EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | March 2016

Dentist's Alleged Sexual Misconduct Not Covered Under EPL Policy

In a victory for Wiley Rein's client, a Florida federal court has held that an employment practices liability policy that provided coverage for "harassment" did not cover a licensing action arising out of a dentist's alleged sexual misconduct. *Turbyfill v. Scottsdale Indem. Co.*, 3:14-cv-283 (N.D. Fla. Feb. 24, 2016). The court also noted that Florida public policy likely precluded coverage for sexual abuse claims and that coverage was unavailable because the insurer was not given timely written notice as required by the policy at issue. Wiley Rein represented the insurer in the case.

A partner in a dental practice was engaged in the practice of sedation dentistry. The Florida Department of Health filed a complaint alleging that on four separate occasions, staff members at the dentistry practice saw the dentist enter rooms where minor patients were sedated and were left alone. According to the Department of Health, those staff members observed the dentist "moving the patients' hands from under blankets and standing near and/or touching them while he was visibly sexually aroused and thrusting his hips and pelvic region on or near them." The Department of Health's complaint charged the dentist with violating a statutory provision prohibiting "sexual misconduct" by a dentist. The dentist denied the allegations.

A staff member at the dentist's office forwarded a short notice to the practice's insurer that "a Partner is being charged with sexual misconduct." The insurer asked for more details by telephone, and the staff member incorrectly advised that the matter had been resolved. Thereafter, the dentist settled with the Department of Health. Subsequently, the dentist made a demand against his partnership for several business torts, some of which were tangentially related to the sexual misconduct complaint. The dentist and the partnership settled the business tort demand, and the partnership assigned its rights under the partnership's EPL policy to the dentist. The dentist brought suit against the EPL carrier seeking coverage for the Department of Health's complaint and the business tort demand.

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New Jersey High Court Holds Prejudice Not Required Under Claims-Made-and-Reported Policy

In a unanimous opinion, the New Jersey Supreme Court, applying New Jersey law, has held that an insurer is not required to show that it suffered prejudice before denying coverage on the basis of the insured's failure to give notice of the claim "as soon as practicable" even when notice was provided during the policy period of a claims-made-and-reported policy, relying in part on the fact that the insurance contract was entered into by sophisticated parties and was not a contract of adhesion. *Templo Fuente De Vida Corp. v. Nat'l Union Fire Ins. Co.*, 2016 WL 529602 (N.J. Feb. 11, 2016).

The insurer issued a D&O policy to the insured, a finance company. The policy was a claims-made-and-reported policy that required the insured, as a condition precedent to coverage, to give written notice of any claim "as soon as practicable" and within the policy period. The insured failed to procure sources of funding for

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No Coverage Under D&O Policy For Misrepresentations Regarding Mortgage-Backed Securities Because Not "Securities Of" the Insured

The United States Court of Appeals for the Ninth Circuit, in an unpublished opinion applying California law, has held that there is no coverage under a D&O liability policy for claims alleging misrepresentations in offering documents for mortgage-backed securities because the mortgage-backed securities did not constitute "securities of an Organization." *Impac Mortgage Holdings Inc., v. Houston Casualty Co.*, 2016 WL 491720 (9th Cir. Feb. 8, 2016). The court also held that coverage was barred by the D&O policy's professional services exclusion, finding that the drafting of offering and SEC documents "plainly requires professional skill."

The insured mortgage company and its subsidiaries sold residential mortgages, securitized them and deposited them into trusts. The trusts then issued certificates, which the insured sold to investors. Subsequently, several investors asserted claims against the insured alleging that they suffered losses caused by insured's false and misleading statements in connection with the sale of the certificates. After the D&O insurer denied coverage for the claims, the insured filed suit against its D&O and E&O insurers. On cross-motions for partial summary judgment, the district court ruled in favor of the D&O insurer on two grounds. First, the court held that the claims against the insured were not "Securities Claims," defined as claims "arising out of, based upon or attributable to . . . the purchase or sale of or offer or solicitation of an offer to purchase or sell any securities of the Organization," because the mortgage-backed securities were not "securities of an Organization." Second, the district court held that the claims were excluded by the policy's professional services exclusion, which barred

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Seven Civil Lawsuits Constitute a Single Claim Subject to a Single Per-Claim Limit

The United States District Court for the Central District of California has held that seven pending civil lawsuits, all of which alleged that the insured had participated in a fraudulent investment scheme, were logically and causally related such that they constituted a single claim subject to a single per-claim limit of liability. *Liberty Ins. Underwriters, Inc. v. Davies Lemmis Raphaely Law Corp.*, No. 2:15-CV-00859 (C.D. Cal. Feb. 23, 2016).

The insured, a transactional real estate firm, purchased three successive professional liability policies for the policy periods between August 1, 2010 and August 1, 2013. The policies each stated that "[c]laims alleging, based upon, or arising out of or attributable to the same or related wrongful acts shall be treated as a single claim." Between 2011 and 2013, seven lawsuits were filed against the insured relating to 23 transactions that occurred between December 2003 and November 2009. Each of the seven underlying actions alleged that the insured made false representations to the investor that the seller would pay all commissions relating to the transaction, when in reality the purchase price of the property was marked up to include commission payments. Each of the plaintiffs alleged that they relied upon these misrepresentations in choosing to invest, and that the insured had knowledge of the alleged misrepresentations at the time it was made.

The insured contended that the underlying actions were unrelated, and that the per-claim limit applied to each of the individual underlying actions. The insurer filed a declaratory judgment action asserting that all of the underlying actions alleged or arose out of the same or related wrongful acts and were subject to a single per-claim limit under a single policy.

The court ruled in favor of the insurer, holding that the seven underlying actions were sufficiently related such that they properly were treated as a single claim, subject to a single per-claim limit of liability under a single policy. In so holding, the court noted that, under California law, the

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Environmental Claims Arose from Prior Orders and Deemed Not First Made During Relevant Policy Period

A federal district court in Washington has held that an insurer had no duty to defend four environmental claims brought against an insured by state and federal agencies because the claims at issue were either first made prior to the policy period or fell within the scope of an exclusion barring coverage for claims related to certain of the insured's preexisting obligations. *The Jorgensen Forge Corp. v. Illinois Union Ins. Co.*, 2016 WL 409822 (W.D. Wash. Feb. 3, 2016).

The insured, a metal forging and manufacturing company, notified its insurer of several environmental claims asserted by state and federal agencies. The insurer denied coverage on the grounds that the claims were not first made during the policy period and that several of the claims were barred by an exclusion for claims related to the insured's preexisting obligations under two previous orders issued by state and federal agencies. The insured later brought a coverage action against its insurer.

After resolving a number of discovery disputes, the court ultimately held that the insurer did not have a duty to defend any of the four environmental claims at issue. The court ruled that coverage for two of the claims was barred by the policy's prior claim exclusion because the claims arose from the insured's preexisting obligations under the relevant orders. In so doing, the court rejected the insured's argument that the earlier order did not require remedial action, noting that the operative exclusion applied to all remediation costs "arising from" the investigation underlying the prior order, not only to those costs incurred during that investigation. The court also ruled that the other two claims at issue concerned legal rights asserted prior to the policy period and therefore did not constitute claims "first made" within the policy period. On those grounds, the court held that there was no coverage under the policy for any of the four claims. ■

No Extrinsic Evidence Allowed Where Policy Language is Unambiguous

The United States District Court for the Northern District of California, applying California law, has held that, where the language of a reinstatement of limits endorsement is unambiguous, extrinsic evidence to show a contrary intent of the parties cannot be introduced to contradict the policy's plain language. *Mayer Hoffman McCann P.C. v. Camico Mutual Ins. Co.*, 2016 WL 631946 (N.D. Cal. Feb. 17, 2016).

The insurer issued a professional liability policy providing $5 million in coverage as part of a $25 million coverage tower. After exhausting the entire tower, the insured sought coverage under a reinstatement endorsement of the primary policy, which provided an additional $5 million in coverage after exhaustion of the coverage tower, provided that "the reinstated Limit of Liability-Policy Aggregate shall not apply to any Claim for which Claim Expenses and/or Damages have been or are paid in whole or in part by the Policy's original Limit of Liability-Policy Aggregate." The insurer denied coverage under the endorsement because it had previously provided coverage under the original limit of liability for the same claim. The insured sought summary judgment for coverage under the endorsement and for reformation, arguing that, despite the plain language of the endorsement, extrinsic evidence demonstrated that the parties had intended for the endorsement to provide an additional $5 million in coverage regardless whether the insurer had already provided coverage for the claim.

The court denied the insured's motion for summary judgment, holding that coverage under the reinstatement endorsement was unavailable under the clear terms of the endorsement. The court concluded that the reinstatement provision was "not reasonably susceptible" to the insured's interpretation that coverage was available regardless of prior coverage for the claim because such an interpretation was "directly contrary to the terms of the Reinstatement Endorsement." Because the policy language of the endorsement was unambiguous and not "reasonably susceptible" to the insured's interpretation, extrinsic evidence to demonstrate the parties' contrary intent could not be introduced to contradict the policy terms. ■

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Dentist's Alleged Sexual Misconduct Not Covered Under EPL Policy *continued from page 1*

The court granted summary judgment for the insurer, opining that this was "not a close case" and "only little discussion is required." The court held that the Department of Health's complaint and the business tort demand were not covered under the EPL policy for several independently-sufficient reasons. First, the EPL policy provided coverage only for claims brought by or on behalf of "any natural person who is a customer, vendor, service provider, client, or other business invitee of the Company." The dentist argued that the sedated minor patients fell within this definition. The court held that the claim was not "brought by or on behalf of" those minor patients; rather, it was brought by the Department of Health, which did not fall within the definition.

Second, the EPL policy provided specified coverage for "harassment," which the court in part determined meant conduct that "annoys, alarms, or causes substantial emotional distress" to a person. The court stated that the dentist's alleged sexual misconduct was not harassment; the court stated that the alleged conduct could not have been designed to annoy or alarm the patients because the patients were sedated. The court also noted that Florida public policy likely would preclude coverage for sexual abuse, particularly against a minor.

Third, the court held that the insurer was "obviously not given timely written notice" of the Department of Health's complaint. Although the insurer had received notice that a partner was charged with sexual misconduct, an employee of the dental partnership subsequently stated that no claim had been filed and that the matter had already been "settled." Therefore, the insurer was never given the opportunity to consent to a settlement or defense costs as required by the terms of the policy.

The dentist did not address the business tort demand in his motion for summary judgment, and the court held that coverage was precluded for substantially the same reasons applicable to the Department of Health's complaint. ■

New Jersey High Court Holds Prejudice Not Required Under Claims-Made-and-Reported Policy

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an underlying claimant, allegedly causing the claimant to suffer losses on the sale of a property. The claimant sued the insured, but the insured waited more than six months before it provided notice of the claim to the insurer. The insurer denied coverage because, while notice was given within the policy period, the insured failed to provide notice "as soon as practicable." As part of a settlement, the insured assigned its rights and interests under the policy to the claimant, who then brought suit against the insurer. The trial court granted summary judgment in favor of the insurer because it found that notice was not given as soon as practicable and that the insurer did not need to show prejudice as a result of the delay in order to deny coverage. The appellate court affirmed.

The New Jersey Supreme Court affirmed, holding that the insurer could decline coverage without demonstrating prejudice because the insured's failure to comply with the notice provisions of the policy constituted a breach of the policy. The court explained that the prompt notice requirement and the requirement that the claim be made within the policy period allows insurers of claims-made policies to maximize their opportunity to investigate, set reserves, and control or participate in negotiations with the third party asserting the claim against the insured. The court also noted that an insurer must show prejudice as a result of untimely notice in an occurrence policy because such policies are usually issued to unsophisticated consumers. However, it stated that proof of prejudice is not necessary to deny coverage for a claims-made policy that fulfills the reasonable expectations of the more knowledgeable and sophisticated policyholder.

The court determined that there was no factual dispute that the notice given by the insured was untimely, as no reason was given to assert why the delay occurred. The court also found that the insured was an incorporated business entity that engaged in complex financial transactions. Therefore, the court held that the insured breached the policy by failing to give notice of the claim as soon as practicable and that New Jersey public policy did not require the insurer to prove prejudice in order to deny coverage when sophisticated parties were involved. ■

No Coverage Under D&O Policy For Misrepresentations Regarding Mortgage-Backed Securities Because Not "Securities Of" the Insured *continued from page 3*

coverage for claims "made against an Insured arising out of, based upon or attributable to any Insured's or Organization's performance of (or failure to perform) any professional services, or any act, error or omission relating thereto."

On appeal, the Ninth Circuit affirmed, noting that the phrase "securities of" "is ordinarily understood to mean 'shares in,'" focusing on the context of the phrase and the fact that an adjacent phrase in the insured versus insured exclusion used the phrase in the same context. In this regard, the court stated that the insured's "interpretation flies in the face of the California Supreme Court's warning not to elevate possible dictionary meanings over context in interpreting insurance policies." The court also concluded that the record did not support the insured's claim that it expected coverage under its D&O policy for professional errors, noting that such a policy would be "duplicative" of its E&O Policy.

The court also confirmed that coverage is further barred by the D&O policy's professional services exclusion, rejecting the insured's argument that the underlying claims do not arise out of its performance of professional services because the documents at issue that it prepared for the offering and for the SEC filing were required by statute. The Ninth Circuit stated that "drafting such documents, which describe complicated financial products, plainly requires professional skill, whether or not the duty to file the documents is imposed by statute." ■

Seven Civil Lawsuits Constitute a Single Claim Subject to a Single Per-Claim Limit *continued from page 3*

term "related" is interpreted to include both logical and causal connections. The court further explained that California courts have concluded that multiple claims are related when they involve wrongful acts that are in service of a "single plan" or the result of a consistent business practice or policy. Accordingly, the court concluded that the underlying seven actions were related, even though they were brought by different plaintiffs, because they all arose from the same single course of conduct: a single party's unified policy of making alleged affirmative misrepresentations to investors in order to induce them to invest in similar commercial real estate acquisitions. The court rejected the insured's argument that a reasonable insured would not have expected the underlying actions to be treated as a single claim under the policy. The court explained that "the relationship between the claims was not so 'attenuated or unusual' that it should come as a shock to [the insureds] to discover that they [were] related." ■

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