Become a Savvy Policyholder

By Kathryn Vanden Berk

SCENARIO: *You have just been handed a Summons and Complaint. It comes from an incident that occurred five years ago with a kid in foster care and a not-so-good employee who failed to monitor a suspicious family member. When the incident occurred you remember thinking that it would probably result in a lawsuit. Now it has come to pass.* ¶ *You know that you have to report the claim, but you've switched insurers twice since then in an effort to keep insurance premiums affordable for the agency, and you have no recollection of how the contracts were negotiated. Which of the three companies will defend it? The last thing you want is a protracted fight with your insurance company over the claim itself. You want to get this behind you. What do you do?*

Insurance is an area of high anxiety for most agency executives. No matter how well the organization is run, there are risks that no amount of preventive action will entirely eliminate. Mark Twain once said, "A loan is an umbrella that your banker is happy to give you on a bright sunny day, and then ask for it back the minute it rains." Unfortunately, insurance can be like that too.

Insurance Is a Contract

Insurance is a strange industry. You must rely on a company in some far-off city to come to your aid when things go wrong. You pay it enormous premiums and all that you get in return is a legal contract that goes into a file and is forgotten. You won't really know whether that contract is any good until you present the company that wrote it with a claim. If you've placed your bet on the wrong company or the wrong policy, you may find your agency must self-fund a significant loss exposure.

Courts know this and have developed several legal principles that favor the policyholder. Insurance language is given everyday meaning, so you shouldn't have to be a lawyer in order to understand your policy (policy language has become much more understandable in recent years because of this). Ambiguous words or clauses are interpreted in your favor and against the insurer. If there is a possibility of recovery on any covered claim, your insurer must provide a defense to the entire lawsuit, even if other allegations are not covered by that policy.

On the other hand, insurance companies have learned over the years that they can make big money by building premium volume and denying claims. Adjusters are compensated on the basis of how little they pay, complicated reporting processes confuse the claimant, and claims processors often lose files and demand repeated submissions of the same paperwork. In short, the barriers to payment can defeat all but the most persistent consumers.

This has given rise to a new legal subspecialty of lawyers who sue insurance companies that deny legitimate claims.

A lawyer who has spent his life battling insurance companies noted, "Remember that bad insurance companies drive good insurance companies out of business. The winner of the race to the bottom makes the most money. Professional and honorable insurance companies cannot compete with charlatans, so they are forced to become charlatans."[1]

What can you do? There isn't much you can do about the industry. The best you can do is become an educated buyer of its products.

Know Your Policy

There are two types of insurance policies: those that pay on an "occurrence" basis and those that pay on a "claims made and reported" basis. Most *general liability policies* are written on an *occurrence* basis so it is relatively easy to match a claim to the policy that covers it. For example, you are hit by a car or you have a fire in one of your buildings. The event that triggers coverage is unambiguous. It can be investigated and objectively measured. If you have made certain that you have continuous policies in effect, even through different insurers, such insurable events should be covered.

However, *professional liability policies* are *claims made and reported* policies. That is, they require "that the claim both be made and reported within the policy term." The claims-made approach to insurance allows for a closer match between premium dollars and claims for incidents that don't arise out of obvious occurrences like fires and auto accidents. Shortly after a policy expires, the insurer can close its books, establish a reserve for unpaid claims, and determine its profit or loss. Under an occurrence policy, especially with agencies that deal with children, the insurer could not determine its profits or losses for decades due to possible but as-yet unreported claims.

Under what is commonly known as a *"prior knowledge" exclusion*, the company will generally exclude coverage for claims

[1] The comment was made by Eugene R. Anderson, founder of Anderson, Kill & Olick, a law firm that exclusively represents policyholders in connection with insurance disputes.

A Word About Directors and Officers (D&O) Insurance

With passage of The Sarbanes-Oxley Act last year, Congress enacted sweeping changes in federal laws that are designed to protect shareholders of *publicly held* corporations from the kinds of shenanigans that led to the downfall of Enron and others. Among other things, it requires public corporations to have audit committees and requires the chief executive and chief financial officers to personally certify each quarterly and annual report when they are made public. It imposes fines and imprisonment for offenders. For example, it penalizes anyone who knowingly destroys or falsifies a document that might be part of an investigation.

Sarbanes-Oxley is certain to have lasting ramifications, and we are learning more about possible applications to the nonprofit sector as time goes on. The most important items to be aware of at this time include:

- Your finance committee must be independent of your auditors. If you don't already have an auditing committee of the board, you should consider creating one. This committee should be the liaison between your organization and its auditors.
- Your chief executive and chief financial officer must be conversant with the contents of your financial statements (and all disclosures that are part of it) when they approve them for distribution. The same goes for the contents of your Form 990 Annual Information Returns. The IRS will most certainly use the principles of personal accountability from Sarbanes-Oxley when and if it challenges them on their understanding of specific statements or disclosures.
- You should amend bylaws to include conflict of interest statements that (1) prohibit loans to executives, directors and/or officers; and (2) clearly delineate the process to be used where a director or officer has an interest in a contract or other transaction with the agency.
- Examine your document retention policies and procedures for financial records. In most cases you should be keeping all financial records at least five years from the issuance of any report upon which they are based. It should be clear in your personnel policies that the unauthorized destruction of financial records is absolutely forbidden.
- Sarbanes-Oxley puts child welfare agencies into uncharted waters from an insurance standpoint. If your D&O premiums have increased, be sure to discuss with your broker the fact that your agency is not publicly held and therefore your risk potential may be significantly lower than the insurer has pegged it to be. At the same time, we must be realistic. The world has changed, and what we are seeing is a fundamental change in accounting practices. What is new and unusual today will be "best practice" tomorrow.

arising prior to the policy period "if, prior to the inception of your first policy with that carrier, you should have reasonably foreseen that such a claim would be made." If you have a "claims made and reported" policy with a "prior knowledge" exclusion, a switch in carriers exposes you to a potential gap in your coverage even if you have maintained continuous policies.

A *"prior acts" exclusion* is common to most professional liability policies. Under such an endorsement, claims arising from an act, error, or omission prior to a specified date are not covered by the policy. This is often worded so that if there is a series of related acts, errors, or omissions, coverage will be denied if the earliest act, error, or omission occurred prior to identified date.

Know How Your Policy Works

If you know how policies work, you can understand why specific policy provisions are needed to avoid gaps in coverage. You can then work with your insurance broker to put together a policy that will provide the best coverage possible for the least amount of premium.

Let me give you an example of how a gap can occur. You receive a claim for an incident that occurred in 2001, but you didn't find out that a reportable claim would arise from it until 2002. You had a claims made and reported policy in 2001 and a similar policy with a different carrier in 2002. Your 2001 insurer could deny coverage because the claim was not first made and reported during its policy period, and the 2002 insurer could deny coverage because you had prior knowledge of a potential claim before its policy kicked in.

How can you prevent this? First, be sure to give notice as you exit a claims made policy of *all significant* occurrences that might result in claims under that clause. Second, purchase "tail" coverage (an extended reporting period endorsement) that will cover future claims within the tail period that are based on acts taking place during the old policy period. Third, negotiate with a new insurer a prior acts date that coincides with the first date you provided services[2] (best case scenario), or if that's not possible and you fear there are gaps in coverage, buy coverage from a separate insurer for claims arising from acts that occurred before the beginning of the policy period.

The worst approach is to ignore an occurrence that may result in a claim, hope that the claim will be resolved or ignored. I have a lawyer colleague who works in the claims department of a huge Chicago-based insurer who warned me with wide eyes. "Be sure to tell them to reveal everything when they're changing insurance!"[3] There, I did.

You might argue that child welfare agencies are susceptible to claims made and reported insurance denials because of the extensive amount of paperwork involved in your licensure, accreditation, and reimbursement processes. From the multitude of incidents that happen in any given year, how can you know which of them might result in a claim years later? The answer is that if you report those potential claims that are significant but miss the one that is actually sued upon, you will have satisfied your obligations under the policy of reporting "material risks." Under most state laws, your insurer will not be able to deny coverage for failure to report this specific claim.

When you review information that could lead to potential claims, use common sense as to which are reportable under your insurance policies. I would report incidents that result in a report to the child abuse hotline by a mandated reporter, incidents that involve angry and/or combative parents or guardians, government inspectors, or placement sources, and incidents that have "front page of the newspaper"[4] potential. You might want to review your incident reporting system with your broker in order to get his/her advice on how best to protect your agency.

Be a Savvy Policyholder

A great deal of preventive action can be taken at the time you renew or change your insurance coverage. Examine your policies (or have an attorney examine them) so you know exactly what coverage you have and what is missing. Be sure you protect your agency if you are changing insurers or brokers.

Finally, assert your rights as a policyholder. If a legitimate claim is denied, demand a reason in writing and compare that reason with policy language or get an attorney to do this for you. Remember that insurance companies are driven by self-interest, and that its interests strongly favor claim denials over payment. You must be an advocate to make certain that you get the benefits of policies that you have purchased. ■

[2] Such coverage under a claims-made policy will cover all acts that occurred before the policy was issued. Others might provide a "limited retroactive window," with a defined retroactive date, meaning that they will provide coverage for situations giving rise to liability occurring on or after a specific date (such as two years prior to the inception date of the policy; or anytime after the first policy with the company went into force, assuming continuous, uninterrupted coverage with the company since that date).

[3] You are obligated under the terms and conditions of your policy to report all incidents of which you are aware to your current carrier. It is imperative that you report all incidents, potential claims, or situations that could reasonably be expected to be basis of a claim immediately or as soon as possible, and certainly prior to your renewal date. Actual claims should be immediately reported to your current insurer. Waiting to report any of the above could jeopardize coverage for these claims.

[4] The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) identifies such incidents as "sentinel events" and gives such examples as infant abductions, medication errors, and suicides.

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