SEC HOLDS DIRECTORS RESPONSIBLE FOR OVERVALUING ASSETS

By Mark Weintraub, Lockton Financial Services, Atlanta

In the aftermath of the recession, regulators and private plaintiffs have taken a critical look at REITs, private equity, business development companies, and other funds with illiquid assets, and are raising questions about their business practices, particularly how they value assets and conduct business with affiliates. Indeed, the SEC recently reaffirmed its enforcement focus in this area and, not surprisingly, a spate of civil litigation has followed. While the current environment is treacherous, lessons can be learned to mitigate increased risk of regulatory action and civil litigation.

Valuing illiquid assets has always been a challenging issue and a powder keg for civil suits. Now the SEC has increased its involvement in this area, recently completing its first enforcement action against a public company that failed to properly value its assets according to the applicable accounting standard. (U.S. Securities and Exchange Commission, SEC Charges New York-Based Fund Executives for Overvaluing Assets During Financial Crisis, Nov. 28, 2012.) In that matter, the SEC fined KCAP Financial, Inc.’s CEO, CIO, and CFO $75,000 for overvaluing assets at the end of 2008, largely for ignoring “exit prices” in its valuation of illiquid assets.

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The SEC commented that “[w]hen market conditions change, funds and other entities must properly take into account those changed conditions in fair valuing their assets,” and that was especially true for companies “whose entire business consists of the assets that it holds for investment.” (Id.) The illiquidity of an asset will not be an acceptable excuse for ignoring market information and, in a market downturn, the firm that does not account for that factor raises a red flag for regulators.

Another danger area arises from holding illiquid assets “at cost” for long periods of time. Shareholders often contend that delays in changing values or valuation methods arise for nefarious reasons and are tantamount to fraud. For example, Wells REIT II waited nearly eight years to reset its per-share value downward from $10 to $7.47. While this wait technically complied with FINRA regulations, that has not prevented plaintiff law firms from instituting “investigations” and trolling for clients. (See, e.g., The White Law Group, Recovery of Wells REIT II Investment Losses, Nov. 14, 2012.) Likewise, Behringer Harvard REIT I, which was recently sued by its investors, waited almost six years before cutting its per share value by more than half. To avoid allegations of “stale” values and fraudulent intent, funds should value their illiquid assets on a regular basis and not use “at cost” values for more than 18 months.

An additional high risk area, particularly for real estate based funds, are perceived conflicts of interests created by complex corporate structures, often consisting of related entities that provide fee based services for the fund. Affiliated entities that perform property management or asset management services and are paid fees out of contributed capital can create the appearance of an improper related transaction. For example, Behringer Harvard REIT I paid out more than $180 million to affiliated property and asset managers over its lifetime, which the recently filed lawsuit will likely seek to disgorge. While disclosing such relationships are a must, other ways to mitigate such claims would be to charge reasonable (or even below market) rates for the services they provide and to avoid charging penalties to change or terminate affiliated advisors.

The post-recession world is a new one for funds investing in illiquid assets and has ushered in unprecedented regulatory oversight and exposure to litigation. Carriers will respond favorably to good practices—like regular valuations based on current market data and true arm’s length relationships with advisors—that can make the difference between being perceived as a good or bad risk. More importantly, good practices can preclude claims from arising in the first place, and in an industry that will only face increased scrutiny, avoiding claims is paramount.
GETTING COVERAGE RIGHT: PROFESSIONAL SERVICES EXCLUSION

By Dan Klein, Lockton Financial Services, Los Angeles

Much litigation has spawned from cryptic endorsements and exclusions contained in today’s D&O policies. If you have trouble interpreting what these exclusions mean, there is no need to feel unsophisticated, as even seasoned Federal and State judges have difficulty deciphering and applying the intricacies of such language. This article focuses on the coverage issues the “Professional Services Exclusions” creates, and some approaches courts are taking when coverage disputes arise with respect to this exclusion.

Insurance claim handlers often use the Professional Services Exclusion to deny coverage under D&O Policies by asserting that the claim arises out of the “performance or failure to perform Professional Services for others . . .” Those of you with companies that provide professional services to clients are probably saying to yourselves that virtually every claim could be subject to this exclusion, which would essentially render your D&O insurance worthless.

To avoid this conundrum, courts have given the exclusion a much more narrow application in the D&O policy context, and have held that the exclusion applies only to claims involving the company’s “implementation of expertise and judgment” in the company’s particular industry.

Example

A biotechnology company has a claim arise regarding its directors’ and officers’ allegedly negligent approval to build a parking structure. Although this occurred in the course and scope of the insured’s business, this claim would not be subject to the exclusion, because decisions about a parking structure are homogenous among all businesses that require parking, and not germane to the biotechnology business. By contrast, however, if the same biotech company had a claim arise out of the alleged negligent decision of management to move forward with human trials of a medical device that was not adequately tested, and which later failed and caused the company’s stock to plummet, this would be properly excluded from coverage, because the decision required the implementation of expertise and judgment in the biotech industry.

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Why Is This Important and What Does This Mean for You, the Insured?

- Courts are not in total agreement when it comes to applying this exclusion, and slight factual variances can often mean the difference between a proper and improper coverage denial. As such, instead of embarking on the often lose-lose venture of coverage litigation, it is best to maintain a separate policy designed to cover the company’s errors and omissions. Let someone else spend the money, time, and effort fighting a coverage battle with the insurance carrier.

- Although maintaining a separate E&O policy is prudent, unfortunately it does not guarantee that no coverage disputes will arise. We have seen claims where our client’s D&O insurer believes a claim involves professional services and their E&O insurer takes the opposite position. There is no way to eliminate the possibility that such a situation will arise. Nevertheless, by ensuring that the E&O policy’s definition of “professional services” is broad enough to include every service the company performs for others, and by also ensuring that the D&O policy’s professional services exclusion is narrow enough that it reaches only matters that would be covered under the E&O policy, the potential problem can be minimized.

Professional services exclusions can be fertile ground for disputes with D&O insurers. While insurers typically try to do the right thing and don’t indiscriminately invoke the exclusion, patient work is sometimes needed to help them understand the claim and the nature of the company’s business. In such situations companies should enlist the help of their insurance broker and its claims advocacy resources to obtain the best outcome.
CYBER RISK NEWS

Final HIPAA/HITECH Rule Released

On January 17, 2013, the U.S. Department of Health and Human Services (HHS) released the long-awaited final rule modifying the HIPAA Privacy, Security, and Enforcement Rules, and the HITECH Act’s breach notification rule relating to protected health information (PHI). For the most part the final rule resembles the interim rule covered healthcare entities and business associates have been subject to for the last couple of years. There are notable exceptions, however.

One of the most significant changes brought about by the final rule is that more entities will now be considered to be “business associates” under HIPAA, and business associates now face direct liability for violation of the HIPAA rules. They also face liability for the acts of their agents and subcontractors.

Perhaps the most important change in the final rule is that the definition of a breach has been changed. Under the interim rule a breach is defined to mean “the acquisition, access, use, or disclosure of protected health information,” which “poses a significant risk of financial, reputational, or other harm to the individual.” This definition requires an evaluation of the risk of harm to be performed in assessing whether a breach has occurred.

As amended in the final rule, harm will now be presumed to arise from a breach of PHI. While the presumption can be overcome, it may be difficult to do so. This may lead data owners to provide notice under circumstances where they might not have done so under the interim rule.

The rule goes into effect on March 26, 2013. Covered entities and business associates must comply with applicable requirements of the rule by September 23, 2013.

For more information about the final rule please see the Lockton’s papers available at http://www.lockton.com/Insights-And-Publications/White-Papers/Final-HIPAAHITECH-Rule-Released.
CYBER RISK NEWS

Cybersecurity Executive Order Issued

On February 12, 2013, President Obama issued an executive order intended to bolster the cybersecurity of critical infrastructure companies. The order is a bit vague on what a critical infrastructure company is, stating only that:

[C]ritical infrastructure means systems and assets, whether physical or virtual, so vital to the United States that the incapacity or destruction of such systems and assets would have a debilitating impact on security, national economic security, national public health or safety, or any combination of those matters.

The executive order will require federal agencies to share classified and unclassified information about cyber threats faced by critical infrastructure companies. The order encourages, but does not require, private sector companies to share threat information with the government.

A second focus of the executive order is the creation of a “Cybersecurity Framework” of standards, methodologies, procedures, and processes that are designed to help critical infrastructure companies identify, assess, and mitigate cyber risks. The Framework is intended to help companies do a better job of preparing for and mitigating cyber threats.

Compliance with the forthcoming Cybersecurity Framework will not be mandatory. Instead, the executive order requires creation of a voluntary compliance program. Incentives will be created to induce companies to cooperate.

COURTROOM CASE NOTES: 
NEWS YOU CAN USE FROM RECENT DECISIONS

An Informal Criminal Investigation is a Claim Under a D&O Policy

Background

D&O policies typically cover formal investigations against individuals provided they are begun in ways specified by the policy. While the most modern policy forms may also cover informal investigations, such coverage is still not available under the majority of standard forms used today. This case provides a bit of hope for insureds facing expenses associated with such investigations.

What Happened

In Gold Tip, LLC v. Carolina Casualty Ins. Co., 2012 WL 3638538 (D. Utah Aug. 23, 2012) Gold Tip’s CEO was the subject of a “formal” criminal investigation by the Utah County Attorney. The County Attorney interviewed numerous witnesses and reviewed many documents, but never served the CEO with a notice that he was being investigated. Ultimately though he did learn of the investigation and instructed his attorneys to meet with the County Attorney to answer his questions and to present the CEO’s view of the situation. In the end the County Attorney closed the investigation and did not bring charges.

Once the investigation was closed Gold Tip and the CEO made a claim under the company’s D&O policy with Carolina Casualty Insurance Company. Carolina Casualty denied coverage for the claim on the grounds that the investigation was not a “claim” as defined in the policy because it was neither a demand for non-monetary relief nor a criminal “proceeding.” The insureds then sued Carolina Casualty.

What Did the Court Decide?

The insureds won. The court held that an investigation that carries the threat of a criminal indictment coerces cooperative conduct on the part of the insured and therefore is a demand for non-monetary relief. The court also held that the investigation was a “proceeding” because it was a step in a process that ultimately would have led to a criminal action being filed had the insureds not cooperated.

WHY IS THIS IMPORTANT?

This case provides a good legal basis to seek coverage for informal investigations against directors and officers. Insurers are certain to resist those efforts though. They are likely to point to the somewhat unique definition of “claim” in the Carolina Casualty policy, and may assert that a case in Utah is not binding in other jurisdictions. Cases like this nevertheless will force insurers to think carefully before denying coverage for investigation costs.
COURTROOM CASE NOTES: NEWS YOU CAN USE FROM RECENT DECISIONS

Wage and Hour Claim Covered Under an EPL Policy

Background

Class action claims for violations of statutes concerning payment of wages and provision of rest breaks are increasingly common. Insurers routinely exclude such claims. This case demonstrates that a close look at the allegations in those suits may reveal grounds to trigger employment practices liability coverage.

What Happened

In *Travelers Casualty & Surety Co. of America v. Spectrum Glass Co.*, 2012 WL 3780356 (W.D. Wash. Aug. 31, 2012) Spectrum Glass was sued in a class action alleging breach of contract, violation of statutes concerning payment of wages, violation of statutes concerning meal and rest breaks, and violation of the Washington Consumer Protection Act. Spectrum reported the lawsuit to Travelers, and Travelers agreed to defend the action subject to a sublimit of $100,000 for defense costs incurred in wage and hour claims. Travelers declined to pay any other loss arising from the claim. Travelers paid the $100,000 sublimit.

Spectrum argued that the lawsuit included matters that were not wage and hour claims and asked Travelers to reconsider its position. Travelers did not change its position and ultimately filed suit against Spectrum to establish that it had no further obligations under the EPL policy. After filing the complaint Travelers paid an additional $125,000 because the Washington Consumer Protection Act claim potentially implicated coverage.

What Did the Court Decide?

Spectrum won. The court determined that the breach of contract claim was potentially covered because the Spectrum employee handbook constituted an implied contract to pay employees for time worked, breaks, and holidays. Even though the cause of action sought payment of wages, the court found that the source of liability was not a wage and hour law and that the policy did not exclude the loss.

The court also held that the allegations regarding meal and rest breaks were potentially covered because they do not relate to payment of wages. While the court acknowledged that the plaintiffs sought to recover wages for missed breaks, the fact that they also sought injunctive relief to require Spectrum to change its practices triggered a defense under the policy.

Finally, the court found that the Washington Consumer Protection Act claim was potentially covered because it was based on the same facts and allegations underlying the breach of contract and meal and rest break claims.

WHY IS THIS IMPORTANT?

Insurers routinely deny coverage for wage and hour claims. Increasingly comprehensive policy exclusions make that possible. Because those claims are often excluded, insurers may not always give careful attention to complaints to look for allegations that could trigger coverage. Insureds facing a wage and hour claim need to work with their attorneys and brokers to closely scrutinize complaints asserting wage and hour claims for matters that might be covered and ask insurers to reconsider coverage denials in light of those matters. This case should help.
COURTROOM CASE NOTES: 
NEWS YOU CAN USE FROM RECENT DECISIONS

Insured vs. Insured Exclusion Does not Apply Where the Claimant was not an Elected or Appointed Director

Background

D&O policies typically exclude claims brought by one insured against another. This case is a good reminder that the exclusion will not apply if the plaintiff does not meet the policy’s definition of an insured person.

What Happened

In Intelligent Digital Systems, LLC v. Beazley Ins. Co., Inc., 2012 WL 5995550 (E.D.N.Y. Nov. 27, 2012) Visual Management Systems, Inc. (VMS) purchased Intelligent Digital Systems, Inc. (IDS) and agreed to place its owner, Jay Russ, on the VMS board. Critically, no formal vote or appointment was made to make Russ a board member. VMS nevertheless did identify Russ as a board member in its SEC filings.

Six days after the sale transaction closed VMS announced a restatement of certain financial statements. VMS subsequently stopped making payments to IDS and Russ. Russ ultimately resigned from the VMS board, and VMS confirmed the resignation in a filing with the SEC. IDS, Russ and others then sued VMS and its directors and officers.

VMS reported the lawsuit to Beazley, its D&O insurer. Beazley denied coverage on the basis that the policy’s insured vs. insured exclusion applied. VMS challenged the denial and filed suit against Beazley.

What Did the Court Decide?

VMS won. The District Court determined that the insured vs. insured exclusion did not apply because Russ did not qualify as a director as that term was defined in the policy because he was never formally elected or appointed to the VMS board.

WHY IS THIS IMPORTANT?

This case is a good lesson that invocations of insured vs. insured exclusions need to be scrutinized carefully. The failure to observe the formalities of placing someone on the board may open the door to coverage for a claim that would on its face appear to be excluded. That being said, no company should avoid such formalities to preserve the possibility of coverage. That failure could prevent someone who is not elected or appointed from being an insured under the policy.
COURTROOM CASE NOTES: NEWS YOU CAN USE FROM RECENT DECISIONS

D&O Coverage Barred for Employee Poaching and Trade Secret Claim by Competitor

Background

It is not uncommon in this day and age for a company who hires employees away from a competitor to be sued by that competitor. This case illustrates some of the reasons why it can be difficult to obtain D&O coverage for those claims.

What Happened

In *Axis Reinsurance Co. v. Telekenex, Inc.*, 2012 WL 6632180 (N.D. Cal. Dec. 19, 2012) Telekenex hired several employees away from its competitor, Straitshot Communications, Inc. Straitshot then sued, alleging that Telekenex, its president, CEO, and the former Straitshot employees stole Straitshot’s trade secrets and confidential customer information and covered up the theft by destroying relevant evidence. Straitshot alleged numerous causes of action including breach of employment contract and the duty of loyalty by the former employees, and interference with Straitshot’s contractual relations with its customers.

Telekenex reported the suit to Axis, its D&O insurer, which agreed to defend the action subject to a reservation of rights. The Straitshot suit went to trial and Straitshot won. Axis then filed suit against Telekenex seeking to establish that the $6.49 million verdict was not covered.
Axis made a number of arguments, one of which was that the policy’s exclusion for illegal profit, remuneration or advantage applied because Straitshot had established that Telekenex had obtained an illegal advantage. Telekenex and the individual defendants argued that the exclusion did not apply because the judgment did not expressly include a finding that any insured had obtained an illegal profit or advantage.

What Did the Court Decide?

Axis won. The court found that the policy exclusion did apply because the judgment, viewed in the context of Straitshot’s allegations and the evidence, clearly indicated that insureds had obtained an illegal profit or advantage from their conduct.

WHY IS THIS IMPORTANT?

Insurers resist covering claims such as this because they see them as avoidable business disputes that arise from intentional decisions to take on the business risk of hiring employees away from a competitor. This decision is a good reminder that insurers may have powerful arguments to resist coverage. While it seems likely that this case is the result of bad facts and bad luck at trial, those same bad facts can affect the availability of coverage for the claim. Insureds need to keep that in mind when they formulate their litigation strategies.
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