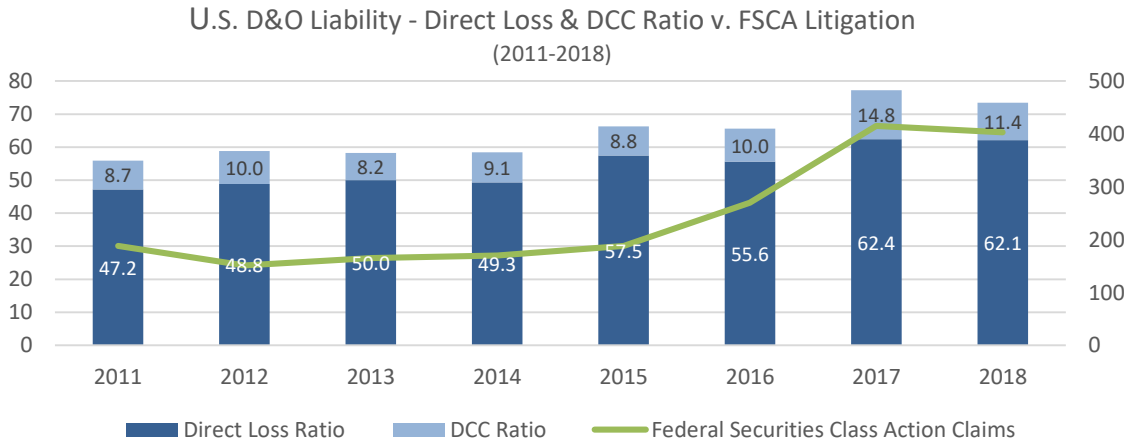
D&O Filings

- In 2018, there were 403 Federal Securities Class Action Claims, which is 94% *above* the trailing ten-year average
- In 1H2019, filings continued at an elevated level, with 197 D&O filings
    - This implies an annualized number of 394 filings, which would be a slight decrease over 2018 (403)
    - At this rate, **approximately 1 in 10 public companies are being sued for securities fraud**



Other Developments and Considerations

- With D&O litigation remaining elevated, carriers continue to push for rate increases on primary and low excess layers.
    - Price increases continue to be most noticeable for small cap companies and companies in challenging sectors.
    - Companies considering an IPO can expect to see dramatically different terms versus 3-6 months ago. Retentions and pricing have been increasing noticeably, and carriers have also begun to cut back on limit deployment.
- D&O insurer performance continues to deteriorate, with many insurers recognizing an underwriting loss.
    - The average D&O loss ratio in 2018 was 73.5. For the Top 15 insurers, the lowest was 36.2 and the highest was 124.7
    - Public D&O claims and losses appear to be driving these results more so than private D&O claims and losses.



Sources: Cornerstone Research; Stanford Law School; A.M. Best Data and Research

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About IMA

IMA Financial Group is a privately held, diversified financial services firm focused on protecting client assets and creating exceptional value for our clients around the world. Our diverse team of experienced and talented professionals shares an unwavering commitment to excellence.

IMA Executive Risk Solutions is our world-class team of 20+ professionals focused on providing thoughtful advice, a unique legal perspective, a broad range of executive risk insurance solutions, and excellent service to our valued clients. Our professionals have deep experience handling complex executive risk exposures for a variety of clients – from pre-IPO start-ups to multi-billion dollar corporations.