

CONSTRUCTION

FREDERICK J. FISHER, J.D.

Surplus Risk Services, Inc./The Fisher Associates Adjusters

navigant.com

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TECHNICAL ASPECTS OF PROFESSIONAL LIABILITY CLAIMS

Professional liability claim management is a unique area of insurance claim responsibilities. Indeed, there are as many ways to supervise, manage, and investigate professional liability claims as there are different lines of professional liability coverage. This article will address the key issues that are involved in the investigation and resolution of nonmedical and non-D&O claims under professional liability policies.

INTRODUCTION

To the uninformed, "a claim is a claim is a claim." To some extent this is true. Any type of liability claim requires proof that the insured owed a duty to another person or entity, that the insured breached this duty, and that the breach was the proximate cause of quantitatively measurable damages suffered by the person or entity to whom the duty was owed. Thereafter, it becomes a matter of determining whether or not there are any defenses such as comparative or contributory negligence on the part of the claimant. Finally, there is the question of coverage—the issue of whether or not the policy will respond to the claim.

This simple analysis applies to claims under all liability coverage lines. In the professional liability arena, however, things are never simple. Often, the issue of liability in a complex real estate transaction, Securities and Exchange Commission (SEC) matter, or tax dispute is not as readily determinable as would be the case in a slip-and-fall or fender-bender claim. Moreover, damages as well as coverage under the policy may not be easy to evaluate in the absence of sophisticated, expert analysis. The issue of plaintiff culpability or the liability of other codefendants could cloud the situation, as well. Claims-made coverage issues may also complicate management decisions, and in the process, make reserving and coverage determination all the more complex. Finally, since most professional liability policies are written with so-called "diminishing limits provisions" (whereby defense expenditures reduce policy limits), this gives rise to a host of other thorny issues when developing a defense and settlement strategy for any given claim. In other words, yes, "a claim is a claim is a claim," but in professional liability insurance, the man-hours necessary to properly evaluate and conclude a professional liability claim are far more extensive than in other, more standardized, lines of insurance.

The following discussion consists of five sections. The first explores the common investigation and resolution issues that apply to nonmedical and non-D&O professional liability claims. The second addresses some specific areas that have particular relevance to certain individual professions. The third analyzes some of the claims-made coverage problems associated with professional liability claims. The fourth touches upon various coverage issues that may affect the handling of a claim against a professional. The discussion concludes with a look at the diminishing limits policy provision and examines its implications for the defense and settlement of professional liability claims.

Professional liability is a fluid arena. What may apply today can be changed tomorrow by a simple stroke of an appellate pen. It is therefore important to accept the fact that professional liability claim analysis is as complicated as are the individual professions themselves. This article will thus seem a bit generalized, which is its intent. Specific, substantive issues associated with a particular profession will not be explored except as examples, when necessary.

PROFESSIONAL LIABILITY CLAIMS MANAGEMENT

There are significant differences between managing professional liability claims, compared to those arising out of more standardized coverages.

A Unique Area

As mentioned above, professional liability claims analysis is more man-hour intensive than most other lines of insurance. While a competent claims adjuster can conduct field investigations of several routine claims per day, this is not the case with professional liability claims. Investigating a single claim and meeting with an insured can last the better part of a day—or more—depending on the complexity of the claim, the profession involved, and the amount of documentation that needs to be reviewed. In contrast, general liability or workers compensation claims, for example, typically require relatively little field documentation because often the claim arises out of a simplified error, such as a slip-and-fall or back injury. These types of claims do not have the factual complexity associated with them as do professional liability claims.

In professional liability claims, it is often the insured's file that contains the information needed to determine coverage, liability, and damages. The insured's file could often be very extensive and involve thousands of pages of documents. Not only must the field investigator develop a number of facts about the claim, but examiners, as well as management, must also review portions of it to make the correct decisions necessary to resolve the claim.

While general liability claim departments may allow examiners to have 250 (or more) claims on active diary, it is not uncommon for the experienced insurer to limit professional liability claims to 175 or fewer per examiner.

The Need for Proactive Claim Handling

Time constraints require that the examiner have the ability to adequately review and properly analyze a file so the correct decisions can be made. Anything less and the claim is often assigned to legal counsel, a situation which tends to remove the usual safeguards of supervision and control. Allowing counsel to set the pace of claim development frequently has the effect of increasing allocated loss adjustment expenses and also lengthens the time required to accurately quantify incurred but not developed reserve amounts. In contrast, more proactive handling, which can be accomplished by realistic caseloads, allows for quicker development of the facts of loss and thus more timely evaluation of damages. Ultimately, this means that reserves will be set more accurately and at an earlier time in the life of a claim file.

GENERAL INVESTIGATIVE ISSUES

Investigation and fact gathering are key elements in all professional liability claims. In many respects, investigating professional liability claims is not unlike any other claims investigation. A meeting with the involved insured(s) should be scheduled as soon as possible, and in the process, a complete copy of the insured's file should be obtained. Any other relevant documents should also be secured, such as general correspondence files and contract files that may also have a bearing on the matter. For instance, an insurance agent's sales/underwriting file on an account is not the only file needed. The agent/broker may have a corporate file with the market he represents that could also be an issue in the claim. Such a file would contain the producer agreement, binding authority

information, and other pertinent documents necessary for liability analysis. An underwriting manual may also be necessary to review. In effect, the investigator should be alert to all documentation that might at first glance appear peripheral, but, given the complexity of most professional liability claims, could ultimately have an important bearing on its final resolution.

The following areas of professional liability claim investigation are general in nature and apply to all professions. More specific points that apply to particular professions will appear later in this article.

The Insured Organization

A proper preliminary investigation should develop all information concerning the insured as an organization. These questions include, but are not limited to: Is the insured a corporation, partnership, or proprietorship? What are the names, home addresses, and telephone numbers of the principals? This is crucial information because claims can be open for a long time, yet people come and go. Accordingly, having access to important people at trial may depend on this information.

The insured's operation should be described in the adjuster's report. The description should include any pertinent observations regarding staffing, equipment, paper flow, and internal review processes. Any other general but relevant information should also be explored. For example, such questions as: Does a law firm have the ability to conduct conflict checks on new matters referred to it and do they actually do so on a routine basis? Does an accounting firm have a dearth of computers at a time when most accountants rely exclusively on them? Any other deviations in the insured's operation that could not only create a liability problem but also constitute an underwriting hazard should be documented.

Insured's Employees

This part of any general investigation identifies the employees or former employees who were involved with the claim at hand. All personal and professional background information pertaining to such persons should be obtained. Most important are resumes, which need to include such information as number of years and types of experience, academic education, specialized/continuing training, and professional certifications or designations. Facts regarding any lecturing, publishing, or teaching in their profession—especially on matters at issue in the claim—should be developed. It should also be determined whether the involved

insureds have ever been a part of any committees or had any involvement with professional organizations that went beyond mere membership. For example, the insured was a member of a professional ethics committee for the local bar association. Such involvement can assist a claim defense or hurt one, and this should be ascertained early in the process. Finally, it should be discovered if any of the principals involved in the claim has ever been subject to any state, federal, or local censure by professional organizations or licensing authorities.

The Claimant

Information about the claimant may reveal a motive for making the claim, which can in turn dictate the appropriate type of settlement strategy. For example, in response to a fee dispute, claimants sometimes allege professional negligence, when in fact there was none; merely a misunderstanding about billing rates or practices. Finally, insight concerning a former client's state of mind may yield important information as to how quickly a matter might be resolved (i.e., the level of cooperation that might be expected from them). For instance, it is valuable to know whether or not the claimant has some type of vendetta against the insured or has a generally litigious nature (i.e., has a history of making claims against professionals in the past). Such facts may lead to the conclusion that this may not be an easy case to resolve because the claimant wants to put up a fight and is adverse to compromise.

Reexamining the client's needs and expectations is useful at this point in the investigation because it may flush out inconsistencies in the insured's (or the claimant's) initial story. Professional liability claims are often an embarrassment and it is not unlikely for an insured to try to present himself or herself in the best possible light, when in fact, his/her conduct was otherwise.

At this point, additional information regarding any changes in the client's status that may have contributed to the claim should be determined. For instance, a probate lawyer who drafted someone's will or trust may have had a duty to recommend changes as a result of his client's divorce. An insurance broker may have had a similar duty to recommend different coverages or enhance coverages because a client's business needs have changed. Finally, it often happens that what a client may want is not what he may need or what the law may require, thus making it necessary for the professional to offer specific recommendations.

Other Involved Parties

In any given professional liability claim, there are often other parties, organizations, or professionals that are not the insureds. All of these entities and the role they played must be identified, examined, and explored. Allocation of fault and therefore damages to these entities or persons may be involved, which is important when setting reserves. If any of these persons/entities are no longer in existence or are unavailable for questioning, this too needs to be determined to properly assess coverage, liability, and damages.

The Claimant's Attorney

Most claimants already have an attorney or have already filed and served a suit by the time a claim is reported to the insurer. It is therefore not uncommon for an insured to have personal knowledge concerning the attorney involved or have had previous official contact with the attorney before suit papers were served. All of these facts need to be determined and thoroughly explored.

Copies of correspondence pertaining to the claim should be obtained, together with any responses from the insured or his representative. If there were none, the reason for the absence of correspondence should also be explored. For example, while it is often true that the first report of claim to an insurer is the lawsuit served on the insured, there is often prior correspondence leading up to the lawsuit that has been exchanged between the insured and the claimant (or the claimant's representative). Sometimes this prior correspondence may give rise to coverage issues as will be discussed later.

The Lawsuit

Most professional liability claims are first reported by way of suit. Most suits will contain specific factual allegations concerning an insured's alleged misconduct. These specific allegations require that the insured be queried extensively as to the substance of such allegations, including the reasons why they may not be true. Any documentation existing to substantiate the insured's defense should also be identified and obtained. This can be in the form of contracts, agreements, correspondence, notes, activity logs, and billing records. Often, an insured believes he did nothing wrong. Documentation that exists may support—or refute—this contention. Either way, gathering such documentation should be expedited.

Investigative Questioning

As a general practice when investigating professional liability claims, adjusters should not hesitate to play devil's advocate. It is often a good idea to ask questions that the plaintiff's attorney might ask at a deposition or at trial. Questions should also be asked that develop additional facts not yet found in the file that could uncover liability where none seems to exist. In effect, the adjuster should play plaintiff's attorney and try to obtain facts regarding liability beyond the insured's statement and the insured's file.

Sometimes, claims may rest solely on a word-against-word contest in which the insured's demeanor can greatly influence a jury as to which side it believes. Investigative questioning can often shed light on such demeanor. Obviously, it is better to have accelerated insight as to how an insured will react to questioning at the earliest possible juncture—rather than 4 years from the initial investigation when trying the case.

Initial Retainer Service Provided

Prior to delving into the facts surrounding the claim at hand, the initial contact or representation of the claimant should be explored. When and how did this take place? Was there a referral or did the claimant respond to an ad or a brochure (a copy of which should be obtained). When did the first and subsequent contact take place and for how long? What was discussed and understood? What were the client's needs and what was the nature of the insured's plan to solve them? Were these understandings put in writing in the form of a retainer or contract? Did the insured maintain notes or were all agreements made orally? Did the insured make recommendations beyond the client's needs that were followed or rejected?

DAMAGES

Quantifiable damages are an essential component of any valid claim. The insured may have vital information regarding this issue that could affect information from the claimant or his representative. Certainly, this information should be obtained not only from the insured and claimant, but from any other source that could shed light on the claimant's demand for damages.

For example, this could include the value of real estate in a professional liability claim against a realtor or the value of inventory lost in an uninsured fire. Often organizations or

individuals that are not parties to the claim (i.e., witnesses) may have important information concerning the values involved in the underlying loss.

The Underlying Loss

Part of the damage issue is often what is referred to as “the underlying loss.” In other words, the facts surrounding the insured’s conduct may give clear evidence of professional negligence. But what if the negligence is not the proximate cause of any damages? Certain professionals, such as attorneys and insurance agents, may commit obvious errors in providing services. However, such errors may not always give rise to damages. For instance, suppose an attorney fails to file a lawsuit on a timely basis, causing the claim to be barred by the statute of limitations. This is a clear case of liability in most instances. Suppose, however, that the attorney’s client did not have a strong case to begin with. In this instance, the claimant may not have suffered any damages—even if the lawsuit had been filed in time. The same can occur for an insurance agent who failed to renew a client’s coverage. In the absence of an uninsured loss, the client has not suffered any damages (with the exception of a commercial client that may have lost a contract because coverage required under the contract was not renewed and the insured was unable to present a valid certificate of insurance).

These exceptions are unusual but can occur. In those professions that do give rise to issues of “underlying matters,” a thorough claims investigation requires that these facts be developed to verify the causation element of the damages being claimed. Not only does the investigation warrant a complete review of the facts as to the insured’s alleged breach of duty, but the underlying matter needs to be thoroughly examined to verify the actual amount of money in controversy (i.e., the damages claimed). It is not uncommon for a claims investigation to thus require the adjuster to assess two losses: (1) the breach of duty “claimed against the insured” and (2) the dollar amount of the underlying loss, such as the true value of the client’s personal injury matter the attorney “blew” or the amount of the client’s now uninsured loss caused by the agent’s failure to renew coverage.

CLAIM HANDLING CONSIDERATIONS FOR SPECIFIC PROFESSIONS

Each profession in the professional liability industry is unique. Accordingly, determining coverage, liability, and damages requires that specific issues be investigated. In some instances,

experts may need to review the matter. For example, expert review could be required if a claim arose when an attorney was dealing with sophisticated clients involving contract matters on complex business deals, “gray area” tax cases, or Securities and Exchange Commission (SEC) claims. Peer review may also be necessary in design-related claims, for example, when only another architect could determine whether the collapse of a structure resulted from another architect’s negligent drawing or if it was caused by faulty construction methods.

Whether a peer review is required or not, there are claims handling issues to consider that are specific to individual professions. The following discussion is not meant to be complete. However, it is intended to focus upon a number of the key areas that may need to be explored as part of the claim process when dealing with attorneys, real estate brokers, insurance agents, accountants, and architects/engineers.

Attorneys

The types of claims against attorneys vary widely and are dependent on the area of practice in which the attorney is engaged. For instance, for trial lawyers this may involve personal injury matters that constitute “the underlying matter” as discussed earlier. Such claims against lawyers usually will first involve a dismissal against the client claimant for failure to file on a timely basis. This could entail the filing of a complaint or other invoking of statutes that regulate the procedural process. Other kinds of claims often deal with a case that did proceed to trial but allege that the attorney was ill-prepared, did not have an expert (when one was needed), or did not have available evidence introduced at trial due to the failure to prepare the case properly.

Obviously, the facts surrounding such allegations need to be obtained. This is required to assess the breach of duty issue in view of the client-claimant’s allegations. Damages will be calculated by assessing whether or not—in the absence of the attorney’s breach of duty—the result would have been different for the client.

Believe it or not, even defense lawyers get sued. These are the lawyers hired by insurance companies to defend policyholders on liability claims. In recent years, defense attorneys have been experiencing increases in claim frequency. Often, the client insurance company is the claimant, and pursues action against defense counsel, alleging inadequate defense or evaluation of a matter. In other instances, the insurer will claim that the attorney did not keep the insurer informed on a timely basis as to new

information that altered the liability or damage issues, contrary to previous evaluations. Such failure can cause the insurer to be surprised at trial when information not known by the insurer results in a verdict far in excess of what had been expected. Defense counsel too can fail to respond in time to procedural requirements that may result in a default judgment being entered or important evidence being excluded at trial.

Defense lawyers may also be sued by the insured they were appointed to represent. The allegations against the attorney may mirror the allegations made by the insurer, such as failure to adequately prepare for trial giving rise to an unexpected adverse verdict. The insured may claim significant losses if a verdict gives rise to adverse publicity affecting the insured's business reputation. The insured may also assert that undervaluing a claim exposed the insured to an excess policy limit verdict for which the insured is now responsible. Finally, in view of diminishing limit policies, the insured may claim that excessive defense costs have equally exposed the insured to excess limits problems. (This issue is discussed in more detail in section IV.H.) These are a few of the exposures now facing defense counsel as a class of professional liability.

Other types of claims against lawyers may involve complex representation on large business transactions, and SEC or tax matters. In these types of claims, the investigation, assessment, and management issues become even more involved. So does the need for early peer review to determine if a breach of duty was committed. Unfortunately, peer review is often associated with the hiring of expert witnesses, too often retained late in the litigation process. Perhaps a better approach is to ascertain as many of the facts as possible early in the life of a claim. This results in developing an accelerated resolution plan. More often than not, the resultant savings in defense costs more than make up for the cost of an early peer review.

Real Estate Brokers

Real estate transactions present specific factual issues. In any given transaction, there are several "parties." There is the property itself. There is also a buyer and a seller (or tenant). There may also be other organizations such as escrow companies, title agents, a title insurer, and a title reviewer (who may be a lawyer as required in some states). In more complex sales involving large commercial transactions, lawyers and accountants representing the parties may be involved, with whom liability and damages may be shared.

Further, a claim against a real estate broker may not allege misrepresentation regarding the condition of property or projected income from commercial property. Instead, the claim may involve the issue of who is entitled to actually purchase the property that is up for sale. Specifically, a dispute may center around the question of which of two buyers actually made an offer that was accepted. This often occurs when a seller finds a buyer willing to pay a higher price than the original buyer had offered and therefore seeks to rescind the deal he made earlier. In all instances, the nature of the claim determines the nature of the investigation, analysis, and resolution of the claim.

One forum in which creative claims resolution techniques can shine is that of claims against real estate professionals. Under the right circumstances, a professional liability insurer might consider purchasing real property to forestall a claim against a real estate broker by a disgruntled buyer. It is then possible to sell the property, thereby transforming a claim into an investment. Even if sold at a loss, the amount would often be less than might be awarded to a buyer at a trial, not to mention the expenditure of defense costs. Insurers also have the option to refinance property if the original financing is the pivotal issue of the claim. Once again, instead of a cash payout and a file closed, a loss becomes an interest-paying loan, yet another example of a claim being transformed into an investment.

Insurance Agents/Brokers

There are many types of claims made against insurance agents and brokers. The specific type is often dependent on the role that the agent/broker played in the initial transaction. Key questions to be answered include: Is the professional a captive agent to an insurer or is he an agent for many insurers? (i.e., an independent agent). Is the professional, as a retail broker, an agent of both the insurer and the insured? Perhaps the broker is a wholesaler, a managing general agent (MGA), or a surplus lines broker. The role of the insurance professional in any particular transaction will determine the unique questions to be asked and the specific nature of the claims analysis to be performed.

The magnitude of the underlying loss will also affect the type of claims investigation to be performed. Was the claim triggered by the failure to renew a private passenger auto policy that involved a fender-bender accident or, at the other extreme, failure to place a product liability insurance policy for the manufacturer of cheese found to be contaminated with salmonella which ultimately causes deaths of consumers? Again,

the size of the underlying loss affects the nature, scope, and complexity of the investigation.

Some of the more important facts to obtain when investigating professional liability claims against insurance agents and brokers include securing all copies of corporate correspondence with a market (i.e., copies of broker agreements, producer agreements, and appointed agent contracts). Often these documents will set forth the underwriting and binding authority that the insured agent/broker may have; this is in addition to the underwriting file itself. Copies of notes, memorandums, or oral conversations with the client are equally important in determining what was discussed with or disclosed to the broker's client. Often these types of claims may boil down to a word-against-word contest. Accordingly, the demeanor of the broker as a witness may become one of the more important facets of the claim to consider when analyzing the magnitude of loss in relation to potential resolution.

Like real estate claims, actions against insurance brokers can also give rise to creative resolutions. In clear liability situations where the producer failed to obtain insurance, it is sometimes possible for the professional liability insurer to act as the intended insurer and "take over the underlying loss." In other words, suppose a client of the broker is being sued for a third-party loss such as an auto accident for which there is no insurance due to broker/agent negligence. It is then possible for the professional liability insurance company to assume the responsibility for the defense and ultimate indemnification of the broker's client. The advantage of this approach is that the professional liability insurer stands in the shoes of the intended insurer. When circumstances warrant, the professional liability insurer can provide another professional to assist the claimant in achieving what the insured was supposed to do in the first place. As such, the magnitude of defense costs, as well as the claim resolution process in general, can be better controlled and the overall loss mitigated since the underlying claim is being resolved on an expedited basis. (This technique of assuming the underlying matter can also be applied to certain claims against attorneys and accountants, as well.)

In some instances, the client-plaintiff may still be responsible for the cost of the service as part of mitigating his damages. For instance, if a broker failed to obtain insurance coverage and the professional liability insurer provides what should have been provided in the first place (i.e., coverage of an uninsured loss), the professional liability insurer is legally entitled to deduct the pro rata cost of the benefit (i.e., what the claimant would have paid

in premium up to the time of the underlying loss event). These are important and creative considerations of which claims people need to be cognizant.

Accountants

Accountants face unique claims, too. These are:

1. Errors that give rise to increased tax liabilities
2. Errors in preparing or reviewing investment programs that give rise to investor losses
3. Errors in reviewing client financial statements without discovering or disclosing losses or financial conditions that later affect the company's solvency, stock price, ability to conduct business, or cause it to forego favorable acquisition opportunities
4. Errors involving management information services (i.e., data processing consulting)

Those claims arising from an increase in taxes generally do not have a high degree of severity. This is because the tax due may not be recoverable as damages, only the penalty and interest. There are exceptions, such as a procedural error that might have otherwise deferred taxes to some point in the future. However, even in those instances, a credit for the eventual tax might arguably be made, as theoretically no tax can be indefinitely deferred. These types of claims do not usually give rise to the policy limit exposures that may exist in other types of actions against accountants.

Investment program losses often involve millions of dollars. Obviously, such claims present significant exposures that have the potential to exhaust the policy limits of most accountants. However, recent appellate activity has limited the scope of an accountant's liability to third-party investors who the accountant could reasonably foresee would rely on the financial statement he prepared. It is therefore incumbent on the claims professional to be aware of those instances where third-party liability may or may not exist as a matter of law. (This issue is discussed in more detail in section XIII.C.)

The loss to a company/client itself, however, is a different matter as there are no third parties relying on the accountant's statement. Instead, it is the client that may suffer a significant loss in the event of an accountant's failure to discover and disclose to management problems found during the course of an audit. Situations of this type can also give rise to significant exposures and policy limit claims.

The investigating of accountants professional liability claims is similar to that required by other professions already discussed. However, in dealing with claims of substantial value or those involving complex tax issues, peer review may become necessary. As is the case with other professional liability claims, expedited peer review is important so that liability and damages can be determined as early in the process as possible.

Architects and Engineers

Architectural-related claims are as varied as there are architectural specializations. Certain architects specialize in single-family homes or apartments. Others concentrate upon commercial offices whether office parks or high-rises. The practice of still others may be limited to landscaping. As a result, most, if not all, claims require peer review.

Further complicating the claims review process is the fact that claims against design professionals often arise from “construction defect” litigation in which there are numerous if not hundreds of defendants and cross claims. One of the significant and costly problems is determining the cause of a defect (i.e., negligent design or negligent implementation by the general contractor or subcontractor). These claims are expensive to evaluate given to the complexity and extent of legal discovery that they require.

Often during the construction process, “change orders” take place that may or may not involve the original architect or engineering specialist. Also true is the fact that some architectural firms may have on-site monitoring responsibilities. These are two significant, additional sources of claims. The claims review and investigation process must keep these important, industry-specific procedures in mind when evaluating a claim.

The same level of claims complexity is equally true of engineers as there are many different specialties that engineers practice. Some may be mechanical engineers, others whose jobs are electrical in orientation. There are soil engineers and those who concentrate in the area of earthquake remedial review. Still others practice solely in environmental and toxic waste disposal. Once again, the claim process will be costly and time-consuming given the variety of the specializations comprising the engineering profession.

From a coverage standpoint, however, there sometimes arises a subtle point of contention. Most professional liability policies exclude from coverage those claims that involve bodily injury and/or property damage. This is especially true of most miscellaneous professional liability policy forms that are frequently used to insure safety consultants and environmental consultants, two important subclasses of engineers. The intent of this exclusion is to distinguish the professional liability policy from the office general liability form that would, for example, protect a firm in the event of a slip-and-fall claim, on or off premises. The GL policy, of course, would exclude from coverage claims arising from the insured’s profession. The obvious problem is that in the event of an error by the safety or environmental consultant, virtually all of the claims would give rise to property damage and/or bodily injury. Thus, the existence of such an exclusion may produce a significant coverage gap to the detriment of the policyholder.

CLAIMS-MADE COVERAGE ISSUES

As in every type of claim, coverage may often be an issue. This is especially true of professional liability insurance, which is written on almost an exclusively claims-made basis. Compared to occurrence-based policies, this creates one additional area where coverage controversies frequently arise. For more information on this topic, refer to the Claims-Made Coverage Triggers section (and especially to the Claims-Made Legal Precedent subsection) as well as the article by Frederick Fisher: “Claims-Made Triggers in Professional Liability Insurance,” *The Risk Report*, July 1990.

Types of Claims-Made Policy Forms

There are several versions of this unique coverage form. There is the “pure” form and the more standard claims-made and reported form (discussed in section VIII.C).

Claims-made and reported policies require a claim to be both made against an insured and reported to the insurer during the policy term, whereas “pure” claims made forms specify only that the claim be reported to the insurer “as soon as possible,” “as soon as practical,” or “within a reasonable period of time,” but not necessarily during the policy period itself.

Regrettably, there has been no standardization of claims-made forms in the industry. Often, new underwriters and programs may “cut and paste” a competitor’s policy without first proofing and evaluating the result to verify consistency. In the long run, this practice may create serious ambiguities in the policy that may not be discovered until a claim is reported and the flaw discovered.

Claims professionals should be consulted at the earliest stages in the development of a program designed to cover any specific profession. This allows them the opportunity to provide real-world experience when drafting the wording of a claims-made policy form.

Key Dates in Claims-Made Policies

Claims personnel must be sensitive to three important dates when determining if a claim falls within the coverage of a given policy. These dates, which may sometimes be different or the same, include:

1. **The date(s) of error** (whether the insured agrees there was an error or not). This is the date that the insured allegedly failed to file the lawsuit or when the broker failed to renew or order an insurance policy for a client. This date may be significant in those state jurisdictions that follow or have upheld prior act limitations on professional liability policies. (Prior act limitations are discussed in more detail in section VIII.D.)
2. **The date of “occurrence.”** This is the date on which an event takes place that sparks the making of the claim. This is *not* to be confused with the traditional insurance usage of the word “occurrence.” This could be the date the claimant finds out his suit was dismissed due to the error of the lawyer. It could be the date a client had his insurance claim denied due to the absence of coverage caused by the broker’s failure to renew a policy.
3. **The date of first notice to the insured.** This is the date when the insured first became aware that a claim could be or was made against him. Often, a professional liability policyholder may become aware that his error has damaged a client before the client is aware of it and before the claimant actually makes a claim against the professional.

These dates may have a profound impact on whether a claim is covered under any of the claims-made forms currently being used by underwriters.

The Problems of Prior Acts and Claims-Made Coverage Triggers

In those instances where the date of error *and* the date of occurrence take place before policy inception, there is always the issue that the insured “was aware of facts or circumstances that a claim could be made” or a claim “was in fact made against him” prior to the inception of the policy. Such an inference is not necessarily true, but does raise a coverage issue to be investigated and determined.

If in fact the insured was aware of a potential claim, this raises two separate and distinct coverage defenses. The first is misrepresentation on the application for coverage. Almost all professional liability applications query the insured as to whether they are aware of any facts or circumstances that a claim may be made against them. If it is shown that the insured was less than candid on the application, it may be possible to rescind the policy for material misrepresentation. This would require an underwriter to testify that had the truth been known, the policy would not have been issued or an endorsement would have been issued excluding the potential claim from coverage.

The second possible defense would be the insurance policy’s own claims-made language which might also give rise to a coverage denial. However, be aware, claims-made policies can be ambiguous due to “cut and paste” terms and conditions. Further, some insurers have attempted to define what may be considered to be a claim against the insured. At times, these definitions are not clear and have created more problems than they have solved. For instance, consider the fact that the insured’s error is really “conduct of the insured affecting the client/claimant.” Consider further that “a claim first made against the insured” is really “conduct of the claimant towards the insured professional” in making a “demand for money or services.” Finally, consider the fact that in claims-made and reported policies, the requirement that the insured “report the claim to the company during the policy term” is conduct of the insured toward the insurer. Suppose a professional liability policy defined “claims-made” as being:

“... a claim is made when reported to the company during the policy term ...”

and this language appears after the usual insuring agreement requiring that:

“... the company will indemnify the insured ... for claims first made against them and reported to the company during the policy period ...”

In this situation, has not the claims-made language been shifted from “the conduct of the claimant towards the insured” to “conduct of the insured towards the insurer?” This is just one example of the kinds of ambiguous definitions that can be created if they are not carefully reviewed. Simply stated, claims-made and reported policies may only need language similar to the following to adequately express underwriting intent.

1. Require that claims be first made against the insured during the policy term or extended discovery term (i.e., conduct of the claimant towards the insured)
2. Require that the claim be reported by the insured to the company during the policy term (i.e., conduct of the insured towards the company)
3. Require that the claim arise out of wrongful acts during the policy term or subsequent to any applicable retroactive date

These are only a few examples of claims-made coverage issues that may complicate the professional liability claim handling process. Further, state interpretation of insurance policies varies widely between different jurisdictions. It is therefore not the intent of this discussion to examine all of the possibilities, only to alert those involved in the claim handling function.

COVERAGE ISSUES IN PROFESSIONAL LIABILITY CLAIM HANDLING

Other coverage issues affecting the claim handling process may arise due to the interpretation and application of provisions in the policy that involve: (1) the scope of coverage for “professional services,” (2) the policy’s conditions, or (3) the policy’s exclusions. Although coverage issues arise when adjusting claims under all types of policies, such issues are especially common in professional liability lines, given the lack of standardized wording that characterizes the policy forms used to insure professionals.

Professional Services Definitions

Sometimes, the nature of the error may not always mesh with a policy’s definition of “professional services.” For instance, consider a real estate lawyer who also may act as a trustee in holding the funds, pending the completion of a complicated three-way tax-deferred real estate exchange. In the event he is providing no technical legal services, but only acting as trustee, can it be said that his alleged act, error, or omission triggered his lawyer’s professional liability policy? This, of course, depends upon the wording and interpretation of his policy’s “professional services” definition. Another example of this situation might be a real estate agent (not the owner/broker) who buys and sells real estate for his own account. Under these circumstances, the question arises as to who the agent is providing services for and would his professional liability policy actually cover situations in which he is trading on his own account—as opposed to providing professional services for a client? The incorrect coverage decision in these instances can often expose an insurer to a serious bad faith suit alleging a wrongful denial of coverage, depending on the state jurisdiction involved. In such instances, the man-hours necessary to properly evaluate a claim are increased as a result of the need to involve coverage counsel in a matter. Coverage counsel’s opinion may have a dramatic impact on the manner in which a claim is resolved and the time necessary to resolve it.

Policy Conditions

Specific facts surrounding claims against professionals may have a bearing upon the way in which the policy’s conditions are applied. Ultimately, this could have a substantial effect upon the insured’s rights under that policy. For example, the question could arise as to whether or not an insured violated any of the conditions in the policy as a result of a claim. More specifically, suppose an insured tries to resolve a claim or control a claim prior to reporting it to his insurer. It may be difficult to prove that an insured, in not reporting a claim as soon as practical or possible, may have exacerbated the ultimate loss, and not mitigated it. This could come in the form of making the claimant angrier or in heightening the level of conflict. Although the insured may have violated the condition requiring prompt notice of a claim or suit, it might be difficult to prove that, had he reported the claim in a timely fashion, a different result would have occurred. (This condition should not be confused with the insuring agreement requirement to report a claim during the policy term, because it is possible for an insured to delay reporting a claim but still report it during the policy term.) Many states require that if an insured violated any conditions, the insurer must show that it

was prejudiced by the breach of such condition. This requires a showing that, had the condition not been violated, a different result would likely have occurred. This is very difficult for most insurers to prove but is an issue that further complicates the claim review and resolution process.

Policy Exclusions

All professional liability policies contain exclusions. Often there are exclusions common to all types of professions as well as exclusions that are unique to the profession insured. For instance, almost all professional liability policies contain exclusions for intentional and/or illegal acts. However, an insurance agent's professional liability form may contain an insolvency exclusion (i.e., not covering the insurance agent or broker for any claim arising from the placement of insurance with an insurer that later goes bankrupt or is declared to be insolvent). Such an exclusion is unique to the insurance broker/agent profession and would not be found in policies insuring architects and engineers. It is important that all facts of a loss, together with background information, be reviewed with the exclusions in mind. If an exclusion is triggered by the facts, then of course, the insurer may be required to issue a reservation of rights letter, seek the opinion of coverage counsel, and/or file a declaratory relief lawsuit to determine its obligations under the policy. In the interim, the insurer may still be required to exercise its duty to defend the insured professional. Some states, such as California, may require that the insured be informed that a conflict exists between the insured and the insurer and as a result, the insured may choose his own lawyer at the insurer's expense (commonly referred to as the *Cumis Doctrine*).

It should be obvious that in view of the nonstandardized nature of professional liability policy provisions, that the claims handling and resolution process becomes even more complex and time-consuming than is the case with other lines of insurance.

DIMINISHING LIMITS ISSUES

There is a final claims and coverage issue associated with professional liability. Specifically, the vast majority of claims-made professional liability policies now contain the so-called "diminishing limit" clause whereby defense expense incurred reduces the limit of the policy. (Diminishing limits policy provisions are discussed in more detail in section VII.B.) This too can have a major impact on an insurer's claim handling process

and overall resolution strategy. While this issue was discussed in the *Professional Liability Insurance Executive Briefing* in November 1994, it is important to reiterate some of the highlights once again.

The Problem of Nuisance Claims

As is well known, the insurance industry has long been plagued with "nuisance" claims. Insurance companies have often settled such claims quickly to avoid defense cost expenditures. At the other extreme, they have attempted not to pay nuisance claims, thereby setting a standard that sends a message to the plaintiff's bar to the effect that nuisance claims will not be honored. In view of the fact that defense costs are to be deducted from policy limits, this places the insurance company in a difficult position. It is generally held that insurers, to avoid "bad faith" problems, must demonstrate that their claims departments have expeditiously handled claims and attempted to resolve them as quickly as possible. This is necessary to show that insurers, in good faith, tried to minimize defense costs which impact policy limits, ultimately to the benefit of the policyholder. Such actions become even more significant when an insured has many other claims pending against it within the same policy period as well as when the insured seeks to strongly defend against, rather than make payment associated with, nuisance claims.

Conflicts Caused by Diminishing Limits Issues

Another key issue associated with diminishing limits policies involves the responsibility of both defense counsel and the insurer to keep the insured adequately informed of amounts expended, future anticipated expenses, and remaining limits. Defense counsel must be especially sensitive to this issue. It has long been held that defense counsel, although retained by the insurance company, owes its primary duty and obligation of professional services to the client-insured, which is traditionally defined as being the policyholder—not the insurance company paying counsel's bill. Thus, defense attorneys must demonstrate that in providing a full and complete defense to the policyholder, they did not wastefully incur expenses in defending the policyholder, thereby reducing remaining policy limits. This duty has the potential to create a conflict of interest between the insurance company, defense counsel, and policyholder. If such is the case, significant claim problems will certainly arise in California and possibly other states.

Trial Strategy Issues

Additional diminishing limits problems often arise when proceeding to trial. Such controversies occur when policy limits have, on the eve of a trial, already been “exhausted” by reserve. Under these circumstances, there may not be enough money available to pay both an adverse verdict as well as defense counsel’s fee. Complications could result if defense counsel seeks a guarantee of payment for its legal services from the insurer in the event of an adverse verdict exceeding the then remaining policy limits. In essence, the insurer could be asked by defense counsel to agree to increase the maximum exposure of its limit of liability.

Another problematic scenario arises should the insurer refuse to make such a guarantee, prompting counsel’s withdrawal on the eve of trial. Certainly, numerous bad faith and professional liability exposures could arise. This scenario becomes even more complex when there are other, unrelated, claims pending against an insured. But the outcome of the one proceeding to trial could affect the availability of future funds for payment and defense of other pending claims.

Communication and Consent Issues

Excellent communication between the claims department and the policyholder is needed so that the policyholder is kept abreast of what is occurring and what decision making process is taking place behind the scenes. In addition, it may be incumbent on the insurance company to seek the policyholder’s assistance and input during settlement negotiations. Certainly, the policyholder should have the right to make a decision as to whether or not a nuisance settlement—or any settlement—should be agreed upon or defended when policy limits appear scarce. Whether the claim is of the nuisance variety or not, the insured must nevertheless be kept fully informed, especially in those instances where policy language requires that his consent to settle is required.

Insurance company claims departments must also provide policyholders with a loss run on a periodic and regular basis as to where the policyholder stands with regard to its available limits. This should be done on at least a quarterly basis. Ideally, the loss run will include a list of all claims charged against the particular policy year, indicating both loss and expense payments. In addition, the insurance company must also indicate all open yet unresolved claims, what their current reserves are for loss and expense, and how these reserves may also affect the remaining limit of liability in the future.

This gives rise to yet another interesting issue. It is not uncommon that a policyholder is required to provide certificates of insurance to other persons or organizations, or for that matter, have additional insured endorsements issued in favor of other persons or organizations with which the policyholder has business relationships. Thus, an argument could be made for the need to send policyholder loss runs, indicating remaining limits, to certificate holders and additional insureds.

CONCLUSION

Professional liability claims are varied, complex, man-hour intensive, and require substantial expertise. It should also be apparent that legal liability and coverage questions frequently associated with professional liability claims typically cloud the efforts needed to resolve them. Hopefully, this article will raise underwriters’ level of concern so that the most competent professionals are utilized to perform the claims review process. This will produce the best possible service, and ultimately minimize overall payouts under the policies.

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