

Mutual Fund D&O/E&O Insurance

A Guide
for Insureds

Mutual Fund D&O/E&O Insurance

Introduction.....	1
Fundamentals	
D&O/E&O Insurance--In General	5
Mutual Fund D&O/E&O Insurance	9
Basic D&O/E&O Concepts.....	11
Particular Fund Industry Risks	
Defense Costs.....	17
Regulatory Investigations.....	21
Prospectus Liability Claims	23
Fee Litigation.....	27
Fraud.....	31
Costs of Correcting Operations-Based Errors.....	35
Structuring a Program	
The Appropriate Amount of Policy Limits	39
Funds-Only Policy Versus Joint Policy	41
Premium Allocation Under a Joint Policy	43
Single-Insurer Program Versus Multiple- Insurer Program	45
Continuity of Coverage When Changing Insurers	47
Fund Acquisitions, Mergers and Liquidations	51
Issues Specific to Independent Directors	
Preserving Insurance Limits for Independent Directors.....	55
Severability	57
Retiring or Terminated Directors.....	59
Appendix: Questions to Consider.....	63

Introduction

Directors and officers coverage and errors and omissions coverage—two types of liability insurance that may be combined in a single “D&O/E&O” insurance policy—are designed to protect insured entities and individuals against the financial impact of judgments, settlements, and legal defense costs incurred in lawsuits (or other “claims” that are made against them) relating to their professional services and/or positions as directors and officers.

In the mutual fund context, such policies typically insure mutual funds themselves as well as their directors and officers. In addition, D&O/E&O policies frequently are structured to extend coverage to the funds’ investment advisers and other affiliated service providers, along with the providers’ own directors and officers.

Following years of heightened claims activity in the fund industry, multimillion dollar settlements, and soaring legal expenses incurred in the defense of regulatory proceedings and civil litigation, it is not surprising to see increased focus by fund groups on their D&O/E&O insurance programs as they seek to achieve an appropriate balance between scope, dollar amount and cost of coverage. Finding the right balance is made more complex by the fact that numerous differences exist among the various options that are available in the insurance marketplace, and also among the insurers offering these options.

Adding to the complexity, multiple parties may have a stake in a fund group’s insurance program, including funds themselves, “inside” fund directors and officers, and (to the extent that they may be co-insureds) advisers and other service providers. Fund independent directors, in particular, also have a stake, and have become more active in the insurance selection process than in the past.

The involvement of multiple stakeholders may raise the issue of who should be viewed as having ultimate responsibility within a fund complex for the insurance program (e.g., the fund board, a delegated individual, or a delegated committee). Also, the engagement of brokers, outside counsel, or other consultants may raise the issues of how such consultants should address what may be differing perspectives by different stakeholders, and how the consultants are compensated.

This guide may be of interest to all of the foregoing stakeholders, and more generally to anyone involved in the insurance decision-making process for fund groups, including senior management, risk managers, in-house counsel, independent directors’ counsel, and outside insurance consultants. It is designed to provide a general introduction to mutual fund D&O/E&O insurance as well as commentary on specific insurance issues that may be of interest to fund boards and others involved in the process.

The observations in the guide are derived from ICI Mutual’s twenty-plus years of experience in providing mutual fund D&O/E&O insurance and in addressing associated insurance claims; from ICI Mutual’s discussions with attorneys, commercial insurance brokers and consultants involved in counseling fund groups on insurance issues; and from ICI Mutual’s review of legal authorities and other information on D&O/E&O insurance and related concerns.

The guide concludes with an appendix that highlights some of the key questions that fund groups may wish to consider in selecting and structuring their insurance programs.

NOTES

By necessity, this guide generalizes as to the insurance issues discussed, and does not include a full legal analysis of the matters presented. As such, it is designed simply to be informative, and should not be construed or relied upon as legal advice (for which interested parties should look to their own counsel).

Of course, the terms and conditions of individual D&O/E&O policies themselves (including any special endorsements that may be added to an insurer's standard policy forms during the course of an insurer's underwriting process) will govern any coverage questions arising in a particular matter.

Also, while insurers have designed D&O/E&O policy forms specifically for investment management

insureds, the case law discussing *mutual fund* D&O/E&O insurance is relatively limited. As a result, resolution of disputed coverage provisions under a mutual fund D&O/E&O policy form would likely be informed by case law from other D&O/E&O insurance contexts. Accordingly, this guide cites such cases to aid consideration of the issues discussed.

Finally, depending upon its domicile state, the affairs of a fund may be supervised by a board of *directors* or a board of *trustees*. For purposes of D&O/E&O insurance, these are essentially equivalent positions such that, for convenience, this guide uses the term "directors" to refer to both directors *and* trustees. For similar reasons, this guide sometimes uses the term "advisers" to refer to both fund advisers and other affiliated service providers.

Part I

Fundamentals

D&O/E&O Insurance—In General

Although “directors and officers” and “errors and omissions” are each a type of professional liability coverage, and although they are frequently combined in a single “D&O/E&O” policy form for mutual fund insureds, the two coverages are distinct. Specifically, D&O coverage generally applies when lawsuits or other “claims” are made against an insured entity’s *individual directors and officers* in their capacity as such, whereas E&O coverage generally applies when lawsuits or other “claims” are made against the *insured entity* in connection with its professional services to others.

D&O

D&O coverage insures against financial losses that individuals may sustain in claims alleging that errors or omissions were committed by them in their capacity as directors or officers.¹ Policy forms often subdivide D&O coverage into a *direct* insuring agreement (sometimes referred to as “side A” coverage) and a *company reimbursement* insuring agreement (sometimes referred to as “side B” coverage).

Direct Coverage

Direct coverage generally applies when indemnification of the directors and officers is unavailable from the insured entity.² This coverage is often viewed as having practical importance in the broader corporate arena, where companies do periodically go bankrupt and therefore are unable to indemnify their directors and officers.

Direct coverage has less practical importance in the fund industry, where a fund bankruptcy would be an extraordinarily unusual event, and where indemnification of fund directors is generally available from the insured entity.³

Thus, in the fund industry, direct D&O coverage is perhaps best viewed as a form of “back up” protection for fund directors and officers. While this coverage may help to alleviate concerns of directors and officers over potential personal liability, its practical value is clearly secondary to company reimbursement D&O coverage.

Company Reimbursement Coverage

Whereas *direct* coverage is an agreement that the insurer makes with individual directors and officers, *company reimbursement* coverage is an agreement that the insurer makes with an insured entity (such as the fund itself). Specifically, under company reimbursement coverage, the insured entity may seek insurance reimbursement for indemnification amounts payable by the insured entity to its directors and officers as a result of claims made against those individuals.

Because a fund’s indemnification of its directors and officers is a fund expense, and because company reimbursement coverage reimburses the fund for such indemnification, this coverage serves to eliminate the immediate impact on fund assets (and therefore, the potential impact on fund shareholders) of indemnifiable liabilities that may be incurred by fund directors and officers in civil litigation or other claims. In the context of mutual funds, company reimbursement coverage may thus be viewed functionally as a hedge against the fund’s own “indemnification risk.”⁴

Some policy forms may require an actual payment by the insured entity, made on behalf of its directors and officers, before company reimbursement coverage is available.⁵ By contrast, under other policy forms, it may suffice for the insured entity merely to be *required* to indemnify, in which case it is unneces-

sary to wait for the entity to actually incur an out-of-pocket loss before the insurance will respond.

E&O

In the mutual fund context, E&O coverage generally insures against financial losses that an insured entity may sustain in claims, made against the insured entity *itself*, that allege errors or omissions committed by the insured entity (or by persons for whose errors and omissions the entity is legally responsible).

E&O coverage is typically viewed as affording coverage for mistakes inherent in the practice of a particular profession. For example, a legal malpractice policy covers errors and omissions committed in rendering *legal advice*, and a medical malpractice policy covers errors and omissions committed in rendering *medical care*. Similarly, a mutual fund E&O insurance policy is typically limited to an *investment management* context.

Specifically, such a policy ordinarily limits E&O coverage for an adviser or other service providers to errors and omissions committed in rendering one or more specified professional services, and may or may not define the covered services. For example, E&O coverage for an adviser may be limited to the adviser's "investment advisory services" and the policy may include a corresponding definition of "investment advisory services." It is thus important for insureds to assess whether the specified services are sufficiently broad to include all of the professional activities for which insureds seek coverage.⁶ Regardless, courts have held that E&O coverage does not extend to generic business activities (e.g., leasing a building, buying supplies, etc.).⁷

OTHER LIABILITY COVERAGES

More specialized liability coverages may also be available from some insurers, either as stand-alone products or as additional insuring agreements in a D&O/E&O policy. One example is "costs of correction," a type of coverage for advisers and other service providers that may also be of interest to funds themselves (for reasons discussed elsewhere in this publication⁸). Other specialized coverages—including coverage for ERISA liabilities⁹ and employment practices liabilities¹⁰—are primarily of interest to advisers or other service providers, rather than funds or fund directors.

Endnotes

- ¹ Policy forms often predicate D&O coverage on the individual director or officer having acted in a certain "capacity," to clarify (among other things) that coverage is not provided for services rendered to *other* organizations. This capacity may be described in the insuring agreements, in definitions of key terms, in one or more exclusions, and/or in one or more specialized endorsements.
- ² While typically offered as part of a combined D&O/E&O policy, direct coverage for independent directors may also be available in a stand-alone product designed specifically for independent director liability. See *infra* Part IV, Preserving Insurance Limits for Independent Directors, at "Stand-Alone Independent Director Policy."
- ³ Indemnification rights remain subject to certain restrictions under state and federal law. See *generally* ICI MUT. INS. CO., INDEPENDENT DIRECTOR LITIGATION RISK 20-23 (2006).
- ⁴ See *id.* at 20-23 (more detailed discussion of the role of indemnification and insurance on liabilities of independent directors).
- ⁵ *Pan Pac. Retail Props., Inc. v. Gulf Ins. Co.*, 471 F.3d 961, 972 (9th Cir. 2006) (observing that "company reimbursement" coverage "is typically considered to require an out-of-pocket loss by the party seeking reimbursement").
- ⁶ See, e.g., *Morgan Stanley Group, Inc. v. New Eng. Ins. Co.*, 225 F.3d 270, 278 (2d Cir. 2000) ("Under no reasonable meaning of the term 'investment

counselor,’ . . . can these allegations be read to allege conduct that is ‘committed in the scope of the Insured’s duties as investment counselors.’ The complaint alleges that Morgan Stanley was acting as a seller’s paid agent while holding itself out as the principal in the sales transaction. The point is that neither role is that of an investment counselor.”).

- ⁷ In this regard, courts often “treat as a touchstone whether or not the wrongful act draws on professional skills as opposed to ordinary business decision-making.” *Massamont Ins. Agency v. Utica Mut. Ins. Co.*, 489 F.3d 71, 73 (1st Cir. 2007).
- ⁸ See *infra* Part II, at Costs of Correcting Operations-Based Errors.
- ⁹ ERISA liability coverage generally insures against liabilities of insured entities (and, in some cases,

insured individuals) in their capacity as fiduciaries to pension or other employee benefit plans (e.g., claims alleging failure by the fiduciary to properly discharge ERISA duties).

- ¹⁰ Employment practices liability insurance has become an insurance product of increased interest to American businesses, including some fund complexes. This popularity is attributable to the significant growth in employment-related claims against American businesses, and to a heightened awareness by both potential plaintiffs and defendants of the significant exposures to which employers may be subject under various state and federal laws. See generally James B. Dolan Jr., *The Growing Significance of Employment Practices Liability Insurance*, GP SOLO MAGAZINE, Sept. 2005, available at <http://www.abanet.org/genpractice/magazine/2005/sep/employmentinsurance.html>.

Mutual Fund D&O/E&O Insurance

D&O coverage is of relatively recent vintage, having first emerged in the 1960s as an insurance product of broad interest to corporations.¹ Since then, it has been widely regarded as useful for attracting qualified persons to serve as mutual fund directors and officers.² By the mid-1980s, most fund groups were carrying both D&O and E&O coverages, although options were limited and policies were not tailored to the fund industry’s specialized needs.

By that time, D&O/E&O insurance, like other lines of casualty insurance, was also proving vulnerable to the traditional commercial insurance market cycle, characterized by periodic swings between—

- *soft markets*, in which reduced claims activity and increased competition for market share among insurance providers lead to reductions in insurance premiums and expansions in scope and amount of coverage, and
- *hard markets*, in which increased claims activity and reduced competition for market share among insurance providers lead to increases in insurance premiums and reductions in scope and amount of coverage.³

CAPTIVE INSURANCE

In the mid-1980s, a severe hard market for professional liability insurance created significant difficulties for fund groups in securing D&O/E&O coverage at reasonable rates from commercial insurers. In response to these difficulties (and similar difficulties regarding fidelity bonding), the Investment Company Institute led the fund industry in

forming ICI Mutual, a “captive” insurance company owned and operated by the industry itself.⁴

Generally, the concept of captive insurance is premised on the view that the presence of a strong industry captive promotes long-term stability in the availability and pricing of insurance for that industry.⁵ In addition (and as with other captive insurers that were established by various large industries during that era⁶), ICI Mutual was designed to provide its industry with a financially stable alternative to the commercial insurance markets, to specialize in the industry’s unique risks and insurance needs, and to serve as a resource on insurance and risk management issues.

TODAY’S MARKET

Over the past two decades, a number of different insurers have competed at one time or another in the mutual fund D&O/E&O insurance market. Even as new insurers have periodically entered the market, others have periodically exited. Meanwhile, ICI Mutual and several commercial insurance companies have offered D&O/E&O coverage on a continuous basis, and have developed and maintained long-standing relationships with their client fund groups.

Today, a small cadre of insurers—ICI Mutual and certain commercial insurance companies—supplies the first level of D&O/E&O insurance for the great majority of all such programs assembled by fund groups. This same cadre of insurers (along with perhaps a dozen other specialty insurance companies) also provides the great majority of “excess” D&O/E&O policies to fund groups seeking additional insurance to supplement their first-level coverages.

POLICY FORMS

Mutual fund D&O/E&O insurers, like corporate D&O/E&O insurers generally, do not use a single common, standard form of insurance contract.⁷ Indeed, mutual fund D&O/E&O policy forms, while generally similar in their broad contours, may vary considerably by insurer, with some insurers employing more than one basic policy form. Moreover, during the course of the insurance application process, the parties may negotiate supplementary terms and conditions in the form of “endorsements” to an insurer’s basic form.⁸

As a result of the foregoing, mutual fund D&O/E&O policies differ, sometimes widely, with respect to the scope of coverages afforded, as well as the terms and conditions to which these coverages are subject.

Policy terms aside, the insurers themselves may also differ, not only with respect to their experience in the mutual fund D&O/E&O market, but also in their claims-handling reputations, their responsiveness to administrative and coverage needs of insureds, and the client services they make available.

Endnotes

¹ Note, *Liability Insurance for Corporate Executives*, 80 HARV. L. REV. 648, 648 (1967) (“Although this form of insurance has been underwritten by Lloyd’s of London for over twenty-five years, the market for it was negligible until only a few years ago.”).

- ² See, e.g., U.S. SECS. & EXCH. COMM’N, EXEMPTIVE RULE AMENDMENTS OF 2004: THE INDEPENDENT CHAIR CONDITION 25 n.75 (2005) (noting that funds purchase such insurance “in large part, to attract the services of qualified directors and officers”).
- ³ See Steve Wilson, *What Departing Directors Need to Know*, RISK MGMT., Jan./Feb. 2009, at 54, 54 (“The D&O insurance market has a history of volatility.”).
- ⁴ See generally Hank Ezell, *ICI to the Rescue*, FIN. PLAN., Oct. 1987, at 165; David C. Isgur, *Seeking Freedom Via Captive Insurers*, FIN. SERVS. TIMES, Aug. 1987, at 22; Memorandum from Kirkpatrick & Lockhart to U.S. Secs. & Exch. Comm’n (Mar. 16, 1987) (on file with ICI Mutual) (reporting on activities of the ICI’s insurance task force, and discussing the industry’s insurance problems).
- ⁵ Captives: Why or Why Not?, <http://www.captive.com/service/SCG/ProsAndCons.html> (last visited Aug. 7, 2008) (citing “stability of pricing” and “provision of coverage otherwise unavailable” as benefits of forming a captive).
- ⁶ Other examples of captive insurers are the Attorneys’ Liability Assurance Society (insuring law firms) and United Educators (insuring educational institutions).
- ⁷ See generally *Aug. Entm’t, Inc. v. Phila. Indem. Ins. Co.*, 52 Cal. Rptr. 3d 908, 913 (Ct. App. 2007) (“[U]nlike general liability insurance, which is typically written on standard forms, D&O policy provisions often vary depending on a number of factors Cases must therefore be reviewed in the context of the specific policy language at issue.”) (quoting treatise).
- ⁸ An insurance policy containing nonstandard provisions that have been negotiated between the insurer and the insured is known as a “manuscript” policy.

Basic D&O/E&O Concepts

Although they differ in their specific wording, D&O/E&O policy forms used by different insurers tend to share a common overall structure. Under this structure, both D&O coverage and E&O coverage typically extend only to *loss* incurred by insureds as a result of *claims made* against them during the policy period for *wrongful acts*. In addition, the insured has an obligation to provide the insurer with timely *notice* of the underlying claim.

LOSS

D&O/E&O policies typically cover an insured only for “loss,” a term that is usually defined in the policy to include amounts paid by insureds to satisfy *judgments* or *settlements* reached in otherwise covered claims (with the caveat that the insurer’s consent is necessary for settlements). This protection against the financial impact of judgments and settlements is a core feature of mutual fund D&O/E&O coverage (as with corporate D&O/E&O coverage generally).

Most if not all policy forms also define “loss” to include *defense costs* (i.e., legal fees and expenses incurred by an insured in its defense of otherwise covered claims, but typically excluding salaries or wages of the insured’s own employees).

In the fund industry, it is not uncommon for lawsuits and other “claims” to generate total defense costs in the seven or even eight-figure range, even where, as is often the case, claims are successfully resolved without payment by insureds of monetary judgments or settlements. As a result, defense costs represent a substantial percentage of all insurance payments made under mutual fund D&O/E&O policies, and coverage for defense costs is generally viewed as an additional core coverage feature.

Policy forms also routinely place certain limitations on the types of “loss” for which coverage may be available. The following common limitations may be of particular interest to fund industry insureds:

- ***Fines, Penalties and Other Commonly Excluded Items.*** Most if not all policy forms define “loss” to exclude fines, penalties, taxes, and matters deemed “uninsurable” under the law pursuant to which the policy is construed.
- ***Uninsurable Items.*** Regardless of an insurance policy’s particular wording, state law may also prohibit insurance recovery for certain matters on public policy grounds. Such “uninsurable” items can include restitutionary relief (i.e., the return of something wrongfully acquired);¹ loss caused by intentional conduct or injuries;² “known loss”;³ and punitive or similar types of damages.⁴
- ***Punitive Damages.*** Some policy forms expressly define “loss” to exclude punitive or similar types of damages, while others do not. At least in the fund industry, however, the importance of insurance coverage for punitive damages is largely academic. For starters, punitive damages must be awarded by a court, yet virtually all lawsuits against mutual funds and directors are ultimately dismissed or settled prior to trial. Second, there have been few, if any, examples of punitive damages in the fund industry.

Even in the uncommon event of a trial to judgment, the likelihood of an award of such damages would appear to be exceedingly low.

CLAIMS MADE

Every D&O/E&O policy specifies a range of dates known as the “policy period” (usually one year in length).⁵ Typically, a policy covers the insured only for lawsuits (or other “claims”⁶) that are first made against the insured *during that policy period*.⁷ In other words, an insured’s *current* policy will not generally respond to a lawsuit or other claim that was first initiated in an *expired* policy period or in a *future* policy period.⁸ Rather, any coverage for such a past or future claim will be available only under the past or future policy.

This “claims made” nature of D&O/E&O policies provides significant advantages to both insurers and insureds.⁹ At the same time, it can raise continuity-of-coverage issues requiring consideration by fund groups who contemplate replacing one insurance carrier with another. (See Part III, at Continuity of Coverage When Changing Insurers.)

WRONGFUL ACT

While it is common to think of D&O/E&O policies as covering liability for, generically, “errors and omissions,” many policy forms instead use the defined term “wrongful act.” Although the definition of “wrongful act” varies among policy forms, the term is often defined to include most or all of the following: errors, misstatements, misleading statements, neglect, negligent acts or omissions, and breaches of duty.

Such definitions generally reflect the fact that mutual fund D&O/E&O policies are designed, at their core, to provide coverage for *unintentional* acts and

omissions. In accord, courts have generally held that D&O/E&O policies do not cover claims based on fraud or other *intentional* misconduct¹⁰ (and, in any event, many intentional acts are specifically excluded elsewhere in these policies¹¹).

For purposes of D&O coverage, the definition of “wrongful act” may be defined in terms of not only *conduct* (e.g., where a director commits or is alleged to have committed specific wrongful acts), but also *status* (e.g., where a director is caught up in litigation merely as a result of his or her status as director).¹²

NOTICE

Policy forms typically dictate when an insured must report a lawsuit (or other “claim”) to the insurer. The formulation used by the policy as to when notice must be provided can take any of several alternative forms—such as “as soon as practicable,” during the policy period, or within a specified number of days after the policy has expired. Whatever the formulation, failure to provide timely notice can preclude insurance coverage for the claim.¹³

Endnotes

¹ See, e.g., *Exec. Risk Indem., Inc. v. Pac. Educ. Servs., Inc.*, 451 F. Supp. 2d 1147, 1162 (D. Haw. 2006) (“A conclusion that restitution is insurable would contravene the express purpose of restitution recognized by Hawaii courts, which is to deter wrongdoers from benefiting or otherwise profiting from their improper actions.”).

² See, e.g., Cal. Ins. Code § 533 (Deering, LEXIS through 2007 ch. 1) (“An insurer is not liable for a loss caused by the wilful [sic] act of the insured . . .”).

³ “Known loss” is a specific loss that the insured knows, before the policy takes effect, “has already happened or is substantially certain to happen.” BLACK’S LAW DICTIONARY 889 (8th ed. 2004).

⁴ See *Carey v. Employers Mut. Casualty Co.*, 189 F.3d 414, 418 n.1 (3d Cir. 1999) (“Generally, courts are divided on the public policy question

whether an insurer may indemnify punitive damages.”).

- ⁵ Each policy may thereafter be renewed upon agreement by the insurer and the insured, with each renewal constituting a separate policy. *See, e.g., Hercules Bumpers, Inc. v. First State Ins. Co.*, 863 F.2d 839, 842 (11th Cir. 1989) (“It is a basic tenet of insurance law that each time an insurance contract is renewed, a separate and distinct policy comes into existence.”).
- ⁶ Of particular interest to fund groups is whether a “claim” includes (in addition to lawsuits) regulatory investigations. *See infra* Part II, at Regulatory Investigations.
- ⁷ *See generally* *Twp. of Ctr. v. First Mercury Syndicate, Inc.*, 117 F.3d 115, 118 (3d Cir. 1997) (“A ‘claims made’ policy, as opposed to an ‘occurrence’ policy, protects the policy holder against claims made during the life of the policy, rather than against ‘occurrences’ which happen during the policy period and for which claims may arise later.”) (citation omitted).
- ⁸ Mutual fund D&O/E&O policies often provide a limited exception to the claims-made form that permits an insured to “bookmark” its current policy for a possible *future* lawsuit or other future claim, provided that specified notice requirements are satisfied. Typically, the applicable notice provisions require the insured to provide the insurer, during the policy period, with specific notice of “wrongful acts” that may give rise to a future claim. *See generally* *LaForge v. Am. Cas. Co.*, 37 F.3d 580, 582 (10th Cir. 1994) (noting that such provisions make the policies containing them “somewhat different from the pure claims made policy”); *FDIC v. Interdonato*, 988 F. Supp. 1, 3 (D.D.C. 1997) (noting that the policy at issue “was not a true claims made policy since it provided coverage for claims after the policy period arising out of ‘occurrences’ sufficiently noticed during the policy period”), *aff’d*, 182 F.3d 919 (D.C. Cir. 1998).
- ⁹ Unlike an “occurrence” policy (which is triggered by a specified “occurrence,” such as the occurrence of property damage or bodily injury, even though the lawsuit against the insured may not be filed until years later), a claims-made policy permits an insurer to evaluate, as of a policy’s expiration date, the frequency and anticipated severity of all insurance claims that may impact the insurer. Because an insurer can better gauge its ultimate exposure at an earlier date and with more certainty, a claims-made policy can result in premium savings to the insured. *See generally* *Am. Cas. Co. v. Continisio*, 17 F.3d 62, 68 (3rd Cir. 1994) (“Claims-made policies are less expensive [than ‘occurrence’ policies] because underwriters can calculate risks more precisely since exposure ends at a fixed point.”).
- ¹⁰ *See, e.g., Transcon. Ins. Co. v. Caliber One Indem. Co.*, 367 F. Supp. 2d 994, 1002 (E.D. Va. 2005) (“[I]t is well-settled that ‘a negligent act, error, or omission’ requirement in a professional liability insurance policy precludes an insurer’s duties to defend and indemnify when the insured is sued for intentional torts”); *N.H. Ins. Co. v. Westlake Hardware, Inc.*, 11 F. Supp. 2d 1298, 1301 (D. Kan. 1998) (“[C]overage for any ‘negligent act, error, omission, misstatement or misleading statement’ does not include intentional acts.”), *aff’d mem.*, 201 F.3d 448 (10th Cir. 1999).
- ¹¹ Examples include express exclusions for claims involving fraudulent, dishonest or criminal acts; libel and slander; intentional violation of law; defamation; and wrongful termination and discrimination.
- ¹² *See, e.g., McAninch v. Wintermute*, 491 F.3d 759, 769 (8th Cir. 2007) (“A proper reading of the policy . . . reveals it is intended to provide coverage to directors for claims based on conduct and for claims based on status.”).
- ¹³ *See, e.g., Fed. Ins. Co. v. CompUSA, Inc.*, 319 F.3d 746, 749-50 (5th Cir. 2003) (holding that thirteen month reporting delay did not satisfy policy’s “as soon as practicable” requirement).

Part II

Particular Fund Industry Risks

Defense Costs

Coverage for defense costs—the legal fees and associated costs incurred by an insured in defense of claims—is a critically important coverage feature for fund industry insureds.

THE RISING COST OF DEFENDING LAWSUITS AND INVESTIGATIONS

In the fund industry, it is not uncommon for defense costs alone to exceed the applicable insurance deductible and, in significant proceedings or lawsuits, to reach well into the range of seven or eight figures.

Indeed, defense cost reimbursements now constitute a substantial percentage of all insurance payments by mutual fund D&O/E&O insurers, a percentage that has increased over the years. Consider ICI Mutual’s own experience: defense cost reimbursements have constituted more than 60% of all D&O/E&O claims payments made by ICI Mutual since the company’s formation.

This significant amount of defense costs reflects both an overall increase in fund industry claims over the past decade as well as an increase in the average amount of defense costs incurred per individual claim.¹

Although the frequency of new claims has decreased significantly since the height of the mutual fund trading scandal of 2003 and 2004, it seems likely—given the growth of the fund industry over the past decades and its highly visible position in the country’s economic and political landscape—that, for the foreseeable future, investigative and litigation activity against the fund industry will remain above the relatively benign levels of prior times. It also seems likely that defense costs will continue to represent a

significant financial exposure for funds, fund directors, and advisers in regulatory investigations and civil litigation.

INSURANCE COVERAGE

Mutual fund D&O/E&O policies have historically been structured to permit insureds broad discretion and flexibility in selecting their own defense counsel and in arranging and controlling defense efforts in claims brought against them. These policies are thus not “duty to defend” policies,² but they typically *do* provide for reimbursement of legal fees and associated costs incurred by the insured in defense of claims.

Mutual fund D&O/E&O policies typically couple the right of insureds to control their own defense with various other provisions that are intended to promote active management of defense costs by insureds and to protect the insurer from excessive defense costs.

For example, as with D&O/E&O policies generally, an insured’s selection of defense counsel is typically subject to the insurer’s consent; there is typically a requirement that the insured cooperate with the insurance company; and the insurer’s obligation to pay defense costs is typically limited to those costs that are reasonable and necessary.³

Defense Costs in Excluded Claims

Even where coverage for a judgment or settlement is excluded, some policy forms may nevertheless preserve coverage for the defense costs incurred by insureds in defending against the excluded claim.

For example, while many mutual fund D&O/E&O policy forms exclude settlements and judgments in fee litigation,⁴ some forms expressly preserve cover-

age for the defense costs incurred in such suits. Given the prevalence of fee lawsuits in recent years, and the high costs of defending such lawsuits, defense costs coverage has itself been of significant value to insureds in such cases.

Advancement of Defense Costs

Regulatory investigations and civil lawsuits may span multiple years before they are finally resolved. In such cases, insureds may wish to seek reimbursement for defense costs while the underlying matter remains ongoing, prior to its final adjudication or settlement. The availability of “advancements” for defense costs in such cases frequently depends upon the particular policy involved.

Some policy forms make specific provision for the advancement of defense costs prior to the final disposition of a claim.⁵ Often, however, such provisions set certain express conditions or exceptions that may limit advancements in some circumstances.

- **“Reasonable grounds” exception.** Policy forms may give insurers latitude to decline to advance defense costs where insurance coverage for the underlying matter is doubtful. For example, the policy may provide that the insurer has no obligation to advance if it has “reasonable grounds” to believe that it will not ultimately have liability under the policy for loss resulting from the claim.⁶
- **Undertaking and/or reimbursement requirement.** Some provisions may condition the insurer’s obligation to advance defense costs on the insured providing a written undertaking to repay the advancements to the in-

surer in the event it is finally established that the insurer is not liable under the policy.⁷ Even in the absence of such an undertaking requirement, however, courts have held that in some circumstances an insurer may nevertheless recover previously advanced defense costs (and, indeed, previously paid indemnity payments) that were incurred with respect to uncovered claims.⁸

Other policy forms contain no specific provision addressing advancement of expenses prior to a final disposition of the underlying matter. In such cases, some courts have nevertheless construed certain policies to require the insurer to fund defense costs as incurred.⁹

Insurance aside, independent directors may wish to additionally confirm that their fund’s governing documents explicitly address the fund’s ability to advance directors’ legal expenses. Fund indemnification is often a strong first line of protection for independent directors.¹⁰

Endnotes

- ¹ See generally ICI MUT. INS. CO., MANAGING DEFENSE COSTS 5-17 (2004) (discussion of the trend towards increased defense costs in the fund industry, and of the various reasons therefor).
- ² In insurance law, the “duty to defend” refers to an express obligation, placed by a liability policy onto the insurer, pursuant to which the insurer itself (rather than the insured) must select and retain defense counsel and direct the insured’s legal defense against claims of liability.
- ³ See, e.g., *Am. Simmental Ass’n v. St. Paul Fire & Marine Ins. Co.*, 107 F. Supp. 2d 1064, 1085 (D. Neb. 2000) (reducing the insured’s recovery of defense costs by 25% upon concluding that the submitted amount of costs was “unreasonable”), *aff’d*, 282 F.3d 582, 589-90 (8th Cir. 2002).

⁴ See generally *infra* Part II, at Fee Litigation.

⁵ Such advancement provisions contemplate a pending lawsuit (or other “claim”), and thus are inapplicable once the underlying matter has ended. *Pan Pac. Retail Props. v. Gulf Ins. Co.*, 471 F.3d 961, 970 (9th Cir. 2006) (holding that cases “which involved an insurer’s duty to provide contemporaneous advancement of defense costs are not controlling where the insureds seek only reimbursement of costs after the underlying litigation has ended”) (citation omitted).

⁶ *Cf.* *Brown v. Am. Int’l Group, Inc.*, 339 F. Supp. 2d 336, 346 (D. Mass. 2004) (holding—based on policy provision that permitted the insurer to “withhold consent to” defense costs “to the extent such Loss is not covered”—that the insurer assumed a duty to advance defense costs “only if the claim suggests a reasonable potential for coverage”).

⁷ See, e.g., *Am. Med. Sec., Inc. v. Exec. Risk Specialty Ins. Co.*, 393 F. Supp. 2d 693, 712 (E.D. Wis. 2005) (“As a condition of any payment of Defense Expenses before the final disposition of a

Claim, the Underwriter may require a written undertaking on terms and conditions satisfactory to it guaranteeing the repayment of any Defense Expenses paid on behalf of any Insured if it is finally determined that this Policy would not cover Loss incurred by such Insured in connection with such Claim.”) (quoting policy).

⁸ See, e.g., *Old Republic Ins. Co. v. FSR Brokerage, Inc.*, 95 Cal. Rptr. 2d 583, 591 (Ct. App. 2000) (“An insurer may . . . recover settlement or defense funds that it had no contractual duty to pay provided it can establish that it reserved a right to reimbursement, and there is otherwise a proper basis for recovery in quasi-contract.”).

⁹ See, e.g., *In re WorldCom, Inc. Sec. Litig.*, 354 F. Supp. 2d 455, 464 (S.D.N.Y. 2005) (holding that the D&O policy at issue required the insurance company to reimburse the directors “as soon as the attorneys’ fees are incurred.”) (internal quotation marks omitted).

¹⁰ See generally *ICI MUT. INS. CO., INDEPENDENT DIRECTOR LITIGATION RISK 20-21* (2006).

Regulatory Investigations

Enforcement proceedings brought by federal regulators, state regulators, and self-regulatory organizations can have severe repercussions for funds, fund directors and advisers. Such proceedings may result in a wide variety of sanctions, including monetary penalties, cease-and-desist orders, and bars or suspensions of individuals from professional practice. Separate and apart from such sanctions, enforcement proceedings may cause substantial reputational damage to fund groups, and can often stimulate the filing of “follow on” shareholder lawsuits by plaintiffs’ lawyers specializing in securities litigation.

THE HIGH COST OF REGULATORY INVESTIGATIONS

Because the staffs of the U.S. Securities and Exchange Commission and other regulators typically conduct comprehensive investigations before deciding whether to initiate enforcement proceedings, and because enforcement proceedings are typically settled promptly following the conclusion of the investigatory phase, a fund group’s best opportunity to “make its case” to regulators generally comes in the investigatory phase itself.

It is during this investigatory phase that a fund group commonly seeks to dissuade the regulator from initiating a public enforcement proceeding (or, if unsuccessful in that effort, to negotiate as favorable a settlement as possible under the circumstances).

For the foregoing reasons, fund groups frequently find it prudent to devote significant resources to the defense of regulatory investigations, and commonly retain specialty outside counsel to spearhead their defense efforts. Some defense counsel suggest that

regulatory investigations now frequently involve higher stakes than in years past, and that regulators now often require fund groups to provide more materials and to make more individuals available for testimony.

It has also become more common for fund groups to retain multiple defense firms to represent different entities or individuals involved in an investigation. Given these factors, it is not surprising that the costs and associated expenses incurred by fund groups in defending against regulatory investigations have increased in recent years, in some cases exceeding applicable D&O/E&O insurance deductibles by significant amounts.

INSURANCE COVERAGE

Because the potential for coverage under a mutual fund D&O/E&O policy is usually triggered only upon the initiation of a “claim” made against an insured, the question of whether insurance coverage may be available for investigatory defense costs typically turns on the meaning of “claim.”

“Claim,” as Defined in Policies

Mutual fund D&O/E&O policy forms may or may not clearly define “claim” to include regulatory investigations. Even among those policy forms that define “claim” to include regulatory investigations, policy forms differ with respect to the availability of coverage for *informal* investigations.

That is, some policy forms may limit coverage to only “formal” regulatory investigations (or even “formal administrative proceedings”). Other policy forms are not so limited, and define “claim” to include “any” regulatory investigation into possible violations of law—a broad definition that extends

potential coverage to both formal *and* informal investigations.

Although formal and informal regulatory investigations are similar in many respects and frequently require a similar commitment of defense resources, specialists in the area agree that, for a number of reasons, it is “generally preferable for defense counsel to attempt to keep an investigation informal.”¹ Given this preference, fund groups may wish to consider the extent to which their D&O/E&O policies afford coverage not only for formal investigations, but for informal investigations as well.

Indeed, coverage for informal investigations can prove valuable even where, as is sometimes the case, an informal investigation ultimately evolves into a formal one. A recent court decision is instructive. In that decision, the insured’s policy defined “claim” to include (as here relevant) only “a formal administrative or regulatory proceeding commenced by the filing of a notice of charges, formal investigative order, or similar document.” The court held that the insurer was only liable for costs that the insured incurred *after* receiving the SEC’s formal investigative order.² Had the insured’s policy included coverage for *informal* investigations, the insured would have been in a position to secure insurance recovery for a larger amount of its total defense costs: namely, costs incurred *prior* to (as well as after) receiving the agency’s formal investigative order.

“Claim,” as Defined by Courts

Where a definition of “claim” is not specifically set forth in the policy form itself, the scope of coverage for regulatory investigations is left to the courts.³ In such cases, court decisions are decidedly mixed as to whether a regulatory investigation constitutes an insurable “claim.”⁴ Where the term “claim” is not specifically defined, the availability of insurance coverage for regulatory investigations thus becomes uncertain, depending on the particular facts and circumstances involved and on applicable court decisions.

Endnotes

- ¹ Richard M. Phillips et al., *SEC Investigations*, in KIRKPATRICK & LOCKHART PRESTON GATES LLP, *THE SECURITIES ENFORCEMENT MANUAL* 39, 47 (Michael J. Missal & Richard M. Phillips eds., 2007).
- ² *Nat’l Stock Exch. v. Fed. Ins. Co.*, No. 06-C-1603, 2007 U.S. Dist. LEXIS 23876, at *17 (N.D. Ill. Mar. 30, 2007).
- ³ *See, e.g.*, *Nat’l Bank v. St. Paul Fire & Marine Ins. Co.*, 975 P.2d 711, 714 (Ariz. Ct. App. 1999) (“[C]ourts have defined the term.”).
- ⁴ *Compare* *Hyde v. Fid. & Deposit Co.*, 23 F. Supp. 2d 630, 633 (D. Md. 1998) (“A claim is something demanded as of right in a court. [The U.S. Resolution Trust Corporation] merely gave the Directors notice that they intended to hold the Directors liable; RTC did not subsequently file a claim in court. . . . Accordingly, no ‘claim’ was made.”) (emphasis in original) *with* *Richardson Elecs., Ltd. v. Fed. Ins. Co.*, 120 F. Supp. 2d 698, 701 (N.D. Ill. 2000) (“The [U.S. Department of] Justice investigation involved a claim because it required [the insured entity] and its officers and directors to comply with various demands for testimony and production of documents.”).

Prospectus Liability Claims

Shareholder litigation constitutes a primary source of D&O/E&O exposure for mutual funds and fund directors, as for public corporations and corporate directors generally.¹ Of particular concern to mutual funds is litigation that challenges the accuracy or completeness of disclosure in a fund prospectus.

SHAREHOLDER LITIGATION IN THE FUND INDUSTRY

In general, shareholder litigation against fund groups is distinguishable from shareholder litigation against public corporations.

For *public corporations*, claims brought under rule 10b-5 of the Securities Exchange Act of 1934 (the basic antifraud provision of the federal securities laws) constitute by far the most significant category of shareholder litigation.² Particularly in recent years, rule 10b-5 claims directed against public corporations and corporate directors tend to focus on alleged fraud in corporate financial reporting, and such claims are frequently filed in the immediate aftermath of significant “stock drops” or corporate financial restatements.

Although investment companies are not exempt from rule 10b-5, securities class actions in the *fund industry* more typically allege prospectus disclosure violations under sections 11 and/or 12(a)(2) of the Securities Act of 1933. The apparent preference of the plaintiffs’ bar for prospectus liability claims in the mutual fund arena seems partly attributable to fundamental differences between investment companies and public corporations, which differences *decrease* the relative appeal to the plaintiffs’ bar of a 10b-5 claim³ and *increase* the relative appeal of a prospectus liability claim.⁴

Prospectus liability lawsuits tend to be most common where a fund’s net asset value (NAV) has declined significantly, and the NAV decline can potentially be linked to particular investment risks or practices for which prospectus disclosure could be alleged to be misleading or incomplete.⁵ Shareholder class actions against funds holding mortgage-backed securities are a recent example of these lawsuits.⁶ For various reasons, fixed-income funds appear to be at disproportionate risk, relative to other types of funds, for prospectus liability claims.⁷

In rule 10b-5 claims, plaintiff shareholders must prove intentional or reckless misconduct by defendants, as well as the fact and extent of their financial harm (i.e., actual damages). By contrast, in prospectus liability claims, these heightened requirements do not generally apply (and defendants can be liable even for “innocent or negligent” misstatements or omissions⁸). For this and other reasons, it may be difficult for mutual funds and their directors to secure dismissals of prospectus liability claims at the pretrial stage of litigation.

Because even a modest decline in a fund’s NAV can frequently result in claimed “losses” for fund shareholders in the tens or hundreds of millions of dollars, a prospectus disclosure lawsuit that survives pretrial challenges can present funds and fund directors with a difficult choice between (1) proceeding to trial and taking the risk (however low) of judgment at or near the amount sought by plaintiffs and (2) settling the lawsuit before trial. Faced with such a choice, fund groups frequently opt to settle the lawsuit for a fraction of the damages claimed by plaintiffs—albeit a fraction that may still, as an absolute matter, run into the millions, or even tens of millions, of dollars.

INSURANCE COVERAGE

In light of the foregoing risks, fund groups typically view coverage for prospectus liability claims as a core feature of mutual fund D&O/E&O insurance.

In some policy forms, affirmative coverage for such claims is *explicitly* provided. In other policy forms, coverage is *implicitly* provided (either under the policy form's definition of "wrongful act" or otherwise⁹).

Either way, policy forms rarely, if ever, expressly exclude prospectus liability coverage. Nevertheless, given the importance of prospectus liability coverage to funds and fund directors, fund boards may wish to seek confirmation, during the insurance selection process, that each D&O/E&O policy form that may be under consideration makes appropriate provision for such coverage.

Insurance counselors to fund boards should also be alert to the fact that a few courts have considered (in the context of public corporations) whether section 11 prospectus liability is uninsurable as a matter of public policy, with mixed results.¹⁰ It is important to recognize, however, that the case law is very thin, such that the question has not been decided (or even considered) by most courts. Also, the prospectuses involved in these decisions were issued by operating companies rather than by mutual funds. In any event, the decisions do evidence that some insurers, at least in the broader corporate arena, may from time to time seek to avoid coverage for prospectus liability claims.

Endnotes

¹ See TOWERS PERRIN, DIRECTORS AND OFFICERS LIABILITY: 2007 SURVEY OF INSURANCE PURCHASING AND CLAIM TRENDS 55 (2008) (reporting that 53% of claims against participating public corporations were brought by shareholders); Tom Baker & Sean J. Griffith, *The Missing Monitor in Corporate Governance: The Directors' & Offi-*

cers' Liability Insurer, 95 GEO. L.J. 1795, 1801 n.21 (2007) ("For public corporations, the dominant source of D&O risk, both in terms of claims brought and liability exposure, is shareholder litigation.").

² See LAURA E. SIMMONS & ELLEN M. RYAN, CORNERSTONE RESEARCH, SECURITIES CLASS ACTION SETTLEMENTS 9 (2008) (of 933 shareholder class actions surveyed, only 36 did not involve rule 10b-5 claims); Baker & Griffith, *supra* note 1, at 1804 n.34 ("In 2005, 93% of securities class actions alleged violations of Rule 10b-5.").

³ Generally, the "fraud-on-the-market" presumption—"which relieves the plaintiff of the burden of proving individualized reliance on a defendant's misstatement," *In re Polymedica Corp. Secs. Litig.*, 432 F.3d 1, 7 (1st Cir. 2005)—is widely considered "key to any Rule 10b-5 class action." JOHN C. COFFEE, JR. ET AL., SECURITIES REGULATION 1008 (10th ed. 2007); see also *Basic Inc. v. Levinson*, 485 U.S. 224, 242 (1988) (plurality opinion) (discussing the impracticality of certifying a class without such a presumption). The economic theory underlying the presumption is that the intrinsic "value" of a stock is reflected in its share price (such that an issuer's fraud regarding the stock's value affects the market price of the stock); but the price of a *mutual fund* share (i.e., its NAV) "reflects nothing about the fund's intrinsic value as an investment." Mercer E. Bullard, *Dura, Loss Causation, and Mutual Funds: A Requiem for Private Claims?*, 76 U. CIN. L. REV. 559, 575-76 (2008).

⁴ Claims under sections 11 and 12(a)(2) must be filed by the earlier of (1) one year after the plaintiff discovered or should have discovered the facts constituting the violation or (2) three years after the public offering or sale of the security. 15 U.S.C. § 77m (2006). Unlike stock shares of a corporation which are typically offered at one moment in time and then traded on a secondary market, shares of an open-end fund are offered continuously. Thus, the three-year limitation applicable to the prospectus that accompanies the offering of a public corporation's stock ordinarily expires sooner than the "evergreen" prospectus that accompanies the continuous offering of a mutual fund.

⁵ A fund's prospectus typically incorporates by reference the fund's statement of additional information (SAI), and shareholder litigation may also challenge the accuracy or completeness of disclosure in a fund's SAI.

- ⁶ *See, e.g.*, In re Charles Schwab Corp. Secs. Litig., No. 3:08-cv-1510 (N.D. Cal. filed Mar. 18, 2008). Citing a precipitous drop in NAV, plaintiffs in this lawsuit allege that fund registration statements contained material misstatements and omissions relating to (among other things) the diversification of the fund and the extent to which the fund made investments in sub-prime mortgage-backed and related securities.
- ⁷ *See generally* ICI MUT. INS. CO., UNDERSTANDING BOND FUND RISKS 1-7 (2002).
- ⁸ *See, e.g.*, In re Suprema Specialties, Inc. Secs. Litig., 438 F.3d 256, 269 (3d Cir. 2006) (“Like Section 11, Section 12(a)(2) is a ‘virtually absolute’ liability provision that does not require an allegation that defendants possessed scienter.”); Knollenberg v. Harmonic, Inc., 152 F. App’x 674, 683 (9th Cir. 2005) (“Defendants may be liable for violations of Section 11 for innocent or negligent misstatements or omissions.”); *id.* at 684 (“Plaintiffs have adequately pleaded a violation of Section 12(a)(2) by alleging that Defendants negligently omitted material facts from the prospectus.”).
- ⁹ *See supra* Part I, Basic D&O/E&O Concepts, at “Wrongful Act.”
- ¹⁰ *Compare* Bank of Am. Corp. v. SR Int’l Bus. Ins. Co., No. 05-CVS-5564, 2007 NCBC LEXIS 36, at *39 (N.C. Super. Ct. Dec. 19, 2007) (“[T]here exists neither statutory authority nor judicial decision in North Carolina holding that claims under Section 11 are uninsurable.”) *with* CNL Hotels & Resorts, Inc. v. Houston Cas. Co., 291 F. App’x 220, 223 (11th Cir. 2008) (“The return of money received through a violation of law, even if the actions of the recipient were innocent, constitutes a restitutionary payment, not a ‘loss.’ It is immaterial whether CNL committed fraud. CNL received money directly from the Purchaser Class through the sale of shares, and CNL returned some of the money after the Purchaser Class alleged that the sale of shares by CNL violated the law.”) *and* Consecro, Inc. v. Nat’l Union Fire Ins. Co., No. 49D130202CP000348, 2002 WL 31961447, at *8 (Ind. Cir. Ct. Dec. 31, 2002) (“The Section 11 plaintiffs essentially sought back the amounts Consecro wrongfully obtained . . .”).

Fee Litigation

The Investment Company Act of 1940 (ICA), the principal federal statute governing mutual funds, imposes a wide range of obligations and restrictions on funds and associated individuals and entities (including fund directors and officers and fund advisers).

At one time, courts tended to grant fund shareholders latitude to pursue civil litigation for alleged violations of these obligations and restrictions, based on the theory that shareholder litigation was impliedly authorized under various provisions of the statute. More recently, however, numerous federal courts (including an influential appellate court) have rejected so-called “implied rights of action” under various provisions of the ICA.¹ As a result (and while the SEC retains clear authority to police violations of the ICA²), the ability of *shareholders* to do so has been sharply circumscribed.

Assuming that implied rights of action remain generally unavailable, plaintiffs are left with only the one avenue of civil litigation expressly allowed by the ICA: section 36(b). Section 36(b) expressly authorizes a fund’s shareholders to bring civil lawsuits challenging the payment of fees or other compensation by their fund to the fund’s adviser or its affiliates.

Many such fee lawsuits have been filed over the years, including a wave of filings in the wake of the 2003-04 trading scandal.³ Several have now reached the federal appellate courts and, in a very significant development, the U.S. Supreme Court has itself agreed to review one of these appellate decisions.⁴ Its forthcoming decision may clarify the proper standard for deciding whether an adviser has violated section 36(b).

Regardless, as section 36(b) is the only ICA section expressly affording private parties the right to bring a lawsuit, fee litigation appears likely to remain a potential exposure, such that fund groups may wish to consider carefully the scope of coverage available under D&O/E&O policies for such litigation.

FUNDS AND INDEPENDENT DIRECTORS

By its express terms, section 36(b) authorizes a lawsuit against only the “recipient” of the allegedly wrongful compensation or payments.⁵ As a result, the principal risk of financial exposure in fee litigation rests with the adviser or other service provider that received the fees or other compensation at issue.

Neither funds nor fund directors and officers are proper defendants in section 36(b) lawsuits because neither funds nor their directors and officers directly receive advisory or other fee-based compensation.⁶ Even so, plaintiffs in fee-based lawsuits have sometimes sought to include independent directors as defendants, in which case the directors must incur defense costs to secure their dismissal from the litigation.

Regardless, even where independent directors are not named as defendants, they are frequently *witnesses* in fee lawsuits. Indeed, litigation under section 36(b) ordinarily involves scrutiny of the actions taken, and the processes followed, by independent directors in evaluating the challenged fees. As a result, independent directors may themselves incur substantial legal costs and expenses for multiple days of deposition preparation, testimony, and the like.

However, because the status of fund independent directors in such cases is that of *non-party witnesses*

rather than defendants, there may be issues under some D&O/E&O policy forms as to whether insurance coverage is available for their legal costs and expenses. In this regard, independent directors may wish to seek clarification, by endorsement or otherwise, as to the scope of their policy's coverage.

ADVISERS AND OTHER SERVICE PROVIDERS

In section 36(b) lawsuits, advisers (or other affiliated service providers) are at risk, at least in theory, for court judgments requiring them to repay the challenged fees to the funds that paid them. In practice, however, the industry's experience over the past twenty-five years has been that very few section 36(b) lawsuits ultimately proceed to an actual trial; and among those that have been tried, adverse court judgments have been rare or nonexistent.

To the contrary, fund advisers have had a long history of success in section 36(b) litigation. Moreover, even in those cases where fund advisers have reached negotiated settlements, the settlements have more typically involved prospective reductions in fee schedules rather than any repayments of fees.⁷ Accordingly, absent some significant future change in the law, the risk to an adviser of being required to repay challenged fees would appear to be a relatively small one.

Judgments and Settlements

It seems almost certain that mutual fund D&O/E&O insurers would uniformly view any such repayment of challenged fees as outside the scope of available coverage. Some policies contain express exclusions for fee-based litigation (particularly after the large number of fee lawsuits brought in the wake of the 2003-04 trading scandal).

Even where a policy does not contain an exclusion expressly referencing fee litigation, an insurer would

generally be expected to take the position that insurance coverage is unavailable—because there is a standard exclusion in most policies for claims involving an insured's gain of an "illegal profit or advantage,"⁸ and/or because repayment of fees may be viewed as uninsurable under applicable law.⁹

Defense Costs

The question of coverage for defense costs in section 36(b) litigation—i.e., coverage for the legal and expert fees and associated expenses that may be incurred by advisers in defending against what are frequently lengthy and complex lawsuits—is of very real practical importance to advisers.

In section 36(b) lawsuits, advisers typically view their reputational risk alone, separate and apart from any potential financial risk involved, as warranting the expenditure of substantial resources for their litigation defense. Also, over the past decade, the emergence of plaintiffs' lawyers having increased expertise in investment management litigation has also added to the challenges associated with these defense efforts. For these and other reasons, it has not been uncommon in recent years for total defense costs in individual fee lawsuits to range in the high seven figures (or even eight figures).

Some policy forms provide express coverage for defense costs incurred by advisers (and other insured defendants) in section 36(b) litigation, regardless of the ultimate outcome of the litigation. Other policy forms, particularly those that may rely on a general "illegal profit or advantage" exclusion, may condition insurance coverage for defense costs on a favorable litigation outcome for the adviser. Finally, as noted above, some insurers in the post-scandal era added an express exclusion for fee-based litigation, often by separate endorsement. Depending on their wording, these exclusions may (or may not) extend to defense costs.

Endnotes

- ¹ See, e.g., *Bellikoff v. Eaton Vance Corp.*, 481 F.3d 110, 117 (2d Cir. 2007) (“[T]he text and the structure of the ICA reveal no ambiguity about Congress’s intention to preclude private rights of action to enforce §§ 34(b), 36(a), and 48(a).”); *Halebian v. Berv*, No. 06-4099, 2007 U.S. Dist. LEXIS 55326, at *43 (S.D.N.Y. July 31, 2007) (“[W]e conclude that Congress did not intend to create a private right of action for violations of section 20(a).”); *But see Northstar Fin. Advisors, Inc. v. Schwab Invs.*, No. 08-4119, 2009 U.S. Dist. LEXIS 12763, at *14 (N.D. Cal. Feb. 19, 2009) (“The Court concludes that there is an implied private right of action under Section 13(a).”).
- ² *Bellikoff*, 481 F.3d at 116 (“§ 42 of the ICA explicitly provides for enforcement of all ICA provisions *by the SEC* through investigations and civil suits for injunctions and penalties.”).
- ³ E.g., *Jones v. Harris Assocs. L.P.*, 527 F.3d 627 (7th Cir. 2008), *cert. granted*, 77 U.S.L.W. 3505 (U.S. Mar. 9, 2009) (No. 08-586); *Gallus v. Ameriprise Fin., Inc.*, 497 F. Supp. 2d 974 (D. Minn.), *appeal docketed*, No. 07-2945 (8th Cir. Aug. 22, 2007); *Amron v. Morgan Stanley Inv. Advisors Inc.*, 464 F.3d 338 (2d Cir. 2006); see generally Lori A. Martin, *Litigation Under the Investment Company Act of 1940*, in 2 MUTUAL FUND REGULATION 26-1 (Clifford E. Kirsch ed., 2008).
- ⁴ *Jones v. Harris Assocs. L.P.*, 77 U.S.L.W. 3505 (U.S. Mar. 9, 2009) (order granting certiorari).
- ⁵ 15 U.S.C. § 80a-35(b)(3) (2006).
- ⁶ See, e.g., *Forsythe v. Sun Life Fin., Inc.*, 417 F. Supp. 2d 100, 117 (D. Mass. 2006) (“I agree with the reasoning of the courts that have recently addressed this issue in the context of nearly identical sets of allegations against other mutual fund trustees that the trustees are not proper § 36(b) defendants where, as here, there are no allegations that the annual compensation received by the Trustee Defendants was in exchange for ‘advisory services’ or in some way represented advisory fees that were to be paid to the [advisor] but instead were diverted to the Trustee Defendants.”).
- ⁷ JAMES D. COX ET AL., *SECURITIES REGULATION* 1211 (3d ed. 2001) (observing that modern fee litigation “has resulted almost uniformly in judgments for the defendants . . . although there have been some notable settlements wherein defendants have agreed to prospective reduction in the fee schedule”).
- ⁸ See *TIG Specialty Ins. Co. v. Pinkmonkey.com, Inc.*, 375 F.3d 365, 370 (5th Cir. 2004) (“A defendant is not legally entitled to an advantage or profit resulting from his violation of law if he could be required to return such profit.”).
- ⁹ See *supra* Part I, Basic D&O/E&O Concepts, at “Loss” (bullet item regarding uninsurable items).

Fraud

Fraud claims constitute a relatively small percentage of fund industry claims, but do arise from time to time. Most notably, during the scandal period of 2003 and 2004, a number of advisers were charged with violating anti-fraud provisions of the federal securities laws and/or state common law in connection with their market-timing practices.

FRAUD EXCLUSIONS

Virtually all D&O/E&O policies contain express exclusions for fraud and other intentional misconduct,¹ reflecting the fact that D&O/E&O insurance, at its core, is designed to provide liability coverage for *negligence*-based conduct rather than *intent*-based conduct. Historically, insurance for intentional wrongdoing has been unavailable because of the acute “moral hazard” problem that such coverage would create.²

Of course, the fact that a claim *alleges* fraud does not mean that fraud has necessarily been committed. In this regard, it is important to recognize that fraud claims, like other fund industry claims, are typically resolved before any trial, and without any admission of misconduct by those charged. Indeed, the evidence relied on by regulators and/or civil litigants in support of fraud charges is frequently susceptible to differing interpretations, so as to leave room for argument over whether fraud has in fact occurred.

The foregoing reality raises the question of whether a fraud exclusion precludes insurance coverage for defense and settlement costs when the fraud was never established in the underlying proceeding. Several approaches to this issue exist.

Exclusion for “Alleged” Fraud

Here, the insurer must demonstrate only that fraud is *alleged* to have been committed. Thus, this formulation may permit an insurer to decline coverage even where evidence of an insured’s actual fraud is scant or nonexistent.³ This formulation now appears to be uncommon in mutual fund D&O/E&O policies.

Exclusion for “Final Adjudication” of Fraud

Here, the insurer must demonstrate that fraud has been established by a “final adjudication.”⁴ Depending on the particular wording of the exclusion, this formulation may be interpreted to mean that there must be a “final adjudication” of fraud in the underlying lawsuit or regulatory proceeding itself.⁵ But, as noted, “final adjudications” very rarely occur in the fund industry because lawsuits and proceedings are typically resolved prior to trial, through settlements or otherwise, and without any admission of misconduct. Thus, this formulation may prevent an insurer from declining coverage, even where evidence of an insured’s actual fraud is strong or dispositive.⁶ Indeed, as a practical matter, this formulation may be tantamount to having no fraud exclusion at all.

Exclusion for “Actual” Fraud

Here, the insurer must demonstrate that there has been “actual” fraud (or, similarly, that there has been fraud “in fact”). This formulation thus preserves insurance coverage for claims based solely on unfounded *allegations* of fraud, but precludes coverage where *actual* fraud has been committed. As such, it represents a middle way between the two formulations discussed above.

Selecting the Appropriate Exclusion

Insurance brokers and insurance consultants generally agree that fund industry insureds should avoid the first formulation (alleged fraud) wherever possible.

As between the second formulation (final adjudication) and the third (actual fraud), some brokers and consultants strongly favor the final adjudication formulation, reasoning that it maximizes the potential for insurance recovery in fraud claims. On this question, however, the perspective of funds and their independent directors may differ from the perspective of advisers and other service providers.

First (and as the 2003-04 scandal period clearly illustrates), any “fraud risk” in the fund industry is overwhelmingly an *adviser* risk, rather than a fund or independent director risk. Indeed, it is difficult to envision how independent directors could have an opportunity to engage in actual fraud, or under what set of circumstances they might have the motive to do so.

Second, with regard to a “joint” policy (in which advisers or other service providers are also insureds), the use of final adjudication language may have the paradoxical effect of placing funds and fund independent directors at *increased* risk. This is because such language may permit an adviser who has clearly engaged in fraud to obtain insurance by settling the underlying claim (thereby avoiding a “final adjudication” of fraud), which, in turn, may exhaust or deplete the shared insurance policy limit that would otherwise be available to funds and their directors.

In addition, because an adviser committing actual fraud may be in a position to avoid a “final adjudication” exclusion by settling the underlying claim, some fund boards may have other concerns regarding this type of fraud exclusion.

RELATED NEGLIGENCE ALLEGATIONS

In particular lawsuits, plaintiffs may allege both fraud and negligence. Where a fraud exclusion precludes coverage (e.g., for an insured service provider that committed actual fraud), coverage may also be precluded for related negligence allegations. Otherwise, plaintiffs could engineer insurance coverage for excluded conduct merely by adding allegations of negligence to their complaints.⁷

However, even in such lawsuits, potential coverage may be preserved for *other* insureds who did *not* themselves commit fraud (e.g., independent directors of an affected fund) if the policy provides for “exclusion severability.” A severability clause ensures that the excluded conduct of one insured (e.g., the insured service provider) may not be imputed to other specified insureds (e.g., independent directors) for purposes of the exclusion.⁸ (See Part IV, Severability, at “Exclusion Severability.”)

Endnotes

- ¹ Although such an exclusion typically reaches intentional wrongdoing in addition to fraud (e.g., dishonesty, criminal acts, intentional violations of law), it is common to refer to the exclusion as a “fraud exclusion.”
- ² “‘Moral hazard’ is the term used to denote the incentive that insurance can give an insured to increase the risky behavior covered by the insurance.” *May Dep’t Stores Co. v. Fed. Ins. Co.*, 305 F.3d 597, 601 (7th Cir. 2002). In light of this hazard, coverage not only for fraud, but for intentional misconduct generally, may be precluded by general “public policy” considerations (separate and apart from any exclusions in D&O/E&O policies themselves). *See, e.g.*, *Cal. Ins. Code* § 533 (Deering, LEXIS through 2007-08 3d Extraordinary Sess.) (“An insurer is not liable for a loss caused by the wilful act of the insured”); *Capitol Indem. Corp. v. Evolution, Inc.*, 293 F. Supp. 2d 1067, 1074 (D.N.D. 2003) (“Even if the insurance policy did not specifically exclude coverage in the present case, public policy precludes an insured from being indemnified for

losses caused by the insured's intentional or willful conduct.”).

- ³ The exclusion is sometimes modified to permit an insured to recover its defense costs if it ultimately “disproves” the allegations of fraud “by a final adjudication favorable to the insured.”
- ⁴ *See, e.g., Newby v. Enron Corp.* (In re Enron Corp. Secs., Derivative & ERISA Litig.), 391 F. Supp. 2d 541, 572 (S.D. Tex. 2005) (“[T]here must be a ‘final adjudication’ by a judge finding the insureds committed or attempted acts of dishonesty and fraud to preclude coverage.”).
- ⁵ *See, e.g., Atl. Permanent Fed. Sav. & Loan Ass’n v. Am. Cas. Co.*, 839 F.2d 212, 216-17 (4th Cir. 1988) (per curiam) (affirming district court’s holding that exclusion precluded recovery only when the dishonest behavior was established in the underlying action itself, “rather than a subsequent coverage suit”).
- ⁶ In regulatory settlements with the SEC, such evidence may be recited in so-called “findings of fact” by the agency. However, because SEC settlement orders ordinarily state that the respondent has consented to the settlement “without admitting or denying” such findings, the findings would

appear unlikely to constitute a “final adjudication.” *Cf. Nat’l Union Fire Ins. Co. of Pittsburgh, Pa. v. Cont’l Ill. Corp.*, 666 F. Supp. 1180, 1197 (N.D. Ill. 1987) (holding that, when the underlying lawsuits had “settled without any sort of adjudication or admission of wrongdoing by defendants,” the dishonesty exclusion did not apply, “because by its own terms that exclusion is limited to situations where the underlying litigation has ‘established,’ by ‘a judgment or other final adjudication,’ the insureds’ commission of ‘acts of active and deliberate dishonesty’”).

- ⁷ *See, e.g., Nat’l Union Fire Ins. Co. of Pittsburgh, Pa. v. AARPO, Inc.*, No. 97-cv-1438, 1999 U.S. Dist. LEXIS 181, at *14 (S.D.N.Y. Jan. 14, 1999) (“[S]trong public policy militates against a rule allowing a plaintiff to impel a defendant’s insurance carrier to provide a costly defense for intentional culpable conduct that it expressly excluded from coverage, simply by adding a claim of negligence.”).
- ⁸ *See, e.g., SEC v. Credit Bancorp., Ltd.*, 147 F. Supp. 2d 238, 265 (S.D.N.Y. 2001) (“[T]he last sentence of the specific exclusion for dishonesty and fraud . . . expressly states that the exclusion does not apply to persons other than the dishonest actor.”).

Costs of Correcting Operations-Based Errors

Operations-based errors by advisers (e.g., pricing errors, mishandling of corporate action requests, and failures to adhere to investment restrictions) may result in financial losses for funds or private advisory clients,¹ who in turn may expect their advisers to compensate them for these losses.

For various reasons, including understandable and legitimate concerns by advisers over the financial and reputational risks associated with litigation, it is rare in the fund industry for aggrieved funds or private advisory clients to file lawsuits (or even to make formal demands) against their advisers in such situations. Rather, the issue of financial responsibility for operations-based losses is generally resolved through a process of negotiation between the parties.

INSURANCE COVERAGE

D&O/E&O insurance is traditionally written on a “claims made” basis, meaning that the availability of coverage is triggered only when a “claim” has been made against the insured during the policy period.² Thus, under a traditional D&O/E&O policy, an actual lawsuit must be filed by a fund or private advisory client (or, under some policies, there must at least be a formal demand made) in order for an insured adviser to seek insurance recovery for amounts paid to remedy its error.

An operations-based error may thus leave an adviser faced with a dilemma: wait for the aggrieved fund or private advisory client to sue (thereby triggering the potential availability of insurance) or unilaterally correct the mistake (thereby foregoing any insurance recovery). Some mutual fund D&O/E&O insurers provide special coverage designed to address this dilemma, either as a standard part of their policy forms, or by separate endorsement.

Generally, under this coverage (commonly referred to as “costs of correction” coverage), the insurer agrees to reimburse the adviser for costs incurred to correct an operational loss *if* the adviser has actual *legal liability* for the loss.³ Conversely, the coverage does *not* extend to payments made by the adviser as a business accommodation, to avoid reputational damage, or for any other reason apart from its own actual legal liability.

Costs of correction insurance is an E&O coverage, and thus is available only to remedy legal liabilities of insured entities.⁴ Because operations-based losses in the fund industry are generally traceable back to the acts or omissions of advisers or other service providers (rather than to the acts or omissions of funds themselves), costs of correction coverage is generally regarded as an adviser coverage. Yet, because operational mistakes can cause funds to incur a loss, this coverage, as a practical matter, also benefits the affected funds and their shareholders.

OUTSOURCING

In recent years, it has become more common for fund advisers and other major service providers affiliated with funds to subcontract, or “outsource,” specialized functions to unaffiliated third-party vendors. Outsourcing creates unique operational risks that have received increasing attention from industry regulators and other observers.⁵

Also, outsourcing may create uncertainty as to (1) when an adviser (or other affiliated service provider) may be held financially responsible to its funds for operations-based losses arising from outsourced functions, and (2) the availability of costs-of-correction coverage for the adviser (or other insured service provider) with respect to such losses.⁶

Endnotes

- ¹ Note that an adviser may elect to purchase a single policy that covers both its services to mutual funds *and* its services to private advisory accounts.
- ² See *supra* Part I, Basic D&O/E&O Concepts, at “Claims Made.”
- ³ The coverage also typically requires the insured to obtain advance consent from the insurer before incurring any costs for which it may seek insurance recovery.
- ⁴ See *supra* Part I, D&O/E&O Insurance—In General, at “E&O.”
- ⁵ See, e.g., Andrew J. Donohue, Dir., Div. of Inv. Mgmt., U.S. Secs. & Exch. Comm’n, Remarks Before the ICI Operations & Tech. Conference (Oct. 18, 2007), <http://sec.gov/news/speech/2007/spch101807ajd.htm> (“With the trend toward a more horizontal structure, where critical functions are increasingly contracted to third parties, gaps are created within the operational process and perfect coordination becomes more difficult.”); *Thorough Vendor Reviews Are Key, Says Panel*, FUND ACTION, June 11, 2007, at 7, 7 (reporting panel’s view that onsite review of service providers “greatly reduces the risk of outsourcing”).
- ⁶ See generally ICI MUT. INS. CO., OUTSOURCING BY ADVISERS AND AFFILIATED SERVICE PROVIDERS (2008) (examining these issues).

Part III

Structuring a Program

The Appropriate Amount of Policy Limits

D&O/E&O insurance policies are issued with a specified aggregate limit. This means that each individual policy is subject to a maximum dollar limit on the amount that the insurer may be required to pay, individually or collectively, to any and all insureds for any and all insurance claims under that policy. This maximum dollar limit is referred to as the policy's "limit of liability," and may range from hundreds of thousands to hundreds of millions of dollars, depending upon the limits that individual insurers are prepared to offer and that insureds deem appropriate for their own protection.

Investment companies are under no regulatory obligation to purchase D&O/E&O insurance in any minimum amount. Thus, the question of "how much" D&O/E&O coverage to purchase is necessarily a business judgment that may be influenced by a number of factors; and, as for the funds' own coverage, the ultimate responsibility for this judgment necessarily rests with fund boards.

In reaching such a judgment, fund boards frequently consult with representatives of other joint insureds, with their insurers, and with their insurance consultants. Among the factors that may be useful for boards to consider are the following:

- **Assets under management.** Some fund boards find it useful to know the amount of limits purchased by fund groups of comparable size. Upon request, some insurers and insurance brokers are willing to provide information (on a no-name basis) regarding amounts of limits purchased by an insurance applicant's peer fund groups.
- **Scope of coverage.** Another factor that may be relevant is the scope of coverage afforded under the policy being purchased. For example, is the policy funds only or is it a joint policy that also covers advisers and other affiliated service providers?¹ If the policy is joint, do the insured service providers have coverage only for the services that they render to insured funds, or do they also have coverage for services rendered to others (e.g., private advisory accounts)? Generally, a larger scope of coverage may warrant higher limits, inasmuch as the policy limit will be exposed to a greater number of risks.
- **Availability of other coverage.** Advisers and other non-fund entities that are part of a larger financial holding company may have liability coverage under a separate insurance policy issued to the ultimate parent company, possibly suggesting a need for lower limits in any joint policy that may be under consideration by the fund board.
- **Claims history.** If the fund complex has been "on the radar" of the plaintiffs bar, it may be appropriate to consider the purchase of additional limits.
- **Indemnification risk.** It bears noting that independent fund directors typically have a right (under state indemnification statutes and/or provisions in fund charters or bylaws) to be

reimbursed from fund assets for certain of their liabilities and legal expenses. In this regard, the purchase of adequate insurance limits may be viewed as a “hedge” against the risk to fund assets posed by the fund’s indemnification obligation.²

Endnotes

- ¹ See *generally infra* Part III, Funds-Only Policy Versus Joint Policy.
- ² See *supra* Part I, D&O/E&O Insurance—In General, at “D&O” (discussing corporate reimbursement coverage as a hedge against fund’s own indemnification risk).

Funds-Only Policy Versus Joint Policy

It is uncommon for funds within a single fund complex to purchase a separate D&O/E&O policy for each individual fund. Rather, a single policy typically covers all funds within the complex (or certain groupings of funds, as when a single complex has multiple “cluster boards”) together with the directors and officers of those funds. Where a policy insures only the foregoing, it is commonly known as a “funds-only” policy.

Where a policy is structured to extend beyond the foregoing, to also include as insureds one or more affiliated advisers and/or other affiliated service providers (together with the providers’ own directors and officers), the policy is commonly known as a “joint” policy.¹ Under a joint policy, coverage for the service providers may be limited to services provided only to investment companies, or the coverage may also extend to services provided to others (e.g., private advisory accounts).

As with other options involving D&O/E&O insurance, the selection between a funds-only policy and a joint policy is a business judgment for the affected funds’ directors.

While this section discusses two of the most commonly-used options for structuring a mutual fund D&O/E&O insurance program—“funds only” and “joint”—other options and variations exist. For fund groups seeking additional information regarding these other options and variations, consultation with counsel or other insurance consultants may be appropriate.

JOINT POLICY

Joint policies are often the most cost-effective approach to purchasing insurance, and frequently

permit individual funds (and their directors and officers) to secure more aggregate coverage at lower overall premiums than would otherwise be feasible for them.²

Also, where funds and service providers are insured under separate policies issued by different insurers, there may be some dispute with and among the insureds and the various insurers as to which policy should respond to a loss within the fund complex. In contrast, a joint policy lessens that risk. In ICI Mutual’s experience, the majority of fund groups purchase joint policies.

That being said, joint policies often create allocation complexities (i.e., how to allocate premiums and/or recoveries³) and erosion risk (i.e., the risk that losses of advisers or service providers will erode the policy limits that would otherwise be available to funds and fund directors⁴). Resolution of these issues—such as “reserving” a certain amount of coverage for funds and independent directors, and/or negotiating some sort of allocation agreement to determine order of payments and related issues should claims arise—can entail considerable analysis and discussion within the complex.

FUNDS-ONLY POLICY

Funds-only policies eliminate most of the issues associated with joint policies discussed above. Also, a funds-only policy may make sense when the adviser and other non-fund entities already have coverage through a parent company’s insurance program (as may be the case when the fund complex is just one of several business units in a larger organization).

Endnotes

¹ While “funds-only” and “joint” policies have the commonly understood meanings discussed above, the SEC, as a technical matter, views *any* policy in which one registered investment company shares coverage with another entity as a “joint” policy. Under this more technical meaning, a policy that insures multiple investment companies is thus a “joint” policy, even if the policy does not insure the funds’ advisers or other service providers. Both types of “joint” policy are permissible under rule 17d-1(d)(7) of the ICA provided that certain conditions are met (e.g., a majority of the independent directors must determine that the joint policy is in the best interest of the fund). 17

C.F.R. § 270.17d-1(d)(7) (2008), LEXIS 17 CFR 270.17d-1.

- ² See Exemption of Certain Joint Purchases of Liability Insurance Policies, Investment Company Act Release No. 10,700 (May 16, 1979), 1979 SEC LEXIS 1544 (“This arrangement . . . may induce individual insurance companies to underwrite more extensive coverage, and may result in lower aggregate premiums.”).
- ³ See *infra* Part III, at Premium Allocation Under a Joint Policy.
- ⁴ See *infra* Part IV, at Preserving Insurance Limits for Independent Directors.

Premium Allocation Under a Joint Policy

When both funds and non-funds (i.e., the funds' investment adviser and other affiliated service providers) are insured under a joint D&O/E&O policy, fund boards typically consider what portion of the joint policy's premium should be allocated to non-funds.

The SEC requires, as a minimum fairness standard,¹ that the allocation to funds under a joint policy be based upon funds' "proportionate share of the sum of the premiums that would have been paid if such insurance coverage were purchased separately by the insured parties."² At the same time, however, the SEC recognizes that a fund group "may be unable, in good faith, to secure quotations for separate coverage" for each fund within the group; and, in such circumstances, expressly allows for allocation "under a reasonable formula."³

Insurers and insurance consultants are sometimes asked to provide their views with regard to an appropriate premium allocation. While they are often willing to do so, it is important to recognize that their views are just one of multiple factors that may be relevant for fund boards to take into consideration when arriving at business judgments regarding appropriate premium allocations. Indeed, different fund groups may have different preferences regarding allocation methodologies, resulting in premium allocations that may vary from one group to the next.

Among the factors that may be relevant for boards to consider in arriving at premium allocations in a joint policy are the following:

- ***Private advisory assets relative to fund assets.*** If private advisory services are covered under a joint policy and private advisory assets are a significant percentage of total assets under management by the fund complex, then it may be appropriate to allocate more premium to insured advisers relative to insured funds.
- ***Prior losses attributable to service providers.*** A fund complex's actual loss history may be instructive. The more defense costs and settlement payments that have been attributable to advisers or non-funds in the past, then possibly the more premium that should be allocated to them (relative to insured funds) in the future.
- ***Prior premium allocations.*** Premium allocations used by a fund group in prior years can be an additional guide, unless a rational basis for departure from prior practice is identified (such as acquisitions, mergers, and other material changes to the relative risks of funds and non-funds).
- ***Separate premium quotations.*** Some fund groups request the extra step of separate premium quotations for, respectively, a funds-only and provider-only policy; calculate the proportionate share of the total represented by each quotation; and then use these same shares as an additional factor to consider.⁴

Endnotes

- ¹ Exemption of Certain Joint Purchases of Liability Insurance Policies, Investment Company Act Release No. 10,891 (Oct. 4, 1979), 1979 SEC LEXIS 571 (“[A]ny allocation formula which would be more advantageous to the investment company than the minimum standard of fairness required by the rule would satisfy the fairness standard of the rule.”).
- ² 17 C.F.R. § 270.17d-1(d)(7) (2008), LEXIS 17 CFR 270.17d-1.
- ³ Exemption of Certain Joint Purchases, *supra* note 1.
- ⁴ *But see supra* text accompanying note 3.

Single-Insurer Program Versus Multiple-Insurer Program

One basic insurance choice faced by many fund groups is whether to place their D&O/E&O insurance with a single insurer, or rather to place it with multiple insurers in a “layered” insurance program.

For example, one fund group may decide to purchase \$100 million in D&O/E&O coverage from a single insurer in a single policy. By contrast, another fund group might instead opt for a “layered” \$100 million program, under which the first \$10 million of loss is contracted to one insurer (known as the “primary” insurer), the second \$15 million to another insurer (known as the “first-level excess” insurer), and so on. In layered programs, excess carriers often “follow form” to (i.e., incorporate the terms and conditions of) the primary policy.

As with other options involving the structuring of D&O/E&O insurance, the decision between a single-insurer program or a layered program is a business judgment for the affected funds’ board of directors. On the one hand, splitting a program among multiple insurers may appear to diversify the risk of insurer insolvency: if one insurer in a layered program becomes insolvent, at least there remains additional layers of insurance provided by solvent insurers.

On the other hand, the risk of insurer insolvency can be mitigated by selecting only highly rated, well capitalized insurers.¹ Moreover, the risk of catastrophic losses bankrupting an insurer may be smaller than it appears, because many insurers themselves purchase insurance from *other* insurers (known as “reinsurers”) for all or part of the original risk.² A catastrophic loss will thus often be shared among the original insurer *and* a number of reinsurers. ICI Mutual, for example, has historically retained only a portion of risk on the D&O/E&O policies that it issues.

Convenience of the claims-adjustment process may be another pertinent consideration for many insureds. In a layered program, the policyholder must seek recovery separately from its primary insurer and from each excess insurer whose coverage may be implicated. If the primary insurer *denies* coverage, the “follow form” excess carriers are likely to adopt that same position with respect to their own layers. However, if the primary insurer *affords* coverage, that determination is not necessarily binding on the excess insurers. Also, a negotiated insurance settlement with the primary insurer for less than the primary policy’s limits may itself generate a coverage dispute with an excess insurer.³

In a single-insurer program, by contrast, the policyholder need interface with only the insurer (and not with any reinsurers of the insurer), and the policyholder may seek full coverage from its single insurer up to the stated policy limit in the event of a covered loss. In these ways, *single-insurer* programs can lessen the administrative burden on the fund group of a very large insurance claim (a context in which the fund group may rather attend to the underlying lawsuits or regulatory investigation), and reduce the risk of coverage disputes with excess layers.

Finally, a given insurer’s willingness to write large limits may be another factor that effects an insured’s choice between a single-insurer or a layered program. In recent years, many mutual fund D&O/E&O insurers—in order to manage their overall “aggregation” risk—have reduced the overall limits they are willing to write for individual fund groups, even as the insurance requirements of many fund groups have increased. Indeed, few mutual fund D&O/E&O insurers remain willing to write very large insurance limits; most insurers now re-

strict the “capacity” that they are prepared to provide on individual fund group insurance programs.

Endnotes

¹ In this regard, many policyholders refer to ratings and analysis provided by A.M. Best Company in order to assess the financial strength and creditworthiness of insurers and other risk-bearing entities. *See generally* About A.M. Best, <http://www.ambest.com/about/> (last visited Aug. 5, 2008).

² *See generally* P.T. O’NEILL & J.W. WOLONIECKI, *THE LAW OF REINSURANCE IN ENGLAND AND BERMUDA 4* (1998) (“The laying off of risk by means of reinsurance traditionally serves three basic purposes. First, reinsurance can increase the capacity of the insurer to accept risk. The insurer may be enabled to take on larger individual risks, or a large number of smaller risks, or a combination of both Secondly, reinsurance can promote financial stability by ameliorating the adverse consequences of an unexpected accumulation of losses or of single catastrophic losses, because these will, at least in part, be ab-

sorbed by reinsurers. Thirdly, reinsurance can strengthen the solvency of an insurer from the point of view of any regulations under which the insurer must operate which provide for a minimum ‘solvency margin,’ generally expressed as a ratio of net premium income over capital and free reserves.”).

³ *See, e.g.,* *Comerica Inc. v. Zurich Am. Ins. Co.*, 498 F. Supp. 2d 1019, 1034 (E.D. Mich. 2007) (holding that primary policy’s \$20 million liability limit was not exhausted by the primary insurer’s negotiated insurance payment of \$14 million); Eric S. Connuck, *Excess D&O Insurance*, *BUS. L. TODAY*, Sept./Oct. 2008, at 45, 45 (“[T]he risk of a possible forfeiture of excess coverage must be factored into any compromise of a coverage dispute that includes less than all of the involved insurers.”); Susanne Scalfane, *“Workouts” Leave Buyers Battling Up D&O Coverage Towers*, *NAT’L UNDERWRITER*, July 7/14, 2008, at 21, 21 (“Buyers of directors and officers liability coverage who have settled claims with their primary insurers may find disgruntled excess carriers unwilling to pay out on their layers for large claims—even when excess policies contain ‘follow-form’ language.”).

Continuity of Coverage When Changing Insurers

When moving a D&O/E&O insurance program from one insurance carrier to another, insureds typically will consider “continuity of coverage” between their expiring insurance program and their new insurance program.

PRIOR ACTS EXCLUSIONS

By way of background to the issue of “continuity of coverage,” it is helpful to appreciate that D&O/E&O policies are “claims-made” policies—meaning that coverage is potentially available for lawsuits (or other “claims”) that are first made during the policy period *regardless* of when the conduct giving rise to the claims may have occurred.¹

In this sense, a claims-made policy may be viewed as providing not only “prospective” coverage for *future* acts (i.e., coverage for claims arising from acts or omissions occurring *after* the policy incept), but also “retroactive” coverage for *prior* acts (i.e., coverage for claims arising from acts or omissions occurring *before* the policy incept).

When a fund group moves its insurance program to a new insurer, the drawback from the new insurer’s perspective is straightforward: exposure to wrongful acts already committed, for which acts the new insurer was not able to underwrite or charge any premium. Indeed, for all the new insurer knows, there may be some pre-existing circumstances that will very shortly bloom into a lawsuit or other claim against the insured.

Although a policy may already exclude *prior and pending litigation* (i.e., litigation brought prior to, or pending as of, the inception date of the policy) as well as claims that were the subject of *prior notice* under a prior policy, neither exclusion entirely ad-

dresses the new insurer’s concern. That is, there may very well exist prior wrongful acts that, while not the subject of prior notice or of prior and pending litigation, could nevertheless give rise to a future lawsuit or other claim against the prospective insured.

There are generally three approaches that a new insurer may take in response to concerns regarding exposure to wrongful acts already committed.

- **Full prior acts exclusion.** Most advantageous to the new insurer, and most disadvantageous to an insured, is a full “prior acts” exclusion, which eliminates coverage for any future claim that is based on “prior acts”—i.e., acts or omissions that occurred prior to the inception date of the new policy. This approach excludes coverage for all future claims based on prior acts, including claims that are unforeseeable to the insured at the date the new policy incept.
- **No prior acts exclusion.** Most disadvantageous to the new insurer, and most advantageous to an insured, is the absence of any prior acts exclusion. This approach may leave the insurer fully exposed to all future claims, including even those future claims that are foreseeable to the insured (but not to the insurer) at the date the new policy incept.²
- **Balanced prior acts exclusion.** This approach attempts to disadvantage neither the insurer nor the insured.

Specifically, future claims that are foreseeable to the insured at the date the new policy incepts are excluded, but future claims that are *un*foreseeable are *not* excluded. Thus, coverage is available for future claims based on prior acts or omissions, unless the insured either knows or could reasonably foresee (prior to the policy period) that such prior acts or omissions might later lead to claims. This type of exclusion is also known as a “prior knowledge” exclusion.

ENSURING CONTINUITY OF COVERAGE

For their part, insureds understandably wish to avoid the possibility that a future claim may be denied under *both* their expiring policy (because the claim was not made until after that policy expired) *and* their new policy (because the claim is excluded under a prior acts exclusion).

If it is not an option to have no prior acts exclusion in the new policy (either because the new insurer is unwilling to issue a policy without such an exclusion, or because the insured does not want to expose its new policy limits to future claims arising out of old wrongful acts), there are various other steps that can be taken in order to seek to address continuity of coverage concerns.

- ***Investigate potential future claims.*** At the outset, insureds may wish to investigate within their organization as to any circumstances that could conceivably ripen into a lawsuit or other claim at a future date. For example, it may be appropriate to poll appropriate employees within the organization who

may have knowledge of such circumstances.

- ***Submit a precautionary notice under the expiring policy.*** D&O/E&O policies typically permit insureds to file “precautionary notices” of circumstances that may give rise to a future lawsuit or other claim; then any future claim arising out of those circumstances will be treated as though it had been made during the period of the expiring policy (thereby triggering potential coverage under the expiring policy). Thus, when an insured’s internal investigation of potential claims identifies a foreseeable lawsuit or regulatory investigation, the insured can typically preserve coverage under its expiring policy by providing requisite notice of the relevant circumstances.³
- ***Obtain a balanced prior acts exclusion in the new policy.*** Even after an appropriate investigation, there may yet exist a potential for a future claim that is simply not foreseeable. Potential coverage for such unforeseeable claims may be ensured by obtaining a new insurance program having the balanced prior acts exclusion described above.
- ***Consider purchasing tail coverage from the old insurer.*** When changing insurers, a fund group can obviate its need for prior acts coverage from the new insurer by purchasing “tail” coverage from the old insurer. Tail coverage is generally designed to provide coverage for claims first made *after* the policy expires that are based on conduct that

occurred *prior to* the policy's expiration date.⁴

Endnotes

¹ See *supra* Part I, Basic D&O/E&O Concepts, at "Claims Made."

² See generally *Nat'l Union Fire Ins. Co. v. Cont'l Ill. Corp.*, 673 F. Supp. 300, 304 (N.D. Ill. 1987) (noting that the insurer that provides full retroactive coverage on claims-made policies "can be the victim of what the insurance trade calls 'adverse selection': the phenomenon that people who already know they have the greatest risks are more likely to seek insurance coverage").

³ The provisions regarding such precautionary notices generally require that the insured provide the insurer with specified information regarding the potential future claims, and that this information be provided *before* the policy's expiration. See *supra* Part I, Basic D&O/E&O Concepts, at endnote 8.

⁴ *Myers v. Interstate Fire & Cas. Co.*, No. 8:06-cv-2347, 2008 U.S. Dist. LEXIS 7053, at *6 n.4 (M.D. Fla. Jan. 30, 2008) ("Tail coverage picks up where the claims-made policy leaves off, with respect to acts committed during the original policy period. Tail coverage does not provide indemnity for new negligent acts or omissions committed during the tail period.").

Fund Acquisitions, Mergers and Liquidations

It is not uncommon, during a policy period, for a fund to be acquired, merged or liquidated. These events raise the issue of coverage for a *future* lawsuit (or other “claim”) that arises out of wrongful acts that were allegedly committed by the acquired, merged, or liquidated fund (and/or its directors and officers) *before* the acquisition, merger, or liquidation.

The following discussion concerns the case of an acquired, merged or liquidated fund that is a separate legal entity (i.e., a registered investment company). Where the fund at issue is not itself a registered investment company, but is instead a *series* of a registered investment company, then the coverage issues may be different, such that consultation with counsel or other insurance consultants may be appropriate.

ACQUISITIONS

In general, D&O/E&O policies are “claims made” policies, meaning that the potential availability of coverage is triggered by the commencement of a lawsuit (or other “claim”) against *an insured* during the policy period. Thus, in order for an acquired fund to have potential coverage under the acquiring fund group’s policy, the acquired fund must be *named as an insured* under the acquiring fund group’s policy at the time the lawsuit is filed.

However, when an acquiring fund group seeks to accomplish the foregoing (i.e., to add the newly acquired fund as an insured in the acquiring fund group’s policy, whether by endorsement mid-policy or in a renewal policy), the insurer will no doubt wish to consider the risk posed by the acquired fund. After all, the insurer has not previously underwritten, or charged premiums for, the acquired fund’s prior activities.

Often, the insurer may agree to add the acquired fund as an additional insured under the acquiring fund group’s policy, and to afford coverage to the acquired fund (and its directors and officers) for their *post*-acquisition acts. However, the insurer will normally apply some type of exclusion for *pre*-acquisition acts. (See the discussion of “prior acts” exclusions at Part III, Continuity of Coverage When Changing Insurers.)

In order to address the possibility that post-acquisition lawsuits (or other “claims”) will be brought based on pre-acquisition acts, the acquired fund (or its former adviser) often arranges for the purchase of “tail” coverage for the acquired fund (and its former directors and officers). In this context, tail coverage, which is typically obtained from the acquired fund’s prior insurer, is generally designed to afford protection for future lawsuits or investigations that are based on such pre-acquisition acts.

Insurers are frequently prepared to provide tail coverage for former insureds. The coverage can be arranged for various time periods, but ordinarily is not indefinite in duration. Known as the “tail period,” the duration is commonly three or six years.¹

MERGERS

Funds may lose their separate legal existence by being merged into other existing funds. Mergers frequently raise insurance issues similar to those discussed above with regard to acquisitions.

As regards the *surviving* entity (i.e., the existing fund into which another fund is merged), most policy forms afford an insurer the right to obtain contemporaneous information about mergers, and to adjust

terms, conditions and/or premium for the surviving entity. (Again, the concern from the insurer's perspective is that its risk may have materially changed as a result of the merger, with no corresponding underwriting or change in premium.) Thus, while the surviving fund may generally continue post-merger as an insured under its existing policy, its coverage (and that of its directors and officers) may not extend to liabilities of the surviving fund that arise from the pre-merger acts of the "disappearing" fund, at least where the disappearing fund was not previously an insured under the same policy.

As for the *merged* entity (i.e., the disappearing fund), the termination of its legal existence ought to eliminate its own risk of liability in future lawsuits (or other "claims"); but its past directors and officers may remain at risk for future liability arising out of acts that were allegedly committed by them before the merger. Yet there may be no coverage for them under the surviving fund's policy (because they are not past directors of any fund that will be named in that policy at the time the future lawsuit is filed).

In these circumstances, the existing insurer of the merged entity's fund group may be willing to continue to provide coverage to the merged fund's former directors and officers under that fund group's ongoing insurance program. If such coverage is unavailable, then special arrangements—in the form of a separate tail policy or otherwise—may be appropriate.

LIQUIDATIONS

Fund liquidations raise insurance issues similar to those discussed above with regard to mergers. Again, from the perspective of the liquidated fund, there ought to be little or no risk of liability for the entity itself in future lawsuits (or other "claims") because the fund's legal existence will typically terminate as a result of the liquidation. By contrast, the directors and officers of the liquidated fund may remain at risk for future lawsuits (or other "claims") arising out of acts that were allegedly committed by them before the liquidation.

As previously noted with respect to merged funds, the existing insurer of a liquidating entity's fund group may be willing to continue coverage under that fund group's ongoing insurance program for the liquidating fund's past directors and officers. If such coverage is unavailable, the past directors and officers of the liquidated fund may wish to consider other arrangements, in the form of a separate tail policy or otherwise.

Endnotes

- ¹ See *generally* Home Ins. Co. v. Law Offices of Jonathan DeYoung, P.C., 32 F. Supp. 2d 219, 224 (E.D. Pa. 1998) ("Tail coverage provides insurance protection for acts, errors, or omissions that occurred while the initial claims-made policy was in effect, so long as a claim is asserted before the expiration of the tail period.").

Part IV

Issues Specific to Independent Directors

Preserving Insurance Limits for Independent Directors

A single “joint” policy insuring independent directors, funds, and service providers is generally the most cost-effective basis on which a fund group can purchase D&O/E&O coverage. However, a joint policy necessarily involves some risk (known as “erosion risk”) that claims against *one* insured will erode the policy limits that would otherwise be available to *other* insureds. In recent years, many fund groups have considered a variety of mechanisms to address independent directors’ concerns in this regard.

RESERVED LIMITS

With reserved limits, a layer of the overall limit of a joint policy is reserved for the exclusive use of independent directors. The independent directors also have access to the policy’s joint layer, and the reserved layer becomes available to the independent directors after the policy’s joint layer has been used up.

INTERNAL AGREEMENTS

Another alternative is an internal agreement—between the independent directors and other insureds, and not involving the insurer—under which the independent directors are guaranteed some minimum amount of coverage and/or coverage is preallocated among insureds in the event losses exceed the policy limit.

“PRIORITY OF PAYMENT” PROVISIONS

In lieu of an internal agreement, directors sometimes inquire about a “priority of payment” endorsement in their insurance policy. Such a provision directs that, in the event a covered loss has occurred, insurance is paid first for loss incurred by directors and officers under the policy’s D&O insuring agreement before any insurance payment is made to an entity under the policy’s E&O insuring agreement. By

specifying a priority of payment in the insurance contract, this approach limits the flexibility that a fund group might otherwise have to coordinate when and how much each insured gets paid.

STAND-ALONE INDEPENDENT DIRECTOR POLICY

An alternative option for independent directors is a stand-alone insurance product for, exclusively, independent director liability (IDL).

An IDL policy is typically placed above (i.e., in excess of) underlying D&O/E&O coverage. Thus, as with the typical excess policy, an IDL policy affords coverage in the event that the underlying coverage has been depleted through payment of claims. However, whereas a typical excess policy affords coverage *only* in that situation, an IDL policy may also “drop down” to provide primary coverage to independent directors in a number of other situations as well (e.g., if the underlying coverage is canceled by any insured other than the independent directors, terminated by reason of acquisition or merger, or uncollectible as a result of insurer insolvency).

Other advantageous features that may be available in an IDL policy include—

- the extension of coverage not only to non-indemnifiable losses but also to indemnifiable losses as well.
- fewer exclusions than are typically found in standard form D&O/E&O policies, and
- limits on an insurer’s ability to rescind or cancel.

Severability

In recent years, some fund groups have voiced interest in the insurance concept known as “severability.” Generally, there are two types of severability—“exclusion” severability and “application” severability—and both types concern the impact of *one* insured’s conduct on *another* insured’s coverage. As such, they may be of particular interest to independent directors who share mutual fund D&O/E&O policy limits with advisers and “insider” directors and officers.

EXCLUSION SEVERABILITY

Exclusion severability generally means that excluded conduct by one insured (such as an insured adviser) will not be imputed to other insureds for purposes of affecting their insurance coverage. As a result, insurance coverage can be available for innocent fund directors, even if other insureds have engaged in fraud or other conduct for which coverage is excluded under the policy.¹

While mutual fund D&O/E&O policy forms often contain provisions that ensure exclusion severability for insured *individuals* (i.e., officers and directors, including independent directors), exclusion severability may not always be available for insured *entities*.

APPLICATION SEVERABILITY

Application severability generally means that a material misrepresentation by one insured on an insurance application will not permit an insurer to void or rescind insurance coverage as to one or more other insureds.²

Whereas *exclusion* severability may indeed be an important policy feature (given the number of standard

D&O/E&O exclusions, and the risk that an underlying lawsuit may implicate one of them), *application* severability has lesser practical importance in the mutual fund arena. This is because mutual fund D&O/E&O insurers are unlikely, except in the most egregious circumstances, to seek to rescind insurance policies. Indeed, ICI Mutual is unaware of any examples of actual rescission of insurance policies in the mutual fund arena, even in the wake of the 2003-04 trading scandal.

Notwithstanding its limited importance, mutual fund D&O/E&O insurers may offer application severability, particularly for fund independent directors. In some cases, such severability must be specially requested, and may be subject to satisfactory responses in the underwriting process.

Endnotes

- ¹ See, e.g., MDL Capital Mgmt., Inc. v. Fed. Ins. Co., No. 05-cv-1396, 2008 U.S. Dist. LEXIS 57089, at *54 (W.D. Pa. July 25, 2008) (“[A]lthough the Court will grant summary judgment on the basis of these exclusions against [one individual insured], the exclusions do not apply to the other insureds based upon the clear and unambiguous language setting forth that knowledge by one insured may not be imputed to another insured.”).
- ² Note, however, that the actual effect of a severability clause for applications in any given case ordinarily entails an uncertain, fact-intensive inquiry. See ClearOne Commc’ns, Inc. v. Nat’l Union Fire Ins. Co. of Pittsburgh, Pa., 494 F.3d 1238, 1251 (10th Cir. 2007) (“[W]hether a severability clause precludes rescission is a fact intensive, case-by-case inquiry dependent on the precise language of the severability clause and the facts of the misrepresentation.”); In re Healthsouth Corp. Ins. Litig., 308 F. Supp. 2d 1253, 1276 (N.D. Ala. 2004) (“Very few decisions exist concerning the effect of severability clauses on the right of a carrier to rescind a policy as to all insureds.”).

Retiring or Terminated Directors

Fund directors who retire from board service, or whose tenures terminate as a result of fund acquisitions, mergers, or liquidations may have concerns regarding their potential exposure with respect to future lawsuits (or other future “claims”) that have not yet been filed at the time they retire or terminate their service. Specifically, they understandably want protection against the direct financial impact of any judgments, settlements, and defense costs incurred in the event of a future claim made against them that involves their past tenure as directors.

There are multiple protections that directors may wish to consider in this regard. First, *indemnification* affords a strong first line of protection. Where directors retire from a fund that will remain in existence, indemnification from that fund will typically remain available to them as past directors.¹

Second, with regard to *insurance*, most D&O/E&O policy forms expressly define “director and officer” to include *past* directors and officers (in addition to current ones). Ordinarily, such definitions thus protect retired or terminated directors if the directors’ fund is still named as an insured under a policy in effect at the time the future lawsuit is filed.

However, if the directors’ fund has been acquired, merged, or liquidated, or is otherwise no longer named in a fund group’s policy, then a coverage issue can arise. This is because the policy definition of “director and officer” ordinarily extends only to past directors of funds that are *named as insureds in the policy*. Thus, if the fund itself is no longer named as an insured in the policy, then that fund’s past directors would likewise not have coverage under the policy.

Where an acquired, merged or liquidated fund was named as an insured under a fund group’s policy prior to such event, the insurer may be willing to make arrangements for continued coverage of the fund’s retired or terminated directors under the fund group’s ongoing insurance program. If not, then the directors may wish to explore other arrangements—in the form of a separate tail policy or otherwise—to ensure that coverage will be available for future lawsuits (or other future “claims”) involving their past tenure.²

A tail policy generally provides coverage for future claims that are based on conduct occurring *prior to* the tail policy’s inception. This coverage can be arranged for various time periods, but ordinarily is not indefinite in duration. Known as the “tail period,”³ the duration of tail coverage is commonly three or six years. Ideally, the tail period should be at least as long as the statutes of limitation that apply to potential liabilities of the retiring or terminated directors.

Endnotes

- ¹ Note, however, that indemnification rights are subject to a number of restrictions under federal and state law. *See generally* ICI MUT. INS. CO., INDEPENDENT DIRECTOR LITIGATION RISK 20-21 (2006).
- ² *See, e.g., Aquila Boards Cover Their Tail...With Insurance*, FUND DIRECTIONS, Feb. 2009, at 1 (“The boards at the Aquila Group of Funds recently decided to look into tail insurance for its trustees.”).
- ³ *Home Ins. Co. v. Law Offices of Jonathan DeYoung, P.C.*, 32 F. Supp. 2d 219, 224 (E.D. Pa. 1998) (“Tail coverage provides insurance protection for acts, errors, or omissions that occurred while the initial claims-made policy was in effect, so long as a claim is asserted before the expiration of the tail period.”).

Conclusion

This guide has discussed the fundamentals of D&O/E&O coverage generally, how the scope of potential coverage afforded by different D&O/E&O policy forms may vary, as well as current D&O/E&O insurance issues that may be of particular interest to fund boards and others involved in the insurance decision-making process for fund groups. The guide is designed to assist fund groups in their evaluation of D&O/E&O insurance issues, and in making business judgments regarding an appropriate scope, dollar amount, and cost of coverage. Fund groups may also wish to refer to the following appendix, which sets forth a number of questions that may be useful to consider in reaching such business judgments. As always, please do not hesitate to contact ICI Mutual with any questions.

Appendix: Questions to Consider

When evaluating and selecting D&O/E&O insurance, fund boards and other stakeholders may wish to consider a number of questions as they seek to achieve an appropriate balance between scope, dollar amount and cost of coverage, and as they assess the various options that may be available in the insurance marketplace. This appendix sets forth some such questions. Please note that these questions are illustrative only. All questions may not be relevant for every fund group, and different fund groups may view different questions as being of greater or lesser importance. Where particular questions are discussed in the guide, cross-references to relevant page numbers of the guide are provided.

Which D&O/E&O Policy Is Appropriate for My Fund Group?

- What D&O/E&O options are available to my fund group? How do these options differ with regard to the basic coverages they provide—e.g., for prospectus disclosure lawsuits (*pp.* 23-24), for formal regulatory investigations and informal regulatory investigations (*pp.* 21-22), for costs of correcting errors (*pp.* 35-36)? How do these options differ with regard to other terms—e.g., fraud exclusions (*pp.* 31-33)? From the perspective of our funds, fund independent directors and other insureds, which of these differences in basic coverages and terms are important to us and which are not?
- How important to my fund group are the following additional factors: (1) price, (2) type of insurer (commercial versus captive) (*p.* 9), (3) reputation of insurer (e.g., for service, claims handling and payments, etc.), (4) financial strength of insurer, (5) insurer’s knowledge of the fund industry, and (6) long-term commitment of the insurer to the mutual fund marketplace (*p.* 9)?
- What factors should my fund group consider when determining how much coverage to purchase? Is peer data available on these questions? (*p.* 39)

What Type Of D&O/E&O Insurance Structure Is Appropriate For My Fund Group?

- What are the advantages and disadvantages of *funds-only* insurance policies (which cover funds and fund directors and officers) versus *joint* insurance policies (which cover funds, fund directors and officers, advisers and other fund service providers, and service provider directors and officers)? (*pp.* 41-42)
- Who should pay the premiums for a “joint” insurance policy and how should these premiums be allocated? (*pp.* 43-44) How should insurance proceeds be allocated under our joint policy? (*p.* 55)
- What are the advantages and disadvantages of single-insurer programs versus “layered” multiple-insurer programs? (*pp.* 45-46)

Should My Fund Group Buy Extra Protection For Fund Independent Directors?

- How strong are the rights to indemnification that our funds provide to independent directors? (*p.* 59) In light of these indemnification rights and other D&O/E&O insurance coverage available to my

fund group, should we obtain special insurance protections for our fund independent directors? (pp. 55, 59)

- What are “reserved limits” and “priority of payment” provisions? Should they be established through the insurance contract with our insurer, or by means of internal agreement within the fund group? (p. 55)
- What are independent director liability (IDL) policies? What are the key differences among the various IDL policies available in the marketplace? (p. 55)
- What are “tail” policies? When are they purchased, and what coverage do they provide? (p. 59)

Other Questions

- Is my fund group contemplating a change in insurance carriers? If so, do we have concerns regarding “continuity of coverage”? How might we address these concerns? (pp. 47-49)
- If some of our funds are acquired, merged or liquidated, should we secure insurance protection against *future* lawsuits (or other future “claims”) arising out of our funds’ *prior* activities? (pp. 51-52)
- Who can my fund group consult on insurance issues? How do the perspectives of different types of insurance consultants differ, and how are they compensated?

ICI Mutual | *an uncommon value*

Aligned Interests:

owned by, governed by and operated for mutual funds and their advisers, directors and officers

Mutual Fund Knowledge and Expertise:

tailored, innovative coverage combined with expert claims handling

Stability and Financial Strength in All Markets:

consistent coverage and strong capital

ICI Mutual is the predominant provider of D&O/E&O liability insurance and fidelity bonding for the U.S. mutual fund industry. Its insureds represent more than 60% of the industry's managed assets. As the mutual fund industry's captive insurance company, ICI Mutual is owned and operated by and for its insureds. ICI Mutual's services assist insureds to identify and manage risk and defend regulatory enforcement proceedings and civil litigation.

ICI Mutual also serves as a primary source of industry information regarding mutual fund insurance coverage, claims, risk management issues, and litigation developments. Publications include an extensive library of risk management studies addressing such topics as corporate action processing, investment management compliance, computer security, defense cost management, identity theft, and independent direction litigation risk, among others, and the *Investment Management Litigation Notebook*, risk manager alerts, and the annual *Claims Trends* newsletter. Additional services include peer group profiles, coverage analyses, and assistance to insureds and their counsel in litigation defense.



ICIMutual
A Risk Retention Group

**ICI Mutual Insurance Company,
a Risk Retention Group**

1401 H Street NW, Suite 1000
Washington, DC 20005

800.643.4246
info@icimutual.com

© ICI Mutual Insurance Company, a Risk
Retention Group 2009