

Understanding Your Claims-Made Professional Liability Insurance Policy

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Introduction

Until the 1970s, almost all liability insurance policies, including professional malpractice policies, were written on "occurrence" policy forms. Under such a policy form, the event, which creates the insured's liability, is also the event which triggers the insurer's contractual obligation to indemnify the insured. That event was variously defined, depending on the type of liability insurance involved, and in the case of professionals was typically defined as any act, error or omission in the rendering of, or failure to render, "professional services" as defined in the policy. In other words, the professional's mistake was the covered event, and the policy imposed no time limit for reporting claims which might arise; once the "occurrence" happened, the insurer became perpetually obligated to indemnify the insured.

In the 1970s, insurers writing professional liability insurance experienced a dramatic upswing in late-reported claims, along with an increase in the average cost of claims that reflected the high inflation of the times, as well as other growth in costs reflecting numerous broad social trends. The industry was faced with a basic inability to accurately set the price for the occurrence policy form, because most of the claims arising out of any given year's professional services would not be reported, and thus, could not be evaluated, until well after the insurer had accepted a fixed price for an open-ended promise to indemnify. Many insurers ceased writing this kind of insurance, and others decided to charge prices they deemed high enough to protect against the uncertainties of their future obligations. For many professionals, such prices were simply unaffordable.

The Modern Claims-Made Policy

As a result of these developments, virtually all insurers writing professional liability insurance switched from the occurrence policy form to the claims-made form. While this form had existed for many years, its use was generally limited to coverage for specific events or projects where any claims would become known immediately. Under a claims-made policy, the event that triggers the insurer's duty is the reporting of a claim within the policy period arising from an occurrence within the same policy period. Since the insurer's liability is not open-ended, costs can be predicted more accurately and high charges for uncertainty can be reduced.

From the insured's point of view, the claims-made form presents some problems, since it is precisely the open-ended aspect of professional liability that causes most professionals to carry insurance. While the cost of a claims-made policy would be less, thus enabling the professional to carry some type of protection, the coverage would also be less, since the annual payment bought protection for only one year, not for eternity.

Further, the claims-made form was not well suited to protecting an ongoing business or professional practice in which coverage would be renewed from year to year and protection would be required to continue indefinitely. In response to these problems the insurance industry (including, by this time, a number of captive insurers formed by the professionals themselves) made a number of adaptations to the basic claims-made policy form, in order to make it more responsive to the needs of the particular profession. For professionals today, while each company's policy form is unique in some respects, it is also true that there are basic features and issues that are common to all such policies. What follows is a brief discussion of some key topics to assist in understanding the modern claims-made form for professional liability insurance in general.

Prior Acts and Tail Coverage

When the insurance industry began converting from the occurrence to the claims-made form in the late 1970s, few professionals had to confront the issue of coverage for prior acts, errors or omissions, since their old occurrence policies provided eternal protection (at least up to their often inadequate limits of liability). When the professional purchased his first claims-made policy, that policy contained a specific date on which coverage began (commonly known as the "retroactive date"), and provided no coverage for claims arising out of occurrences that took place prior to the retroactive date. However, with each succeeding renewal of the policy, its coverage expanded to include claims arising out of occurrences during the prior periods covered under the same policy. In other words, the retroactive date remained the same, rather than moving forward with each renewal to encompass only one year's activity, as would be the traditional claims-made approach.

While this adaptation dealt reasonably well with the open-ended aspect of professional liability, it did not solve the problems which arise when insureds switch from one claims-made insurer to another. In this situation the issue is determining which company would be responsible for which claims, in cases where the occurrence took place under the earlier policy but the claim was reported under the latter policy.

The industry's initial response was to offer, for a considerable extra charge, an endorsement providing so-called "tail" coverage (adopting industry jargon describing the lag between occurrence and report of claim as the "long tail" of professional liability business). This endorsement provides an additional period of time (either limited or unlimited) in which the insured can report claims which arise from occurrences while insured with the first company. Of course, for as long as the insured continues to renew with the same company there is no need for this endorsement, for with each succeeding renewal the policy expands in terms of the number of years of practice exposure it is covering. But, when the insured switches insurers, or retires or changes the practice setting, it may become necessary to secure this endorsement. Depending on the number of years of additional reporting time that the particular insurer is willing to offer, the combination of claims-made policy with tail coverage endorsement becomes more like the old occurrence form. If the insurer offers an unlimited period of additional reporting time, then the combination is functionally the equivalent of an occurrence policy for the years covered.

Over time the industry also developed another approach, under which the new company would accept liability for claims based on occurrences under the old policy. This feature has become known as "prior acts coverage." Under this approach, the new insurer writes a policy, which either includes the retroactive date established under the earlier policy, or provides coverage for claims arising out of prior acts without any specific time limitation in the past. The latter coverage is commonly referred to as "full prior acts" coverage. For professionals today, the prior acts coverage approach is far more common than the tail coverage approach as a means of allocating responsibility for claims between the new and the old insurer. This approach leaves the old insurer responsible only for claims which were actually reported while the old policy was in effect; the new insurer assumes responsibility for all unknown claims arising out of occurrences within the prior acts period, as well as all claims arising from occurrences in the current policy period. This approach has two benefits. First, it eliminates some disputes about which insurer is responsible for a claim. Second, it encourages the early reporting of claims, thus eliminating other possible disputes and, at least in the opinion of many experts, at the same time reduces the cost of claims and enables the insurer to price its product more equitably.

It is important to know, when switching claims-made insurers, exactly what is the scope of prior acts coverage being afforded, if any. First, it should be understood that the insurer is not legally obliged to offer any prior acts coverage when an insured first takes out a policy. Most companies will not offer any prior acts coverage in the following situations:

- * The insured has not continuously carried professional liability insurance in the recent past;
- * The insured has purchased a tail coverage endorsement from its prior carrier;
- * The insured is leaving a firm to establish a new practice.

In addition, many companies will offer only limited prior acts coverage (i.e. with a stated retroactive date sometime in the past) in the following circumstances:

- * The insured purchased or otherwise obtained tail coverage at some time in the recent past;
- * The insured had a gap in coverage at sometime in the recent past;
- * The insured's current professional liability policy contains a retroactive date;
- * The insured's past practice exhibited risk characteristics deemed unacceptable by the insurer, but the current and prospective practice is deemed insurable.

Pricing Aspects of the Claims-Made Policy

When the insured obtains claims-made coverage for the very first time, the premium will be much lower than would be the cost of an occurrence policy providing the same coverage, since the former is providing coverage for only one year and only as to claims arising and reported in that same year - a much smaller obligation than is assumed under the occurrence policy. However, when the policy is renewed for a second year, the claims-made insurer's liability has grown to include claims reported arising out of occurrences in two years of practice. It is obvious in a common sense way that the insurer should charge more in the second year than in the first, all other things being equal, since the scope of its liability has expanded.

In determining how to price the first year of coverage and succeeding renewals, the claims-made insurers' actuaries closely monitor statistical data reflecting the lag time between occurrences which create liability and the reporting of claims arising out of those occurrences. In addition, they study the impact of various economic factors on the value of claims during this lag time. From this data they derive conclusions about the number of years likely to elapse before all of the claims arising out of any one "occurrence year" are reported and settled and the ultimate cost of defending and settling those claims. Depending on the profession, territory, and numerous other considerations, they then use these conclusions to establish rating factors to determine the cost of a claims-made policy as it renews each year. These rating factors are commonly referred to as "step rates" because they evolve in a stair-step pattern.

To use a simplified example, assume that with respect to the "occurrence year" 2000, the statistical analysis suggests that claims arising out of occurrences in that year will be reported in the following pattern:

Year reported	Percent Reported	Cumulative Percent Reported
2000	30%	30%
2001	25%	55%
2002	15%	70%
2003	10%	80%
2004	10%	90%
2005	5%	95%
2006	5%	100%

This table would then provide a basis for calculating the premium for each year's renewal policy. The 2000 policy would, of course, be priced to reflect the 30 percent of claims expected to be reported in that year. The 2001 policy would reflect not only the 30 percent of expected claims attributable to the 2001 occurrence year, but also the additional 25 percent expected to be reported in 2001 for the 2000 occurrence year. The process would continue for each renewal until that for the 2007 occurrence year. At that point, under these assumptions, there are no more residual claims relating to 2000 occurrences, so no charge is made for them. At this point, for premium rating purposes, the policy is considered "mature" with respect to the 2000 occurrence year and premiums will be

calculated for future renewals on the basis of a rolling seven-year period of exposure. For coverage purposes, of course, claims arising out of 2000 are still covered.

For many professionals, these aspects of pricing are more theoretical than practical issues. This is because many professionals have maintained claims-made coverage for many years, and when they switch insurers they are granted full prior acts coverage, meaning their premium rate is already mature. However, for some insureds, the early years of claims-made coverage will include significant built-in cost increases due to these step factors. Among those commonly affected are the following:

- * Insureds who had no prior coverage;
- * Insureds who became covered with a retroactive date that reflects less than the full number of years covered by step rates;
- * Insureds who have obtained tail coverage with a prior carrier.

Claims-made insurance has sometimes been described as "pay as you go" coverage, since it is premised on paying premium in relation to the claims expected to be reported in a limited period of time, rather than all claims whenever reported in the future. The step-rate feature is consistent with this description.

It is important to remember that at any given point in the process of renewing a claims-made policy, the insured has a mix of mature and immature years being covered. When, eventually, the claims-made policy is no longer renewed, but terminates, the insured will still have a need to either obtain prior acts coverage from a new carrier, if continuing in practice, or to obtain tail coverage from the existing carrier. In general, the cost of tail coverage will be related roughly to the expected cost of future claims arising out of unreported occurrences in the immature years of the policy. Some companies promise to offer tail coverage upon termination (with certain exceptions) at a premium that is guaranteed in the policy as a percentage of the premium for the last year of coverage. Other companies promise to offer tail coverage but do not specify the price. There are also differences in the number of additional years of reporting time that may be purchased.

Limits of Liability

As experience with the modern claims-made policy has grown, one of the little noticed benefits of the claims-made form has emerged.

While the old occurrence form did provide perpetual protection, it did so only for the limits of liability purchased for the year of the occurrence. That protection may be more theoretical than practical if the amount of coverage has been eroded by inflation and social trends as reflected in the costs of defense and the ultimate value of judgments and settlements. The fact that a consultant carried \$50,000 of occurrence coverage in 1970 may be of little comfort if the claim is reported and must be defended in 2007.

Under the modern claims-made policy, the limits of liability in effect at the time the claim is reported apply, even if the occurrence took place earlier and the limits were then lower. In the above example, if the consultant had carried \$50,000 of claims-made coverage in 1970, and gradually increased his limits over the years in pace with changes in the environment, then his 1970 occurrence would probably be covered by adequate limits.

Considerations for the Individual Consultant

For those consultants in solo practice, the discussion included in October's article should prove generally accurate without further elaboration. Today, however, many consultants practice in firms of two or more, and there is increasing mobility between firms and practice settings. These consultants need to be aware of some special issues affecting their coverage for professional liability claims.

In all professional liability policies, the named insured is the firm. In the case of a sole practitioner, of course, the firm and the consultant are identical. With two or more consultants, however, the case is different. It is the firm which holds the rights and duties of the named insured under the policy, with respect to such matters as payment of premium, giving and receiving notices and exercising various options which may be available. Thus, while individual consultants may be protected under the policy, many of them know little about it because the matter is handled by others at the firm. Thus, consultants often have little idea who, if anyone, is providing their professional liability coverage, either currently or for prior acts, nor do they understand the scope of protection being afforded to them personally.

Regardless of the practice setting and any contemplated changes, take the time to know what professional liability coverage exists to protect you and your firm against claims. The following checklist may assist in better understanding these issues and avoiding unintended gaps or deficiencies in coverage:

- * Try to recreate for your personal records a "Personal Insurance History" going back to the day you began private practice.
- * If you are leaving one firm either to join another, or go into sole practice, request a copy of the old firm's current professional liability policy, as well as a summary of prior coverage while you were there. This will provide you with basic information you will need to obtain insurance on your own, as well as the ability to avoid gaps in coverage as you continue your practice elsewhere.
- * If you are joining a new firm, be sure to determine the scope of prior acts coverage being afforded to you, and satisfy yourself that, when taken together with prior and continuing coverage from your old firm, the new firm's policy provides you with continuous protection for your entire practice. Generally, so long as your old firm continuously renews claims-made coverage, its policy would respond to claims against you based on your practice there. However, in some cases your new firm's policy may

also provide you with prior acts coverage – an important consideration if our old firm should disband or merge into another without obtaining adequate tail coverage, or without notifying you of the change. There are also cases where your prior firm's tail coverage only applies to former members of the firm who are no longer engaged in private practice, not covering those who leave for another firm or to start their own practice.

- * If your firm is dissolving, and there is no clear successor firm, investigate the available options for tail coverage, since you may find limited availability of prior acts coverage regardless of whether you establish your own practice or join another firm. One advantage of obtaining tail coverage is that your future practice (if you are establishing one) would normally be covered under a first-year claims-made rate, which will be much lower than the premium you would have to pay if your new insurance had to cover prior acts. One possible drawback is that the tail coverage for the dissolving firm may only provide a limited additional period of time to report claims arising from the dissolved firm's practice. The available policies vary in how much additional time they will offer, how much you have to pay for various time periods (although in some cases the policy does not guarantee the price for tail coverage), and what you must do to exercise your tail coverage options.

When purchasing or renewing a policy for yourself or your firm, it is important to provide the carrier with all the relevant information to help them give you the best pricing possible. Keep in mind:

- * A complete Claim history is important. Reporting potential matters and claims to your carrier in a timely manner not only protects your coverage rights; it provides the carrier with the information needed to help you manage the situation. And it is not true that turning in a potential claim will automatically increase your insurance rates. A main function of the underwriter is to determine what situations are valid and which ones may only be nuisance cases. Obviously if there is a pattern within a firm's potential claims an underwriter may choose to recommend risk control procedures or take rating action.
- * Provide information on your internal systems and processes. Even if you have provided this information on past applications, let the carrier know what improvements you have made. For an underwriter, knowing a firm's internal procedures can make a definite impact on how the overall risk is viewed.

Retirement

Special considerations exist for professionals who are retiring from practice, or entirely ceasing private practice due to health considerations, to pursue another occupation or for other reasons. Although no longer actively practicing, such professionals do need continuing insurance protection for claims that may be asserted after retirement based on occurrences while still in private practice.

For professionals retiring or withdrawing from a firm that continues to carry professional liability insurance for the ongoing practice, coverage is usually afforded automatically under the policy of the firm, so long as it continues to be renewed. Even if the firm switches carriers, the retired professional is usually covered so long as the new carrier is providing prior acts coverage. The retired professional shares in the coverage afforded the firm with respect to limits of liability and deductibles.

Such an arrangement is often satisfactory where the continuing firm is stable and well established, and can clearly afford to continue carrying coverage. The retiring professional should, however, consider the following factors:

- * What is the likelihood that the firm would ever discontinue carrying professional liability insurance?
- * If the firm no longer carried a policy protecting the retired professional, would other sources of coverage be available?
- * Does the firm's policy provide retiring professionals the option to purchase on an individual basis an extended reporting period endorsement? (Some policies do provide this option, which would continue the coverage as to the retired professional regardless of the firm's discontinuance of the policy.)

Practice Management and Claim Prevention

The experience of the insurance industry with the modern claims-made policy for professional liability insurance since the 1970s has been positively affected by the efforts of numerous professional groups to educate their members in claim prevention and risk management. Although there is no way to measure the number of claims that were not made as a result of such efforts, there is ample statistical support for these basic conclusions:

- * by altering their patterns of behavior in professional practice settings, professionals can reduce the likelihood that a claim will be made against them for professional negligence;
- * the methodology for pricing claims-made insurance coverage permits the insurer to recognize savings from claim prevention earlier than if the insurer were writing occurrence coverage, and many insurers have exhibited a pattern of passing through much of the savings to their insureds in order to be competitive.

Claim prevention requires an organized, structured effort to adapt procedures and patterns of practice to the perceived likelihood of claims that could result from the particular area under discussion. The following is a brief summary of major areas of interest and attention in a risk management program.

Substantive competence

When professionals fail to keep up with current developments in their areas of practice or accept engagements which require expertise or levels of commitment of time, personnel and administrative support beyond the capabilities of their offices, claims are more likely to occur.

Time management

Every business and professional practice must manage time and deadlines. Poor time management practices also lead to stress and disorganization within the office, which enhance the risk of claims of all types. The essential objectives of a good time control system include (1) centralization, to make sure that all key dates and events are entered, (2) redundancy, to make sure there is a "fail-safe" backup to alert responsible professionals even in the absence of regular personnel, (3) cross-checking on a regular, frequent basis, to be sure that all calendars reflect the same dates and events, and (4) follow-up, to be sure that all dates, and events are actually communicated to the responsible professional(s) as intended.

Widespread availability of inexpensive personal computers and software for time management makes it more feasible, and thus more important, for the office to develop and maintain time control systems.

Ethical considerations

Effective procedures to identify and avoid conflicts and other ethical problems can prevent claims. Many professional groups provide their members with a toll free "ethics hotline" from which members can obtain references to authoritative sources dealing with particular ethical issues.

Administrative management

In many ways a sound office management system is the underpinning for claim prevention. Claims are more likely to arise where the practice fails to deal effectively with such seemingly mundane matters as handling of mail and telephones, filing and record keeping. Sound administrative management systems and procedures are also key to effectively dealing with other critical risk management issues such as time management and avoidance of conflicts.

Financial management

Numerous claims arise because the firm does not properly manage its receipts and disbursements, or adequately account for them. Fee disputes with clients are a particularly fertile source of claims, and one of the best ways to avoid such claims is to avoid having large outstanding receivables. Doing so requires effective time keeping and billing procedures, as well as regular and prompt attention to overdue items by a responsible person within the firm.

Professional education and development

Proper selection, training, supervision and continuing education of both professional and non-professional personnel can help to avoid claims. The professional's emphasis should

not be merely on meeting the minimum requirements, but on developing and maintaining knowledge and skills that will support high quality services for clients.

Assistance programs

Professionals with personal difficulties such as stress, financial, family or substance abuse problems, are more likely to engage in behavior that leads to claims, whether by neglect of professional matters or errors in judgment resulting from preoccupation with personal issues.

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