GOLDBERG SEGALLA

Professional Liability Monthly

Compendium 2013

Dear Reader,

Thank you for your continued interest in Professional Liability Monthly *throughout 2013. In this special edition we have compiled all the Featured Articles from 2013 along with the year's most popular blog posts from* Professional Liability Matters. *For your convenience, we have linked each author's name to their online biographies in the event you would like more information regarding the article or post.*

Happy Holidays!
Sharon Angelino, Brian R. Biggie, and Richard J. Cohen
Editors, Professional Liability Monthly

FEATURED ARTICLES 2013

Avoiding E&O Claims

By Colleen M. Murphy and Matthew S. Marrone

A recent New York ruling makes it easier for insureds to sue agents. Here's what to do about it. On November 19, 2012, the New York Court of Appeals in *American Building Supply Corp. v. Petrocelli Group, Inc. et al.* ruled for the first time on the issue of whether an insured's receipt of the insurance policy without complaint barred an E&O claim against an insurance agent or broker. The Court of Appeals concluded that "the [insured's] failure to read the policy, at most, may give rise to a defense of comparative negligence but should not bar, altogether, an action against a broker."

The ruling is a significant decision that is likely to influence other jurisdictions. It is a call to insurance agents and brokers to revisit and fortify their loss control procedures. Consideration should be given to working with their E&O insurers and/or E&O attorneys to tailor procedures to the particular business of the insurance agency or brokerage.

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In so ruling on *American Building Supply*, the Court of Appeals considered whether the 100-year-old legal presumption set forth in its decision of *Metzger v. Aetna Ins. Co.,* 227 NY 411, 416 (1920), that an insured who is in receipt of the insurance policy has a duty to read it and is presumed to know the contents thereof, applies to bar an E&O action against an agent or broker who has allegedly failed to obtained the insurance coverage specifically requested by the insured. The court concluded that the presumption did not apply:

> The facts as alleged here, that the plaintiff requested specific coverage and upon receipt of the policy did not read it and lodged no complaint, should not bar the plaintiff from pursuing this action.

Although the Court of Appeals noted that it is a good idea for the insured to read its insurance policy, it opined that the insured could rely in this regard upon the expertise of the insurance agent or broker:

> While it is certainly the better practice for an insured to read its policy, an insured should have a right to "look to the expertise of its broker with respect to insurance matters" (Baseball Off. of *Commr. v. Marsh & McLennan,* 295 A.D.2d 73, 82 [1st Dept 2002]; see also *Bell v. O'Leary,* 744 F2d 1370, 1373 [8th Cir 1984]). The failure to read the policy, at most, may give rise to a defense of comparative negligence but should not bar, altogether, an action against a broker (see Baseball Off. of Commr. 295 A.D.2d at 82).

The Court of Appeals found that there were issues of fact as to whether the plaintiff requested specific coverage for its employees and whether the defendant failed to secure a policy as requested, and thus concluded that it was inappropriate to award summary judgment to the insurance broker because the "plaintiff's failure to read and understand the policy should not be an absolute bar to recovery under the circumstances of this case."

The Court of Appeals reiterated that ordinarily, absent a special relationship, an insurance agent or broker has the duty to obtain only the insurance that was specifically requested by the insured:

> [I]nsurance agents have a common-law duty to obtain requested coverage for their clients within a reasonable time or inform the client of the inability to do so; however, they have no continuing duty to advise, guide or direct a client to obtain additional coverage" (*Murphy v. Kuhn,* 90 N.Y.2d 266, 270 [1997]). To set forth a case for negligence or breach of contract against an insurance broker, a plaintiff must establish that a specific request was made to the broker for the coverage that was not provided in the policy (see *Hoffend & Sons, Inc. v. Rose & Kiernan, Inc*., 7 N.Y.3d 152, 155 [2006]). "A general request for coverage will not satisfy the requirement of a specific request for a certain type of coverage" (Id. at 158).

The facts of the case were as follows:

American Building Supply (ABS) provided building materials to general contractors. DRK, LLC sublet a building to ABS. Under the primary lease, DRK was responsible for procuring a general liability insurance policy with a minimum of $5 million in coverage covering bodily injury and property damage from a New York licensed carrier.

As part of its sublease agreement, ABS was required to comply with all the terms of the of the original lease agreement, including the provision to procure insurance. ABS hired the insurance broker, Pollack Associates, which procured a policy from Burlington Insurance Company. The Burlington policy included a cross-liability exclusion that excluded claims between the policyholders (ABS and DRK) as well as all claims asserted by an "employee of any insured." ABS and DRK then transferred coverage to a new insurance broker, Petrocelli Group, Inc. (Petrocelli), which renewed the Burlington policy for a second policy year.

ABS asserted that it specifically requested "general liability for the employees ... if anyone was to trip and fall and get injured in any way." ABS also alleged that Petrocelli was aware that ABS was a wholesale operation and that only employees were on the premises. Neither ABS nor Petrocelli read the policy and, therefore, were unaware that the policy contained the exclusion. The exclusion came to light in October 2005, when an ABS employee was injured after a forklift fell on his leg and Burlington denied the claim pursuant to the cross-liability exclusion. Although the Supreme Court ordered Burlington to provide coverage to ABS, the Appellate Division, First Department (First Department) reversed, citing the above-mentioned exclusion.

ABS then sued Petrocelli for breach of contract and negligence for failing to procure the correct policy. Petrocelli moved for summary judgment, but the Supreme Court denied the motion, claiming there were issues of fact for a jury to decide regarding the plaintiff's request for specific insurance coverage. The First Department reversed, stating that any recovery was precluded because ABS had failed to read and understand the policy. As such, there were no material issues of fact and summary judgment should have been granted.

In the wake of this decision, given that the receipt of the policy defense will no longer act to bar E&O lawsuits, it is important for insurance agents and brokers to review the procedures in place at their agencies for offering coverages, documenting the insured's specific request for insurance coverage and delivering the insured's insurance policy.

1. Offer a Full Range of Coverage

Although under the Court of Appeals decision of *Murphy v. Kuhn,* supra., ordinarily a New York insurance agent or broker has no duty to advise, guide or direct an insured to obtain a particular type or amount of coverage absent a specific request, the prudent insurance agent or broker will offer a wide range of coverage and document the insured's file with respect to the coverage the insured selected, as well as the coverage that the insured declined. Use checklists to prompt the agent to offer a wide range of coverage. Proposals can reflect the coverage that was offered. Emails and correspondence to the insured can document the coverage that was offered to the insured and detail the coverages that the insured accepted or declined. If warranted, the insured can sign off on major declinations or reductions of coverage.

2. Document the Insured's Specific Request for Insurance

Currently, with the loss of the receipt of the policy defense, there is little to prevent an insured, after a denial of a claim or a partial claim denial, from alleging that he or she requested whatever coverage is lacking, essentially making agent's E&O policy substitute coverage. Such an allegation will often be enough to survive the agent's motion for summary judgment, allowing the insured to get to the jury in an E&O trial.

E&O trials can be expensive and time-consuming and something that most agents or brokers would like to avoid. To strengthen and bolster the agent's recollection as to what insurance the insured specifically requested, the agent should establish a regularly followed procedure for documenting the insured's specific insurance request in the insured's file. This documentation could also include notes as to the insured's description of the risk. An email or correspondence to the insured documenting the insurance that was specifically requested could prove very useful in defending an ensuing E&O lawsuit. Equally important is careful preparation of the insurance application, which the insured should sign only after the agent instructs him to review for accuracy. A copy of the signed application should be kept in the insured's file.

3. Deliver the Insurance Policy With an Offer to Review

Even though the receipt of the insurance policy defense as a complete bar has been eliminated, agents should implement regularly followed procedures surrounding the delivery of the policy to the insured. When the policy comes in to the agency, a knowledgeable and fully trained policy checker should promptly check it against the application for accuracy. The agent should also be familiar with the forms and endorsements of the various polices offered, which can differ from insurer to insurer.

The policy should then be delivered to the insured with a cover letter advising the insured to review the insurance policy and contact the agent with any questions. The cover letter should also offer the insured the opportunity to review the insurance policy with the agent. A copy of the correspondence should be kept in the insured's file.

Application of Consumer Protection Laws to Licensed Professionals: Conflicting Standards and Murky Coverage Implications

By Matthew S. Marrone

I. Introduction

The vast majority of states have consumer protection laws, and over the last several decades in particular, courts across the country have debated whether such laws should apply to licensed professionals. Although the cases throughout the country are quite similar in nature, judges considering these issues have created a complex web of conflicting decisions based on highly subjective and speculative parameters. This article will explore some of these decisions, and the rationale behind them. It will conclude with a number of considerations relevant to both insurers and defense counsel.

II. Background of Antitrust and Consumer Protection Laws

The study of consumer protection laws should begin with antitrust, as the Federal Trade Commission (FTC) Act protects consumers both from deceptive practices related to competition and unfair trade practices. Today, the FTC is entrusted with enforcement of both antitrust and consumer protection. Consumer protection laws used in almost every state in the nation were drafted borrowing language from the FTC Act. The most important connection between antitrust and consumer protection is Section 5 of the FTC Act, which the FTC uses to discharge both is antitrust and consumer protection missions.

While broad in mission, the FTC has often taken a narrow path in choosing its enforcement actions — likely because of budgetary constraints. *(See Mark D. Bauer, "The Licensed Professional Exemption in Consumer Protection: At Odds with Antitrust History and Precedent," 73 Tenn.L.Rev. 131-176 (2006) (citations omitted)*.

Subsequently, states began enacting their own consumer protection statutes, often referred to as "Little FTC Acts," because they contain identical language to the FTC Act forbidding, typically, "unfair competition and unfair deceptive acts and practices."

Despite the moniker of "Little FTC Acts," there is actually considerable variation between state consumer protection laws. Typically, states have either a) copied Section 5 of the FTC Act in its entirety; b) adopted all or part of three model state consumer protection laws; c) copied the

FTC or a model act but changed some of the wording; or d) combined two or more of these approaches. Although the states have followed different paths in trying to protect consumers, there are very significant and strong commonalities between most — if not all — of the states.

With the exception of Iowa's Consumer Fraud Act, all state acts provide for private enforcement and private remedies. State consumer protection laws prohibit unfair or deceptive practices in the trade or commerce in goods or services. Anyone harmed by such practices may bring a private action against the offending party, and if successful, may recover costs of suit, attorney's fees, and triple the amount of her actual damages. As such, a plaintiff's incentive to assert such a cause of action (and the insurer's potential exposure) is great.

III. Licensed Professionals and States' Little FTC Acts

Whether the learned professions, such as doctors, lawyers, accountants, architects, and engineers should be included under Little FTC Acts has been debated for years. Presently, it appears that roughly half the states in the country permit such claims to be asserted against licensed professionals, without any statutory or case law exceptions. New York and California, for example, appear to be included among these states.

The states where courts have found some or all professionals to be outside the scope of their Little FTC Act, however, have suggested more than one reason to exempt professionals.

A. Trade or Commerce Exemptions

Similar to the FTC and Sherman Acts, the majority of states require that allegedly unlawful conduct under consumer protection laws be made in "trade or commerce." Substantially all of the remaining states require the offending conduct arise from "trade." What constitutes "trade or commerce" is subject to debate.

For instance, in *Short v. Demopolis*, 691 P.2d 163 (Wash. 1984), the Washington Supreme Court held that an attorney's conduct in the practice of law may not be "trade or commerce." A billing dispute arose between a law firm and client concerning both the size of the bill and whether the client had agreed that two associates — rather than a partner — would work on the case. The client alleged a violation of Washington's Little FTC Act. The Washington Supreme Court held that the learned professions are not part of trade or commerce; ergo, the practice of law cannot constitute trade or commerce under the Washington Little FTC Act. Id at 168. Although the Washington Supreme Court did hold that "certain entrepreneurial aspects of the practice of law may fall within the 'trade or commerce' definition" of the Little FTC Act, it refused to recognize that all attorney conduct was trade or commerce.

Other courts have indulged in more creative analyses. In trying to distinguish antitrust cases concerning the learned professions, the Illinois Court of Appeals in *Frahm v. Urkovich*, 447 N.E.2d 1007 (Ill.Ct.App. 1983) suggested that such cases "dealt only with the commercial aspects of the legal profession through activities which would have a direct effect on the consuming public and not with the practice of law itself." Although the court failed to describe the type of activity which would involve the practice of law but not have a direct effect on the consuming public, the court held that "trade or commerce" did not include the actual practice of law.

B. Non-Entrepreneurial Activities Exemptions

The jurisprudence underlying the aforementioned cases perhaps set the stage for further distinction within the learned professions when determining whether consumer protection laws apply. Several state courts have created a subjective test to determine the applicability of a Little FTC Act: if the licensed professional is engaged in an "entrepreneurial activity," then the conduct falls within the ambit of the Little FTC Act; if the activity involves the learned profession itself, then the Little FTC Act does not apply.

For instance, in *Kessler v. Loftus,* 994 F.Supp. 240 (D. Vt. 1997), a Vermont law firm represented to a divorce client that her claims against her former spouse's land were "adequate security" for a debt that was owed, and that the firm committed to provide her with "competent representation," neither of which she received. Although the court noted that it was required to construe Vermont's law in accordance with FTC precedent, and that attorneys received no blanket exemption from the law, the court held that representations of "adequate security" and "competent representation" were legal opinions and not entrepreneurial. Therefore, no viable claim could be asserted.

In *Suffield Development Associates, L.P. v. National Loan Investors, L.P.*, 802 A.2d 44 (Conn. 2002), a debtor alleged that a law firm fraudulently and deceptively tried to collect a debt. While the Supreme Court of Connecticut agreed that the law firm abused the debt collection process, the court denied relief under relevant Connecticut law. Id. at 53. Although the debtor alleged that the law firm sought to recover an amount in excess of what was owed, the court concluded it was not entrepreneurial and instead may have been actionable professional misconduct.

In a Tennessee case, *Constant v. Wyeth*, 352 F.Supp. 847 (M.D.Tenn. 2003), a doctor prescribed the drug Fen-Phen to a patient, and the drug was later withdrawn from the market because of concerns about serious health effects. The court succinctly held that doctors are immune from Tennessee's Little FTC Act when the "allegations concern the actual provision of medical services."

C. "Regulated" Professions Exemptions

Another reason that some state courts have chosen to exempt licensed professionals stems from the license itself, as some states' courts yield to the regulatory scheme already in place for licensed professionals. In *Gadson v. Newma*n, 807 F.Supp. 1412 (C.D.Ill. 1992), an Illinois psychiatrist accused a hospital and another psychiatrist of deceptively creating financial incentives to admit patients to the hospital. While the court acknowledged that state-regulated professionals were not exempt from the FTC Act itself, and that the Illinois Little FTC Act called upon courts to consult FTC precedent, the court found "[t]he medical and legal professions are afforded immunity from the Illinois law primarily, because, unlike other commercial services, medical and legal bodies are regulated by governmental bodies."

In *Hampton Hospital v. Bresan*, 672 A.2d 725 (N.J.Super. 1996), a New Jersey plaintiff alleged that a hospital inflated its medical bills by unnecessarily extending a patient's stay. Holding hospitals to be beyond the scope of the New Jersey Consumer Fraud Act, the court noted that hospitals were already strongly regulated by the state department of health. The court did not note, however, whether this separate regulatory scheme included a right of private action or multiple damages. New Jersey has similarly ruled that consumer fraud act claims cannot be asserted against attorneys or insurance producers.

In *New Hampshire,* the state Supreme Court decided that attorneys and other professionals were exempt from the New Hampshire law because of vague wording exempting trade or commerce subject to a "regulatory board." *Rousseau v. Eshleman*, 519 A.2d 243 (N.H. 1986). The New Hampshire Legislature has since repealed the relevant language, suggesting a legislative intent to include professionals.

IV. The Beyers Decision of the Pennsylvania Supreme Court

Pennsylvania is a state that has addressed this issue more recently than other states, in the 2007 case of *Beyers v. Richmond*, 937 A.2d 1082. In fact, the split opinion (5-2) of the Pennsylvania Supreme Court (the highest appellate court) in *Beyers* effectively incorporates all of the above rationale, and represents the competing viewpoints advanced most often when considering this issue.

In *Beyers*, a woman who had settled her personal injury case sued her attorney, claiming he improperly siphoned some $26,000 in phantom costs out of her settlement. She alleged he listed these costs as a loan repayment and various medical bills, when in fact they did not even exist. In addition to various other causes of action, she claimed he violated Pennsylvania's Unfair Trade Practices and Consumer Protection Law (UTPCPL) in the process of collecting and distributing the settlement proceeds.

Generally speaking, the UTPCPL — like other states' consumer protection laws — prohibits unfair or deceptive practices in the trade or commerce in goods or services. Anyone harmed by such practices may bring a private action against the offending party, and if successful, may recover costs, attorney fees, and treble damages. Clearly, the incentive to assert such a cause of action is great.

The narrow issue presented in *Beyers* was whether the practice of law falls within the "services" contemplated by the UTPCPL. The majority found it does not, but in doing so, chose to view the case more broadly. Attorneys in Pennsylvania are regulated exclusively by the Pennsylvania Supreme Court. Thus, the majority ruled, including attorneys' conduct within the ambit of the UTPCPL would effectively subject them to regulation by someone else, thereby encroaching upon the court's authority. The majority found this unacceptable and therefore exempted attorney misconduct from the UTPCPL.

The majority view in *Beyers* echoes the rationale used by other courts to exempt professional misconduct from consumer protection laws. This rationale accepts that such laws essentially are enacted to keep the conduct of purveyors of goods and services in check. By contrast, attorneys (and other licensed professionals) are already subject to licensing bodies which regulate their conduct and impose disciplinary measures when appropriate. Thus, the reasoning goes, it would be inappropriate to additionally subject them to consumer protection laws.

The dissenting justices in *Beyers* represented the counterargument, disagreeing with the micromanagement espoused by the majority. They questioned how licensing bodies are supposed to police each and every instance of professional misconduct. Consumer protection laws, they said, are laws of general applicability, and people should not be exempt just because of their status as (insert: attorneys, physicians, insurance brokers, real estate agents, etc.).

They further noted that many jurisdictions which have generally exempted attorneys from consumer protection laws have refused to exempt their business, non-professional activities. The dissent argued since the mere distribution of settlement funds is not a "core function of legal representation" and "does not involve the exercise of legal

judgment," any court-created exemption to the UTPCPL should not apply.

V. Conclusion

The hodgepodge of conflicting court interpretations exempting licensed professionals from state Little FTC Acts is difficult to fully understand, and presents a challenge, in particular, for insurers writing business across the country. The conduct of a doctor or a lawyer in one state may be ruled unlawful, while the same conduct in another state under an identically worded statute may not be actionable. Even worse, the entire decision may be predicated on whether a judge subjectively determines the action at issue was one of entrepreneurialism or professional judgment.

If a law firm pads its bills, is that entrepreneurialism run amok, or is it a lapse in professional judgment? If a plastic surgeon advertises a procedure to improve one's looks and it fails, is that false advertising akin to rabid entrepreneurialism, or can it be excused as a professional failure outside the scope of a Little FTC Act? If a certified public accountant fails to give one's finances the attention promised in print ads, can the wrong be characterized solely as malpractice, or is it also false advertising? How would the conduct of "miscellaneous professionals" — who may not be licensed by any governing body — be addressed?

From the perspective of defense counsel, the jurisdictions which have exempted professionals can provide guidance for arguments to be made in those jurisdictions which have not. It never hurts to advance an argument, preserve a basis for appeal, and try to make new (or change existing) case law in a particular state.

From an insurer's perspective, these issues can be tricky, and pose numerous questions relevant to both the defense and coverage of professionals. From a liability standpoint, where do you draw the line between "professional services" and "business activities?" And is that line different from a coverage standpoint? Is the coverage grant (i.e. definition of "professional services") in an insuring agreement more broad or narrow than the liability the insured is subject to in a particular jurisdiction? Is there an exclusion in the policy for activities that parallel the "business activities" contemplated by existing case law in a particular state?

On the issue of damages and indemnity, are treble damages imposed by consumer protection laws considered the equivalent of punitive damages that may or may not be covered by the professional liability insurance policy? What if the policy form covers the activities of a professional which would fall within the purview of a state's consumer protection law, but contains an exclusion for punitive or statutory damages? In such a scenario, a conflict in the policy might arise as the insurer would have agreed to cover the professional activities giving rise to a consumer protection claim, but not the resulting damages.

When these questions are raised in jurisdictions around the country — and they will be, if they haven't been already — individual judges will be the people who ultimately answer them. However, they are questions worth considering by the insurer when drafting the policy form, the broker and underwriter when offering coverage, claims personnel when making coverage determinations, and defense counsel when advancing the defense.

For Financial Industry Professionals, Understanding Changes to FINRA's Suitability Rule Is Key to Managing Risk

By Jill C. Owens and Colleen M. Murphy

Introduction

In July of last year, with the adoption of rule 2111, the Financial Industry Regulatory Authority (FINRA) effectuated significant revisions of the applicable rule and standard for determining the suitability for the customer of investments in securities. Careful review and understanding of new requirements for making suitability determinations, and of the regulatory policy reasons for the change, is critically important to an investment firm's implementation of best practices in order to manage risk of loss from customer claims of sales practice violations.

To place this discussion in context, it may be useful to explain that suitability refers to the determination whether a recommendation by a broker or firm of a particular security or investment strategy is in keeping with the customer's risk tolerance and investment profile. The suitability inquiry relates only to recommended transactions in securities and to recommended investment strategies. Suitability does not come into play when the broker is merely taking and filling customer orders.

Although the new rules took effect on July 9, 2012, the policy reasons underlying the rule changes are still very much on FINRA's radar even close to a year later. In its annual issuance of regulatory priorities of January 11, 2013, FINRA referenced its concern that in the current economic setting of slow growth and low interest rates, investors are challenged to find desired returns within risk tolerances appropriate to their financial situations. Given this, FINRA continues to focus close attention on sales practice abuses arising from the attempt to obtain yields commensurate with investor's high expectations without due regard for appropriate risk levels. The recommendation of unsuitable investments and investment strategies remains a priority sales practice abuse that FINRA continues to monitor closely in its role as a the primary independent financial industry regulator.

Recent Developments In Enforcement of the Suitability Rule

If there was any question about FINRA's focus on suitability, one need look no further than the case of former FINRA

member Jeffrey Rubin, who on March 7, 2013, accepted the finding of FINRA's Enforcement Division that he be barred for life for making unsuitable investment recommendations to at least 31 NFL players including retired superstar wide-receiver Terrell Owens.

According to the settlement letter that Rubin executed with FINRA, between 2006 and 2011 he offered the players an opportunity to invest through his so-called financial-related "concierge" services, for which Rubin charged each of them $40,000 annually. Rubin steered the millionaire athletes to several very risky, illiquid deals without regard to their earnings horizons and financial needs.

Rubin was found to have recommended that one high-profile player invest the majority of his liquid net worth in a concentration of illiquid, high-risk securities including ownership interests in a now bankrupt Alabama casino. The player lost approximately $3.2 of this $3.5 million investment. Other Rubin customers who were NFL players lost a total of $40 million with this same casino investment.

With respect to the player who lost $3.2 million, FINRA's findings were that:

> Rubin recommended those transactions without having reasonable grounds for believing that such transactions were suitable for the customer in view of the nature of the account and the customer's financial situation, investment objectives and needs. Moreover, [Rubin] failed to understand the risks associated with investing in those securities.

Although arising under the prior suitability rule, the Rubin case highlights the vigor with which FINRA applies the suitability rule to its members. Although the investor was clearly a high net worth individual, that fact did not render Rubin free to recommend an over-concentration in the same illiquid, high-risk investment without regard to his customer's risk tolerance, earnings horizons, and financial needs.

The Former Suitability Rule

The superseded rule, FINRA Rule 2310, required the broker and broker-dealer to have "reasonable grounds" for belief in the suitability of an investment recommendation in a security. Specifically, the rule stated:

> In recommending to a customer the purchase, sale, or exchange of any security, a member shall have reasonable grounds for believing that the recommendation is suitable for such customer upon the basis of the facts, if any, disclosed by such customer as to his other securities holdings and as to his financial situation and needs.

What's New — The Current Suitability Rule

As of July 10, 2012, FINRA Rule 2111 applies and provides that:

> [A] member or an associated person must have a reasonable basis to believe that a recommended transaction or investment strategy involving a security or securities is suitable for the customer based on information obtained through reasonable diligence of the member or associated person to ascertain the customer's investment profile.

In contrast with the old rule, Rule 2111 no longer accepts a passive reliance upon "facts, if any disclosed by the customer," but, instead, commands the active, reasonably diligent gathering of customer information from which the belief in suitability may be reasonably based.

The new rule significantly broadens the kinds of recommendations requiring determination of suitability. The old suitability rule applied transaction-by-transaction as of the time of the recommendation. The new rule still applies to individual transactions in securities, but has been expanded to apply to investment strategies, to series of transactions, and to recommended account features. Thus, for example, the broker may not recommend that at customer hold a security unless there has been analysis of the reasonableness of such a suggested strategy to the customer's investment objectives, finances and needs. In another example, the recommendation that a customer trade on margin is itself a recommended strategy subject to retroactive review for its suitability for the particular customer. As discussed below, excessive trading is now analyzed from a suitability perspective and thus expands the analysis from one transaction to a series of transactions and, indeed to the customer's entire portfolio. These additional areas represent a significant expansion of suitability review.

In response to firms' inquiries regarding the kinds of communications with a customer that constitute "recommendations," FINRA has explained that the following communications are exempt and not considered recommendations for suitability purposes: general financial and investment information; basic investment concepts; historical asset class returns; estimates of future retirement income needs; descriptive information about retirement plans; and provision of non-customer specific asset allocation models based on general investment theory. Whether a communication constitutes a recommendation is a fact-based inquiry based on objective evidence.

The new rule recognizes the three central suitability categories that were largely developed in case law interpreting the

former rule: customer-specific suitability, reasonable-basis suitability, and quantitative suitability.

Customer–specific suitability requires the advisor to have a reasonable basis to believe that a recommendation of the security or strategy is suitable for the particular customer based upon application of the expanded "Know Your Customer" Rule (FINRA Rule 2090), and the aforementioned broader information gathering requirements.

Reasonable-basis suitability involves the requirement that a broker engage in a reasonable due diligence study of the nature of a recommended security or investment strategy involving securities, including study of risks and upside, to arrive at a determination for what kind investor the investment is suitable based on a range of risk tolerances.

Quantitative suitability requires the advisor who controls his or her customer's account to have a reasonable basis to believe that a series of recommended transactions, even if suitable in isolation, are not excessive, i.e., do not rise to the level of churning.

Getting to "Know Your Customer" Even Better for Suitability Purposes

The new rule substantially expands the responsibility of the broker-dealer and broker to obtain an even longer list of facts and information pertinent to the customer's financial situation and investment profile in order to conduct the "reasonable grounds" suitability analysis that animates Rule 2111.

In its regulatory notices to members, FINRA has explained that the "the reasonable belief" must derive from information obtained through the "reasonable diligence" of the firm or advisor to ascertain the customer's investment profile. Under the closely related (and also new) "know your customer" rule (FINRA Rule 2090), firms have always been required to obtain information about their customers at account opening, in part in order to conduct the former suitability analysis, but also, for example, to fulfill the requirements of federal anti-money laundering laws. The current rule adds to the categories of information the firm and advisor were responsible for collecting from customers under the superseded rules. The prior rule had required information regarding other investments, financial situation, investment needs, tax status, and investment objectives. The current rule adds to that list the following specific information:

- Age
- Investment experience
- Investment time horizon
- Liquidity needs
- Risk tolerance

FINRA's regulatory guidance notices to its members demonstrate recognition that although firms may ask, customers are not obligated to provide all of the information requested. Thus, when information is unavailable despite the firm having requested it, the prudent firm may either limit the scope of the recommendations it will make for that customer, or, in extreme cases, will decline to do business with the customer. That said, the suitability rule does not prohibit a firm from making a recommendation where, for example, the customer has withheld one or a few items of information from their investment profile, so long as the firm determines that it has adequate information to arrive at a reasonable basis to believe that the investment strategy is suitable based upon the available information. Whether the firm has acted reasonably based on sufficient information will, again, be a fact-based inquiry.

The "know your customer" and suitability rules require more fluid knowledge of the customer. Thus, it is unlikely to be found sufficient merely to obtain an investor profile once, at account opening, in a lengthy customer relationship. Sales practice claims have arisen in which a customer states that their circumstances changed drastically through, for instance, radically changed personal or financial circumstances, and that the broker knew or should have known this. Thus, firms and brokers would be wise to institute internal procedures for obtaining updated customer information to confirm periodically, or at the time of a series of new transactions, that the customer's risk tolerance has not changed materially over time.

FINRA has advised that firms may use a risk–based approach to documenting compliance with the rule. So, for instance, a firm is free only to discuss profile information with a customer without requiring it in writing. However, a firm must evaluate the risks attendant to doing business that way. In a litigious culture such as ours, where the worst case scenario is winding up in a protracted arbitration with a customer raising a suitability claim regarding a large loss, obtaining a written disclosure or consent, or at least sending a confirmatory email regarding the discussion will place the firm and broker in a far more defensible position than will being stuck in a "he said, she said" debate over whether the required information was obtained orally or not, or whether the information was accurately recorded.

Similarly, in response to firm feedback regarding the rule, FINRA clarified that it was not requiring firms to revise all of their new account documentation to include the additional information required to be gathered. That said, firms would be wise at least to create one or more additional forms to facilitate straightforward collection of the additional information in writing. To the extent the client declines to provide certain information, the forms could require the

customer to acknowledge this in writing, for example by initialing the relevant lines on the form.

Understanding the Product Being Recommended

Since the institution of the new suitability rule, FINRA has issued regulatory notices to its members specifically relating to the suitability of complex products. Reasonable-basis suitability requires the firm and the advisor to understand the terms, conditions, risks, and rewards of the investment being recommended in order to assess for what hypothetical investor such product would be suitable.

A recent decision of the United States Court of Appeals for the First Circuit upholding a FINRA arbitration decision highlights the application of reasonable-basis suitability. In *Cody v. Securities Exchange Commission,* 693 F.3d 251, 259 (1st Cir. 2012), the court reviewed the argument of a FINRA member that he had sufficient understanding of collateralized mortgage obligations (CMOs) in order to recommend them to customers. The court held that it was inconsistent with the broker's claim of adequate understanding of the product that he recommended a risky security to customers who had indicated a preference for safe investments. Also of no help to the broker's case was his admission during the arbitration hearing that he thought CMOs were substantially the same as other bond investments that he did not know that the credit rating of the CMO he recommended had recently been downgraded, and that he did not know that the particular security he recommended was one of the riskiest of the classes of securities collateralized by the same pool of assets.

This example highlights the need for a firm's compliance personnel to put in place procedures to ensure that the registered persons within the firm are trained to understand the products they can and do recommend, including specific risks attendant to the investments.

When Is the Quantity of Account Activity Unsuitable?

In adopting a specific category of quantitative suitability, FINRA simply codified a long line of excessive trading cases. To avoid quantitative unsuitability, a broker-dealer must have a reasonable basis for believing that a series of recommended transactions are not excessive and unsuitable for the customer in light of their investment profile. Thus, even if each recommended transaction is suitable when viewed in isolation, the possibility remains that as a group, the transactions are quantitatively unsuitable. This element of suitability requires, more than the others, that the broker-dealer review its customer's entire portfolio. The quantitative element of suitability requires evaluation of classic excessive trading measures such as turnover rate, cost-equity ratio, and short-term trading. While "churning" is a sales practice that has long received regulatory scrutiny, FINRA has now placed the churning analysis squarely under the rubric of suitability.

Acting in Its Customer's Best Interests

FINRA has also adopted the requirement from cases interpreting suitability and broker-dealer's sales practice obligations that a broker's recommendations be consistent with the customers' "best interests." The regulatory guidance documentation explains that this "best interests" rule prohibits the advisor from placing his or her own interests ahead of those of their customers. According to FINRA, a broker acts in contravention of a client's best interests by, for instance, recommending a product in order to receive a larger commission then an alternative investment; or by recommending securities being sponsored or pushed by the brokers own firm because of internal firm pressures to do so. Firms would be wise to weigh against their profit motivations the cost of a public, negative finding that the firm had pressured their brokers to push investments to the point of unsuitability.

Conclusion

While the modified rules may seem onerous and requiring of more and more documentation, which sometimes creates tensions or interferes with the fast pace at which these transactions are recommended and executed, from another perspective, they should give comfort. In large measure, they codify in one place the ways in which courts and arbitrators had already been interpreting suitability requirements.

Moreover, on the upside, whether or not a transaction or strategy was suitable is determined as of the time it was recommended. Thus, whether or not the investment or strategy made or lost money is irrelevant to the suitability determination. As such, it can be expected, and certainly argued in arbitration of a sales practice claim, that it should not be assumed from the fact that a strategy or investment lost money that it was inherently too risky and, hence, unsuitable.

Prudent firms should be working with their compliance departments, their legal counsel, and their professional liability carriers to tighten their systems in the areas of information-gathering procedures, training regarding complex investments and their risk/reward profiles, and supervision as to suitability. Vigilance in these areas can reduce the number of customer complaints received. Moreover, when a serious complaint is lodged that has the potential to result in significant loss, the firm can be more confident that their procedures and documentation will afford them the best possible defense to claims of sales practice

abuse and supervisory and compliance shortcomings.

Two Recent Cases Suggest the CEPA Tide Turning In Favor of Employers in New Jersey

By Caroline J. Berdzik and Michael S. Katzen

Background

The Conscientious Employee Protection Act (CEPA) — also known as New Jersey's "Whistleblower Act" — was designed to prohibit employers from taking retaliatory action against an employee because the employee engages in certain protected "whistleblower activity." In order to make a case under CEPA, an employee must establish that:

- he/she reasonably believes that his/her employer's conduct was violating either a law or a rule or regulation promulgated pursuant to law, or a clear mandate of public policy (or in the case of a licensed or certified healthcare professional, he/she reasonablly believes that the conduct of the health care provider he/she is employed by constitutes improper quality of patient care that violates a law, rule, regulation, or professional code of ethics);
- he/she performed a "whistleblowing activity" described in CEPA (e.g., complains to a supervisor or discloses to a public body);
- an "adverse employment action" was taken against the employee (e.g., discharge, suspension, demotion, or other negative change in the terms and conditions of his/her employment); and
- a causal connection exists between the whistleblowing activity and the adverse action.

Historically, New Jersey courts have interpreted CEPA and the definition of "protected whistleblower activity" broadly, erring on the side of providing employees with the most legal protection possible. However, one recent CEPA decision, and another decision that is on the way, might chisel away at CEPA's unmitigated expansion, signaling some much needed relief for New Jersey employers.

Hitesman v. Bridgeway

In *Hitesman v. Bridgeway Inc.,* 2013 N.J. Super. LEXIS 44 (App.Div., March 22, 2013), Bridgeway Care Center, a long-term care facility, terminated the employment of Jason Hitesman, a registered nurse, after he called various governmental agencies and the media to report his concerns about Bridgeway's response to what he considered an inordinate rate of infections among residents. He sued, alleging Bridgeway violated CEPA. Hitesman alleged he had an objectively reasonable belief, in part based on the American Nursing Association's (ANA) Code of Ethics, that Bridgeway provided "improper quality of patient care." A jury ruled in Hitesman's favor on the issue of liability, but awarded no damages, and both parties appealed.

The sole issue facing the Appellate Division was whether Hitesman had established a reasonable belief that Bridgeway's conduct violated a professional code of ethics. The court decided that Hitesman had not met this standard and ruled that Hitesman's belief that Bridgeway violated the ANA's Code of Ethics was not "objectively reasonable" because the section of the code at issue provided standards for employees to follow, and did not apply to Bridgeway as an employer. It is expected that Hitesman will appeal this ruling to the New Jersey Supreme Court.

Battaglia v. United Parcel Service

How broad is the definition of "protected whistleblower activity" under CEPA?

A case currently before the New Jersey Supreme Court provides some hope to employers that are seeking for the court to limit what is considered to be "protected whistleblower activity." In A-86/87-11 *Michael Battaglia v. United Parcel Service, Inc.* (069405), the plaintiff, Michael Battaglia, alleged that his employer, United Parcel Service (UPS), violated CEPA by demoting him in retaliation for complaints he voiced about the work practices of other employees. Specifically, the sole basis for Battaglia's CEPA claim was one alleged conversation between Battaglia and his supervisor in 2004, during which Battaglia claimed that several unidentified supervisors told him that employees were "abusing" the corporate credit card and taking "liquid lunches." Battaglia also brought claims under New Jersey's Law Against Discrimination.

The jury found for Battaglia and awarded him $500,000 in economic damages and another $500,000 for emotional distress (which was later reduced to $205,000), and the trial court judge denied UPS's post-trial motion for judgment on the CEPA claim. The Appellate Division similarly denied UPS's request for judgment or a new trial on the CEPA claim, but vacated the emotional damages award and ordered a new trial. Both parties appealed to the New Jersey Supreme Court, which granted certification and heard oral argument on April 17, 2013.

During oral argument, counsel for UPS argued that there was no valid basis for Battaglia's CEPA claim, and asked the New Jersey Supreme Court to, among other things: (1) require that a whistleblower actually report an activity that is intended to be covered by CEPA (as opposed to a "nebulous allegation of liquid lunches");

(2) uphold CEPA's requirement that an employee must, at a minimum, have a reasonable belief that fraud or illegality occurred (noting that Battaglia did not actually witness any of the conduct he complained of, never testified that anyone was falsifying credit card documentation, and conceded during cross-examination that he did not believe the activity he complained of constituted fraud); and (3) follow settled law that does not allow CEPA claims for disputes over internal policy issues.

This will be a critical decision for New Jersey employers, as employees are continuing to stretch the definition of protected activity. If employees are permitted to bring CEPA claims based on vague allegations that appear to implicate purely private disputes over internal company policy issues, practically any type of complaint could conceivably fall under CEPA's purview which will increase litigation in this area.

Practical Pointers

In light of these cases, employers should continue to investigate and thoroughly document whistleblower allegations, the outcome of such investigations, and any communications with the whistleblower. This evidence could play a crucial role in defending against a future CEPA lawsuit. When a CEPA lawsuit comes in, discovery should be focused on having plaintiff specifically identify the protected activity he or she engaged in and what law, public policy, or other basis is being relied upon in support of the claim.

The Federal Medicaid Act's Anti-Lien Provision: A Look at the Supreme Court's Decision in *WOS v. E.M.A.*

By Matthew R. Shindell

The resolution of any personal injury action involves the calculation of damages a plaintiff should be awarded. This task is particularly difficult in cases involving catastrophic injuries where ongoing medical care is required during the duration of the plaintiff's life. Under 42 U.S.C. § 1396k(a)(1)(A), Congress has directed states in administering Medicaid programs to seek reimbursement for medical expenses incurred on behalf of beneficiaries who later recover from third-party tortfeasors. However, Section 1396p(a)(1) prohibits states from attaching a lien on the property of a Medicaid beneficiary to recover benefits paid by the state on the beneficiary's behalf. This provision does not permit a state to take any portion of a Medicaid beneficiary's judgment or settlement that does not pertain to payments for medical care.

In *Wos v. E.M.A.*, 133 S.Ct. 1391 (U.S. March 20, 2013), a medical malpractice claim was filed in North Carolina state court on behalf of a child who suffered injuries at birth that rendered her deaf, blind, unable to sit, walk, crawl, or talk. Moreover, the child is mentally retarded and suffers from a seizure disorder. It was determined that she requires between 12 and 18 hours of ongoing skilled nursing care each day. The child will never be able to work or live independently.

The plaintiff's expert witnesses in *Wos* determined medical and life-care expenses, loss of future earning capacity, and other expenses such as specialized transportation equipment will total in excess of $42 million. Furthermore, damages were sought for pain and suffering in addition to her parents' emotional distress. However, the plaintiff's experts did not calculate the last two categories.

Under North Carolina General Statute Annotated § 108A-57, up to one-third of any damages recovered by a beneficiary for a tortious injury must be paid to the state for reimbursement of any payments it made for medical treatment. In compliance with this statute, the plaintiff in *Wos* informed the North Carolina Department of Health and Human Services of settlement negotiations. A representative from the state indicated Medicaid paid $1.9 million for medical care. The court ultimately approved a $2.8 million settlement, which apparently represented the defendants' policy limits. One-third of this amount was placed into an interest-bearing account pursuant to the aforementioned statute.

The plaintiff in *Wos* filed a declaratory judgment action in federal court and argued the North Carolina statute violated section 1396p(a)(1). The issue on appeal to the Supreme Court concerned the interaction between provisions of the federal Medicaid statute and North Carolina law. The United States Supreme Court confronted this issue previously in *Arkansas Dept. of Heath and Human Servs. v. Ahlborn*, 547 U.S. 268 (2006). In that case the court held the general anti-lien provision in the federal Medicaid statute does not permit a state from recovering any portion of a settlement or judgment not attributable to medical expenses. While the federal law enables the state to recover the amount paid for medical care, it cannot attach the remainder of a settlement because the beneficiary has a property right in the proceeds of same. The Supreme Court agreed to revisit the issue previously addressed by Ahlborn because unlike *Wos*, the parties in that case entered into a stipulation concerning the amount that represents appropriate compensation for medical care.

The *Wos* court emphasized the long-standing rule under the Supremacy Clause that where state and federal law conflict, the state law must give way. Hence, the

Medicaid anti-lien provision prohibits North Carolina from making a claim on any part of a Medicaid beneficiary's tort recovery not designated as payments for medical care. The state law does not have a process for determining what portion of a beneficiary's tort recovery pertains to medical expenses. Consequently, the North Carolina statute was preempted and struck down.

The obvious distinction between *Wos* and *Ahlborn* is that the parties in the former never agreed to the amount of medical expenses paid by Medicaid. However, a judicial or administrative proceeding can be conducted on a case by case basis if the beneficiary and the state cannot agree on what portion of the settlement pertains to medical expenses. Trial judges and trial lawyers can find objective benchmarks to make projections of the damages the plaintiff likely could have provided.

The Supreme Court's decision is *Wos* is significant because it provides clear guidance for any attorney involved in a personal injury action with a Medicaid beneficiary. State Medicaid programs are prohibited from enforcing programs that arbitrarily determine how much a beneficiary can recover. Such reimbursements must be limited to the amount that was actually designated for medical care.

Danger from Within? Sex Offenders in Long-Term Care Facilities

By Angeline N. Ioannou

As evidenced by continued legislation on the controversial topic of sex offenders in long-term care facilities, it is clear that this is a difficult issue with many ethical, legal and operational dimensions and consequences. This article provides a brief overview of the law as it pertains to registered sex offenders living in these facilities and the unique challenges long-term care facilities and their legal providers encounter in managing registered sex offenders and others demonstrating propensities to commit sexual abuse who reside in these facilities. Additionally, the impact that housing and caring for registered sex offenders may have on the facility, fellow residents, employees, and visitors will be discussed. As the population continues to age and as acuity levels increase, more registered sex offenders will be in need of treatment in long term care facilities. The industry needs to be prepared to manage the difficulties and risks that these individuals may pose to a facility and its residents and staff.

This issue came to the attention of the Federal Government in 2006, when Congress asked the Government Accountability Office (GAO) to evaluate the prevalence of sex offenders living in long-term care facilities such as skilled nursing and intermediate care facilities. The study examined the national sex offender database and eight state databases for sex offender registries and found about 700 registered sex offenders living in nursing homes or intermediate care facilities for people with mental retardation. Most of these registered sex offenders were male and younger than 65, and represented .05 percent of the approximately 1.5 million residents of nursing homes and intermediate care facilities. In this survey, about 3 percent of nursing homes housed at least one identified sex offender. There has not been an update to this survey, but ostensibly this number has increased as states have continued to broaden and refine the categories of sex offenses and the relevant population has continued to age.

Federal law requires that law enforcement in the 50 states enact sex offender registries and notification laws in order to receive funding for law enforcement initiatives. States are free to set their own laws on how registries and notifications are made and this has created a "hodge podge" of conflicting regulations. Consequently, this can be very confusing for operators of long-term care facilities that operate in a variety of states. Few states have enacted legislation regarding notification of registered sex offenders in long-term care facilities and/or certain procedures regarding admission or the prohibition of admission of certain registered sex offenders in facilities. Among them are California, Illionois, Minnesota, Oklahoma, Virginia, Oregon, Massachusetts, and Texas. Similar legislation is pending in Iwoa, Ohio, and South Carolina.

Proponents of such notification statutues argue that these laws provide information to residents that are not easily accessible to them, because not all residents have internet access. More importantly, many residents are elderly, infirm, or cognitively impaired and as such unable to appreciate the potential dangers present when a registered sex offender is living in their facility. Thus, notification laws provide valuable personal safety information to residents and their families.

Opponents of these laws cite obvious privacy issues and point out that most sex offenders in nursing homes are not predatory, such as those required to register following a conviction for statutory rape. Thus, those residents are "outed" as sex offenders when they never posed any real threat to the other residents. Therefore, in the absence of any real risk of sexual assault in the facility, these notification laws will stigmatize the resident and create fear and possibly hysteria when the incidence and risk of harm is very low.

Obviously, depending on the state in which the long-term care facility is in, the population that it treats and its tolerance for risk, a determination needs to be made as to what the facility's policy will be in terms of admitting sex offenders to long-term care facilities. As many providers will tell you, because of regulatory requirements

regarding readmissions and difficulty in discharging residents, the best time to prevent registered sex offenders from living in a long-term care facility is at admission. However, it may be difficult for a facility to outright ban the admission of any registered sex offender because it may implicate due process concerns, the Americans with Disabilities Act (as amended), or other laws. There are different ways providers can seek to obtain or conversely, not obtain this important information.

Long-term care facilities can conduct background checks of all prospective residents after seeking legal authorization to run these checks from the resident or his or her legal representative, if he or she is incompetent to authorize such a background check. In addition to the significant costs associated with conducting a criminal background check of all potential residents, there is the time associated with conducting such a check. However, if a facility chooses to do a background check, it should conduct a thorough background check or the check could be useless. Many times national registries are insufficient to pick up state level crimes. These background screening results can take several days and many times admissions to these facilities come at nights, on weekends and facilities must act quickly to accept these admissions from hospitals or other medical providers or the facilities may potentially lose a steady flow of patients from the admitting source to a competing facility.

Perhaps a facility will instead decide to make passage of a successful background check a condition of admission in the admissions agreement and then seek to discharge the resident or void the admissions agreement if negative information is received. However, as many operators will attest, this can become quickly complicated by regulatory agencies who more often than not will intervene on behalf of the resident and will make such a discharge or transfer a complicated and legally risky endeavor for the facility.

In an effort to save money on background screenings of potential residents and to better leverage their internal resources, some long-term care facilities will have staff members conduct background checks or similar searches on prospective residents. Unfortunately, many times these searches may run afoul of the Fair Credit Reporting Act (FCRA) as the facility has not secured the authorization of the resident or their legal representative prior to conducting the search. As these registries vary greatly from state to state in terms of how they are organized (Social Security number, last name, city where the individual resides) and how the various offender levels are defined, there is significant room for mistaken identity and error which could lead to regulatory action and litigation.

Another possibility is to have a question on the admission application inquiring whether the individual is a registered sex offender. While this self disclosure may be the least administratively intensive way of obtaining this information, such a query will obviously invite further questions from potential residents and their families on how the facility safeguards against admission of registered sex offenders beside the self-disclosure. Admissions staff may also be weary of such a question on an application as it may be believed it would chill admissions or signal to a prospective resident that there has been a problem with registered sex offenders in the past at the facility.

Other long-term care facilities that are located in states where it is not required to disclose the existence of registered sex offenders in the facility may decide not to inquire about the status of a resident upon admission at all. This could stem from concern that if there is information that is obtained that there is a registered sex offender and a decision is made either to admit and there is a negative outcome that it can increase potential liability to the facility. Many times these types of policies are called into question when it is discovered by another resident, employee, or family member who does his or her own research on the registry and discovers that a registered sex offender is living in the facility.

While there do not appear to be any laws which strictly prohibit a facility from denying admission to a registered sex offender, facilities need to be careful not to inadvertently violate the law by not admitting someone who may have committed a sex crime based on a mental disability or other medical condition or by failing to administer a policy on a consistent basis (denying admission to male registered sex offenders, but admitting female registered sex offenders). A facility would be prudent to weigh the pros and cons of admission of a registered sex offender such as the level of offense, the years since the offense was committed, the nature of the offense, whether or not any rehabilitation occurred, and the resident's current medical condition. If the risk of admitting the resident is too great to bear, then the facility may decide not to move forward with the admission. Some facilities will outright deny admission to any registered sex offenders without conducting any type of risk analysis and would rather deal with any litigation that is brought by the registered sex offender.

On the other hand, if a facility decides to admit a registered sex offender, any notification required by law must be given. Further, it is also wise to devise a safety plan to deal with the resident. It may not be possible to place this resident in a semi private room based on a risk assessment. The resident may need more frequent checks by staff than other residents.

There are varying state and federal laws pertaining to registered sex offenders in long-term care facilities. There is not a "one size fits all" approach in dealing with

registered sex offenders in the resident or employee population. However, it is clear that facilities must enact certain protocols to protect residents and to limit liability without compromising the interests of the registered sex offenders. Operators should consult with counsel need to keep apprised of legal developments in this area and should enact proactive policies to mitigate risk.

Trends in Equitable Subrogation: The Court's Not-So-Equitable Application to Attorneys

By Elizabeth M. Cristofaro and Lila M. McKinley

It is relatively rare to see a legal malpractice claim against defense counsel retained by an insurance carrier to defend an insured. In the majority of states, direct claims of legal malpractice by a primary or excess insurer are disfavored, and for the most part not permitted. The reasoning behind these decisions stems from the sanctity of the attorney-client relationship and a hesitation to interfere with defense counsel's duty to the insured. Few claims of this nature have been successful.

However, excess insurers have had limited success in bringing direct claims against defense counsel retained by primary insurers under the theory of equitable subrogation. This essentially means that the excess insurer stands in the shoes of the insured. When legal malpractice is committed by defense counsel resulting in overpayment on a claim triggering an excess policy, the excess insurer can collect for that overpayment in the same manner as the insured would be able to if they were personally required to pay out any money.

While these claims have enjoyed more success than the direct legal malpractice claims, the success still has been quite limited. Again, courts are not quick to permit such claims for fear that the attorney-client relationship would be damaged between the insured and the counsel selected to defend the insured. Only a handful of courts have permitted such claims.

But this trend might just be changing. Two new decisions issued addressing the issue suggest that perhaps the law is moving in a different direction — perhaps a more favorable direction for excess carriers. While this development might be fruitful for excess carriers, it rightfully has given cause for concern to both defense counsel and professional liability carriers.

History of Use of Equitable Subrogation

Excess insurers use of equitable subrogation is not new. In the early 1990s, excess carriers attempted to use equitable subrogation to assert claims against defense counsel selected by the primary insurer and were sometimes quite successful in doing so. For example, in a 1992 case, *American Continental Ins. Co. v. Canal Ins. Co.*, 843 S.W.2d 480 (Tex. 1992), a Texas court permitted an excess insurance carrier to use equitable subrogation. Other courts have also permitted its use in this context. See *Atlanta Int.l Ins. Co. v. Bell*, 475 N.W.2d 294 (Mich. 1991); *Allstate Ins. Co. v. American Transit Ins. Co.*, 977 F. Supp. 197 (E.D.N.Y.); *National Union Ins. Co. v. Dowd & Dowd*, P.C., 2 F. Supp. 2d 1013 (N.D. Ill. 1998).

But this success was widely limited to a few states. From the 1990s on, numerous courts in various states reached an opposite result, suggesting a general trend against an excess insurer's ability to collect against defense counsel. These courts concluded that an excess carrier has no right to bring an equitable subrogation claim against the attorney hired by the primary insurer to defend the underlying action. See *Continental Casualty v. Pullman Comley, Bradley & Reeves*, 929 F.2d 103 (2d Cir. 1991); *American Continental Ins. Co. v. Weber & Rose*, P.S.C., 997 S.W.2d 12 (Ky. Ct. App. 1998); *Essex Ins. Co. v. Tyler*, 309 F.Supp. 2d. 1270 (D. Colo. 2004); *Querrey & Harrow, Ltd., v. Transcontinental Ins. Co.,* 885 N.E.2d 1235 (Ind. 2008).

The primary reasoning behind these decisions was the attorney's duty of loyalty to his or her client. The decisions emphasized that the attorney was retained for the benefit of the insured and owed a duty of complete loyalty to the insured. The courts feared that allowing for liability of the attorney to the excess carrier put that relationship in jeopardy. The overall underlying concern was that permitting liability on claims of equitable subrogation forces the attorney to be concerned about the excess carrier's view of his or her case, handling which has the potential to undermine the attorney's relationship and undivided loyalty to the insured.

Other courts have gone as far as to equate this type of action to one of an assignment of a legal malpractice claim, which has been frequently rejected by most courts for the same reasoning — that it undermines the attorney-client relationship. Still other courts point to more practical reasons for disallowing these types of claims relying on the fact that excess carriers typically have the right to appoint their own counsel to protect their interests and monitor the action.

Notwithstanding the different reasoning of the courts, for the most part, excess insurers have enjoyed limited success on equitable subrogation claims, with history demonstrating that until very recently most courts took an unfriendly view toward equitable subrogation applied in this context.

Recent Success of Excess Subrogation Claims

Two cases issued in the last year indicate that courts might just be warming up to

equitable subrogation claims by excess carriers. The two decisions — *Great American E & S Ins. Co. v. Quitairos, Prieto, Wood & Boyer,* P.A., 100 So. 3d. (Miss. 2012) and *ACE American Ins. Co. v. Sandberg, Phoenix & Von Gontard, P.C*, (S.D. Ill. 2012) — issued by the Mississippi Supreme Court and Federal District Court for the Southern District of Illinois have seemingly reset the compass on this issue and suggest that perhaps equitable subrogation might be a viable avenue for direct claims by carriers against defense counsel.

The facts of the two cases are fairly similar in nature. In *Quitairos*, a law firm that had been hired by a primary insurer failed to timely designate expert witnesses on behalf of the policyholder. The failure resulted in a substantially increased settlement of the case causing the primary insurer to tender its policy. The excess carrier now stuck with the remaining damages exceeding the primary insurance sued the law firm for legal malpractice and also under a theory of equitable subrogation.

On appeal, the Mississippi Supreme Court affirming the Appellate Court in part concluded that while the excess carrier could not bring a direct legal malpractice action against defense counsel, the excess carrier could pursue a claim against the firm under the theory of equitable subrogation. Citing to the previous 1992 Texas decision discussed above, the court adopted the Appellate Court's reasoning finding that where an attorney's negligence results in a judgment in excess of the primary policy limits, the excess carrier would be the only party with any incentive to pursue any sort of claim against the attorneys for their negligence.

In *Sandberg*, the Southern District Court of Illinois reached the same conclusion. There, the policyholder was sued in a product liability action which again resulted in a substantial settlement. This settlement was reached after the trial judge severely sanctioned the defendant policyholder for discovery abuses by defense counsel retained by the primary carrier and struck all of the pleadings. The excess insurer brought suit against the policyholder's counsel, arguing that its misconduct exponentially increased the costs of settling the litigation. The court allowed both the direct legal malpractice and equitable subrogation claims to proceed. With respect to the equitable subrogation claims, the court predicted that the Illinois Supreme Court would allow an excess carrier to enforce duties owed by the attorney to the insured. The court distinguished this case from those cases in which courts have forbidden the assignment of a legal malpractice claim, reasoning that an assignee is typically a stranger to the attorney-client relationship who has suffered no injury from the lawyer's actions, whereas an excess insurer may suffer a direct injury as a result.

A Growing Trend?

The two decisions issuing within short temporal proximity of each other do suggest that perhaps the courts are softening their stance a bit on the availability of equitable subrogation to excess carriers. At this point, we should be careful in calling it a current trend or complete shift in favor of the use of equitable subrogation. In fact, Illinois has long been in the minority with respect to actions against defense counsel by carriers and this is not the first time that courts in this state have permitted equitable subrogation claims to lie against defense counsel. Nevertheless, this was an issue of first impression for Mississippi. At the very least, the two decisions provided additional support to what was has long been considered a minority view, giving it a bit more strength than it had before.

While it may be a bit too early to describe the two decisions as the beginning of a trend toward increased court approval of equitable subrogation, they should not be ignored. Given the publicity that these cases have received, it is likely that we will see an increase in the frequency of these types of suits whether the claims are ultimately successful or not. Defense counsel must recognize the potential exposure to these types of suits against them and should be aware of the potential parties who might bring claims against them. And primary insurers should also recognize their own exposure to claims of vicarious liability when selecting defense counsel, and professional liability insurers should be aware of the growing potential for the possibility of these types of claims.

Nursing Home Litigation: The Importance of the Defense Trial Theme

By Caroline J. Berdizk

With the rise of the elderly population came the regulation of nursing home facilities that provide care for the elderly. These regulations — Omnibus Budget Reconciliation Act of 1987 amended 1990 under Title 42, §483 et seq., and the corresponding state regulations — evolved from establishing standard of care to providing for broad resident rights such as dignity and respect.

The corresponding rapid rise in nursing home litigation has revealed that the plaintiff's trial themes have likewise evolved from focusing on violation of the standard of care provided by the facility to exploiting societal anxieties regarding aging with dignity and respect. In litigation, counsel for the plaintiffs know that the potential juror may experience feelings of guilt when thinking about leaving a parent in a nursing home, or fear when thinking about what may happen to the juror when he gets older. Therefore, the plaintiff's counsel can depend on the ready sympathy of the juror. In light of this, it is particularly important for the defense attorney tasked with

defending nursing homes to understand the anxieties that lead to bias of potential jurors and develop a credible trial theme that counteracts it. Defending a nursing home requires first that the defense attorney considers the facts particular to the case and anticipate the theme(s) most likely to be used by the plaintiff's counsel.

The plaintiff's counsel will point out any violation of regulations but will also know that compensatory damages are limited by the age and life expectancy/wrongful death claim of the resident who is elderly, retired, and unlikely to be financially supporting anyone. A skilled plaintiff's attorney is aware that a large verdict (inflated compensatory damages or punitive damages) is more likely when the jury is at once sad and inflamed. Common trial themes used by plaintiffs include vulnerability/frailty of the elderly person (statistically more likely to be female than male) and breach of trust or "profit over people," in which the nursing home is cast as a corporation caring more for the bottom line than the elderly resident.

The defense theme should essentially be the defense case encapsulated in a sentence that the jury cannot ignore or forget because it is introduced at *voir dire*, reinforced as the case develops and clearly supported by closing arguments. It does not have to be catchy, but it does have to be credible and credibly repeated.

In a nursing home case, while much of the trial may be consumed with details of assessments and regulations, charts, entries, and staffing time sheets, the effective defense trial theme is better focused on the humanity of providing care. In thinking of humanizing the nursing home defendant, it should be remembered that jurors are likely to have experienced nursing in other settings and are likely to view a nurse as a noble, caring person. Jurors are also likely to think favorably of the idea of "home" as the best place for anyone to be. The concept of these two terms can form a significant part of an effective defense trial theme which should also directly refute the plaintiff's claim.

The defense trial theme should be focused on empathy and consistently present at trial. It should be supported by evidence of the personalities that provide care and a clear picture of the community that supported the resident. This should go a long way in eliminating any juror bias and persuading the juror to see the story from the nursing home's perspective.

Good Faith, Internal Controls, Commercially Reasonable Practices and Coverage Under Financial Institution Bonds and Crime Policies

By Joseph A. Oliva

Every bank or credit union and its customers seeks easier and more efficient methods of transferring money or completing fund transfers. In addition, clients have grown accustomed to having their demands met and questions answered immediately. Being able to provide immediate, efficient and extraordinary service separates the playing field. With that as a goal, banks and credit unions encourage customers to enter into agreements which demonstrate the customer service that is expected. With respect to fund transfers, these service agreements meet the needs of our "green" society, allowing money to be transferred by a phone call, a text, a facsimile, or an email. Based on the voluminous amount of fund transfers, safeguards must be in place to attempt to protect against fraud.

Agreements with customers often require "call-backs" when a request is made to transfer money via an email or facsimile. The call-back must be made to the secure phone number on file with the financial institution to verify the request. The financial institution may also require signature verification based on the signature on file with them. While financial institutions will likely allow electronic signatures to be deemed originals, the call-back requirement protects them against fraudulent emails.

Further, all banks and credit unions must follow commercially reasonable practices to protect themselves from mishaps. The financial institution's internal controls must be followed to protect the customers and the banks from fraudulent behavior. The employees must be educated and trained on curious requests and out-of-the-ordinary behavior. Employees must be aware of the bank secrecy haven countries and customer's normal habits of transactions. If requests are being made to a bank secrecy haven country, or if a customer who rarely requests wire transfers suddenly requests wire transfers abroad, these should be red flags to that financial institution and its employees.

The insurers of financial institutions are also aware of the risks associated with fund transfers via electronic means. The policies that insure banks and credit unions often require that these institutions be in possession of an original request and signature. Original requests are usually not facsimiles or emails but rather a handwritten request of the customer and the customer's original signature. Policies often defined original to mean something that does not include photocopies or electronic transmissions even if received and printed. Demonstrating that the insured is in possession of an actual, physical instruction is often vital to coverage.

The policies also often require a tested means of verifying the request, usually a call-back, which assist in safeguarding against identity theft and fraudulent request for money transfers. When the insured is a victim of fraud with fund transfers, he or she will seek coverage under the financial institution bond or crime policy.

Insuring agreements will likely require a form of quality control by the insured in order to implicate coverage. This places the burden on the insured to maintain adequate internal controls to avoid losses. Implicit in this computer crime coverage is the commercial reasonableness requirement. This requirement demands that the insured follow its internal procedures. These insuring agreements require that if an insured's employee performs a data entry change that causes a customer's account to be debited, that it perform the task in good faith, on an instruction from a tested telex or similar means of tested communication. Policies often define tested to mean a method of authenticating the contents of a communication by placing a valid test key on it which has been agreed upon by the insured and a customer.

Insureds will often assert that emails are tested forms of communications. However, depending on the policy language, emails may not be a "telex." Test keys may not be defined by the agreement with the customer or in the policy; however, internal procedures of a financial institution may demand that a tested method be followed and usually in the form of a call-back. The main issue with many of these claims is that the internal procedures were not followed because the employee knew the customer, or wanted to satisfy the customer's request.

Courts throughout the United States have held that a bank's failure to follow reasonable commercial standards constitutes superseding and intervening causes which will break the connection between covered risks and resulting loss.

In Experi-Metal, Inc. v Comerica Bank, the plaintiffs' bank accounts were the victim of a "phishing attack" in which approximately $1.9 million was wire transferred out of its accounts with the defendant bank. The court was required to address the question as to whether the defendant bank acted in observance of reasonable commercial standards of fair dealing when acting on and processing fraudulent wire transfers. The court looked toward the UCC for guidance. The UCC requires the use of ordinary care in conducting transactions. The plaintiff surged the court that the defendant bank failed to act reasonably because it failed to act on warnings that included the limited wire transfer history, the volume and pace of the wire instructions, and the destinations of the wire transfers. The court found that the defendant bank failed to act in a commercially reasonable manner as it did not appropriately act on those factors as well as the bank's prior knowledge of phishing attempts.

The UCC §4A-201 provides guidance to banks in employing commercially reasonable security procedures, which it defines as "a procedure established by agreement of a customer and a receiving bank for the purpose of (i) verifying that a payment order or communication amending or canceling a payment order is that of the customer or (ii) detecting error in the transmission of the content of the payment order or communication … A security procedure may require the use of … callback procedures."

The UCC §4A-202 provides that the commercial reasonableness "of a security procedure is a question of law to be determined by considering the wishes of the customer expressed to the bank … A security procedure is considered commercially reasonable … if the customer expressly agreed in writing to be bound by any payment order … issued in its name and accepted by the bank in compliance with the security procedure chosen by the customer."

The banking industry must educate its employees and train them to follow internal procedures and guard against the red flags. The commercially reasonable standards, while burdensome at times for customers and employees alike, must be followed. Compliance with them will be a critical factor in assessing coverage under these types of claims.

As we continue the move toward faster and easier methods of money transfers, the banking and insurance industries must be — and remain in — assessment mode to combat the inherent risks associated with these types of transactions. The industries must work together to protect themselves against the types of frauds and losses that will inherently occur.

NYDFS Issues New Circular Letter Warning That Insurance Producers Cannot Offer Free Services to Get Force-Placed Business in NY

By Colleen M. Murphy and Aaron J. Aisen

One basic premise of business marketing is to offer a discount or free service to a potential client as a means of getting business. However, in New York, this general business premise butts up against the insurance law when insurance agents and brokers offer discounted or free services or products as a means of inducing new business. A recent example of this concerns insurance producers offering free services to mortgage lenders who might need to purchase force-placed insurance down the road.

Force-placed insurance is insurance that a mortgage lender can obtain when a homeowner's policy is not purchased or lapses. The lender then passes along those premiums for the force-placed insurance to the homeowner. Critics have argued that these policies generally cost more and cover less.

The New York Department of Financial Services (NYDFS) has recently scrutinized the force-placed insurance industry. As part of this scrutiny, the NYDFS issued a

warning in Supplement No. 1 to Insurance Circular Letter No. 14 (1995), August 21, 2013 to insurance producers that offering free or reduced services is not permitted. The NYDFS is specifically concerned with a practice where insurance producers offer to track insurance coverage on properties for mortgage lenders to ensure that these properties have proper coverage. These services are offered for free or at reduced prices. The NYDFS is concerned that these services are offered as a *quid pro quo* — producer offers these services in exchange for the force-placed business if the coverage is inadequate or lapses. The NYDFS based the authority for its warning on NY Insurance Law § 2324(a):

> Insurance Law § 2324(a) prohibits, among other things, a licensed insurance producer or any person acting on behalf of the insurance producer from directly or indirectly paying or offering to pay an insured any rebate from the insurance premium specified in the insurance policy or contract, or giving or offering to give any valuable consideration or inducement, not specified in the insurance policy or contract, except that the insurance producer or other person may give or offer to give any valuable consideration not exceeding $25 in value that is not specified in the policy or contract. (Supplement Circular Letter 14.)

The NYDFS notes that "insurance tracking services likely exceed $25 in value."

Insurance producers in New York need to be very careful about what they offer any client in exchange for a potential business opportunity. The $25 limit applies to any incentive whether it is a good or service. In particular, New York insurance producers must heed the NYDFS warning with respect to force-placed insurance or find themselves swept up in the recent regulatory scrutiny.

PROFESSIONAL LIABILITY MATTERS — TOP TEN BLOG POSTS FROM 2013

(Click on the headlines below to read the full blog post from Professional Liability Matters*)*

Employee Fired for "Private" Facebook Post

Plaintiff Deborah Ehling thought she could comment freely on Facebook because she limited her posts to a restricted group of her "friends," and her posts were not available to the general public. She was wrong. When her employer learned of the controversial posts and terminated her, she thought she had recourse. She was wrong. In an important ruling for employers, the District Court of New Jersey recently dismissed *Ehling v. Monmouth-Ocean Hospital Service Corp.*, *et al.*, (August 20, 2013). This case put to the test the Federal Stored Communications Act, 18 U.S.C. §§ 2701-11 (SCA) as applied to social media content in the workplace.

Calculating FMLA Leave: What Employers Need to Know

The Family Medical and Leave Act (FMLA) provides job security to employees who require time away from work due to illness or the need to care for family. By some accounts, the FMLA is one of the most difficult employment laws for an employer to administer, and therefore is a risk management "legal labyrinth." In particular, the seemingly simple task of calculating the duration of FMLA leave can be daunting.

Off the Clock, On the Hook: Unintended Consequences of Working Remotely

Sitting down to dinner but still have a long to-do list from the office? Hear your work e-mails pinging as you watch the game? Not a problem that you can't handle with your smartphone or tablet. Whatever your take on this 24/7 connectivity, it is undeniable that the proliferation of mobile devices has made working away from the office easier and perhaps expected by employers (and clients). While such a policy may result in an increase in productivity, it can also create a legal risk for employers, namely, unexpected claims for overtime pay.

Breach of Contract or Negligence: Does it Really Matter?

The Pennsylvania Supreme Court is set to entertain argument on an important appellate issue regarding the types of damages available to a plaintiff in a legal malpractice dispute. The decision may also highlight the fundamental differences, if any, between a malpractice suit grounded in tort or contract. In 2006, a national law firm agreed to represent the plaintiffs in the sale of a company that had incurred over $2 million in unpaid taxes. According to the plaintiffs, the law firm advised them that the sale would terminate their personal liability for the unpaid taxes. When the company's assets withered after the transaction, however, the individuals that sold the company were held personally liable for all unpaid taxes and they turned to their former lawyers to recover.

Serious Sanctions Imposed for Deleting a Facebook Account

A New Jersey federal judge recently ruled that a plaintiff's deletion of his Facebook account amounted to the sanctionable destruction of evidence. This decision has major implications on social media discovery in all litigation. Some (*Law360* — subscription required) experts believe that this result proves that "social media access is fair game in litigation and that workers who try to conceal their online lives will pay a high price."

The Ethics of Billing During Travel

Client billing and fee disputes are at the heart of a significant percentage of all malpractice claims brought against attorneys each year. There are myriad courses and guides for ethical billing available for all professionals,

yet lawsuits and administrative complaints abound regarding billing issues. However, even the most well-intentioned attorneys encounter situations where the "rules" of client billing are not crystal clear; perhaps none moreso than the debate regarding billing for travel.

A First of its Kind: FDIC v. Independent Auditor

A recent decision in a closely watched accounting malpractice matter —the first of its kind initiated by the FDIC — may suggest cause for concern for accountants. As receiver for a failed bank, the FDIC may sue professionals who played a role in the failure of the institution. In the wake of recent bank failures, the FDIC has targeted officers and directors, attorneys, and brokers. Until recently, however, the FDIC had not pursued an audit firm. That all changed on November 1, 2012, when the FDIC, as receiver for the failed Colonial Bank, initiated a $1 billion malpractice claim against the bank's auditors PricewaterhouseCoopers and Crowe Horwath. This lawsuit, and a recent decision denying the defendants' motion to dismiss, raise critical questions.

Are Deposition Breaks Privileged?

Attorneys should proceed with caution when consulting with a client during deposition breaks. Whether it be a hospitality break, for lunch, or for an overnight adjournment, there is room for trouble when a client and attorney discuss aspects of an ongoing deposition. Depending on the jurisdiction, communication between attorney and client may not be considered privileged and may be fodder for deposition questioning.

Attorney Sued for Wrongful Death

One of the foundations of the attorney-client relationship is confidentiality. Apart from limited exceptions, attorneys are generally precluded from disclosing a client's confidential information to a third-party and must act at all times in the client's best interest. It is well established that failure to do so may constitute an ethical violation and perhaps professional misconduct. A recent $40 million lawsuit claims that an attorney's breach of his client's confidences led to the client's murder. Uh-oh.

Workplace Bullying: More than a Dolphins' Problem

Thanks to the developing news regarding the Miami Dolphins, workplace bullying has generated national attention. There has been considerable press of late concerning school bullying and its impact on children but it is now clearer than ever that in some environments, bullying can exist in the workplace and can cause serious damage to professionals and their employers.

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780 Third Avenue, Suite 3100 | New York, New York 10017
OFFICE 646.292.8700

LONDON
65 Leadenhall Street | London EC3A 2AD
OFFICE +44.20.3371.5450

PHILADELPHIA
1700 Market Street, Suite 1418 | Philadelphia, Pennsylvania 19103
OFFICE 267.519.6800

PRINCETON
902 Carnegie Center, Suite 100 | Princeton, New Jersey 08540
OFFICE 609.986.1300

HARTFORD
100 Pearl Street, Suite 1100 | Hartford, Connecticut 06103
OFFICE 860.760.3300

BUFFALO
665 Main Street, Suite 400 | Buffalo, New York 14203
OFFICE 716.566.5400

ROCHESTER
2 State Street, Suite 1200 | Rochester, New York 14614
OFFICE 585.295.5400

SYRACUSE
5786 Widewaters Parkway | Syracuse, New York 13214
OFFICE 315.413.5400

ALBANY
8 Southwoods Boulevard, Suite 300 | Albany, New York 12211
OFFICE 518.463.5400

WHITE PLAINS
11 Martine Avenue, Suite 750 | White Plains, New York 10606
OFFICE 914.798.5400

GARDEN CITY
100 Garden City Plaza, Suite 225 | Garden City, New York 11530
OFFICE 516.281.9800