A trend of coverage denials under D&O and professional liability policies for contractual liability claims

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Professional liability policies afford coverage to professionals for the services they perform. Directors and officers policies afford coverage for company management. Although the particular language of the insuring provisions may differ among professional liability and D&O policies, a common thread of both is that the policies typically provide coverage for "claims" for "loss" or "damages" resulting from a "wrongful act."[1] These policies frequently afford entity coverage as well — extending coverage to claims against the corporation, partnership or other entity for which the professional, director or officer works.

Professional liability and D&O policies frequently contain contract exclusions or, in the health care or Employee Retirement Income Security Act areas, "benefits due" exclusions. Insurers often rely on such exclusions as a basis to deny coverage for claims arising from a policyholder's breach of a contractual obligation to a third party, most often in the context of the policyholder's failure to pay amounts that it owes. The rationale for this position is simple. It is nearly impossible for a professional liability insurer to underwrite coverage from an actuarial standpoint if it could be held liable as the guarantor of all the policyholder's contractual liabilities to third parties.

Even when an express contract or "benefits due" exclusion is not included in the policy, insurers have argued that liability policies should not afford coverage for the contract price of a business deal gone wrong. Insurers have advanced two primary arguments in support of this position:

- The "loss" or "damages" caused by the policyholder's breach of its pre-existing contractual obligations is not the result of a "wrongful act," but arises from its decision to enter into the contract in the first instance.
- Providing insurance for a policyholder's contractual obligations creates a "moral hazard," incentivizing an insured to breach its contractual obligations or otherwise to engage in risky behavior.

One of the seminal cases in which a court declined to afford coverage for a policyholder's contractual obligations, even without a specific exclusion, is *August Entertainment Inc. v. Philadelphia Indemnity Insurance Co.*, 146 Cal. App. 4th 565 (Cal. Ct. App., 2d Dist. 2007).

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In 2012, in what appears to be a trend, a number of courts in several jurisdictions have adopted the reasoning in *August Entertainment*, in whole or in part. These courts have upheld the denial of both defense and indemnity coverage when the gravamen of the underlying claim involves the policyholder's failure to pay amounts owed under a contract, even in cases in which no contract exclusion appears in the policy.

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AUGUST ENTERTAINMENT

In *August Entertainment*, Robert Maclean, a corporate officer of InternetStudios.com Inc., entered into a contract with August Entertainment Inc. to obtain film distribution rights in exchange for a $2 million payment. When there was a dispute over the contract, August Entertainment sued InternetStudios.com and Maclean in the Los Angeles County Superior Court, seeking to recover the $2 million contract price. InternetStudios.com and Maclean submitted a claim to D&O insurer Philadelphia Indemnity Insurance Co., which rejected the claim.

August Entertainment, InternetStudios.com and Maclean settled the suit for $2 million plus interest, and Maclean assigned his rights and claims against PIIC to August Entertainment, which then sued the insurer for breach of contract and bad faith. The Los Angeles trial court ruled in favor of PIIC, and August Entertainment appealed.

The 2nd District Court of Appeal, however, rejected the argument that Maclean

may obtain insurance coverage for his company's contractual debt. Even without an explicit exclusion in the D&O coverage part of the policy, PIIC was not liable for the policyholder's failure to pay on a contract, the appellate court said. The settlement of contractual liability was not a "loss" resulting from a "wrongful act," as required in PIIC's policy, the court said.

The court also adopted Judge Richard Posner's well-known "moral hazard" argument from *May Department Stores Co. v. Federal Insurance Co.*, 305 F.3d 597 (7th. Cir. 2002), as an additional basis to deny coverage for the policyholder's pre-existing contractual obligation.[2] The court held that to provide coverage for such contractual obligations would encourage corporate policyholders to risk a breach, knowing that, in the event of a breach, the D&O insurer would ultimately be responsible for paying the corporate debt.

Although the court in *August Entertainment* found that the insurer was not liable for the stipulated judgment entered against the policyholder in connection with the settlement, it left unanswered the significant related issues of defense costs, the recovery of attorney fees for such claims, or both. Recent decisions, in particular *Health Net Inc. v. RLI Insurance Co.*, 206 Cal. App. 4th 232 (Cal. Ct. App., 2d Dist. 2012), and *Sauter v. Houston Casualty Co.*, 276 P.3d 358 (Wash. Ct. App., Div. 1 2012), have now provided answers to these unresolved issues.

HEALTH NET

In a published opinion written by Justice H. Walter Croskey, the author of the leading treatise on the state's insurance law, California's 2nd District Court of Appeal addressed whether an insurer owed its policyholder defense costs in this context. As in *August Entertainment*, the professional liability insurance policies issued to Health Net did not contain an exclusion for "benefits due."

The insurance coverage action arose after Health Net alleged it paid $60 million to defend against an ERISA class action, which it eventually settled for $215 million. The plaintiffs in the underlying suit sought unpaid benefits owed under health insurance plans administered by Health Net or its subsidiaries. The appeals court found, however, that Health Net's professional liability policies did not cover the defense costs and settlement amounts related to these unpaid benefits.

The court reasoned that claims for unpaid benefits do not seek "damages ... resulting from any claim or claims ... for any wrongful act" under the policies' insuring agreement, because Health Net was already contractually obligated to pay those benefits to its subscribers, independent of any wrongful act. The court relied heavily on *August Entertainment*'s reasoning to find that Health Net's professional liability insurers were not liable for Health Net's settlement because the failure to pay benefits on a contract was not a "loss" resulting from a "wrongful act."

> It is nearly impossible for a professional liability insurer to underwrite coverage from an actuarial standpoint if it could be held liable as the guarantor of all the policyholder's contractual liabilities to third parties.

Significantly, the court also found that there was no coverage for the underlying $70 million attorney fee award to the class plaintiffs' counsel to the extent that it, too, was related to the class plaintiffs' claim for unpaid benefits.[3] Health Net had argued that the class plaintiffs' claim for statutory attorney fees was itself "damages," regardless of whether the underlying claim was covered. The appeals court rejected Health Net's argument. Instead, it reaffirmed a prior California authority finding that an award of attorney fees was inconsistent with the meaning of the word "damages" in the ordinary and popular sense inasmuch as the award does not compensate a plaintiff for the actual injury that originally brought the plaintiff into court.[4]

SAUTER

In *Sauter*, Michael Sauter, S-J Management's chief executive officer, executed a personal guaranty for a $2.8 million loan to the corporation. When S-J Management defaulted on the bank loan, the bank threatened to sell Sauter's real estate properties that secured the personal guaranty. Sauter demanded indemnity from S-J Management, which then tendered the bank's demand to its D&O insurer, Houston Casualty Co. The insurer denied coverage for the claim.

The Washington Court of Appeals upheld Houston Casualty's denial, finding that Sauter had not acted in an insured capacity when executing the personal guaranty, as required by the policy. In addition, relying on *August Entertainment*, the appellate court found that Sauter's liability to the bank because of the personal guaranty was not a "loss" resulting from a "wrongful act," but instead was the result of the guaranty itself.

The court also found that the "moral hazard" considerations discussed in *August Entertainment* (that is, providing coverage for a policyholder's contractual obligations encourages corporations to breach their contractual obligations, because they know that their D&O insurer will ultimately be responsible for paying the debt) applied with equal force.

WELLPOINT

In *WellPoint Inc. v. Continental Casualty Co.*, 2012 WL 4803595 (Ind. Super. Ct., Marion County Jan. 31, 2012), WellPoint Inc. (formerly known as Anthem Inc.) and Anthem Insurance Cos. sought coverage under reinsurance certificates issued to Anthem Inc. by Continental Casualty Co. for amounts paid to settle claims against Anthem. These claims were brought by providers of health care services either pursuant to contracts directly between Anthem and the providers or pursuant to an assignment of the subscribers' rights under their health care plans. The cash payment component of the settlement fund was $198 million.

An Indiana state court granted Continental's motion for summary judgment on numerous grounds, including that Indiana public policy precludes coverage for an insured's contractual obligations.[5] Although the court does not cite *August Entertainment*, the "moral hazard" analysis is similar.

IMPLICATIONS OF RECENT DECISIONS

'Negligence' and 'wrongful act'

Some policies limit their definitions of "wrongful" acts to "negligent" acts, whereas others do not.[6] Some courts focused on the "negligent" modifier to uphold the denial of coverage for breach of contract claims. These courts said that the refusal to pay amounts contractually owed is intentional, rather than

Implications of recent decisions

- Limiting wrongful acts to negligent acts matters less and less
- Contract exclusion not necessary
- Underlying pleadings do not determine coverage
- Continuing vitality of the "moral hazard" argument

negligent. This is so, even if the initial failure to pay the obligation was due to a mistaken belief as to the terms of the contract or to simple oversight.

The policy language in *Health Net* did not expressly limit "wrongful" acts to "negligent" acts; thus, relying on this fact, Health Net argued that the policy should afford coverage for breach of contract. The *Health Net* court did not find this argument persuasive, and so the distinction between policies defining "wrongful" acts to be "negligent" acts and those that do not should no longer be relevant, at least under California law.

Contract exclusion not necessary

As discussed above, in *Health Net* and *Sauter*, the policies did not have a "benefits due" or contract exclusion. In cases in which such exclusions are present, courts have enforced them to preclude coverage for the same sort of ERISA claims for unpaid health benefits at issue in *Health Net*, because the "benefits due" exclusion precludes coverage for unpaid contract benefits.[7]

Therefore, under *Health Net*'s reasoning, it makes no difference whether the policy contains a "benefits due" exclusion. Rather, for the Court of Appeal, the pivotal question was whether the amounts sought by the class plaintiffs under their health plans were amounts that Health Net was legally obligated to pay as the result of a "wrongful act," or whether they were amounts that Health Net, its subsidiaries or both were already obligated to pay the plan subscribers pursuant to their contracts with them (the health plan), independent of any "wrongful act" (that is, the failure to pay). Thus, it does not matter whether the insured committed a "wrongful act" (breached a fiduciary duty by failing to pay) — the result of which is that the contractual amounts owed were not paid. A negligent or innocent failure to pay does not convert pre-existing contractual obligations into covered insured events.

Courts may extend the holdings of *Health Net* and *Sauter* to other cases involving a policyholder's claim for coverage under a D&O or professional liability policy for the breach of its contractual obligations.

Underlying pleadings do not determine coverage

Even claims for breach of fiduciary duty, negligence or other torts may not be covered if the claim derives from the policyholder's failure to perform its contractual obligations. That is, even if the policyholder may have been negligent in not fulfilling its contractual obligation or did not believe it had any contractual obligation to pay, the claim may still not be afforded coverage. In California, for example, it is the nature of the damage and risk involved that governs, not how parties plead the causes of action.[8] As noted by the Court of Appeal in *Health Net*, the costs of the unpaid benefits "cannot be passed onto [Health Net's] insurers simply because [Health Net] may have committed a wrongful act in its failure to pay them."

Health Net's holding is particularly important in cases involving insurance coverage for unpaid benefits brought under ERISA, because plan participants and beneficiaries of ERISA plans, as in the case of Health Net, frequently assert statutory claims for breach of fiduciary under the ERISA, in addition to statutory breach of contract claims.

Continuing vitality of the 'moral hazard' argument

Courts in California and in other jurisdictions have held that allowing liability coverage for amounts due under a contract, for an insureds' pre-existing obligations (such as claims for unpaid benefits or wages), or both would create an unacceptable moral hazard by encouraging risky and socially harmful behavior by insureds.

The court in *Health Net* declined to address the "moral hazard" argument, instead relying on the insuring provisions of the policy. However, *August Entertainment* in California and numerous other cases, including the recent *Sauter* and *WellPoint* decisions, continue to stand for the proposition that coverage for an insured's contractual obligations would violate public policy.

CONCLUSION

Expect the recent trend of courts rejecting coverage for breach-of contract claims to continue. Clear precedent indicates that there is no potential for coverage for a policyholder's non-payment of its pre-existing contractual obligations, including defense costs (absent an express grant of coverage in the policy), plaintiffs' attorney fees and interest for such claims. Thus, it can be expected that insurers, both in California and other jurisdictions, will rely upon these decisions, and in particular the *Health Net* decision, to disclaim coverage for contractual damage claims involving defense and indemnity. WJ

NOTES

[1] Eric M. Holmes, ed., Appleman on Insurance 2d (2003) § 146.1, at 46-47.

[2] *August Entm't*, 146 Cal. App. 4th at 582 (quoting *May Dep't Stores*, 305 F.3d at 601). ("'It would be passing strange for an insurance company to insure a pension plan (and its sponsor) against an underpayment of benefits, not only because of the enormous and unpredictable liability to which a claim for benefits ... could give rise, but also because of the acute moral hazard problem that such coverage would create. ... Such insurance would give the plan and its sponsor an incentive to aggressive (just short of willful) interpretations of [federal pension law] designed to minimize the benefits due, safe in the belief that if, as would be likely, the interpretations were rejected by the courts, the insurance company would pick up the tab.'").

[3] However, relying on many of the same out-of-state cases that the California Court of Appeal cited, the 4th U.S. Circuit Court of Appeals (applying Virginia law) recently came to the opposite conclusion, holding, instead, that although there was no coverage for the insured's preexisting obligations to pay wages compliant with the Fair Labor Standards Act, statutory attorney fees were "damages" resulting from an insured's alleged "wrongful act" in failing to pay back wages and overtime pay. *See Republic Franklin Ins. Co. v. Albemarle County Sch. Bd.*, 670 F.3d 563, 568 (4th Cir. 2012).

[4] *Health Net*, 206 Cal. App. 4th at 256-57 (citing *Cutler-Orosi Unified Sch. Dist. v. Tulare County Sch. Dists. Liab./Prop. Self-Ins. Auth.*, 31 Cal. App. 4th 617, 632 (Cal. Ct. App., 5th Dist. 1994)).

[5] *WellPoint*, 2012 WL 4803595 ("A liability policy cannot be construed as a performance bond to pay an insured's corporate contractual obligations.").

[6] Compare *Baylor Heating & Air Conditioning v. Fed. Mut. Ins. Co.*, 987 F.2d 415, 417 (7th Cir. 1993) (policy provided coverage for "negligent act, errors or omission in the 'administration' of your 'employee benefit programs'"), and *Oak Park Calabasas Condo. Ass'n v. State Farm Fire & Cas. Co.*, 137 Cal. App. 4th 557, 562 (Cal. Ct. App., 2d Dist. 2006) ("wrongful act" defined as

"negligent acts, errors, omissions"), with *August Entm't*, 146 Cal. App. 4th at 571 ("'wrongful act' meant any 'actual or alleged error, misstatement, misleading statement, act, omission, neglect, or breach of duty'"), and *Medill v. Westport Ins. Corp.*, 143 Cal. App. 4th 819, 826 (Cal. Ct. App., 2d Dist. 2006) ("'Wrongful act(s)' [are] 'any actual or alleged error or omission, negligent act, misleading statement, or breach of duty.'").

[7] *See, e.g., UnitedHealth Group Inc. v. Hiscox Dedicated Corp. Member Ltd.*, No. 09-CV-0210 (PJS/SRN), 2010 WL 550991 (D. Minn. 2010) (no coverage for unpaid benefits because the definition of "damages" excluded "amounts, benefits, coverages owed to any enrollee, member, subscriber, or client under any contract, healthcare plan, insurance policy, reinsurance policy, or program of self-insurance"), and *Exec. Risk Indem. v. Cigna Corp.*, 976 A.2d 1170, 1173 (Pa. Super. Ct. 2009) (exclusions "'for liability of the assured under contract or agreement, except liability which would have attached to the assured even in the absence of such contract or agreement'" and "'for benefits, coverage, or amounts due or allegedly due, including any amount representing interest thereon, from the assured as: (a) an insurer or reinsurer, under any policy or contract or treaty of insurance, reinsurance, suretyship, annuity or endowment'" barred coverage for class action settlement of breach of contract claims). *See also May Dep't Stores*, 305 F.3d 597 ("benefits due" exclusion precluded coverage for pension benefits sought under the ERISA plan), and *BOC Group v. Fed. Ins. Co.*, 2007 WL 2162437 *12 (N.J. Super. Ct. App. Div. July 30, 2007) ("benefits due" exclusion precluded coverage for plaintiff's ERISA claims, including plaintiffs' claim for statutory attorney fees under ERISA).

[8] *Vandenberg v. Super. Ct.*, 21 Cal. 4th 815, 839 (Cal. 1999) ("The nature of the damage and the risk involved, in light of particular policy provisions, control coverage.").

NEWS IN BRIEF

CALIFORNIA BILL AIMS TO FIGHT INSURANCE FRAUD

California Gov. Jerry Brown, D, has signed a bill that will increase funding for local district attorneys to combat fraud in disability and health insurance, according to a Sept. 24 statement by the state's Department of Insurance. "The individuals perpetrating this type of fraud have become more sophisticated with their efforts. This funding will aid local district attorneys as they adapt to keep pace with this increasing criminal activity," Commissioner Dave Jones said in the statement. The agency noted that from 2007 to 2010, it received more than 6,000 health and disability claims suspected of being fraudulent. Only a fraction was turned over to local district attorneys for prosecution, resulting in 656 investigations. Of those, investigators made 221 arrests and won 184 convictions on fraud totaling $223 million, it said. Assembly Bill 2138 goes into effect Jan. 1, 2013.

NEW CALIFORNIA LAW SAFEGUARDS LIFE POLICIES

A new California law will provide safeguards for life insurance policyholders, according to a Sept. 18 statement by the state's Department of Insurance. "This legislation will further protect California consumers and many seniors by ensuring that they are provided sufficient notice before their life insurance policy is canceled," Insurance Commissioner Dave Jones said in the statement. Currently, life insurance policyholders in the state can lose policy protection if they miss a single premium payment. If a policyholder seeks reinstatement, he or she might have to have a new physical exam, which could result in a more expensive policy with higher premiums, the statement said. AB 1747 requires insurers to send a "pending lapse notice" to policyholders within 30 days of nonpayment and allow for one or more designees to receive the notice. The law goes into effect Jan. 1, 2013.

OXFORD HEALTH TAGGED WITH $665,000 FINE

New York's Department of Financial Services has fined Oxford Health $665,000 for failing to explain coverage to policyholders and tell them how to challenge claim denials, according to a Sept. 20 statement. The agency said it cited Oxford Health Plans NY Inc. and Oxford Health Insurance Inc. for a total of about 300,000 instances of failing to provide explanation-of-benefits statements. "Insurers must provide their members with clear descriptions of their benefits each and every time a claim is processed. Consumers have every right to know what their health plans cover, what the plans don't cover and what they can do when their claims have been denied improperly," Superintendent Benjamin Lawsky said in the statement. The agency said Oxford has agreed to take all necessary steps to correct its conduct.