Chapter 4 Claims-Made Insurance Policies

When no contract is involved, or can be implied, "fault" is often determined by the courts. Negligence is the primary reason a professional is sued. When looking at the history of the United States, we can see the expansion from strict adherence to contract law to the emergence of the concept of fiduciary duty owed by a professional to his or her client. If the professional breaches one or more of his or her fiduciary duties, he or she can be found guilty of negligence in a court of law. It is evident that the concept of negligence has loosened up and the requirements for a lawsuit have become easier to meet.

It is in a tort action for negligence that the standard of care required of a professional comes into play. Basically, the legal question asked by the courts is: "Did the professional have a duty to the client to conform to a required standard of conduct and if so, did the professional fail to conform to that standard?"

There must be reasonable evidence of negligence but that has become increasingly acknowledged in areas that were previously unheard of. In today's world, professionals are foolish not to carry some type of coverage. The name of the coverage may vary slightly but in all cases, the goal is to have claims covered if the lawsuit is successful and the costs of litigation provided by the insurance policy. A professional liability policy does not typically declare precisely what the professional must do in his or her professional activities except to say whatever you do, do it conscientiously and well. In fact, many professionals feel the policy exclusions say more about what the policy covers than the rest of the contract.

This type of liability insurance coverage may be called errors and omissions coverage (E&O), professional liability coverage or malpractice insurance. Whatever the name, the goal is to provide the individual with protection from lawsuits and the court costs that go along with that.

There are two types of professional business insurance policies: claims-made and occurrence policies. Of the two, occurrence policies are the more expensive due to how the coverage is provided. Occurrence policies carry greater risk for the issuing insurer, so they are most likely to offer claims-made coverage.

Claims-made Policy
"Claims-made" insurance policies are defined as an insurance policy that provides coverage only if a claim is made during the policy period or any applicable extended reported period. A claim made during the policy period could be charged against a claims-made policy even if the injury or loss occurred many years prior to the policy period. If a claims-made policy has a retroactive date, an occurrence prior to that date is not covered.

The extended reporting period referred to means a period of time allowing for making claims after expiration of a claims-made policy, also known as a "tail."

Occurrence Policy
An "occurrence policy" is one in which the insured has liability coverage only for injury or damage that occurs during the actual policy term, regardless of when the claim is filed. A claim made in the current policy year could be charged against a prior policy year, or may not be covered, if it arises from an occurrence prior to the effective date.

For any risk to be insurable, certain criteria must exist. The first requirement is a sufficiently large number of exposure units to make the potential loss reasonably predictable. In the case of errors and omissions insurance for example, if a significant number of professionals did not buy the insurance, it would be difficult for the insurance company to estimate future loss. The second

requirement is that the loss produced must be definite and measurable. The insurance company must be able to identify when a loss has taken place and must be able to determine the dollar amount of the loss. The third requirement is that the loss must be accidental. It cannot be an inevitable fact that each professional who is insured will be sued (although in today's world it certainly feels like that is the case). It must be an occurrence that may or may not happen. The final requirement is that the loss must not be catastrophic. In other words, the loss should not occur to a large number of policyholders at the same time. If an insurer, for example, found that a large number of a particular group of professionals were consistently sued, the company may decide to discontinue such coverage; in this case the insurer would decide that the risk of providing insurance to the professional group is too great.

The reason insurance companies are more likely to offer claims-made insurance over occurrence insurance has to do with the risk involved. Since occurrence insurance continues to be open to lawsuit payouts past the termination of the policy, insurers find it more difficult to measure their potential future losses. As the reader continues with this course, the reasons why will become clear.

Liability Awareness

In a claims-made liability insurance policy, coverage is triggered by the date the insured first becomes aware of the possibility of a claim. This awareness might be the result of a claim that is actually filed or it may be the result of a conversation with another individual demonstrating that a claim is a possibility. Whatever the case, the insurer should be notified as soon as such awareness or knowledge is acquired.

The typical claims-made policy protects the insured for wrongful acts or negligence that occur and are reported to the insurance company while the claims-made policy is in continuous force or in any extended reporting period under a tail insurance provision. As long as the insured has maintained continuous coverage, the issuing insurance company will be responsible for paying any covered claims, subject to policy limitations.

Claims-made contracts are often selected over occurrence contracts since claims-made are less expensive to purchase. Premiums are typically discounted the first few years since there may be significant time between the negligent event or omission and the time a claim is actually filed. As a result, claims-made policy premiums are structured to start out lower and then become progressively more expensive. In effect, the rising premiums are a reflection of the rising risk of a claim being filed against the insured. Pricing is typically more reliable for a claims-made policy versus an occurrence policy, so it is easier for the professional to budget for the premium costs, even when considering the increased cost over the first few years.

Since most claims-made policies provide coverage on an annual basis – that is, one year at a time – insured should never assume that their renewal policy will be identical to the ending policy. It is always possible that there could be coverage changes. If the insured decides to change to another company upon policy renewal and the ending policy does not include tail insurance to cover claims filed after the policy lapses or is canceled, this must be considered as a separate option. There are also policies known as Prior Acts Coverage, which is designed to protect the insured that had a claims-made policy immediately prior to the current policy period, but it is issued from a different insurer than the one that issued the lapsing or canceled policy. In other words, tail insurance would be issued by the company that had the original policy while Prior Acts Coverage would be issued by the newly purchased insurance company.

There is a big difference between a claims-made and an occurrence coverage policy. An occurrence coverage policy is one that provides liability coverage only for injury or damage that happened (occurred) during the actual policy term, regardless of when the claim is finally filed. Under an occurrence policy, a claim made in the current policy year could be charged against a prior policy year, and therefore may not be covered if it arises from an occurrence prior to the

effective date. In other words, under an occurrence policy the claim must have originated during the actual policy term - when the claim is finally filed does not matter – only the date the incident actually took place or occurred matters.

Claims-made policy
Claims-made policies are more rigid than occurrence policies, but claims-made contracts have gradually become the norm in the professional liability field, states Cheryl Toman-Cubbage, author of "Professional Liability Pitfalls for Financial Planners." Under a claims-made policy the insured individual is covered only for claims filed or announced (when the claim was "made") during the actual policy term. Under an occurrence policy, the insured individual is covered for any injury or damage that happened during the policy period; it does not matter when the claim itself is filed. In both cases, however, the validity of the claim is determined based on a date: either the date the claim occurred (occurrence policies) or the date the claim is filed (claims-made policies).

Occurrence policies pay based on the date the event that caused the loss occurred while

Claims-made policies look at the date the claim is actually made (filed or announced).

Occurrence policies do not provide coverage for prior acts but coverage remains available for claims that arise years after the policy has expired, as long as the event that caused the loss occurred during the time the policy was active. It is this protection against future claims that make these policies so valuable (and expensive to purchase).

Claims-made policies may reach backwards in time (based on policy language) providing coverage for claims made today from negligent acts, errors, or omissions that occurred years before the policy was even purchased. Of course, policy conditions must be met before prior acts coverage is granted. Claims-made contracts are easier for insurance companies to analyze and determine their potential profit or loss. The insurer can close a policy and determine these things immediately. Under an occurrence policy profit or loss cannot be determined since the insurer's liability (risk) continues on, sometimes for decades, because of possible incurred-but-not-reported claims.

Many professionals feel the occurrence policies are much easier to understand: if a potential loss to a client occurs during the policy term, it will be covered regardless of when the claim is actually filed. Claims-made policies are much more difficult or complex because the insured must fully understand that once the policy ends or is terminated no coverage exists, even if the claim originates from an event that happened during the policy term when coverage was active. This fact puts the writing agent in a difficult position and makes the purchase of proper coverage even more important for the buyer.

A particular disadvantage for claims-made policies happens when the buyer decides to change companies or discontinue carrying coverage altogether. The disadvantage is the necessity of following precisely the notification procedures for claims and potential claims situations. Coverage is triggered by the insured's awareness and notification to the insurer of a claim or potential claim situation. Failing to properly notify the insurer will eliminate coverage. If the insured is changing insurance companies and fails to notify either company of a potential claim, he or she could easily end up with no coverage at all when the claim is finally filed.

For example, Emily is a professional that decides to change professional liability carriers. Unfortunately she fails to notify the expiring carrier of her knowledge of a potential claim situation. Another professional has warned her that a particular client seems to like the idea of suing professionals and this person recently transacted business with Emily. This troublesome client eventually decides to sue Emily after she has made the change in claims-made coverage from one insurer to another to reduce her premium costs. Both the old and the new carrier deny coverage. The old carrier denies coverage because the potential lawsuit was not disclosed and

officially stated during the time the policy was in force. Their policy is no longer in force at the time the claim against Emily is filed. The new carrier denies coverage based upon the breach of notification requirements. In short, both companies wanted notification of the potential lawsuit and Emily failed to notify either company. Changing insurers does not need to be complicated but in order to do so without gaps in coverage, all contract provisions must be known and followed.

Leaving a profession also has its complications when it is a profession that has liability issues. In the case of insurance, for example, individuals commonly leave the insurance profession in search of greener (and easier) pastures. Emily has tired of trying to sell policies to people that seem uninterested. After two years of trying to make an insurance living Emily gets a job at a local department store and allows her insurance license to lapse. She also allows her claims-made errors and omissions insurance to lapse since it was provided by her employer. Not wishing to pay the premiums herself, she merely allows the policy lapse without seeking or buying tail insurance. With the lapse of her claims-made E&O coverage, she has no protection from lawsuits even if the bad act occurred during the time the policy was active. A year later, a previous client dies. His heirs decide that Emily committed an omission by not actively seeking to place a specific type of policy. They file a lawsuit and Emily discovers that she is without coverage and must pay the costs of litigation personally. If the family wins their lawsuit Emily will also have to pay awarded damages out of her own pocket.

It is easy to understand why insurers would prefer the claims-made policies over occurrence contracts. A claims-made policy has a specific time limit during which the insurance company has liability (risk). Under an occurrence policy, the insurance company's liability (risk) could potentially go on forever. Obviously, this is not the ideal position for the insurer, since the insurer could be held liable on a policy that expired ten years previously. The following is a quotation from an insurance textbook:

"The phenomenon of latent injury is illustrated by asbestosis, an occupational lung disease incurred by workers in a variety of industries. Persons who suffer asbestosis may not discover the injury until long after it occurs. Medical experts testify that injury occurs at the first "insult to the body" – that is, when asbestos fibers first enter the lungs. Employees who began working with asbestos in the 1950's did not discover they had the disease until the 1970's or 1980's. The insurers who provided liability coverage for asbestos manufacturers on an occurrence basis were paying for losses in the 1980's on policies that had long since expired."

In today's lawsuit prone society, it is a daily occurrence to see advertisements on television by legal groups seeking to file class action lawsuits, hoping to draw in large enough numbers of people to receive the next great payout from wrong-doers and their liability insurance carriers.

The general business professional is unlikely to be involved in the type of class action lawsuit that asbestos generated, but there is always the possibility that an unintended error could cause the filing of a claim against them. Just as automobile owners and drivers purchase liability insurance in case they cause an accident, professionals should purchase insurance coverage for their business activities. Buying business liability insurance is not an admission that an error will be made; it is protection from those "what if's" in the business world.

When considering the insurer's potential risk it is easy to understand why insurance companies are now issuing primarily claims-made liability policies:

Claims-Made Policies

Limits of Coverage

Coverage will respond to incidents arising on or after the policy retroactive date and which are reported during the term of the policy.

Prior Acts or Retroactive Coverage

Policy may be endorsed to respond to incidents that occurred prior to the policy start date. This is referred to as the policy retroactive date.

Extended Reporting (Tail Coverage)
Tail coverage provides benefits for incidents that have not been reported to the company during the policy term. Some companies offer a fee tail at retirement, subject to policy conditions. This should never be assumed by the insured; contract provisions will give exact terms of coverage.

Cost
Claims-made coverage involves a step process with premium increases over the first five years of coverage in increments proportional to the claims reporting for that experience. The initial premium and subsequent years' premiums are substantially lower than an occurrence policy, for obvious reasons. By the fourth or fifth year the claims-made premium reaches a mature level and premium adjustments are based on annual rate changes only.

Occurrence Policies

Limits of Coverage
Coverage will respond to incidents arising from the coverage period regardless of when the claims are actually reported.

Prior Acts or Retroactive Coverage
No prior acts coverage is needed due to the way the policy covers claims.

Extended Reporting (Tail Coverage)
No tail coverage is needed because incidents that occurred during the policy period are covered no matter when they are actually reported.

Cost
Occurrence coverage tends to be very expensive because the insured is pre-paying for tail costs whether the tail gets used or not.

Claims-made policies are sometimes called Discovery Policies because the contract indemnifies against all claims made (filed) during a specified period, regardless of when the actual incidents occurred causing the claims to be reported at a later date. The coverage is effective if the negligent or omitted act is discovered and brought to the attention of the insurance company during the policy term. Sometimes an occurrence policy will also be referred to as a discover policy if the negligent act or omission happened during the policy term, regardless of the date of discovery, but most agree it should only be used for claims-made contracts. Using the discovery policy term can, therefore, be confusing and it is best to use the terms claims-made or occurrence policies to avoid such confusion.

Based solely on cost, claims-made policies are the most popular. However, it is unwise to ignore the restrictions these policies carry. As an insurance agent with a claims-made policy, if you make a mistake in January that adversely affects your policyholder but your client does not discover your error until a year later, your claims-made errors and omissions policy may only cover your claim if you are still with the same insurer, both when the error happened and when the claim was filed. If you could not have known the error happened nor had any knowledge that it provoked a potential claim, your current company will likely cover it. If you knew or should have known that the incident could bring about a claim, then the new company must be notified at the time of policy application. Failure to notify the new insurer could mean neither company will cover the loss. The lapsed policy would not cover it because no claim or notification was made during the policy term. The new policy may not cover if known information regarding the possibility of the claim was withheld at the time of application.

On the other hand, if you held an occurrence errors and omissions liability policy at the time that

the error was made, you will be covered for the liability claim even if you have since abandoned the policy and allowed it to lapse for nonpayment of premium. As long as the occurrence policy was in effect at the time of the error, coverage remains. Obviously occurrence policies carry much greater risk for the issuing insurance company so the premiums will reflect this additional risk on the insurer's part.

Policy Triggers

"Trigger" is an insurance term referring to the event that activates coverage under the policy. Courts often look to trigger theories when the insured's burden to prove coverage under his or her policy seems insurmountable due to the difficulty in determining when the underlying injury or damage actually happened.

A professional liability policy has no value until a claim is filed. Until that point it is merely a promise of protection; it is the filing of a claim that gives the contract value. It is important to note that the filing of a claim does not necessarily mean that the liability policy will pay the claim. For that to happen, the claim must fall within the scope of the policy. It must be determined if the wrongful act is of the type covered and within the dates required by the policy.

Different types of insurance policies have different types of benefit triggers. In professional liability contracts it is all about the dates involved, either the date the wrongful act occurred or the date the claim is indicated or filed.

Policy triggers are tied to the date of the event or accident causing the loss and eventually the filing of the claim against the professional and their insurance company. The coverage mechanism, referred to as the trigger, is the determination that there has been a claim for loss. In the case of "occurrence" forms, the loss event must occur during the time the policy was in force and in "claims-made" forms the claim must be filed or made during the policy term. It is the date of the loss or claim that triggers policy payment, if payment is owed.

There are four generally accepted trigger-of-coverage theories:

-Exposure
-Manifestation
-Continuous trigger
-Injury in fact
-Exposure Coverage Trigger Theory

The exposure theory has primarily been applied in asbestos bodily injury cases and other events similar to this. The Forty-Eight Insulations court explained that coverage is triggered under the exposure theory when the first injury-causing conditions occur. In the case of asbestos, that would be upon the first inhalation of asbestos fibers. Of course, the claims did not show up until years later.

Manifestation Coverage Trigger Theory

The manifestation or discovery trigger activates policy coverage when the personal injury or property damage becomes known, or is discovered by the person filing the claim. Even when courts apply the manifestation theory, they do so without the consistency one would expect. Some courts consider the policy triggered when the damage is actually discovered while others consider the trigger to be when the damage could or should have been discovered.

Continuous Coverage Trigger Theory

The continuous trigger, also referred to as the multiple trigger or triple trigger, originated in asbestosis cases where bodily injury progresses and becomes more serious over time. The court in Keene Corp. v. Insurance Co. of N. Am., 667 F.2d 1034 (D.C. Cir. 1981), illustrated the origin of the multiple trigger in the following manner:

In sum, the allocation of rights and obligations established by the insurance policies would be undermined if either the exposure to asbestos or the manifestation of asbestos-related disease were the sole trigger of coverage. We conclude, therefore, that inhalation exposure, exposure in residence, and manifestation all trigger coverage under the policies. We interpret "bodily injury" to mean any part of the single injurious process that asbestos-related diseases entail.

Keene at 1047.

Owens-Illinois, Inc. v. United Ins. Co., 650 A.2d 974 (N.J. 1994), applied a continuous trigger to "the small percentage of [the insured's] asbestos related expenditures" on property damage claims. In the primarily bodily injury case, the court explained that here, where none of the parties suggested the process was anything but continuous, "claims of asbestos-related property damage from installation through discovery or remediation (the injurious process) trigger the policies on the risk throughout that period." The court refused to address when "the injurious process" ends.

Injury-in-fact Coverage Trigger Theory
When applying an injury-in-fact, or actual injury trigger, coverage under a general liability policy is triggered when the personal injury or property damage underlying the claim actually occurs. GenCorp., supra, held that the appropriate trigger for claims arising out of the disposal of hazardous waste was:

A continuous trigger employing injury-in-fact as the initial triggering event is the applicable theory in this case if GenCorp can substantiate its claim that the injuries were continuing in nature. In the absence of such a showing, injury-in-fact will be the governing trigger. In addition, since there is no indication that the initial point of injury in this case is difficult to ascertain - GenCorp's expert has even opined on the matter - it appears that injury-in-fact rather than exposure should be the event that is deemed to trigger continuous coverage. That is, depending on the evidence presented at trial, coverage will be triggered for the periods between the first point of injury-in-fact and manifestation.

Insurance Agent's E&O Claim Trigger
Some professionals feel that a subpoena is a benefit trigger for a professional's errors and omissions policy. While this is not necessarily the case, it is still wise to report the subpoena to the issuing insurer. The receipt of a subpoena by itself does not constitute a claim under most errors and omission policies but it is certainly a risk indicator of a pending claim. It is always wise to be cautious in such situations and obtain the benefit of expert advice if it is available from the insurer.

While it might seem obvious that a subpoena is a trigger for an E&O claim that is not always true. All definitions of "claim" in errors and omission policies are similar but not exactly the same; it is necessary to review precisely what the individual policy states. For example, one policy states: "Claim means a demand for monetary damages arising out of a professional service made against the insured."

In this case, the key wording is the "demand for monetary damages." The subpoena is not a demand for monetary damages, and would therefore not trigger a claim under this policy example. Even so, most policies have some mechanism to report an incident which might lead to a claim. For example, one policy states "an event about which an insured obtains knowledge which might result in a claim should be reported in writing to us." As every agent should know, it is always wise to read and fully understand a policy, and this applies to agent errors and omissions policies as well as those agents sell to the general public.

A subpoena should certainly trigger a realization that there is the potential for a demand for

monetary damages at a later date even though that is not always the case. In some cases a subpoena simply means the individual must give testimony; it does not necessarily mean the person is himself being sued. Each situation is different, and legal counsel may be necessary to determine if any liability exists.

Trigger Language

It is the contract's language that determines what is covered and what is excluded. Most claims-made contracts allow the insured to report a fact or circumstance that has the possibility of eventually leading to a claim against the insured and his or her insurer at some future date. It is extremely important that such reports be made (when allowed) where a claims-made policy is concerned since reporting of the fact or circumstance can be the difference between having coverage and lack of coverage. If the reported fact or circumstance becomes a filed claim at a later date, the insurer to whom the incident was first reported will treat the claim as having been filed during the policy term. While this may not affect the insured that remained with the same insurance company, it certainly matters to the individual who either changed companies or allowed their coverage to lapse entirely.

There have been cases where insured's attempted to cover themselves by submitting a long list of "potential claims" to their insurer as a means of self-protection. Insurance companies responded by requiring their policyholders to do the following:

-Provide specific details of the act, error, or omission that caused the circumstance for a potential future claim (eliminating vague language when reporting an incident).

-Provide the specific injury or damage that he or she feels may result in a potential future claim.

-Provide the facts by which the insured first became aware of the act, error, or omission that may bring about a circumstance that will cause a future claim.

Reporting the possibility of a future claim is typically called the "Incident Reporting Provision" (IRP) and is not the same as the claim-reporting requirement. An "incident" must be reported in sufficient detail prior to the expiration or lapse of the policy. An IRP that does not provide sufficient information will be regarded as incomplete and is unlikely to accomplish what the policyholder hoped for. Unless otherwise provided in the contract, the insured does not have any additional time to file an incident report beyond the termination of the policy.

Agents and policyholders absolutely must know and understand the difference between an incident report and a claim report. An incident report relates to the possibility of a claim whereas a claim report relates to the actual filing of a claim. A claim that is filed during the time a policy is active is covered under a claims-made policy because it was filed during the policy term. A claim will be covered within the terms of the contract even if the policy then lapses as long as it was filed during the policy term. If the claim was filed with the insured rather than the insurer, the insured may have (depending on exact policy terms) 30 to 90 days to forward the claim on to the insurer. This is true even if the policy lapses during that 30 to 90 day time frame.

Most insurance companies issuing claims-made policies use what is called the "Claims-Made-and-Reported" form for actual claims; it would not be used for incident reports. This form has been in use since the 1990's. It may vary somewhat from company to company but the foundation of the form is fairly uniform. Basically it means that not only must a claim first be made during the policy term, but to obtain policy protection it must also be reported during the policy term or during any extension period allowed under the policy (that 30 to 90 days we talked about). Issuing insurers want to pressure their policyholders into turning in claims as soon as possible and this is one of the functions of the claims-made-and-reported policy provisions.