Summer 2015

Perspectives
on Insurance Recovery

pillsbury

Welcome to the latest edition of Pillsbury's Perspectives on Insurance Recovery. Whether you need an advocate in a dispute with carriers, or some advice on the placement of coverage, you can count on Pillsbury's team of 25 attorneys in five offices across the country to provide you with knowledgeable, efficient and practical assistance. As this 2015 edition of Perspectives demonstrates, our team is working on the most challenging issues—from cyber-insurance and complex claims arising out of major disasters, to coverage disputes arising from the explosion of merger-related litigation.

Pillsbury's team is also handling an unusual number of insurance coverage trials this year, including a high-profile bad faith case against AIG in California. Among major law firms with insurance recovery practices, Pillsbury's ability to pursue such claims free of conflicts is becoming increasingly unusual.

We hope you enjoy this edition, and welcome any feedback.

Peter Gillon and Robert Wallan
Co-leaders, Insurance Recovery & Advisory

ARTICLE HIGHLIGHTS

Don't Wait Until It's Too Late: Top Ten Recommendations For Negotiating Your Cyber Insurance Policy

By James P. Bobotek

As more and more companies of all sizes ranging across a wide spectrum of industries have been exposed to network and data security breaches in recent years, the market for insurance products dedicated to cover cyber risks has grown just as fast. With policies sold under names like "cyberinsurance," "privacy breach insurance," "media liability insurance," and "network security insurance," the market for this coverage often seems chaotic, with premiums and terms varying dramatically from one insurer to the next.

Unlike more traditional insurance policies that contain very similar terms, conditions and exclusions no matter which insurer issues them, cyber insurance policies are far from uniform. Prior to placing or renewing a cyber policy, it is therefore crucial to understand not only what you are being offered, but also how to negotiate coverage for the risks inherent in your business. Every policy's coverage is different. Before you buy or renew a cyber policy, be sure to review and understand the following guidelines.

Don't Wait Until It's Too Late: Top Ten Recommendations...

1. Buy Only What You Need

Many cyber policies provide an "à la carte" arrangement that includes the option to purchase seven basic coverages. Three of those coverages involve third-party losses: (i) Privacy Notification and Crisis Management Expense; (ii) Regulatory Defense and Penalties; and (iii) Information Security and Privacy Liability. Two involve first-party losses through what are commonly referred to as "time element" coverages: (i) Business Interruption and (ii) Extra Expense. The other two, also first-party related, provide "theft of property" coverages: (i) Data Assets and (ii) Cyber Extortion.

With all the bells and whistles now offered by some insurers, consider the specific risks against which you wish to insure, and whether you really need all of the coverages being offered. Always include notification and crisis management expense coverage, as well as regulatory defense coverage. Time element coverage is also important, especially for small businesses, as lack of income for even a short period may be disastrous.

If an insurer is unwilling to remove an objectionable exclusion or limitation from its policy, then ask your broker to get bids from other insurers. The cyber insurance market is highly competitive, with many insurers currently focused on building market share. This means that one might be willing to provide coverage or terms that another will not.

2. Carefully Vet the Limits of Liability

One of the most important issues in negotiating cyber coverage is determining the appropriate limits of liability. The costs of responding to a data breach can be substantial. In 2014, the average organizational cost of a data breach was approximately $5.8 million. Response costs for breaches involving the loss or theft of personal data were as much as $950 per electronic record. To put that number in context, a data breach involving just 25,000 records—a below-average total—would exhaust a $5 million policy. And if plaintiffs in a class-action suit obtained a judgment under a state statute that imposes $1,000 in damages for each claimant, the judgment alone could consume $25 million of insurance policy limits. Because cyber insurance is relatively inexpensive, you should choose limits of liability in line with your total potential liability exposure in the event of a breach. Your broker should be able to assist you in determining appropriate limits by utilizing its benchmarking databases.

Most cyber policies impose sublimits on some coverages, such as for crisis management expenses, notification costs or regulatory investigations. These sublimits are not always obvious, and they are often inadequate. They should be scrutinized carefully and set realistically. Also make sure that the policy's aggregate limit applicable to all coverages is not less than the total of all sublimits.

3. Obtain Retroactive Coverage

Many cyber policies limit coverage to breaches that occur after a specified "retroactive date." In some, this date is the same as the policy's inception date. This means there may be no coverage provided for claims made due to breaches that occurred before the policy period, even if the insured did not know about the breach when it bought the policy.

Because breaches may go undiscovered for some time before claims are made, insureds should always ask for a retroactive date that is earlier than the inception date. This will ensure that the coverage includes unknown breaches that first occur prior to the policy's inception, but do not manifest themselves until after that date. Insurers do not always offer retroactive coverage unless asked, but it is commonly available for periods of one, two, five or ten years. Some offer unlimited retroactive coverage.

4. Beware of Broadly Worded Exclusions

It is not uncommon to find cyber insurance provisions that contradict the insured's basic purpose in buying the coverage. Sometimes these provisions have been cut from other insurance policy forms and pasted into cyber insurance forms where they do not belong. For example, some policies broadly exclude coverage for any liability arising from a breach of contract. Many insureds collect and store confidential information from customers, patients or business partners pursuant to contracts that require them to maintain the confidentiality of the information. They buy cyber insurance precisely to protect them in case a privacy breach gives rise to damages claims under such confidentiality agreements.

Many insurers, if asked, are willing to modify exclusions to make it clear that they will not bar coverage for claims that go to the core of an insured's business. This is just one of many examples of broadly worded exclusions that need to be reviewed carefully and narrowed to make sure that they will not defeat the reasonable expectations of the insured in buying cyber insurance.

5. Beware of Panel and Consent Provisions

Many cyber policies require that any investigators, consultants or attorneys used by the insured to respond to a claim or potential claim be drawn from a list of professionals that have been pre-approved by the insurer. If you would like your preferred consultants and attorneys to be involved in the event of a loss because they already know your business operations, it is a good idea to ask to add these professionals to the insurer's pre-approved list during the underwriting process.

Cyber policies also often contain consent provisions stating that the insured must obtain the insurer's consent before incurring any expenses to notify customers or patients of a data breach, conduct forensic investigations or defend against third-party claims. Such prior consent

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Indemnity And Insurance Provisions In Construction Contracts

By Jeffrey A. Kiburtz

In a profession with some notoriety for topics having little mass appeal, it takes a truly special area of the law to inspire judicial commentary like this:

> The comedy troupe Monty Python once made the subject of insurance—insurance of all things—the butt of a comedy skit. But we doubt that even comedians of their caliber would try to make "indemnity" the topic of comedy. It is a topic so deadly dull that it makes insurance look interesting. That is not to say, however, that the topic is not of vital importance in many commercial contexts, particularly in California's construction industry.

Crawford v. Weather Shield Mfg., Inc., 136 Cal. App. 4th 304, 306 fn.4 (2006). (See also https://www.youtube.com/watch?v=kO2R_DDZPCM.)

Setting aside whether indemnity is truly "deadly dull" and insurance is only generically boring, few can disagree that these risk allocation mechanisms are tremendously important in construction contracts. While numerous issues can lead to risk allocation not functioning as the parties intended, the lack of a clear relationship between the contractual indemnity provisions and insurance requirements can give rise to considerable uncertainty. It is important, therefore, to understand how indemnity and insurance provisions can interact, some key differences between the two, and related contracting considerations.

Indemnity Versus Insurance: Varying Scopes of Protection

While insurance is often considered a "backstop" to indemnity, it does not necessarily follow that the scope or nature of the insurance protection is coextensive with or limited to that provided by indemnity. Rather, insurance can provide protection under terms that are either broader or more restrictive than that provided under the indemnity provision.

Unlike typical indemnity provisions which can, subject to legislative limitations, provide protection against almost any loss bearing a sufficient connection to the indemnitor's activities, the coverage provided by commercial general liability (CGL) policies are generally limited to bodily injury and property damage, and numerous exclusions further limit the protection provided.

As one example of the differing scope between a typical indemnity provision and the insurance provided by a CGL policy, a contractor will likely be indemnified by an at-fault subcontractor for a pure delay claim brought by an owner, but unless there is bodily injury or property damage it is unlikely that the contractor would have insurance coverage for that same claim. Another possibility is situations in which the indemnity agreement obligates the indemnitor to assume contractual responsibilities going beyond those imposed by an ordinary tort standard of care. Under these circumstances, an insurer might claim that coverage is barred by the breach of contract exclusion common to CGL policies.

If there is concern that a critical subcontractor may not have sufficient resources to honor the full breadth of its indemnification obligations, CGL insurance therefore would not be an effective "backstop." Obtaining "additional insured" status under the subcontractor's CGL policies would not change that result, as the fundamental issue is a lack of coverage under the CGL policy.

One option for addressing this risk is the surety bond. While categorically different than insurance policies, surety bonds can offer protection against, among other items, pure delay and other risks generally not covered by CGL policies. Protections may be limited by the terms of the bond, however, and even when expressly encompassed within the scope of the bond there can be substantial delays and litigation required to effectuate performance. That is not always the case, however, and sureties often provide

1. Construction contracts typically contain two types of provisions under which a party will bargain for some form of protection against claims and losses: Indemnity and insurance. "Indemnity" involves one of the parties agreeing to provide that protection in its own right. "Insurance" is being used here to refer to protection provided by a third-party, usually an insurance company, even if the contractual arrangement is not technically "insurance" (as in the case of surety bonds).

Indemnity And Insurance Provisions...

timely performance under a payment bond claim or when hiring a completing contractor.

Parties are increasingly looking to subcontractor default insurance (SDI or "Subguard"[2]) to address the risks associated with the default of a subcontractor, including those not covered under CGL policies. While SDI typically provides for interim payments which can address the delay in receiving the protection contemplated by surety bonds and insurance policies, SDI is not without limitations. Among others, SDI can be difficult for some contractors to obtain, and coverage for liquidated damages, delay and other costs is often subject to restrictive sublimits.

The foregoing discussion addresses situations in which the protection provided by third-parties is nominally more restrictive than that provided by indemnity, but that relationship is not always present. Indeed, due to "anti-indemnification" legislation passed in most jurisdictions, it is increasingly common for the indemnity terms to be less inclusive than the available protection from third-parties like insurance companies.

The issues raised by this type of relationship can be complex, as some states' "anti-indemnification" laws purport to limit insurance coverage to those situations in which indemnity can legally be negotiated. Even when there is no legislative restriction on the scope of coverage, courts have in certain circumstances looked to the underlying indemnity agreement rather than the terms of the policy itself to delineate the scope of protection provided. Accordingly, parties cannot necessarily assume that insurance coverage that is nominally broader than the underlying indemnity provision will ultimately perform as intended.

Indemnity Versus Insurance: Timing of Performance

While insurance and other third-party protection is often perceived as a "backstop" for indemnity, there is no hard-and-fast requirement that a party first pursue indemnification. Rather, in certain circumstances, the indemnitee can bypass the indemnitor and seek protection directly from the insurer or other third-party indemnitor. (Three such circumstances were mentioned earlier—"additional insured" status under a CGL policy, SDI, and surety bonds.)

The ability to seek performance directly from the third-party has significant benefits. For one, it increases the number of potential sources of funds. Thus, if the contractor is insolvent or has taken a very hard position on the claim, there is the possibility of a solvent, more malleable party from whom to recover. And, as discussed below, it is more likely that the third-party will present a better source of recovery.

Second, the nature of the third-party obligation in those circumstances is oftentimes more favorable. With SDI, for example, there is often the opportunity to submit interim proofs of loss to receive funds to address the default, which is an option that is rarely available under an indemnity provision. For its part, status as an "additional insured" carries the right to receive an immediate, insurer-funded defense. While cases such as *Crawford* provide that a contractor may have an immediate obligation to defend, that result turns on the specific indemnity language and can be difficult to achieve in practice.

Indemnity Versus Insurance: Likelihood of Performance

Central to likelihood of performance are two distinct factors—the party's willingness to pay and its ability to pay. For a variety of reasons—including the nature of regulatory scrutiny, differing institutional interests and differences in substantive law—there probably is, in general, a higher likelihood of receiving payment from a third-party indemnitor (most often, an insurance company) than a contractor. But, as discussed below, that is not always the case.

Regulatory scrutiny on insurance companies is focused heavily on solvency, and insurers as a whole therefore are generally likely to be able to pay claims. The differing nature of insurers' and contractors' respective businesses also provides vastly different incentives—while an insurer that pays a claim is merely doing what it was expected to do, payment of a claim by a contractor can be perceived as an admission that it did something it should not have done. Moreover, between the insurers' obligations of good faith and fair dealing to their insureds and more nuanced differences in how courts interpret insurance policies versus contractual indemnity provisions, the law also provides insurers with more incentives to pay than contractors.

That is not to say, however, that insurers are always more willing to pay. Various of the many parties involved in significant construction projects may be insured by non-admitted insurers with differing levels of regulatory scrutiny and/or concern for their reputation. Insurers' claims positions can also be driven by factors affecting the company or industry as a whole, rather than just the merits or economics of an individual claim. Conversely, contractors are often very mindful of their reputation within the industry and may have a strong desire to be perceived as "standing behind their work" and, therefore, may be willing to pay even when the merits of a particular claim do not necessarily warrant it.

Conclusion

When allocating risk inherent in a construction project, it is necessary to pay close attention to the interplay between indemnity and insurance to ensure the objectives of the parties are achieved. Each has its advantages and limitations, but can effectively be combined to secure the performance of the myriad participants in construction projects of all complexities.

2. "Subguard" is a registered trademark of Zurich Services Corporation, but is often used generically to refer to similar policies offered by a number of carriers.

FCA Threats Are Likely Greatest Outside The Fortune 100

By Jeffrey A. Kiburtz and Joseph D. Jean

A version of this article was originally published on Law360.com on May 15, 2015.

The federal government recovered nearly $6 billion from False Claims Act cases in fiscal year 2014. Of that amount, over half ($3.1 billion) came from banks and other financial institutions, with $1.85 billion of that amount coming from a settlement with Bank of America Corp. alone. The federal government recovered another $2.3 billion for alleged fraudulent claims submitted under federal health care programs, such as Medicaid and Medicare, with almost half of that amount coming from a $1.1 billion settlement with Johnson & Johnson and its subsidiaries related to allegations of off-label use of certain medications.

But it is not only financial institutions involved with federally insured mortgages and health care companies that are at risk, as the government release reflects actions against software and information technology companies, defense contractors and a bank acting as a guarantor of trade credit. FCA suits can arise even in the absence of any government contracts, as is the case with alleged customs fraud by importers.

That "most" of the matters leading to these settlements were qui tam actions and the whistleblowers in them received $435 million underscores the potential reach of scrutiny in this area. Importantly, however, the numbers from the U.S. Department of Justice do not include actions and recoveries by state prosecutors, which have been multiplying in recent years and resulted in significant settlements, especially when—as is not uncommon—prosecutors from multiple states join forces to pursue claims.

While the very large settlements involving Fortune 100 companies grab headlines, they tend to draw attention away from the significant number of private and middle-market companies against which federal and state FCA suits are brought. Indeed, a review of the press release section of the Department of Justice's website reveals that, during the first part of 2015, a party agreed to pay at least several million dollars to settle FCA allegations almost every week. And even though the amounts involved in many of these actions are not nearly as attention-grabbing as those mentioned above, the often significant defense costs and out-of-the-spotlight settlements could represent a greater financial risk on a relative basis to these private and middle-market companies.

The Role of Insurance

In addition to having a potentially greater need to rely on insurance to manage the financial burden of an FCA suit, private and middle-market companies likely have a greater chance of obtaining coverage for such claims. Between generally broader directors and officers liability coverage, greater availability of policies that specifically provide coverage for FCA suits and potentially less scrutiny from underwriters, the private and middle-market are likely the places where most FCA-related insurance coverage claims are paid.

This article highlights the potential sources of insurance coverage and issues most likely to be faced while seeking to obtain coverage for FCA suits.

D&O/Management Liability Policies

D&O liability policies (also referred to as "management liability policies" in certain contexts) generally provide coverage for "loss" on account of a "claim" for a "wrongful act." A wrongful act is generally construed broadly to include virtually anything that could give rise to an assertion of wrongdoing, including allegations of defrauding the government. For private companies, "directors and officers" liability insurance is almost a misnomer, as most policies issued to private companies provide relatively broad coverage for the entity itself, even in the absence of claims brought against individual directors and officers. (This is in contrast to policies issued to public companies, for which the entity coverage is typically limited to "securities claims.") Between this broad entity coverage and individuals being targeted in FCA suits, a D&O policy issued to a private company often provides the most likely source of coverage for a private company.

That is not to say, however, that private company D&O policies are certain to provide coverage for FCA suits in all situations. D&O policies issued to private companies vary dramatically in terms of the quality of coverage actually provided, with a seemingly increasing number loaded with a variety of exclusions which, taken together, eliminate coverage for almost all conceivable risks. Moreover, D&O policies issued to companies, like health care companies, with perceived FCA and regulatory risks also may contain regulatory or other exclusions which could present hurdles to coverage.

Coverage issues may also exist under even the highest-quality policies, including the applicability of the so-called conduct and improper benefit exclusions. These exclusions, which can bar coverage for intentionally wrongful conduct or when the insured is ordered to return money it wrongfully obtained, are often subject to provisions which limit their applicability unless and until there is a final adjudication that the insured did, in fact, commit

FCA Threats Are Likely Greatest...

intentionally wrongful acts or wrongfully obtain a benefit to which it was not entitled.

Insurers also may claim that the relief sought in an FCA suit does not constitute "loss" for purposes of obtaining coverage. While the relief sought in FCA suits can be subject to characterization as disgorgement or restitution, a broad variety of remedies may be available, including damages. Moreover, even if the settlement or judgment in an FCA suit can be characterized as being something other than "loss," many policies will provide defense costs coverage even when there proves to be no loss subject to indemnification. And because defense costs for these matters can be incredibly high, this coverage can be incredibly important, especially for private and middle-market companies.

Depending on the context of the FCA matter (for example, whether it is an investigation or a suit), a policy's definition of "claim" and the breadth of coverage for formal and informal investigations also may be important. While many D&O policies are being written with broader definitions of "claim" that include coverage for investigations and administrative proceedings, policyholders should pay careful attention to the language utilized, as many traps can exist in seemingly straightforward language. Moreover, care should be taken when purchasing broader coverage in a renewal policy, as circumstances which did not give rise to a claim under a prior policy may be deemed a claim made prior to the policy period (and therefore not covered) under a more expansive definition of "claim."

Despite the likelihood of at least some coverage issues, companies should not automatically assume that an insurer's declination of coverage is correct. Recent decisions confirm that FCA suits can be covered under D&O and similar management liability policies. See, e.g., *Carolina Cas. Ins. v. Omeros Corp.* (W.D. Wa. March 11, 2013); *Community Health Ctr. of Buffalo Inc. v. RSUI Indem. Co.* (W.D.N.Y. March 5, 2012).

And while both of those decisions confirm that coverage can be available for FCA suits, those cases serve as a reminder that FCA claims can present complicated notice issues. In particular, both Omeros and Community Health involved, to some degree, a dispute over the timing of when the claim was made versus when it was reported to the insurer. Timing issues such as these arise frequently with D&O and other claims-made-and-reported policies (like professional liability and employment practices policies, discussed below), under which coverage is generally available—subject to related claims provisions which can alter the analysis—only when a claim is made against the insured during the policy period and reported to the insurer during the policy period or other contractually prescribed time. While these disputes are by no means limited to FCA suits, the timing and notice issues for FCA suits can be more challenging in that a qui tam suit might remain effectively dormant for an extended period of time after it is filed while the government determines whether it will intervene.

Professional Liability Policies

FCA claims may also be covered under professional liability policies, which typically provide coverage for "professional services" rendered by the insured to another party for a fee. Because professional liability policies have been adapted for use in a wide variety of settings (e.g., ranging from more traditional lawyer malpractice policies to technology companies to health care billing companies), the nature of the coverage that can be provided by a "professional liability policy" varies dramatically. So, too, can the likelihood of obtaining coverage for FCA lawsuits.

The professional liability policies most likely to provide coverage are those which specifically contemplate coverage for FCA lawsuits. Within this group, a commonly seen variant are the specialized professional liability policies issued to health care companies. Subject to significant variation depending on the particular policy form and the specific nature of the health care business, these policies will generally respond to lawsuits involving alleged violations of federal and state FCAs, whether brought as a qui tam action or directly by the government. Even under these policies, however, policyholders should expect insurers to assert there is no coverage for settlements or judgments that represent or constitute amounts which were wrongfully withheld or obtained from the government. Insurers also may take the position that amounts subject to characterization as fines, penalties or multiplied damages are either not covered or subject to sublimits. The merits of these positions, if any, likely would depend on the facts of the underlying and specific policy language used, and should in any event be carefully considered by the insured because there are frequently factual and procedural arguments that make these exclusions inapplicable.

That certain professional liability policies specifically contemplate coverage for FCA lawsuits does not, however, mean that coverage is unavailable under policies which do not on their face reflect that coverage. Rather, coverage for FCA lawsuits can be obtained under more general professional liability policies like in *Certain Underwriters v. Huron Consulting Group Inc.*, Case No. 650339/2011 (appeal pending), a case recently decided by the New York Supreme Court.

The insureds in *Huron* were sued in an FCA lawsuit premised upon excessive Medicaid and Medicare billing. They sought coverage under a "Professional and Technology Based Services, Technology Products, Computer Network Security and Advertising Liability Insurance Policy." The policy defined "professional services" as "Health and Educational Consulting," which was further defined to include a wide variety of activities presumably performed by the insureds.

Given the broad range of activities enumerated in the policy's definition of "professional services," the main coverage

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Time Element Extensions: An Important Endorsement To Commercial Property Insurance Policies

By Geoffrey Greeves and Vernon Thompson

While the recent riots and citywide curfews in Baltimore exposed a tenuous relationship between police and citizens, they also serve as a lurking reminder that policyholders should reacquaint themselves with widely available extensions of time element coverages. These time element extensions may be purchased as endorsements to commercial property insurance policies. Here is how they work.

Civil authority and ingress/egress provisions insure potential business income losses following events that prevent the insured's or customer's access to undamaged premises owned by the insured. Traditionally, these are referred to as S.R. & C.C. coverages. While relevant orders and events giving rise to civil authority and ingress/egress claims sequentially follow a variety of causes, such as natural disasters, riots, protests or even terrorist attacks, these coverages focus geographically on the zone immediately around a catastrophe. Following the riots that stemmed from the assassination of Dr. Martin Luther King Jr. in the 1960s, and the beating of Rodney King, in the 1990s, for example, many businesses turned to the civil authority and ingress/egress extensions of their commercial property insurance policies to find coverage for their business losses resulting from curfews and other measures imposed by local governments that prevented access to the businesses. Business owners similarly impacted by limited access due to civil unrest or other causes would be wise to recheck their policies and ask whether they are able to make a claim for business income loss.

Civil authority and ingress/egress are intended to cover losses suffered as a result of orders that restrict, or events that partially or fully impair access to an insured's place of business. Although the language of the provision may vary from policy to policy, civil authority coverage generally requires all of the following: (a) a lawful order or action by a civil authority that (b) prohibits access to premises, (c) is caused by or results from a peril not excluded and (d) involves damage to property *other than* the insured property. Similarly, ingress/egress generally requires that access to or egress from real or personal property is impaired in connection with or following a peril insured against. In many instances, an event triggers both, entitling a policyholder to recover under both provisions, provided any relevant deductible and/or waiting period required by the policy is met.

Because a curfew or evacuation order does not itself inflict physical damage on the insured property, many policyholders erroneously assume that their property policy does not respond. To the contrary, many civil authority and ingress/egress provisions merely require that property damage occurs in a hypothetical zone (e.g. a specific geographic radius) around the insured's premises, such as within five statute miles, before the coverage is triggered. (See *Syufy Enters. v. Home Ins. Co.,* No. 94-0756 FMS, 1995 U.S. Dist. Lexis 3771 (N.D. Cal. Mar. 20, 1995) (which found

SF Bay Area Must Read

Pillsbury participates in a comprehensive study of the potential impact of major storms

Pillsbury recently participated in an independent, scientific study published by the Bay Area Council Economic Institute to analyze the effects of climate change and the risks to the San Francisco Bay Area arising from sustained winter storms.

The study is a must-read article for businesses with operations in Northern California, as it estimates that a superstorm event (similar to Superstorm Sandy in 2012) would cause $10.4 billion of damage region-wide. On the insurance front, Pillsbury partners Robert Wallan and Rob James authored a section of the report that identified issues that have been hotly contested in the wake of major storms: flood vs. named storm; hurricane vs. named storm; concurrent causation issues; civil authority and ingress/egress; service interruption; "loss of market" exclusions; and waiting periods.

To read the full article, go to **http://goo.gl/1VPXdB** or scan the **QR code below** with your mobile phone. You can also read the entire study by going to **http://documents.bayareacouncil.org/survivingthestorm.pdf.**

Time Element Extensions: An Important Endorsement...

that coverage was not triggered for damages suffered as a result of curfews imposed following the Rodney King riots where there was no damage to "adjacent" property as required by the policy's civil authority provision.)

Even for policies that do not include a specific geographic radius, there must still be a causal connection between prior physical damage and the order preventing access. The order cannot be solely in anticipation of, or seeking to prevent, future physical damage. For example, in *Dickie Brennan & Co., Inc. v. Lexington Ins. Co.,* 636 F.3d 68 (5th Cir. 2011), the Fifth Circuit considered a civil authority provision that provided coverage for loss "caused by action of civil authority that prohibits access to the described premises due to direct physical loss of or damage to property, other than at the described premises." The policyholder sought coverage under this provision following a mandatory evacuation order issued on August 30, 2008, by the mayor of New Orleans in anticipation of the arrival of Hurricane Gustav, which was approaching Louisiana from the Gulf of Mexico. The Fifth Circuit determined that because the mayor's order was solely concerned with potential future storm damage, and not prior damage caused by the storm in the Caribbean, there was no causal relationship between the order and "damage to property, other than at the described premises." Thus, according to the court, coverage under the civil authority provision was not triggered. By contrast, in *Assurance Co. of Am. v. BBB Serv. Co. Inc.,* 265 Ga. App. 35 (2003), the policyholder was able to provide evidence that the property damage caused by Hurricane Floyd in the Bahamas before it arrived in Georgia served as a basis for the evacuation order. As a result, the Court of Appeals of Georgia determined there was coverage for the policyholder under a civil authority provision similar to the one considered in *Dickie Brennan.*

Some modern civil authority and ingress/egress provisions, however, have taken the available coverage a step farther, permitting coverage even where there is no damage to property at all. (See, *e.g., Fountain Powerboat Indus. v. Reliance Ins. Co.,* 119 F. Supp. 2d 552 (E.D. N.C. 2000), (which found that a policy covering "the necessary interruption or reduction of business operations conducted by the insured and *caused by loss*, damage, *or* destruction *by any of the perils* not excluded" did not require physical damage to trigger civil authority or ingress/egress coverage.) (Emphasis in original).

Some policies, however, expand civil authority coverage to include not only governmental orders, but also "orders or actions" from "civil or other authority." This language is beneficial to policyholders susceptible to losses stemming from actions of non-governmental organizations or agencies, such as other businesses, that might restrict or impair access to premises. For example, in addition to the curfews imposed by the city government in Baltimore as a result of the recent riots, the Orioles baseball team canceled and/or postponed several of its games—even playing one of the team's games in an empty stadium without allowing fans access to the ballpark. Although this might not qualify as a government order, it could certainly qualify as an "action" by "other authority" preventing access to premises with respect to policyholders dependent upon access to the stadium.

Like all insurance coverage questions, the coverage available for a specific loss depends on the wording in the policy form at issue. Thus, it is important for policyholders to seek professional advice to understand the terms of their civil authority and ingress/egress provisions so that they are aware of the coverages offered by the policy, and the relationship these coverages have to the types of losses policyholders might expect to encounter. By doing so, policyholders may avoid losing access to their insurance coverage even when they are unable to access their property.

Maximizing The Return On Your D&O Insurance For Merger Objection Lawsuits

By Peter Gillon and Alex Hardiman

With the explosion of "merger objection" lawsuits being filed by the plaintiffs' securities bar in the last decade, policyholders seeking coverage under their directors' and officers' (D&O) liability insurance for those suits have increasingly been butting heads with their insurance carriers over the application of the "price change exclusion" (also referred to as the "bump-up" exclusion). This has been a major source of frustration for companies reasonably expecting their policies to respond fully to merger objection suits—especially shareholder suits claiming breach of fiduciary duties by the target company's Board of Directors in approving the sale of the target. Many companies and their securities defense counsel have capitulated in the face of their carriers' declinations of coverage. But, as this note explains, it is critical to consult with coverage counsel on these matters as insurers' assertion of the price change exclusion is often misplaced.

Between 2007 and 2014 the percentage of merger and acquisition (M&A) transactions valued at $100 million or more that were challenged by merger objection lawsuits rose from 44% to 93%.[1] These merger objection lawsuits usually are filed as putative class actions on behalf of the shareholders of the company to be acquired (the "target"), often shortly after the announcement of the proposed M&A transaction. The lawsuits typically allege that the terms of the proposed acquisition are unfavorable to shareholders, that the proposed price for the target company is too low, the acquisition process for approving was inadequate, or that the shareholders were provided with misleading or incomplete disclosures about the transaction. The overwhelming majority of merger objection lawsuits have historically been resolved by settlement.[2]

The defendants named in a merger objection lawsuit are usually the target company, its board of directors, and sometimes the acquiring company and its board based on an "aiding and abetting" theory. Although the causes of action and relief requested vary, generally a merger objection lawsuit will contain some or all of the following types of causes of action and requests for relief: (1) violation of sections 14(a) and 20(a) of the Securities Exchange Act based on allegations of material omissions or misrepresentations in the proxy statement filed in connection with the M&A transaction; (2) breach of fiduciary duty based on allegations that the target's directors breached their duties by failing to conduct proper due diligence, make required shareholder disclosures, or obtain an adequate price; and (3) requests for equitable relief in the form of additional disclosures to shareholders, an injunction against the M&A transaction or a change in the price for the transaction.

As the number of merger objection lawsuits has risen, so have the efforts of D&O insurance companies to resist or reduce coverage for those lawsuits. Central to this effort has been insurance companies' reliance on the so-called "bump-up" or price change exclusion in D&O policies. The language of price change exclusions has evolved over recent years, and tends to vary widely from policy to policy. It generally appears as a limitation on the definition of "Loss," even though technically it is drafted as an exclusion, and thus should impose the same burden of proof on the insurer to prove its application. A common version from a leading insurer purports to exclude from the definition of "Loss" the amount of a settlement or judgment "representing the amount by which [the price or consideration paid for the target] is effectively increased":

> In the event of a Claim alleging that the price or consideration paid or proposed to be paid for the acquisition or completion of the acquisition of all or substantially all the ownership interest in or assets of an entity is inadequate, Loss with respect to such Claim shall not include any amount of any judgment or settlement representing the amount by which such price or consideration is effectively increased.[3]

This wording reflects a bit of an obfuscation of the language found in earlier forms of the exclusion, which were clearly limited to acquisitions by the insured of an ownership interest in another company, and not to the sale of the insured's own stock. In the above-quoted version, which has yet to be tested judicially, the argument could still be made that by implication it only applies to acquisitions of other companies by the insured, but few insurers accept that view. On the plus side, this version only excludes the amount of the change of price or consideration, and not defense

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1. *Shareholder Litigation Involving Acquisitions of Public Companies - Review of 2014 M&A Litigation*, Cornerstone Research (2015), https://www.cornerstone.com/GetAttachment/897c61ef-bfde-46e6-a2b8-5f94906c6ee2/Shareholder-Litigation-Involving-Acquisitions-2014-Review.pdf
2. *Id.* (noting that historically with respect to merger objection lawsuits resolved prior to close of an M&A transaction, over 90% of such suits were resolved by settlement with the remainder either voluntarily withdrawn by the plaintiffs or dismissed by the courts, and that resolution of post-closing suits was primarily withdrawal or dismissal.)
3. *See* AIG "PortfolioSelect for Public Companies" policy, *http://www.aig.com/Chartis/internet/US/en/PortfolioSelect_for_Public_Companies_Specimen_Policy_tcm3171-533001_tcm3171-543667.pdf*

Don't Trust, Verify: What Every Business Needs To Know About Certificates Of Insurance

By Joseph D. Jean, Alexander D. Hardiman and Matthew F. Putorti

The general rule in New York is that a certificate of insurance (COI), by itself, does not provide insurance coverage. That means that businesses that rely solely on COIs as evidence of their status as additional insureds might not actually be covered in the event of a loss. A recent New York case, however, is a reminder that this general rule is not the end of the inquiry and that there are possible ways to still get recovery.

Certificates of Insurance

Certificates of insurance often are used in contracting relationships: the subcontractor might provide the contractor and owner with a certificate of insurance either to show that it has insurance or to demonstrate that it has listed the contractor, owner or another party as an additional insured as required by contractual provisions. COIs provide details of the insurance policies held by a policyholder as of a certain date, and usually include information such as the policy number, the name of the insurance company, the type of insurance, the limits of liability, the name of the policyholder, and a list of any additional insureds. COIs, however, do not usually indicate the policy deductible or what exclusions are included in the policy. COI holders should therefore make it a practice to request and review the actual insurance policy to confirm the existence and scope of coverage.

In New York, any party holding a COI, or any party relying on a COI to demonstrate coverage, must know that courts often view a COI merely as "evidence of a carrier's intent to provide coverage but not [as] a contract to insure the designated party nor [as] conclusive proof, standing alone, that such a contract exists." See *Tribeca Broadway Assocs., LLC v. Mount Vernon Fire Ins. Co.*, 774 N.Y.S.2d 11, 13 (1st Dep't 2004). This is especially true where the COI contains some variation of the following statements, of which any party reviewing a COI should be aware:

- "This certificate is issued as a matter of information only and confers no rights upon the certificate holder."
- "This certificate does not amend, extend, or alter coverage afforded by the policies below."
- "If the certificate holder is an additional insured, the policies must be endorsed. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsements."

Despite this general rule in New York that COIs do not confer coverage, a decision from the New York County Supreme Court on April 13, 2015, serves as a reminder that, depending on the facts of the situation, there might still be options to acquire recovery. For example, a COI may at least be sufficient to raise an issue of fact as to coverage in order to defeat an insurance company's motion for summary judgment, especially when additional factors exist that favor coverage. See *Southwest Marine & Gen. Ins. Co. v. Preferred Contractors Ins. Co.*, No. 153861/2014, 2015 N.Y. Slip Op. 30544(U) (N.Y. Cnty. Apr. 13, 2015). An additional insured who defeats an insurance company's motion for summary judgment increases its chances for a settlement with the insurance company. But defeating summary judgment alone does not guarantee coverage.

Agent's Actions

Southwest Marine also reaffirms that an insurance company may find itself bound to provide coverage even though it did not issue the COI, but where its agent, acting within its authority, issued the COI. This possibility is explained more fully in *Mohawk Power Corp. v. Skibeck Pipeline Co. Inc.*, 705 N.Y.S.2d 459 (4th Dep't 2000). The insurance company's agent issued a COI correctly listing the contractor as an additional insured, but then issued another COI that mistakenly removed the contractor as an additional insured. The court held that the agent "was acting within the scope of its actual or apparently authority" in adding the contractor as an additional insured. The agent's issuance of the COI therefore bound the insurance company to extend coverage, and the clerical error in removing the contractor as an additional insured on the second COI was not enough to deny coverage.

In many situations, however, neither the insurance agent nor the policyholder actually is authorized to issue a COI. Therefore, there may be a question as to whether a COI actually extends coverage, and if not, whether the insurance agent can itself be liable to the COI's recipient. Insurance agent liability, like insurer liability, can turn on complicated factual issues including the specific representations of the insurance agent, the reasonable reliance of

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Florida Appeals Court Overturns Notice/Prejudice Ruling Against Policyholder

By Eric M. Gold

A version of this article was originally published on Pillsbury's construction blog, Gravel2Gavel.com on May 29, 2015.

Florida's Third District Court of Appeals recently held that whether "prompt" notice was given to an insurer of a claim occurring over three-and-a-half years after a hurricane caused damages to a condominium is a question of fact that must be given to the jury. This ruling confirms that the date on which an insureds' duty to report a claim is triggered under an insurance policy's notice provision is an issue of fact not ripe for summary judgment. (The case is Laquer v. Citizens Property Insurance Corporation.)

The plaintiff, Edie Laquer, owned a condominium unit in South Florida and purchased an insurance policy from Citizens Property Insurance Corp. to insure personal property from damage by a hurricane or other weather conditions. Between approximately 2001 and 2008, Laquer rented her condominium unit fully furnished to a tenant.

Hurricane Wilma struck South Florida on October 24, 2005.

After the hurricane, Laquer's unit, which was protected from hurricane damage by hurricane shutters, was visited by the condominium manager and other individuals on a monthly basis. At no time did they observe damage to the walls or floors of Laquer's unit.

In September 2008, the tenant moved out and Laquer visited the unit to prepare it for the next rental. At that point, she discovered that some of the wood flooring had warped due to water damage and, in April 2009, hired an environmental contractor to perform mold remediation. The contractor discovered "severe mold growth" and water stains on the interior of the wall. Based on the contractor's experience, he concluded that, after wind-driven rain entered the adjacent condominium, it came through the demising wall and into Laquer's unit, causing damage to Laquer's personal property. In May 2009, after an inquiry to the condominium manager regarding the potential source of water seepage into her condominium, Laquer learned for the first time that the likely cause was Hurricane Wilma.

Laquer immediately reported the personal property damage to Citizens, on May 19, 2009, and submitted a sworn proof of loss within sixty days of Citizens' request, pursuant to the terms of the Citizens policy. Citizens denied the claim, arguing that a delay of more than three years in reporting the claim did not comply with the policy requirement that, "[i]n case of a loss to covered property, [Laquer] must . . . [g]ive prompt notice to" Citizens.

The trial court had previously entered a partial summary judgment, holding that the insurance claim was not "prompt" as a matter of law. At trial, the jury concluded Citizens was also prejudiced by Laquer's delay in reporting the claim. The Third District Court of Appeals, however, disagreed.

Noting that the damages to Laquer's unit were not obvious until years after Hurricane Wilma and had not been observed by any of the many individuals regularly visiting the unit, and relying on case law holding that undefined phrases like "prompt," "immediate," and "as soon as practicable" do not require "instantaneous notice," the Court held that "the issue of whether an insured provided 'prompt' notice generally presents an issue of fact."

The Court refused to accept either parties' contention regarding the triggering event for notice. While Citizens contended that Hurricane Wilma was the event triggering the notice requirement, and Laquer asserted that the duty to provide notice did not arise until the date she became aware of the extent or cause of the damage, the Court instead held that fact issues existed regarding when a "reasonable and prudent person would believe that a potential claim for damages might exist."

Finally, with respect to the jury's finding that Citizens was prejudiced by Laquer's delay in providing notice, the Court held that the issues of "prompt" notice and prejudice were so factually intertwined with the triggering date of Laquer's duty to provide such notice that that they could not be tried separately. Accordingly, the Court reversed and remanded for a new trial on both issues.

This victory for Laquer is yet another reminder that policyholders should carefully consider their options when an insurer denies coverage for a claim based on late notice. Numerous factual and legal issues may arise when attempting to correctly identify the event triggering a policy's notice requirement, and based on the date of that event, whether the insurer definitively suffered prejudice. While notice may not be "prompt" in the eyes of an insurer, instantaneous notification of a claim is not required, and the specific factual circumstances at issue may provide an avenue towards coverage.

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Don't Wait Until It's Too Late: Top Ten Recommendations...

(cont. from page 2)

provisions are sometimes invoked by insurers to deny coverage when emergency costs have been incurred without the insurer's consent, even if the costs are entirely reasonable and necessary. If prior consent provisions are included in the policy and cannot simply be removed, you should, at a minimum, change them to provide that the insurer's consent "shall not be unreasonably withheld."

It is also a good idea to keep your insurer on speed dial when a breach happens so that it cannot assert that it has been kept in the dark about any emergency-response costs you incurred.

6. Allocation of Defense Costs

Where both covered and non-covered claims are asserted in the same lawsuit against the insured, an issue often arises regarding the proper allocation of defense costs: what portion of the insured's defense costs must the insurer pay? There are a number of ways that insurance policies can respond in this situation, with some policy provisions being more advantageous to the insured than others.

For example, some policies provide that the insurer will pay 100% of defense costs if the lawsuit alleges any claim that is potentially covered. Others say that the insurer will only pay the portion of defense costs it unilaterally believes to be covered until a different allocation is negotiated, arbitrated or judicially determined.

These issues are less likely to arise in a "duty to defend" policy (where the insurer must assume the insured's defense of any third-party claims), which typically covers 100% of defense costs so long as any of the claims against the insured is potentially "covered." However, under a "duty to reimburse" policy (where the insurer agrees to reimburse the insured for its defense costs or pay them on its behalf), allocation is more likely to be disputed. It is important to understand the allocation method contained in the policy. Try to negotiate one up front that is favorable to you.

7. Obtain Coverage for Vendor Acts and Omissions

Chances are that at least a portion of your organization's data processing and storage is outsourced to a third-party vendor. Therefore, it is crucial that your cyber policy covers claims against you that result from breaches caused by your data management vendors.

Most cyber policies provide coverage for such vicarious liability, but not all do. It is widely understood in the insurance industry that policyholders expect coverage for claims that arise out of the acts and omissions of their vendors, consultants and subcontractors. If such coverage is not initially offered, or is at all ambiguous, you should demand that it is clearly included in the policy.

8. Dovetail Cyber Insurance with Indemnity Agreements

You should also ensure that your cyber policy and vendor indemnity agreements complement each other so you can maximize your recovery from both sources. Some cyber policies state, for example, that the policy's deductible or self-insured retention "shall be borne by the insured [and remain] uninsured at its own risk." Some insurers may interpret this language as requiring the insured to pay the deductible or retention out of its own pocket, and take the position that if the insured gets reimbursed for this amount from the vendor that caused the breach, then it has failed to satisfy this precondition to coverage.

This kind of clause can present you with a Hobson's Choice: either pursue indemnity from your vendor and give up your insurance, or collect from your insurance company and let the responsible vendor off the hook. This unfair outcome is not in the interest of either insurer or insured. As a result, insurers are often willing to modify these provisions to clarify that the insured can collect its self-insured retention from a third party without compromising its insurance coverage.

9. Align Cyber Insurance with Other Insurance

Some cyber policies also cover claims made against you for losses caused by data breaches suffered while the data is in your third-party vendor's custody. There may be business reasons for wanting vendors to be insured under your policy in a particular case. But it is generally better to contractually require your vendors to obtain their own cyber insurance to act as the primary coverage for claims, and to also require that they name you as an additional insured under that policy. Then, arrange for your policy to state that it will only apply to claims against you arising out of your vendor's data breach in excess of that vendor's insurance. This structure can reduce the odds that your insurance policy limits will be depleted by claims for which your vendors are primarily responsible.

10. Get a Partial Subrogation Waiver

If your insurer pays a loss, it may become "subrogated" to your claims against any third parties that were responsible for causing the breach. This means that the insurer can try to recoup its payment to you by pursuing your claims against the responsible parties. Many cyber policies contain a provision stating that you cannot take any action to impair the insurer's subrogation rights.

One problem with such provisions in the cyber context is that contracts with data management vendors commonly include limitation of liability provisions. These provisions can give rise to disputes about whether you have breached your insurance contract by impairing or limiting your insurer's recourse against the culpable vendor.

A possible fix is to insist that a partial "waiver of subrogation" provision be added to your cyber policy. Such provisions, which are quite common in other lines of coverage, simply provide that the insurer will not assert that its subrogation rights have been impaired by any contract into which you entered before a loss occurs. Some insurers are willing to agree to such provisions in the cyber context, but others may not be. If your insurer is not willing to

give a partial subrogation waiver, you should consider shopping elsewhere.

FCA Threats Are Likely Greatest...

(cont. from page 6)

dispute involved the applicability of two exclusions—a conduct exclusion applicable to intentionally wrongful conduct and a regulatory exclusion applicable to actions brought by or on behalf of certain government agencies. The court rejected the insurer's arguments under both exclusions. As to the former, the court found the conduct exclusion did not apply unless and until there had been an actual adjudication the insured had engaged in intentionally wrongful or similar conduct which triggered the exclusion. The court found the regulatory exclusion inapplicable because the underlying lawsuit, brought as a qui tam action, did not qualify as an action by or on behalf of a government entity.

One interesting aspect of the *Huron* decision is the underlying allegations appear to have been focused on alleged overbilling, and not the adequacy of the services rendered, which in the past has been considered an important distinction. In particular, there are decisions in which insurers have successfully argued that unlike cases involving the adequacy of services, there should be no coverage when a company seeks to profit from billing the government for services that were not performed or for which too high a fee was billed. See e.g., *Horizon West Inc. v. St. Paul Fire & Marine Ins. Co.*, 45 Fed. Appx. 752 (9th Cir. 2002); *Zurich Am. Ins. Co. v. O'Hara Regional Ctr. For Rehabilitation*, 529 F.3d 916 (10thCir. 2008); and *Chicago Ins. Co. v. Center for Counseling and Health Resources* (W.D. Wash., March 31, 2011).

While those and similar lawsuits arguably reflect a general understanding that FCA lawsuits are not covered under ordinary professional liability policies, those cases more likely reflect a reluctance to find coverage for narrow allegations of overbilling under policies which either do not define professional services or have definitions limited to the providing of actual care to patients. But irrespective of which of those competing views is correct, those decisions highlight the importance of carefully scrutinizing the definition of "professional services" to make sure it encompasses all aspects of an insured's business for which coverage is sought.

Employment Practices Liability Insurance (EPLI) Coverage

EPLI is another source of coverage when FCA claims are asserted by a former employee, especially when there are allegations that the employee was terminated in retaliation for raising issues related to the allegedly false claims. As with professional liability policies, some—but not all—EPL policies expressly contemplate coverage for FCA suits. In particular, some EPL policies define "retaliation" to include actions taken by an insured in response to FCA suits or "any other federal, state, local or foreign 'whistleblower' law." But, again, coverage should not be necessarily limited to policies which expressly contemplate coverage for FCA suits, as such claims may come within the scope of more generic coverage grants.

Coverage disputes can nevertheless arise even where an EPL policy expressly contemplates coverage for FCA suits. For example, insurers frequently try to deny coverage for multiplied damages or a relator's attorneys' fees claiming they do not qualify as "loss" or "damages" under the policy. As with D&O and professional liability policies, insurers sometimes argue investigations by the government do not constitute a "claim" for purposes of triggering the policy. Similarly, an insurer may contend that even if there is a "claim," it relates to some earlier event and therefore is not "first made" during the policy period.

Fidelity/Employee Dishonesty/ Commercial Crime Coverage

Another possible source of coverage for FCA lawsuits could be a company's fidelity policy. These policies, which are sometimes referred to as commercial crime or employee dishonesty policies, generally provide first-party coverage for loss resulting directly from certain, enumerated criminal or other wrongful conduct. There may be fewer circumstances under which coverage might be available under a fidelity policy, but the coverage provided under these policies can be broad, so they should not be overlooked as a potential source of coverage.

Even where the circumstances giving rise to the FCA lawsuit fit within the type of conduct contemplated by a fidelity policy (which may or not be criminal), insurers typically argue the damages sought in the FCA lawsuit do not "result directly from" the alleged misconduct. Although there are cases that insurers rely on to argue that such language implies a tight causal nexus between the loss and the conduct (see, e.g., *Aetna Cas. & Sur. Co. v. Kidder, Peabody & Co.*, 676 N.Y.S. 2d. 559 (1998); *Vons Companies Inc. v. Federal Ins. Co.*, 212 F.3d 489 (2000)), there is support for the proposition that a commercial crime policy can apply even when the loss for which coverage is sought materializes through a third-party suit. See, e.g., *New Hampshire Ins. Co. v. MF Global Inc.*, 970 N.Y.S.2d (2013). Again, as with claims under almost any policy, carrier positions denying or limiting coverage should be carefully scrutinized.

Conclusion

There can be little doubt that FCA lawsuits present a significant risk for a growing range of companies. The damages sought in these cases can be astronomical, as partially evidenced by the very large settlements which the government obtained during 2014. What's more, the costs for defending these lawsuits can be very expensive. The potential for insurance to help mitigate the cost of responding to an FCA lawsuit should not be overlooked, especially for the middle-market private companies frequently targeted by the government and for whom FCA lawsuits can amount to bet-the-company cases. And to be sure, insureds should not simply accept their insurers' denial of coverage for such claims without careful evaluation by an experienced coverage attorney.

Maximizing the Return On Your D&O Insurance...

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costs, plaintiffs' attorneys' fees or other such elements of Loss.

Recently, we have seen insurers assert the price change exclusion as a potential defense to coverage at the most critical moment: just when the litigants are seeking to settle shareholders' breach of fiduciary duty claims against the directors and officers. The result has been to inject several complicating factors into the already difficult process of litigating and settling these claims. One factor is that the exclusion generally does not apply to defense costs, and therefore the insureds may be incentivized to continue litigation—particularly because after the merger closes, the parties in charge of the litigation (the executives of the acquirer), are unlikely to be in the cross-hairs of discovery and unlikely to be as concerned with the burden of litigation as the target's former directors and officers. Another factor is that the exclusion is more pernicious for claims being litigated after the merger closing. Pre-closing, the remedies may include increased disclosures and other non-monetary consideration; whereas, after closing, settlement becomes more difficult, as non-monetary settlement terms are frequently no longer available as settlement tools, and the derivative claims against the directors may be non-indemnifiable, thus escalating the importance of coverage. (As in other derivative claims, Side A DIC coverage may drop down and fill in any coverage gaps.)

Fortunately, policyholders have numerous avenues to challenge insurers' assertion of the price change exclusion with respect to breach of fiduciary duty claims. First, because the exclusion requires that "the [acquisition] price or consideration is effectively increased" to be triggered, the exclusion should not apply unless there has in fact been an increase in the price paid for the acquisition as a result of the merger objection lawsuit. Thus, for example, a settlement of a pre-merger closing suit which consists of increased disclosures and other non-monetary relief, plus plaintiffs' attorneys' fees, would not fall within the exclusion. Similarly, claims based on Sections 14(a) and 20 of the Securities Exchange Act, which typically seek damages for alleged misrepresentations or omissions in a proxy filing, would not implicate the exclusion because they do not seek a change in the acquisition price.

Second, the common version of the exclusion cited above should not apply to damages resulting from an alleged breach of fiduciary duties by the Board. A negotiated lump sum damage settlement does not constitute a change of price. Furthermore, assuming the exclusion applies in the first place to shareholder claims against the insured's Board for sale of the insured's own stock to an acquirer, it is simply not true that the requested relief must effectively be a change of price. For example, the court could rule that the Board's process for approving the merger was totally flawed and unfair to shareholders, resulting in a breach of fiduciary duties, but that the price paid for the company was fair. See, e.g., *Kahn v. Tremont Corp.*, 694 A.2d 422, 432 (Del. 1997).("[H]ere, the process is so intertwined with price that under Weinberger's unitary standard a finding that the price negotiated by the Special Committee might have been fair does not save the result.")

Third, claims alleging wrongdoing by individual directors or officers that are indemnified by the target may fall outside the scope of some versions of the exclusion. Better forms prevent its use against breach of fiduciary claims by limiting the exclusion to claims against the insured organization, thus excepting claims against the Board. See *Genzyme Corp. v. Federal Insur. Co.*, 622 F.3d 62 (1st Cir. 2010) which held that Chubb's exclusion applies by its terms only to the portion of Loss for which the insured entity is liable, not to the portion allocable to Side B indemnification of individual D's and O's by the corporation. Because claims were made against both entity and board, case was remanded to district court for appropriate allocation.

As with all such issues, policyholders are well advised to review their policies and to consult with their counsel about opportunities to improve their policy language to avoid these types of disputes. In some cases, that may require a change of carrier.

To summarize, policyholders should review and seek appropriate clarification if not modification of the "bump up" or price change exclusion in their D&O policies. In our practice, we frequently see carriers attempt to assert the exclusion in inappropriate circumstances. Policyholders should resist insurance company attempts to apply the exclusion beyond its intended or written scope.

Don't Trust, Verify: What Every Business Needs...

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the COI holder, and the insurance agent's actual or apparent authority to issue the COI.

When the Insurance Company Is Estopped

Additionally, an insurance company might be estopped from denying coverage on the basis of a COI—although appellate courts in New York are split over this question and so policyholders should investigate the law of their jurisdiction. See *10 Ellicott Square Court Corp. v. Mt. Valley Indem. Co.,* 634 F.3d 112, 122–23 (2d Cir. 2010).

In jurisdictions where an insurance company can be estopped from denying coverage, this outcome is factually specific, and whether the insurer must provide coverage turns on several different factors, including the specific language of the COI, the language of the insurance policy, the detrimental reliance of the recipient on the representations of the party providing the COI, the authority of the party that issued the COI, and the involvement, if any, of the insurance carrier in issuing or approving the COI. For example, in *Bucon Inc. v. Pennsylvania Manufacturing Association Insurance Co.*, 547 N.Y.S.2d 925 (3d Dep't 1989), a subcontractor agreed to add a contractor and the property owner to its insurance policy as additional insureds and to indemnify them against liability arising from its work. An initial COI did not name them as additional insureds,

Earthquakes Are Spreading – Is Your Insurance Program Ready?

By Vince Morgan and Tamara Bruno

North Texas never felt an earthquake until 2008. Since then, well over one hundred have been recorded—including a whopping five earthquakes confirmed in a single day in April 2015. Oklahoma had 585 earthquakes of magnitude 3 or greater in 2014 alone, and is on track to have more than 800 this year. Areas spread across the central and eastern United States, from Colorado to Ohio, are experiencing increased seismic activity and the increased risk of earthquake-related property damage that comes along with it.

Many policyholders in these areas have not historically purchased insurance coverage for earthquakes. Most commercial property insurance policies exclude coverage for "earth movement." Depending on the policy's terms, this may include earthquake, landslide, mudflow, mine subsidence, earth sinking, and/or earth rising or shifting. Many policies also include "anti-concurrent causation" wording that attempts to exclude coverage for damage resulting from an excluded peril (such as earth movement) even if the loss is also caused by a covered peril (such as, for example, negligence). Further, these policies typically only insure business interruption loss if there is covered property damage. Policyholders with property in areas experiencing an increasing number of earthquakes could therefore find their insurance claims denied or reduced on the basis of earth movement exclusions if their insurers believe seismic activity contributed to their property damage.

Property owners can purchase either an endorsement to their commercial property policy that adds back coverage for "earth movement" or a standalone earthquake insurance policy. However, it is important to understand what coverage the earthquake insurance actually provides. For example, deductibles for earthquake coverage usually range somewhere between 2 to 20% of the covered property's total insured value, instead of a set dollar amount. Earthquake coverage may also be subject to sublimits that provides a lower amount of coverage for earthquake damage than the policy's total limit.

There are also potential coverage issues specific to areas with recent spikes in earthquakes. In interpreting insurance policies, some courts have distinguished between man-made and naturally occurring earth movement, finding that only naturally occurring "earth movement" qualifies as such under policy coverage grants or exclusions. Disputes about whether fracking and injection wells are causing increased seismic activity could therefore lead to disputes about whether resulting damage is covered, excluded or subject to different terms such as earthquake sublimits. In March 2015, for example, the Oklahoma Insurance Commissioner issued a bulletin stating that fewer than 10% of Oklahoma earthquake claims filed in 2014 had been paid and expressing concern that insurers are denying claims under exclusions for man-made damage "based on the unsupported belief that these earthquakes were the result of fracking or injection well activity." Insurance coverage for loss from earthquakes in these areas therefore may depend on a number of variables, including (i) developments in the study of these earthquakes, (ii) theories and outcomes of lawsuits seeking liability or coverage for allegedly fracking-related earthquakes, and (iii) differences and developments in policy language relating to earthquake loss.

Seismic activity is an increasing reality across the central and eastern United States. It is important to understand the risks relating to earthquake damage—and how to protect against those risks—before it occurs.

and so the insurance company issued a second COI correcting the omission. The Third Department found that the insurance company was informed that the contractor had required a revised COI, had relied on the amended COI to permit the subcontractor to work, and that this reliance was reasonable despite language on the COI that it did not "amend, extend or otherwise alter the terms and conditions of" the policy. Moreover, the insurance company could not overcome the estoppel effect based on its conclusory averment that adding the contractor's name to the COI was a clerical error. Accordingly, the insurance company was estopped from denying coverage because it had issued a COI indicating the contractor was covered, and the contractor relied on this in working with the subcontractor.

Conclusion

Although COIs are commonly requested as evidence that a contracting party's coverage extends to include the COI holder as an additional insured, COIs may not always provide the coverage the parties think they have. Under the right circumstances, New York courts will find that a COI, even one prominently displaying disclaimer language, binds the insurer to provide coverage. But those circumstances are fairly narrow. Nonetheless, contracting parties should be wary of COIs. The best practice is to always be sure to obtain a copy of the actual policy, including all endorsements, and to carefully review the terms and conditions to make certain that the insurance company is providing the required coverage.

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