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CHANGING CLAIMS-MADE INSURERS: IT'S MORE THAN THE RETROACTIVE DATE

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Our clients and prospects tell us that they are concerned about potential gaps in coverage if they change from one insurer to another. Although the fear is justified, steps can be taken to mitigate the risks and protect your corporate assets during a change in insurers.

The following examples have occurred during actual changes. The use of specific insurers' policy wordings throughout this discussion is not intended to disparage any insurer but only to serve as an example. Other insurers use the same or similar wording.

EXAMPLE ONE

A behavioral health facility that provided substance abuse and mental health counseling on an inpatient basis, discharged a patient with appropriate outpatient counseling arranged following his discharge. Several weeks later an employee of the facility read in the local newspaper that the former patient had committed suicide by jumping from a bridge. The facility reported the incident to their current insurer (Admiral), although no claim was made during the policy term.

At the next renewal, the facility's broker sought alternative quotations and obtained one from The Philadelphia Insurance Company that included a lower premium as well as more advantageous terms and conditions. The broker was careful to ensure that the Philadelphia quotation included the same Retroactive Date used by Admiral.

The Philadelphia policy, however, contained an exclusion for known prior acts. This exclusion did not appear to be a problem, since the insured had been diligent in reporting incidents to Admiral.

Two years later the family of the deceased former patient filed suit alleging that the facility should have monitored the patient after his discharge and, therefore, failed to render adequate care.

The incident was reported to Philadelphia, who denied the claim based upon its Known Prior Acts exclusion. The position was difficult to argue, since the insured did know of the incident and had reported it to Admiral.

Admiral also denied the claim since their policy did not contain an Incident Reporting provision and was triggered only by claims actually made against the insured and reported to Admiral during their policy term.

Admiral's claim trigger was:

> "We will pay on behalf of the 'Insured' those amounts...which you are legally obligated to pay as 'damages' for a 'claim' first made against you during the 'policy period' and reported to us in writing during the 'policy period', or an Extended Reporting Period..."[1]

EXAMPLE TWO

A risk manager of a health plan has a primary professional liability policy written with a claims made and reported coverage trigger; the coverage will likely be changing to a different insurer at renewal. The risk manager began the tedious, but necessary, process of analyzing the claim and incident data for purposes of compiling a loss run or "laundry list" to report.

The fundamental question for this risk manager is what exactly should – or should not – be submitted under the expiring "claims made and reported" policy to (a) maximize coverage under the expiring and new policies and (b) minimize coverage gaps created when moving to a new carrier?

During the risk manager's review, she learned of a subpoena received 18 months earlier that she now thought could be a candidate for reporting. The subpoena came from a regulator seeking information about an industry marketing practice in which the health plan did not engage. After the health plan's prompt response to the regulator, nothing further was heard. The risk manager did not believe the subject of the subpoena would turn into a claim against the health plan.

THE DIFFERENCE BETWEEN OCCURRENCE, CLAIMS-MADE AND CLAIMS MADE AND REPORTED COVERAGE TRIGGERS

Before the malpractice crisis in the mid-1970s, medical professional liability policies were written on an occurrence basis, meaning the wrongful act, occurrence or medical incident (hereafter just referred to as a wrongful act) had *to occur during the policy period, but could be reported to the carrier at any time, even long after the policy expired.* The duty to report a claim under occurrence forms was and typically still is "as soon as practicable," "immediately" or "promptly" (hereafter referred to as "as soon as practicable"). But the insuring agreement does not provide guidance as to when the claim must be reported. A few insurers continue to offer policies with an occurrence coverage trigger; e.g., Medical Protective and ProMutual.

To better and more promptly assess its liabilities for each specific policy year it wrote insurance, St. Paul rocked the malpractice world in 1976 by moving its medical professional liability forms from occurrence coverage to a claims-made basis. This meant that a claim needed to arise from a covered incident or wrongful act committed after the policy's inception date (or its retroactive date if a "start" date other than the policy inception date

had been negotiated), and *made against the insured during the policy period.* The date the claim was made against the insured determined which policy applied. In practice, so long as an insured maintained a continuous coverage relationship and the same retroactive date with an insurance company, the insured had leeway in terms of which reporting period was "as soon as practicable" after the claim was made. A few insurers still offer "pure claims-made" coverage triggers.

By early 2000, insurers using a claims-made coverage trigger sought further certainty in determining their policy period liabilities and tightened the timeline further for claim reporting. The new policy prevailing today is the "claims made and reported form." This new language means that a claim must:

- Arise from a covered wrongful act committed after the policy's retroactive date
- Be made against the insured during the policy period
- Be *reported to the insurer during that same policy period (or on some policies within a specified 30-90 day grace period after policy period expiration)*

Some policies (mostly those from the London and Bermuda insurers) require an annual bordereau (listing of all claims and potential claims made and reported within a policy period) be delivered within the grace period. This bordereau then becomes the definitive claims made and reported list under that policy.

CLAIMS-MADE TO OCCURRENCE

We all understand that changing insurers from a policy with a claims-made or claims made and reported coverage trigger to a policy with an occurrence trigger can leave a gap in coverage unless precautions are taken to provide coverage for the Incurred But Not Reported claims. The insured must either:

- Purchase an Extended Reporting Period (Tail) from the prior claims-made insurer or
- Negotiate with the new (occurrence) insurer to provide coverage for the claims that occurred prior to their policy period but are made within their policy period (Nose)

Less well known are the potential consequences of changing from one claims-made insurer to another.

CLAIMS-MADE TO CLAIMS-MADE

Many policies with a claims-made or claims made and reported coverage trigger, and especially those that provide professional liability for health care providers, contain a retroactive date. It is important to remember that a retroactive date functions as an exclusion. It excludes coverage for an incident that occurred prior to the retroactive date.

When changing from one claims-made policy to another, there are two options for preventing a gap in coverage for the Incurred But Not Reported incidents:

- The new insurer can agree to honor the same retroactive date as the prior coverage (Nose Coverage)
- The insured must purchase a Tail (Extended Reporting Period) from the prior insurer

Purchasing a Tail is a very costly alternative, since Tail coverage is frequently 200% or more of the last annual premium.

In addition, some insurers do not allow an insured to purchase a Tail if the insured voluntarily changes from one insurer to another. On some policies a Tail may be purchased only when the insurer cancels or non-renews the coverage (Unilateral Election). When purchasing claims-made coverage it is important to determine whether the option to purchase Tail coverage is unilateral (available only if the insurer cancels or non-renews) or bilateral (available if either the insured or the insurer cancels or non-renews). Bilateral election provisions are clearly preferable.

Finally, many insurers offer only a limited Tail of one, two or three years. Unless an unlimited Tail is available, there may still be potential uncovered incidents if the claim is made after the Tail expires.

KNOWN PRIOR ACTS EXCLUSIONS

It is not sufficient to simply purchase the same retroactive date from the new insurer, since most health care professional liability policies contain an exclusion for Known Prior Acts.

A typical Known Prior Acts Exclusion is:

> "This insurance does not apply to any **medical incident, claim** or **suit** arising out of:
> A. Prior Acts
> Acts, errors or omissions of which an **Insured** had knowledge prior to the inception date of the policy period, or if, as of such date, an **Insured** could reasonably foresee a **claim** might result."[2]

An alternative example not only excludes incidents that the insured actually knows about but also those that they "should have" known, which is a much broader exclusion:

> "Prior Known Acts
> Any 'Claim' based upon, arising out of or relating to any 'Medical Incident' that was known or should have been known by an Insured, or was first reported to any insurer, prior to the effective date of the 'policy period.'"[3]

If the insured knew of an incident, but no claim was made until the policy period that contains such an exclusion, there will be no coverage available from the new insurer.[4]

In the managed care E&O universe, a more problematic version of the prior acts exclusion (because it is not restricted to knowledge of proceedings brought against the insured) reads:

> C.8. "based upon, arising out of, resulting from, or in any way involving any fact, circumstance, situation, transaction, event, **Wrongful Act** or series of facts, circumstances, situations, transactions, events or **Wrongful Acts:**
> (a) underlying or alleged in *any* litigation or administrative or regulatory proceeding brought prior to and/or pending as of the [Initial] Inception Date stated in ITEM 2(a) of the Declarations:
> ... (ii) with respect to which any **Insured,** as of the Inception Date, *knew or should reasonably have known* that an **Insured** would be made a party thereto;" [italics supplied][5]

INCIDENT REPORTING TRIGGER

The solution to this problem is to report the incident to the prior insurer before the policy expires. This is commonly called "Laundry Listing" and it is important that sufficient time be allowed to research any prior incidents and report them to the insurer before the policy expires. However, this requires that the notice of an incident to the prior insurer will trigger their coverage. This is commonly called an Incident Reporting Trigger.

An example of an incident reporting trigger is:

> "D. Duties in the Event Of A **Claim, Suit,** or **Medical Incident**
> 1. If during the **policy period,** the **First Named Insured** shall become aware of any **medical incident** which may reasonably be expected to give rise to a **claim** being made against any insured, the **First named Insured** must notify us in writing as soon as practicable...
> Any **claim** arising out of such **medical incident** which is subsequently made against any **Insured** and reported to **us,** shall be considered first made at the time such notice was given to **us.**
> Receipt by **us** of an incident report, including but not limited to variance reports, will not be considered a claim to **us.**"[6]

Not all claims-made policies have such a trigger and changing to a new insurer poses a particular problem when the current insurer does not allow for reporting of incidents.

An Anti-Laundry Listing exclusion has now appeared on at least one insurer's policy, although the policy allows for incident reporting. Such exclusions should be avoided.

DEFINITION OF AN INCIDENT AND A CLAIM

Broadly speaking, an expiring professional liability policy will 1) define what is reportable as a claim or potential claim and 2) require the claim or potential claim to be reported in the same policy period it is asserted against the insured. The proposed policy will work to exclude "burning buildings" that are not yet claims. We find that even with subtle differences, health plan and hospital professional liability forms yield similar reporting recommendations.

In Example Two above, a typical definition from a managed care professional liability policy is as follows:

> "... **Claim** means a written communication received by an Named Insured's Risk Management or Legal Department seeking damages or other civil, administrative or injunctive relief, or threatening suit or arbitration, including service of suit or institution of arbitration proceedings;"[7]

The subpoena doesn't fit into the definition of claim—it seeks information, not damages or other relief, and it doesn't threaten suit.

A typical definition of a potential claim on a managed care liability form is:

> "If, during the effective period of the Policy or any Extended Reporting Period, you become aware of any act, error or omission that may be reasonably likely to give rise to a **Claim** for which coverage may be afforded under this Policy, and if you immediately give us written notice of (1) the specific act, error or omission, (2) the resulting damages, if known, (3) how, when, and where the act, error, or omission took place and (4) the names and addresses of all known participants and available witnesses, then any **Claim** that may subsequently be made arising out of that act, error or omission will be deemed to have been made on the last day of the effective period of the Policy; provided, however, that the act, error or omission must have occurred after the Retroactive Date stated in the Declarations and before the termination of this Policy."[8]

Is the subpoena a potential claim? Does the subpoena allege an act, error or omission reasonably likely to become a claim? No, because it sought information regarding an industry practice in which the health plan did not engage, and the length of time elapsed since its initial response without regulatory follow-up suggests it is not a target.

Is there enough detail about the potential claim (as defined in the policy) to be confident the current insurer will not deny for lack of specificity?

TIME FOR REPORTING AN INCIDENT OR POTENTIAL CLAIM

Most claims-made professional liability forms require that potential claims or incidents be reported within the policy term in which the insured first becomes aware of the incident. Incidents cannot be reported within a subsequent term nor within the Extended Reporting Period (ERP or Tail), if one is purchased.

In the example of the subpoena received by the health plan, the reporting period may not be open if the health plan learned about the potential claim before the last renewal, but didn't disclose it during last year's policy period.

If it's a potential claim the health plan did not disclose before the renewal because it didn't think it would turn into anything, the bad news is that courts tend to enforce the claims made and reported language condition, only requiring occurrence-triggered insurers to show that their interests were prejudiced by late reporting.

Under most policy forms, potential claims can only be reported in the policy term in which they first become known. The next opportunity to report a potential claim is when it is actually asserted by the claimant – if the Known Prior Acts exclusion does not prohibit coverage. A review of the potential claim definition is important; e.g., the Lexington 0109 language above says "and if you *immediately* [emphasis supplied] give us written notice..."

Does the subpoena involve a wrongful act that the insured knew or should reasonably have known that it would be made a party to? Here is the treacherous ground: would a reasonable person predict that the subpoena would turn into a claim? If so, the new carrier has grounds to deny a future claim involving acts which were the focus of the subpoena. This may force reporting of the subpoena to the current carrier and risk the denial of the report of circumstance for lack of enough specificity, and even more likely, denying the report as too late – not reported during the policy year it was received.

AVOIDING THE PROBLEM

It is necessary to allow sufficient time for the following review when considering a change from one claims-made insurer to another. Changing claims-made insurers is not recommended when quotations are received the day before the renewal. There is simply not sufficient time to review the quotations and to "Laundry List" the prior insurer if necessary.

Be clear in your claim reporting protocol that today's professional liability policies are written on a claims made and reported basis. This means that both claims and potential claims (to the extent you opt to report potential claims) must be reported in the same policy year that the claim or potential claim becomes known to you.

- Plan in advance and specify that all underwriters provide quotations in sufficient time to analyze the differences in the quotations.

- Always make sure to receive a detailed written proposal which includes a specimen copy of the policy form as well as the full text of all quoted endorsements.

- Make sure that the quotation from the new insurer uses the same retroactive date as the prior coverage.

- Determine if the new insurer has a Known Prior Acts exclusion.

- If a Known Prior Acts exclusion exists, add an Amended Notice of Loss provision specifying that the insured will be construed to have notice of an incident only when it is received by the risk manager, general counsel or executive officer. The more limited the Amended Notice of Loss, the more advantageous it is.
  - The best Amended Notice of Loss specifies a single individual or position and limits their knowledge to incidents that they knew would give rise to a claim. If possible, do not agree to prior acts exclusionary language that contains a subjective standard for reporting: delete *"reasonably believed"* in favor of *"knew would give rise to a claim."*

- Become conversant with the Tail or Extended Reporting Provisions of the expiring policy.
  - Determine if you have the right to purchase a Tail (Extended Reporting Endorsement), if necessary. Are the election provisions for the Extended Reporting Provisions unilateral or bilateral?
  - What is the cost of the Tail?
  - What is the duration of the Tail?

- Receive the quotations with sufficient time to "Laundry List" the current insurer.

- Discuss with your brokerage team and third-party administrator (if applicable) any known incidents and determine whether or not the incidents have been reported to the expiring insurer.

- Review the expiring coverage to determine if the policy has an incident reporting trigger.

- If the policy has an incident reporting trigger, report all known incidents to the current insurer prior to the expiration of the policy. Reporting should be done in a fashion that will guarantee that the report:
  - Reaches the insurer prior to the expiration date and time
  - The method of transmission generates a receipt, such as certified mail, Federal Express tracking receipt, etc.

- If a known incident lacks adequate specificity to report as a potential claim or does not meet the definition of a potential claim, discuss the incident with the new insurer. A new insurer may be more flexible in order to obtain a new

piece of business. If, once you've disclosed the potential claim to the new insurer, the underwriter wants to attach a subjectivity to the quotation requiring the potential claim be reported to the expiring carrier, try to secure the new carrier's agreement as follows:
  - If the expiring insurer rejects the potential claim for lack of specificity, the new carrier will accept the potential claim report
  - Not exclude as "previously reported to another carrier"

If the expiring policy does not contain an incident reporting trigger and the client knows of incidents that may give rise to a claim in the future, you should explore three alternatives:

1. Extended reporting period purchase from the expiring carrier
2. Reporting of known potential claims to the new carrier
3. Not changing insurers, and concurrently providing a clear explanation to your corporate management regarding why changing insurers may result in an uninsured claim

SUMMARY

There are six interrelated policy provisions that must be carefully reviewed before changing from one claims-made policy to another.

- Known Prior Acts Exclusion
- Amended Notice of Loss
- Potential Claim Reporting Provision
- Retroactive Date
- Definition of a claim and/or potential claim
- Extended Reporting Provisions

It is not sufficient to simply arrange for the new insurer to pick up the same retroactive date as the prior insurer. All provisions must be carefully reviewed to ensure that there will be no gap in coverage.

Your Willis brokerage team is available to review each of these items with you and to act as your advisor through the transition from one insurer to another. We will provide the knowledge expertise to make the transition smoothly.

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[1] Admiral Insurance Company, Medical Professional Liability Insurance – Claims Made [EO 09 55 07 04]

[2] Lexington Insurance Company, Healthcare Professional Liability Claims Made Coverage Part [79225 (07/03)]

[3] Steadfast Insurance Company, Health Care Umbrella Liability Policy, Health Care Professional Liability – Claims Made [U-HCU-703-A CW (04/03)]

[4] Special note should be made of the unqualified word "Insured" in both exclusions. Employees are "Insureds" under most health care professional liability policies. Therefore, if a nurse knew of a medical incident but did not report it, there may be no coverage. Adding Amended Notice of Loss Wording is always advisable.

[5] Darwin Managed Care Professional Liability Claims Made H1000 62005

[6] Lexington Insurance Company, Healthcare Professional Liability Claims Made Coverage Part [79225 (07/03)]

[7] Lexington Insurance Company, Managed Care Errors & Omissions Claims Made Coverage Part 95230 0109

[8] Ibid