PROFESSIONAL LIABILITY INSURANCE COVERAGE TRIGGERS

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Professional Liability Insurance Coverage Triggers
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Chapter 1
Introduction and Overview

IRMI has teamed up with WebCE to bring you this quality continuing education course.

This Web CE course is designed to give a moderately experienced insurance person a detailed look at how both claims-made and occurrence coverage triggers function and are used in professional and executive liability insurance policies. It begins by defining the term "coverage trigger," introduces both claims-made and occurrence coverage triggers, and provides an example of how claims-made coverage triggers apply in a claim situation. Next, the course distinguishes between the two different kinds of claims-made policies: those written with pure claims-made coverage triggers and those containing claims-made and reported coverage triggers. It introduces the concept of the retroactive date, commonly included within claims-made policies. The course discusses discovery provisions and also addresses the two factors that complicate the application of claims-made coverage triggers. Next, the problem of coverage gaps in claims-made policies, and how to close them by means of extended reporting periods and prior acts coverage, is reviewed. The course discusses the rationale for using claims-made coverage triggers as well as the advantages and disadvantages they present for both insureds and insurers. Since a handful of professional liability coverage lines are sometimes written on an occurrence basis, these coverage triggers—and how they differ from claims-made policies—are also explained.

Following is a chapter-by-chapter breakdown of the course.

- Chapter 2 defines the term "coverage trigger." It provides brief introductions to the two types of coverage triggers—claims-made and occurrence—and concludes with an example of how claims-made coverage triggers apply in a claim situation.
- Chapter 3 distinguishes between the two different kinds of claims-made policies: those written with pure claims-made coverage triggers and those containing claims-made and reported coverage triggers. It also introduces the concept of "first made" language and explains why this is important in claims-made policies.
- Chapter 4 introduces the concept of the "retroactive date" found within claims-made policies. It begins by defining the term, discusses the purpose of retroactive dates, and illustrates the uses of retroactive dates.
- Chapter 5 provides additional of examples of how claims-made coverage triggers apply in claims situations. It also introduces the concept of discovery provisions and explains how they can be used to lock-in coverage, even before a claim is actually made against an insured.
- Chapter 6 introduces the two factors that complicate the application of claims-made coverage triggers: the questions of "when" a wrongful act takes place and when a claim is "made."

- Chapter 7 discusses the three causes of coverage gaps in claims-made policies: retroactive date advancement, (2) cancellation or nonrenewal by insurer or insured, and (3) replacement of a claims-made policy with an occurrence policy.
- Chapter 8 explains how to close the three types of coverage gaps—discussed in the preceding chapter—that are sometimes created within claims-made coverage triggers. The two methods of closing these gaps are (1) purchasing an extended reporting period (ERP) endorsement or (2) obtaining prior acts coverage in a replacement policy.
- Chapter 9 describes the two rationales for why professional liability policies are written with claims-made coverage triggers: (1) they make it easier for underwriters to determine the extent of their ultimate liability on a book of business, relatively soon after policies have expired; and (2) they make it easier for one insurer, often in a series of different insurers, to determine which insurer is actually responsible for paying a given claim.
- Chapter 10 analyzes the advantages and disadvantages of claims-made policy forms, from the perspectives of both the insurer and the insured.
- Chapter 11 defines the term "occurrence coverage trigger," explains how occurrence coverage triggers function in claim situations, and discusses the advantages and disadvantages they present for both insureds and insurers.

Upon successful completion of this course, you will be able to:

1. Define the term "coverage trigger" and give an example of how one applies to a situation involving multiple policy periods.
2. Identify the two types of coverage triggers and distinguish between the two.
3. Differentiate between the two major types of claims-made coverage triggers: "pure" claims-made and claims-made and reported.
4. Explain the key terms associated with claims-made coverage triggers, including: claims "first made" language, post-policy reporting periods, and retroactive dates.
5. Enumerate and describe the three conditions required to trigger coverage under a claims-made and reported policy that contains a retroactive date.
6. Show how claims-made coverage triggers apply in actual claim situations.
7. Provide examples of how discovery provisions can be used to lock-in coverage even before a claim is reported.
8. Describe how the questions of (1) when a wrongful act takes place and (2) when a claim is made complicate the application of claims-made coverage triggers.
9. List and analyze the three causes of gaps in claims-made policies.
10. Demonstrate how extended reporting periods and arranging coverage on a prior acts basis can be used to close these gaps.
11. Discuss the various elements contained within extended reporting period (ERP) provisions and show why these elements are important in determining coverage in a claim situation.
12. State and explain the two major rationales for insurers' use of claims-made coverage triggers.

13. Analyze the major advantages and disadvantages of claims-made coverage triggers from the perspective of both the insurer and the insured.
14. Explain how occurrence coverage triggers function, illustrate their application in a claim situation, and discuss the advantages and disadvantages they offer for both insureds and insurers.

Chapter 2
Coverage Triggers: What Are They and How Do They Apply?

This chapter begins by defining the term "coverage trigger." It also provides brief introductions to the two types of coverage triggers: claims-made and occurrence. The chapter concludes by providing an example of how a claims-made coverage trigger applies in a claim situation.

What is a "Coverage Trigger?"

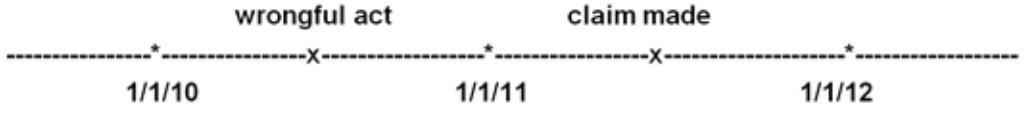
A liability insurance policy's coverage trigger is the provision defining the nature and sequence of events that must take place for the policy to cover a claim against an insured. The coverage trigger determines which policy—often in a series of policies spanning a number of years—will respond to a particular liability claim.

Claims-Made Coverage Triggers: a Thumbnail Sketch

The vast majority of professional and executive liability insurance policies contain claims-made coverage triggers. A claims-made coverage trigger in a professional or executive liability policy obligates an insurer to defend and/or pay a claim that is made against the insured during that policy. The terms and conditions of the policy that were in effect at the time the claim was made, are the ones that apply. This is illustrated in Exhibit 2.1.

EXHIBIT 2.1
HOW A CLAIMS-MADE COVERAGE TRIGGER APPLIES

Policy Term #1: 1/1/10–11; Wrongful Act Committed
Policy Term #2: 1/1/11–12; Claim Made
Coverage under *both* policies is written with a claims-made trigger.



In Exhibit 2.1, coverage under both policies is written on a claims-made basis. Coverage applies under Policy Term #2 because the making of the claim against the insured is the event that triggers coverage. Coverage does not apply during Policy Term #1 because the commission of the wrongful act did not trigger coverage under a claims-made policy; no claim was actually made during Policy Term #1.

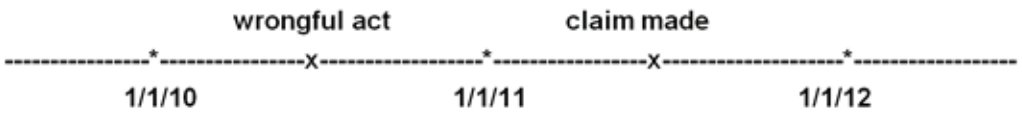
Occurrence Coverage Triggers: a Thumbnail Sketch

Although the vast majority of professional/executive liability policies are written with a claims-made coverage trigger, a handful of such policies contain an occurrence coverage trigger. More specifically, occurrence triggers are occasionally included in professional liability policies written for media liability, police liability, medical malpractice, and hospital professional liability. Occurrence policies will be discussed in more detail in this course, beginning in Chapter 9. But for now, a brief explanation is necessary because before that chapter, this course will also refer to occurrence coverage triggers.

An occurrence coverage trigger in a professional liability policy obligates an insurer to defend and/or pay a claim if the claim arises from a wrongful act that was committed during the period in which the policy was effective. The terms and conditions of the policy that were in effect at the time the wrongful act took place are the ones that apply. This is in contrast to claims-made coverage, in which the terms and conditions of the policy in force at the time the claim is made—are the ones that apply. Exhibit 2.2 illustrates an occurrence coverage trigger.

EXHIBIT 2.2
HOW AN OCCURRENCE COVERAGE TRIGGER APPLIES

Policy Term #1: 1/1/10–11; Wrongful Act Committed
Policy Term #2: 1/1/11–12; Claim Made
Coverage under *both* policies is written with an occurrence trigger.



In Exhibit 2.2, coverage under both policies is written on an occurrence basis. Coverage applies under Policy Term #1 because the commission of the wrongful act is the event that triggers coverage. Coverage does not apply during Policy Term #2 because the making of the claim does not trigger coverage under an occurrence policy.

How Claims-Made Coverage Triggers Operate: A Claim Scenario

The following example illustrates how a claims-made coverage trigger applies under a professional liability policy.

Consider a situation in which a physician negligently performs surgery on a patient in year 1. An infection resulting from that surgery begins to develop in year 2. The patient experiences illness in year 3 and as a result, threatens to sue the doctor. In year 4, the doctor is served with a lawsuit (which he tenders to his insurer). In years 5, 6, and 7, the physician's insurer negotiates settlement of the claim with the patient's attorney. In year 8, the insurance company settles the claim with the patient's attorney. These events are summarized below.

Year(s)	Event(s)
1	Surgery performed
2	Infection develops
3	Illness develops, lawsuit threatened
4	Doctor served with lawsuit
5, 6, 7	Settlement negotiations
8	Claim settled

Assuming the doctor's professional liability insurance policy during this 8-year period was written with annual policy terms, he could conceivably have been protected by eight different insurance companies between the date of the medical error giving rise to the claim (year 1 in this example) and the date on which the claim was settled (year 8). The coverage trigger provisions included in the doctor's professional liability insurance policies in force during this period will determine which policy (or combination of policies) must respond to the claim.

Potential Complications

If the doctor had been covered by claims-made policies during this period, the policy in year 4 would likely be the one to pay. In contrast, if a series of occurrence policies had been in place throughout this 8-year period, it would be very debatable as to which policy (year 1, year 2, year 3) might pay. Indeed, this scenario presents a prime example of why claims-made coverage triggers are normally used in professional liability policies.

Chapter 2 Review Questions

1. Because Loon Company's D&O policy contains a claims-made coverage trigger, its insurer is obligated to defend and/or pay for*:*
   a. accidents that happen during the policy period.
   b. claims made against the insured during the policy period.
   c. events involving the insured during the policy period.
   d. occurrences that happen during the policy period.

2. Egret Co has had three D&O policies with *occurrence* triggers covering these dates: Policy A—June 1, 2010–June 1, 2011; Policy B—June 1, 2011–June 1, 2012; Policy C—June 1, 2012–June 1, 2013. On September 11, 2012, a claim was made against Egret alleging that a wrongful act occurred on September 11, 2010. Coverage for this claim does *not* apply under Policy C, because:
   a. the insurer's ability to defend the claim was prejudiced by the delay.
   b. Policy B is primary.
   c. Policy C's other insurance provision precludes duplicate coverage.
   d. making a claim does not trigger coverage under an occurrence policy.

Answers to Chapter 2 Review Questions

1. b. A claims-made trigger obligates an insurer to defend and/or pay a claim that is made against the insured during that policy.
2. d. The making of the claim does not trigger coverage under an occurrence policy.

Chapter 3
The Two Types of Claims-Made Coverage Triggers

There are two different kinds of claims-made policies: those written with pure claims-made coverage triggers and those containing claims-made and reported coverage triggers. Chapter 3 defines and differentiates between the two. It also introduces the concept of "first made" language and explains why this is important in claims-made policies.

"Pure" Claims-Made Policies

With a pure claims-made policy, a claim must be first made against an insured during the term of the policy for coverage to be triggered under the policy. However, "pure" claims-made policies do not impose a specific time period during which the claim must be reported to the insurer. Instead, they specify only that the claims must be reported "as soon as possible" or "as soon as practical."

When claims-made policies were originally introduced, nearly all were written on a "pure" claims-made basis. But in recent years (for reasons explained below), pure claims-made policies have become much less common. Currently, the vast majority of professional/executive liability insurance policies are written with claims-made and reported coverage triggers.

Claims-Made and Reported Policies

A claims-made and reported policy imposes two requirements before coverage is triggered. First, like the pure claims-made policy, the claim must be first made against the insured during the policy period. Second—and unlike pure claims-made policies—the claim must also be reported to the insurer during a specific reporting period.

Why Claims-Made and Reported Policies were Developed

Claims-made and reported policies were introduced because "pure" claims-made policies created two problems for insurers: problems in defending claims and difficulties in estimating claim liabilities.

Defense Problems

First, insurers found it difficult to defend claims that were reported many months, and in some cases many years, after they were made against an insured. This is because the investigation process was hampered by these reporting delays. Specifically, given the passage of time, both witnesses and other forms of physical evidence become less available, making it much harder for the insurer to defend claims.

Claim Projection Problems

Second, late reports of claims made it more difficult for underwriters to project ultimate claim liabilities, which defeated the purpose of the claims-made coverage trigger and, in effect, transformed the policies into occurrence forms. (This problem also makes it more difficult for actuaries to develop appropriate rates for the product.) For example, consider a book of professional liability business consisting of 1,000 policies, each policy written with a 1/1/10–11 term. Also assume that 25 claims are made against the insureds under these policies during this policy period, but that all 25 claims are not reported to the insurer until 1/1/13—i.e., 2 years after policy expiration. In this situation, an insurer cannot make an accurate estimate of its ultimate claim liabilities for this book of business until 2 full years after the policies had expired. For this reason, observers have commented that a pure claims-made policy was more like an occurrence policy, in which coverage is triggered by virtue of the wrongful act that produces a claim, irrespective of when the claim is made against the insured or reported to the insurer.

Reporting Requirements in Claims-Made Policies

To alleviate these two problems (i.e., difficulties in defending claims and problems in projecting ultimate claim liabilities), insurers began to modify their policy forms so that reporting requirements were included within the pure claims-made forms described above. Such requirements mandated that insureds report claims made against it to the insurer, during the policy period.

Drawbacks of Reporting Requirements

Unfortunately it is sometimes impossible for an insured to comply with a reporting requirement specifying that the insurer be notified of claims made against the insured during the policy period. There are two sets of circumstances under which this problem commonly arises.

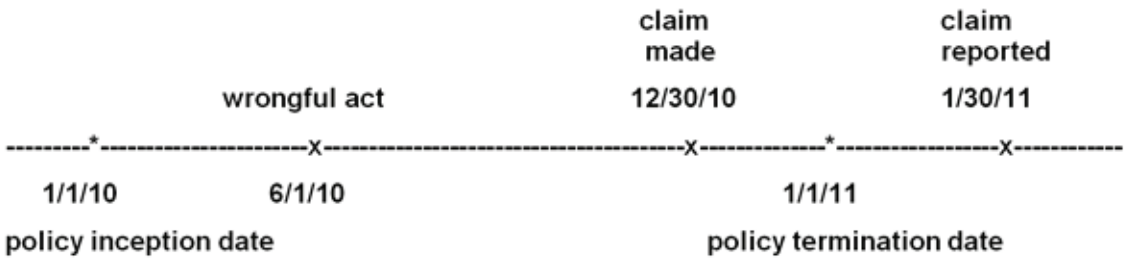
- **Claim Made Late in Policy Period**. First, compliance is often impossible when claims are made against an insured very late in a policy period. For instance, assume that an insured physician has a professional liability policy written with a January 1, 2010 to January 1, 2011 term. On December 31, 2010, a summons is delivered to the physician's office. However, the day before, the physician left town to go on vacation. By the time he returns on January 6, 2011 and receives the summons, it will be impossible for him to comply with his policy's reporting requirement.
- **Claim Filed but Not Yet Served**. Second, similar difficulties result when a lawsuit has been filed against an insured—during the policy term—but the insured is not served with a summons until after the policy has expired. Thus, the insured is unaware of the lawsuit until served with the summons. (In some instances, weeks or even months can elapse between the filing of a lawsuit and actual personal service.)

Post-Policy Reporting Windows

In both instances noted above, a reporting requirement, coinciding with the policy's termination date, has the potential for unjust consequences. Therefore, it is always in an insured's best interest if the reporting requirement included in a claims-made and reported policy provision contains what is known as a 30-day or, preferably, a 60-day "reporting window." This provision allows the insured to report claims made against the insured during the policy period, to the insurer, for 30 or 60 days after that policy has expired. Exhibit 3.1 illustrates the operation and importance of a post-policy reporting window.

EXHIBIT 3.1
THE IMPORTANCE OF POST-POLICY REPORTING WINDOWS

Policy Term: 1/1/10–11
Wrongful Act: 6/1/10
Claim Made Against Insured: 12/30/10
Claim Reported to Insurer: 1/30/11



This scenario illustrates the importance of post-policy reporting windows. Unless the insured's claims-made and reported policy contained either a 30- or 60-day reporting window, there would be no coverage for the claim. Although the claim was made against the insured during the policy period, it was not reported to the insurer until 30 days after the policy expired. So absent a 30- or 60-day reporting window, there would be no coverage for the claim.

Claims "First Made" Language

Coverage applies under claims-made policies only if a claim is first made against the insured during the policy period. The phrase "first made" is meaningful because coverage does not apply if the claim was previously made against the insured during a prior policy period—regardless of whether or not such policy was written by the current insurer or by a different insurer.

"First Made" Language: Two Key Implications

"First made" wording has two key implications: (1) it precludes coverage for claims that should rightfully be the responsibility of a previous insurer, and (2) it prevents the insured from obtaining coverage under a subsequent policy written by the current insurer that may be more favorable to his or her interests. For example, if an insured makes a claim under an insurer's January 1, 2010-11 policy that contains a $1 million limit, it may not make the same claim under the insurer's January 1, 2011-2012 renewal policy that contains a $2 million limit. . Given these reasons, virtually all claims-made policies (regardless of whether or not they are pure claims-made or claims-made and reported forms) are written with "claims first made" language.

Chapter 3 Review Questions

1. Because Dr. Swan has a pure claims-made policy, his coverage is triggered when a claim is:
   a. based on an occurrence during the term of his policy and reported to the insurer as soon as possible.
   b. both made against Dr. Swan and reported to the insurer during the term of his policy.
   c. made against Dr. Swan during the term of his policy and reported to the insurer as soon as practical.
   d. reported to the insurer during the term of his policy.
2. On June 30, 2001 a claim against her arrived in her law office's mail, but Jill Eagle did not personally receive it until she returned to work on July 5, 2001 after an extended holiday weekend. Upon finding the claim, Jill immediately called her insurance company to report it. Jill Eagle's professional liability policy has effective dates from 7/1/00 to 7/1/01 and a claims-made and reported trigger that *did not* contain a post-policy reporting window. Based on this information, one must conclude that Jill has:
   a. coverage for this claim because Jill's office received it during the policy period.
   b. coverage for this claim because Jill reported it as soon as practical.
   c. coverage for this claim because it was made during the policy period.
   d. no coverage for this claim because it was reported after the policy period.
3. Jay Blue has had three professional liability policies with claims-made triggers covering these dates: Policy A—June 1, 2010–June 1, 2011; Policy B—June 1, 2011–June 1, 2012; and Policy C—June 1, 2012–June 1, 2013. Policy C also has a 60-day post-policy reporting window. On May 30, 2013, a claim was made against Blue alleging that a covered type of error or omission occurred on September 11, 2010. Blue reported the claim to his insurer on June 15, 2013. Based on this information, it is most likely that:
   a. coverage applies under Policy A.
   b. coverage applies under Policy B.
   c. coverage applies under Policy C.
   d. no coverage applies.

Answers to Chapter 3 Review Questions

1. c. A claim must be first made against an insured during the term of the policy and the claim must be reported "as soon as possible" or "as soon as practical.
2. d. Jill did not comply with policy requirements—which were essentially impossible to comply with. She did not (and could not) report it during the policy period.
3. c. The claim was made during Policy C's term and reported during the reporting window.

Chapter 4
Retroactive Dates in Claims-Made Policies

Chapter 4 introduces another important element of claims-made policies: retroactive date requirements. The retroactive date can be thought of, in simple terms, as the start of the policy coverage period. These requirements state that for coverage to apply to a claim, the wrongful act giving rise to that claim must have taken place on or after the policy's retroactive date—regardless of when the claim is ultimately made against the insured.

Conversely, no coverage applies if the wrongful act took place prior to a policy's retroactive date. For example, a January 1, 2010, retroactive date would bar coverage for claims resulting from acts that took place prior to that date, even if such claims are not made against the insured until after January 1, 2010.

The Purpose of Retroactive Dates

There are two purposes of retroactive dates: (1) to eliminate coverage for situations or incidents known to the insured that have the potential to give rise to claims in the future and (2) to preclude coverage for "stale" claims that arise from events far in the past, even if such events are unknown to the insured.

In the former case, the retroactive date preserves the principle of fortuity, that is, the insurer should not be called upon to cover the so-called "burning building." In the latter instance, the retroactive date makes policies more affordable by precluding coverage for events that, while theoretically insurable, are remote in time.

Not All Policies Contain Retro Dates

It is important to recognize that not all—although the majority—of professional/executive liability policies are written with retroactive dates. Of course, it is to the insured's advantage if a policy does not include one. If an underwriter insists that a retroactive date be made part of a policy, it is also to the insured's advantage if the retroactive date is as early as possible in time, thereby affording coverage for the greatest possible number of events.

For example, if a policy has a term of January 1, 2010 to January 1, 2011, a January 1, 2006 retroactive date is far preferable to a January 1, 2010 retroactive date. This is because under the latter retroactive date, there would be no coverage for wrongful acts that took place prior to January 1, 2010. In contrast, if the policy contained a January 1, 2006 retroactive date, coverage would only be precluded for wrongful acts that took place prior to January 1, 2006. In effect, the January 1, 2006 retroactive date provides the insured with an additional 4-year "window" during which claims resulting from wrongful acts that took place from January 1, 2006 to January 1, 2010 would be covered by the policy (provided the claims associated with these acts are made against the insured during the 1/1/10–11 policy period).

A Retroactive Date Alternative: Excluding Coverage for a Specific Event

Rather than writing a policy with a retroactive date, an underwriter can insert an exclusion for a specific event or events that could produce a claim in the future. For example, assume that a personal injury attorney (insured under a lawyers professional liability policy) represented a client who was seriously injured in an automobile accident. Also assume that the case was tried before a jury, yet the jury found in favor of the defendant driver who caused the claimant's injuries. Under these circumstances, the client might allege that her failure to prevail in the case was the result of the attorney's negligent presentation of her case to the jury. If the attorney decided to change insurers upon the expiration of his or her professional liability policy, an underwriter could offer to write a policy without a retroactive date, on the condition that the policy would contain an exclusion should this specific situation produce a claim in the future. Although a potential claim that could arise from this incident would be precluded by such an endorsement, the insured attorney would still have coverage for all other potential claims that arose from wrongful acts that took place prior to the inception of the policy term.

This approach is equitable because it protects the underwriter from a known incident to which the policy should not rightfully be exposed. However, because the policy would not contain a retroactive date, it provides the insured with coverage for unknown, fortuitous events.

The foregoing points concerning retroactive dates are summarized in Exhibit 4.1.

EXHIBIT 4.1
KEY POINTS ABOUT RETROACTIVE DATES

- It is preferable to have no retroactive date in a professional/executive liability policy.
- If the insurer insists on a retroactive date, it is best to have it as early in time as possible.

  A policy can be written without a retroactive date and yet exclude coverage for certain

Chapter 4 Review Question

1. Having been in her profession for more than 20 years, Phoebe wants to be sure the next professional liability policy she buys has the broadest coverage possible. Assuming all the following retroactive date alternatives are actually available, the broadest coverage would be provided by a policy with*:*

   a. a retro date that coincides with the current policy's expiration date.

   b. a retro date that coincides with the current policy's inception date.

   c. a retro date that is 1 year earlier than the current policy's inception date.

   d. no retro date.

Answer to Chapter 4 Review Question

1. d. Not all policies contain a retro date, and it is to the insured's advantage if a policy does not include one.

Chapter 5
Applying Claims-Made Coverage Triggers

This chapter begins by summarizing the three conditions required to trigger coverage under a claims-made and reported policy that contains a retroactive date. It continues by providing additional examples of how claims-made coverage triggers apply in actual claims situations and concludes by introducing the concept of discovery provisions, explaining how they can be used by insureds to lock-in coverage, even before a claim has been made against them.

Conditions Precedent to Triggering Coverage

The term "condition(s) precedent," as used here, refers to an event (or set of events) that must first take place before coverage applies under a given insurance policy. For coverage to apply under a claims-made and reported policy that contains a retroactive date, the following three conditions must be met:

- **Retroactive Date Requirement**—The wrongful act giving rise to the claim must have taken place on or after the policy's retroactive date (which is normally specified in the policy's declarations page).
- **Claims First Made Requirement**—The claim must be first made against the insured, prior to the policy's expiration date.
- **Reporting Requirement**—The claim must be reported to the insurer within the reporting period of the policy.

Applying the Conditions to a Claim Example

Assume that an accountants' professional liability policy is written with a claims-made and reported coverage trigger provision. The policy has a term of January 1, 2010 to January 1, 2011 and contains a retroactive date of January 1, 2010 and a 60-day reporting window. For coverage to apply under this policy:

- the wrongful act giving rise to a claim must have taken place on or after January 1, 2010, *Retroactive Date Requirement;*
- the claim must have been first made against the insured before the policy expired on January 1, 2011, *Claims First Made Requirement*; and
- the claim must be reported to the insurer no later than March 2, 2011, *Reporting Requirement* (i.e., the 60th day following expiration of the policy).

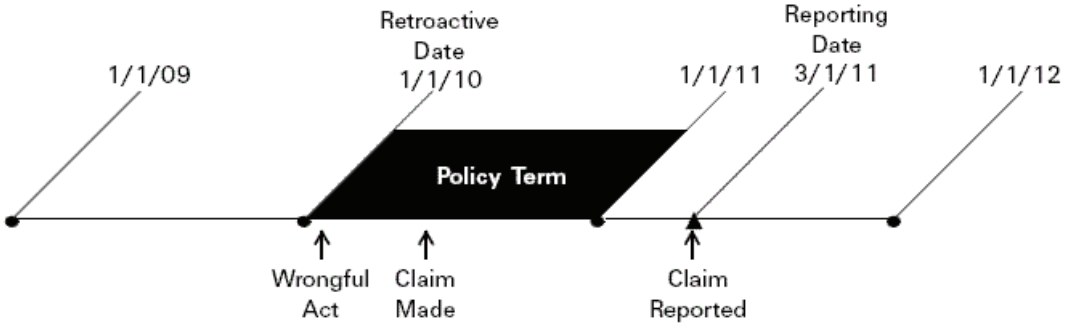
Unless all three of these requirements are met, coverage would not be available under a professional liability policy written with a claims-made and reported coverage trigger provision that also included a retroactive date. Exhibit 5.1 provides an example of the way an insurance policy written with a claims-made and reported coverage trigger—including a retro date requirement and a 60-day reporting window—operates.

EXHIBIT 5.1
APPLICATION OF COVERAGE UNDER A CLAIMS-MADE AND REPORTED POLICY

In each of the four situations noted below, the policy in question:

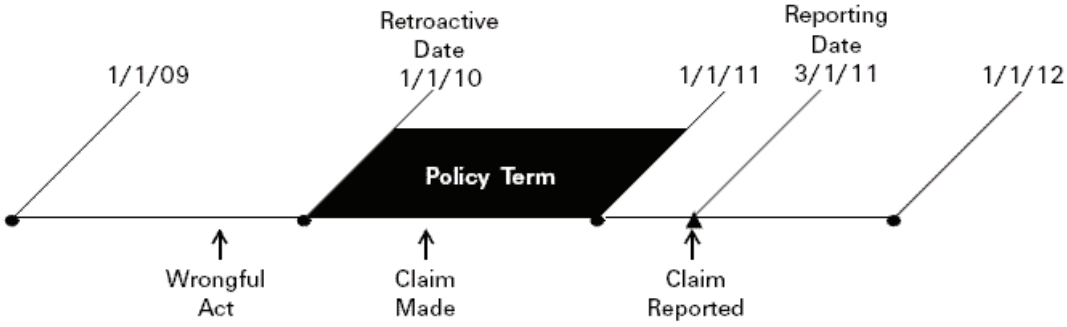
- has a term of January 1, 2010, to January 1, 2011
- is written with a January 1, 2010, retroactive date
- includes a provision requiring claims to be reported to the insurer within 60 days following expiration of the policy

Case #1 (Coverage Applies)



The claim is covered because the wrongful act took place after the policy's retroactive date, the claim was made against the insured *during* the policy term, and the claim was reported to the insurer *within* 60 days of the policy expiration date.

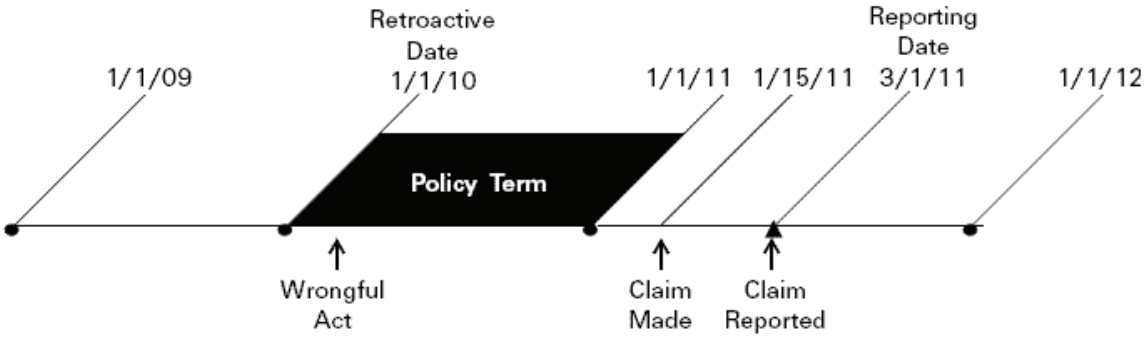
Case #2 (No Coverage Applies)



The claim is not covered because the wrongful act *took place* prior to the policy's retroactive date.

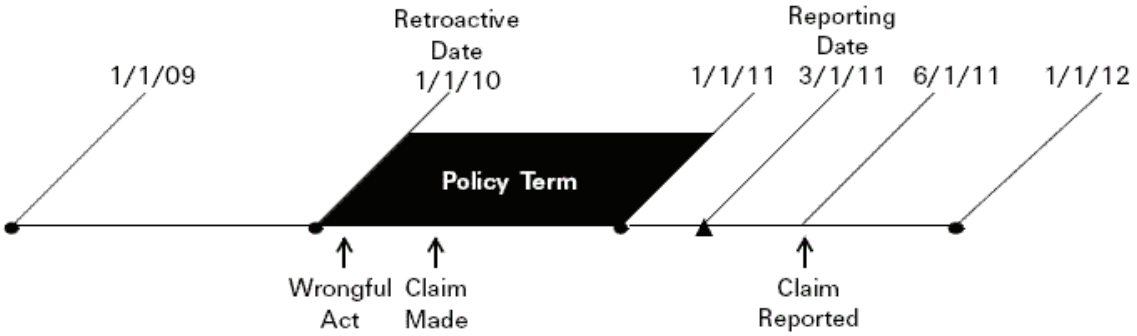
EXHIBIT 5.1
APPLICATION OF COVERAGE UNDER A CLAIMS-MADE AND REPORTED POLICY (CONTINUED)

Case #3 (No Coverage Applies)



The claim is not covered because it was *made* after the policy expired.

Case #4 (No Coverage Applies)



The claim is not covered because it was not *reported* within 60 days of the policy expiration date.

Coverage Application under the Medical Malpractice Example

Now that the requirements necessary to trigger coverage under a claims-made and reported policy have been discussed, it is worthwhile to return to the previously-described medical malpractice example in Chapter 2 of this course.

Assume that the following policies were in effect during the sequence of events described earlier and that all eight policies were written with claims-made and reported coverage triggers and all contained a January 1, 2002 retroactive date.

Policy Term	Event(s)
1/1/06–1/1/07	Surgery performed
1/1/07–1/1/08	Infection develops
1/1/08–1/1/09	Illness develops, lawsuit threatened
1/1/09–1/1/10	Doctor served with summons, doctor reports claim to insurer
1/1/10–1/1/11	Settlement negotiations
1/1/11–1/1/12	Settlement negotiations
1/1/12–1/1/13	Settlement negotiations
1/1/13–1/1/14	Claim settled

Coverage Applies Under the 1/1/09–10 Policy

In this example, the claim against the physician was made during the January 1, 2009 to January 1, 2010 policy period. As a result, the limits, deductibles, terms, and conditions of that policy would apply to the claim. The fact that different events related to the claim took place during the other seven policy periods is of no consequence for the purpose of determining which policy applies.

Retroactive Date Requirement Satisfied Under the 1/1/09–10 Policy

It is also important to note that the claim met the retroactive date requirement—i.e., the January 1, 2009 to January 1, 2010 policy had a January 1, 2002 retroactive date, and the wrongful act that gave rise to the claim took place after that date.

Reporting Requirement Satisfied Under the 1/1/09–10 Policy

Finally, the claim met the reporting requirement—i.e., the claim was reported during the January 1, 2009 to January 1, 2010 policy period.

Discovery Provisions: The Option To Report "Potential Claims"

From the insured's standpoint, one of the problems inherent in claims-made policies is that unless a claim is made against an insured during the policy period, coverage will not be triggered. This is true even though the act, error, or omission was committed during the policy period, and a claim is virtually certain to result. For example, a general surgeon who has a cocaine addiction passes out while performing a routine appendectomy. Immediately afterwards, the patient goes into cardiac arrest and dies. Although a claim probably will not be filed for at least several months, legal action against the doctor is all-but-inevitable. Assume that the surgeon's professional liability policy expires in 2 weeks. In this instance, coverage is not likely to be available under the current policy because a formal claim cannot be reported to the insurer until the surgeon receives a formal claim (i.e., in the form of a summons and complaint). Making the situation even worse for the doctor is the fact that on the day his policy expires, his medical license is suspended and as a result, his current insurer refuses to renew his professional liability coverage. Accordingly, he will not be able to report the claim under his next policy since such coverage will not be available.

The apparent lack of coverage under this scenario is not as great a problem as it may first appear. This is because virtually all professional and executive liability insurance policies contain what are known as discovery provisions (also sometimes referred to as "notice of potential claim" or "awareness provisions").

Such provisions allow insureds to report to the insurer and thereby lock-in coverage for incidents or circumstances that may, in the future—but at the time they are reported—have not yet produced claims. In effect, discovery provisions allow an insured to secure coverage for such events so that coverage will apply under the current policy—regardless of how far in the future a claim is eventually made in conjunction with the incident that has been reported. So in the foregoing example, if the surgeon reported the incident prior to the expiration of his current policy, regardless of the fact that when he reported the incident to his insurer he had not received a formal claim, coverage for any future claim would be available under that policy, regardless of: (1) how far in the future a formal claim is made against the doctor and (2) regardless of whether or not the doctor's current insurer refuses to renew the policy upon expiration.

What is an "Incident" or "Potential Claim"?

An "incident" or "potential claim" is any event or situation which does not immediately, but could, in the near future result in a claim. The following scenario offers an example of what would be considered a reportable "incident" under the discovery provision of an employment practices liability insurance (EPLI) policy.

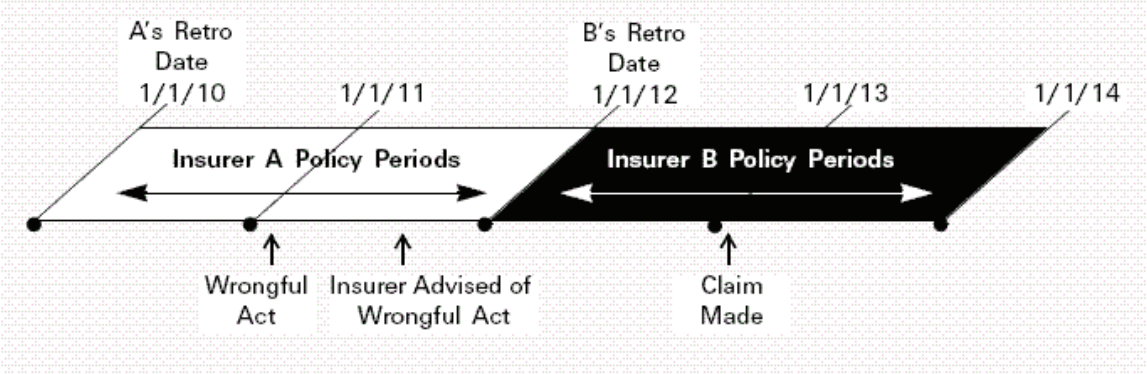
After a heated and contentious exit interview on June 24, 2009, during which an employee is advised that his job is being eliminated, the employee tells the company's human resources manager "after 20 years with this company, this is a really raw deal you're giving me! I'm going to sue you personally, as well as this lousy company for everything it's worth." After these remarks, the now-former employee storms out.

Although the company has not yet received a lawsuit, given these circumstances, there is a reasonably high probability that it eventually will be sued, most likely for wrongful termination, a type of claim which would be covered by the EPLI policy. Accordingly, if the company were to provide details of this situation to its insurer, it would qualify as a "reportable incident" or "potential claim" under that policy's discovery provision.

Using Discovery Provisions To Prevent Coverage Gaps

A professional or executive who notifies his or her insurer of circumstances that could at some future time result in a claim would, as result, be in a position to minimize gaps in coverage when: (1) changing insurers or (2) discontinuing coverage completely. This concept is illustrated in Exhibit 5.2.

EXHIBIT 5.2
USING A DISCOVERY CLAUSE TO PREVENT COVERAGE GAPS



Coverage applies under A's policy because notification of the incident was provided during the January 1, 2011/2012 policy term by means of that policy's discovery provision.

Insured Changes Insurers

In the situation noted by Exhibit 5.2, the insured replaced insurer A with insurer B on January 1, 2012. Because the wrongful act/incident took place before the January 1, 2012 retroactive date of B's policy, B would not cover the claim (despite the fact that the claim was made against the insured during B's policy). However, since the insured notified insurer A of the wrongful act/incident per the discovery provision, coverage applies under A's policy, despite the fact that a claim was not made against the insured until after A's policy had expired.

Insured Discontinues Coverage Altogether

Note also that even if the insured had completely discontinued carrying any professional liability coverage after his policy with Insurer A expired on 1/1/12, he still would have had coverage for the claim under A's policy. This is because coverage is locked-in, once an incident is reported under a policy's discovery provision—regardless of how far in the future a claim associated with that incident is eventually made against the insured.

The "Specificity" Requirement

One key aspect of discovery provisions is that they require insureds to report, in considerable detail, the information associated with any given incident or circumstances they feel could eventually produce a claim. Generally, discovery provisions require insureds to report what the policies term "full particulars," regarding a potential claim, including:

- the specific act(s) surrounding it, including the date of the act(s);
- a description of the injury or damages caused by the act;
- details about how the insured became aware of the incident or circumstances;
- the reasons why the insured thinks the incident could eventually give rise to a claim; and
- an estimate of potential damages associated with the possible claim.

Note that in the wrongful termination example (above), other than an estimate of potential damages, the information conveyed in the description of this incident would be sufficient to qualify as a reportable incident.

Exercising a Discovery Provision

Given the specificity requirement, to exercise the discovery provision at the expiration of a policy, an insured physician would not be able to simply provide a list of all the patients he or she treated within the preceding 3 months. Rather, the insured would be required to provide the date on which a problematic medical "incident" took place, describe the nature of the treatment he provided, give an indication of why injuries could result from such treatment, and make an estimate of the extent of any possible resulting injuries.

In short, the purpose of the specificity requirement found within discovery provisions is to prevent an insured from handing the insurer a blanket client list, (also known as a "laundry list"), unless it contains specific details as to why the insured believes that a specific client has suffered some form of damage and that a claim could result as a consequence.

EXHIBIT 5.3
USFEUL SITUATIONS FOR DISCOVERY PROVISIONS

Reporting an incident or circumstance under a policy's discovery provision can be particularly valuable when an insured:

- Plans to obtain coverage from another professional/executive liability insurer at expiration of his or her current policy
- Intends to cancel his or her policy midterm (whether or not he or she intends to replace it)
- Receives notice from the insurer that his or her policy is about to be canceled or will not be renewed
- Retires from practice
- Sells his or her practice
- Merges with another professional organization
- Refuses to provide additional services to a client for any reason (including nonpayment of bills for past services)
- Discovers an error in his or her work, but before the client becomes aware of the mistake
- Confronts a client who expresses dissatisfaction with services performed but has not yet expressed the intention to sue
- Receives a request from a client to provide additional, remedial services—without charge—to correct alleged deficiencies associated with work that has already been performed

Advantageous Uses of Discovery Provisions

As already explained, discovery provisions can be invaluable for an insured in securing coverage when: (1) changing insurers and (2) when discontinuing coverage altogether.

In addition, there are other, more specific situations, noted in Exhibit 5.3 above, in which the use of discovery provisions can be especially advantageous. If any of the conditions noted in the exhibit exist, the professional or executive should prepare—-prior to policy expiration or termination—a list of circumstances that could, at some time in the future, give rise to claims and submit this list to the insurer.

Exhibit 5.4 provides a number of profession-specific scenarios in which a discovery provision can and should be used to an insured's advantage.

EXHIBIT 5.4
PROFESSION-SPECIFIC SCENARIOS WHERE DISCOVERY PROVISIONS WOULD BE VALUABLE

In each of the four scenarios noted below, the insured, upon learning of the events described, should immediately notify her professional liability insurer of a potential claim under the policy's discovery provision, despite the fact that a claim has not yet been made against the insured.

- **Real Estate Broker's E&O Policy.** A real estate broker closes a sale. Two weeks after the closing, the foundation of the home she sold collapses, causing extensive structural damage.
- **Director & Officer's Liability Policy**. A Fortune 100 corporation announces a quarterly loss of $2 per share. Wall Street analysts were expecting a profit of 25 cents per share. The company's stock price then drops from $75 to $50 during the next week.
- **Allied Healthcare Professional Liability Policy**. While performing a massage, a physical therapist hears a loud "pop" in his client's neck, immediately after which, the client can no longer move his neck and feels excruciating pain radiating down his arm.
- **Fiduciary Liability Policy**. The corporate trustee for a company-sponsored, defined benefit pension plan announces to the company's employees that the plan will only be able to pay 50 percent of its promised benefits. This is due to heavy investment losses in sub-prime related investments.

Catch-22 Aspects of Discovery Provisions: To "Laundry List" or Not

Despite the benefits they convey, discovery provisions are not without drawbacks. On the surface, it would appear to benefit an insured to notify his or her insurer of all possible, potential claims prior to policy expiration—a practice known as "laundry listing." There are, however, four problems that may result when an insured engages in this practice.

Higher Premiums in Renewal Policies

Although a claim may not yet have been made, an underwriter will be inclined to provide a somewhat higher premium in renewal policies, given the potential claim(s) that the underwriter could be called on to pay in the future. A safety margin of this kind will increase the cost of an insured's renewal policy(ies).

Possible Cancellation/Nonrenewal

Many underwriters believe that "frequency breeds severity." Therefore, if an insured reports numerous incidents, it could indicate recurring problems associated with the insured's professional practice or corporation which might, at some time, eventually produce a catastrophic loss. Accordingly, if, in the underwriter's perception, an insured begins to over-report incidents, the underwriter may question the wisdom of continuing to insure him or her—at any premium—and may be inclined to cancel or refuse to renew upon expiration.

Problems When Changing Insurers

Reporting numerous incidents under discovery provisions makes it more difficult for the insured to secure replacement coverage should he or she decide to change insurers. This is because when an insured discloses circumstances surrounding possible claims to an incumbent insurer, he or she must also reveal these circumstances (on the application form) to an insurer who is providing a quotation for a replacement policy. This has two important implications. First, the replacement insurer will not cover claims that may eventually be made in conjunction with such incidents. Second, if several such circumstances are revealed on the application, the prospective replacement insurer might become wary of the insured and decline to provide coverage.

Possible Admission of Guilt

If an insured reports an incident to an insurer, and the incident eventually gives rise to a claim, evidence of that report will be discoverable by the claimant's attorney during the litigation process. While a report of this kind is not necessarily an admission of an insured's culpability, it nevertheless provides evidence that the professional/executive was concerned about either the level of competence with which his or her services were performed or about the outcome produced by the performance of those services. Either way, evidence of the report will make it more difficult to defend the insured against a claim. It is always advisable for insureds to report all relevant information concerning an incident, especially any details that would absolve, or at least mitigate the professional's potential liability.

When "Laundry Listing" Is Advantageous for the Insured

A certain degree of selectivity is required when notifying an insurer of potential claims under a policy's discovery provision. There is, however, one situation in which it is clearly advantageous to report every possible incident as a potential claim. This happens when an insurer will no longer be writing a specific line of coverage and therefore nonrenews or cancels all policies (of a certain coverage line, or in a specific territory, for example).

In this case, an insured may consider reporting more possible circumstances under a policy's discovery provision than he or she ordinarily would be inclined if the policy were being renewed. By laundry listing these circumstances, the insured would not be faced with higher renewal premiums or possible cancellation/nonrenewal by the incumbent insurer. Also important is the fact that a replacement insurer would tend to be more understanding of an insured who "laundry lists" under these conditions, recognizing that the measure is more justifiable because there is no guarantee that the insured will be able to secure a replacement policy.

When "Laundry Lists" Are Rejected

On the other hand, "laundry lists" are often rejected by insurers. This is especially true if, as already noted, an insured merely compiles a list of all clients, cases, or projects conducted within the past

several years, without providing specific details about the acts that could result in potential liability associated with services rendered. Therefore, under most circumstances, an insured should only supply information about circumstances that he or she believes—on a "good-faith" basis—have the potential for producing a claim.

Chapter 5 Review Questions

1. Phoebe has a professional liability policy with a policy term of 6/1/10 to 6/1/11, a retroactive date of 6/1/09, and a 60-day post-policy reporting window. As a result of a wrongful act on 12/1/08, a claim was made against Phoebe on 12/1/10 and reported to the insurer on 7/1/11. Based on this information, coverage for this claim*:*

   a. applies because the claim was first made after the retro date.

   b. applies because the claim was first made before the policy expired.

   c. does not apply because the claim was reported too late.

   d. does not apply because the wrongful act took place prior to the retro date.

2. Dr. Rooster prescribes a medication for a female patient during Year 1. She becomes pregnant during Year 2 and gives birth to a child during Year 3. In Year 4, studies demonstrate that the medication can adversely affect a fetus. In Year 5, the patient sues Dr. Rooster, who immediately reports the claim to his insurer. The child is closely monitored. In Year 7, the child begins to show symptoms. Dr. Rooster had a *different* claims-made policy every calendar year, but all policies had the same January 1, Year 1 retroactive date. The limits, deductibles, terms, and conditions of the policy in force during *which year* apply to this claim?

   a. Year 4.

   b. Year 5.

   c. Year 6.

   d. Year 7.

3. Polly Parrot has had three professional liability policies from three different insurers covering these dates: Policy A—June 1, 2010–June 1, 2011; Policy B—June 1, 2011–June 1, 2012; and Policy C—June 1, 2012–June 1, 2013. All three policies have a discovery clause and a retroactive date that coincides with the beginning of each policy period. An error or omission likely to result in a claim took place on March 11, 2011. Polly informed her insurer of the incident on May 11, 2011. A claim was made against Polly on June 11, 2012, and reported to her insurer on July 11, 2012, based on the March 11, 2011 incident. Based on this information:

   a. coverage applies under Policy A.

   b. coverage applies under Policy B.

   c. coverage applies under Policy C.

   d. no coverage applies.

4. Following a terrorist attack, Attorney Wilson Warbler helped many clients receive compensation for their losses from a federal compensation fund. In return for receiving such compensation, the clients waived their rights to sue in tort. Following recent news reports concerning other victims' successful lawsuits, Warbler is concerned that some victims who were his clients might allege that they would have recovered more had they sued rather than followed his advice. The best way for Warbler to lock in coverage by exercising a discovery provision in his policy is to:

   a. contact former clients, apologize, and return the fee charged for his services.

   b. continue to renew his policy with new retro dates that coincide with each policy's inception.

   c. give his insurer a list naming of all clients who received fund compensation with his assistance.

   d. give his insurer very specific details concerning each client who might arguably have been undercompensated.

5. After Dr. Mac deNife amputates a patient's diseased left leg, she re-examines the chart and sees that she should have amputated the right leg which was in even worse condition, so, while the patient is still anaesthetized, she removes the remaining right leg. Although both legs were diseased, Dr. deNife is nevertheless afraid she might be sued and reports the incident to her medical professional liability insurer. Which of the following could happen as a result of her reporting the incident to her current insurer?

   a. another insurance company will offer her a much lower premium in recognition of her honesty in reporting her own error to her current insurer.

   b. the current insurer refuses to renew her policy.

   c. the insurer posts her name on a laundry blacklist.

   d. the patient is much less likely to file a claim against her.

Answers to Chapter 5 Review Questions

1. d. The wrongful act giving rise to a claim must have taken place on or after 6/1/09.
2. b. The claim was made during Year 5, after the retroactive date, and clearly met the reporting requirement.
3. a. Because the insured notified insurer A of the wrongful act/incident per the discovery provision, coverage applies under A's policy, despite the fact that a claim was not made against the insured until after A's policy had expired.
4. d. The specificity requirement found within discovery requires explicit details as to why the insured believes that a specific client has suffered some form of damage and that a claim could result as a consequence.
5. b. Reported incidents make an insured less desirable from an underwriting perspective.

Chapter 6
Complicating Factors in Applying Claims-Made Coverage

Chapter 6 addresses two factors that often create complications in determining whether coverage applies under a claims-made policy in any given claim situation:

1. When is a claim made?
2. When does the wrongful act take place?

When Is a Claim Made?

Determining when a claim is made, is the first complicating factor in applying claims-made coverage triggers. Indeed, defining the exact time at which a claim is "made" for the purpose of satisfying the claims-made requirement is not always simple. Unfortunately, this issue is further complicated by the fact that there are a number of different ways in which the term "claim" is typically defined by professional liability policies. These definitions are not limited to, but most commonly include, the following.

- "Claim" is notice to the insurer, by the insured, of an incident that could give rise to a claim in the future.
- "Claim" is a "written demand" for money or services.
- "Claim" is notification of a "criminal," "administrative," "alternative dispute resolution proceeding," or "EEOC (Equal Employment Opportunity Commission) proceeding.
- "Claim" is an investigation by a government agency or an investigation by any similar regulatory body

"Claim" Is Notification of a Potential Claim

From the insured's perspective, this definition is quite favorable because it affords the insured—rather than the insurer or a claimant—control over when the policy's coverage is triggered. If an insured believes an incident could give rise to a claim in the future, by reporting the surrounding circumstances, he or she would be able to lock in coverage—regardless of how far in the future a claim is eventually made. In effect, this definition of "claim" allows the insured to trigger coverage by notifying the insurer of a potential claim via a policy's discovery provision. (Discovery provisions were discussed earlier in Chapter 5 of this course.)

"Claim" Is a Written Demand for Money or Services

This definition of the term "claim" requires a "written" demand for money or services to trigger a claim. At one time, insurers often specified that a "claim" was triggered by a "demand," the implication being that an "oral" demand would also trigger a claim. However, such wording is rarely used today.

"Claim" Is Notification of a "Civil," "Criminal," "Administrative," "Alternative Dispute Resolution Proceeding," or "EEOC Proceeding"

This definition triggers coverage when the insured is notified (regardless of the source of the notification) that one (or more) of a variety of legal/administrative actions have been filed. This is a favorable definition because not only does notification of a civil action (i.e., a claim alleging negligence) trigger a "claim," but, in addition, the following events can also have this effect:

- institution of a criminal action (which could happen prior to the filing of a civil suit),
- notification of an administrative inquiry (e.g., a professional disciplinary hearing),
- alternative dispute resolution proceeding (e.g., a claimant's demand for arbitration or mediation), or
- an Equal Employment Opportunity Commission (EEOC) proceeding (e.g., a discrimination claim brought by an employee).

The last bullet point is particularly important with respect to employment practices liability policies because an insured employer's first awareness of an employee's claim often comes via notification that the EEOC is investigating an employee's complaint against an employer—rather than by means of a civil lawsuit.

"Claim" is an Investigation by a Government Agency or Regulatory Body

This definition triggers coverage when a government agency or regulatory body begins an investigation of an insured—even before any allegations of civil or criminal wrongdoing have been made against an insured—or before any monetary damages have been alleged. Such definitions are also favorable for insureds, and in recent years, have been applicable to a number of situations. For example, during the summer of 2006, more than 100 corporations were under investigation by either the Department of Justice or by the Securities and Exchange Commission in connection with unlawful stock option backdating practices. Having such investigations trigger a "claim" is important, because these kinds of investigations require insureds to expend monies for defense costs, expenses which would have been covered by directors & officers liability policies—even if such investigations never result in a civil lawsuit. Another example: an insurance agent is notified by the state by the state insurance department of claim handling-related complaints, made against her by several insureds. (Note: the distinction between this coverage trigger—an investigation by a government agency or regulatory body—and the preceding trigger—notification of a civil, criminal, administrative proceeding—is that in the latter situation, it is actually alleged that the insured has committed a wrongful act. In the former situation, there is only the possibility that such an act has been committed, which is why an investigation is necessary to determine if this is actually the case.)

When Is a Claim Made? Some Examples

Returning once again to the medical malpractice example discussed in Chapter 1 and again in Chapter 5, will illustrate that, depending upon a policy's particular definition of "claim," coverage can be triggered during a variety of policy periods.

Notification of Incident

During the actual surgical procedure (in 2006), the physician could have realized that he committed an error. At that point, he might have notified his insurer and, under the first definition of the term "claim," (i.e., the physician's notification of the incident) he would have triggered coverage under the January 1, 2006 to January 1, 2007 policy.

Investigation by a Government Agency or Regulatory Body

Similarly, during the year the patient developed the infection (2007), the patient may have complained to the state medical board, accusing the doctor of making an error during the surgery. If, at that point the medical board opened an investigation, advised the doctor accordingly, who, in turn, notified his insurer, a claim would have been made under the fourth definition of "claim" (above), thus triggering the January 1, 2007 to January 1, 2008 policy.

Demand for Money or Services

Using this definition of "claim," coverage will not be triggered until the 1/1/09-10 policy period, because it was not until this period during which the doctor was actually served with a summons and complaint by the patient-claimant.

This scenario illustrates the importance of the definition of "claim" in a professional or executive liability policy. Clearly, the exact way in which "claim" is defined has a significant bearing upon which policy, in a series of policies, will actually respond to that claim. As already emphasized, it is always in an insured's best interest to have a policy with a definition of "claim" that allows an incident—rather than a claim—to trigger coverage. This is because when an incident triggers coverage, the insured controls the coverage trigger, whereas when a claim triggers coverage, the insured must depend on another party (usually the claimant) to activate coverage. In effect, (1) the more control an insured has in triggering coverage and (2) the earlier coverage is triggered (whether by an insured or someone else), the more favorable the policy's definition of "claim" is for the insured.

When Does the Wrongful Act Take Place?

The second complicating factor in determining the application of coverage under policies written with claims-made coverage triggers is arriving at the exact point in time at which the wrongful act took place.

This is necessary to satisfy a retroactive date requirement, if present, in a policy. However, determining this point is not always a straightforward process because professional/executive liability claim situations often involve a series of separate but continuing acts that take place over an extended period of time. For instance, a professional liability claim against an attorney may have arisen out of several conferences in which advice on a single matter was rendered to a client during a 6-month period.

Unfortunately, few professional/executive liability insurance policies provide a definition for arriving at the exact point in time at which a wrongful act takes place. Rather, the majority sidestep the issue by including a "wrongful act" definition pertaining only to the types of acts that are covered.

When a Wrongful Act Takes Place: The General Rule

Despite these ambiguities, for the purpose of assessing compliance with a retroactive date requirement, a wrongful act is, by custom and practice, generally considered to have taken place when the professional service/executive decision that ultimately causes the loss or damage has been completed or should have been completed (but was not). This is as opposed to:

- the time at which the service ultimately causes loss or damage,
- the time at which the service commences,
- when the professional discovers the loss or damage, or
- when the claimant discovers the loss or damage.

Determining the Time of a Wrongful Act: A Case Study

The following example will clarify this concept. Assume that an engineer is hired to design a roof structure for an office building. On January 1, 2009, the plan for the roof is sealed (evidencing the fact that the design has been submitted and is the work of that particular engineer). Three years later, on January 1, 2012, the roof collapses. It is later determined that the original design was incorrect because the size of the beams it specified were not adequate for the load they bore. In this situation, the wrongful act can be considered to have taken place on January 1, 2009, because it was on that date that the engineer had actually finished providing his professional services. This is as opposed to January 1, 2012, the date on which the professional error actually caused the loss. This is illustrated in Exhibit 6.1.

EXHIBIT 6.1
DETERMINING WHEN A WRONGFUL ACT TAKES PLACE

In this example, the wrongful act is considered to have taken place on 1/1/09 because it was on that date that the architect's work was *completed*. Conversely, the wrongful act did not take place on 1/1/12, the date on which the building collapsed because that is the date on which the wrongful professional act *resulted* in damage or loss.

Despite the clarity of the example in Exhibit 6.1, the general rule indicated above does not completely solve the problem of determining exactly when a wrongful act takes place. As was noted earlier in this section, evaluating situations in which a claim results from services rendered on a continuing basis unfortunately poses problems and often defies straightforward determinations.

Chapter 6 Review Questions

1. Allen, a doctor, has professional liability insurance. Depending on the wording of the professional liability policy in question, any of the following scenarios might fit the definition of a "claim," *except:*

   a. A client sends Allen a letter demanding that Allen pay her money as compensation for her financial loss resulting from his wrongful act.

   b. Allen fails to meet the continuing education requirements necessary to retain his professional license.

   c. Allen notifies the insurer of an incident that might result in a claim.

   d. The Internal Revenue Service begins investigating Allen.

2. Violet Green's professional liability policy from Brown Tree Insurance Company (BTIC) defines "claim" as "a written demand for money or services." As compared with other possible definitions of "claim," this definition has all of the following characteristics, *except*:

   a. It includes situations in which the insured is made aware of an incident that could give rise to a demand for damages.

   b. It is more precise than a definition specifying that a claim is triggered by a "demand for money or services."

   c. It is rarely used today.

   d. It precludes the possibility that coverage might be triggered by an oral demand.

3. Dr. Sparrow prescribes pills for a female patient during Year 1. She becomes pregnant during Year 2 and gives birth to a child during Year 3. In Year 4, Dr. Sparrow learns of studies demonstrating that the pills can adversely affect a fetus. During Year 5, the patient sues Dr. Sparrow, demanding $10 million, at which time the doctor reports the claim to his insurer. The child is closely monitored. In Year 7, the child begins to show symptoms. Dr. Sparrow had a different claims-made policy every calendar year, but all policies had the same January 1, Year 1 retroactive date. If his policy defined claim as "a demand for money or services," Dr. Sparrow could have triggered coverage as early as:

   a. Year 1.

   b. Year 4.

   c. Year 5.

   d. Year 7.

4. Dr. Sparrow prescribes pills for a woman during Year 1. She becomes pregnant during Year 2 and gives birth to a child during Year 3. In Year 4, Dr. Sparrow learns of studies demonstrating that the pills can adversely affect a fetus. During Year 5, the woman sues Dr. Sparrow, who reports the claim to his insurer during Year 6. The child is closely monitored. In Year 7, the child begins to show symptoms. Dr. Sparrow had a different claims-made policy every calendar year., but all policies had the same January 1, Year 1 retroactive date. Custom and practice indicate that a "wrongful act" occurred during:

   a. Year 1.

   b. Year 2.

   c. Year 3.

   d. Year 47.

Answers to Chapter 6 Review Questions

1. b. Allen continues to practice without a license, the likelihood of a successful claim against him might increase, but this by itself would not qualify as a claim under any policy.
2. a. Awareness of an incident is not a written demand for money or services.
3. c. The suit, which occurred in Year 5, was the earliest point at which the claimant made a demand for money or services.
4. a. The professional service that ultimately caused the loss or damage (prescribing the pills) took place during Year 1.

Chapter 7
Causes of Potential Claims-Made Coverage Gaps

Policies written on a claims-made basis have the potential to produce coverage gaps. Chapter 7 discusses the three ways in which such gaps are created. Exhibit 7.1 lists the three most common circumstances under which gaps in claims-made policies arise.

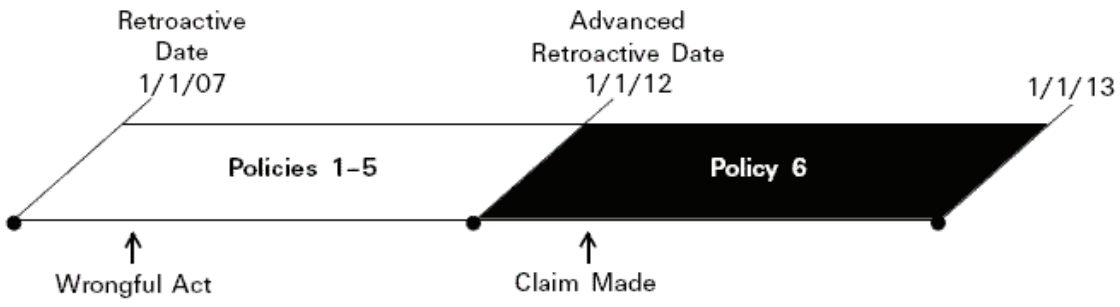
EXHIBIT 7.1
POTENTIAL CAUSES OF CLAIMS-MADE COVERAGE GAPS

- Retroactive date advancement
- Cancellation or nonrenewal by insurer or insured
- Replacement of claims-made policy with occurrence policy

Retroactive Date Advancement

Retroactive date advancement is a situation in which a policy's retroactive date is later than the date the policy it is replacing (e.g., expiring policy retroactive date: 1/1/10; renewal policy retroactive date 1/1/11). Although it is rare for an incumbent insurer to offer a renewal policy with a later retroactive date, insurers occasionally do so. The example in Exhibit 7.2 demonstrates the effects of a later retroactive date advancement in a replacement policy.

EXHIBIT 7.2
THE EFFECT OF RETROACTIVE DATE ADVANCEMENT



An insured had five consecutive, 1-year policies written by XYZ insurance company from January 1, 2007 to January 1, 2012. All five of the policies in force during this time contained a January 1, 2007 retroactive date. On January 1, 2012, the insured decides to change insurers. The new insurer offers a policy with a January 1, 2012 to January 1, 2013 term that contains a January 1, 2012 retroactive date. The advanced retroactive date will preclude coverage for claims from wrongful acts that took place before January 1, 2012 (the new retroactive date), if claims produced by those acts are made during the January 1, 2012 to January 1, 2013 policy period.

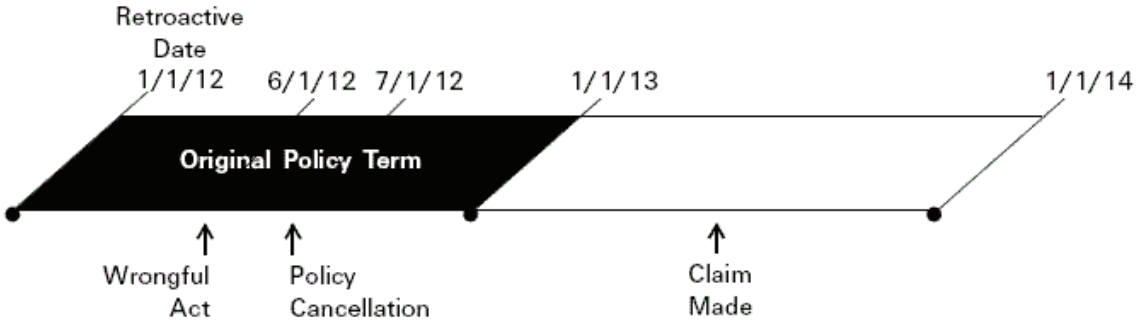
In this example, the claim made against the insured during the replacement insurer's policy will not be covered by that policy. This is because the wrongful act that gave rise to the claim resulted from a wrongful act that took place prior to the replacement insurer's 1/1/12 retroactive date. On the other hand, had the retroactive date remained at January 1, 2007, claims made during the new January 1, 2012/2013 policy period—that resulted from wrongful acts taking place on or after January 1, 2007—will be covered.

Cancellation or Nonrenewal by the Insurer or Insured

The second way in which a coverage gap can be created is if an insurer (or insured) decides to cancel or nonrenew a policy written on a claims-made basis and the insured does not replace the policy. The gap results because there will be no coverage for claims arising from wrongful acts that took place during the term of the now-expired/canceled policy period that are made against the insured after the policy has expired/been canceled (unless the insured has exercised a specific discovery provision for that expiring policy). Exhibit 7.3 illustrates this situation.

EXHIBIT 7.3
COVERAGE GAP CAUSED BY NONRENEWAL OR CANCELLATION

Original Policy Term: January 1, 2012/2013
Retroactive Date: January 1, 2012
Policy Cancellation Date: July 1, 2012



Note that there is no coverage for the claim because, although the wrongful act took place *before* the policy was canceled (and after the retroactive date), the claim was not made until *after* the policy had been canceled.

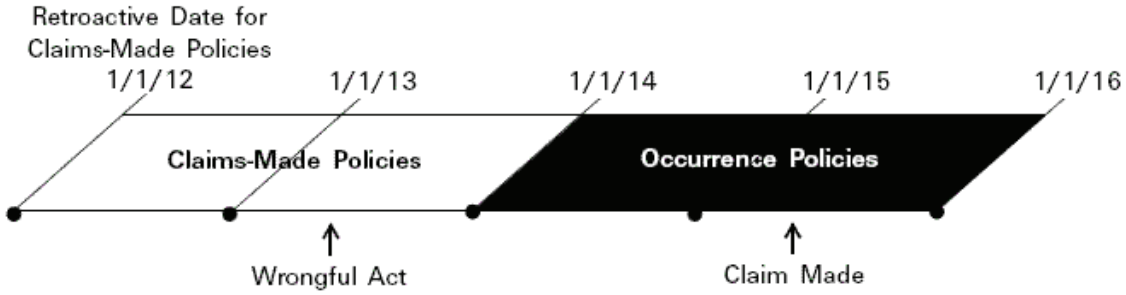
The third event that can create a coverage gap is when an insured switches from a claims-made to an occurrence policy (although this is an unusual event). This is because there will be no coverage for

claims that result from wrongful acts that took place *before* the inception of the occurrence policy, which are made *during* the term of the replacement occurrence policy. Exhibit 7.4 illustrates this situation.

EXHIBIT 7.4
CHANGE FROM CLAIMS-MADE TO OCCURRENCE POLICY

This exhibit illustrates how a coverage gap is created when changing from a claims-made policy to an occurrence policy. The insured would have no coverage for the claim indicated below under any of the policies.

Policy Date	Retro Date	Coverage Trigger
January 1, 2012–January 1, 2013	January 1, 2012	Claims-made
January 1, 2013–January 1, 2014	January 1, 2012	Claims-made
January 1, 2014–January 1, 2015	N/A	Occurrence
January 1, 2015–January 1, 2016	N/A	Occurrence



None of the four policies noted in Exhibit 7.4 would cover the claim, for the following reasons.

- **No Coverage under Claims-Made Policies**. The January 1, 2013/2014 claims-made policy had expired on the date the claim was made. Coverage under this policy will apply only if the claim is made against the insured between 1/1/13 and 1/1/14. The fact that the wrongful act producing the claim took place during this time period is of no bearing in determining coverage. For coverage to apply to the wrongful act, a claim associated with that wrongful act must be made during the term of a claims-made policy.
- **No Coverage under Occurrence Policy**. The January 1, 2015/2016 occurrence policy would not cover the claim because the wrongful act giving rise to the claim occurred before the inception of the policy. Under an occurrence policy, coverage is triggered by the occurrence of a wrongful act—not by the making of a claim associated with that wrongful act.

Chapter 7 Review Questions

1. Thomas Train has had three professional liability policies from three *different* insurers covering these dates: Policy A—June 1, 2010–June 1, 2011; Policy B—June 1, 2011–June 1, 2012; and Policy C—June 1, 2012–June 1, 2013. Policies A and B have a retroactive date of June 1, 2010, and Policy C has a retroactive date of June 1, 2012. An error or omission likely to result in a claim occurred on March 11, 2011. Thomas informed his insurer of the incident on May 11, 2011. A claim was made against Thomas on July 11, 2012 based on the March 11, 2011 incident. Based on this information:

   a. coverage applies under Policy A.

   b. coverage applies under Policy B.

   c. coverage applies under Policy C.

   d. no coverage applies.

2. Perry Winkel retired on June 1, 2013 and did not renew his professional liability coverage. Before retiring, he had professional liability policies from three different insurers covering these dates: Policy A—June 1, 2010–June 1, 2011 (claims-made policy); Policy B—June 1, 2011–June 1, 2012 (claims-made policy); and Policy C—June 1, 2012–June 1, 2013 (occurrence policy). Both claims-made policies had retroactive dates of June 1, 2010, and neither had a discovery provision. An error or omission likely to result in a claim occurred on March 11, 2011 but no claim based on that incident was made until September 11, 2012. Based on this information, it is most likely that:

   a. coverage applies under Policy A.

   b. coverage applies under Policy C.

   c. coverage applies under Policies A, B, and C.

   d. no coverage applies.

Answers to Chapter 7 Review Questions

1. a. Coverage was triggered under Policy A, when the incident likely to produce a claim was reported to the insurer on May 11, 2011. Under that policy's discovery provision, coverage for the claim will apply under Policy A, regardless of how far in the future the incident matures into a formal claim.

2. d. No claim was made during the term of a claims-made policy, and no occurrence took place during the term of the occurrence policy.

Chapter 8
Closing Coverage Gaps in Claims-Made Policies

Chapter 8 explains how to close the three types of coverage gaps, discussed in the preceding chapter, that are sometimes created within claims-made coverage triggers. The two methods of closing these gaps include (1) purchasing an extended reporting endorsement or (2) obtaining prior acts coverage in a replacement policy.

Extended Reporting Periods

Purchasing an extended reporting period (ERP) endorsement is the first method of closing gaps in claims-made coverage. An ERP permits an insured to report claims that are made after a policy period has expired or been canceled, provided the wrongful act giving rise to the claim took place during the expired/canceled policy term. (ERPs are sometimes referred to as and are synonymous with the terms "reporting tails" and "tail coverage," although this course will not use that terminology.)

Using an Extended Reporting Period to Close Coverage Gaps

Exhibit 8.1 provides an example of how an extended reporting period can be used to close a coverage gap.

There are two important points that should be observed about the example in Exhibit 8.1.

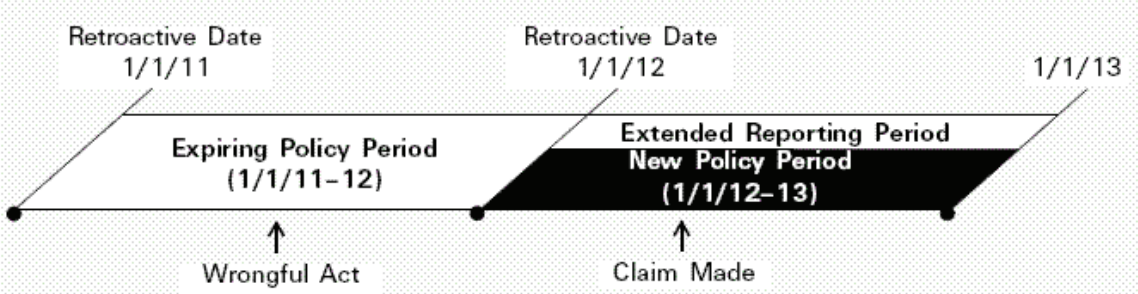
- **Wrongful Act Must Take Place Prior to Policy Expiration**. Extended reporting provisions apply only if the wrongful act took place before termination of the policy. Thus, there is no coverage under an ERP if the wrongful act is committed during the ERP. Accordingly, in Exhibit 8.1, had the wrongful act taken place during the ERP, there would be no coverage for the resulting claim—despite the fact that the claim was also reported to the insurer during the ERP.
- **Limited Time Period**. Extended reporting provisions typically apply for a limited period of time. The example in Exhibit 8.1 depicted a 1-year ERP. Most professional/executive liability extended reporting provisions are for 1 year. Occasionally, insurers will offer, and insureds will purchase, ERPs of longer duration. As a result, in Exhibit 8.1, which depicted a 1-year ERP, there would have been no coverage for the claim, if, for example, it had been reported after the ERP expired on 1/1/13 (unless the insured had purchased an ERP of longer than a 1-year duration).

Important Extended Reporting Period Terms

There are several key aspects of extended reporting period provisions that should be reviewed carefully. Each of these items will be discussed in more detail in succeeding paragraphs.

EXHIBIT 8.1
APPLICATION OF AN EXTENDED REPORTING PERIOD

The following scenario provides an example of how such an extended reporting provision operates.



Expiring Policy Period: January 1, 2011–January 1, 2012
Retroactive Date: January 1, 2011
Extended Reporting Period: One Year

New Policy Period: January 1, 2012–January 1, 2013
Retroactive Date: January 1, 2012

In this situation, the insured would have coverage under the January 1, 2011/2012, policy for the claim, despite the fact that the claim was *made* during the January 1, 2012/2013, policy period. This is because the extended reporting endorsement covers claims made during the 1-year period following the January 1, 2011–January 1, 2012, policy's termination.

Insured's Right To Purchase an ERP

The vast majority of insurers' policies provide an extended reporting period if cancellation or nonrenewal is at either the insured's or the insurer's option. This is known as a two-way or bilateral ERP.

At one time, a significant minority of insurer's forms only offered an ERP if the insurer opted to cancel or nonrenew the policy. This is known as a one-way or unilateral ERP. However, given a competitive professional/executive liability market since the early 2000s, policy forms providing a one-way ERP have become a rarity.

Clearly, two-way ERPs are much more advantageous for an insured, compared to a one-way ERP. This is because if an insured decides to change insurers, there will be an automatic coverage gap unless it is able to buy an ERP. However, this is not permissible under a policy containing a one-way ERP provision, since, under such policies, an insured can purchase an ERP only if the insurer cancels or nonrenews a policy. These circumstances make it extremely difficult for an insured to change

insurers, unless the current insurer decides to cancel or non-renew. Accordingly, insureds should not accept a policy form containing a one-way ERP provision.

Duration of ERP

As already noted, most commonly, professional/executive liability policy forms offer an ERP of 1 year's duration. However, ERP provisions are occasionally worded so that the insured has the option of selecting one of several different ERP lengths. Of course, this is advantageous for the insured, because, depending on an insured's business situation and assessment of potential exposure to claims, it can select the ERP duration option it considers best.

ERP Pricing

Premiums for ERPs vary, but generally fall between 50 percent and 150 percent of the expiring policy's annual premium, for a 1-year ERP. The premium the insurer will charge for the ERP should always be specified in the policy (as a percentage of the current premium). However, professional liability policies sometimes contain ERP provisions noting that premiums will be determined "according to the company's rules and rates at the time the extended reporting period is purchased." Unfortunately for the insured, such a provision functions as a "blank check" for the insurer—a situation that is not in an insured's best interests. This underscores the need to agree on specific pricing of an ERP *prior* to policy inception, if a specific premium is not enumerated in the policy.

Time Allowed To Purchase ERP

Some policies grant as many as 60 days in which to purchase an ERP following expiration of the policy. However, 30 days is the most common period of time (following expiration of the policy) in which the insured is given to make the election to purchase an ERP. Of course, the longer the period of time available to exercise this option, the better for the insured.

No Reinstatement of Limits

Virtually all ERP provisions state that purchasing an ERP does not "reinstate" policy limits. For example, assume an insured purchased a professional liability policy with a $1 million aggregate limit. Also assume that during the policy term a claim was made against the insured and that the insurer paid $250,000 for legal expenses and settlement costs in conjunction with that claim. If, at the expiration of the policy, the insured purchases an ERP, only $750,000 of coverage will be available for any claims reported during the ERP. Therefore, no additional limits will be added to the ERP simply because actual (or potential claim dollars) have been/will be paid, in conjunction with claims made during the expiring policy period.

Automatic Extended Reporting Provisions

Under some professional liability policies (although rarely under executive liability policy forms), insurers make available what are termed "automatic" ERPs. These provisions operate in a manner identical to standard ERPs, with three differences. First, they apply for only limited periods of time, typically 30 or 60 days following cancellation or nonrenewal of the policy. Second, they are offered at no additional premium charge. Obviously, such provisions are favorable for insureds. Third, under most policies, automatic ERPs are offered on a one-way basis (i.e., they are available only if cancellation or nonrenewal is at the insurer's option), while under a minority of forms they are offered on a two-way basis (i.e., they are available regardless of whether cancellation or nonrenewal is at the insurer's or the insured's option).

Coverage for "Notice of Circumstances" during ERP

A key variation between the ERPs in professional/executive liability forms is whether a report of circumstances or incidents that have the potential—but have not yet resulted in a formal claim against the insured—are covered by an ERP. In effect, under some insurers' ERP wording, the policy's discovery provision is operative, whereas in others, it is not.

Case in point: a D&O liability policy expires on January 1, 2012, at which time the organization buys a 1-year ERP. On August 1, 2012, the organization becomes aware of circumstances that could potentially materialize into a formal claim, but have not yet. Under some insurers' ERP wording, the report of circumstances to the insurer would trigger coverage. However, under other insurers' ERP wording, no coverage would apply until the organization has a formal claim made against it. Given this situation, the insured would be compelled to purchase another ERP at the expiration of the current ERP, if the potential claim had not yet been made against the company—but a claim was expected at some point.

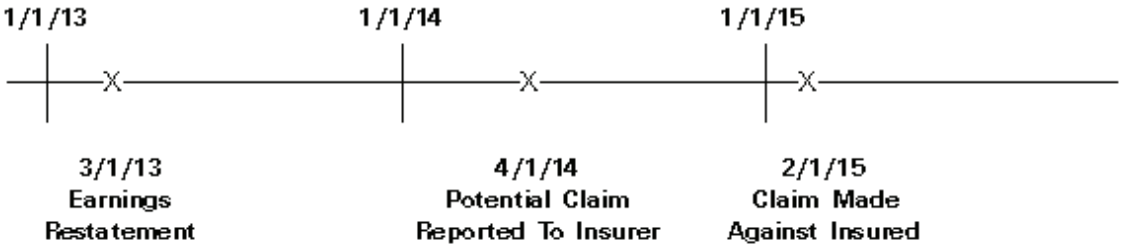
One key caveat is that under *no insurers' forms* will coverage apply if the wrongful act that gave rise to the claim *also* took place during the ERP. Rather, under all ERPs, the wrongful act must always take place during the expired or canceled policy period that preceded the term of the ERP. For example, after the expiration of its January 1, 2013-14 D&O policy, a corporation buys an ERP with a January 1, 2014 to January 1, 2015 term. On March 1, 2014, the corporation acquired the XYZ Company. As part of the acquisition, it agreed to pay XYZ's stockholders $500 per share. On July 1, 2014, the corporation is named a class action lawsuit, alleging that the company's directors and officers vastly overpaid XYZ's stockholders as part of the acquisition deal. In this instance, no form of ERP would provide coverage because the wrongful act that gave rise to the claim—the agreement to pay XYZ shareholders $500 per share—took place during the ERP, rather than during the expired policy period. This concept is illustrated in Exhibit 8.2.

EXHIBIT 8.2
COVERAGE/LACK OF COVERAGE FOR "NOTICE OF CIRCUMSTANCES" DURING AN ERP: TWO EXAMPLES

Example #1: Coverage Applies

- Policy Term: 1/1/13–14
- ERP Term: 1/1/14–15
- Date of Earnings Restatement: March 1, 2013
- Date Potential Claim Reported: April 1, 2014
- Date Claim Made: February 1, 2015

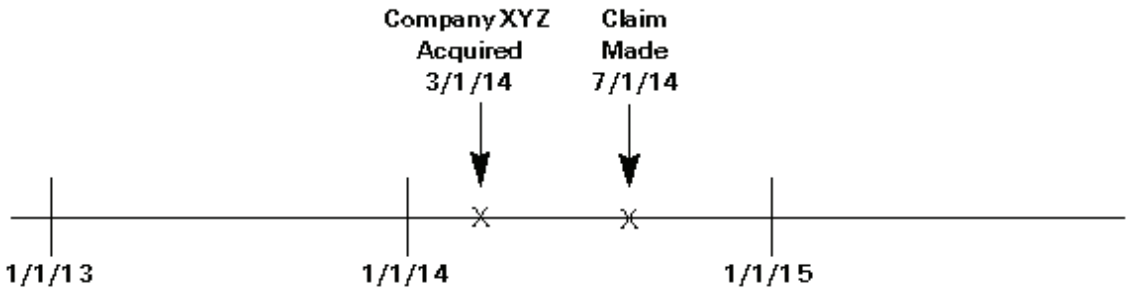
Coverage applies because the act giving rise to the claim (the earnings restatement) took place during the policy period *and* notice of these circumstances was reported to the insurer during the ERP. The fact that the claim was made against the insured *after* the ERP expired does not affect the application of coverage under the ERP.



Example #2: Coverage Does Not Apply

- Policy Term: 1/1/13–14
- ERP Term: 1/1/14–15
- Date Company XYZ Acquired: March 1, 2014
- Date Claim Made: July 1, 2014

Coverage does not apply because the wrongful act giving rise to the claim—the acquisition of Company XYZ at an inflated price—took place during the ERP, rather than during the 1/1/13–14 policy period. No coverage applies unless the act giving rise to the claim took place during the original policy period.



Situations in Which Purchasing an ERP Is Prohibited

A few insurers' forms bar insureds from purchasing ERPs in certain situations, despite the fact that ERPs would otherwise be available. For the most part, these restrictions apply in situations where previous or expected moral hazard could be considered a problem. Specifically, the following are the most common instances in which an insured may be prohibited from purchasing an extended reporting period:

- cancellation of the policy due to nonpayment of premium,
- cancellation resulting from failure to reimburse deductible amounts for previous claims,
- cancellation due to breach of policy conditions (e.g., material, intentional misstatements on the application), or
- suspension/revocation of an insured's professional license.

Such restrictions are justifiable given the problems that could result if such an insured were permitted to buy an ERP.

Restrictive Extended Reporting Provisions

As discussed previously, some insurers offer merely a one-way tail, whereby an ERP is available only in the event that the insurer—rather than the insured—cancels or nonrenews the policy. However, some insurers offer an even more restrictive version of the one-way tail by also including language stating that an offer to renew a policy at a different premium does not constitute nonrenewal. Such provisions are unfair because, in the event that an insurer no longer wished to cover a specific insured and also wanted to avoid the necessity of providing ERP coverage, it could, for example, simply triple the renewal premium. Under these conditions, the insured would have no choice but to nonrenew and would therefore be unable to purchase an ERP.

Another variation of this provision also considers renewal quotations with different deductible amounts, policy limits, or policy provisions, as not constituting nonrenewal by the insurer. Thus, if an insurer were to double a policy's deductible, halve the policy's limit, and add a number of exclusions that substantially restricted the scope of coverage—and the insured failed to renew—a provision of this kind would relieve the insurer of the obligation to offer an ERP under these circumstances. When such provisions are found within policies containing one-way ERPs, the results can be unfair for insureds and they should strongly object to them.

Implications of ERP Coverage Terms and Premiums

ERP coverage terms and premiums should always be discussed during purchase negotiations because little leverage remains with the insured after coverage is bound. Moreover, insurers are even less likely to agree upon broadened ERP provisions once a policy has been canceled, nonrenewed, or has expired.

Admitted versus Nonadmitted

Whether a policy is written on an admitted or nonadmitted basis also has a bearing on the breadth of ERP coverage that an insurer will be likely to offer. Nonadmitted policy forms do not require approval from the various state insurance departments in which they are written. Therefore, unlike admitted forms (which usually are required to offer broader ERP coverage), they do not need to include expansive ERP provisions and can consequently be written at a lower price. Conversely, the ERP provisions contained in admitted forms add considerably to the cost of such policies. Thus,

admitted policies tend to offer more favorable extended reporting period provisions than their nonadmitted counterparts, albeit at a higher premium.

Runoff Provisions

Like ERP provisions, runoff provisions also permit an insured to report claims (that resulted from wrongful acts taking place during prior policy periods) for a specified length of time in the future, following policy termination or cancellation. However, in contrast to ERPs, runoff provisions are typically restricted to situations in which a professional retires or reorganizes by becoming affiliated with a different professional organization. In a D&O context, runoff provisions are usually purchased when one organization acquires or merges with another; that is, the acquired company often purchases a runoff policy to cover wrongful acts that took place prior to the acquisition (but are not reported to the insurer until after the acquisition has been completed).

In other words, runoff provisions are generally not used when one insurer is being replaced by a different insurer, as is normally the case with extended reporting endorsements. Rather, they are purchased when an insured no longer offers professional services or when a business is acquired by another and ceases to do business under its pre-acquisition name.

Two Types of Runoff Provisions

There are two basic types of runoff provisions. The first type of runoff provision is written so that the insured pays a lump sum amount upon terminating his practice (or following acquisition of one corporation by another). This premium then allows the reporting of claims for a number of years thereafter, generally 3 to 6 years. The second type of runoff provision is written with renewable 1-year terms, whereby the premium in each succeeding year is lower, reflecting the reduced potential for claims against the insured. Normally, the terms of runoff provisions are not stated in policy forms. Rather, they are offered to the insured and negotiated at the time they are purchased.

Prior Acts Coverage

Obtaining replacement coverage that includes prior acts coverage is the second way in which gaps caused by claims-made policies can be closed.

Key Definitions

There is an important difference between coverage written on a full prior acts basis and coverage written on a prior acts basis.

Full Prior Acts Coverage

Insurers offering claims-made coverage with no retroactive date are providing full prior acts coverage.

Prior Acts Coverage

Insurers offering claims-made coverage with the same retroactive date as the policy it is replacing, is providing prior acts coverage.

Under both full prior acts and prior acts coverage, there will be no gaps created by the change from one claims-made insurer to another. Exhibit 8.3 illustrates this concept.

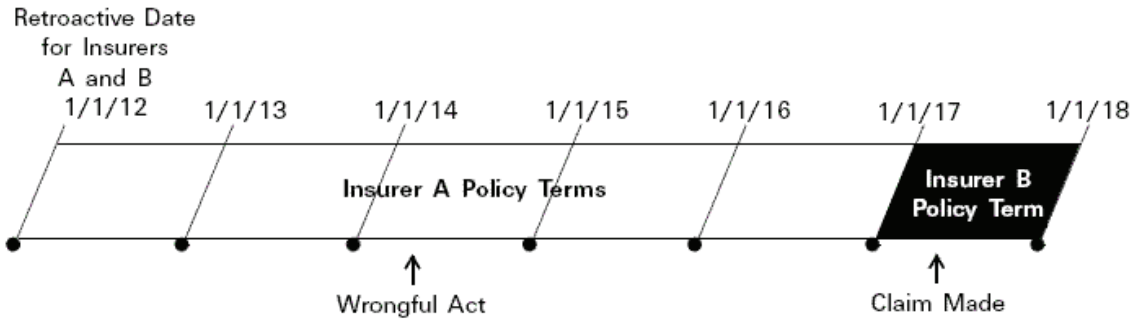
EXHIBIT 8.3
PRIOR ACTS COVERAGE IN A REPLACEMENT POLICY

Assume that a professional was insured by Insurer A during the following periods:

January 1, 2012/2013
January 1, 2013/2014
January 1, 2014/2015
January 1, 2015/2016
January 1, 2016/2017

and that the retroactive date for all five policies was January 1, 2012.

If Insurer B writes a policy with a January 1, 2017/2018 term, containing a January 1, 2012 retroactive date (the same as the policies written by Insurer A), no *new* coverage gaps are created (although the professional would still be without coverage for claims arising out of acts committed prior to January 1, 2012). This is because any claims arising out of wrongful acts that took place during Insurer A's policy will be covered under Insurer B's policy if they are reported from January 1, 2017 to January 1, 2018.



Coverage in this situation applies under B's policy because the wrongful act took place *after* the retroactive date in B's policy *and* was made during the term of that policy as well.

Alternatives to Full Prior Acts Coverage

There are several alternatives to providing full (i.e., no retroactive date) prior acts coverage.

Prior Acts Coverage with Same Retroactive Date as Prior Insurer

Most often, when an insured obtains replacement of an existing professional/executive liability policy, the replacement insurer writes a policy with a retroactive date that is the same as the insurer that it is replacing. This has the effect of preventing any coverage gaps for the insured because the replacement insurer will cover any claims that resulted from acts during the prior insurer's policy, if claims resulting from such acts are made during the replacement insurer's policy term.

Prior Acts Coverage with Same Retroactive Date as Initial PL/EL Policy

Alternatively, replacement insurers will also offer to write coverage containing the same retroactive date as the insured's first PL/EL policy. This has the effect of covering any claim resulting from a wrongful act that took place during any previous policy, provided the claim is made against the insured during the replacement insurer's policy term. This approach not only prevents any coverage gaps between the replacement policy and the previous insurers' policies, but it also assures coverage for any act that took place since the insured first began buying PL/EL insurance. This alternative is, of course, more favorable for an insured than a policy written on a prior acts basis with the same retroactive date as the prior insurer (noted above).

Limited Prior Acts Coverage

As an alternative to providing full prior acts coverage, some insurers are willing to write a replacement policy offering a limited form of coverage for prior acts. Specifically, this would cover acts that took place during a specified period of time (e.g., 1 to 5 years) prior to the inception date of the replacement policy. An approach of this kind is often a workable solution to the problem of obtaining prior acts protection when changing professional liability insurers. In most instances, 5 years of prior acts coverage would provide protection for reasonably foreseeable claims arising from acts that took place during expired policy periods. At the same time, by restricting prior acts coverage to 5 years, the insurer is not subjected to "stale" claims that could have been caused by acts far in the past.

Prior Acts Coverage Using Claims-Made Step Rates

Given the foregoing situation, some insurers will provide prior acts coverage in claims-made policies (that replace a prior insurer's policy) by using what are known as "step rates." Such rates apply on a sliding scale so that the longer the period of prior acts coverage applicable, the higher the premium rate. For example, assume that an insured seeks quotations for various durations of prior acts coverage. If this were the case, an underwriter might provide a quotation based on the table noted by Exhibit 8.4. The step rate in the right hand column indicates the amount by which the premium for a January 1, 2012/2013 policy would be multiplied to provide prior acts coverage for the corresponding number of years.

EXHIBIT 8.4
CLAIMS-MADE STEP RATES FOR PRIOR ACTS COVERAGE

Retro Date	Years of Prior Acts Coverage	Step Rate
January 1, 2007	5	2.1
January 1, 2008	4	2.0
January 1, 2009	3	1.9
January 1, 2010	2	1.7
January 1, 2011	1	1.4
January 1, 2012	0	1.0

An Example

Assume that the premium for a January 1, 2012/2013 policy with a January 1, 2012 retroactive date is $10,000. (Such a policy would afford no prior acts coverage.) Based on the step rates given in Exhibit 8.4, if the policy were instead written with a January 1, 2007 retroactive date (so as to provide 5 years of prior acts coverage), the premium would be $21,000 (i.e., $10,000 x 2.1). If the policy were written with 3 years of prior acts coverage, the premium would be $19,000 ($10,000 x 1.9).

Why Prior Acts Coverage Is Frequently Available

Although underwriters offering prior acts coverage are exposed to claims from acts that took place before they covered an insured, there are several incentives for providing insurance under these circumstances.

No Coverage for Known Incidents

Despite an underwriter's additional risk when offering prior acts coverage, insurers will do so only on the basis that the policy does not extend to any known incidents that have not yet, but could, give rise to claims in the future. This is because virtually all applications for professional/executive liability insurance require the insured to warrant that he or she knows of no incidents which could be expected to produce future claims. Accordingly, any known incidents will be specifically excluded by endorsement in a policy that offers prior acts coverage.

Limited Prior Acts Coverage Approach

There is an alternative to offering full prior acts coverage (i.e., coverage with no retroactive date). An underwriter could, for example, issue a policy with a retroactive date that is 5 years prior to the replacement policy's inception date. On that basis, the underwriter can still charge a mature claims-made premium, while limiting his or her exposure with a 5-year cut-off date. For example, referring to Exhibit 8.3, above, because Insurer B provided a policy with a 1/1/12 retroactive date, the insurer has limited its exposure to claims from wrongful acts that took place prior to January 1, 2007 (i.e., wrongful acts that took place more than 5 years prior to the inception of B's 1/1/17–18 policy will not be covered).

Higher Premiums

Offering prior acts coverage allows an underwriter to charge the insured a higher premium than could normally be justified for an ordinary first-year claims-made policy. Affording prior acts coverage gives an underwriter the right to charge what is called a "mature claims-made rate," which can often be a significant multiple of a first-year policy premium that provides no prior acts coverage. For example, in Exhibit 8.3, had the replacement insurer B provided a 1/1/17 retroactive date—instead of a 1/1/12 retroactive date—it would have had to charge a much lower premium. This is because under a policy with a 1/1/17 retroactive date, coverage would only apply to claims caused by wrongful acts taking place on or after 1/1/17. Although such an arrangement considerably limits insurer B's exposure to claims, a policy written on this basis is much less valuable to an insured, compared to one containing a 1/1/12 retroactive date.

Why Prior Acts Coverage Is Not Always Available

Although affording prior acts coverage by a replacement insurer eliminates the potential for coverage gaps when changing insurers, it is not always possible to obtain such coverage, for three reasons.

Lack of Information about Insured in Previous Years

First, many insurers believe that since they were not covering the insured during the prior years (and yet could be responsible for acts that took place during that time), they should not presently be placed in a position to assume such risks. Although insurers can obtain information about an insured's current professional practice (and are therefore in a position to make assessments about future exposures and loss potential), they cannot do so for previous years. As a result, some professional liability insurers simply refuse to provide prior acts coverage at any price.

Moral Hazard during Non-Insured Years

Second, underwriters are reluctant to furnish prior acts coverage applying to years in which the insured did not maintain insurance. Thus, when a professional who was never previously insured, requests coverage for the first time—and also requests prior acts coverage—this poses a possible moral hazard. Clearly, their sudden desire to buy insurance might suggest their intent to report a claim resulting from an act that took place from a period during which they did not maintain insurance.

An Insured's Marginal Loss History

A third reason for an underwriter to be reticent about providing prior acts coverage is an insured's marginal loss history. If the insured has reported a number of claims recently, an underwriter will be concerned about additional claims that have yet to be made, but could be at some future time. Similarly, an underwriter would also be wary if such an insured did not have a loss control in place in previous years but suddenly becomes very interested in developing one at the time that prior acts coverage is being sought.

Chapter 8 Review Questions

1. Savannah Sparrow had professional liability policies from two different insurers covering these dates: Policy A—June 1, 2010–June 1, 2011, and Policy B—June 1, 2011–June 1, 2012. She then discontinued further coverage. Both policies had a retroactive date that coincided with the beginning of their respective policy periods. Policy A has a 1-year extended reporting period endorsement. An error or omission occurred on March 11, 2011. A claim was made against Savannah on September 11, 2011. Based on this information:

   a. coverage applies under Policy A.

   b. coverage applies under Policy B.

   c. coverage applies under both Policy A and Policy B.

   d. no coverage applies.

2. Savannah Sparrow had professional liability policies from two different insurers covering these dates: Policy A—June 1, 2010–June 1, 2011, and Policy B—June 1, 2011–June 1, 2012. She then discontinued further coverage. Both policies had a retroactive date that coincided with the beginning of their respective policy periods. Policy A has a 1-year extended reporting period endorsement. An error or omission occurred on March 11, 2011. A claim was made against Savannah on September 11, 2012. Based on this information*:*

   a. coverage applies under Policy A.

   b. coverage applies under Policy B.

   c. coverage applies under both Policy A and Policy B.

   d. no coverage applies.

3. Fred has received a proposal for a new professional liability policy. In evaluating the policy's ERP provision, Fred would consider all the following ,aspects of the ERP to be favorable for him, *except*:

   a. The availability of more than just one ERP duration option.

   b. A 60-day period in which to activate the ERP provision following expiration of his policy.

   c. The actual ERP premium is specified in the policy.

   d. The option to purchase the ERP is available on a unilateral basis.

4. Dolly Llama purchased a 1-year extended reporting period (ERP) after her professional liability policy expired. During the ERP, she became aware of circumstances that could lead to a claim and reported them to her insurer, but the ERP expired before any claim materialized. In this type of situation:

   a. The notice triggers coverage under some, but not all, insurers' policies because under some insurers' ERP wording, the policy's discovery provision is operative, whereas in others, it is not.

   b. All insurers would provide coverage if a claim is eventually presented.

   c. No insurer would provide coverage if the wrongful act occurred before the ERP.

   d. No insurer would provide coverage under the ERP unless a claim is made during the ERP.

5. Although he continued to provide advice to a few long-term clients, Sam Shovel retired from active practice on June 1, 2013 and did not renew his professional liability coverage. Before retiring, he had three professional liability policies from three different insurers covering these dates: Policy A—June 1, 2010–June 1, 2011; Policy B—June 1, 2011–June 1, 2012; Policy C—June 1, 2012–June 1, 2013. All policies had retroactive dates of June 1, 2010, and none had a discovery provision. After retiring, Sam purchased a 1-year extended reporting period that took effect on June 1, 2013. An error or omission likely to result in a claim occurred on September 11, 2013 and was reported to the insurer on March 11, 2014, but no claim based on that incident was made until September 11, 2014. Based on this information:
   a. coverage applies under Policy A.
   b. coverage applies under Policy C.
   c. coverage applies under Policies A, B, and C.
   d. no coverage applies.
6. The best time for a professional to discuss her policy's ERP coverage terms and premiums is:
   a. after the current policy expires.
   b. during purchase negotiations and before the policy inception date.
   c. before the current policy expires.
   d. after the current policy has been canceled.
7. Upon her retirement, Flo Down's professional liability insurer is likely to offer to extend her coverage in which of the following ways?
   a. a 5-year runoff provision for which she will pay a lump sum.
   b. a 50-year runoff provision with premiums paid in annual installments.
   c. a 3-month extended reporting period for which she will pay a lump sum.
   d. a series of 1-year extended reporting periods with annual premiums that quadruple every year.
8. Gary Groom started his business on June 1, 2010. To date he has had three professional liability policies from three different insurers covering these dates: Policy A—June 1, 2010–June 1, 2011; Policy B—June 1, 2011–June 1, 2012; Policy C—June 1, 2012–June 1, 2013. All three policies have retroactive dates of June 1, 2010. Based on this information and assuming Policy C is currently in force, it seems that:
   a. Gary should attempt to negotiate a later retroactive date on his current policy.
   b. the insurers that issued Policy B and Policy C intended to provide full prior acts coverage.
   c. Gary has coverage for any act that took place since he first began buying professional liability insurance, provided a claim is made before June 1, 2013.
   d. the insurers that issued Policy B and Policy C probably made a mistake.

9. Stu Dent, an intern in the insurance company's professional liability underwriting department, learned in college that the principle of fortuity means you can't write insurance on a building that is already burning. Why then, he asks, are underwriters willing to issue claims-made policies with prior acts coverage that would pay claims resulting from acts that have already occurred? A veteran underwriter explains to Stu that:

   a. claims for prior acts are always denied because they invariably involve fraud.

   b. liability insurance is different from property insurance.

   c. prior acts coverage is theoretically available, but it is never purchased because the rates are prohibitively high.

   d. professional liability policies exclude potential claim incidents that are known by the insured and declared in the insurance application.

Answers to Chapter 8 Review Questions

1. a. The extended reporting period endorsement extends coverage applicable under Policy A.
2. d. The claim was made after Policy A's extended reporting period ended, and it was based on an incident prior to Policy B's retroactive date.
3. d. A bilateral option is more favorable than a unilateral option. Under the latter, the insured can buy the ERP only if the insurer, but not the insured, decides to cancel or nonrenew a policy.
4. a. Under some insurers' ERP wording, the policy's discovery provision is operative, whereas in others, it is not.
5. d. The wrongful act occurred during the ERP.
6. b. Little leverage remains with the insured after coverage is bound.
7. a. One type of runoff provision is written so that the insured pays a lump sum amount upon terminating his practice in exchange for a runoff provision that allows the reporting of claims for a number of years thereafter, generally 3 to 6 years.
8. c. A retroactive date on the current policy that is same as the retroactive date on the insured's first PL has the effect of covering any claim resulting from a wrongful act that took place during any previous policy, provided the claim is made against the insured during the replacement insurer's policy term.
9. d. Virtually all applications for professional/executive liability insurance require the insured to warrant that he or she knows of no incidents which could be expected to produce future claims, and any known incidents are then specifically excluded by endorsement.

Chapter 9
The Rationale for Claims-Made Insurance

This chapter explains why the insurance industry uses claims-made coverage triggers in professional and executive liability policies: (1) they improve the ability of underwriters and actuaries to project ultimate claim liabilities for a given book of business, and (2) they assist in determining which insurer (in a series of insurers) is liable for a specific claim situation where the date on which the wrongful act giving rise to the claim took place is unclear.

Increased Predictability of Claim Liabilities

It is inherently difficult to project the amount of money that will ultimately be paid out under a given set of insurance policies written with occurrence triggers. Under occurrence policies, coverage is triggered by a wrongful act (e.g., a physician's error), compared to a claims-made policy, where coverage would, in this instance, be triggered by the making of a claim against the physician as a result of the physician's wrongful act. Occurrence policies require an underwriter to predict expected ultimate losses in year 1, despite the fact that many of the claims applying to that policy period will not even be made for a number of years after that policy has expired.

Given the time lags between wrongful professional acts and the making of claims, underwriters offering occurrence coverage must charge a premium to cover claims that may not even be made against the insured for 10 or more years after the policy expires.

Three problems make it difficult to determine the premium that should be charged for occurrence coverage: (1) time lags in making claims against professionals and executives, (2) the problem of incurred but not reported (IBNR) claims, and (3) the fact that inflation causes insurers to underestimate their ultimate dollar liabilities on claims that require many years to close. These problems and the ways in which claims-made policies solve them are discussed in the following pages.

Time Lags in Making Claims

There are four reasons for the significant time lags between the date on which most wrongful professional acts take place and the date on which they result in claims made against professionals.

Time Necessary for Injuries/Damages To Cause Damage/Injury

Claims against attorneys who draw up wills provide a clear example of the fact that wrongful acts often do not immediately cause injuries. Assume that on January 1, 2006, a lawyer drafts a will for a client who requests that all proceeds of his estate go to his current wife. The client dies 5 years later

on January 1, 2011. When the client's will is probated after his death, it is determined that the lawyer committed an error in drafting the client's will, which allows his *first* wife to collect half the proceeds of his estate, much to the chagrin of his current wife who then sues the lawyer. In this situation, there was a 5-year lag between the date of the wrongful act and date on which the act caused injury.

Time Necessary for Injuries/Damages To Be Discovered

Claims against surgeons provide an example of the fact that there is often a lag between the time a wrongful act causes damage and the date on which the damage is actually discovered. Assume that in Year 1, a surgeon accidentally left a sponge in a patient's stomach during an operation. Although the sponge actually begins to cause damage from the moment it was left inside the patient's body, the patient does not begin to experience physical problems until year 5, when it is discovered that he now has a softball-size growth in his stomach, as a result of the sponge being left inside.

Claimants Do Not Always Seek Immediate Legal Redress

Even after discovering an injury arising out of a professional service or executive act, some people are reluctant to bring a lawsuit. There are three reasons for this:

- **Lack of Awareness.** They are not immediately aware of the true severity of the injury. For example, in the above case of the surgeon, the patient, even after being told of the growth in his stomach, may not sue the surgeon for 2 additional years, until he is advised that the growth is malignant.
- **Difficulty in Connecting Injury with Specific Professional**. They discover an injury but are initially unable to attribute it to a specific individual and therefore do not immediately make a claim. For example, the patient in this example may have had surgery performed by three different doctors within the previous 5 years.
- **Personal Relationships.** They are reticent to sue a professional with whom they have had a previously satisfactory relationship. In the case of the lawyer, the decedent's wife, even after learning of the lawyer's mistake, may be reluctant to sue immediately, given the attorney's 30-year relationship with her family.

Attorneys Intentionally Delay Filing Suit

There are several reasons attorneys delay making claims.

- **Potential Damages Increase.** In certain cases, injuries worsen substantially over time, and attorneys often feel it is advantageous to make an initial claim for a larger sum rather than increasing the size of the amount demanded as the injury or damage becomes progressively worse.
- **Increased Policy Limits.** Others, recognizing the claims-made nature of most professional/executive liability insurance coverage, are aware that over time, professionals tend to increase the size of the policy limits they maintain. Since the limit of coverage that is in force at the time the claim is made is the one that will be available (rather than the one that is in place at the time the wrongful act took place), attorneys often prefer to wait several years so a higher potential coverage limit will be available.

- **Time Created by Statutes of Limitation.** Still others wait until near the expiration of the statute of limitations simply because they are busy and have other, more immediate filing deadlines to meet. Attorneys can, however, only delay filing suit for so long. This is because all states have statutes of limitations during which time claims must be filed. Such statutes require that claims be filed within 2–4 years (depending upon the state) after the claimant discovers an injury resulting from a professional service.
- **Added Difficulties for the Defense.** Finally, delay tactics are used because as time elapses, witnesses may no longer remember details clearly. In addition, professionals tend to purge their older client files. Such factors make it more difficult to defend against allegations of professional negligence.

The IBNR Problem: Claims-Made versus Occurrence Reserving

Claims that are "incurred but not reported" (IBNR) are those which have actually occurred but have not yet been reported to an insurer. (The sum of IBNR losses plus incurred losses provide an estimate of the insurer's eventual liabilities for losses during a given period.) The following example illustrates how IBNR claims make it difficult to evaluate an insurer's ultimate dollar liability under a book of business written on an occurrence basis.

This study illustrates the difference between claim reserving, when one book of PL/EL business is written on an occurrence basis and the other is written on a claims-made basis.

Occurrence Book of Business

Assume that a professional liability underwriter's book of business consists of 1,000 occurrence policies, all having a January 1, 2006 to January 1, 2007 term. On January 1, 2007 (when the policies have expired), 15 claims under these policies have been reported to the insurer. At that point, the underwriter can set reserves for each of these claims and will, at that juncture, attempt to determine pricing for the policies that renew on January 1, 2007. However, given the known time lag between wrongful acts and the eventual making and reporting of claims, the 15 claims reported thus far represent perhaps only one-quarter to one-third of all the claims that will ultimately be made in conjunction with wrongful acts occurring during the January 1, 2006/2007 policy period. Therefore, on January 1, 2007, the underwriter has only a vague notion of what his actual loss experience for the January 1, 2006/2007 policy year will ultimately be. This is because only a fraction of the claims from that policy period have even been made, thus making it difficult to set reserves for what may—or may not be—an additional 20 to 30 claims. These estimated 20 to 30 claims constitute the IBNR problem.

Claims-Made Book of Business

Contrast this situation with a book of business written under a book of claims-made policies, for the same January 1, 2006 to January 1, 2007 policy term. On January 1, 2007, the underwriter could set up a reserve for these 15 claims that would apply to the January 1, 2006/2007 policy year. Unlike the occurrence underwriter in the preceding paragraph, the claims-made underwriter would know about most of the claims applying to the recently-expired January 1, 2006/2007 policy period and would therefore be in a better position to set reserves for the 15 claims. In effect, on January 1, 2007, he would know about perhaps 80 to 90 percent of the claims that will eventually apply to the just-expired policy period. He or she could add an additional two to five claims for those made very late in the policy period, (or during 30 or 60 day post-policy reporting windows), which have not yet been reported to the insurer. Yet, under these conditions, pricing the January 1, 2007/2008 book of

business will be done with a much greater degree of precision and confidence than for occurrence policies, because almost all of the known claims from the preceding policy year can be reserved on a fairly accurate basis.

The Bottom Line: Liabilities Easier To Estimate under Claims-Made Books of Business

This case study illustrates the problem of IBNR losses that is associated with offering occurrence policies. Despite the fact that the occurrence policies have expired, numerous claims from the just-expired 1/1/06/2007 policy year could still be made against insureds and reported to the insurer many years after expiration of the policies that expired on January 1, 2007. As already noted, this is especially common in professional liability/executive liability insurance lines, which are characterized by a long-tail exposure. However, as the case study illustrated, a book of business written on a claims-made basis almost completely eliminates this problem.

The Inflation Problem

Inflation makes it difficult for insurers to accurately estimate their ultimate dollar liabilities on claims that require many years to close. Although inflation has averaged about 3.5 to 4 percent over the past 30 years, it has been much higher/lower during a number of individual years within this time frame. Such variability therefore lessens the accuracy with which inflation can be estimated in any given year. When this difficulty in estimating inflation combines with the inherent time lags in receiving and settling professional/executive liability claims (i.e., the IBNR problem), the effects of inflation are even more pronounced under occurrence books of business than under those written on a claims-made basis.

Prejudgment Interest

Prejudgment interest refers to monies that accrue if the amount of a claimant's damages had been allowed to accumulate interest from the moment she suffered damage from the professional's conduct, but prior to an initial judgment or verdict against the professional.

Post-judgment Interest

This refers to interest that accrues following the rendering of a judgment but before that judgment is actually paid to the claimant. In the event that the defendant-professional decides to appeal a judgment, post-judgment interest continues to accrue until a final judgment is reached (i.e., until such time as the judgment is either reversed on appeal or upheld on appeal).

Inflation, in the realm of professional/executive liability underwriting, refers to the following three elements, all of which increase settlement levels over time:

- a decline in purchasing power
- changes in public attitudes
- judicial and legislative trends

The following sections illustrate why inflation makes it more difficult to evaluate an insurer's ultimate dollar liability under a book of business written on an occurrence basis, compared to a book written on a claims-made basis.

A Decline in the Purchasing Power over Time

The fact that the dollar buys more today than it will 10 or 20 years hence exerts upward pressure on claim settlement levels with the passage of time. In other words, the injury requiring $100,000 of medical treatment in 2005 will ultimately be settled for a much greater sum 10 years later, given the fact that $100,000 will not, in the year 2015, provide the same amount of treatment as it did in 2005.

Changes in Public Attitudes

These changes may manifest themselves in markedly increased jury awards and/or inflated notions on the part of claimants and their attorneys as to the value of claims against professionals. Public attitudes, as reflected in jury award levels, also affect settlement levels. This has been referred to as "social inflation." In recent decades, individuals' concepts of fault, coupled with the standards of care that the public believes they are owed by professionals and corporate executives, appear to have markedly increased the general level of jury awards in personal injury and class action claims involving corporate securities. These attitudes are also reflected in terms of higher claim frequency.

Judicial and Legislative Trends

Such factors also impact the general level of liability claim settlement levels against professionals. As an example, the joint and several liability doctrine, which is a product of common (i.e., judicially-created) law, has significantly increased liability claim payment levels.

- **Joint and Several Liability.** The joint and several doctrine comes into play when multiple defendants are held jointly responsible for causing an injury. Under this doctrine, their liability for payment of damages can be apportioned in any manner—irrespective of the degree of fault. For example, assume an uninsured motorist and a truck driver employed by a Fortune 500 company, are concurrently negligent in causing an automobile accident. Even if their degrees of fault are 90 percent and 10 percent, respectively, the Fortune 500 company, given its greater financial resources, could, under the doctrine of joint and several liability, be held legally responsible for paying the entire amount of any judgment rendered, irrespective of the organization's relatively small (i.e., 10 percent) degree of fault in causing the injury. This often happens when one of negligent parties that caused the accident is or becomes insolvent.
- **Multiple Claims from the Same Act.** Laws that permit separate claims by both injured minor claimants and by their parents, provide an example of legislative trends that influence the levels of liability claim settlements. Such suits can be separated by many years because in a number of states, the statute of limitations in personal injury cases brought by minors does not begin to run until the minor reaches majority. Thus, a professional can sometimes be sued twice for the same wrongful act (i.e., first by an injured minor's parents and later by the minor when he or she reaches the age of 21).

IBNR Compounds the Inflation Problem

It should be evident that the inflation problem compounds the IBNR problem. For example, as already noted, at the expiration of a book of occurrence policies, an underwriter can set reserves for only 20 to 30 percent of all expected claims. In addition, the underwriter can only make a rough estimate of the extent to which inflation will ultimately affect the final settlement levels of these IBNR claims—because such claims may not be reported for a number of years. Although both occurrence and claims-made underwriters must grapple with the inflation problem on their "known" claims, the claims-made underwriter need not worry about the inflation factor as respects IBNR losses because, unlike the occurrence underwriter, he or she has none.

Reporting Time Lags + IBNR + Inflation: Factors Making it Difficult To Price Coverage

Let us return briefly to the IBNR case study earlier in this chapter. On January 1, 2011, when most of the claims under the January 1, 2006/2007 occurrence policy period will probably have been reported to the insurer, the occurrence underwriter will finally have an accurate concept of what his or her ultimate liabilities will be. However, during the preceding 5 years, the underwriter has been forced to price his or her books of business for the January 1, 2007/2008; January 1, 2008/2009; January 1, 2009/2010; and January 1, 2010/2011 terms on the basis of only a rough estimate of the actual dollar loss levels experienced during the January 1, 2006/2007 period. Therefore, the combined effects of IBNR claims, coupled with inflationary forces throughout this 5-year time span, will have made it almost impossible to do little more than guess when trying to accurately price coverage in succeeding policies.

Summary

Claims-made policies overcome many of the problems caused by claim reporting time lags, the IBNR factor, and the inflation factor discussed in the preceding pages. Claims-made forms almost completely solve the difficulties posed by claim reporting lags and, in the process, also remove the threat posed by IBNR claims. Although the inflation factor is still operative as respects known claims, a book of business written on a claims-made basis is well-protected from the effects of inflation upon unknown claims—because there are usually only a relatively small number. And because they need not be overly concerned about unknown claims, insurers writing claims-made policies are in a much better position to accurately project loss levels on their current books of business and ultimately develop more accurate rates on future business, than if they wrote coverage on an occurrence basis.

In contrast, professional liability insurance written on an occurrence basis has an inherent tendency to be underpriced, given the time lag, IBNR, and inflationary factors discussed above. In the final analysis, underpricing destabilizes the professional liability insurance market, a condition that is ultimately to the detriment of all professionals seeking insurance coverage. Clearly, claims-made policies successfully overcome many of the problems caused by these factors, as witnessed by (with a few exceptions, notably medical malpractice), the relative stability of the professional liability insurance market during the past 20 years.

Ease in Determining the Responsible Insurer

The second major advantage of claims-made policies is the improved ability to determine the responsible insurer for any given loss. Historically, the insurance industry has used the date of the injury as the triggering event for the application of liability coverage.58This is known as an

occurrence coverage trigger, whereby the policy in effect at the time a loss or damage occurs must respond to any claim.

The occurrence coverage trigger works well in many instances. Two prime examples are commercial auto policies and property insurance policies—both involve loss situations in which the date of the accident is usually quickly followed by the reporting of a claim. This makes it easy to ascertain the appropriate insurer.

However, in a number of situations, it is difficult to determine which insurer, in a series of insurers is responsible for a claim. Specifically, if an injury or claim develops from a series of wrongful acts taking place over a long period of time, it is difficult to assign responsibility to a single policy if the applicable policies during this period have all been written with occurrence coverage triggers.

Complications from Occurrence Triggers: A Case Study

The following example illustrates the problem of assessing insurer responsibility under an occurrence coverage trigger. Imagine that, beginning on January 1, 2006 and continuing for nearly 6 years (until December 1, 2011), an accounting firm performed annual audits of the XYZ Company. On December 15, 2011, XYZ declares bankruptcy. On December 31, 2011, the accounting firm receives a claim by a number of persons (i.e., in a class action suit) who purchased XYZ stock during the preceding 6 years. The claimants allege that the accounting firm's audits within that time failed to reveal the true financial condition of XYZ and that, throughout this period, XYZ had been in severe financial difficulty. During this time, the accounting firm was insured by occurrence policies with three different insurers. Under this scenario, it would be almost impossible to assign responsibility for the claim to a single insurer. On the other hand, had the policies been written with claims-made coverage triggers, the insurer covering the accounting firm at the time the claim was made (December 31, 2011) would be the one responsible.

However, in the absence of claims-made coverage in such situations, courts tend to decide that the insured is entitled to the broadest possible scope of coverage. For example, assume the three insurers during the January 1, 2006–2012 time period were as follows.

Insurer	Policy Period(s)	Policy Limit
A	January 1, 2006/2007	$500,000
	January 1, 2007/2008	$750,000
B	January 1, 2008/2009	$750,000
	January 1, 2009/2010	$1 million
C	January 1, 2010/2011	$2 million
	January 1, 2011/2012	$2 million

"Stacking" of Limits

Based on this situation, the wrongful acts (i.e., the misstatement of XYZ's financial condition in annual audits conducted from 2006 to 2011) may reasonably be considered by a court to have taken place in each of the 6 policy years during which occurrence coverage was in force. Therefore, the accounting firm could make an excellent case that the limit available to pay the claim should be the total of the limits provided by all six policies indicated above, or $7 million.

This rationale is known as "stacking of limits," a result that was never intended by the insurance industry in such situations. On the other hand, the use of claims-made coverage triggers avoids this stacking of limits problem, so in the above example (assuming all of the policies had been written with claims-made coverage triggers), Insurer C's $2 million policy limit would be the only one available to pay the claims because that was the one in force at the time the accounting firm was sued.

Despite the clear-cut determination of coverage in the preceding paragraph, it should be pointed out that unless the retroactive date of C's policy was January 1, 2006 (or earlier), problems would arise in determining the extent to which C is responsible for the claim, given that some of the wrongful acts producing the claim probably took place prior to the time C insured the accounting firm. (In effect, unless C provided prior acts coverage back to January 1, 2006, C would not be responsible for the entire claim.)

Despite such complications, the controversies in determining coverage are usually a great deal less contentious under claims-made than under occurrence policies.

Chapter 9 Review Questions

1. One of the problems with occurrence policies from the standpoint of an insurer is that they*:*
   a. cover claims made during the policy period for occurrences prior to the policy period.
   b. cover claims made for a limited period after the policy expires for occurrences during the policy period.
   c. cover claims made long after the policy expires for events that occurred during the policy period.
   d. cover only claims made prior to the policy's expiration.
2. In 2010, real estate broker Carla Shark makes a mistake in completing her friend Squatter's real estate purchase transaction. Specifically, Carla gives Squatter a defective deed to the property he has purchased. Although Squatter is aware that the deed contains an error, he takes possession of the property regardless and does not make a claim against Shark. However, when Squatter attempts to sell the property in 2020, the error in the deed makes it impossible to sell the property. As a result, he sues Carla. Likely reasons for the delay include all of the following, *except:*
   a. Shark had been very helpful and friendly in every other aspect of the transaction.
   b. Squatter wanted immediate redress for the wrong that had been done to him.
   c. Squatter was not immediately aware how severe the problem was.
   d. Squatter was not sure whether the "little problem" was the fault of Shark, Squatter, or some other party.

3. Ignoring loss adjustment expenses, an insurer's ultimate dollar liability for claims covered by a book of professional liability insurance policies is:
   a. incurred losses minus IBNR losses.
   b. incurred losses plus IBNR losses.
   c. paid losses minus IBNR losses.
   d. paid losses plus IBNR losses.
4. As compared with occurrence policies, a book of claims-made professional liability policies:
   a. almost completely eliminates the long-tail.
   b. curls the long tail.
   c. wags the same long-tail.
   d. stretches the long-tail.
5. Alex the architect makes an error in a blueprint in 2000. His error causes a building to collapse in 2010. The claims that resulted from the collapse are not settled until 2020. Which of the following factors are likely to have an effect on the amounts for which the claims were eventually settled?
   a. Decrease in the value of the dollar.
   b. The premium levels for architects & engineers liability insurance.
   c. The number of insurers writing professional liability insurance.
   d. Licensing standards for architects.
6. The effect of inflation on claims under occurrence and claims-made liability policies:
   a. is greater for claims-made policies, because more claims are not known until some future date.
   b. is greater for occurrence policies, because more claims are not known until some future date.
   c. is identical, as both are affected by the same factors.
   d. is unaffected by IBNR claims.

Answers to Chapter 9 Review Questions

1. c. Claims applying to the policy period may be made years later.
2. b. Delaying the claim also delays any redress.
3. b. The sum of IBNR losses plus incurred losses provide an estimate of the insurer's eventual liabilities for losses during a given period.
4. a. A book of business written on a claims-made basis almost completely eliminates the long-tail problem.
5. a. The dollar's purchasing power has declined—you need more dollars now than in the past to buy or offer the same services. So if a claimant's income loss was $100,000 in 2010 when his injury occurred, his income for the same period of time would be much larger when the claim was settled in 2020.
6. b. Many claims against occurrence policies are incurred during the policy period but reported much later.

Chapter 10
Advantages and Disadvantages of Claims-Made Forms

There are both positive and negative aspects associated with claims-made forms for insurers and for insureds. Chapter 10 discusses these advantages and disadvantages.

EXHIBIT 10.1
PROS AND CONS OF CLAIMS-MADE POLICY FORMS

Insurer's Perspective

Pros	Cons
1. Price Advantage	1. Public Relations Problems
2. Retention of Insureds	2. Multi-Year Claim Exposure
3. More Accurate Loss Projection	
4. Avoidance of Disputes and Limit Stacking	

Insured's Perspective

Pros	Cons
1. Lower Premium	1. Continuity Problems
2. Stable Coverage Market	2. Captive Customer
3. Prior Acts Coverage	3. Need for Post-Retirement Coverage
4. Insurer Solvency	
5. Appropriate Limits	

The Insurer's Perspective: Pros

As noted previously, the two major advantages of claims-made policies from the insurer's standpoint are the greater ease with which losses can be projected and the avoidance of disputes among a series of insurers regarding liability for a given claim (and consequential stacked policy limits). Additionally, insurers derive two other significant benefits from policies written on a claims-made basis, as discussed below.

Marketing

From a sales standpoint, an insurer can offer an immature claims-made policy at rates that are much lower than an occurrence policy. Assuming an insured is changing from an occurrence to a claims-made policy or is just beginning a professional practice, no coverage gap would be produced by the claims-made policy. Claims-made coverage for such persons will be substantially less expensive than a policy written on an occurrence basis. This concept is illustrated in Exhibit 10.2.

EXHIBIT 10.2
OCCURRENCE TO CLAIMS-MADE POLICY CHANGES CAUSE NO COVERAGE GAPS

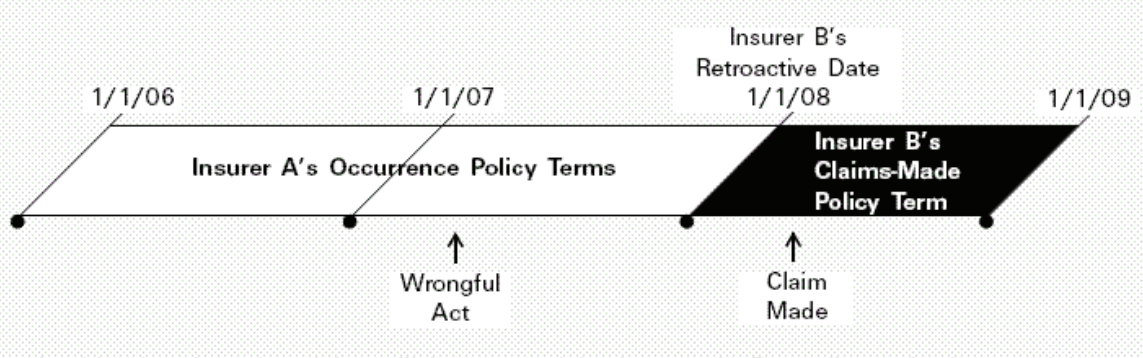
This exhibit shows how no coverage gaps are created when an insured switches from an occurrence to a claims-made policy.

Insurer A's Occurrence Policy Terms

January 1, 2006/2007
January 1, 2007/2008

Insurer B's Claims-Made Policy Term:

January 1, 2008/2009 with a retroactive date of January 1, 2008



In this situation, the claim will be covered by Insurer A. Regardless of when a claim is made under A's occurrence policy, it will be covered as long as the wrongful act giving rise to the claim occurred during either January 1, 2006/2007 or January 1, 2007/2008. As a result, no coverage gap is created by the change from an occurrence to a claims-made policy.

Retention of Insureds

As noted in Exhibit 10.1, insureds face a number of financial disincentives when changing from one claims-made insurer to another. Either it will be necessary to pay two premiums (e.g., one for ERP coverage and one for the new policy) or a "loaded" premium will be charged by a replacement insurer who offers prior acts coverage. It should be mentioned, however, that insureds do not always pay a higher premium for a replacement policy covering prior acts if the expired/canceled policy was already priced at a fully mature claims-made rate. A "fully mature" claims made rate refers to the rate applied to a claims-made policy that covers at least 5 years of prior acts. Assume a lawyer had 5 years of coverage with insurer A from January 1, 2010 to January 1, 2015. Insurer B writes a policy with a

1-year term from January 1, 2015 to January 1, 2016 that includes prior acts coverage back to January 1, 2010. In this instance, the attorney will likely be charged a "fully mature" claims-made rate.

A less expensive but equally unpalatable alternative is to secure a replacement policy that does not cover prior acts, and to not purchase the ERP in the expiring or canceled policy. The problem with this course of action is that there would be no coverage for wrongful acts that took place during the prior policy which are not reported until the new policy's term.

As indicated by the preceding paragraphs, most changes of insurers involve either additional premium costs or exposure to claims from potential coverage gaps (and sometimes both). Thus, professionals must have meaningful reasons for making such a switch. Given these disincentives to change insurers, underwriters are better able to retain profitable accounts and thereby improve the quality of their books of business.

This situation may, however, also prove to be an advantage for insureds. Because claims-made coverage makes price shopping more difficult, since the early 1990s it appears to have played some role in stabilizing the entire market, leveling rates, and ultimately avoiding the availability crises that plagued professional/executive liability coverage lines in the 1970s, 1980s, and early 1990s—time frames when occurrence-triggered policies were more common.

The Insurer's Perspective: Cons

Although claims-made policies are largely favorable to the interests of insurers, they contain several drawbacks, which are discussed below.

Public Relations Problems

However advantageous a claims-made coverage trigger is from an underwriting standpoint, the general public continues to find something intuitively wrong with the concept. Many insureds feel that if coverage is in force at the time a wrongful act takes place, protection should be afforded, irrespective of when a claim is ultimately made. Although the principles underlying claims-made insurance are becoming better understood and increasingly accepted by insureds, there is, and probably always will be, some resistance to the way the forms operate. Among other effects, this resistance has caused a number of lawsuits concerning claims-made policy provisions.

Such attitudes obligate insurers to continually assist agents and brokers in dealing with consumers of claims-made forms. Full disclosure and understandable explanations must be made to consumers by agents because it is the producer, rather than the underwriter, whose contacts serve as the true focal point in educating buyers.

Although there have been a number of legal challenges to claims-made policy provisions, public relations problems are, in fact, easing for a number of reasons. First, professional/executive liability insurance consumers are becoming more familiar with the operation of the claims-made form. Second, consumers of claims-made forms who are also professionals and business executives are more sophisticated than the typical consumer of personal lines insurance. This is especially true considering the substantial outlays required of professionals who purchase such coverage.

Exposure to Claims from a Number of Years when Writing Prior Acts Coverage

Unlike an occurrence policy that covers damage which has been caused by wrongful acts taking place in a single year, a claims-made policy covering prior acts can potentially be called on to pay claims that have resulted from wrongful acts performed during multiple years. Therefore, underwriters providing prior acts coverage must be extremely thorough in evaluating any professional liability risk. Not only must the assessment examine the nature and extent of the exposure on a prospective basis, but the underwriter must also analyze the exposure in terms of the retrospective exposure to loss. In this respect, a claims-made policy form places a heavier burden on an underwriter than does an occurrence policy, because the underwriter must view the risk from two different perspectives rather than only one.

The Insured's Perspective: Pros

Insurance buyers have difficulties in understanding that there are, in fact, some advantages inherent in a claims-made insurance policy form. These advantages are discussed below. These pros include:

- lower premium
- a stable market for coverage
- availability of prior acts coverage
- a lower risk of insurer insolvency
- the ability to update limits, commensurate with exposures that increase over the years

Lower Premium

Initially, at least, an immature claims-made policy will cost significantly less than a new occurrence policy. This can be a meaningful advantage for a professional who is just beginning a practice and often does not have a great deal of funds available to pay insurance premiums or for a start-up corporation that buys D&O coverage for the first time. (Admittedly, however, a mature claims-made policy would not cost substantially less than a comparable occurrence policy, so that the cost differential eventually ceases.)

Stable Market for Coverage

As noted in the section on insurer advantages, the fact that insureds will think twice before switching insurers should, in theory, have the effect of stabilizing the professional/executive liability insurance market. The absence of price shopping should make it easier to retain insureds, thereby preventing the "buying" of accounts and writing coverage at inadequate rates. Adequate pricing should ultimately stabilize the professional/executive liability insurance market, thereby making coverage more readily available.

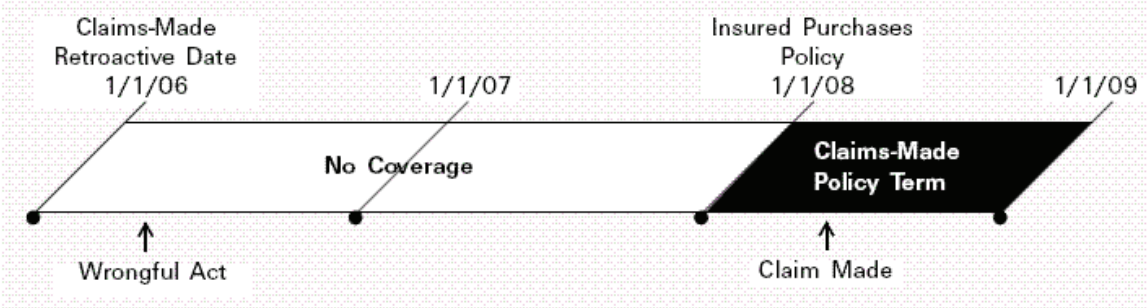
This argument is still not without holes, however. Claims-made policies have been the rule in professional liability lines for at least 40 years. Yet, during this time, especially in the 1970s and 1980s, the industry has had availability problems. This weakens the contention that a claims-made form promotes a completely stable and available market for professional liability coverages. Nevertheless, the 1990s and 2000s (except with respect to medical malpractice coverage in the mid-2000s) have not yet produced similar availability problems.

Coverage for Prior Acts

It is not uncommon for a professional to begin and continue his or her practice for several years before purchasing professional liability insurance coverage. Claims-made policy forms may be advantageous for such persons, because they can provide coverage for wrongful acts that were committed before the professional had purchased insurance (assuming such policies contain a retroactive date concurrent with the inception of the professional's practice). This concept is illustrated in Exhibit 10.3.

EXHIBIT 10.3
CLAIMS-MADE COVERAGE FOR PRIOR ACTS

Year	Insurance Coverage
2006	None
2007	None
2008	Claims-Made Policy (Retroactive Date: January 1, 2006)



In this situation, there will be coverage for the claim under a claims-made policy because the policy was in force at the time it was made, despite the absence of coverage on the date of the wrongful act.

The fact that the wrongful act in Exhibit 10.3 took place prior to the inception of the claims-made insurer's policy term is irrelevant since the 2008/2009 policy contained a January 1, 2006 retroactive date. Thus, the claims-made policy, which is written to cover prior acts (note the January 1, 2006 retroactive date), would provide coverage under those circumstances.

Admittedly, not all underwriters will be agreeable to providing a retroactive date on a professional's first policy that is concurrent with the date on which he or she first began practicing. Moral hazard is a potential problem under these circumstances, because the professional's sudden desire to purchase coverage for the first time may indicate that he or she intends to report a claim under the new policy. However, as a condition of purchasing prior acts coverage, an insured must warrant that he or she knows of no circumstances which could reasonably be expected to give rise to claims in the future, As a result, and in consideration of the additional premium that must be paid for prior acts coverage, underwriters will often agree to provide it.

Note that the lack of coverage for prior acts is a corresponding disadvantage of occurrence policies. Professionals who do not purchase insurance at the inception of their practice and then obtain an occurrence policy will have no coverage for acts performed prior to the first occurrence policy.

Insurer Solvency

The solvency factor is especially important in a long-tailed line, such as professional liability, in which an apparently solid insurer in year 1 may be in a completely different financial situation in year 10, when it will finally be called on to pay a claim. As already explained, this time lag between the inception of a policy and the actual payment of a claim is somewhat reduced with a claims-made policy, compared to an occurrence form. Ultimately, this means that professional/executive liability insurers will have a better handle on their claim liabilities which should improve the overall solvency of the industry.

Solvency Issues: Risk Retention Groups and Captives

Insurer solvency is even more critical given today's trend toward "private" insurance coverage arrangements. More specifically, the national movement to risk retention groups, captives, and similar pooling/alternative funding arrangements for professional liability lines has produced a number of fledgling and financially untested risk-bearing entities. In theory, claims-made policies should stabilize their underwriting results and, in the process, reduce insolvencies.

Insureds' Response to Insurer Financial Condition

Also related to the insurer solvency issue is the ability of insureds to react quickly to situations where a claims-made insurer is having financial problems, compared to how quickly insureds can react when such difficulties affect an occurrence insurer. For instance, assume that at the end of a January 1, 2006/2007 claims-made policy term with Insurer A, an insured is notified that A is insolvent. To close the potential coverage gap created by this situation (i.e., no coverage for claims from acts that took place January 1, 2006 to January 1, 2007 that are made after January 1, 2007), the insured can purchase a replacement policy for the January 1, 2007/2008 term that covers prior acts back to January 1, 2006. On the other hand, if the insured's January 1, 2006/2007 policy were written on an occurrence basis (and he or she replaced it with a January 1, 2007/2008 occurrence policy), he or she would have a permanent coverage gap as respects claims produced by acts committed from January 1, 2006 to January 1, 2007.

Appropriate Limits

Under an occurrence form, an insured runs the risk that the policy limit in effect at the time a claim is actually settled may be woefully inadequate, given the inflation factor discussed earlier. For example, imagine that a physician operates on a 6-year-old child in 1995. The negligent effects of the operation are not discovered until 15 years later in 2010 when the patient, now an adult, makes a claim. Assume that a judgment is rendered 5 years after the claim is made. When the claim is finally closed in 2015, the physician's $500,000 occurrence policy limit purchased in 1995 may not be sufficient to pay a judgment rendered 2 decades later. However, had the physician been covered by a series of claims-made forms during this time, he or she would have had the opportunity to increase his or her policy limits throughout this period to keep pace with inflation. Undoubtedly, his limit of coverage in 2010 (under a claims-made policy) would have been higher than the $500,000 limit that he carried under the 1995 occurrence policy.

The Insured's Perspective: Cons

As noted earlier, claims-made insurance presents several potential problems for insureds. These are discussed briefly in the following pages. These cons include:

- lack of continuity assurance
- difficulty in changing insurers
- the need to maintain coverage after retirement

Lack of Continuity Assurance

There are three situations that can give rise to coverage gaps when claims-made insurance is involved: (1) retroactive date advancement, (2) nonrenewal/cancellation, and (3) change to occurrence insurance. Each of these situations were examined in detail in Chapter 7.

Difficulty in Changing Insurers

Because it is usually difficult to change insurers once an insured is covered under a claims-made form, a reasonable argument can be made that the inherent nature of claims-made insurance inhibits an insured's freedom of choice in selecting lower cost insurance coverage alternatives (such as captives or lower-priced policies offered by other insurers), or if, for example, the insured seeks coverage with a different insurer to obtain better claims handling service.

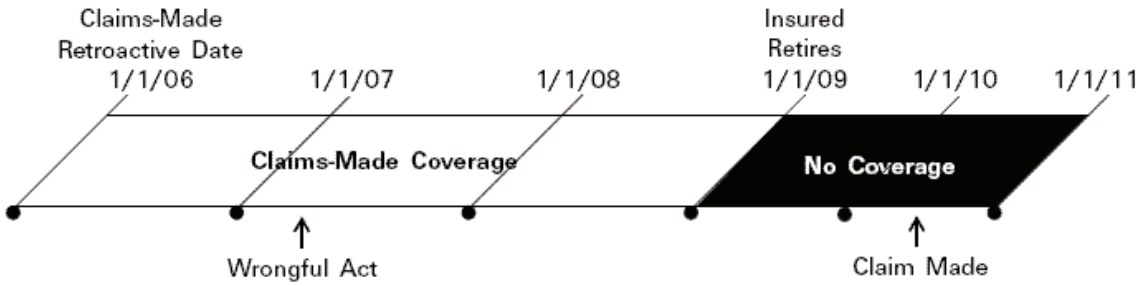
Coverage Needed after Retirement

If an insured has purchased claims-made policies throughout the term of his professional practice, it will be necessary to continue buying coverage for claims that may not be made until after he or she concludes that practice. Typically, this is handled by runoff endorsements, discussed in Chapter 8. Yet to many consumers, this seems intuitively unfair. Why?

Conversely, if a professional had been covered by a series of occurrence forms, there is generally no need to continue purchasing coverage once he or she ceases to practice. This concept is illustrated in Exhibit 10.4.

EXHIBIT 10.4
POST RETIREMENT COVERAGE

This exhibit illustrates the need to continue professional liability coverage even after retirement when the insured is covered by a claims-made policy.



The insured has consecutive 1-year claims-made policies (all with a January 1, 2006 retroactive date) for the following terms:

January 1, 2006/2007
January 1, 2007/2008
January 1, 2008/2009

If the insured retires on January 1, 2009, he or she has no coverage for claims made after January 1, 2009.

As shown in Exhibit 10.4, there will be no coverage for any claims made after the 2008/2009 policy expires, despite the fact that they were the result of acts taking place before the insured retired on January 1, 2009. Thus, the claim noted in the exhibit would not be covered unless the professional had purchased an extended reporting endorsement after the termination of his or her January 1, 2008/2009 policy. Conversely, had all the policies in Exhibit 10.4 been written on an occurrence basis, any claims resulting from acts taking place between January 1, 2006 and January 1, 2009 would be covered, regardless of when they were made.

Chapter 10 Review Questions

1. From an insurance company's perspective, the advantages of using claims-made policy forms rather than occurrence policy forms include:
   a. coverage for prior acts.
   b. more accurate loss projection.
   c. multi-year claim exposures.
   d. stacked limits.

2. John Lemon had three professional liability policies covering these dates: Policy A—June 1, 2010–June 1, 2011; Policy B—June 1, 2011–June 1, 2012; and Policy C—June 1, 2012–June 1, 2013. Policies A and B were occurrence policies; Policy C is a claims-made policy with a retroactive date of June 1, 2012. On September 11, 2012 a claim was made against Lemon alleging that a wrongful act occurred on September 11, 2010. Based on this information, it appears that:

   a. coverage applies under Policy A.

   b. coverage applies under Policy B.

   c. coverage applies under Policy C.

   d. coverage applies under Policies A, B, and C.

3. When claims-made professional or executive liability insurance is involved, the financial disincentives involved in changing from one insurer to the next have all of the following effects, *except*:

   a. Insureds find price shopping more difficult.

   b. The general public intuitively favors prefers the claims-made approach.

   c. The professional/executive liability insurance market has become more stable because it is costly for insureds to change insurers.

   d. Underwriters are better able to retain profitable accounts because it is costly for insureds to change insurers.

4. In the beginning phase of her creative accounting practice, Janice has limited funds available for insurance. In comparing claims-made with occurrence professional liability policies for a person in her situation, she will probably discover that:

   a. a first-time occurrence policy costs significantly less than a new claims-made policy.

   b. after 5 years, occurrence coverage will cost significantly less than claims-made coverage, assuming she continues to renew her initial claims-made or occurrence policy.

   c. a first-time claims-made policy costs significantly less than a new occurrence policy

   d. claims-made coverage costs more the first year than an occurrence policy when she considers the added cost of the ERP coverage.

5. Giraffe Insurance Company writes claims-made professional liability policies, rather than occurrence policies, under the theory that the use of claims-made policies improves its chances of remaining solvent and able to meet future claims. All of the following assumptions support Giraffe's theory, *except*:

   a. Insurers have a better handle on their claims liabilities with claims-made insurance compared to occurrence policies.

   b. Professional liability is a long-tailed line of insurance which is better suited to claims-made, rather than occurrence policy forms.

   c. The average time period between policy inception and the actual payment of claims is shorter with claims-made policies than with occurrence policies, which makes it easier to determine ultimate claim liabilities.

   d. Claims-made premiums are much higher, especially for immature policies.

6. A plastic surgeon opened her practice on 1/1/90. Her professional liability limits since that time were: $100,000 from 1/1/1990–95 under Policy A, $250,000 from 1/1/95–2000 under Policy B, $500,000 from 1/1/2000–05 under policy C, and $1 million from 1/1/2005–10 under Policy D. All of the policies are written without retroactive dates. In 2008, a claim is made against the surgeon, alleging that in 1990, her surgical error caused a patient to develop a tumor, which eventually resulted in his death in 2007. Assuming previous claims have not reduced the limits available, the doctor has coverage for this claim in the amount of:

   a. $100,000 because this was the limit in effect at the time of the wrongful act.

   b. $1,000,000 because this was the limit in effect at the time the claim was made.

   c. $1,100,000 because the limit that applies is the total available under Policies A , the limit in effect at the time of the wrongful act and D, the limit in effect at the time the claim was made.

   d. $1,850,000 because the limit that applies is the total available under Policies, A, B, C, and D, the total of all policies in effect from the time of the wrongful act to the time the claim was made.

7. Before retiring on June 1, 2013, Sam Iam had three professional liability policies with claims-made triggers covering these dates: Policy A—June 1, 2010–June 1, 2011; Policy B—June 1, 2011–June 1, 2012; and Policy C—June 1, 2012–June 1, 2013. Sam did not renew Policy C or do anything else to continue his coverage, because he was no longer pursuing any professional activities. On September 11, 2013 a claim is made against Sam alleging that a covered type of error or omission occurred on September 11, 2010. Sam reported the claim to his three previous insurers on December 15, 2013. Based on this information, it appears that:

   a. coverage applies under Policy A.

   b. coverage applies under Policy B.

   c. coverage applies under Policy C.

   d. no coverage applies under any of the policies because no coverage was in force on September 11, 2013, the date on which the claim was made against Sam.

Answers to Chapter 10 Review Questions

1. b. It is easier for an insurer to project the losses for which it will be responsible under a claims-made policy.
2. a. An occurrence policy covers wrongful acts that occur during the policy term.
3. b. The general public finds something intuitively wrong with the claims-made concept.
4. c. Initially, at least, an immature claims-made policy will cost significantly less than a new occurrence policy.
5. d. Claims-made premiums are lower, especially for immature policies.
6. b. The claim was made while a $1 million policy is in effect.
7. d. No coverage was in force on September 11, 2013, the date on which the claim was made against Sam.

Chapter 11
How Occurrence Coverage Triggers Operate

Chapter 11 defines the term "occurrence coverage trigger," explains how occurrence coverage triggers function in claim situations, and discusses the advantages and disadvantages they present for both insureds and insurers.

The majority of professional liability policies are written with a claims-made coverage trigger. There are, however, a few coverage lines, most notably media liability, police professional liability, medical professional, and hospital professional liability, that are occasionally offered on an occurrence basis.

There are two reasons for this. First, and especially with respect to media and police liability, there is generally a relatively shorter time lag between an alleged wrongful act and the actual making of a claim—compared to other types of professionals. For example, within days after a magazine or newspaper prints what a claimant considers to be libelous material, an immediate retraction is usually demanded. Lawsuits are typically filed within weeks, rather than months or years, after such conduct by a media insured. The same is true as respects most police "incidents" in which false arrest and/or excessive force is alleged. Accordingly, insurers in these lines sometimes provide coverage on an occurrence form. Second, and especially as respects medical and hospital professional liability, insurers will occasionally offer to write occurrence-based coverage for competitive reasons, most often in hopes of encouraging insureds to switch from their current claims-made insurer to their own occurrence policy form. For these reasons, it is necessary to discuss the nature of occurrence coverage triggers; how they apply, as well as how they differ from claims-made coverage triggers.

What is an Occurrence Coverage Trigger?

An occurrence coverage trigger in a professional liability policy obligates an insurer to defend and/or pay a claim if the claim arises from a wrongful act that took place during the period in which the policy was effective. Unlike a claims-made policy, the date on which the claim is actually made against the insured or reported to the insurer is irrelevant from the standpoint of triggering coverage. Rather, the terms and conditions of the policy that were in effect at the time the wrongful act took place are the ones that apply. This is in contrast to claims-made coverage, in which the terms and conditions of the policy in force at the time the claim is made, are the ones that apply.

Occurrence Trigger Application

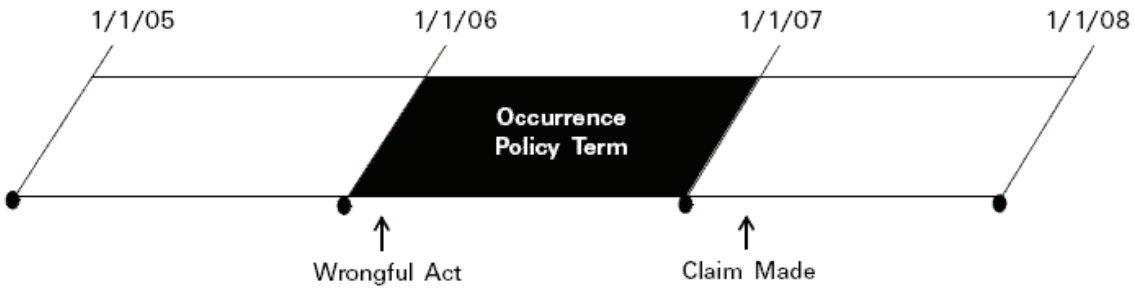
An example demonstrates how an occurrence coverage trigger functions in a claim situation. Assume an insured has a professional liability policy written on an occurrence basis with a term of January 1, 2005 to January 1, 2006. If the insured commits a wrongful act on July 1, 2005, but the resulting

claim is not made until July 1, 2010, the claim would be covered by the 2005/2006 policy, regardless of the 5-year lag between the time the wrongful act was committed and the date on which the claim was made. In other words, the date on which the claim is actually made is irrelevant to the issue of determining coverage. The date on which the wrongful act occurred—regardless of the date the damage from that wrongful act took place or was discovered—is the only date that controls the trigger of coverage. Exhibit 11.1 provides an illustration of how an occurrence coverage trigger operates.

EXHIBIT 11.1
OCCURRENCE COVERAGE TRIGGER APPLICATION

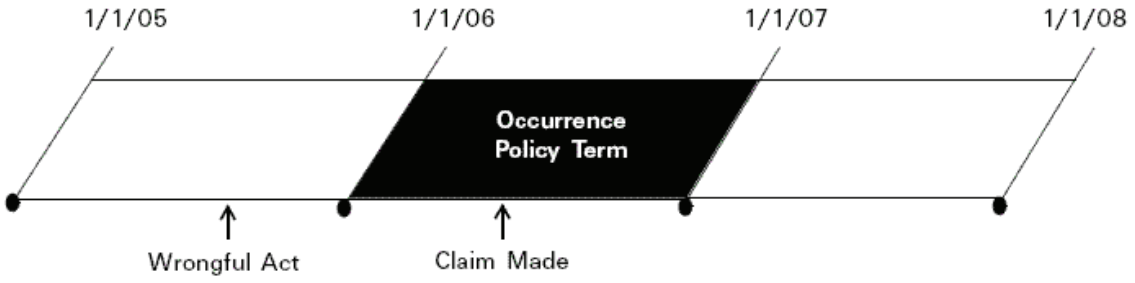
In each of the two examples noted below, the occurrence insurance policies are written with a January 1, 2006 to January 1, 2007 policy term.

Case #1 (Coverage Applies)



Coverage applies because the wrongful act occurred during the January 1, 2006 to January 1, 2007 policy term. The date on which the claim was made has no bearing on the trigger of coverage. The claim could have been made during the January 1, 2006/2007 policy period or any time after the policy had expired, and the claim would still have been covered.

Case #2 (No Coverage Applies)



Coverage does not apply in this situation because the wrongful act did not occur during the January 1, 2006 to January 1, 2007 policy period. Although the claim was made during this span of time, that fact has no bearing when determining the triggering of coverage under an occurrence policy.

Advantages and Disadvantages of Occurrence Policies

There are a number of pros and cons associated with professional liability policies written on an occurrence basis. These advantages and disadvantages are examined from both the standpoint of the insurer and the insured. They are noted in Exhibit 11.2 and discussed in the pages that follow.

EXHIBIT 11.2
ADVANTAGES AND DISADVANTAGES OF OCCURRENCE POLICIES

Insurer's Perspective

Pros	Cons
1. Underwriting Ease	1. Long-run Pricing Problems
2. Public Relations	2. Problems in Determining the Responsible Insurer

Insured's Perspective

Pros	Cons
1. Guaranteed Continuity	1. Need To Retain Policies
2. Availability of Higher Limits in Multi-Claim Situations	2. Potentially Inadequate Limits
	3. No Coverage for Prior Acts
3. Greater Freedom of Choice	4. Greater Insurer Insolvency Risk

The Insurer's Perspective: Pros

Unlike claims-made policies, occurrence forms are not, on an overall basis, beneficial for insurers. They do, however, offer some advantages.

- They are easier to underwrite.
- They are perceived in a better light than claims-made policies.
- They provide a competitive edge against other insurers that are offering a claims-made form.

Underwriting Ease

A less advanced degree of technical underwriting knowledge is needed to provide coverage on an occurrence basis than on a claims-made basis. This is because the following underwriting decisions are not required to be made when offering occurrence coverage:

- the exclusion or coverage of prior acts,
- the availability and pricing of extended reporting periods,
- the review and evaluation of information about exposures from years past (that might eventually give rise to claims), and
- the more complex rating process involved with claims-made coverages (e.g., the need to use step rates when providing prior acts coverage)

Public Relations

The concept underlying occurrence policies, compared to coverage written on a claims-made basis, is easier for most insureds, as well as many insurance professionals, to fully grasp. Moreover, insureds tend to be less familiar with claims-made policies, despite the fact that they are not a new phenomenon in professional/executive liability insurance. Therefore, fewer problems are associated with offering occurrence as opposed to claims-made policies.

The sheer volume of litigation involving the application of claims-made policy provisions (as compared to the litigation involving occurrence policy provisions), provides evidence not only that occurrence forms are significantly different from claims-made policies but also that occurrence policies are easier to market and administer.

Competitive Advantage

An insurer's willingness to write a professional liability policy on an occurrence basis might prove to be the decisive edge when competing against other insurers (that offer only claims-made coverage) for a valued account. All other things being relatively equal, most insureds would prefer to have their coverage written on an occurrence rather than on a claims-made basis.

The Insurer's Perspective: Cons

As already discussed in this course, occurrence policy forms have caused considerable difficulties for insurers throughout the years, including problems in pricing coverage and difficulties in determining the insurer or insurers responsible for responding to a claim when a series of policies have been written. These problems are discussed in the following paragraphs.

Long-Run Pricing Problems

Again, as previously noted in this course, it is difficult to project ultimate liabilities on a book of occurrence business, given the time lag, incurred but not reported (IBNR), and inflation problems discussed earlier. In extreme cases, these have led to under-pricing, financial instability, and eventual bankruptcy of a number of professional liability insurers.

Problems in Determining the Responsible Insurer

It is often difficult to ascertain which insurer, in a series of insurers, is responsible for covering a claim because the act out of which the claim arose may have taken place over a period of time, spanning several different policies and/or insurers. When a wrongful act takes place over an extended period of time, the date of the wrongful act is almost impossible to pinpoint.

Given this ambiguity, courts have taken the position that the limits of all the insurers writing occurrence coverage during periods in which a series of wrongful acts took place, apply. This produces a stacking of limits situation, which markedly expands the scope of coverage originally intended by professional liability underwriters.

The Insured's Perspective: Pros

Occurrence coverage triggers provide a number of significant advantages for insureds, such as guaranteed continuity of coverage, availability of higher limits, and greater freedom of choice among coverage alternatives. These include:

- Guaranteed continuity

- Availability of higher limits in multi-claim situations
- Greater freedom of choice

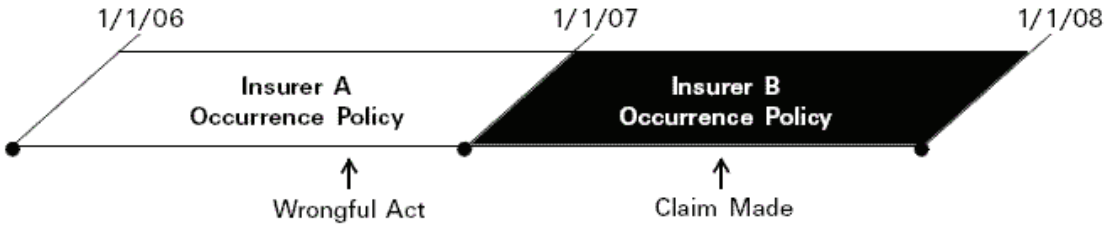
Guaranteed Continuity

The most important advantage provided by an occurrence policy is that, when moving from an occurrence policy to either a claims-made policy or another occurrence policy, there are never any gaps or uncovered exposures from prior policy periods, as long as coverage is continuously renewed. This is demonstrated in Exhibit 11.3.

EXHIBIT 11.3
OCCURRENCE POLICIES ASSURE CONTINUITY

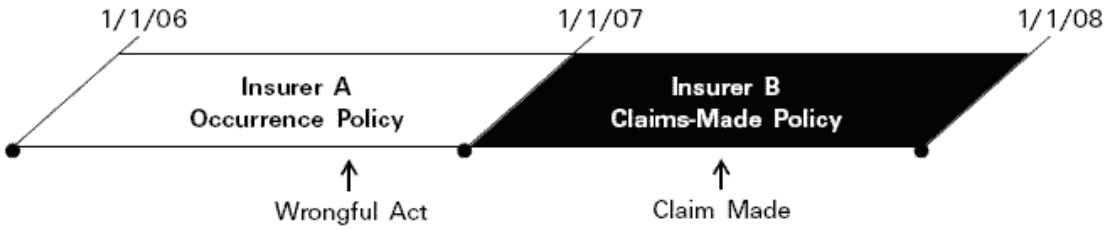
In both of the situations noted below, no coverage gaps result—despite a change of insurer.

Case #1 (Occurrence to Occurrence)



In this situation, the claim would be covered under A's policy (because the wrongful act occurred during A's coverage term), and the change to insurer B would create no gaps if coverage was continuously renewed. Regardless of when the claim is made, it will always be covered by A's policy.

Case #2 (Occurrence to Claims-Made)



In this situation, the claim would also be covered under A's policy because the claim arose of out of a wrongful act occurring during A's term of coverage. Even if insurer B's policy had a January 1, 2007 retroactive date (and did not cover prior acts), the claim would be covered under A's policy because the claim arose from a wrongful act during A's term of coverage.

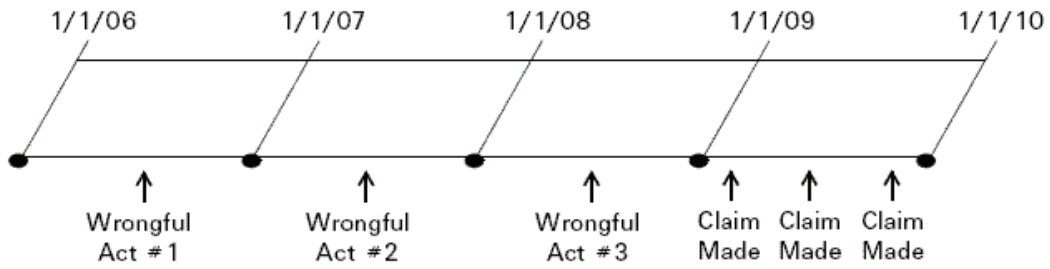
Availability of Higher Limits in Multi-claim/Multi-Year Situations

In multiple claim situations made over a period of years, occurrence policies afford insureds the possibility of having larger total and individual coverage limits available. Exhibit 11.4 demonstrates the manner in which a series of occurrence policies, compared to an analogous sequence of claims-made policies, provides both higher aggregate as well as specific limits under multiple claim scenarios.

EXHIBIT 11.4
AGGREGATION OF POLICY LIMITS FOR BOTH CLAIMS-MADE AND OCCURRENCE FORMS

Policy Terms	Policy Limits* (each claim and aggregate)
January 1, 2006/2007	$1 million
January 1, 2007/2008	$1 million
January 1, 2008/2009	$1 million
January 1, 2009/2010	$1 million

*For both an occurrence and claims-made policy



Between January 1, 2009 and January 1, 2010, one claim was made in conjunction with each of the wrongful acts that took place from January 1, 2006 to January 1, 2009.

Under Occurrence Insurance

Limit available for each claim: $1 million
Total limits available for all three claims: $3 million

Under Claims-Made Insurance

Limits available in the aggregate for all three claims: $1 million

As Exhibit 11.4 demonstrates, if all three of the claims were reported after January 1, 2009, there would be coverage in the amount of $1 million for each of the resulting claims under a series of policies written with occurrence coverage triggers. Under claims-made forms, however, the total amount of coverage available for all three claims would only be $1 million (i.e., the $1 million limit

contained in the January 1, 2009/2010 policy) because all three claims were made in the same policy year.

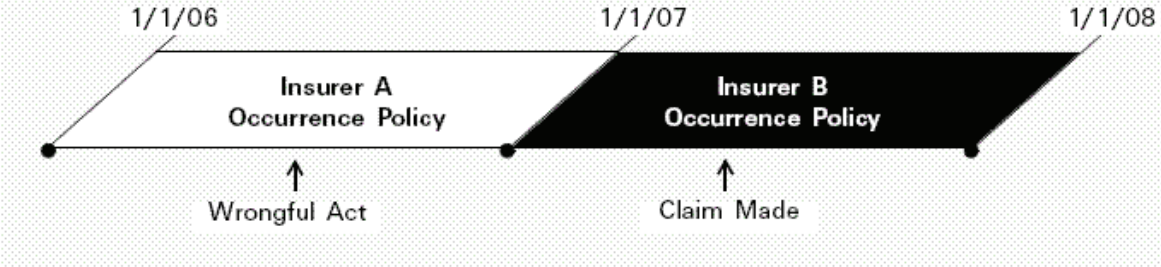
Under scenarios such as these, occurrence policies offer insureds the benefit of higher limits when multiple claims are made within a single policy year.

Greater Freedom of Choice

A strong case can be made that a claims-made coverage trigger tends to keep the insured a "captive customer" to the insurer. As has been noted throughout this course, under claims-made coverage, it is difficult to change insurers. With occurrence policies, however, there is never any such problem because the substitution of a different occurrence insurer creates no gaps in coverage and does not require purchasing either an extended reporting endorsement or prior acts coverage, as indicated in Exhibit 11.5.

EXHIBIT 11.5
REPLACING OCCURRENCE INSURERS CREATES NO COVERAGE GAPS

Insurer	Trigger	Policy Period
A	Occurrence	January 1, 2006–January 1, 2007
B	Occurrence	January 1, 2007–January 1, 2008



Coverage for the claim applies under Insurer A's policy. This would be true regardless of how many years in the future the claim is actually made.

The Insured's Perspective: Cons

There are four disadvantages inherent in occurrence policies from the insured's perspective.

- The need to retain policies
- Potentially inadequate limits
- The lack of coverage for prior acts
- Greater insurer solvency risk

Insurance Policy Retention

A minor disadvantage of occurrence policies from the insured's standpoint is the necessity of maintaining copies of all occurrence policies indefinitely. This is because there is no limit as to how far in the future a claim can be made that arose from a wrongful act which took place during a previous policy period. For instance, a claim caused by a wrongful act occurring during a January 1, 2006/2007 policy could conceivably be reported 20 years after the policy expired (on January 1, 2027). Thus, an insured professional must keep copies of all occurrence policies even after he has ceased practicing.

Again, statutes of limitation, referred to earlier in this course, mitigate this problem to some extent. However, such statutes do not begin to run when a claimant suffers an injury. Rather they begin to run when a claimant discovers an injury. In the case of a patient who has a sponge left in his stomach during surgery and doesn't discover it until a number of years later, the statute of limitations will not begin to run for some time. This often delays the filing of a claim, thereby necessitating the retention of old policy forms.

Potentially Inadequate Limits

A more meaningful disadvantage associated with occurrence policies is that the limits of such policies will not necessarily keep up with inflation and may result in an insured having inadequate limits available to respond to one or more claims.

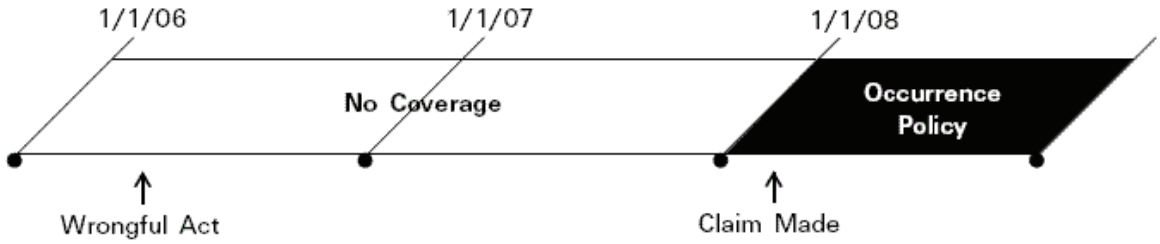
Case-in-point: an insured physician purchased a $1 million limit in a January 1, 2006/2007 policy written on an occurrence basis. Assume that a high-dollar claim associated with a wrongful act committed during this policy period is not made until January 1, 2013. In this situation, the $1 million occurrence policy limit from the January 1, 2006/2007 term will apply. However, had the physician been covered by a claims-made policy on the date the claim was made, that policy is likely to have contained a higher limit than the occurrence policy written 7 years earlier. In addition, the physician may have had one or more other, smaller claims made against him—prior to the time the large claim was made in 2013—in conjunction with wrongful acts committed in 2006/2007. Such claims would also erode the policy's $1 million aggregate limit, a fact that adds to the problem of limit inadequacy under occurrence policies.

No Coverage for Prior Acts

It is common for professionals (especially in the early years of practicing) to work initially without professional liability insurance coverage. When such individuals do purchase an occurrence policy, they will be without coverage for wrongful acts that were committed prior to the inception date of the first policy. Exhibit 11.6 depicts this situation.

EXHIBIT 11.6
NO PRIOR ACTS COVERAGE IN OCCURRENCE POLICIES

Year	Insurance Coverage
2006	None
2007	None
2008	Occurrence Policy



There is no coverage for the claim under an occurrence policy because the wrongful act giving rise to the claim took place prior to policy inception. The fact that the claim was made during the occurrence insurer's policy term is irrelevant from the standpoint of determining coverage under these circumstances.

It should be mentioned that in certain instances, occurrence insurers will write policies that include coverage for prior acts. However, under an occurrence policy form such as the one in Exhibit 11.6, coverage for prior acts does not apply.

Note that the availability of coverage for prior acts is a corresponding advantage of claims-made policies (i.e., for professionals who do not purchase insurance at the inception of their practice and then obtain a claims-made policy).

Greater Insurer Solvency Risk

Insureds with occurrence policy forms face greater risks of coverage gaps caused by insurer insolvency than when their coverage is written on a claims-made policy form. This is especially true given the long-tailed nature of professional/executive liability claims. Admittedly, states do maintain guaranty funds to pay the outstanding claims of insolvent insurers. However, these funds cannot be relied upon to make full payment of such obligations, and in most cases, these claims are "compromised" at only 10 to 40 cents on the dollar.

Two Examples

First, consider a scenario where in Year 1, when an insured buys an occurrence policy from an insurer, the insurer is in strong financial condition. Since that time, however, the insurer's financial condition began to worsen, so that by Year 4, the insured started buying coverage from a different insurer. Unfortunately for the insured, a wrongful act committed in Year 1 results in a claim that is not made against the insured until Year 5 and the claim is not settled until Year 10. But by that time the insurer is insolvent. In contrast, imagine this same scenario, except for the fact that in Year 1, the insured bought a claims-made policy from the same insurer. Also assume that in Year 4, as the insurer's financial condition began to worsen, that the insured changed to a new claims-made insurer. In this situation, when the claim was made against the insured in Year 5, the new—and solvent—insurer would be responsible for covering the claim.

A second scenario illustrates that under claims made-policies, insureds can react more quickly to situations where a claims-made insurer is having financial problems, compared to how quickly insureds can react when such difficulties affect an occurrence insurer. For instance, assume that at the end of a January 1, 2006/2007 claims-made policy term with Insurer A, an insured is notified that A is insolvent. To close the potential coverage gap created by this situation (i.e., no coverage for claims from acts that took place January 1, 2006 to January 1, 2007 that are made after January 1, 2007), the insured can purchase a replacement claims-made policy for the January 1, 2007/2008 term that covers prior acts back to January 1, 2006. On the other hand, if the insured's January 1, 2006/2007 policy were written on an occurrence basis (and he or she replaced it with a January 1, 2007/2008 occurrence policy), he or she would have a permanent coverage gap as respects claims produced by acts committed from January 1, 2006 to January 1, 2007.

Conclusion: An Occurrence versus Claims-Made Choice Is Not Often Available

Despite the disadvantages for an insured posed by claims-made versus occurrence policies, except for certain coverage lines already mentioned , insureds will virtually never be given the option of selecting a policy with an occurrence rather than a claims-made coverage trigger. In the preponderance of situations (media, law enforcement, medical malpractice, and hospital professional liability coverages are four of the few exceptions), insureds have no choice but to accept coverage written on a claims-made basis. Thus, for most classes of professional/executive liability insurance, the claims-made coverage trigger represents the only available means of insuring against potential losses.

Regardless of its drawbacks, claims-made coverage triggers are a permanent fact of life in professional/executive liability insurance. The point of this course has not been to focus on the negative aspects of claims-made coverage. Rather, it has been to explain the problems inherent in such coverage so that those difficulties can be avoided or at least minimized.

Chapter 11 Review Questions

1. The only date that is relevant in triggering the coverage of an occurrence-type professional liability policy is the date on which a:

   a. claim is made against the insured.

   b. claim is paid to the claimant.

   c. claim is reported to the insurer.

   d. wrongful act allegedly harms the claimant.

2. Clark Barr, a surveyor, has been somewhat inconsistent in maintaining his professional liability insurance. Clark has the following professional liability insurance history since he began his practice on January 1, 2000: from 2000 through 2003 he had *occurrence* coverage from Insurer A; from 2004 through 2006 he had no professional liability policy; from 2007 to the present , he has *claims-made* coverage from Insurer B that has a January 1, 2000 retroactive date. In 2008, Diane makes a claim against Clark alleging that his mistake in surveying her property back in 2005 caused her to build a home that encroaches on a highway right-of-way and must now be torn down. Based on this information, it appears that:

   a. Clark has coverage for this claim from both Insurer A and Insurer B.

   b. Clark has no coverage for this claim.

   c. Clark has coverage for the claim from Insurer A.

   d. Clark has coverage for this claim from Insurer B.

3. Claims-made policies are more difficult to underwrite than occurrence policies for all of the following reasons, *except*:

   a. long tail nature of the exposures

   b. complexity of the rating process.

   c. decisions concerning prior acts coverage or exclusions.

   d. decisions concerning extended reporting periods.

4. When moving from an occurrence policy to either a claims-made policy or another occurrence policy, there are never any gaps or uncovered exposures from prior policy periods as long as:

   a. coverage is continuously renewed.

   b. extended reporting periods are purchased.

   c. limits are increased.

   d. underwriting requirements are met.

5. A journalist is writing a professional trade magazine article concerning when certain documents can safely be discarded. Because of your insurance expertise, she asks you for advice on retaining professional liability insurance policies. Hoping she gets it right, you carefully explain that:
   a. both occurrence and claims-made policies can safely be destroyed when a professional retires.
   b. both occurrence and claims-made policies should be kept forever.
   c. occurrence policies can safely be discarded if no claim has been made by the end of the policy term, but claims-made policies should be kept until it is clear that no claim has been made during the policy term or any applicable extended reporting period.
   d. occurrence policies should be kept forever, but claims-made policies can safely be discarded once it is clear that no claim has been made during the policy term or any applicable extended reporting period.
6. After providing professional services to local and state organizations for several years, Sarah Redstate is now taking on a national account that will no doubt investigate her professional background. Although she believes nothing in her previous practice provides grounds for a professional liability claim, the client's investigation could uncover some issues. She therefore decides to purchase her first professional liability insurance policy. Which of the following factors is most relevant to Sarah's decision?
   a. It is easier with a claims-made policy to change insurers.
   b. It is easier with occurrence policies to keep up with inflation.
   c. Prior acts coverage is often available in a claims-made policy.
   d. Prior acts coverage is never available in an occurrence policy.
7. For most professions:
   a. only occurrence policies are available.
   b. only claims-made policies are available.
   c. both claims-made and occurrence policies are available.
   d. policies without coverage triggers are available from some insurers.

Answers to Chapter 11 Review Questions

1. d. The occurrence trigger obligates an insurer to defend and/or pay a claim if the claim arises from a wrongful act that took place during the period when the policy was effective.
2. d. Clark clearly has coverage for the claim made during Insurer B's policy. The claim was made against him during B's policy term and since that policy covers prior acts back to 2000, coverage applies to the wrongful acts that took place during 2005.
3. a. Both claims-made and occurrence policies deal with long-tail exposures, but the impact is more significant with occurrence policies.
4. a. This is the most important advantage provided by a claims-made policy.
5. d. There is no limit as to how far in the future a claim can be made that arose from a wrongful act during a previous policy period.
6. c. The availability of coverage for prior acts is an advantage of claims-made policies for professionals who do not purchase insurance at the inception of their practice.
7. b. Only claims-made policies are available for most professions, with the exception of some such as media and law enforcement.