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Navigating The Intersection Of Bankruptcy And Insurance

Law360, New York (July 1, 2011) -- An insurance policy may be an insolvent insured's most valuable asset, and the availability of insurance proceeds to satisfy claims against a debtor insured is becoming increasingly critical in bankruptcy proceedings. Appreciating the insurance coverage issues that frequently arise in the context of bankruptcy proceedings is important to effectively assess the chances of recovery and determine how to maximize the protection afforded by insurance proceeds.

This article examines issues that typically arise concerning general liability and directors and officers liability insurance coverage in the bankruptcy context — including critical steps to initiate claims for potential coverage, avoiding the pitfalls of common coverage exclusions, and the intersection of bankruptcy courts rules and insurance policy provisions regarding priority of payments and entitlement to proceeds.

Claims Made and Reported

There are two types of liability policies: occurrence policies and claims-made policies. Occurrence policies respond to damage or injury that occurs during the policy period. Claims-made policies respond if a claim is made and reported to the insured during the policy period. General liability policies are usually occurrence policies, whereas D&O policies are usually claims-made.

By way of example, assume that someone slips on a crack in the sidewalk and breaks a leg in 2009 and, in 2011, that person sues the landowner. The responsive policies would be: an occurrence policy in effect in 2009 or a claims-made policy in effect in 2011.

With few exceptions, claims-made policies require that the insured report the claim in the same policy year in which it receives the claim. As a general rule, there are no exceptions. Failure to report a claim in the correct policy year is fatal to coverage, regardless of whether the insured acted reasonably or the insurer has incurred prejudice. Failure to provide such notice is the single most common reason for the denial of coverage under claims-made policies.

Notice of Circumstances and Application

An application to renew a claims-made policy is fraught with risk. The application normally asks the

insured to provide details of any circumstances likely to give rise to a claim. This is a representation by the insured, and the insurer will not provide coverage if a claim involving circumstances that the insured did not list on its application arises. Many insureds do not perform a proper due diligence in dealing with an application and omit mention of circumstances of which they are aware that may give rise to a claim. This is another frequent reason for disclaimers.

Many insureds also do not realize that while they must report claims to the insurer during the policy period, they also have the right to report circumstances during the current policy period that may give rise to a claim in the future. This locks in coverage during that policy period for any claim that may arise in the future from those circumstances.

What Is a "Claim"?

A policy's definition of "claim" significantly affects the scope of coverage provided under that policy — and the breadth of the "claim" definition can differ substantially from one policy to another. One reason for companies' frequent forfeiture of coverage due to late notice is that the definition of "claim" in a liability policy can be very broad.

For example, a typical definition of "claim" will state any "written demand for monetary or nonmonetary relief." While a company may know to provide notice to its insurer when it receives a complaint, it often does not know that, for example, it needs to provide notice when it receives an angry letter.

Who Receives the Insurance Proceeds?

D&O policies contain an inherent conflict between the individual insureds and the company. A D&O policy has a single limit for both attorneys fees and damages. The individuals want to draw on the policy to pay their attorneys fees, while the company, or the trustee or creditors' committee, wants to preserve the policy limits to pay damages. The interplay between these conflicting interests often leads to disputes, is very fact intensive, and has produced substantial case law.

Two mechanisms exist through which the policy tries to maintain the limits for the use of the individuals. One is known as Side A coverage — this is a separate policy, usually on an excess basis, that is devoted solely for the benefit of the individuals and which the company cannot access.

The other is a "priority of payments" provision, which states that the policy must pay the individual insureds before it pays the company. Bankruptcy courts have concluded that a "priority of payments" provision has the effect of excluding from the bankruptcy estate certain of the proceeds of the policy, thereby granting directors and officers access to those policy proceeds.

Insurance and the Automatic Bankruptcy Stay

Prepetition insurance policies are generally considered property of the bankruptcy estate and are protected by the automatic stay under section 362(a)(3) of the Bankruptcy Code. Policies that provide

coverage to individuals typically state that the primary purpose of coverage provided under the policy is to protect and benefit natural person insureds.

Further, some policies provide that, if a liquidation or reorganization proceeding is commenced, in regard to a covered claim the insureds waive any automatic stay or injunction to the extent it may apply in such proceeding to the proceeds of the policy and agree not to oppose or object to any efforts to obtain relief from any stay or injunction applicable to the proceeds of the policy.

Courts have also been protective of individual insureds in this regard, and will frequently examine the claims and potential claims against the estate to determine the remoteness of the possibility that exhaustion would leave insufficient proceeds to pay claims for which the estate might seek coverage.

For example, the Bankruptcy Appellate Panel of the Ninth Circuit affirmed a bankruptcy court's grant of a motion by a debtor's sole director to modify the automatic stay to allow payment of defense costs under the A-side coverage of the debtor's directors and officers liability insurance policy in In re MILA Inc., 2010 WL 455328 (B.A.P. 9th Cir. Jan. 29, 2010).

The panel reasoned that, assuming that the proceeds of the policy were property of the estate, it was proper for the bankruptcy court to balance the harm to the debtor if the stay were modified with the harm to directors and officers if they were prevented from executing their rights to defense costs.

Retroactive Date and Prior Acts Exclusions

Ideally, a claims-made policy provides coverage for any acts that occurred in the past, no matter how distant, if the claim is made during the current policy period. However, because insurers do not like open-ended exposure, they frequently try to limit their exposure to provide coverage only for recent acts. A policy may simply have a prior acts exclusion, denying coverage for any claims where the act precedes a certain date. This date is often called a retroactive date.

If a policy is in effect for 2011 and has a retroactive date of Jan. 1, 2008, it means that the policy will not provide coverage for claims made during the policy period arising from acts that predict Jan. 1, 2008. Retroactive dates can also become a critical issue when a company changes insurance carriers, because this presents a risk that the new carrier will incorporate a retroactive date reflecting the policy's inception and exclude coverage for acts alleged to have occurred prior to that date.

Restitution v. Damages and Bump-up Exclusion

If someone steals from a company and has to repay the money that he or she stole, there is no coverage for the repaid funds. The premise is simple: If money is stolen from you, and the thief is forced to return it, there is no loss for your insurer to reimburse because the thief never had a right to the money in the first place.

You cannot insure against the risk of having to return stolen property. This seemingly simple concept, however, has morphed into a major but amorphous concept of "damages versus restitution": An

insurer's "restitution defense" posits that a claim for restitution or disgorgement is uninsurable as a matter of law.

This was most prominently laid out in Level 3 Communications Inc. v. Federal Insurance Company, 272 F.3d 908 (7th Cir. 2001). In Level 3, the court held that insurance policies provide coverage for damage that the insured causes, but not for sums that the insured should have paid in the first place or must repay as restitution.

For example, assume that a company paid $10 a share to purchase the shares of a company, and the court holds that Company A should have paid $20 per share. When Company A has to now pay an additional $10 a share, the restitution defense holds that there is no coverage — the insured is paying only the sum that it should have paid in the first place.

Some courts have limited the scope of this doctrine, while courts in other jurisdictions have given it broad application. Most D&O policies now contain a "bump-up exclusion" specifically to address the issue of a company not paying a sufficient price when it purchased stock.

Bankruptcy Exclusion

The insurance policy itself is only the beginning of the analysis of a D&O policy because many of the operative provisions are added as endorsements. One such available endorsement is an exclusion for claims arising out of a bankruptcy. Bankruptcy exclusions can contain broad language and have results..

In Associated Community Bancorp Inc. v. The Travelers Cos., 2010 WL 1416842 (D. Conn. April 8, 2010), the insureds were a bank holding company and its wholly owned subsidiary, a nationally chartered bank. Investor customers of the bank filed four lawsuits against the insureds seeking return of funds and fees paid to the insureds after the investors lost all of their investments in connection with the Bernard Madoff Ponzi scheme.

The investors allegedly entered into a custodian agreement that directed the insureds to invest their funds in the scheme. When the scheme unraveled and the broker-dealer running the scheme filed for bankruptcy, the investors were unable to recover their lost investment from the broker-dealer, which resulted in suits against the insureds. The insureds tendered notice of the underlying actions to its insurer, seeking payment of its costs to defend the suits.

The insurer denied coverage for the underlying suits based on, among other things, the insolvency exclusion, which exclude loss [including defense costs] "on the account of any claim made against any insured ... based upon, arising out of or attributable to the insolvency, ... receivership, bankruptcy or liquidation of, or financial inability to pay ... by any ... investment company, ... or any broker or dealer in securities or commodities." The district court ruled in favor of the insurer, holding that the insolvency exclusion unambiguously barred coverage for the underlying suits.

"Insured v. Insured" Exclusion

This exclusion applies to claims by one insured against another. It exists for two reasons. First, it prevents collusive claims, such as a claim by a corporation against an officer that is made for the purpose of accessing the D&O policy. Second, the exclusion keeps the insurer from becoming involved in what are essentially financial quarrels among insureds.

Unfortunately, many claims are brought by one insured against another and fall victim to this exclusion. Insurance companies are offering more and more exceptions to this exclusion, most notably for claims by bankruptcy trustees, creditor committees and debtors in possession. Without such an exception, a substantial body of case law exists as to whether claims brought by these people are within the "insured v. insured" exclusion.

Reported cases are few and in sharp conflict as to whether the "insured v. insured" exclusion applies to claims where the plaintiff is a bankruptcy trustee or other third party in a bankruptcy situation. In Reliance Insurance Co. v. Weis, 148 B.R. 575 (E.D. Mo. 1992), aff'd, 5 F.3d 532 (8th Cir. 1993), cert. denied, 510 U.S. 1117 (1994), where a creditors' committee in a Chapter 11 bankruptcy sued former directors and officers, the court held that the exclusion applied and denied coverage.

The court reasoned that the claims were necessarily brought on behalf of the company because they originally belonged to the company. According to the court, the committee was simply an assignee of the company's claims; and since the company itself could not obtain the benefit of the D&O coverage, its assignee stood in no better position.

By contrast, the Delaware Chancery Court has held that an "insured v. insured" exclusion does not apply to a suit brought by a creditors' committee on behalf of a debtor's estate, because the committee is not bringing suit "on behalf of" the debtor in possession. Cirka v. Nat'l Union Fire Ins. (Del. Ch. Aug. 6, 2004). Rather, the committee is acting directly on behalf of the bankruptcy estate, as "a party with derivative standing granted by a bankruptcy court pursuant to its equity powers."

Likewise, in the Second Circuit, the leading case discussing the insured v. insured exclusion in the bankruptcy context found the exclusion inapplicable to claims brought by a chapter 11 trustee. Cohen v. Nat'l Union Fire Ins. Co. (In re County Seat Stores Inc.), 280 B.R. 319, 328-329 (Bankr. S.D.N.Y. 2002).

Conduct Exclusions

Insurance policies contain exclusions for fraud, intentional wrongful conduct, and the payment to the insured of any sums to which he or she is not entitled. These are known as the conduct exclusions, and they pose a problem for parties making claims against directors and officers in a bankruptcy. While D&O policies cover grossly negligent and reckless conduct, they do not cover intentional wrongdoing. It is important for insurance purposes to assert at least that the individual acted negligently or recklessly, and not just that the individual intentionally committed a wrongful act.

Most D&O policies now place restrictions on the insurer's ability to disclaim coverage because of the conduct exclusions. Some policies state that the insurer cannot disclaim coverage unless there is a finding "in fact" of intentional wrongdoing, while the better policy language is that the insurer cannot

decline coverage unless there is a "final adjudication" of intentional wrongdoing.

Other Exclusions

D&O policies contain a broad exclusion for contractual liability. Essentially, if a party contracts with a company that enters bankruptcy, that party cannot recover the benefit of the contract under the D&O policy.

D&O policies also contain a broad exclusion for professional services. Such claims are covered under an errors and omissions (E&O) or management liability policy. Unfortunately, many companies neglect to purchase such policies. It is important to frame actions against the directors and officers of a bankrupt company as claims for tortuous breach of fiduciary duty in order to avoid these exclusions.

Tail Coverage

Claims-made coverage is effective insofar as the insured purchases it every year. Once the insured stops purchasing D&O coverage, there is no coverage for claims that are first made after that date. This situation is dealt with through tail coverage. Tail coverage provides coverage for acts taken up to a certain date, such as the insured's bankruptcy, that produce claims after that date.

The tail does not extend coverage into the future for new acts, but only provides continuing coverage for new claims for prior acts. Some D&O policies specifically provide for tail coverage, while in other instances the insured must negotiate for it.

Severability

This important policy provision has two distinct applications. The first is in the area of the conduct exclusions. A D&O policy may read that if one insured under the policy acts with wrongful intent, that intent is imputed to all other insureds. A severability provision prevents such imputation.

The second application is in the area of rescission. The issue here is that the person who signed the application may have done so with knowledge that the application contains falsehoods. Once again, a severability provision prevents the signer's intent from being imputed to other insureds.

Consider, for example, Great American Insurance v. GeoStar Corporation. (E.D. Mich. March 5, 2010). In this case the insured, a privately held company engaged primarily in the development of oil and gas properties, organized a limited liability company to operate a "mare lease program" to raise capital.

The program, which allowed investors to lease thoroughbred mares for one year and take ownership of any foals born during the lease period, encountered difficulties, including a shortage of horses needed to meet investor demand. IRS audits of investors in 2003 also disallowed tax deductions the program was designed to provide. In 2004, following issuance of primary and excess D&O policies, investors brought civil suits against the insureds, and the two managers of the lease program ultimately pled guilty to tax-related criminal charges.

Upon exhaustion of the primary policy through payment of defense costs, excess carriers of GeoStar commenced coverage litigation, seeking (among other things) to rescind based on material misrepresentations in the applications and a declaratory judgment. But the policy's severability provision saved coverage — the U.S. District Court for the Eastern District of Michigan dismissed the rescission claim, concluding that the severability provision required the insurer to plead facts establishing that each individual insured had knowledge of alleged misrepresentations in the application for the policy.

Rescission

The application for a new insurance policy acts as a representation and warranty. Thus, incorrect statements in the application allow the insurer to void, or rescind, the policy ab initio. The application usually incorporates the documents that accompany it, such as the annual report and 10-B5. Thus, a restatement of earnings may provide an insurer with cause to rescind.

Also, whether intentionally or negligently, it is easy for an insured to make a mistake on the application. There are several cases where the person who filled out and executed the application does not reveal that he or she is engaged in fraudulent activity that if, had it been revealed to the insurer, would have affected its decision to issue a policy.

As can be imagined, rescission is a favorite tool for insurers looking to avoid coverage, and the case law on this issue is often favorable to them. The best position for the insured is a provision that states that the policy is non-rescindable, or at least non-rescindable as to the directors and officers.

It is also necessary to have a severability provision stating that the knowledge of one insured will not be imputed to another insured. However, insurers often insist that the knowledge of the person executing the document, or of the CEO or CFO, does bind all other insureds under the policy.

Broker Malpractice

As this survey indicates, D&O policies are very complex documents. It is easy for an insurance broker to make a mistake when preparing a D&O policy or when filing a claim under it. Some states, such as New Jersey, hold the insurance broker to be a professional with a fiduciary obligation, such that an error can easily translate into a malpractice claim.

Other states, such as New York, consider the broker to be no more than an order taker, and significantly limit the possibility of bringing a broker malpractice claim. When a D&O policy does not provide coverage, it is unfortunately necessary to see if the lack of coverage is the result of broker malpractice.

Conclusion

Bankruptcy proceedings can be complicated in their own right, and all too frequently they are compounded by complex insurance issues. Creditors and insureds that engage skillful legal advisers will

have a strategic advantage when confronted with questions of how to maximize insurance dollars available to pay claims out of insolvency.

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