GOLDBERG SEGALLA LLP

Professional Liability Monthly

A national professional liability newsletter

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In this month's edition:

FEATURED ARTICLE

The Effect and Implication of a Bruised But Upheld Affordable Care Act

The High Court's ruling upholding the Affordable Care Act has surprised many. The response to the ruling has been mixed thus far and although some view it as much needed clarity on the issue, others have been quick to denounce its effect and will wait to take any action until after the upcoming elections.

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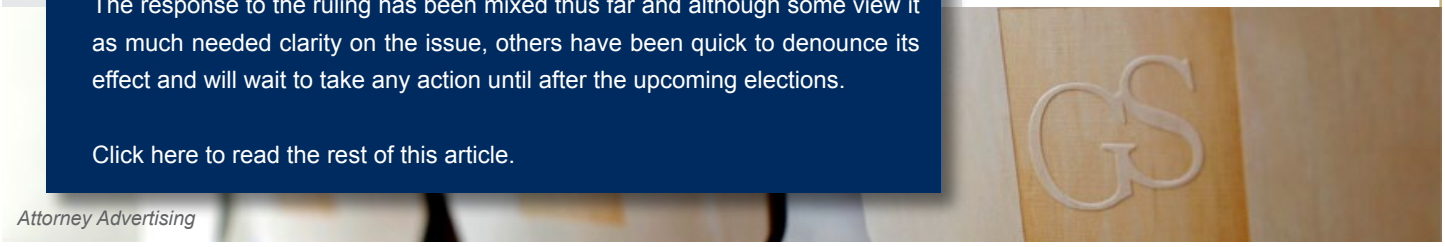

DIRECTORS AND OFFICERS

Asset Managers Do Not Owe Fiduciary Duty to Note Holders

ODDO ASSET MANAGEMENT v. BARCLAYS BANK PLC, ET AL.
(N.Y. Court of Appeals, June 27, 2012)

This lawsuit arose out of the collapse of two investment vehicles known as SIV-Lites. The plaintiff, Oddo Management, is a French asset management company with over 350 institutional clients. From 2005 to 2006, Oddo purchased mezzanine notes from Barclays in two SIV-Lites: Mainsail and Golden Key. An SIV-Lite is a type of structured investment vehicle that borrows money and raises equity to purchase asset-backed securities. SIV-Lites borrowed money by issuing commercial paper (essentially short-term promissory notes), mezzanine notes and capital notes. Commercial paper holders were paid a fixed rate of return and their entire principal was to be repaid upon maturity (90 days). When the commercial notes matured, the SIV-Lites were required to raise fresh funds in a process known as "rolling over" the commercial paper. Mezzanine notes had a four- or five-year term of maturity. The capital notes had longer maturity terms and were the first to absorb losses from declines in the SIV-Lites' asset value.

The SIV-Lite business model was to generate a higher rate of return from its asset-backed securities (primarily residential and commercial mortgage-backed securities) than the interest paid to holders of commercial paper, mezzanine notes and capital notes. The profits yielded from this were shared between the capital note holders and collateral managers.

Barclays formed Golden Key and Mainsail as LLC's in the Cayman Islands. Barclays warehoused asset-backed securities for purchase and selected the collateral managers of Golden Key and Mainsail, nonparties, Avendis Financial Services Limited (Avendis) and Solent Capital (Jersey) Limited. The collateral managers were responsible for ensuring that the investment portfolio satisfied specific investment eligibility criteria and that it maintained a level of credit quality. In their management agreements, Avendis and Solent promised to perform their responsibilities with "reasonable care, in good faith, and in a manner generally consistent with … [the] standard of care and degree of skill exercised by, institutional managers of international standing."

Oddo alleges that Avendis and Solent conspired with Barclays to offload to Golden Key and Mainsail impaired sub-prime mortgage-backed securities. Upon transfer of the sub-prime mortgage-backed securities warehoused by Barclays, Golden Key allegedly suffered an immediate loss of approximately $123 million, or 21 percent of the value transferred to Barclays. Barclays also transferred similar securities to Mainail, which immediately suffered a loss of $505 million. Oddo alleges that Barclays intentionally offloaded the sub-prime asset-backed securities in order to shift losses from Barclays to the SIV-Lites. Oddo further alleged that Avendis and Solent acquiesced to the plot because they did not want to jeopardize their relationship with Barclays.

Approximately 28 days after S & P had confirmed an AAA rating of the mezzanine notes of both Golden Key and Mainsail, it issued a report downgrading the rating to a CCC, some 17 grades. Because the SIV-Lites held assets worth significantly less than their liabilities, they were unable to re-borrow in the commercial paper market, triggering mandatory acceleration events and ultimately causing their collapse.

Oddo commenced suit against Barclays, S & P and Solent asserting claims sounding in breach of fiduciary duty, tortious interference with contract and aiding and abetting as against Avendis and Solent. The defendants moved to dismiss the complaint based upon failure to state a claim and lack of personal jurisdiction. The trial court granted the motions and plaintiff appealed. The appellate division affirmed and the Court of Appeals granted the plaintiff's motion for leave to appeal.

In affirming the decision, the Court of Appeals noted that "there is generally 'no fiduciary obligation in a contractual arm's length relationship between a debtor and a note-holding creditor.'" Although the mezzanine notes had some equity-like features, the court determined that there was no factual basis to elevate Oddo's rights to that of a shareholder. Finally, the court concluded that while the collateral managers may have owed fiduciary and contractual duties to the SIV-Lites, they owed no such duty to mezzanine note holders.

Impact: Although the Court of Appeals was quick to recognize the unique nature of the SIV-Lites, courts in New York are loath to enlarge the circumstances pursuant to which a fiduciary duty exists, observing that "courts should not ordinarily transport [contractual relationships] to a higher realm of relationship and fashion the stricter duty for them."

LEGAL MALPRACTICE

Second Circuit Finds That State's Attorney Has Absolute Immunity in Applying For and Presenting Evidence to Connecticut's Unusual One-Person Investigatory Grand Jury

LAWLOR v. CONNELLY
(2nd Cir., June 11, 2012)

The defendant, a former state prosecutor, applied for a special, one-person investigatory grand jury pursuant to Connecticut law to investigate an incident where the plaintiff, a police officer, used deadly force in the line of duty, to see if there was probable cause to arrest the plaintiff. The grand jury investigation ultimately resulted in the arrest of the plaintiff police officer, but he was acquitted following a trial. The plaintiff then sued the prosecutor under 42 U.S.C. § 1983 alleging that the prosecutor failed to disclose exculpatory evidence when applying for the grand jury investigation, and during, and after the investigation. The defendant moved to dismiss the complaint arguing that, as a prosecutor, he was entitled to absolute immunity. The motion to dismiss presented two issues of first impression to the district court: 1) whether absolute immunity applied to a prosecutor's conduct in seeking appointment of Connecticut's unusual, investigatory grand jury; and 2) whether absolute immunity applied to a prosecutor's presentation of evidence to such a grand jury.

The district court granted the defendant's motion to dismiss and the Second Circuit affirmed the ruling on appeal. The Second Circuit noted that it affirmed for substantially the same reasons as set forth in the district court's opinion. The district court noted that whether or not a prosecutor's conduct is protected by absolute immunity depends on the function he is performing. Absolute immunity applies where a prosecutor is performing his responsibilities as a state's advocate and an officer of the court, or where a prosecutor is engaged in conduct that is intimately connected to judicial proceedings or the initiation of prosecution. Absolute immunity may not apply when a prosecutor is engaged in other tasks such as investigative or administrative tasks. As to the first issue of first impression, the district court determined that the prosecutor's actions in preparing and filing an application for an investigative grand jury were protected by absolute immunity because he was performing a task assigned by law to a state's attorney, the task was intimately associated with the judicial phase of the criminal process, and he was acting as an advocate of the State. The Second Circuit agreed and noted that it has repeatedly held that a prosecutor is absolutely immune from liability under 42 U.S.C. § 1983 for his conduct before a grand jury.

As to the second issue of first impression, the district court ruled that a prosecutor is entitled to absolute immunity in the presentation of evidence before a traditional grand jury, and this rule should apply equally to the presentation of evidence before Connecticut's unique investigatory grand jury. The district court also ruled that the defendant was entitled to absolute immunity relating to the plaintiff's allegation that the defendant failed to disclose exculpatory information after the grand jury investigation was over and the case against the plaintiff was being prosecuted by another prosecutor. The Second Circuit concurred with the district court and noted that a prosecutor is also immune from § 1983 liability for withholding exculpatory evidence from a grand jury.

Impact: This is an important decision for prosecutors. The Second Circuit clearly sided with the prosecutors office in every regard and provided a strong measure of protection to a prosecutor while presenting evidence to a grand jury.

Rule 1.6 of the Professional Rules of Conduct Allows an Attorney to Reveal Client Information and the 'At Issue' Exception to the Attorney Client Privilege

JASON FEINSTEIN v. KIMBERLY RIZZA & JASON FEINSTEIN v. DAVID KEENAN
(Sup. Ct. of Conn., June 6, 2012)

In *Feinstein v. Rizza*, the plaintiffs filed a two-count complaint against Attorney Kimberly Rizza who represented them in the purchase of real estate. The complaint alleges professional negligence and breach of contract in connection with her representation of the plaintiffs. In *Feinstein v. Keenan*, the plaintiffs brought the simultaneous action against the sellers sounding in breach of contract, fraud,and negligence in the sale of their property.

At issue in both these cases is the parties' interest in taking the deposition of Rizza. In both actions, Rizza filed a motion to quash the subpoena, and a motion for protective order arguing that there are privileged issues that prevent her from testifying. In the legal malpractice action, Rizza argues that, while the Feinsteins have provided a signed waiver of any

issues they may have in connection with the legal malpractice action, there are privileged issues also associated with the Keenan's attempt to depose her in the parallel lawsuit that are not covered by the waiver, such as confidentiality issues.

The court stated that in Connecticut the attorney-client privilege can be waived explicitly or by implication, and that in this case both forms of the waiver are present: the signed writing explicitly waiving the privilege, and by implication as a result of the legal malpractice action. The court stated that by suing their lawyer, the plaintiffs have opened the door to a disclosure of the privileged communications relating to the transaction at issue. In the *Rizza* case, the court rejected Rizza's argument that the express waiver is a "selective waiver" limited to this case against Rizza, and that it does not apply to the *Keenan* litigation where Rizza is not a party. In the *Keenan* case, the court stated that a client cannot selectively waive the privilege only for certain purposes or against certain opponents. Citing to *Permian Corp. v. United States*, 665 F.2d 1214 (D.C. Cir. 1981), which rejected the "selective waiver" doctrine fashioned by the Eighth Circuit, "the client is not permitted to pick and choose among his opponents, waiving the privilege for some and resurrecting the claim of confidentiality to obstruct others, or to invoke the privilege as to communications whose confidentiality he has already compromised for his own benefit."

The court also discussed Rule 1.6 of the Rules of Professional Conduct dealing with confidentiality. The court stated that the client's rights to confidentiality are inapplicable under subsection (d) of the rule itself, which allows a lawyer to reveal such information to establish a claim or defense on behalf of the lawyer in a controversy between the lawyer and the client or to respond to allegations in any proceeding concerning the lawyer's representation of the client. In the *Keenan* case the court discussed that Connecticut's Rule 1.6 mirrors the American Bar Association's Rule 1.6 of the Model Rules of Professional Conduct. The comment to the ABA's Rule 1.6 states that the same is true for a claim based on the representation of a former client. The court held that while initially the communications were confidential between the Feinsteins and Rizza, where the lawsuit places in Attorney Rizza's conduct, Rule 1.6 allows Rizza to reveal confidential information.

Impact: This decision helps to allay fears of violating the attorney client privilege when sued, or when asked to act as a witness in a lawsuit in which the attorney client privilege has been waived; however, it is still prudent for the attorney to seek an order from the court so that the issue of whether the privileged communications were waived by the attorney is not raised in a subsequent lawsuit, especially when the attorney is acting only as a witness or when the waiver appears to be less than full.

Court Rules That Attorney's Ethical Violation Cannot Sustain Legal Malpractice Allegations Based Upon 'Case Within a Case' Analysis

MORRISON v. DAVIS
(E.D.N.Y., June 14, 2012)

Attorney Tarik Davis first met the plaintiff, Kenneth Morrison, and Mr. Morrison's older sister, Acynthia Bowman, in his office in March 2006. Ms. Bowman retained Davis to assist in the execution of a no-consideration transfer to the plaintiff of her condominium and to prepare her last will and testament. In August of 2007, the plaintiff retained Davis to represent him in an application to be named a legal guardian for Ms. Bowman due to her deteriorating physical and mental condition. Given Ms. Bowman's consistent indications that she wanted her brother to be appointed guardian, Davis believed the potential for a potential conflict was minimal. However, later at a November 2007 guardianship hearing, Ms. Bowman indicated through separate counsel that she preferred that her daughter act as her legal guardian, and expressed that she did not want the plaintiff to assume that role.

Thus, Davis was confronted with the conflict of interest in having previously represented Ms. Bowman in her no-consideration transfer to the plaintiff, and being adverse to her in the guardianship proceeding. Notwithstanding the apparent conflict of interest, Davis remained active in the guardianship hearing in November 2007. At some point during that hearing, upon the request of Ms. Bowman and her lawyer, the plaintiff voluntarily reconveyed the condominium to her in exchange for reimbursement of the property tax payments he had made

since taking over the condominium. The plaintiff claims he was pressured by Davis into agreeing to return ownership of the condominium to his sister. Davis claims that he simply relayed the fact that Ms. Bowman, through her attorney, planned to challenge the transfer if the plaintiff did not voluntarily re-convey the condominium.

The plaintiff subsequently filed a civil action complaint against Davis alleging legal malpractice and seeking $1.3 million in damages (alleged to be the fair market value of the condominium), and other consequential damages. The plaintiff claimed he would not have reconveyed the condominium to his sister if it wasn't for Davis' poor legal representation. The defendant filed a motion for summary judgment. The court held that because the defendant sat on both sides of the disputed transaction involving Ms. Bowman's property, a reasonable juror could conclude that such continued representation constituted an ethical violation falling short of the standard of reasonable conduct expected of a member of the legal profession.

But summary judgment was nonetheless granted for the defendant because the plaintiff's case imploded on the issue of causation. The court found no evidence of record to address whether the plaintiff would have successfully defended his claim to the property. In light of Ms. Bowman's deteriorating condition at the time of the transfer in 2006, which was near total incapacitation and the fact that the transfer could have been undermined by a strong inference of undue influence, the record established that the plaintiff could not have met the burden of proving that the disputed transaction would have been upheld. Rather, the evidence pointed to the only conclusion which was that the plaintiff's title to the condominium was inevitably doomed. The court raised concerns about the conflict of interest but noted that it was not outcome determinative as it pertained to the property transfer.

Impact: This case illustrates that even if an attorney's conduct may be in violation of legal/ethical standards, a plaintiff in a legal malpractice suit must still prove the merits of the underlying case, i.e. the case within the case doctrine. If the plaintiff cannot prove he would have been successful in the underlying matter but for the defendant-attorney's conduct, the legal malpractice claim will fail. Any legal misconduct committed by the defendant must proximately cause an actual or ascertainable damage to plaintiff.

MEDICAL MALPRACTICE

In Pennsylvania, a Certificate Of Merit In Professional Malpractice Matters Must Be Supported By An Appropriate Professional

FREED v. ST. LUKE'S HOSPITAL (County Ct. of Common Pleas, Jan. 31, 2012)

In Pennsylvania, any claim that a licensed professional deviated from the applicable standard of care must be accompanied by a certificate of merit. Pursuant to these certificate of merit rules, Pa.R.C.P. 1042.3 et seq., all claims of professional negligence must include a certificate from an appropriate professional affirming that the professional has reviewed the plaintiff's claims and, if true, the conduct amounted to professional negligence. These rules govern the steps necessary to plead professional malpractice and, in the event that a plaintiff fails to timely file a certificate, the defending professional may move to dismiss the claim. The holding in *Freed v. St. Luke's Hospital* serves as a reminder of the dire consequences of failing to comply with the certificate of merit rules.

The issue in *Freed* was whether the court properly granted the defendants' motion to enter judgment of non pros where the plaintiff's certificates of merit in her medical malpractice action were not supported by the expert testimony of an appropriate licensed professional." The defendants moved to strike the plaintiff's certificates of merit and enter judgment of non pros. The court granted the defendants' requested relief. When the plaintiff petitioned the court to strike the judgment of non pros, thereby permitting her claims to proceed, the court refused and dismissed the plaintiff's claims.

The plaintiff alleged that the defendants were negligent in performing a colonoscopy, which is a gastroenterology procedure. However, the expert testimony that supported the certificates of merit was provided by a doctor certified in physical medicine and rehabilitation. Accordingly, the court held that the doctor did not practice in the same subspecialty as the defendants, was not qualified to testify regarding the appropriate standard of care, and therefore could not be considered an appropriate licensed professional pursuant to the certificate of merit standards. As a result, the plaintiff lacked the requisite support needed to maintain a professional liability action and her claims were dismissed.

Impact: This decision serves as a reminder of the consequences of failing to comply with the certificate of merit rules. Moreover, this decision also highlights the import of carefully evaluating the plaintiff's certificate of merit, including reviewing the professional who prepared the statement. Should that expert lack experience in the particular field at issue, it is possible to strike the certificate of merit and dismiss all claims.

Physician Files §1983 Claim Based On Being Reported to NPDB

DRABICK M.D. v. SEBELIUS
(M.D. Pa., June 26, 2012)

In this case, plaintiff Dr. Joseph A. Drabick, who served in the U.S. Army, sued a number of defendants who were involved in the process and decision to report him to the National Practitioner Data Bank (NPDB) Specifically, Dr. Drabick alleged that the defendants violated 42 U.S.C. Sec. 1983 by failing to follow the directives of the Health Care Quality Improvement Act of 1986, in reporting him to the NPDB.

The various defendants were involved, at one point or another, in investigating the standard of care provided by Dr. Drabick to a patient that ultimately died due to an incorrect dosage of a chemotherapy drug. A malpractice claim was ultimately brought by the family of the decedent, and settled for $1 million without consultation or discussion with the plaintiff.

A review panel was subsequently convened and concluded that Dr. Drabick did not meet the standard of care because he signed off on orders containing a multiplication error which he failed to notice. Dr. Drabick was reported to the NPDB due to the determination that a medical malpractice payment was made, at least in part, because of his professional negligence. Ultimately, the defendants, all part of the U.S. government, prevailed because the claims were barred since the basis of Dr. Drabick's claims stemmed from negligent actions committed during his military service.

Impact: While the reporting party ultimately prevailed in this litigation, the case highlights the need to be prudent before reporting a physician to the National Practitioner Data Bank.

Decision Precluding Testimony Regarding Poor Recordkeeping Upheld

SMITH v. LONTAI
(Sup. Ct. N.J., June 26, 2012)

The plaintiff appealed from a defense verdict entered in favor of the defendant, a physician, at trial in a medical malpractice matter. Specifically, the jury found the defendant did not deviate from the accepted standard of medical care in not referring her to the hospital in a timely fashion. Two days after the defendant examined the plaintiff she was diagnosed with a massive pulmonary embolism. The plaintiff claimed the defendant's negligence contributed to her subsequent permanent and persistent shortness of breath.

Prior to filing the complaint, the plaintiff sought her complete medical records from the defendant. The defendant testified before the court that his records only consisted of three pages, which were test results. Furthermore, he referenced a dispute with a psychologically-impaired widow of a doctor from the medical practice the defendant took over, which resulted in his inability to obtain all of the plaintiff's medical records. Prior to trial, the court granted the defendant's motion to bar the plaintiff's expert from rendering any testimony about poor recordkeeping. The trial court ruled that N.J.R.E. 403 indicates testimony concerning recordkeeping would result in undue consumption of time and would be a distraction to the jury.

On appeal, the plaintiff argued the trial court improperly granted the defendant's motion to preclude any testimony about poor record keeping. In addition, the plaintiff argued the lack of records inhibited her ability to develop the defendant's faulty recollection of time he had been treating the plaintiff as a way to undermine his credibility.

The appellate court denied the plaintiff's appeal. She was permitted, through cross-examination, to develop the defendant's faulty recollection of the length of time he treated the plaintiff by eliciting testimony that he did not have patient records before 2002, and he may have treated the plaintiff since 1993.

The plaintiff also argued on appeal that the trial court improperly vouched for the defendant's credibility. During the plaintiff's counsel's cross-examination of the defendant, the judge informed the jury that the defendant admitted that he neglected to place a diagnosis in the records and only submitted same to the insurance carrier. Furthermore, the judge stated this failure to place the diagnosis in the records was not relevant to the standard of care. The appellate court found these comments are incapable of producing an unjust result and do not rise to the level of plain error.

Impact: The defense verdict was upheld on appeal. Pursuant to N.J.R.E. 403, testimony regarding recordkeeping in a medical malpractice case is unduly prejudicial and a waste of time.

Rare Grant of Summary Judgment in Baby Brain-Injury OB case

BEDARD v. KLEIN
(N.Y. 2nd Dept., October 11, 2011)

Courts are very circumspect in assessing motions for summary judgment since granting the motion deprives the plaintiff of their day in court before a jury of peers. This circumspection is even more acute in obstetrical cases involving brain-damaged babies since the staggering cost of lifetime care is at stake, for both parties. In *Bedard*, New York's Appellate Division granted summary judgment in an obstetrical case involving the premature birth of triplets, all with neurologic injury. During her pregnancy, the mother experienced a condition which threatened the viability of the pregnancies and, to treat this, her physician performed a cerclage (an operation suturing the cervix closed). She was also prescribed medication to prevent or stop labor, to prolong the pregnancy for the developmental benefit of the fetuses.

During the six weeks of her hospital admission following the cerclage, several physicians rotating on coverage for the attending physicians and several nurses were involved in monitoring, administering, and reporting on her condition. The plaintiffs alleged that their care departed from good and accepted medical practice. They also argued that factual questions precluded summary judgment concerning whether the physicians' orders were so clearly contraindicated by accepted obstetrical practice that some inquiry was required by the hospital staff regarding the correctness of the orders. The plaintiffs opposed the motion on the basis that the non-physician staff inappropriately exercised independent judgment in administering to the mother.

The appellate court upheld the trial court's order which granted summary judgment to the medical defendants. The interesting aspect of the case is that opposition to motions like this with the affidavit of an expert is usually sufficient to generate some question of fact which ties the court's hands and compels trial by jury to resolve factual issues.

Impact: In this case the court did not address the assertions of the experts, and rather summarily concluded that no departure from the standard of care existed either with respect to independent medical judgment or whether the physicians' orders were contraindicated by accepted obstetrical practice. One explanation may be that the court appreciated that the pregnancy had taken a turn for the worse and a last-ditch effort to save it (cerclage) had failed, and the court would not let that circumstance morph into whether extraordinary measures were within ordinary standards of care. The case is of value in similar motions for summary judgment with respect to the court's approach to whether the physicians' orders were contraindicated by accepted obstetrical practice.

ACCOUNTANT MALPRACTICE

Accounting Firm Not Liable Where Evidence Demonstrated That it Neither Maintained Nor Managed the Financial Activities of Certain Trusts

TAYLOR v. BARBERINO
(App. Ct. Conn., June 19, 2012)

The defendant accounting firm was retained in the 1970s by two trusts originally established by a father for the benefit of his daughter. After some questionable conduct on the part of father occurred in the 1980's in connection with the handling of the trusts, the named trustees brought suit against both the father and the defendant accounting firm. With respect to the accounting firm, the plaintiff trustees claimed that the defendant was negligent and breached its fiduciary duty in failing to accurately maintain the records of the operations of the trusts and failing to properly account for the financial activities of the trusts.

The defendant accounting firm moved for summary judgment as to the plaintiff's claims against it, and asserted that as demonstrated by the evidence, it was not engaged by the trusts to maintain the trusts' records or manage or account for the trusts' financial activities. Rather, it was only responsible for preparing the trusts' tax returns based on information furnished by the clients and could not be held liable for not doing a job it was never hired to do. The trial court agreed with the defendant, and found that the plaintiff had not provided any evidence defeating the defendant's arguments and demonstrating that the defendant was retained to maintain the trusts' records or manage the account for the

trusts' financial activities. The plaintiffs appealed.

On appeal, the appellate court affirmed the trial court. The court concluded that the defendant accounting firm had sufficiently demonstrated on its motion for summary judgment that the firm was only engaged to prepare annual tax returns for the trusts, and not engaged to perform bookkeeping services or the day-to-day maintenance of the trusts' books and records. Specifically, the appellate court noted that the defendant had provided statements from its accountants who performed services with respect to the trusts, both of whom stated that they were only retained to and only did in fact prepare annual tax returns. The court also noted that the plaintiff provided the deposition testimony of the father responsible for establishing the trusts. In his testimony he indicated that the accounting and maintenance of the trusts' documents were performed by a different individual. The father further asserted that even though the defendant firm did receive documents and other accounting, it was only to facilitate the preparation of the trusts' tax returns.

On the other hand, the appellate court found that the plaintiffs offered no legitimate evidence to refute the defendant's claims. The court reasoned that even though the plaintiffs submitted affidavits of the plaintiffs' attorney and one of the trustees to support their claims, the affidavits were insufficient as the facts contained therein were not based on personal knowledge.

Accordingly, the court found that the plaintiffs failed to demonstrate the existence of any material fact showing that the defendant accounting firm was responsible for maintaining the trusts. Therefore, the defendant could not be held liable and its motion for summary judgment was granted.

Impact: Liability for accounting firms will only be imposed for the specific accounting services that it was retained to perform. This is so despite the fact that it may receive accounting documents and other financial information relating to the trust so long as those documents were received to assist the firm in the service it was retained to perform.

Accounting Malpractice Claim Allowed to Proceed Despite Absence of Privity

BANCROFT LIFE & CAS. LTD. V. INTERCONTINENTAL MGMT. LTD. (W.D.Pa., June 29, 2011)

In *Bancroft,* an insurance company filed, in part, a malpractice claim against an accounting firm alleging that the latter's work was deficient and otherwise not in accordance with the controlling professional standards. The accounting firm was retained by a management company for the insurance company "to prepare financial statements and semi-annual reports for [the insurance company] and affiliated entities." During the time the accounting firm was performing the audit work, the management company for the insurance company placed its interest above those of the insurance company by, for example, billing it "for hundreds of thousands of dollars for services that either were not performed or performed so poorly that it was as if the service had not been performed at all." The accounting firm moved to dismiss the malpractice claim on the ground that Pennsylvania law requires strict privity of contract between the parties in order for a plaintiff to assert a colorable accounting malpractice claim.

The court rejected this argument and, as a result, allowed the malpractice claim to proceed beyond the pleadings stage. In particular, the court reasoned that strict privity is not necessary for a plaintiff to assert a colorable accounting malpractice claim. In the absence of privity, a plaintiff may still pursue a viable malpractice claim "where the professional specifically undertook to furnish services for the plaintiff." Here, the court reasoned that the accounting firm, while hired by the management company, was retained for the purpose of performing specific services for the insurance company. The court, in short, found that strict privity was a not predicate for the plaintiff to pursue its accounting malpractice claim.

Impact: The *Bancroft* opinion is noteworthy for one very important reasons. Specifically, the opinion is in line with the growing trend in Pennsylvania of moving away from requiring strict privity of contract in order for a plaintiff to assert a cognizable accounting malpractice claim. In recent years, the courts have been more willing to embrace accounting malpractice claims even in the absence of strict privity. The *Bancroft* opinion is another example of an instance where the court further chipped away at the protections previously afforded by the strict privity requirement.

AGENTS AND BROKERS

FIDELITY INSURANCE

Third-Party Losses Not Covered by Fidelity Bond

NEW JERSEY TITLE INS. CO., v. NATIONAL UNION FIRE INS. CO. OF PITTSBURGH
(D. N.J., December 27, 2011)

The plaintiff, New Jersey Title Insurance Company, (NJTIC) is a title insurance company in the business of underwriting title insurance policies in New Jersey, and engages agents to settle and close title for real estate closings. In May 2008, NJTIC entered into an agency agreement (agreement) with Landserv Title, LLC (Landserv). The agreement established Landserv as NJTIC's representative or agent to solicit applications for title insurance, to examine and issue commitments to insure, to countersign policies of title and to close title.

The agreement provided that Landserv was to collect all fees for commitments to insure and policies from the responsible parties. The language of the agreement specifically limited the authority of Landserv to receive and hold funds on the account of NJTIC. Under its terms, Landserv was prohibited from receiving any funds in the name of the Insurer but was authorized to hold premium and reinsurance fees for NJTIC, which were to become the property of NJTIC immediately upon receipt of a collection. All other monies entrusted to Landserv in the course of their operation were to be kept segregated in a bank account by Landserv. Upon settlement, the agent was directed to disburse funds from said trusts to pay off prior mortgages, taxes, water bills, and other municipal charges on the property for which insurance has been issued.

The agreement also provided that Landserv was to maintain employee fidelity insurance coverage, with a minimum liability of $500,000. The agreement stated that the insurer would be liable for claims arising out of title insurance forms issued and the like.

The defendant, National Union, issued a financial institution bond to provide insurance coverage to NJTIC. The financial institution bond provided coverage for loss resulting directly from dishonest or fraudulent acts committed by an agent but limited coverage to those agents listed in the rider to the bond and only for the amount applicable to that agent. The bond did not cover loss to property owned by the insured, held by the insured in any capacity and for which the insured was legally liable. The bond specifically excluded any loss "resulting directly or indirectly from "contractual or extra contractual liability sustained by the Insured in connection with the issuance of contracts or purported contracts of insurance, indemnity, or suretyship."

In November of 2009, NJTIC discovered that an employee of Landserv had misappropriated funds from Landserv's account for her own personal use. As a result of the misappropriation, Landserv was unable to make the requisite payments to clear title for properties for which NJTIC had issued title insurance. NJTIC subsequently filed a claim with National Union for coverage for the loss associated with the misappropriation by Landserv. The plaintiff estimated the total amount of diverted trust funds to be $616,894.79.

National Union denied coverage for NJTIC's claim asserting that the claim did not fall within the coverage of the bond, that the claimed losses arose from contractual liabilities excluded from coverage, and that the coverage provided by the bond was only excess over any valid and collectible insurance obtained, and NJTIC had not established that any primary insurance coverage had been exhausted.

The plaintiff commenced this lawsuit. On motions for dismissal, the court found that NJTIC did not allege a loss that was within the insurance coverage provided by the defendants. The court held the misappropriated funds were not owned by NJTIC, as the agency agreement specifically provided that Landserv was to receive the funds for its own account, with only the premiums and reinsurance fees to become the property of NJTIC. The court found that the funds were not being held by NJTIC since the agreement noted the nature of property that NJTIC agents could hold on its behalf. Finally, the court found that NJTIC did not provide any reason with respect to the misappropriated funds, why NJTIC would be required to pay. NJTIC did not point to any language in the agreement representing an intent of the parties to indemnify a misappropriation. Further, Landserv was not a designated agent in the bond and therefore the bond was not applicable to Landserv.

Therefore, the court dismissed the complaint for failure to state a claim upon which relief could be granted.

Impact: This decision provides an excellent discussion on the relevance and importance of reading the language of the bond and knowing its intended meaning. The first place to start understanding coverage as it applies to specific facts it the policy language itself.

FEATURED ARTICLE

The Effect and Implication of a Bruised But Upheld Affordable Care Act

The High Court's ruling upholding the Affordable Care Act has surprised many. The response to the ruling has been mixed thus far and although some view it as much needed clarity on the issue, others have been quick to denounce its effect and will wait to take any action until after the upcoming elections. The court's ruling lifted the fears of the health insurance industry as it avoided the worst case scenario—fear that the individual mandate would be stricken down while the remaining provisions upheld leaving insurers to provide more cost-free preventative care to policyholders without a means to increase premium volume.

The Act's effect will remain unsettled until at least November.

Presidential candidate Mitt Romney and GOP congressional leaders have already vowed to repeal the law if they succeed in this year's election. Romney claims he will act to repeal the law in his first day in Office. States have followed differing paths in preparing for the decision. Some states have but a hold on any action until after the election and some have already begun to plan for implementation of the new requirements under the Act.

With regard to a cornerstone of the Act, the creation of insurance exchanges, many states have refused to take steps or plan for their creation. Under the Act the creation of these online marketplaces will allow for individuals and small businesses to comparison shop for health insurance. States that have put efforts on hold will now have to rush to get their plans approved by January and will have to get their programs up and running by the following year.

It is estimated that 30 million uninsured people will receive coverage under the Act. Cutbacks to government reimbursement schemes, new fees, taxes, and pressures to create new payment models that focus on efficiency and the quality of care could alter the American standard of health care in an effort to affordably finance the new insureds. The upside to this is the impact on the health care and insurance industry with 30 million new individuals required to pay policy premiums, and correspondingly, 30 million new individuals with means to pay for health care. Under the Act we will likely see congruity in coverage levels across carrier's with competing plans due in large part to mandated service levels. The Act had already led to changes in the insurance industry, as many insurers pledged to keep some of the Act's reforms regardless of the ruling.

The most talked about reforms are the requirements to keep young adults covered until age 26, eliminating an insurer's right to deny coverage for children with health problems, elimination of lifetime benefit limits, eliminating co-pays for preventative services, and eliminating the practice of charging people with medical problems, and women higher premiums. As insurers face these new requirements there will surely be a focus on cutting costs in providing coverage. What is already being seen is that insurers are beginning to move away from the traditional style of paying fees for each service and instead are tying reimbursements to quality of care provided and are rewarding providers that keep costs under control.

As with any reform, there must be a system in place to report on whether or not the costs of health care required under the Act have been contained and/or decreased. It will be a challenge for insurers to enroll 30 million new policyholders in a short period of time and will this process will likely entail premium increases for those with existing coverage. With heavy mandates and wide availability of coverage there is no doubt that insurers will seek rate increases to keep the playing field fair. In judging the effectiveness of the Act, the numbers of individuals that have actually taken advantage of the Act and sought regular and preventative medical care should be tracked. It will also be critical that individuals required to purchase insurance retain a choice in how and from whom they receive their health care services.

Both insurers and policyholders have expressed concerned over the insurance premium taxes called for in the Act. Many worry about the adverse impact of the premium tax particularly on small businesses and seniors. The Act imposes a large sales tax on health insurance beginning at $8 billion in 2014 and rising to $14.3 billion in 2018. This premium tax will raise the cost of coverage for small employers, individual market customers.

Another area that deserves attention is the shift away from employer sponsored insurance that is likely to follow the Act's implementation. It is expected that overall thirty percent of employers will stop offering employer sponsored insurance after 2014. This move may make sense for employers and its lower income workers. Employers will need to be prepared to react to the market changes, and it is likely that employers will increase compensation in other

ways in order to retain talent and remain competitive. Employers work with their employees to educate them to become actively involved in the purchase of heath care, including sharing in premium costs, making strategic decisions as to co-payments and deductibles, incentives with HSA payments, and wellness programs.

However, if the Act has the effect of eliminating a large portion of private-sector employment-based health coverage, ERISA's current regulation of health benefits may need to be amended or repealed. ERISA laws apply to privately purchased, individual insurance policies or benefits only in certain situations. Therefore, the move away from employer sponsored plans may call the viability of ERISA's regulations into question.

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780 Third Avenue, Suite 3100, New York, New York 10017
Telephone: 646.253.5400 Fax: 646.253.5500

LONDON
No. 1 Cornhill | London EC3V 3ND
Phone: +44.20.3427.6560 Fax: +44.20.3178.5764

PHILADELPHIA
1700 Market Street, Suite 1418, Philadelphia, Pennsylvania 19103-3907
Telephone: 267.519.6800 Fax: 267.519.6801

PRINCETON
902 Carnegie Center / Suite 100, Princeton, New Jersey 08540-6530
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2 State Street, Suite 805, Rochester, New York 14614-1342
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5786 Widewaters Parkway, Syracuse, New York 13214-1840
Telephone: 315.413.5400 Fax: 315.413.5401

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8 Southwoods Boulevard, Suite 300, Albany, New York 12211-2364
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