Words and Jurisdictions Matter – The Preamble Problem

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Exclusionary provisions in Director and Officer ("D & O") Liability and Professional Liability policies –not all of which are necessarily contained in the policy section specifically entitled "Exclusions" – warrant close examination of the preamble wording of the exclusion.

These preambles are essentially of three different variations as follows.

1. "For" wording, which is typically the least restrictive and most desirable for the policyholder;
2. "Absolute" wording, which is much broader and thus more favorable to the insurers; and
3. "Super absolute" wording, which is rarely used and is the most favorable to the insurer.

"For" Wording

The following is an example of a bodily-injury and personal-injury exclusion that is fairly typical of that found in most D&O policies in the market today.

> The Insurer shall not pay **Loss** in connection with *that portion of any **Claim*** made against an **Insured Executive** for any **Wrongful Act** . . . that is
> . . . .
>
> *for* emotional distress, mental anguish, humiliation, outrage, libel, slander or other defamation (except when any or all of the foregoing are alleged to be employment-related), physical or bodily injury, sickness, disease, death, invasion of privacy, trespass, nuisance or wrongful entry or eviction, assault, battery or loss of consortium . . . . [1]

Emphases added, boldfaced terms are defined in the policy.

This exclusion would be inapplicable to a claim such as a shareholder derivative suit alleging board malfeasance in the handling of a major rail or air disaster. It would, however, apply to any claim brought by any party who allegedly suffered bodily injury from the disaster event. That is reasonable because coverage for these types of claims should be, and is intended to be, covered under the policyholder's Commercial General Liability insurance policies.

That being said, there is little, if any, case law on the meaning of this "for" preamble. It came about primarily because of broker and policyholder counsel concerns that the "absolute" preamble wording discussed below could result in denials of coverage for shareholder and similar suits that the D & O policy was intended to cover.

[1] Hudson Insurance Company, Executive Liability and Corporate Securities Liability Insurance Policy Form HFP-PYP-001 (Ed. 7/10)

The language "in connection with that portion of any **Claim"** is further restrictive and beneficial to the policyholder. That phrase is not, however, ubiquitous in policies available in the current market.

"Absolute" Wording

An exclusion preamble that is most often the subject of coverage litigation, and the cases discussed in this article, states:

> The Insurer shall not pay **Loss** in connection with *that portion of any **Claim*** made against An **Insured Executive** for any **Wrongful Act** . . .
> that is
> . . . .
> *based upon, arising from, or in any way related to* the liability of others assumed by an **Insured** under any employment contract or agreement; provided, however, this exclusion shall not apply to liability that would have been incurred in the absence of such contract or agreement[2] (emphases added, boldfaced terms are defined in the policy).

Although the preamble wording *based upon, arising from, or in any way related to* may vary somewhat from one policy form to another, it is of considerably broader scope than the simple *for* wording discussed above.

This contractual-liability exclusion, provides at least some basis for insurers and policyholders to disagree on the proper scope of the exclusion. For example, does it only apply to claims brought by a party to the contract? Insurers would argue that it is not so limited, but there is reasonable debate as to how broadly it should be applied.

"Super Absolute" Wording

Although the authors are not aware of any case law in this area or the below language appearing in an actual policy or endorsement, the following would be a good hypothetical example of the super-absolute approach, which is decidedly pro-insurer.

> The Insurer shall not pay Loss in connection with any Claim made against an Insured for a Wrongful Act that is based upon, arising from, or in any way related to, *whether in whole or in part,* physical or bodily injury, sickness, disease, death of any person.

The addition of the "*whether in whole or in part"* wording to what is otherwise an "absolute" exclusion renders it even more favorable to the insurer. The insurer would have a reasonable

[2] Hudson Insurance Company, Executive Liability and Corporate Securities Liability Insurance Policy Form HFP-PYP-001 (Ed. 7/10)

basis for arguing that the exclusion applies to the entire Claim even if only a portion of the underlying asserted claim fell within the scope of the exclusion. This would make it difficult for a policyholder to prevail on an allocation argument as among covered and noncovered portions of the Claim. For this reason, astute brokers and policyholder counsel will resist having this language included in an exclusion.

A "But For" Coverage Dispute:

Beazley Ins. Co. v. ACE American Ins. Co., 880 F.3d 64 (2d Cir. 2018)

The Beazley coverage dispute arose out of the initial public offering for Facebook, Inc. A number of technical difficulties in executing the IPO resulted in trades not being performed properly. Retail investors sued NASDAQ. The claims were eventually settled for $26.5 million.

NASDAQ maintained both D & O and E & O insurance policies. Neither ACE American Insurance Company ("ACE") nor Illinois National Insurance Company ("Illinois National")—NASDAQ's first- and second-layer directors and officers insurers—contributed to the settlement and, in fact, denied coverage citing their Policies' professional-services exclusions.

Chartis and ACE, NASDAQ's primary- and tertiary-layer E & O insurers, respectively, contributed to both the settlement and defense costs. Chartis paid its $15 million limit of coverage, and ACE paid $4.9 million of its third-layer E & O policy towards the settlement. Beazley, NASDAQ's second-layer errors-and-omissions insurer, paid out its policy limit of $15 million to settle the claim. Beazley's settlement contribution was made in exchange for an assignment by NASDAQ of its contractual rights against its D & O insurers ACE and National.

The ACE D & O policy's professional-services exclusion stated:

> The Insurer shall not be liable for Loss on account of any Claim . . . by or on behalf of a customer or client of [NASDAQ], alleging, based upon, arising out of, or attributable to the rendering or failure to render professional services."

The ACE policy did not define "customers" or "clients." The court, citing its prior decision in *Hugo Boss Fashions, Inc. v. Fed. Ins. Co*., 2252 F.3d 608, 617 (2d Cir. 2001), looked to the terms' meanings under federal law. The court determined that "the vast majority of federal courts" considering the issue, found retail investors to be "customers" of a stock exchange.

The court then turned to the issue of "professional services," and, consistent with New York law, applied the "but for" test to determine "whether the asserted claim could succeed but for the rendering of professional services." *Id*. at 71. Specifically, the court ruled that if the allegations in the underlying action clearly fall within the exclusion, and none of the causes of action would exist but for the excluded activity or state of affairs, then the insurer is free of any obligation to defend the action.

“Arising Out of” Coverage Disputes:

Court decisions interpreting “arising out of” preambles in insurance-policy exclusions generally fall into one of two camps. The first camp interprets this language broadly regardless of the fact that it is being used in an exclusion of coverage. The second camp interprets the preamble broadly in coverage-granting policy sections but narrrowly in coverage excluding sections of the policy. Turning now to a discussion of specific “arising out of” jurisprudence, we begin with a recent decision of the Delaware Supreme Court.

Broad Interpretations of the Preamble in an Exclusion:

Iberia Bank Corp. v. Illinois Union Ins. Co., 2019 WL 585288 (E.D. La. Feb. 13, 2019, *aff’d*, 953 F.3d 339 (5th Cir. 2020)

This decision arose from a dispute regarding coverage under bankers' professional liability insurance policies, including one issued by Chubb as in the *Guaranteed Rate* case discussed below. The underlying litigation arose from the following facts.

Iberia Bank participated in a lending program under the Federal Housing Administration ("FHA"), which insures approved lenders against losses on mortgage loans made to buyers of single-family homes. A former Iberia Bank employee and a then-current Iberia Bank employee brought a whistleblower *qui tam* action on behalf of the United States government against Iberia Bank alleging violations of the False Claims Act ("FCA"). These Relators in the *qui tam* action alleged that the bank submitted false and fraudulent claims and records regarding mortgage loans Iberia Bank made to its borrower clients to secure mortgage insurance from the FHA.

The court ruled in favor of the insurer in the ensuing coverage dispute on the basis that coverage under a professional-liability insurance policy is not triggered by claims asserted under the FCA because such claims are not predicated on the insured's professional services that are covered by such a policy.

The coverage dispute here involved a professional-liability policy and not a D&O policy. Insurers contended that a plain reading of the policy demonstrated that Iberia Bank's claim was not covered. Specifically, the Iberia Bank insurers argued that the government was not a customer or client of the bank for whom the bank performed professional services as defined in the policy. The government did not seek advice from the bank or pay it for services in issuing mortgages. Rather, the bank’s clients were the borrowers to whom it issued mortgages, as a part of the underwriting that constituted its professional services. Because the court agreed with the insurers that the bank simply obtained mortgage insurance from the government and did not render any professional services to it, the court found the *qui tam* action was not covered under a professional-liability insurance policy.

SXSW, LLC v. Federal Ins. Co., Case No. 1:21-CV-00900-RP, 2022 WL 1648500 (U.S.D.C. W.D. Tex. May 24, 2022)

The underlying suit in *SXSW* arose when SXSW, LLC ("SXSW")—the organizers of a music, film, and interactive festival known as "South by Southwest"—faced numerous lawsuits brought by customers after the City of Austin cancelled SXSW 2020 due to the COVID-19 pandemic. Citing the "no refund" condition in its Participation and Credentials Terms and Conditions that customers signed at the time of purchase, SXSW declined to refund the purchase price of wristbands, tickets, passes, etc. ("Credentials"), that customers bought. Instead, SXSW offered customers discounts on future Credentials purchases and a deferral to a future year of their 2020 Credentials.

In the ensuing litigation, the plaintiffs alleged breach of contract, unjust enrichment, and conversion. Their requested relief included actual damages, equitable monetary relief and/or a return of their Credentials purchase price, pre- and post-judgment interest, and injunctive relief.

Federal Ins. Co. ("Federal"), SXSW's D & O carrier, denied coverage of the underlying suit on the bases that its Policy's contract exclusion, and the Policy's professional-services exclusion barred coverage for Claims. The Policy's contract exclusion stated that Federal "shall not be liable for Loss on account of any Claim against [Insured]: based upon, arising from or in consequence of any liability in connection with any oral or written contract or agreement to which the [Insured] is a party, provided that this Exclusion [] shall not apply to the extent that [Insured] would have been liable in the absence of such contract or agreement."

The court noted that, under Texas law, similar contract provisions were found to be unambiguous and that "such exclusions are 'given a broad, general, and comprehensive interpretation.'" *Id*. at *10. Citing several Fifth Circuit decisions, the court stated that, to "fall within such exclusions, a claim need only bear an incidental relationship to the described conduct for the exclusion to apply." *Id*. The court thus held that the exclusion operated to bar "coverage for all claims in the Underlying Suit." *Id*. at *11.

Narrow Interpretations of the Preamble in an Exclusion:

ACE Amer. Ins. Co. v. Guaranteed Rate, Inc., No. 360, 2022 Supreme Court of Delaware, 2023 WL 5965619 (Sept. 14, 2023)

Guaranteed Rate was a lender in the federal government's mortgage-insurance program, and it underwrote and issued loans to various borrowers. The underlying litigation was a *qui tam* action under the federal False Claims Act ("FCA").

The coverage dispute here involved two policies issued by the same insurer. One was a professional-liability policy and the other was a management-liability policy (referenced as "D & O"). While the policyholder sought coverage under both policies, the professional-liability

insurer disclaimed coverage under its policy because that policy expressly excluded the FCA allegations. The insurer also disclaimed coverage under the D & O policy because the FCA allegations arose from professional services. Only the D & O policy was at issue before the Delaware court.

The D&O policy's professional-services exclusion applied to Loss from any Claim *alleging, based upon, arising out of, or attributable to* any Insured's rendering or failure to render professional services. Thus, it is an example of an "absolute" preamble. Although the term "professional services" was undefined in the policy, the professional-liability policy defined it as "mortgage banking and mortgage underwriting services and loan servicing for others for a fee."

Despite the policy's "absolute" preamble, the court upheld the decision of the lower court that the FCA allegations involved alleged defrauding of the government and not professional services rendered to borrowers. Because it was a policy exclusion that was at issue, the court believed it had to apply that exclusion narrowly, and it expressed concern that the insurer's interpretation would extend the exclusion to anything remotely connected to professional services.[3] Thus, in a sense, the court applied the exclusion as if it were of the *for* variety.

Affinity Living Group, LLC v. StarStone Specialty Ins. Co., 959 F.3d 634 (4th Cir. 2020)

The underlying allegations in the *Affinity* coverage dispute pertained to a qui tam action against Affinity in which Affinity, the operator of an adult-care facility, was alleged to have fraudulently billed Medicaid for professional services that were not performed. StarStone's umbrella policy provided coverage for "damages resulting from a claim arising out of a medical incident." Taking the position that its policy did not provide coverage for the false-claims suit, StarStone denied coverage. Affinity argued that even though its submissions to Medicaid for reimbursement were not themselves "medical incidents," they arose out of medical incidents. *Id*. at 640.

Like in most other jurisdictions, North Carolina courts interpret "arising out of" broadly so that only a causal connection is required to satisfy the coverage granting preamble. Unlike some other jurisdictions, however—Texas, for example—North Carolina courts interpret the phrase more narrowly when used to exclude coverage. When used in an exclusion, "arising out of" requires proximate causation.

In response to StarStone's argument that Affinity's billing Medicaid for personal-care services was "'wholly disassociated from, independent of, and remote from' the personal-care services,"

[3] Of some interest is the fact that the court noted that this insurer took a seemingly contradictory position on the same exclusionary provision in *Iberia Bank Corp. v. Illinois Union Ins. Co.*, 2019 WL 585288 (E.D. La. Feb. 13, 2019, *aff'd*, 953 F.3d 339 (5th Cir. 2020). The authors note that ACE American Insurance Company and Illinois Union Insurance Company were both member companies in the Chubb Group of Insurance Companies at all times relevant to these decisions.

the court noted that but for Affinity's failure to provide the services, no claim for damages would exist. Of note is the fact that "failure to render" services was a covered "medical incident" as that term was defined under StarStone's policy. Thus, the court found that the failure to "render medical professional services" bore a causal relationship to the allegedly false billing to Medicaid.

As evidenced by the above sampling of recent "preamble" cases, while words matter, it is the combination of the policy's wording and the applicable policy-interpretation maxims that ultimately decide the coverage issue at hand.