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*Errors and omissions insurance policies protect against the risk of malpractice claims. Far too often, seeking coverage under these policies is rife with risk of its own.*

## Omission Impossible?

DIANA SHAFTER GLIEDMAN

Professional organizations and practitioners rely on errors and omissions (E&O) insurance — also known as professional liability insurance or malpractice insurance — to protect against the risk that a disgruntled customer or client will bring a claim for malpractice. Purchasing E&O insurance, however, is not without its own set of risks. Malpractice policies are replete with exclusions and conditions, which insurance companies often cite in an attempt to deny coverage for malpractice claims. It is therefore crucial that all professional institutions — and their risk managers — familiarize themselves with the language of their policies and with the arguments that insurance companies most frequently raise against coverage.

The most commonly raised coverage defenses tend to fall into three broad categories. First, did the allegedly negligent or wrongful act arise out of rendering or failing to render a “professional service”? Many policyholders are stunned when their malpractice insurer denies coverage for a malpractice claim purportedly because the alleged wrongful act did not arise out of a covered professional service. Second, when did the policyholder first learn of the possibility that it could be the subject of a claim? Insurance companies frequently argue that the policyholder knew — or should have known — that it could be the subject of a lawsuit before the inception of the policy, thus vitiating coverage. Finally, is the malpractice claim in any way related to a prior claim that has already

been reported? Insurance companies often argue that a current claim is somehow related to a prior claim, reported under a different insurance policy — and that, as such, any coverage for the new claim falls within the scope of the prior policy. Below, we examine decisions that come down on both sides of these questions.

### What Constitutes a Professional Service?

Professional organizations expect that their professional liability insurance policies will provide them with a defense and indemnity if and when a disgruntled client or customer brings a lawsuit related to the provision of “professional services.” Many insurance companies, however, take a very narrow view of precisely what constitutes a “professional service,” arguing that their policyholders are not covered for malpractice claims — despite their costly malpractice insurance policies.

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For example, in an action entitled *Minnesota Lawyers Mutual Insurance Company v. Antonelli, Terry, Stout & Kraus LLP*,<sup>1</sup> a Virginia law firm (the Antonelli firm) provided myriad legal services, including patent and investment advice, to Telefind, a technology firm involved in the development of wireless e-mail technology. Several members of the law firm also became investors in Telefind.

In 2008, a number of investors in Telefind sued the Antonelli firm. According to the investors, one lawyer with the firm, Donald Stout, concocted a scheme whereupon the patents for the wireless e-mail technology were transferred to a new company, purportedly to safeguard those patents from the firm’s creditors.<sup>2</sup>

The investors further alleged that Stout and certain partners in the new company subsequently granted a third company a perpetual license to the patents in exchange for \$612.5 million — money that was not shared with any of Telefind’s original investors.<sup>3</sup>

Upon receiving notice of the investors’ lawsuit, the Antonelli firm notified Minnesota Lawyers Mutual Insurance Company (MLM), which had sold it a professional liability insurance policy. MLM denied the law firm’s claim, however, arguing, among other things, that the complaint did not result from “the rendering or failure to render professional services” because Stout and the other investors were business associates.<sup>4</sup> As such, MLM reasoned, any advice rendered by Stout or the Antonelli firm was not “legal” in nature, and not covered under a legal malpractice policy.<sup>5</sup> MLM also argued that even if Stout’s advice constituted legal advice, the investors’ damages did not arise from this advice, but from acts of “fraud and chicanery” that do not constitute the provision of legal services.<sup>6</sup>

The United States District Court for the Eastern District of Virginia disagreed. First, the court held that the advice offered to the investors regarding the protection of the wireless e-mail technology qualified as “professional legal services.”<sup>7</sup> Next, the court held that:

MLM attempts to re-characterize the [Investor] Plaintiffs’ damages as “resulting from” something other than the provision of professional services simply because Insureds are alleged to have breached legal duties while providing them. *This interpretation unduly marginalizes the essential role played by Stout’s status as a trusted attorney providing the plaintiffs with legal advice. ... [the Investors’] allegations depict a sophisticated scheme conceived of, proposed, and executed by a man upon whose legal advice the plaintiffs relied. ... The final step of the alleged “con” — Stout’s refusal to share the [\$612.5 million] with Telefind’s owners and investors — cannot simply be treated as one foul act occurring outside the larger context of the parties’ long-running professional relationship. ... This Court holds that the damages claimed by the [Investor] Plaintiffs result from Insureds’ practice of law, as that term appears in the Policy.*<sup>8</sup>

In the 1998 case *Medical Records Associates Inc. v.*

*American Empire Surplus Lines Insurance Company*,<sup>9</sup> the court reached a different conclusion. In *Medical Records (MRA)*, a medical records processing company was accused of overcharging for copies of patient medical records and of potentially including improper charges on its bills.<sup>10</sup> MRA contacted American Empire Surplus Lines Insurance Company (American Empire), its malpractice insurance company, seeking a defense and indemnification for claims based on the company's professional services. The insurance company, however, declined coverage.<sup>11</sup> MRA sued and the case eventually made its way to the United States First Circuit Court of Appeals, which held that American Empire was not liable and did not owe MRA a defense or indemnification.

The Declarations attachment identifies the professional services as "Medical Records Processor," but contains no elaboration of that term. *The policy thus requires American Empire to provide a defense and coverage for any claim that MRA improperly 'rendered or failed to render' the Professional Services of a medical records processor. The question for us is whether the conduct that is the subject of the demand letter — fee-setting and billing — is among those services.* Guided by the relevant cases and, as the caselaw directs, 'ordinary experience and common sense,' we conclude that it is not.<sup>12</sup>

The Court added:

We think the bottom line ... is that 'professional services' as covered by an E&O policy in Massachusetts embrace *those activities that distinguish a particular occupation from other occupations — as evidenced by the need for specialized learning or training —* and from the ordinary activities of life and business.<sup>13</sup>

It is clear from these cases that the inquiry into whether a malpractice claim arises out of the rendering of professional services is highly fact-specific. Policyholders should keep in mind, however, that an insurance company is obligated to defend its policyholder against an underlying claim if there is even a *possibility* of coverage for any of the allegations.<sup>14</sup> Thus, if a complaint includes even one cause of action that arises out of the rendering of or failure to

render a professional service, the insurance company will be required to defend that claim.

### **When Did You Learn That You May Have Breached a Professional Duty (Or That Someone Might Claim That You Did)?**

Professional organizations seeking to switch their professional liability insurers are often asked to fill out an application that asks, among other things, whether any of the covered individuals are aware of "any acts that could form the basis for a malpractice claim against them." Lawsuits arising from acts that occurred prior to the application process typically will not be covered under the newly issued claims-made-and-reported professional liability policy, even if the actual claim for malpractice arises during the new policy period.

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This deceptively simple language begs several questions, however. Precisely when will a policyholder be deemed to be "aware" of an act that "could" form the basis for a malpractice claim? Many insurance companies seek to argue that the policyholder "should have" foreseen a claim was coming prior to the filing of a complaint in court. But what if it didn't? Is the policyholder still entitled to coverage?

Often the answer is yes. Such was the case in the recently decided *Liberty Insurance Underwriters Inc. v. Corpina Piergrossi Overzat & Klar LLP*.<sup>15</sup> In *Corpina*, a law firm represented a client in connection with a medical malpractice claim for personal injuries allegedly caused by vaccinations administered when the client was an infant.<sup>16</sup> During the course of the representation, an associate at the law firm wrote a

letter to the client's father, informing him that the deadline to file a claim under the National Vaccine Injury Compensation Program (NVICP) was approaching and requesting materials to complete said application.<sup>17</sup> The application was never filed, the deadline passed, and the firm ceased representation of the client. Shortly thereafter, the law firm purchased its first legal malpractice policy from Liberty Insurance Underwriters (Liberty).

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Some years later, the (former) client's new attorney advised the law firm by letter that he had been retained to prosecute a legal malpractice claim based on the failure to file the NVICP claim.<sup>18</sup> The law firm promptly provided notice to Liberty. Rather than defend, however, Liberty brought a declaratory judgment action against the law firm, arguing that the policy excluded coverage for “any claim arising out of a wrongful act occurring prior to the policy period if ... you had a reasonable basis to believe that you had breached a professional duty, committed a wrongful act, violated a Disciplinary Rule, engaged in professional misconduct, or should have been able to foresee that a claim would be made against you.”<sup>19</sup>

The law firm argued that even if the associate (and, by imputation, the law firm) knew of the NVICP and the deadline, the law firm did not know that the failure to file a timely administrative claim under the NVICP had the additional legal consequence of foreclosing any civil action for damages. Because the firm did not learn this fact until after the Liberty policy's inception, it argued, the known-claims exclusion should not apply to bar coverage, at least for the portion of the malpractice claim alleging that the firm's negligence had prohibited the plaintiff from collecting civil damages.

The Supreme Court of New York agreed with Liberty and granted its motion for summary judgment, declaring that Liberty had no duty to defend or indemnify the law firm. On appeal, the Appellate Division, First Department, applied a two-pronged test in which the court “must first consider the subjective knowledge of the insured and then the objective understanding of a reasonable attorney with that knowledge.”<sup>20</sup> More particularly, the court stated, “the first prong requires the insurer to show the insured's knowledge of the relevant facts prior to the policy's effective date, and the second requires the insurer to show that a reasonable attorney might expect such facts to be the basis of a claim.”<sup>21</sup> The court then held:

The insurer ... objects that the attorneys are in essence seeking to be rewarded for their ignorance in connection with the medical malpractice action for which they were retained. The reward of coverage, however, is the necessary and intended consequence of a test with a subjective component. The insurer is in essence objecting to the practical reality that enables it to sell any malpractice coverage, including retroactive coverage on a claims made basis. *To obtain protection from the consequences of their ignorance is a key reason why attorneys purchase and insurers are able to sell malpractice insurance.* A purely objective test would provide insurers with far greater protection against the risks of both “adverse selection” and outright fraud. But if attorneys had to run that gauntlet to obtain coverage, they would have little or no reason to buy malpractice insurance. *After all, the promised retroactive coverage would be illusory if it could be denied solely because a reasonable attorney would have known at the time of the act or omission that a malpractice claim could be made.*<sup>22</sup>

The trial court's decision was overturned, and Liberty's motion for summary judgment denied.

Sometimes, a policyholder simply cannot demonstrate that it did not know a claim was forthcoming. In these instances, the policyholder will likely be denied coverage. For example, in *Harris Thermal Transfer Products v. James River Ins. Co.*,<sup>23</sup> an Oregon manufacturer of equipment entered into a 2007 contract whereupon it agreed to design, manufacture, and

sell heat exchangers to the Delta-T Organization.<sup>24</sup> According to Delta-T, Harris failed to complete performance on its obligations under the contract by the agreed “substantial completion date.”<sup>25</sup> Delta-T and Harris exchanged several letters throughout 2007 discussing Harris’s failure and efforts to rectify the situation.<sup>26</sup>

In 2008, Harris purchased a professional liability insurance policy from James River Insurance Company, pursuant to which James River agreed to provide Harris with a defense and indemnification for claims arising out of or resulting from the performance of or failure to perform professional services first made against Harris and reported to James River between February 9, 2008, and February 9, 2009.<sup>27</sup> On October 23, 2008, during the effective period of the policy, Harris notified James River of Delta-T’s claim against it.<sup>28</sup>

On May 18, 2009, Delta-T filed an action against Harris in Virginia, arising from manufacturing defects in the heat exchangers Harris manufactured and sold to Delta-T under the contract.<sup>29</sup> Harris promptly tendered the complaint to James River, which refused to undertake Harris’ defense, claiming that Harris should have foreseen that a claim could arise against it prior to February 9, 2008.<sup>30</sup> The court agreed:

A person of no more than ordinary prudence could reasonably have foreseen from the July 2007 letter that the defects in Harris’ installation could give rise to a demand for money damages, not least because the July 2007 letter expressly stated that Delta-T might seek to hold Harris liable for Delta-T’s damages.<sup>31</sup>

As a result, the court found that Harris was not covered for the Delta-T claim.

### **Is Your Alleged Wrong Related to Another (Prior) Wrongdoing?**

Finally, many malpractice insurers seek to disclaim coverage by arguing that an alleged error or omission that occurred and was reported during their policy’s period nonetheless falls *outside* the coverage period because the error is somehow “related” or “inter-related” to another prior wrongdoing that occurred during a different policy period. Most professional liability insurance policies include what is known as

an “interrelated wrongful acts” provision similar to the following:

All Claims arising out of the same Wrongful Act and all Interrelated Wrongful Acts of the Insureds shall be deemed to be one Claim, and such Claim shall be deemed to be first made on the date the earliest of such Claims is first made, regardless of whether such date is before or during the Policy Period. All Damages and all Claims Expenses resulting from a single Claim shall be deemed a single Damage and Claim Expense.<sup>32</sup>

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In *ACE American Insurance Company v. Ascend One Corp.*, Amerix, a company that provides assistance to credit counseling agencies, was the subject of two claims. First, in a 2004 class action (the “Jones Action”), the named plaintiffs alleged that Amerix and other defendants engaged in “unfair, deceptive and misleading debt management, credit counseling, budget planning and debt collection activities” related to their sale of Debt Management Plans to consumers.<sup>33</sup> Second, in 2006, the Attorney General’s offices of Maryland and Texas served investigative demands and subpoenas on Amerix pursuant to each state’s consumer protection statutes.<sup>34</sup> Amerix informed its professional liability insurance company about the subpoena and demand. The insurance company, however, denied coverage, arguing among other things that “even if the investigation involved wrongful acts, such acts have a common nexus of facts with [the] 2004 class action against Amerix and its affiliates and is therefore excluded” under the provision cited above.<sup>35</sup> The United States District Court, District of Maryland, disagreed, holding:

The appropriate approach in this case is to examine whether there is a sufficient nexus of facts, circumstances, events or causes between the Jones action and the Multi-State Claim.

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Because the Multi-State Claim is focused on circumstances and events that occurred subsequent to the alleged Wrongful Acts underlying the Jones claim, and because the Subpoena and Texas Demand appear to be related to a broad investigation of Amerix's marketing consumer counseling business practices rather than focusing on the specific experiences of the Jones plaintiffs, the Multi-State Claim does not arise from the same "fact, circumstance, situation, event, transaction, cause or series of related facts, circumstances, situations, events, transactions or causes" as the Jones action and is therefore not Interrelated.<sup>36</sup>

Indeed, many courts hold that where actions allege different wrongs to different parties, arising out of different alleged duties, they shall *not* be deemed to arise out of the same or interrelated acts.<sup>37</sup>

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## Conclusion

Professional organizations and practitioners purchase E&O insurance to protect against the risk of malpractice claims. Far too often, however, professionals also face the risk that their insurance company will deny their claim for malpractice insurance. To maximize recovery under these policies, professionals and their risk managers must familiarize themselves with all the terms and conditions of their E&O policy as well as the arguments that insurance companies commonly raise in an effort to deny coverage. Armed with this knowledge, professionals can argue against denials and often obtain the coverage to which they are entitled.

## Endnotes

- 1 *Minnesota Lawyers Mutual Insurance Company v. Antonelli, Terry, Stout & Kraus LLP*, Civil No. 1:08-CV-1020, 2010 WL 4853300 (E.D. Va. 2010).
- 2 *Antonelli*, 2010 WL 4863300 at \*3.
- 3 *Id.* at \*4–5.
- 4 *Id.* at \*8.
- 5 *Id.* at \*7.
- 6 *Id.* at \*9.
- 7 *Id.* at \*8.
- 8 *Id.* at \*10 (emphasis added).
- 9 *Medical Records Associates Inc. v. American Empire Surplus Lines Ins. Co.*, 142 F.3d 512 (1st Cir. 1998).
- 10 *MRA*, 142 F.3d at 513.
- 11 *Id.*
- 12 *Id.* at 514 (emphasis added).
- 13 *Id.* (emphasis added).
- 14 *See BP Air Conditioning Corp. v. One Beacon Ins. Group*, 871 N.E.2d 1128, 1131, 8 N.Y.3d 708, 714, 840 N.Y.S.2d 302, 305 (N.Y. 2007) ("If [a] complaint contains any facts or allegations which bring the claim even potentially within the protection purchased, the insurer is obligated to defend") (citing *Technicon Elecs. Corp. v. American Home Assur. Co.*, 542 N.E.2d 1048, 1050, 74 N.Y.2d 66, 73, 544 N.Y.S.2d 531, 533 [1989]).
- 15 *Liberty Insurance Underwriters Inc. v. Corpina Piergrossi Overzat & Klar LLP*, \_\_\_ N.Y.S.2d \_\_\_, 2010 WL 4825892 (N.Y.A.D. 1st Dep't, November 30, 2010).
- 16 *Corpina*, 2010 WL 4825891 at \*1.
- 17 *Id.*
- 18 *Id.*
- 19 *Id.*
- 20 *Id.* at \*2.
- 21 *Id.* (citing *Executive Risk Indem. Inc. v. Pepper Hamilton LLP*, 13 NY3d 313, 322 [2010]) (internal citations omitted).
- 22 *Id.* (emphasis added).
- 23 *Harris Thermal Transfer Products v. James River Ins. Co.*, No. CV 09-718-PK, 2010 WL 2942611 (D. Or. July 19, 2010).
- 24 *Harris Thermal*, 2010 WL 2942611 at \*1.
- 25 *Id.* at \*3.
- 26 *Id.*
- 27 *Id.* at \*2.
- 28 *Id.*
- 29 *Id.* at \*3.
- 30 *Id.*
- 31 *Id.* at \*7–\*8.
- 32 *See ACE American Ins. Co. v. Ascend One Corp.*, 570 F.Supp.2d 789, 793 (D. Md. 2008).

33 *Ascend*, 570 F.Supp.2d at 799.

34 *Id.* at 791–92.

35 *Id.* at 792.

36 *Id.* at 801.

37 See *National Union Fire Ins. Co. of Pittsburgh PA v. Ambassador Group Inc.*, 691 F. Supp. 618, 623 (E.D.N.Y. 1988) (noting that, while claims were “interrelated to the extent that they all involve[d] allegations of wrongdoing of one sort or another and relate[d], in some way” to the demise of the same company, four claims alleged against one company were legally distinct, for purposes of determining when notice was

given to the company’s insurance company, as they “allege[d] different wrongs to different people”).

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